1 AGENDA

Kent and Medway Mental Health NHS Trust

Title of Meeting Trust Board Meeting (Public)
Date 30th July 2026
Time 09.30 to 12.15
Venue Meeting Rooms 2 and 3, Farm Villa, Hermitage Ln, Maidstone ME16 9PH

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/26-27/37	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/26-27/38	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/26-27/39	3.	Personal Experience – My experience within KMMH services, including inpatient rehabilitation	FD	Verbal	DHS	09.35
STANDING ITEMS						
TB/26-27/40	4.	Minutes of the previous meeting	FA	Paper	Chair	09.50
TB/26-27/41	5.	Action Log & Matters Arising	FA	Paper	Chair	
TB/26-27/42	6.	Chair's Report	FN	Paper	CL	09.55
TB/26-27/43	7.	Chief Executive's Report	FN	Paper	SS	10.00
TB/26-27/44	8.	Board Assurance Framework	FA	Paper	JK	10.05
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/26-27/45	9.	Neighbourhood Alliance Progress Report	FD	Paper	SS	10.10
TB/26-27/46	10.	Impact Report	FD	Paper	AR	10.20
SUB-BOARD COMMITTEE REPORTS						
TB/26-27/47	11.	Report from Quality Committee • Including Mortality Report	FD	Paper	SW	10.30
TB/26-27/48	12.	Report from People Committee	FD	Paper	KL	
TB/26-27/49	13.	Report from Mental Health Act Committee	FD	Paper	SBK	
TB/26-27/50	14.	Report from Finance, Business and Investment Committee	FD	Paper	MW	
TB/26-27/51	15.	Report from Charitable Funds Committee	FD	Paper	SBK	
TB/26-27/52	16.	Report from CYP / AAED Committee	FD	Paper	SW	
SCHEDULE 10-MINUTE BREAK						
OPERATIONAL ASSURANCE						
TB/26-27/53	17.	Integrated Quality and Performance Report	FD	Paper	SS	10.55
TB/26-27/54	18.	CQC Community Survey	FD	Paper	JK	11.00
TB/26-27/55	19.	Finance Report – Month 3	FN	Paper	NB	11.10
TB/26-27/56	20.	Workforce Deep Dive – Workforce Activity	FD	Paper	ALS	11.20
TB/26-27/57	21.	Freedom to Speak Up Annual Report	FD	Paper	SS	11.35
TB/26-27/58	22.	System Governance and Joint Committee Alignment	FA	Paper	SS	11.45
TB/26-27/59	23.	Governance Improvement Plan	FA	Paper	CL	11.50
CLOSING ITEMS						
TB/26-27/60	24.	Reflection on delivery of the Trust values in reports and discussions			Chair	12.00

TB/26-27/61	25.	Any Other Business • Board Development Programme			Chair	
TB/26-27/62	26.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 24th September 2026					

Members:		
Colin Lynch	CL	Trust Chair
Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Sean Bone-Knell	SBK	Non-Executive Director
Kevin Corrigan	KC	Non-Executive Director
Margaret Dalziel	MD	Non-Executive Director
Dr Julie Hammond	JH	Associate Non-Executive Director
Pam Creaven	PCr	Associate Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Julie Kirby	JK	Acting Chief Nursing Officer
Nick Brown	NB	Chief Finance and Resources Officer
Ali Layne-Smith	ALS	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Kindra Hyttner	KH	Director of Strategy and Engagement
Tony Saroy	TS	Trust Secretary
Lucia Barnes	LB	Interim Deputy Trust Secretary
Daryl Judges	DJ	Deputy Trust Secretary
Julia Hart	JHa	Deputy Director multi-neighbourhoods
Hannah Hulks	HH	Deputy Ward Manager for Rivendell Unit (Personal Story)
Apologies:		
Julius Christmas	JCh	Non-Executive Director

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

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Kent and Medway Mental Health NHS Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.00 on Thursday 28th May 2026
Via MS Teams

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Kim Lowe	KL	Non-Executive Director
	Julius Christmas	JCh	Non-Executive Director
	Kevin Corrigan	KC	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Margaret Dalziel	MD	Non-Executive Director
	Pam Creaven	PC	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Julie Kirby	JK	Acting Chief Nursing Officer
	Ali Layne-Smith	ALS	Interim Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Colin Lynch	CL	Designate Joint Chair KCHFT and KMMH
	Kindra Hyttner	KH	Director of Strategy and Engagement
	Daryl Judges	DJ	Deputy Trust Secretary
	Julia Hart	JHa	Acting Programme Director, Kent & Medway Provider Collaborative
	Ben Francis	BF	Head of Improvement
	Rachel Daly	RD	Consultant Psychiatrist and Director of Medical Education
	Vicky Fernandez	VF	Ward Manager (Continuous Improvement Story)
	Andrew Simmons	AS	Lived Experience (Personal Story)
	The Board was joined by members of the public and members of staff.		
Apologies:			
	Tony Saroy	TS	Trust Secretary
	Dr Julie Hammond	JH	Associate Non-Executive Director

Item	Subject	Action
TB/26-27/1	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and noted the apologies which had been received. All written reports were taken as read. The Chair welcomed Margaret Dalziel, Non-Executive Director and Colin Lynch, Designate Joint Chair KCHFT and KMMH to their first meeting.	
TB/26-27/2	**Declarations of Interest** No interests were declared.	
TB/26-27/3	**Personal Experience – The Acute ward and its patient's journey**	

Item	Subject	Action
	The Board received a patient experience presentation detailing an acute episode of mental illness characterised by rapid deterioration and suicidal behaviour, followed by a prolonged inpatient stay during which recovery was supported through a comprehensive multidisciplinary approach. The patient emphasised the importance of structured activity and therapeutic engagement in supporting recovery, alongside the positive impact of coordinated inpatient care, leading to a successful discharge with ongoing support from community services. Board discussion reinforced the need to strengthen patient-centred care and therapeutic relationships, improve early identification of deterioration, and enhance discharge pathways to ensure greater continuity between inpatient and community teams, including a review of post-discharge medication and follow-up processes. **Action: By July 2026, AQ to review post discharge medication and follow-up processes, to ensure continuity of care and sufficient reviews.** The Board thanked Andrew and **noted** the Personal Experience Story.	
TB/26-27/4	**Continuous Improvement Story – Physical Health Monitoring – For Newly Prescribed Anti-Psychotics** The Board received a presentation outlining improvements to ward-round processes through the introduction of a structured weekly ward-round timetable, supported by visual management tools, alongside processes to ensure the involvement of families and carers. The Board recognised a range of reported benefits, including improved patient understanding and preparedness, increased engagement from carers, and enhanced staff efficiency and time management. A reduction in complaints and incidents was also noted, together with positive feedback from both patients and staff, with 80% of patients reporting an improved experience and all staff expressing a preference for the new system. In discussion, the Chair emphasised the importance of scaling successful improvements across the Trust and noted that as part of the impact report to the July 2026 Board an evaluation of the past year's continuous improvement stories would be provided. The Board **noted** the Continuous Improvement Story.	
TB/26-27/5	**Minutes of the previous meeting** The Board **approved** the minutes of the meeting held in March 2026 subject to addition of Stephen Waring, Non-Executive Director, to the attendance list.	
TB/26-27/6	**Action Log & Matters Arising** The Board reviewed the action log and confirmed that all actions should be closed, with the following exceptions: • TB/25-26/128 – "Provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis" should remain	

Item	Subject	Action
	open and will be addressed as part of the refined Integrated Quality and Performance Report in July 2026 • TB/25-26/125 – "Present a 'broader health inequalities' update for the Board" should be deferred until September 2026. • TB/25-26/127 – "Finalise the NED Visit Insight Framework" should remain open as a further update will be provided in July 2026.	
TB/26-27/7	**Chair's Report** The Chair informed the Board that it had been their honour and privilege to Chair the Trust and commended the culture of the organisation. The Board **noted** the Chair's Report.	
TB/26-27/8	**Chief Executive's Report** The Chief Executive presented key updates, including: 1) Participation in NHS England review and government mental health strategy consultation 2) Development of Kent and Medway system architecture, including Provider Alliance arrangements 3) Positive initial feedback from CQC Well-Led inspection, noting strengths in leadership and improvement trajectory The Board noted the effective transition of Children's and Young People and All Age Eating Disorder Services to the Trust. Board members then highlighted the impact of changes to the national system architecture and potential impact on Chief Executives. The Board **noted** the Chief Executive's Report.	
TB/26-27/9	**Board Assurance Framework (BAF)** The Board received the updated Board Assurance Framework, noting: • The transition to a redesigned BAF, with the intention for a draft to be considered in July 2026, with a finalised version to be embedded in September 2026. • Several risks had been revised in advance of the transition to the redesigned BAF Discussions primarily focused on the further enhancements required to the BAF as part of the redesign process, including: ▪ Consideration of the inclusion of a specific risk associated with insufficient co-creation of services ▪ Strengthening alignment to the new strategy ▪ Improving clarity on risk trajectory, timeframes and milestones ▪ Alignment with national priorities and prevention agenda The Board suggested it would be beneficial for a Board Seminar session to be held on the redesign of the BAF, to ensure that the final version met the requirements of the Board.	

Item	Subject	Action
	Action: By July 2026, JK to liaise with Trust Secretariat regarding the scheduling of a Board Seminar session on the redesign of the Board Assurance Framework. The BAF was **approved**.	
TB/26-27/10	**Sustainable Communities Provider Collaborative Progress Report** The Board noted the continued transition toward neighbourhood-based system working, with ongoing delivery across key programmes. With the shift in focus to neighbourhood development, the Board highlighted the need to maintain strong assurance reporting at Board level in relation to urgent care performance, memory services, and delivery of the Community Mental Health Framework. Additional challenges were identified in relation to data reliability, particularly regarding increases in ambulance and police conveyances, and the Board recognised the need for greater clarity to understand underlying drivers. The Board also noted delays in the development of crisis house provision, attributed to estate-related constraints, which continued to impact progress within urgent and emergency care pathways. The Board emphasised the importance of integrating system-level metrics into Trust reporting, to provide a more comprehensive view of performance and risk. Members further stressed the need for improved triangulation of data across system partners, to strengthen assurance and support more effective oversight of system-wide delivery The Board noted delays in delivery milestones, emphasising the importance of providing revised timelines with clear narrative explanation in future reports. **Action: By July 2026, JH to ensure that future Sustainable Communities Provider Collaborative Progress Reports include revised timelines and narrative explanation for those milestones where delivery was 'off-track'.** The Board **noted** the Sustainable Communities Provider Collaborative Progress Report.	
TB/26-27/11	**Scope of Clinical Plan** The Board noted that phase one of the Clinical Strategic Plan was structured around core themes of prevention, continuity of care, pathway simplification, and workforce and digital enablement, with a clear ambition to shift the organisation toward more proactive, integrated models of care. In discussion, the Board emphasised the importance of ensuring that the developing plan remained focused and deliverable, noting the risk of overly broad scope. Members highlighted the need for clear prioritisation, alignment with the Integrated Quality and Performance Report (IQPR) and current operational challenges, and robust governance and oversight arrangements to support delivery.	

Item	Subject	Action
	The Board also reflected on the implications for workforce capacity and organisational capability, and stressed the importance of maintaining strong clinical engagement throughout the next phase of development. In addition, members explored a number of strategic tensions, including the balance between episodic and continuous models of care. The Board was informed that there had been strong clinical engagement to date in shaping the plan. It was emphasised that the next phase would focus on prioritising a small number of high-impact initiatives, supported by a clear delivery framework, and that the intent was to pursue radical transformation, rather than incremental change. The Board **noted** the Scope of Clinical Plan	
TB/26-27/12	**Integrated Quality and Performance Report (IQPR)** The Board acknowledged the on-going development of a revised IQPR, supported by the introduction of clearer performance measures aligned to breakthrough objectives, including: • Four-week access to assessment and 18-week access to intervention as core measures for the Community Mental Health Framework; • A focused objective to eliminate patients waiting over 38 weeks, with a target trajectory aligned to prior improvement methodologies; • Enhanced reporting on corridor care in East Kent and associated system pressures Discussions focused on the temporary reduction in routine eating disorder activity, attributed to workforce availability, with assurance provided that urgent referrals continued to be met in full. The Board recognised the areas of positive performance which included the achievement of 100% compliance for place of safety detention within 24 hours; and strong performance in early intervention in psychosis. The Board sought clarification regarding the rational for the significant increase in the “perinatal assessments (against annual target)” performance between March 2026 and April 2026. **Action: By July 2026, DHS to provide clarification regarding the increase in the “perinatal assessments (against annual target)” metric in April 2026.** The Board suggested that greater ambition was required beyond the April 2027 timeframe for the 344 patients waiting over 38 weeks for community services. The challenge was accepted. In relation to workforce productivity metrics, the Board raised concerns regarding the effectiveness of the current measure relating to senior clinical contact, particularly given the need for highly qualified staff to support work with the most complex patients. It was confirmed that this metric will be revised to focus on delivery against agreed job plans, with improved reporting of compliance. The Board **noted** the IQPR.	
TB/26-27/13	**Finance Report – Month 1**	

Item	Subject	Action
	The Board received the month 1 finance report, noting: • That the apparent increases in workforce levels were largely attributable to the transfer of Child and Young People (CYP) services, with underlying staffing broadly static; • The centrality of workforce costs, representing approximately 75% of the cost base, as a key driver of financial performance; • Ongoing challenges relating to agency expenditure, particularly within CYP medical staffing In discussion, Board Members queried whether alternative methodologies should be adopted for the presentation of the data, rather than the current point and absolute based reporting which was adopted by the Trust. The Board suggested the adoption of ratios or pay trends, which would be minimise the distortion resultant from CYP data. **Action: By July 2026, NB to explore with MW and KC alternative approaches to the presentation of the Trust's financial data, to first be considered by the Finance, Business and Investment Committee.** The Board **noted** the Finance Report.	
TB/26-27/14	**Workforce Deep Dive - Workforce Race Equality Standard and Workforce Disability Equality Standard** The Board was informed that the People Committee had allocated limited assurance to the report due to a number of adverse indicators, including continued disproportionate outcomes in disciplinary processes and recruitment and the limited improvement over recent years, despite a range of interventions. The Board noted the further work required to ensure that interventions were embedded and sustained. It was confirmed that a revised People Plan was being developed, aligned to the Trust Strategy, with a greater degree of prioritisation and focus on measurable impact. Key areas to improve include recruitment practices, disciplinary disproportionality, and career progression for underrepresented groups. Discussions focused on: • The disappointing lack of improvement across key metrics, particularly where the Trust is performing below national averages; • The importance of learning from system partners and external best practice; • The need to prioritise a small number of high-impact interventions The Board emphasised the importance of improving data quality and availability to support targeted interventions. It was highlighted that the Trust being an early adopter of the new ESR programme provided an opportunity to ensure the required data was captured. **Action: By September 2026, AR to explore what support can be provided by the transformation team to improve workforce race and disability data, to enable clear linkage between workforce metrics, analysis and actions.**	

Item	Subject	Action
	Over the proceeding 18-months the Trust had focused on allyship training, violence and aggression, and the utilisation of an external expert to attempt to address the underlying issues. It was expected that progress on the cultural issues would take time; however, the limited progress in relation to race and disability equality highlighted that further work was required, particularly in relation to supporting global majority staff. The Board **noted** the Workforce Deep Dive.	
TB/26-27/15	**Restrictive practice trends deep-dive** The Board received the Restrictive practice trends deep-dive and noted the actions which had been implemented including strengthened oversight arrangements, immediate post-incident learning processes (swarm huddles), and ongoing enhancements to staff training and supervision. Board members highlighted the importance of understanding variation across patient groups and care settings, and emphasised the need to differentiate more clearly between types of restrictive practice and their associated levels of risk. In discussion, the Board emphasised the importance of continuity of care, particularly through the consistent use and transfer of behavioural support plans between community and inpatient settings, recognising this as a key factor in reducing restrictive interventions. Board members also noted the need to strengthen understanding of the underlying drivers of incidents, including whether trends reflect systemic issues or are attributable to individual patient complexity, in order to inform more targeted improvement actions The Board **noted** the restrictive practice trends deep-dive.	
TB/26-27/16	**Safer Staffing Report (aka Nursing Establishment Review)** Discussion centred on the Chief Nurse's identification of the top four key findings and actions, including the associated timeframes for completion of the actions. The Board **noted** the Safer Staffing Report.	
TB/26-27/17	**Governance Improvement Plan** The Board received the Governance Improvement Plan, noting the rationale for its development, and that the plan set out a structured approach to strengthening governance arrangements across the Trust, with a particular focus on improving assurance, oversight, and the effectiveness of decision-making processes. The Board recommended that a future Board Seminar session be dedicated to the Governance Improvement Plan and the underlying approach to the delivery of assurance to the Board and its sub-committees. **Action: By July 2026, Trust Secretariat, JC and SS to discuss the scheduling of a presentation of best practice for delivering assurance to the Board and its sub-committees at a future Board Seminar**	

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Item	Subject	Action
	Board members emphasised that there was a need to ensure equal focus on organisational culture, behaviours, and leadership capability, recognising that these are integral to effective governance. Discussions highlighted the importance of the triangulation of data, particularly through Non-Executive Director and Executive Director visits. The Board **approved** the Governance Improvement Plan	
TB/26-27/18	**Co-creation strategic plan: implementation update** A brief discussion was held regarding the underlying action plan and associated timeline and it was agreed that oversight should be provided by the Quality Committee. **Action: By July 2026, KH to liaise with Trust Secretariat to confirm the scheduling of the underlying action plan for the co-creation strategic plan at the Quality Committee** The Board **noted** the co-creation strategic plan: implementation update.	
TB/26-27/19	**Standing Orders Amendment (CYP & All AED)** The Board **approved** the Standing Orders Amendment.	
TB/26-27/20	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report and **approved** the establishment of the Quality & Patient Safety Assurance Group.	
TB/26-27/21	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/26-27/22	**Report from Mental Health Act Committee** The Board considered a concern raised by the Mental Health Act Committee regarding the Health-Based Place of Safety, which had been assessed as providing limited assurance. The Board was advised that there are no breaches of Mental Health Act requirements and that extended stays were managed safely through appropriate clinical pathways, including reclassification to inpatient status where necessary. The issue was framed as a consequence of operational and system flow challenges, particularly delays in accessing inpatient beds, linked to broader urgent and emergency care pressures. The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/26-27/23	**Report from Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee Chair's report.	

Item	Subject	Action
TB/26-27/24	**Report from Finance, Business and Investment Committee** The Board received and **noted** the Finance, Business and Investment Committee Chair's report.	
TB/26-27/25	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/26-27/26	**Any Other Business** None.	
TB/26-27/27	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board will be held on Thursday 30th July 2026.	

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 21/07/2026

NHS
Kent and Medway Mental Health NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JULY 2026								
29/01/2026	TB/25-26/119	Continuous Improvement Story – Standardising Medication Storage in Allington Centre	Produce a Trust-wide scale-up plan with measurable safety metrics and report it to the Finance, Business and Investment Committee	AR	July 2026		Covered in the impact report. To be closed.	**In progress**
29/01/2026	TB/25-26/128	Integrated Quality and Performance Review	Provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis	JK	March 2026	July 2026	Revised date agreed at the May 2026 Trust Board meeting	**In progress**
29/01/2026	TB/25-26/127	Trust Quality and Safety Agenda	Finalise the NED Visit Insight Framework	TS	May 2026	July 2026	A new system of NED visit feedback will be implemented over the next quarter, with digital submission of NED visit feedback	**In progress**
26/03/2026	TB/25-26/153	Five-year trust strategy 2026-2031	At its June seminar, SS to present the strategic workplan which shows how the strategy will have operational effect.	SS	June 2026		A seminar session on the Trust's Strategic Workplan was held in June 2026. To be closed.	**In progress**
28/05/2026	TB/25-27/3	Personal Experience – The Acute ward and its patient's journey	Review post discharge medication and follow-up processes, to ensure continuity of care and sufficient reviews	AQ	July 2026		This is being picked up as part of work around discharge processes via Acute Directorate. To be closed.	**In progress**
28/05/2026	TB/25-27/9	Board Assurance Framework (BAF)	Liaise with Trust Secretariat regarding the scheduling of a Board Seminar session on the redesign of the Board Assurance Framework	JK	July 2026		A Board seminar has been scheduled for the 6th August 2026. To be closed.	**In progress**
28/05/2026	TB/25-27/10	Sustainable Communities Provider Collaborative Progress Report	Ensure that future Sustainable Communities Provider Collaborative Progress Reports include revised timelines and narrative explanation for those milestones where delivery was 'off-track'	Jha	July 2026		All milestones have been reviewed with revised timelines added, where known and explanations added to exception reporting. To be closed.	**In progress**
28/05/2026	TB/25-27/12	Integrated Quality and Performance Report (IQPR)	Provide clarification regarding the increase in the "perinatal assessments (against annual target)" metric in April 2026	DHS	July 2026		NHSE count when patients have the first face to face or video contact. If they are seen in a subsequent financial year, they are counted again at that point. This is why the in-month figures for April and May are higher than other months, as patients already on the caseload	**In progress**

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Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							receiving their first contact of the new financial year are counted along with new patients. To be closed.	
28/05/2026	TB/25-27/13	Finance Report – Month 1	Explore with MW and KC alternative approaches to the presentation of the Trust's financial data, to first be considered by the Finance, Business and Investment Committee	NB	July 2026		This has been discussed in FBI committee and will be developed over the coming months. To be closed.	**In progress**
28/05/2026	TB/25-27/17	Governance Improvement Plan	Discuss the scheduling of a presentation of best practice for delivering assurance to the Board and its sub-committees at a future Board Seminar	TS / JC / SS	July 2026		A verbal update will be given at the meeting.	**In progress**
28/05/2026	TB/25-27/18	Co-creation strategic plan: implementation update	Liaise with Trust Secretariat to confirm the scheduling of the underlying action plan for the Co-creation strategic plan at the Quality Committee	KH	July 2026		A six-monthly update on the Co-creation strategic plan will be considered at the Quality Committee in May and November annually. To be closed.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
29/01/2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Present a 'broader health inequalities' update for the Board	AR	July 2026	September 2026	Revised date agreed at the May 2026 Trust Board meeting.	**Not Due**
28/05/2026	TB/25-27/14	Workforce Deep Dive - Workforce Race Equality Standard and Workforce Disability Equality Standard	Explore what support can be provided by the transformation team to improve workforce race and disability data, to enable clear linkage between workforce metrics, analysis and actions	AR	September 2026			**Not Due**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29/05/2025	TB/25-26/9	Board Assurance Framework (BAF)	Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework	NB	July 2025	May 2026	Closed – This will be captured in the wider work on the BAF.	**CLOSED**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 21/07/2026

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Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29/01/2026	TB/25-26/121	Action Log & Matters Arising	Provide an action plan to improve ethnicity recording, to be combined with ethnicity data improvement plan action.	AR	March 2026	May 2026	This has been incorporated into the IQPR narrative: Ethnicity recording has improved to 88.2% of community (MHT/MAS) referrals through clear, practical changes. Since January 2026, 176 staff have completed protected characteristics training, reporting increased confidence to ask for information, explain Trust data and use data to inform practice. Patients can now see why we collect this information on the Trust website, with additional information sheets in development. New processes have also been introduced to make ethnicity easier to record. Targeted work in West Kent using the Doing Well Together methodology increased recording from 76.1% to 86.2% in 2025/26. In all, this has been an important first step, with further improvement still needed. With these foundations in place, the Ethnicity, Diversity and Inclusion PowerBI report is now being used to support improvement, and focused work on Restrictive Practices, Mental Health Act detentions and MAS access shows how data is being put into action to improve care.	CLOSED
29/01/2026	TB/25-26/121	Action Log & Matters Arising	Present a Trust wide ethnicity data improvement plan to address gaps in the Trust's ethnicity data for both staff and patients (Quality Committee)	ALS/ AR	May 2026		Closed – covered on the IQPR paper.	CLOSED
29/01/2026	TB/25-26/123	Chief Executive's Report	Strengthen the stakeholder engagement plan, including targeted communication to Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) and local councillors	KH	May 2026		Closed – a planned and proactive approach will be in the final communications and engagement strategic plan that is being developed now.	CLOSED

BOARD OF DIRECTORS ACTION LOG
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Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29/01/2026	TB/25-26/124	Board Assurance Framework (BAF)	Reconcile inconsistencies in inpatient flow data with update provided to Quality Committee	JK / AQ	May 2026		Closed- This was provided to QC.	CLOSED
29/01/2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Provide a verbal update as part of the Sustainable Communities Provider Collaborative Progress Report regarding the Health Inequalities Improvement Plan and collaboration with Kent Community Health NHS Foundation Trust	SS	May 2026		A verbal update to be given at the meeting by AR.	CLOSED
29/01/2026	TB/25-26/126	Digital Progress Against Plan	Present the mapping of system-level digital responsibilities and dependencies	NB	May 2026		The Trust's digital plan is presently being developed locally with emerging joint working with KCHFT. National funding is anticipated to support our work in AVT, with the trust part of one of the national pilots in this area. We anticipate this is an emerging picture and will include further detail into the board strategy session in June.	CLOSED
29/01/2026	TB/25-26/127	Trust Quality and Safety Agenda	Produce a plan to address fear of reprisals and strengthen leadership behaviours	ALS	May 2026		Closed - a series of actions have been agreed through People Committee at the end of 2025 and throughout this year are in place to address these and other cultural and behaviour issues and risks. These include continued monitoring and reporting through FTSU, launching the "Staff Voice" (like a staff council) for every directorate, strengthening staff networks, and the continued roll out of a new leadership development programme for Band 7 and above. In addition, we are planning a Trust Wide cultural transformation programme through our "Doing Well Together" methodology. A BAF risk related to culture is being drafted so these sorts of issues are monitored at Board level. .	CLOSED
29/01/2026	TB/25-26/128	Integrated Quality and Performance Review	Lead a Trust-wide audit of waiting-well arrangements, incorporating patient experience data	DHS	May 2026		Closed – covered on the IQPR paper.	CLOSED

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NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29/01/2026	TB/25-26/128	Integrated Quality and Performance Review	Deliver a deep-dive report on restrictive practice trends, drivers and mitigation plans	JK	May 2026		A verbal update to be given at the meeting.	CLOSED
29/01/2026	TB/25-26/132	Freedom to Speak Up 6 Month Report	Report to the People Committee the: • Implementation of the principles-based Change Management Framework; and Embedding of closed-loop reporting back to staff	ALS	May 2026		A verbal update to be given at the meeting.	CLOSED
26/03/2026	TB/25-26/151	Board Assurance Framework (BAF)	TS to adjust the Board Development and Seminar Planner to include a seminar on Data Triangulation for the BAF. The precise date for the seminar will be agreed by the Chair and SS.	TS	May 2026		Closed – this has been completed.	CLOSED
26/03/2026	TB/25-26/156	Integrated Quality and Performance Review	By 31.05.26, SS must ensure that the next iteration of the Integrated Quality and Performance Report includes a dedicated page setting out corridor care in East Kent, including scale, drivers, risks, mitigating actions and trajectory.	SS	May 2026		Closed – covered in the IQPR.	CLOSED
26/03/2026	TB/25-26/157	Independent Quality and Safety Governance Review	By May 2026, JK to provide an update on progress against plan for the Trust-wide Quality and Corporate Governance Development Programme.	JK	May 2026		Closed – this is covered CEO report.	CLOSED

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30 July 2026**
Title	**Chair's Report**
Author	**Colin Lynch, Trust Chair**
Presenter	**Colin Lynch, Trust Chair**
Purpose	**For noting**

1. Introduction

I am delighted and privileged to have taken on the role of Trust Chair. Thank you to all Board members, our Governance team, Executive Assistants and indeed all colleagues that I've met for making me feel so very welcome. Particular thanks to my predecessor Dr Jackie Craissati for her leadership of KMMH over the years, her clinical and wider system insights to Board and for being so generous with her time for me as incoming Chair.

Working closely with colleagues, partners and communities, our Board is determined that we excel in the delivery of our strategy, *Doing Well Together*. For every Public Board, I will present a report focusing on some matters of significance. In this first report, in Section 3 I include a brief summary of the themes that I believe are key to the successful delivery of our *Doing Well Together* strategy. Going forward, my report will link more closely to these themes.

2. Board Membership and Non-Executive Director Changes

This report also provides an opportunity to acknowledge several important changes within our Board.

Firstly, I would like to extend my sincere thanks to Sean Bone-Knell and Mickola Wilson as they conclude their terms as Non-Executive Directors. Although as Board colleagues, we overlap for a very short time, it's clear that both colleagues have made significant contributions; consistently bringing insight, challenge and support to Board discussions.

Sean has been a strong advocate for quality improvement, patient experience and partnership working. Through his visits and engagement with frontline teams, he has demonstrated a genuine interest in understanding the experiences of staff and patients, helping to ensure that Board decision-making remains grounded in the realities of service delivery.

Mickola has similarly made a valued and valuable contribution through her thoughtful challenge, leadership particularly in the area of financial assurance and focus on improving outcomes for the communities we serve. Her contribution has helped

strengthen Board assurance and supported the Trust in maintaining its focus on quality and improvement.

On behalf of the Board, I thank both Sean and Mickola for their service to Kent and Medway Mental Health NHS Trust and wish them every success for the future.

I am equally pleased to welcome Sue Baker as a new Non-Executive Director. Sue joins the Board on 1st August bringing considerable experience and expertise in relation to partnership working, cultural development and Board effectiveness, and I know she will make a valuable contribution to our Board.

I am also delighted formally to welcome Pam Creaven as a Non-Executive Director. Pam has already made a significant contribution during her time as an Associate Non-Executive Director, demonstrating a strong commitment to our patients, our staff and our communities. Her appointment provides valuable continuity and ensures that the Board retains the benefit of her knowledge and insight as she transitions into her new role.

Together, these changes reflect both continuity and renewal within our Board. They strengthen our collective ability to govern effectively and are geared towards supporting the delivery of our strategy.

3. Key themes and initial reflections

Introduction – Our Strategy and the NHS Ten-Year Health Plan

Since joining the Trust, I have been encouraged by the strong sense of purpose and ambition across the organisation. For *Doing Well Together* to succeed, our focus must now shift from defining our ambitions to delivering meaningful and sustained improvements for patients, service users, carers, our colleagues and communities.

Our strategy aligns closely with the NHS Ten-Year Health Plan and is built around five priorities: improving timely access to care, keeping people safe, creating positive experiences, using resources wisely and helping people stay well through prevention and early intervention.

As a Board, we have spent time considering what success looks like in the first year of delivery. While our ambitions are long term, we must demonstrate timely, tangible progress through reduced waiting times, improved patient and staff experience, safer care and better flow through our services. By strengthening neighbourhood-based care, working more closely with partners and maintaining a tireless focus on our quality, safety, culture and service improvement, we will help more people access the right support at the right time and closer to home. And both reduce inequalities in access and outcomes and improve the engagement and experience of our colleagues.

KMMH colleagues and team engagement, development and service improvement

Positive team and organisational culture so often underpins sustainable service improvement, colleague wellbeing, retention and productivity. Embedding the right balance between supportive central guidance and local autonomy, maximising psychological safety, and developing a shared understanding of what really good performance and accountability looks like – right across KMMH - are all critical if we are to deliver on our ambitions.

We have some strong foundations upon which to build, not least a remarkable commitment from colleagues working in challenging circumstances and a genuine appetite to improve services for patients, service users and carers. The cultural development work underway, alongside our co-produced values of being Caring, Inclusive, Curious and Confident, provides an important framework. Our values in action and being the best leaders and managers we can be – again importantly at all levels and right across KMMH – will become more obviously Board business.

Our ability to listen and communicate effectively with all colleagues and partners, remove barriers to local innovation, spread best practice quickly and support colleagues to lead improvement will become ever more important. Creating the best possible sustainable culture, where colleagues feel valued, supported and empowered and where expectations and accountability are clear will be fundamental to the successful delivery of *Doing Well Together.* We have the opportunity to use our avenues of communication as real enablers of positive change.

System leadership for sustainable patient and partner benefit

As the only mental health provider serving the whole of Kent and Medway, KMMH has a unique role within our Integrated Care System. The challenges facing health and care services cannot be solved by any organisation acting alone. Financial pressures, increasing demand, workforce challenges and persistent inequalities require stronger and more effective collaboration across NHS and VCSE providers, local authorities, primary care and communities. This has been recognised by the reset in the Kent and Medway system's transformation and collaboration architecture.

The Kent and Medway system continues to place increasing emphasis on neighbourhood health, prevention and supporting people closer to home. Through Mental Health Together, integrated neighbourhood working and our wider partnerships, we have an opportunity to play a leading role in helping deliver those ambitions. Moreover, we have a responsibility to be the best partner that we can be and actively commit to what the recent Joint Committee report refers to as moving from "organisational optimisation to system outcomes".

We are determined to play our full part in this collaboration, ensuring that mental health remains central to local planning and decision-making. This does not mean trying to do everything; rather, it means being the best partner we can be, strengthening relationships and helping create the conditions in which clinical and

professional leadership across organisational boundaries can flourish. By doing so, we can improve outcomes for some of the most vulnerable people in our communities.

Board effectiveness, resilience and being fit for the future

As a Board, we have an important responsibility to provide effective leadership, assurance and oversight while supporting the continued development of the organisation. Delivering our strategy successfully requires us to be more than the sum of our individual contributions.

Whether through succession planning, mitigation of key risks, ensuring that we have the right skills and experience, or strengthening the quality of Board assurance, we need to maintain a clear focus on both immediate priorities and future challenges. A particular area of focus for our Board will be building a stronger and more widespread understanding of what high-quality Board assurance looks like and how it supports better decision-making, accountability and outcomes.

I have been encouraged by the openness, attitude and commitment of Board colleagues and look forward to working together as we continue to strengthen our effectiveness, resilience and readiness for the future.

4. System activity

Kent and Medway ICB and NHS provider Chairs and Chief Executives met with local Members of Parliament in Westminster. We were questioned on, and provided assurance regarding, our engagement to date and future plans to address the significant financial, quality, and health inequality challenges facing our system.

Discussions highlighted the need for more ambitious, transparent and transformative collaborative working across Kent and Medway, including with Local Government, Primary Care, the voluntary, community and social enterprise (VCSE) sector, and neighbouring NHS providers.

For KMMH, this collaborative approach is particularly important in improving mental health outcomes, reducing inequalities in access to services, and supporting earlier intervention and prevention. Our role in Integrated Neighbourhood Working is pivotal, enabling us to work alongside partners to deliver more joined-up, person-centred care, better support people within their communities, and address the wider determinants of mental health and wellbeing.

5. Trust Board meetings

Since the last Trust Board meeting, the Board has held in-depth discussions on specific topics and reviewed our Strategy Workplan. In particular, the Board Seminar on 26 June provided a valuable opportunity for Board members to consider the practical delivery of *Doing Well Together*, reflect on the implications of the emerging NHS Ten-Year Health Plan and discuss how the Board can further strengthen its approach to assurance, governance and organisational development. The session

also enabled constructive discussion about the behaviours, leadership and partnerships that will be required to support successful delivery of our strategic priorities.

I am working with our Chief Executive and Governance team on a more forward looking, more obviously priority themed plan to our Board development work. A core element to this will be a sustained focus on a better, more widespread understanding of what is high quality Board assurance.

I want this demonstrably and quickly to enable Executive Directors and other management colleagues to provide better and continuously improving assurance to Board and for our Non-Executive Directors to maximise their constructive contributions. Some good work is clearly underway in this area and it's important for both our Quality Improvement Plan and Governance Improvement Plan. There is though scope for considerable development in this area.

6. Trust Chair and non-executive director (NED) visits

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

Where	Who
April 2026	
The Courtyard, Pudding Lane	Dr Jackie Craissati / Julie Hammond
Littlebrook Wards	Dr Jackie Craissati / Julie Hammond
St Martens	Mickola Wilson
May 2026	
Mental Health Learning Disability Service	Dr Jackie Craissati / Julie Hammond
Rehabilitation Services – The Grove	Kim Lowe / Julius Christmas
Rehabilitation Services – Ethelbert Road	Kim Lowe / Julius Christmas
MHLD Service, Archery House	Dr Julie Hammond
Rehabilitation services - Rivendell	Kevin Corrigan
June 2026	
Maidstone Studios	Kevin Corrigan
Priority House Wards	Mickola Wilson

As an aside, I am working with our Governance team and Chief Executive on how we can best integrate our reporting and analysis of the valuable feedback from Non-Executive Director visits more systematically and effectively into our Board assurance.

Chair's visits

Visiting our Mother and Baby Unit, it's clear that there is a good working relationship between clinical and operational lead colleagues and that there is plenty of active support for each other. The colleagues I met are particularly proud of the co-designed and co-produced nature of the facility and the services, which underpins it's success. In terms of what's going well, colleagues emphasised: no vacancies,

little use of bank and agency, the truly integrated nature of the multi-disciplinary team working and the partnership working and relationships with acute trust and VCSE sector partners. I do wonder whether there are lessons for us to learn and share more widely in KMMH from this team's approach to partnership and MDT working.

In terms of areas for improvement and a plea for help, the consistent theme was the attitude of some colleagues to flexible working, the difficult of local management of people issues and a feeling that both our policies and the workforce support that is available make it difficult for managers to manage effectively. Sometimes it feels like the preference of individual team members are given a higher priority than patient and service user need. The central support that we offer was described as inconsistent and not particularly helpful, in the sense that managers on the ground feel relatively powerless. I picked up an almost resigned sense of 'that's just what it's like here in KMMH'. The cultural, accountability and colleague development priorities that sit behind making this a very different situation going forward are key for us; they directly impact upon our ability to deliver our strategy for the benefit of our patients, our service users and the vast majority of our colleagues.

I should also mention a brief visit to our wards at Priority House. This was more a brief introduction than a full visit, but it did give an opportunity to sit in on a team meeting of our physical health colleagues within Priority House. In summary, there was a really constructive attitude and a healthy appetite for engaging earlier with doctors, in relation to care plans in particular. The enthusiasm for closer, more innovative links between mental and physical health – so we think and provide holistic care to the whole person – was infectious. Clearly, there is no shortage of ideas on the ground and a continued focus on facilitating colleagues right across KMMH in putting their great improvement ideas into action remains central to the successful delivery of our strategy. It's an area where we are clearly making progress and going forward, at Board we'll highlight more and more of this developing quality improvement.

Non-Executive Directors

Julie Hammond / Dr Jackie Craissati – Mental Health Learning Disability Service

The visit highlighted a committed multidisciplinary team providing specialist support for people with learning disabilities and mental health needs. Positive themes included manageable caseloads, clear referral pathways, strong partnership working and effective support to mainstream services around autism and reasonable adjustments. Challenges related to reductions in local authority social care provision, concerns regarding capacity assessments, and difficulties accessing consistent clinic space. Overall, the visit demonstrated strong team working alongside ongoing risks associated with social care provision and estates.

Julie Hammond / Dr Jackie Craissati – Littlebrook Hospital

The visit found stable staffing, positive leadership and good progress with recruitment to the new female PICU. Teams described initiatives to reduce administrative burden and improve understanding of ward manager workload. Areas requiring continued focus included documentation quality, patient flow, staffing models and estate limitations, particularly on Pinewood Ward, where the environment was felt to impact safety and therapeutic care. Overall, the visit reflected a well-led service with a number of operational and environmental challenges requiring ongoing oversight.

Mickola Wilson – Complex Emotional/Personality Disorders Training

Attendance at an iLearn training session provided valuable insight into the experiences and needs of people with complex emotional and personality disorders. Discussions reinforced familiar themes relating to variation in practice, communication and feedback mechanisms across services. Participants were also interested in the issues routinely considered by the Board, including patient flow and community discharge challenges.

Mickola Wilson – Broughton Ward, Priority House

The visit demonstrated strong multidisciplinary working, a supportive team culture and compassionate patient care. Staff highlighted the importance of meaningful therapeutic activity in supporting recovery, while ongoing challenges were noted in relation to discharge delays and access to community support. Overall, the visit reflected a committed and resilient team delivering high-quality care within a demanding inpatient environment.

Kent and Medway Mental Health NHS Trust

Chief Executive's Board Report

Date of Meeting: 30th July 2026

Introduction

It has been an exceptionally busy period since we last met as a Trust Board. We have seen the start of the transition for the board with our Trust Chair and Non-Executive Directors (NEDs) leaving as they have reached the end of their tenure, new Chair and NEDs joining us. In addition, there has been a lot of work happening in the Kent & Medway system to shape future working and services and also a number of key national meetings that I have covered in my report today.

I am delighted to welcome Colin Lynch, who joins us as joint Chair of our trust and Kent Community Health NHS Foundation Trust. This is an exciting opportunity for us.

Colin will be getting to know and work closely with colleagues across both trusts, including Boards, Chief Executives, Governors and system partners across Kent and Medway. The joint chair role will help support more effective, joined-up leadership across mental health and community health services, strengthening collaboration and driving transformative improvement in services and outcomes for local communities.

National Update

National CEO Meeting

Dr Adrian Richardson, Director of Transformation and Partnerships attended the NHS England CEO meeting this month on my behalf, where the clear national message was a strong focus on delivery, particularly urgent and emergency care, outpatient reform, neighbourhood working and winter resilience. The discussion reinforced the importance of continuing to shape our mental health contribution within neighbourhood models, including prevention, crisis alternatives, earlier support, and reducing avoidable presentations to emergency departments through partnership working across Kent and Medway. There was a clear financial message that further progress will need to come through genuine transformation and better use of existing resources, alongside preparing for expected changes to mental health and community block contracts. We were asked to ensure staff vaccination is embedded within our winter planning.

Government's new mental health strategy

The government has launched a call for evidence to inform the development and implementation of a new cross-government mental health strategy for England, aligned to the 10 Year Health Plan for England. The government is seeking practical examples and implementation evidence to inform its new approach. We have contributed, sharing examples from our community transformation and the Mental Health Together service; our work to reduce self-harm; our Assist and Embrace model in East Kent to reduce repeat

mental health admissions at acute emergency departments; Open Dialogue therapy; and work within our new children and young people directorate to deliver online support and interventions for young people. The new strategy is expected to launch later this year, and we will continue to keep the Board, staff and wider stakeholders informed on how this will impact us and whether we need to reprioritise our strategic efforts.

National Mental Health CEO Meeting

At the national meeting, the focus of the discussion was regarding the development of the NHS Mental Health Strategy 2026. This will set out a significant shift towards prevention, early intervention and recovery-focused care, with an emphasis on delivering more holistic, person-centred support within local communities. The strategy prioritises integrated neighbourhood models that bring together mental and physical health services, seamless 0–25 pathways for children and young people, improved access and outcomes for underserved populations, and the expansion of digital and AI-enabled care. Alongside strengthening community support for people with severe mental illness (SMI), the strategy will seek to improve productivity, quality and value through service modernisation and outcomes-based commissioning. Delivery is likely to be underpinned by five national priorities: eliminating out-of-area placements, reducing 12-hour breaches in EDs, improving waiting times for children and young people, strengthening staff engagement, and ensuring patients and carers are actively involved in shaping and evaluating services.

National Oversight Framework (NOF)

There has been significant engagement over the reporting period regarding the NOF, including the publication of the latest NOF position for individual providers in the NHS As colleagues are aware, this confirmed a change in the trust's segment rating from segment 1 to segment 3. This reflects a combination of staff and patient experience survey feedback, and sustained operational pressures. While the assessment highlights areas requiring continued focus, these areas are already aligned with challenges recognised by the trust. It should be noted at this stage any improvements we have made in the past year will not be included in the results. A comprehensive response is being delivered through the trust's Quality Improvement Plan. A detailed update on the CQC community survey is included in today's papers for the Trust Board to discuss. Our work is further supported by our five-year strategy, *Doing Well Together*, which provides a clear focus on improving quality, culture, performance and outcomes for the people and communities we serve.

Mann Review

The Lord Mann Review was commissioned in October 2025 by the Secretary of State for Health and Social Care to examine how the NHS and healthcare regulatory system address antisemitism and wider forms of racism.

It was undertaken against a backdrop of rising antisemitism in the UK, including the Heaton Park Synagogue attack (2 October 2025) and a series of serious antisemitic incidents in April 2026, particularly in London. The review was published in June 2026.

Disappointingly, the review finds that racism, including antisemitism and anti-Muslim, is persistent and, in some cases, normalised within the NHS, impacting both staff experience and patient trust and access to care. The review sets out a clear expectation for immediate, Trust and system-wide action calling for the NHS to:

- Protect staff and patients
- Strengthen accountability and leadership
- Embed a proactive anti-racist culture across all levels

Through our previous Equality Diversity Inclusion (EDI) plans we are already working to address 75% of the 15 recommendations highlighted in the report and will incorporate deliverables for the remaining 3 areas into our future People Plans. Progress is expected to be monitored nationally, we will continue with our local updates to our People Committee.

Quality Strategy for NHS funded care in England

NHS England has published a new Quality Strategy for NHS-funded Care in England, positioning quality as the organising principle for NHS-funded services over the next decade. The strategy establishes a shared framework centred on three interdependent domains of quality – safety, effectiveness and experience – with the overarching aims of improving health outcomes, reducing health inequalities and enhancing patient experience. Initial national priorities include reducing unwarranted variation in outcomes, strengthening patient safety, improving experience of care and restoring trust in services, with a renewed focus on accountability, continuous improvement and the consistent delivery of evidence-based, person-centred care across the NHS

The publication of Quality strategy for NHS-funded care in England reinforces the national expectation that quality should be the organising principle of NHS-funded services, with a focus on safety, effectiveness and patient experience. For KMMH, the strategy supports and strengthens our existing priorities within the Quality Improvement Programme and governance review, including improving patient safety, reducing unwarranted variation, enhancing patient and carer experience, tackling inequalities and strengthening quality assurance arrangements. As the Trust continues its improvement journey, the strategy provides a helpful national framework against which we can demonstrate progress, accountability and sustained improvements in the quality of care we provide to our communities.

Kent & Medway System Update

Neighbourhood Collaborative

Dr Adrian Richardson, Director of Transformation and Partnerships attended the Neighbourhood Collaborative Board on my behalf. The meeting focused on accelerating neighbourhood health delivery across Kent and Medway, with significant discussion on single and multi-neighbourhood models, mental health integration, data and outcomes reporting, and the need for clearer alignment between providers to deliver measurable improvements in population health and reduce unnecessary hospital attendance. KMMH provided the mental health update, highlighting priorities around mental health presentations to emergency departments (EDs), dementia diagnosis and post diagnosis support, and the role of Additional Roles Reimbursement Scheme (ARRS) staff, with agreement that the next phase of work must strengthen data sharing, provider collaboration and embedding mental health into neighbourhood-based care.

South East Regional Chair Visit

I had the pleasure of inviting Sir Jonathan Montgomery the South-East Regional NHS England (NHSE) Chair to Britton House this month to visit our Medway and Swale Community Services. Jonathan was joined by Angela McNab the Interim ICB Chair. I was also joined by Donna, Kindra and Wendy Dewhurst Service Director and Dr Mo Eyeoyibo, Clinical Director for the North Kent Directorate. Jonathan and Angela also spent time with our clinical teams and partners to hear more about the services we provide. The visit was positive, supportive and strategic. Much of the discussion centred on the future direction of mental health, neighbourhood working, clinical leadership and how Kent and Medway Mental Health Trust can play a stronger leadership role across Kent and Medway.

The visit highlighted several opportunities for future development:

- Strengthening our narrative and championing further mental health in system conversations
- Tell more human stories, be proud and informative
- Develop stronger evidence of prevention and outcomes
- Explore partnerships with academic organisations to demonstrate longer-term impact beyond traditional NHS metrics.

The strongest message was that the Trust should have greater confidence in its role, be more ambitious in influencing the wider system, and do more to demonstrate the public value of mental health through compelling evidence, stronger clinical leadership and authentic storytelling that connects with patients and the public.

System Leadership Group (SLG)

The meeting focussed on the latest Financial Improvement Programme (FIP) review for the Kent & Medway system, it highlights that, whilst significant progress has been made in identifying savings schemes and delivering early benefits, particularly through workforce controls and reduced variable pay, the principal challenge has now shifted from planning to delivery. Boards are expected to take a more active leadership role in overseeing financial recovery, with clear visibility of risks, robust challenge of delivery assumptions, and ownership of remedial actions where required. Sustained Board focus will be essential to ensure plans are realistic, deliverable and translated into recurrent financial benefit, with particular attention to workforce-related schemes, recovery trajectories and the mitigation of delivery risks. I know this is something we have complete grip on as a board and we will discuss at our board meeting today.

Local Government Reorganisation

Following the public consultation on local government reorganisation, it has now been confirmed that in Kent and Medway the county's 14 existing authorities (Kent County Council, Medway Council, and 12 district/borough councils) will be replaced with four unitary authorities starting in April 2028 covering the below, local areas. As the only NHS provider operating across the whole footprint, this significantly increases our statutory partnership base and affects both our community directorate model and the future neighbourhood

locality model, which don't align with the new boundaries. We are scoping this at both a system and trust-level with colleagues, with an update to follow as arrangements develop.

- North Kent: Dartford, Gravesham, and Medway.
- West Kent: Sevenoaks, Tonbridge & Malling, Maidstone, and Tunbridge Wells.
- Mid Kent: Swale, Ashford, and Folkestone & Hythe.
- East Kent: Canterbury, Dover, and Thanet.

Trust Update

Launch of Doing Well Together – our five-year strategy

I am pleased to report that the Trust has formally launched its new five-year strategy, *Doing Well Together*. The strategy has been shaped by one of the most extensive engagement programmes the trust has undertaken, drawing on more than 700 hours of insight gathered over the past two years and direct engagement with over 300 staff and more than 150 patients, carers, partners and community representatives.

This strong level of involvement was recognised positively by Board members and provides confidence that the strategy reflects what matters most to the people we serve and those who work alongside us. The strategy sets out a clear ambition to improve mental health services through five fundamental shifts: from waiting to earlier support, from fragmented services to connected communities, from variation to consistency, from treatment to living well, and from complexity to simplicity.

These shifts are underpinned by five strategic ambitions that represent our 'true north' and define the impact we want to achieve over the next five years. The strategy is deliberately aligned to the priorities being delivered across the Kent and Medway system and supports the direction of the Integrated Care Board (ICB) and wider system improvement programmes. It contributes to our shared ambition to improve quality, safety and outcomes, reduce unwarranted variation, strengthen partnership working and deliver more care closer to people's homes and communities and achieve financial sustainability,

Through programmes such as Mental Health Together, neighbourhood working and our partnerships with primary care, local authorities and the VCSE sector, the strategy provides a clear framework for working collaboratively across the system to improve outcomes for local people.

Success will mean more timely access to care, with 85% of people referred to Mental Health Together seen within 18 weeks; safer care, with a 10% reduction in harms; positive experiences for patients and colleagues; smarter ways of working that release more time for patient care and deliver productivity improvements; and better support for people to recover and stay well in their communities. Together, these ambitions provide a clear and measurable framework for improving outcomes, experience and value for the population we serve.

Charity

Our charity and corporate volunteering work continues to develop, with growing support from external partners who want to contribute positively to the experience of our patients, staff and services. Last month, we received a donation of over £7,500 from the NFU Mutual Agency Giving Fund, and they are now working with our charity on further initiatives across the Trust. Corporate volunteering is continuing to grow, with Amazon South East working with us this month on their biggest donor project of the year, which saw 53 Amazon employees supporting work at Oakwood Nature Reserve in Maidstone to help maintain a therapeutic environment for our patients and staff. Thank you to all involved this is excellent progress!

Parliamentary engagement

We are working to strengthen relationships with local MPs and system partners and on 12 June, we welcomed Mike Martin MP, Sir Roger Gale MP, Sojan Joseph MP, and representatives from the office of Jim Dickson MP to Farm Villa. The meeting provided a constructive and supportive opportunity to discuss future priorities for mental health services across Kent and Medway and the role of national and local partners in supporting improvement.

Discussions focused on the need to work collaboratively with the ICB to deliver the wider system changes required to improve outcomes for local people and secure future investment to ensure mental health services in Kent & Medway are funded to a similar level as other regions. There was positive engagement around dementia services, particularly post-diagnostic support, with recognition of the important contribution the VCSE sector can make in supporting people to live well following diagnosis.

The meeting provided an opportunity to discuss Child and Adolescent Mental Health Services (CAMHS) and waiting times, leading to a broader conversation about Learning Disability and Autism pathways. There was a shared recognition of the need for a comprehensive system-wide review of services for both adults and children, and MPs were highly supportive throughout – offering support where needed.

Following this meeting, Chairs and Chief Executives from across Kent and Medway also met with several Kent and Medway MPs in Parliament to discuss the challenges facing the local health and care system and the collective plans being developed through the new provider alliances. While I was unable to attend due to leave, the trust was represented by our new Chair and Director of Strategy and Engagement, Kindra Hyttner. Feedback from the meeting was positive, with MPs demonstrating a good understanding of both the scale of the challenges facing the system and the collective commitment of partners to improve quality, safety and outcomes for local people while delivering long-term financial sustainability. Understandably, MPs were particularly interested in the practical implications of these changes for their constituents. Further engagement will take place as the emerging strategy and commissioning intentions progress through provider and ICB governance processes.

Awards and recognition

Since May, the trust has continued to receive significant regional and national recognition for both its clinical innovation and its people. At the Kent and Medway Dementia Conference and Dementia Friendly Kent Awards, the trust played a leading role in delivering the event

and was recognised as a finalist for its dementia research partnership with Kent and Medway Medical School, reflecting the growing impact of its work to improve earlier diagnosis and develop more inclusive care pathways.

This momentum has continued with a series of prestigious national award shortlists. The trust and its partners have been shortlisted in 5 categories at the HSJ Patient Safety Awards 2026. These include Best Use of Integrated Care and Partnership Working in Patient Safety and Improving Safety for Older People Initiative of the Year for the Dementia Diagnosis Transformation Partnership, delivered through the Kent and Medway Provider Collaborative; the Improving Medicines Safety Award for integrating pharmacy expertise across Community Mental Health Teams; and the Mental Health Safety Improvement Award and Early-stage Patient Safety Innovation of the Year for the Minimal Risk Activity Packs (MRAP) programme, which is designed to reduce self-harm incidents.

This national recognition also extends to the Nursing Times Awards, where Amy Cunningham, Liaison Psychiatry Senior Clinical Practitioner, has been shortlisted for the Nursing in Mental Health Award. Amy has been recognised for 'Start-a-fresh', a targeted therapy programme supporting patients who repeatedly self-harm.

Alongside recognition for service improvement and patient safety, the trust has continued to celebrate the contribution of its staff. Chief Pharmacist Jag Bahia and Postgraduate Administrator Anne Clark were selected to attend the Queen's Centennial celebrations at Westminster Abbey, having been nominated in recognition of the way they consistently demonstrate the trust's values in their day-to-day work.

Together, these achievements demonstrate growing external recognition of the trust's leadership in dementia care, patient safety, research and innovation, while also reflecting a strong commitment to recognising and valuing the contribution of colleagues across the organisation.

Value in Practice Awards

We continue to receive lots of nominations for our trust Value in Practice Awards. Please see the appendix for the latest winners – a massive congratulations to you all. It is fantastic to see the contributions our staff make but also the recognition from colleagues and appreciation of each other.

Summary and Conclusion

As I have said at the start of my report a warm welcome to our new Chair and NEDs, I look forward to working with you in the year ahead. We have been part of some very important discussions in the last month either national or local regarding how we will take forward mental health services in Kent & Medway. It is an exciting time as we plan services that are fit for the future and meet the needs of our local population. We have also launched our new five-year strategy for the Trust this month, that aligns with the system ambitions. Our visit from the South-East Regional Chair confirmed to us as a team that we need to be more confident (living our value) and that we are in a strong position in the wider health system within Kent and Medway to shape mental health services but also influence the systems

wider thinking regarding population health. I look forward to the year ahead as we start to demonstrate further the impact we can have.

Sheila Stenson
Chief Executive
30th July 2026

Executive Team Visits

Sheila Stenson:
WK MAS, Neuropsychology and EIP
Woodchurch and Sevenscore Wards
Canterbury Wards
Britton House

Donna Hayward-Sussex
Ruby, Emmetts and Walmer Ward – West Kent
Neuropsychiatry Service Adult services- Highlands House
Children's & All Age Eating Disorder Community Hub – Highlands House & Dartford
Liaison Psychiatry - Tunbridge Wells Hospital
Secondary Care Psychology Service - Highlands House
MHT/MHT+ - adult services - Dartford
East Kent Inpatient Wards – Sevenscore and Woodchurch
Liaison Psychiatry – Thanet
Acute Inpatients – Priority House
Early Interventions for Psychosis & Mental Health Plus – Britton House

Julie Kirby

CYPMHS&AAED, Maidstone Studios
Thanet Mental Health Unit
Rivendell - Site Visit
Dartford LPS and Willow Suite

Kindra Hyttner
Highlands House
Britton House

Nick Brown
Rosewood Mother & Baby Unit
Tarentfort Centre - Rivendale and Marle Ward

Dr Afifa Qazi
Rosewood Mother & Baby Unit

Adrian Richardson
The Red House
Rosebud
111 Tonbridge Road

Ali Layne-Smith
Jasmine Ward

Value in Practice Awards

Directorate	April	May
North	Roy Baril, Senior OT Team : Later Life Pathway Medway/Swale	Amy Cunningham, Liaison Psychiatry Practitioner
East	Lorraine Wager, Administrator Assistant Team : Rivendell	Sarah May, SMT Administrator
West	Rebecca Pooley, Senior Business Administrator Team : MHT	Sofia Leigh, Staff Nurse
Forensic	Simon Greenhill, Administrator Co-Ordinator Team : Forensic & Outreach Liaison Services	-
Support services	Cheryl York, Senior HR Advisor Team : HR Helpdesk	Jamie Cowdrey, Information Analyst
Acute	Lorraine Lawrence, Administrator Assistant Team: Sevenscore Ward	Julie Brett, Ward Manager
Children & Young Persons and All Age Eating Disorders	Only started in May	Sarah Warnock, Interim Modern Matron

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Board Assurance Framework: Current Position and Redevelopment Update
Author:	Louisa Mace, Risk Manager, supported by Andrew Hughes, ANHH
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Assurance, Discussion and Endorsement
Submission to Board:	Regulatory Requirement

Overview of paper

This paper provides the Board with a current view of the Trust's Board Assurance Framework (BAF): the position it now shows, an assessment of its limitations, and the programme to redevelop it. The wider governance changes are described in the *Governance Improvement Programme (GIP) Progress Report* elsewhere on this agenda, within which the BAF is Theme 6.

The Board is asked to receive the current BAF for interim assurance, to endorse the redevelopment approach and the seven proposed strategic risks, and to endorse the revised timeline of a Board Development workshop on 6 August, formal sign-off in September and embedding from October. The recommendations are set out in full at Section 8.

Issues to bring to the Board's attention

The live BAF, updated on 15 July 2026, contains 14 open risks. Five are rated extreme (a current score of 15 or above), and ten of the fourteen sit outside the Trust's agreed risk appetite. The highest-rated risk is Inpatient Flow (ID 08065), which has risen to 20 (likelihood 5 by consequence 4). The increase reflects a higher number of patients clinically ready for discharge (CRFD) and greater use of out-of-area beds.

Governance

Implications/Impact:	Patient safety/ Legal
Assurance:	Limited to Moderate Assurance (See section 4)
Oversight:	Audit and Risk Committee

Version 2 - **Public**

Board Assurance Framework.

Current Position and Redevelopment Update

1. Purpose of this paper

This paper provides the Board with a current view of the Trust's Board Assurance Framework (BAF): the position it now shows, an assessment of its limitations, and the programme to redevelop it. The wider governance changes are describes in the *Governance Improvement Programme (GIP) Progress Report* elsewhere on this agenda, within which the BAF is Theme 6.

The Board is asked to receive the current BAF for interim assurance, to endorse the redevelopment approach and the seven proposed strategic risks, and to endorse the revised timeline of a Board Development workshop on 6 August, formal sign-off in September and embedding from October. The recommendations are set out in full at Section 8.

2. The current BAF position

The live BAF, updated on 15 July 2026, contains 14 open risks. Five are rated extreme (a current score of 15 or above), and ten of the fourteen sit outside the Trust's agreed risk appetite. The highest-rated risk is Inpatient Flow (ID 08065), which has risen to 20 (likelihood 5 by consequence 4). The increase reflects a higher number of patients clinically ready for discharge (CRFD) and greater use of out-of-area beds.

The May BAF report described the profile as static, with no change in scores since March 2026. That is no longer the case. Scores have moved in both directions. Inpatient Flow has increased to 20, and the Memory Assessment Service risk (ID 00580) has reduced from 16 to 12 as it becomes more likely that KMMH will not remain the sole provider of these services. The Board should treat the current profile as current rather than fixed.

Summary of the current BAF risks

Scores shown are current (residual). Amber shading indicates a score of 12; red indicates an extreme score of 15 or above.

ID	Strategic risk	Executive lead	Now	Target	Appetite	Direction
00580	Organisational inability to meet Memory Assessment Service Demand	Director of Partnerships & Transformation	**12**	12	Outside tolerance	Down
08065	Inpatient flow	Chief Medical Officer	**20**	3	Outside tolerance	Up
08157	Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.	Chief Operating Officer	**16**	6	Outside tolerance	Static
07891	Organisational Management of violence and aggression	Chief Nurse	**12**	6	Outside tolerance	Static
02290	Delivery of safe, high-quality care (formerly CQC compliance)	Chief Nurse	**16**	6	Outside tolerance	Static

ID	Strategic risk	Executive lead	Now	Target	Appetite	Direction
07960	Reduce Self harm in our female patients on Acute Wards	Chief Nurse	16	6	Outside tolerance	Static
08337	Organisational Culture impact on Delivery of Strategic Ambitions	Chief People Officer	9	6	In appetite	Static
04673	Organisational Risk - Cyber Attack	Chief Finance & Resources Officer	15	6	Outside tolerance	Static
07557	Trust agency usage	Chief Medical Officer	9	9	In appetite	At target
08174	Delivery of financial targets	Chief Finance & Resources Officer	12	8	Outside tolerance	Static
08175	Delivery of Underlying Financial Sustainability	Chief Finance & Resources Officer	12	6	Outside tolerance	Static
08480	Risk to Stakeholder confidence	Dir Communications & Engagement	12	9	Outside tolerance	Static
08173	Delivery of a fit-for-purpose estate	Chief Finance & Resources Officer	9	6	In tolerance	Static
08146	Maintenance of a sustainable estate	Chief Finance & Resources Officer	9	6	In appetite	Static

Direction key: **Up** = score increased since the last review; **Down** = decreased; **Static** = unchanged; **At target** = residual score is at the agreed target.

Notable movements and pressures this period

- **Risk ID 08065 - Inpatient flow (increased to 20).** Work is now aligned under the new strategy to three workstreams: preventing admissions, reducing CRFD, and improving discharge on the wards. Pressure has increased. The target residual score is 3 by March 2027.
- **Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (reduced to 12).** Phase 1 optimisation is embedded in weekly sustainability huddles, and the community model is being rolled out in Folkestone and Hythe. The reduction reflects the likelihood that KMMH will cease to be the sole provider, rather than demand being fully met.
- **Risk ID 07960 - Reduce Self harm in our female patients on Acute Wards (Current Risk Score - 16).** An evidence-based approach is in place across admission, inpatient care and discharge. The target residual score is 6 by September 2026.
- **Risk ID 08337 - Organisational culture impact on Delivery of Strategic Ambitions (9)** Work continues to ascertain the right actions to take to improve staff experience. New NHS Staff Standards Guidance has been released which will support this work and defining priorities.
- **Risk ID 07557 – Trust Agency Usage (9).** This risk is within appetite, and agency usage is at its target score. A CYP recruitment plan is going to People Committee for sign-off.
- **Target dates requiring review.** Two finance risks (08174 and 08175) still show target completion dates of 31 March 2026, which have now passed. These should be updated as part of the current review.

3. Assessment of the current framework

The current BAF pre-dates the Trust's new five-year strategy, *Doing Well Together*, and reflects the objectives in place before April 2026. The CQC Well-Led inspection in March 2026 found the BAF and Corporate Risk Register underdeveloped, some significant risks absent from the register, and mitigations that did not set out clear ownership. The framework currently serves as a bridging position while a new model is developed.

The Board should note that the current BAF:

- is aligned to the previous strategic framework and not yet to the new strategy;
- contains a mix of strategic and operational risk, with around half the entries operational, which reduces Board-level focus;
- provides broad coverage and regular reporting, but functions more as a risk register than as an evaluative assurance tool;
- does not yet demonstrate a consistent link from strategy through risk, control, assurance and impact;
- lists controls and describes assurance but does not rate control effectiveness or evaluate the strength of assurance.

These points concern the framework rather than the management of the risks. Narrative updates show active oversight at operational and programme level across the major risks. The limitation is in Board-level evaluative assurance, which remains immature, rather than in day-to-day management.

4. Level of Assurance

The current BAF provides **limited-to-moderate assurance**. It gives the Board reasonable visibility of the principal risks and evidence of management oversight, but assurance is constrained by the maturity of the framework: limited evidence of control effectiveness, variable clarity on impact, and incomplete alignment to the new strategy. This is consistent with the limited assurance position set out in the wider GIP report. The redevelopment programme is intended to address these constraints.

5. Redevelopment of the BAF

The case for change

Four developments have changed the Trust's risk picture at the same time: the CQC Well-Led findings; the new five-year strategy; the transfer of Children and Young People's Mental Health (CYPMH) and All-Age Eating Disorder (AAED) services from NELFT on 1 April 2026; and the appointment of a new Chair and a new Chair of the Audit and Risk Committee. The BAF is being redeveloped now, ahead of the draft inspection report, so that the framework reflects this changed position.

A risk, cause and effect model

The redeveloped BAF uses a risk, cause and effect model, aligned to NHS England guidance, the CQC Well-Led framework, HFMA good practice and the Three Lines Model:

- **Risk:** the strategic uncertainty, or what could prevent the Trust from achieving a strategic objective. Each risk begins “There is a risk that the Trust will not…”, and there are no more than seven.
- **Cause:** the underlying drivers that make the risk more or less likely. This is where the Board scores and challenges.
- **Effect:** the strategic consequence if the risk materialises, across patients, quality, finance, reputation and regulatory standing.

The change is in the purpose of the BAF as well as its format: from a framework that informs the Board to one the Board uses to make decisions. The visual format will follow the KCHFT model preferred by the joint Chair, populated with KMMH-specific content.

The intention is to move to a fixed group of seven strategic risks.

Reclassifying operational risks

A significant feature of the redesign is that risks are removed from the BAF before the format is finalised.

This is a change of classification rather than a reduction in the seriousness of the risk.
A risk scored 20 today, for instance, would move to become a named, scored cause under the relevant strategic risk.

6. Timeline and change to the original plan

The May BAF paper anticipated a revised framework at the July meeting. This has been re-sequenced. Settling the committee architecture first, and allowing each committee time to shape its own risk, means the completed BAF is now scheduled for formal sign-off in September rather than July. The purpose of the change is to allow the framework to be developed and embedded properly.

The revised timeline is as follows:

1. **June: architecture agreed.** The seven risks, the model and the proposed removals were agreed by the Executive, and controls and assurances populated. The new framework has also shared at two meetings with Committee Chairs.
2. **July to August: executive build and Committee Chairs’ agreement.** Causes, controls and key risk indicators drafted for each risk, and Committee Chairs briefed.
3. **6 August: Board Development workshop.** The Board tests the seven risks and confirms risk appetite.
4. **September: sign-off and go-live.** The Board approves the new format by formal resolution, and the first full GIP progress report is received.
5. **October onwards: embedding.** The Corporate and Directorate registers are realigned, and BAF-led deep dives begin.

A weekly BAF Revival Group, comprising the Acting Chief Nurse, the Chief Finance Officer, the Risk Manager and external support, is taking the work forward and reports alongside the weekly GIP working group. A separate commissioning risk view, possibly a Commissioning BAF, is under consideration to reflect the Trust’s lead-provider role.

7. Risks to delivery

The programme carries its own risks, which the Board should note:

- **Use of the framework.** The framework will only be effective if the Board and its committees actively own and interrogate the BAF, rather than simply receiving them.
- **Maintaining the number.** There will be continued pressure to add further risks. New concerns need to be captured as causes if the strategic focus is to be maintained.
- **Capacity and timing.** The redevelopment is running alongside the CQC response, the service transfer and the committee restructuring, drawing on the same executive and non-executive capacity.
- **Culture and capability.** The Board and committees will need support to use an evaluative BAF. A BAF handbook, a revised Risk Management Policy and independent testing of embedded controls through Internal Audit are planned alongside the redesign.

8. Recommendations

The Board is asked to:

1. **RECEIVE** the current Board Assurance Framework (as at 15 July 2026) and note the risk profile: 14 risks, 5 rated extreme, 10 outside appetite, with Inpatient Flow the highest-rated risk at 20.
2. **UNDERSTAND** that the profile is no longer static, with Inpatient Flow increased and the Memory Assessment Service risk reduced since the last review.
3. **ACKNOWLEDGE** the interim nature and the limitations of the current framework, consistent with the CQC Well-Led findings, and the limited-to-moderate assurance it provides.
4. **ENDORSE** the redevelopment approach, comprising the risk, cause and effect model and seven strategic risks, each with a named owning committee and defined appetite.
5. **SUPPORT** the reclassification of operational risks to the Trust and Directorate registers as causes within the seven strategic risks and seek assurance that escalation routes keep these risks visible and owned.
6. **ENDORSE** the revised timeline, comprising the Board Development workshop on 6 August, sign-off and go-live in September, and embedding from October, noting that this re-sequences the framework previously expected at the July meeting.
7. **CONFIRM** the expectation of formal sign-off in September and quarterly progress reporting thereafter.

Updated: 15 July 2026

Board Assurance Framework

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

Kent and Medway Mental Health NHS Trust

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMMH remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment or services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years.	5	5	25	System wide response to achieve improved Memory Assessment services across Kent and Medway through the Neighbourhood Alliance. •Standardised operational oversight within directorates with direct accountability assigned to individuals, and reviewed within the Trust SDR process. •Management of Waiting list policy and SOP in place •Demand and Capacity modelling for community services including MAS is being finalised •Community Model Task Force formed comprising KMMH and wider NHS and VCSE partners.	Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team Highlight reports to Trust Leadership Team, FBI and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	3	4	12	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Phase 2: Launch of multi-disciplinary assessment model within KMMH — Director of Partnerships and Transformation — Parked (To review in 6 months) Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 29/05/2026 — R Phase 2 resourcing and implementation — Director of Partnerships and Transformation — Parked (To review in 6 months) Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 31/12/2026 — A Scoping impact of Improved DDR rate on Dementia pathways — Director of Partnerships and Transformation — 06/04/2026 — R	Director of Partnerships and Transformation	Outside of Tolerance	3	4	12	31/12/2026

12/06/2024 — Risk Opened

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 08065	Jun 2024	Chief Medical Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	4	20	Patient flow team jointly working with Liaison Psychiatry, Home Treatment and community services on case by case basis to ensure each admission is purposeful, and inappropriate admissions are avoided. At the same time, we are ensuring that the clinically ready for Discharge patients get the right support in a timely manner so that they spend the least amount of time, beyond what is clinically relevant, in hospital. Twice daily reports including the Place of Safety Breaches Daily system calls Daily bed flow call chair by the Deputy Chief Operating Officer to examine demand, capacity, escalations, 7-day discharge trajectory and complex case review. This can increase twice a day if OPEL 4 is triggered. Daily bed flow meeting is clarifying reasons for admission and alternative to admission to support purposeful admission. Winter plan underpinned by NHSE Mental Health OPEL Framework. Local and system escalation of delayed discharge as required. CORE 24 in place all acute hospital's liaison teams Dedicated resource for CRFD with senior clinical lead and discharge co-ordinators in place from 1st July. System wide focus on CRFD programme continues in conjunction with the ICB and Local Authority. Working with the ICB to explore additional step-down capacity. Red to Green and purposeful admission methodology in operation on all wards to support discharge.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	5	4	20	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recovery Houses across the County — Deputy Chief Operating Officer — BLOCKED Improving proactive early discharge processes on the ward with support from the Acute Directorate. — Chief Medical Officer — 30/06/2026 — R Enhanced social care presence on the wards — Chief Medical Officer — 30/10/2026 — A Directorate based beds — Chief Medical Officer — 31/01/2027 — A Shared discharge pathways — Chief Medical Officer — 31/01/2027 — A	Chief Medical Officer	Outside of Tolerance	1	3	3	30/03/2027

12/06/2024 — Risk Opened

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 08157	Aug 2024	g Officer	**Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and**	5	5	25	Community Mental Health Programme milestone plan to implement change to service, which will support access, waiting times and case load management.	Robust team level management Dashboards Caseload management tool	4	4	16	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**	g Officer	Tolerance	2	3	6	/10/2026

				Initial rating				Current rating						Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	L	C	Rating	Target Date (end)
=	A	Chief Operatin	**In the right place.** If we do not provide the right intervention to the right people due to extraordinary demand that matches the right capacity to provide accessible and responsive treatment and/or support THEN we will a) not be able to understand and meet peoples need in a timely manner b) delay commencement of treatment and/or support RESULTING IN poor service user experience, a potential risk to safety and a delay in meeting the outcome that are important to them.				- Daily review of waiting lists at service level, weekly review of waiting list at operational level (led by service directors) and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. - Actions in place to reduce the overall caseload for MHT and MHT plus, which will support transition to a new approach, which will be completed by April 2026. - Review of the front door are underway as part of the Community Mental Health Programme refresh, and it is agreed that we will launch the Medway Approach. - The COO agendas referrals, waiting times and caseload at their operational report meeting, to understand exception reporting. This is also scheduled regularly at the Quality Improvement Plan CQC Huddles on at least a monthly basis. - Review underway to simplify the mechanism for managing contacts and waits, this includes the DIALOG plus being launched as the initial assessment, care plan and baseline outcome at the point of triage in Q4 2025/26. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse. - A new approach to managing people waiting over 15 weeks is being developed with the service directors to ensure there is a consistent approach to waiting well system. - Referrals, waiting lists and caseload are subject to review and action at the directorate and trust wide SDR process. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse.	Partnership Forums					Implementation of Demand and Capacity Modelling	Deputy Chief Operating Officer	COMPLETED	G	Chief Operatin	Outside of T				31/
													Risk Assessment compliance *All teams to deliver the Trust Quality Improvement Plan for Risk Assessment compliance*	Deputy Chief Nurse	30/10/2026	A					
													Implementation of Care Navigation at the Point of Access (East and West Kent)	Deputy Chief Operating Officer	30/10/2026	A					
													Compliance with DIALOG plus at initial contact	Deputy Chief Operating Officer	31/10/2026	A					
1.2 - Creating safer and better experiences on our wards																					
04/12/2014 BAF Risk Opened — 20/07/2023 Risk returned to BAF																					
ID 07991	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** **Risk Statement** If the Trust does not effectively manage violence and aggression, staff and patients may be exposed to physical and psychological harm. **Impact** This may result in: Increased use of restrictive interventions (including restraint and seclusion) Prolonged recovery for patients Reduced staff confidence in managing and reporting incidents Increased staff sickness absence and reduced workforce capacity Challenges in delivering safe, high-quality care Reduced staff retention and recruitment difficulties Reputational damage Reduced willingness of agency/bank staff to work in high-risk environments Lower staff engagement in violence reduction initiatives	5	3	**15**	Key Controls (Current Position) Restrictive Practice Framework (policy, guidance and oversight) Violence Reduction Strategy with aligned Trust workstreams (including inpatient and racial incident reduction) Continuous Improvement Approach supporting QI methodology and local interventions Personal Safety and Security (PSS) and Security Strategy, including CCTV where available Compliance with Use of Force Act and Operation Cavell Supporting clinical policies (e.g. therapeutic observations, ligature risk, safer staffing) Incident reporting and monitoring via InPhase, supported by Quality Improvement data	Incident reporting via InPhase Quality Improvement Data / Staff surveys	4	3	**12**		**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Nurse	Outside of Tolerance	2	3	**6**	**31/03/2027**
													Improvement project is in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. Now testing directorate level assurance phrase.	Deputy Chief Nurse	30/07/2026	A					
													Enhance data-driven oversight and learning - Develop integrated reporting and thematic review of violence and aggression incidents, using InPhase and workforce data to identify hotspots and ensure learning is fed back to teams.To report into new Patient Safety and Quality Assurance group	Deputy Chief Nurse	31/08/2026	A					
													New Violence and Aggression Policy 2025	EPR Lead	COMPLETED	G					
													Violence and Aggression Listening Sessions to be held with Community Teams	Diversity and Inclusion Manager	COMPLETED	G					
													Allyship Training for Community and Children and Young People Teams	Diversity and Inclusion Manager	12/04/2027	A					

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
01/04/2014 — Risk Opened — 25/06/2025 — Risk escalated to BAF																			
ID 02290	Apr 2014	Chief Nurse	Previously named - CQC Regulatory Compliance Risk **Re named to - Delivery of Safe, High-Quality Care** **Risk Statement** If the Trust does not consistently deliver safe, effective and high-quality care, supported by robust systems for governance, assurance and continuous improvement, there is a risk of harm to patients and variability in care standards, including failure to meet regulatory requirements. ---------- **Potential Impact** Increased risk of avoidable harm to patients Inconsistent quality and safety of care across services Failure to meet CQC Fundamental Standards, resulting in adverse inspection findings or enforcement action Reduced patient, carer and stakeholder confidence Reputational damage Increased risk of legal challenge and financial implications	4	4	16	Key Controls (Current Position) Trust Quality Improvement Plan, providing structured oversight of improvement activity and progress across directorates New Patient Safety and Quality assurance group with escalation to Quality Committee, ensuring oversight of quality, compliance and improvement actions Learning Review Group (LRG) embedding learning from incidents, complaints and reviews CQC engagement arrangements, including routine engagement meetings and tracking of regulatory requirements and actions Mental Health Act review processes, with oversight through MHLOG and MHAC ----------	Top Actions to Reduce Risk 1- Strengthen Trust-wide quality governance and assurance Improve the reliability and consistency of quality oversight, escalation and action tracking, ensuring that risks are identified early and managed proactively. 2- Improve triangulation of quality intelligence Strengthen integration of incident, audit, complaints and performance data to provide a coherent and real-time picture of quality and compliance risks. 3- Enhance frontline ownership of quality and standards Increase staff understanding of what "good" looks like under CQC quality statements, ensuring consistent delivery and evidence of high-quality care in practice. 4- Strengthen delivery and assurance of improvement through the quality improvement plan- Ensure all quality and regulatory actions are outcome-focused, time-bound and subject to robust assurance, with clear evidence of sustained improvement.	4	4	16	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Place of Safety Quality Improvement Plan - aims to embed key areas for improvement including a flowchart detailing staff actions regarding consent to treatment, clarity regarding the process of patients remaining longer than 24 hours and standards of care expected. Addresses contents of the S29a warning notice. — Chief Nurse — COMPLETED (two previous MHAC committees evidenced no breaches, evidencing assurance of embedded actions) — G Community Teams & Crisis services Quality Improvement Plan - aims to deliver and embed key areas addressed from the community inspections, including the S29a warning notice. These include actions across four key themes - Safety & Risk/ Access & waiting times/ Environment, experience & equity/ Leadership, culture & governance. — Chief Nurse — COMPLETED (S29a section met) — G Strengthen delivery and assurance of quality improvement plan Ensure all actions are time-bound, outcome-focused and demonstrate sustained improvement — Chief Nurse — 01/10/2026 — A Enhance directorate accountability for quality and compliance through triumvirate leadership - regular triumvirate workshops occuring Strengthen performance oversight, challenge and escalation at directorate level — Chief Nurse, Chief Operating Officer, Chief Medical Officer — 01/12/2026 — A Improve triangulation of quality intelligence Integrate data from incidents, complaints, audits and performance to identify and respond to emerging risks — Chief Nurse/ Chief Operating Officer — 01/10/2026 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2027
02/04/2024 — Risk Opened — 08/09/2025 — Risk escalated to BAF																			
ID 07960	Apr 2024	Chief Nurse	**Reduce Self harm in our female patients on Acute Wards** IF we do not take an evidence based approached to self harm across admission, discharge and inpatient care. THEN we have increased frequency and severity of self harm. RESULTING IN risk of serious injury and/or death, escalation in self harm, increased observations and restrictive practice, financial impact, poor patient experience, increased regulatory oversight.	5	4	20	Evidence based approach across the three pillars of i) decisions to admit, ii) inpatient care and, iii) timely decisions around discharge Admissions: 1) Apply urgent senior clinical shared decision making to requests for admission by drawing upon NICE Guidelines (CG78) discerning between Acute and Chronic Risk. Includes 'Patient flow', 'Acute Directorate', 'Liaison Psychiatry Services'; CRHT, and MHT+. 2) Keen focus on 'Purposeful Admission Policy' and specifically the 'Gate Keeping Form' KMMH CED Admission guidelines developed to test requests for admission against evidence based practice. Test & learn goes live in West Kent Liaison Services on 19/1/26 During Admission: 3) Patient specific bespoke Self Harm Care Planning including: Co created Psychological formulation & Simple PBS plans 4) Embedding/ and reinforcing across MDT / morning handovers 5) Focus on patient responsibility and ownership 6) Acute Clinical Risk Forum – supports positive risk taking, and discharge planning (1d) 7) ASH project & MWRAP - evaluation complete and roll out plan developed Discharge: 9) Acute SLT focus and follow-up on discharge planning to address any barriers to discharge. Attention to specific long stay patients for whom inpatient care is not helpful/ exacerbating self harm. Trustwide: - Trust wide self harm steering group (1d) - High intensity user pathway - Trust risk forum	Acute SDR - Driver Metrics Incident reporting- identifying trends and themes per area. New BI dashboard to support data analysis. Matrons daily huddle Governance Huddle Clinical risk forum minutes Trust wide self harm steering group meeting records Yearly environmental ligature audit Safety Culture bundles	4	4	16	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Clinical risk forums have been reimplemented. These can be requested by teams and chaired by the Chief Medical Officer. TOR to be agreed and approved. — Deputy Chief Medical Officer — 30/06/2026 — R Self harm data analysis on wards — Head of Nursing and Quality, Acute — 28/02/2026 — R Enhanced Therapeutic Observations and Care (ETOC) - national pilot underway, safer staffing training in January 2026 and policy refresh. — Head of Nursing and Quality, Acute — COMPLETED — G CAPLET training for all inpatient staff working in female acute wards — Head of Nursing and Quality, Acute — 04/05/2026 — R Develop and launch self-harm formulation tool for staff and patients — Strategic Lead for Allied Health Professions — 01/05/2026 — R Develop information leaflets / resources for patients and families in relation to self-harm — Strategic Lead for Allied Health Professions — 27/07/2026 — A	Chief Nurse	Outside of Tolerance	3	2	6	12/09/2026
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																			
			No Risks Identified against this Strategic Objective																

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
2 - We are a great place to work and have engaged and capable staff living our values																						
2.1 - Creating a culture where our people feel safe, equal and can thrive																						
30/01/2025 → BAF Risk Opened																						
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Delivery of Strategic Ambitions** If there is an inconsistent culture across the trust, with pockets of excellence alongside areas of closed and poor culture, then change, phycological safety, openness and willingness to learn and improve are not consistently embedded. Resulting in the potential for reduced staff engagement and retention, weakened speaking up, further inconsistent practice, increase incidents and complaints, and increase regulatory scrutiny impacting the delivery of safe, effective and equitable care and the Trust strategic ambitions.	4	4	16	Leadership and Management development programmes Work to introduce and embed new and coherent organisational values Delivery of leadership development programme Delivery of equality, diversity and inclusion interventions Delivery of 'Doing Well Together' and improvement capability building Prioritisations and regular review of Strategic Priorities and capacity	Staff Survey results Pulse Survey results	3	3	9	⇔	Delivery of Leading Well Together programme	Deputy Chief People Officer	29/05/2026	R	Chief People Officer	In Appetite	2	3	6	31/03/2027
													Embedding of staff voice initiatives	Deputy Chief People Officer	14/12/2026	A						
													Improving Change Management Processes	Deputy Chief People Officer	COMPLETED	G						
2.2 - Building a sustainable workforce for the future																						
			No Risks Identified against this Strategic Objective																			
2.3 - Creating an empowered, capable and inclusive leadership team																						
			No Risks Identified against this Strategic Objective																			
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																						
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																						
			No Risks Identified against this Strategic Objective																			
3.2 - Working together to deliver the right care in the right place at the right time																						
			No Risks Identified against this Strategic Objective																			
3.3 - Playing our role to address key issues impacting our communities																						
			No Risks Identified against this Strategic Objective																			
4 - We use technology, data and knowledge to transform patient care and our productivity																						
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																						
22/07/2015 → Risk Opened → 15/06/2025 Risk escalated to BAF																						
ID 04673	Jul 2015	Chief Finance and Resources Office	**Organisational Risk - Cyber Attack** IF the Trust is the victim of a successful cyber attack THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation.	4	5	20	Omitted for security reasons	Omitted for security reasons	3	5	15	⇔	Omitted for security reasons				Chief Finance and Resources Office	Outside of Tolerance	2	3	6	29/03/2027
4.2 - Enhance our use of IT and digital systems to free up staff time																						
			No Risks Identified against this Strategic Objective																			
4.3 - Effective digital tools are in place to support joined-up, personalised care																						
			No Risks Identified against this Strategic Objective																			

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5 - We are efficient, sustainable, transformational and make the most of every resource																						
5.1 Achieve financial sustainability																						
22/08/2023 Risk Opened																						
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Sign off of Medical Agency spend at exec level. [3a] Sign off for above cap rate posts at CEO level [3a] Reporting to Trust Board [3a] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend Medical lead for recruitment appointed to support areas which are challenging to recruit to. All non medical vacant posts are reviewed at the weekly vacancy control panel. No retrospective approval of Agency shifts Increase in recruitment and retention premium for consultant posts in the East. Virtual consultant post is being tested for the East Vacancies.	Monthly IQPR (reported to each public board) Monthly statements to budget holders [1a] Monthly Finance Report [1h] Internal audit [3d]	3	3	9	⟺	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Medical Officer	In Appetite	3	3	9	**28/09/2026**
													Reduce Nursing Agency Spend by 50% to meet the National ask	Chief Medical Officer	COMPLETED	G						
													Review all medical agency and rationale as part of planning for 2026/27, identifying strategies to reduce usage	Deputy Chief Medical Officer	COMPLETED	G						
													Review agency controls on all staffing groups to ensure appropriate controls to maintain balance between financial discipline and clinical need	Associate Director of Finance (Financial Management)	COMPLETED	G						
25/06/2024 Risk Opened																						
ID 08174	Jun 2024	Chief Finance and Resources Officer	**Delivery of Financial Targets** IF the Trust is unable to deliver its financial targets THEN additional scrutiny will be attached to its financial position RESULTING IN sanctions from NHS England	3	5	15	Standing Financial Instructions [2e] Delegated budgets [1a] Agency recruitment restriction [2e] CIP Process [2e] Monthly statements to budget holders [1a, 1h] Budget holder authorisation [2a] Authorised signatories [2a] Trust Capital Group oversight [2b] Business Case review group [2b]	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	12	⟺	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer	Outside of Tolerance	2	4	8	**31/03/2026**
													Review of the use of temporary staffing and identify appropriate mitigations and controls	Associate Director of Finance	31/03/2026	R						
													Scenario Planning & Risk Modelling	Associate Director of Finance	31/03/2026	R						
25/06/2024 Risk Opened																						
ID 08175	Jun 2024	Chief Finance and Resources Officer	**Delivery of Underlying Financial Sustainability** IF the Trust fails to maintain financial sustainability THEN this could lead to an inability to deliver core services and health outcomes, and financial deficit, RESULTING IN intervention by NHS England and insufficient cash to fund future capital programmes.	3	4	12	Long term sustainability programme [1g] Cost Improvement Programme [1d]	Monthly external reporting to ICB and NHS England	3	4	12	⟺	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer	Outside of Tolerance	3	2	6	**31/03/2026**
													Separate workstream for Corporate Savings to monitor delivery to include system stretch requirement	Associate Director of Finance	31/03/2026	R						
													Agreed Cost Improvement Plan programme of work with agreed timeframes	Associate Director of Finance	Completed	G						
													Review of Trust controls on Non Pay	Associate Director of Finance	Completed	G						
													Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising	Associate Director of Finance	Completed	G						
													Refresh and review underlying position at service and commissioner level.	Associate Director of Finance	31/03/2026	R						
													Delivery of Cost Improvement Plan programme of work with agreed timeframes. Slippage in delivery to be mitigated by alternative plans	Associate Director of Finance	31/03/2026	R						
													Implement 3 year planning model	Associate Director of Finance	31/03/2026	R						
5.2 Exceed the ambitions of the NHS Greener programme																						
			No Risks Identified against this Strategic Objective																			

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5.3 Transform the way we work																			
19/01/2026 Risk Opened																			
ID 08480	Jan 2026	Director of Communications and Engagement	**Risk to stakeholder confidence** If heightened scrutiny following CQC activity and political / regulatory engagement leads to renewed attention on Trust performance and historic themes, Then media and stakeholder challenge may increase and escalate rapidly, particularly where complex issues are misunderstood or reported without context, Resulting in loss of confidence among patients, carers, staff and partners, increased regulatory and political scrutiny, workforce impacts, and reduced capacity to focus on and deliver improvement.	4	4	16	Executive-led issues management, escalation process and stakeholder management for sensitive matters Routine media monitoring and issues horizon scanning Coordinated handling of enquiries and reputational issues across communications, quality/safety, safeguarding, HR and legal Established governance for incidents, complaints and duty of candour Reactive briefing materials maintained for high-risk themes and external milestones A structured comms approach ahead of known scrutiny milestones. Proactive strategic storytelling to evidence improvement and learning, supported by updated briefings for senior leaders and services. Crisis Communications Plan Business Continuity Management Policy	Board oversight through formal committee and assurance reporting routes	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Development of a Media Training Plan — Deputy Director of Communications and Engagement — 31/03/2026 — R Development of a media and communications dashboard to enable thematic reviews — Head of Communications and Marketing — 30/09/2026 — A Development of a new process for responding to Out of Hours Media contacts — Head of Communications and Marketing — 30/09/2026 — A Improved process for the triangulation of data to include consideration of an ICB approach, potentially through the purchase of a media monitoring system — Deputy Director of Communications and Engagement — 30/09/2026 — A	Director of Communications and Engagement	Outside of Tolerance	3	3	9	27/03/2027
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
29/03/2024 Risk Opened																			
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in refreshing its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FBI regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** To complete the Annual ERIC Return — Deputy Director for Estates — COMPLETED — G Tender for 6 Facet Survey — Deputy Director for Estates — 30/03/2026 — R CAMHs Estate due diligence to understand and identify risk level within current estate and inform future investment needs — Deputy Director for Estates — 31/03/2027 — A	Chief Finance and Resources Officer	In Tolerance	2	3	6	31/03/2027
01/04/2020 Risk Opened																			
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Services Business Continuity Plans	Reporting to FBI TIAA Audit Contract Monitoring Minutes	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of the present hybrid working arrangements — Director of Estates and Facilaities — 31/03/2026 — R	Chief Finance and Resources Officer	In Appetite	2	3	6	08/04/2027

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	30th July 2026
Title of paper:	Neighbourhood Health Collaborative Board Progress Report
Author:	Julia Hart, Deputy Director, Neighbourhood Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of paper

This paper provides an update on work of the Neighbourhood Health Collaborative Board

There are updates on the workstreams which previously fell under the Mental Health and Learning Disability Collaborative. Also, wider updates from the new collaborative board, which covers, mental health, dementia and neighbourhood.

This report includes:

- Outcome of the lead social worker Clinically Ready for Discharge workstream
- Dementia transformation update
- An update on key performance metrics including Urgent and Emergency Care.

Areas to bring to the Board's attention

- The lead social workers work stream pilot has come to an end, progress made and challenges faced are noted.
- Dementia progress across the tiered diagnostic model and the actions being taken to accelerate delivery, evaluation and future scaling across Kent and Medway**.**

Version control 02 - **Public**

- UEC Mental Health and commissioning of 6 additional Crisis House beds in Thanet.

Governance

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

1. Board reporting – programme update forward plan for 2026-27 and The Kent and Medway Neighbourhood Collaborative.

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

Please note that the forward plan is provisional, noting recent changes to the system architecture and how this may impact reporting on programmes.

The Kent and Medway Neighbourhood Collaborative represents a significant system-wide opportunity to improve population health outcomes through more integrated, preventative and person-centred models of care. As a core partner within the Collaborative, Kent and Medway Mental Health NHS Trust (KMMH) is committed to ensuring that mental health, learning disability and autism services are fully embedded within neighbourhood-based approaches and contribute effectively to the wider ambition of reducing inequalities, improving access, strengthening community support and reducing avoidable reliance on acute services.

Mental health transformation remains a critical enabler of the Neighbourhood Health Model. Whilst progress has been made, there remains a need to accelerate the shift from reactive, bed-based care towards earlier intervention, prevention and integrated multidisciplinary support delivered closer to people's homes and communities.

In response, the Trust is leading work across three priority areas identified through the Neighbourhood Collaborative programme: mental health presentations in Emergency Departments, dementia pathway transformation, and the alignment of Additional Roles Reimbursement Scheme (ARRS) workforce capacity to neighbourhood and population health priorities

2. Programme updates July 2026

2.1 Lead Social Worker Workstream Closure Report

Purpose
This report provides a final update on the Lead Social Worker (LSW) workstream established as part of the wider programme to reduce delays for patients who are Clinically Ready for Discharge (CRFD). The workstream is now closed following completion of the pilot and evaluation period.

Background
The workstream commenced in July 2025 with two Lead Social Workers seconded into inpatient services. The objective was to strengthen discharge planning, improve partnership working with local authorities and reduce CRFD delays through earlier social care involvement, legal expertise and system leadership. The work was overseen through bi-weekly meetings with KMMH and local authority representation and reporting of qualitative and quantitative metrics.

Outcomes and Impact
The evaluation identified several positive operational, clinical and partnership impacts. Lead Social Workers directly contributed to approximately 22% of CRFD discharges during the pilot period and were involved in 84% of placements into the Clarendon step-down pathway. The interventions supported an estimated 1,830 bed days being released for patient care. The roles strengthened discharge planning, improved collaboration with local authority partners, increased focus on 'Home First' approaches and enhanced application of statutory frameworks including the Care Act, Mental Capacity Act and Section 117 aftercare.

One of the key goals set for the work stream was to work collaboratively cross organisationally to support early and appropriate discharge planning – coordinating processes, ensuring clear and consistent communication and preventing duplication of work. Feedback from clinical colleagues, local authority partners and patients was consistently positive. Stakeholders reported improved communication, reduced duplication, provided stronger legal oversight and greater confidence in complex decision-making. Patient feedback highlighted the value of holistic support, improved understanding of discharge arrangements and positive contributions to recovery and independence.

Assessment Against Original Aim
The KMMH Board is asked to note the following and confirm closure: despite these benefits, the workstream did not achieve its primary objective of delivering a sustained reduction in overall CRFD numbers, reduced admissions, and shorter lengths of stay by enhancing health and social care alignment. Trust performance data did not demonstrate a consistent improvement in the key outcome measures used to assess success. Analysis suggests that most delays continued to be driven by wider system factors, including shortages of care home placements, supported accommodation capacity, and delays in social care assessment and funding processes. These issues sit largely beyond the direct control of the Lead Social Worker function.

Learning and Next Steps
The pilot has generated valuable learning for the Trust and system partners. It has reinforced the importance of early discharge planning, strong health and social care integration, legal literacy and senior social work leadership within inpatient pathways. It has highlighted workforce interventions alone are unlikely to deliver significant reductions in CRFD without parallel improvements across housing, social care and community provision.

The workstream will therefore close, with learning incorporated into future pathway improvement work. Positive elements of the model, including strengthened partnership working, improved discharge practice and enhanced understanding of discharge barriers, should be considered within future service development and transformation programmes.

Conclusion
The Lead Social Worker workstream has delivered clear qualitative benefits for patients, staff and partners and has demonstrated value in supporting complex discharge pathways. However, it did not achieve the principal outcome of reducing CRFD at a system level. On that basis, the workstream is now closed. The Board is asked to note both the positive contributions of the pilot and the lessons learned, which will inform future improvement activity across Kent and Medway.

2.2 Dementia Transformation Update

The Dementia Diagnosis Rate remains below the national ambition of 66.7%, with March 2026 performance at 62.4%. Whilst incremental improvement has been achieved, the current position reinforces the need for continued Board oversight of delivery risks, particularly primary care participation, operational capacity, and future commissioning arrangements. This report provides an update on progress across the tiered diagnostic model and the actions being taken to accelerate delivery, evaluation and future scaling across Kent and Medway.

The Level 1 work has been shortlisted as a finalist in the HSJ Patient Safety Awards in two categories: *Best Use of Integrated Care and Partnership Working in Patient Safety* and *Improving Safety for Older People Initiative of the Year*. This provides external recognition of the partnership approach and the programme's focus on improving access to diagnosis for older people in care home settings.

Key delivery risks continue to be actively managed and monitored through programme governance arrangements. Whilst progress has been made across both Level 1 and Level 2 delivery, the following risks have the potential to impact programme timescales, evaluation activity and future scalability if not mitigated. The narrative below goes into further depth surrounding these.

Risk	Impact	Mitigation	RAG
Level 1 - Primary Care funding not agreed	Limits Level 1 scale-up	ICB focused discussions through neighbourhood health contracting and active Local Medical Committee engagement	
Level 1 - Insufficient DiADeM activity	Delays evaluation of model and wider scalability	Targeted care home engagement and dedicated training programme, looking at data for areas of low uptake	
Level 2 - KMMH MAS workforce availability for pilot alignment	Delays go-live for 'test and learn' pilots	Expressions of interest process and provisional timeline for resource alignment agreed to be in place by the end of July. With appointments in place for August.	

<u>Level 1 – Care Home Diagnosis</u>

Level 1 implementation has continued to progress, with further training sessions for both care home staff and GP practices delivered. Although training uptake has increased, supported by targeted outreach and engagement.

Targeted outreach includes attendance at the KICA Conference in May, engagement through all Local Mental Health Networks in June, and planned promotion through the Medway Provider Event in September and Kent Registered Managers Conference in October. A bitesize webinar is being delivered to social care colleagues in July to improve understanding of the Level 1 pathway and how it can support frail individuals, including those assessed through care home and home visit routes.

A number of DiADeM assessments have been completed and are providing useful learning from the pilot phase. However, further uptake is required to ensure a sufficiently robust and balanced evaluation of the care home model. Progress continues to be affected by the ability of care homes

to release staff for training and by the lack of a confirmed funding mechanism to support primary care participation.

The ICB is now pursuing funding for primary care involvement through neighbourhood health contracting arrangements. This follows the previous expectation that a Locally Enhanced Service would be in place from April 2026. Discussions led by Dr Rakesh Koria, with the Local Medical Committee, are ongoing and are expected to support resolution of the approach to primary care engagement and participation.

Next steps are as follows:

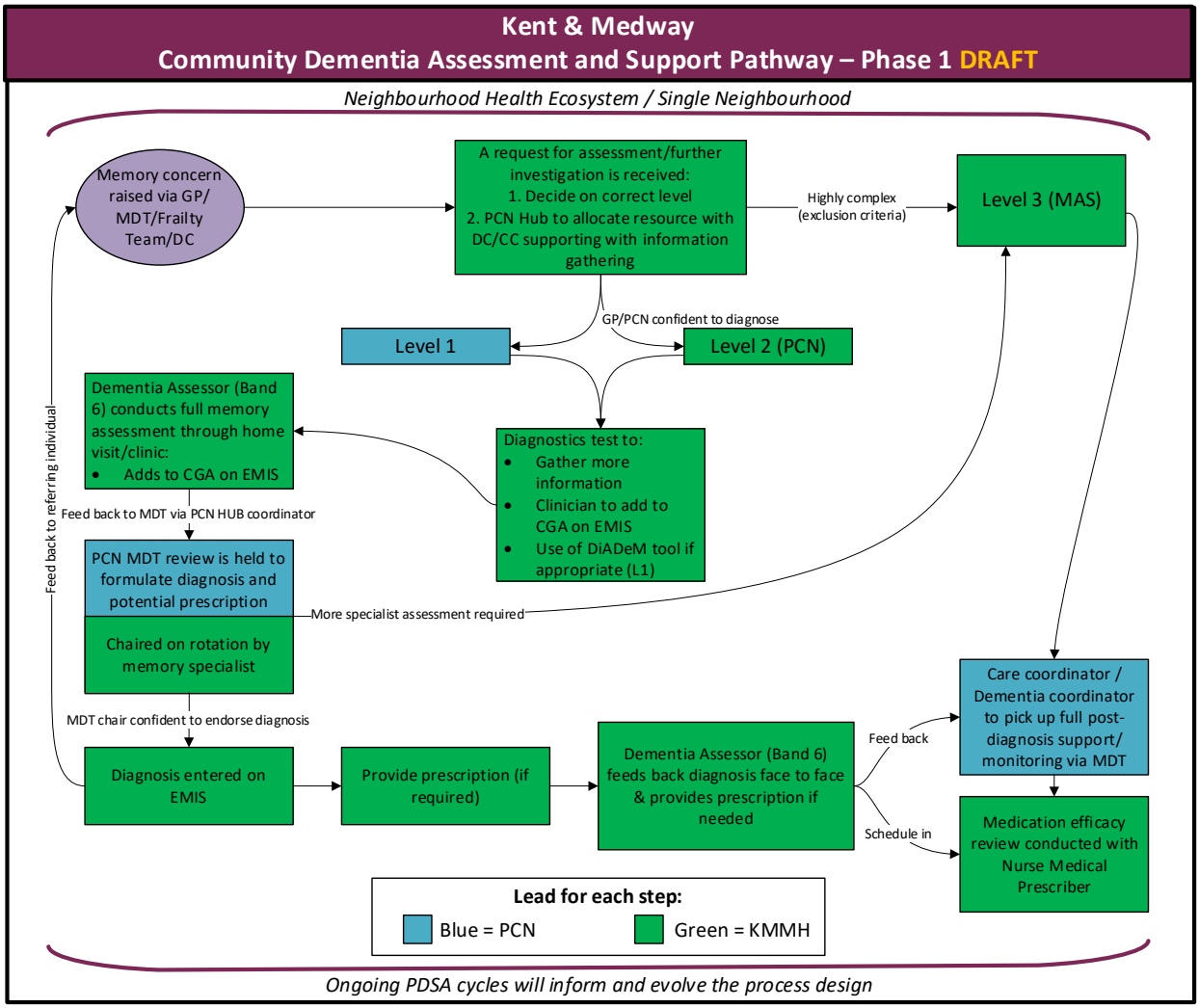
- Project team to increase care home and primary care uptake across engagement events scheduled for July-October
- Dementia transformation clinical lead to expand the train-the-trainer model training to ensure sustainability (August-September)
- ICB to confirm the route for primary care funding (August)
- Project team to complete the evaluation once sufficient DiADeM activity has been generated post-funding enabler going live (TBC)

Level 2 – Community Diagnosis

Development has progressed for the Level 2 community diagnostic model through the Folkestone, Hythe and Rural Neighbourhood Health pilot. The below pathway overview sets out a multidisciplinary model with KMMH in-reach and specialist support across triage, assessment and diagnostic decision-making, with clear escalation routes into Level 3 Memory Assessment Services for complex presentations.

The Standard Operating Procedure has been further developed and describes the anticipated scope of the pilot, clinical governance arrangements, workforce roles, and expected patient and system benefits. The model is intended to support diagnosis closer to home for appropriate non-complex presentations, while maintaining specialist oversight and clinical safety. Delivery will be tested through iterative Plan-Do-Study-Act (PDSA) cycles, enabling learning from early implementation to inform pathway refinement, operational adjustments and future scalability.

Engagement has progressed with wider primary care partners within the locality. Board presentations have taken place with The Marsh PCN and Total Health Excellence West PCN, with further conversations planned to support alignment and enable future go-live alongside the Folkestone, Hythe and Rural PCN. This will help test the model across a broader neighbourhood footprint and inform future scalability.



Lived experience engagement has continued to directly inform Level 2 design. Between April and June 2026, the programme visited more than 10 in-person groups across KMMH and Alzheimer's and Dementia Support Services, supplementing feedback from the Dementia Test and Learn Group and Dementia Transformation Lived Experience Working Group. Consistent themes around access, communication, pathway navigation and post-diagnostic support are being built into the developing model to ensure future delivery reflects the needs of people living with dementia and carers.

Work is progressing to ensure the digital infrastructure supports delivery and future scalability. Colleagues are working to adapt the KMCR to support both Level 1 and Level 2 pathway requirements, including adaptation of the Cognitive Geriatric Assessment template for DiADeM at Level 1 and ACE-III within the Level 2 model.

Plans are in place to issue expressions of interest for KMMH resource aligned to the pilot at the end of July 2026, with a view to individuals commencing in August and supporting pilot go-live. The pilot will run for 3 months and will see phased scaling across GP surgeries attached to the Folkestone, Hythe and Rural Neighbourhood Pilot footprint. This timeline remains indicative and is subject to stabilisation of operational factors. Work is ongoing with Service Directors and operational colleagues to define staffing model, confirm delivery arrangements and ensure the pilot can be implemented safely and sustainably.

The ICB's commissioning intentions will be a key determinant of how Level 2 is taken forward beyond the initial pilot. This will include consideration of future scale, recurrent resource requirements, alignment with neighbourhood health footprints and the role of KMMH within any expanded community diagnostic model

Pre and Post-Diagnostic Support

Pre and post-diagnostic support has been agreed as in scope for the Dementia Transformation Programme. This reflects feedback from people with lived experience, carers and partners, which has highlighted the need for clearer pathway navigation, improved communication, more consistent support after diagnosis, and better coordination across statutory, voluntary and community services.

A delivery plan is being developed to support service mapping, gap analysis and public engagement to inform recommendations for the system from September 2026. This work will establish the current support offer across Kent and Medway, identify gaps and variation, and ensure that the views of people affected by dementia inform future service design.

Next steps

For Level 1, priorities are to confirm primary care participation arrangements, increase DiADeM activity through targeted engagement, and strengthen the evidence base for evaluation ahead of the November Board report.

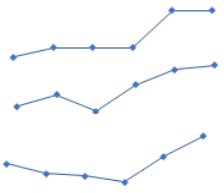
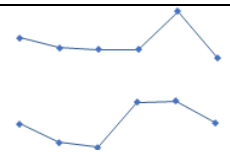
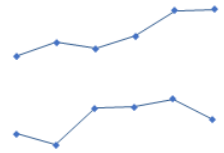
For Level 2, priorities are to mobilise the Folkestone, Hythe and Rural pilot, confirm KMMH operational resource, align participating PCNs, and use PDSA cycles to capture early learning following go live. This will inform model refinement, scalability and alignment with wider intentions for neighbourhood health.

Cross-cutting priorities include progressing KMCR digital enablement across Levels 1 and 2 and commencing public engagement on pre- and post-diagnostic support.

The November update will provide assurance on Level 1 evaluation, early Level 2 implementation learning, and feedback from public consultation surrounding pre and post-diagnostic services to support future commissioning decisions.

3. Current performance data

Measure	Agreed trajectory	Current data						AVG	Line Graph
		Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26		
Methodology: RAG is determined by two factors; • Agreed target, or • Averages. These are compiled based on performance data for the previous 6-month financial period covered and may therefore change for the report period being covered. The RAG rating reflects this same 6-month period. • A 10% tolerance is proposed for attributing an amber status within the respective data point cell.									
		Programme: Dementia Pathway Transformation							
Increase dementia diagnosis rate	66.7% by March 2026	62.1%	62.0%	62.0%	62.4%	-	-	N/A	.3%
		Programme: Mental Health Urgent and Emergency Care							

Reduced MH A&E attendance and increase in attendance at safe havens	Reduce	*% MH A&E presentations against total presentations*						2.02%	
		1.8%	1.9%	1.9%	1.9%	2.3%	2.3%		
	Reduce	*A&E attendances for adult patients with primary MH need*						802	
		713	771	688	820	898	920		
	Increase	*Safe Haven attendance*						1880	
		1887	1778	1748	1681	1976	2210		
Crisis house bed occupancy	85%	*Medway bed occupancy*						N/A	
		80%	75%	74%	74%	94%	70%		
		Ashford bed occupancy							
		80%	90%	80%	68%	95%	81%		
Reduced mental health in ambulance/ police conveyances to A&E	Reduce	*Primary MH A&E presentation - Ambulance conveyance*						434	
		346	399	375	424	527	533		
		Primary MH A&E presentation - Police conveyance						42	
		31	23	50	51	57	42		
Reduction in incidence of Section 136	Reduce	66	73	55	56	56	-	61	

Exception reporting on performance

- Whilst the Dementia Diagnosis Rate (DDR) continued to demonstrate incremental improvement during the reporting period, reaching 62.4%, the March 2026 ambition of 66.7% was not achieved. Although performance against the improvement trajectory was assessed as Amber, the year-end position remains below target and therefore the overall RAG rating is Red. Work is underway to further scale and embed the multi-tiered dementia diagnostic model across the system, which is expected to strengthen diagnostic capacity and support continued improvement in performance over time.
- From April 2026 onwards, Dementia Diagnosis Rate (DDR) performance is reported nationally on a quarterly basis. Therefore, monthly data is no longer available and future reports will reflect quarterly performance updates.
- A&E attendance has increased in April and May, significantly for Medway Foundation Trust. Increase aligned to seasonal variability.
- The ICB has awarded funding for 6 additional Crisis House beds in Thanet, which are expected to be operational from October 2026 and support the reduction in A&E MH presentations locally.
- Medway crisis house saw a drop in occupancy rate accompanied by an increase in A&E attendances. The ICB report that they are currently in transition to the new clinical model, however Medway is the best performing of all MHT teams. The Safe Haven has also seen an increase over the last few months The reporting period months traditionally see a peak in demand with Easter seen as winter in Mental Health services.

4. Programme Milestones for 2026-2027

Milestone Tracking Key

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

Community Mental Health Framework					
Milestone	**26-27**				
	Q1	**Q2**	**Q3**	**Q4**
Demand and capacity for MHT+ workforce productivity				
Development of refined operating model to support delivery of agreed clinical model (to incorporate demand/capacity, workforce, digital, estates and contracting)		X		
Transition and sustainability of refined clinical and operating model to BAU			X	
Implementation of new CHYPS AMS pathway into the CMHF		X		
Dementia Pathway Transformation				
Milestone	**26-27**			
	Q1	**Q2**	**Q3**	**Q4**
Level 1 – Continuation to roll out new care home diagnosis process and training across the county	X	X		
Level 1 – Additional funding for primary care supporting level 1 and 2 dementia diagnosis to be agreed	X	X		
Level 1 – Evaluate the care home pilots based on data and completed DiADeMs. Expected evaluation period to be assessed in September 2026	X	X		
Level 2 – Go live with community dementia diagnosis pilot in Folkestone & Hythe	X			
Level 2 – Conduct a clinical audit on Folkestone & Hythe to assess efficacy of model	X	X		
Level 2 – Scale up pilot across 2 additional PCN areas within the Folkestone & Hythe footprint		X		
Mental Health Urgent & Emergency Care					
Milestone	**25-26**	**26-27**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**
Bespoke Conveyance (to include sit and wait) go-live	X				
Publishing of revised Crisis 136 Standards				X	
Centralised HBPOS Go Live				X	
William Harvey Safe Haven increase to 24-hour service				X	
Procurement of Thanet and Medway Crisis Houses					X
Joint Working Across Health & Social Care					
Milestone	**26-27**			
	Q1	**Q2**	**Q3**	**Q4**
Evaluation of KMMH Social Worker secondment work takes place	X			

Exception reporting on milestones

CMHF

- The refined model of care has been agreed, and work is ongoing to operationalise it. The transition to the new model, originally planned for completion by Q4 2025/26, is now scheduled for Q2 2026/27.
- Adopting a continuous improvement approach by locality, there is no fixed completion date; however, an indicative date has been set to evaluate impact. Implementation is being rolled out in phases at locality level, with rollout already underway in some areas.
- Workstreams have been established to support the programme in the areas of workforce, digital & data, model of care, and communications/engagement. Partner discussions are underway to assess the impact on them now that modelling is complete. Elements of the operating model are being progressed through task-and-finish groups, with locality-level plans to be developed aligned to each area's stage of readiness.
- Further work is required on the new Children and Young People Adolescent Mental Health Services pathway to CMHF, following the transfer of services to KMMH.

Dementia

- Whilst a number of DiADeMs have been completed and targeted outreach has supported training delivery; further uptake is required to enable a robust and balanced evaluation of the care home pilots. Engagement has been constrained by challenges releasing care home staff for training and the lack of agreed funding for primary care participation. Consequently, the evaluation has been reprofiled to Q2 2026/27.

MH UEC

- Bespoke Conveyance/Sit and Wait: Procurement due to commence September. Service will mobilise February 2027, go live April 2027.
- Centralised Health Based Place of Safety expected to open Q3 26/27 (delays due to construction issues); team will continue to use current health-based place of safety (HBPoS).
- Revision of S136 standards will now be implemented in Q3 26/27 as above in line with the changed HBPOS go live date.
- Ashford Safe Haven: Ashford's planned move is still progressing, but the capital build, part of a wider East Kent Hospitals programme, has experienced delays. This is due to construction timelines. Alongside this, NHS England's new Crisis Assessment Centres are being introduced nationally. These centres are consultant-led clinical services differing from the Kent and Medway Safe Havens model. Discussions are ongoing across the system about how these models will work alongside each other. No final decisions have been taken, and we are committed to making sure we deliver community crisis alternative services that meet the needs of residents of Kent and Medway. To support transparency and involvement, a workshop is being organised for September, where the new clinical model and the future offer for Kent and Medway will be discussed in detail. This will be an opportunity for the ICB to hear directly from system partners to help shape the next phase of crisis support.
- Medway Crisis House: Evaluation and Moderation completed. Contract award in process. Expected launch date 01 October 2026.
- Thanet Crisis House: six-bedroom property identified. Contract with provider for signature. Expected launch date 01 October 2026

Joint Working

- The Joint Working (Lead Social Worker) workstream evaluation report was completed but given the cessation of the workstream no further action was required, given the decision based upon the CRfD numbers not having seen a reduction.

5. Upcoming changes to board reporting

Due to changes within the system architecture and restructure; the Sustainable Community Care Collaborative Board will change to reflect this. Therefore, future reports will be submitted from the Neighbourhood Health Collaborative Board moving forward.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Improvement Collaborative – Impact Paper 2025/26
Author:	Sarah Atkinson, Deputy Director of Transformation & Partnerships Sue Venables, Clinical Audit & Effectiveness Manager Sukhi Shergill, Director of Research & Innovation
Executive Director:	Dr Adrian Richardson, Director of Transformation & Partnerships Dr Afifa Qazi, Chief Medical Officer

Purpose of paper

Purpose:	Assurance and Discussion
Submission to Board:	Board requested

Overview of paper

The Board can take moderate assurance that the Improvement Collaborative is now established and is beginning to demonstrate measurable impact across improvement capability, innovation, research participation and clinical effectiveness.
Assurance is strongest in relation to increased staff capability, Minimal Risk Activity Packs (MRAP), medicine administration, trainee experiences, audit and research outputs.
Assurance is weaker in relation to conversion data, benefits capture, spread, directorate ownership and true north alignment.

Issues to bring to the Board's attention

Assurance Level: Moderate Assurance

1. Assurance Board can take:

- Improvement Collaborative is established.
- There is growing organisational use of the route into improvement, innovation, research, service evaluation and clinical audit.
- There is measurable impact from selected projects.
- Staff capability has increased.

Version 2 - **Public**

2. Gaps in assurance:

- Benefits capture is inconsistent.
- Spread is not yet systematic.
- Directorate ownership is variable.
- True North alignment needs strengthening.
- Some examples remain promising but not fully evidenced.

3. Board discussion requested:

- Note the progress made in establishing the Improvement Collaborative as a single route for improvement, innovation, research, clinical audit and service evaluation;
- Take moderate assurance from the early evidence of measurable impact;
- Note the identified assurance gaps around benefits capture, spread, directorate ownership and True North alignment;
- Support the proposed 2026/27 focus on benefits realisation, spread, directorate ownership and reporting through agreed committee routes.

4. Next steps:

- Establish benefits realisation framework.
- Develop spread tracker for proven improvements.
- Confirm directorate ownership.
- Bring a 2026/27 progress update through agreed governance route.

Rationale: The Board can take moderate assurance that the Improvement Collaborative is established and beginning to demonstrate measurable impact. The strongest evidence relates to improvement capability, frontline improvement, innovation and early benefits realisation. Examples include 192 staff trained in Yellow Belt, 591 staff trained in basic continuous improvement, reductions in self-harm through MRAP, improved trainee experience and reduced medicines administration time. Further assurance is required in 2026/27 on consistent benefits capture, spread of proven changes, directorate ownership and reporting against Trust strategic priorities and True North measures.

Governance

Implications/Impact:	No specific risk is currently recorded on the Trust risk register. However, this paper identifies delivery risks relating to benefits capture, spread, directorate ownership and strategic alignment. These will be managed through the proposed 2026/27 reporting and committee oversight arrangements
Assurance:	Moderate
Oversight:	Quality Committee & Finance, Business and Investment Committee

Executive Summary

Impact at a Glance

Impact Area	What we did	Evidence of Impact	Board Assurance
Single Route to Improvement	129 requests received	Shows use of a single organisational route	Assurance that fragmentation is reducing, but further work needed on conversion from request to benefit
Improvement Capability	192 Yellow Belt (A3 Thinking) trained	Staff now applying improvement methods	Assurance strongest where projects have measurable outcomes
Continuous Improvement Awareness	591 staff trained	Improvement language and basic method reaching wider workforce	Further assurance needed on whether training translates into local delivery
Patient safety innovation	MRAP reductions in self-harm	64% and 47% reductions cited	Strong impact example; Board needs assurance on spread and sustainability
Service Efficiency	Time saved per medication round	Up to eight hours nursing time released per month	Good ward-level productivity example. Further assurance needed on adoption, consistency and sustained benefit across inpatient services
Workforce & Education	Improved trainee experience	Mock Clinical Assessment of Skills and Competencies (CASC) improvements resulted in 100% trainee satisfaction and reduced pass/fail marking variation from 44% to 29%.	10-point plan compliance shared at Board level. Positive GMC training survey
Research Growth	Over 50 publications produced by 40 staff	Increased research capability, visibility and collaboration across Kent and Medway, the NHS and academic partners.	Board assurance received via Quality Committee
Clinical Effectiveness and Assurance	191 new Clinical Audit and Service Evaluation projects commenced	40 projects completed and 55 interim reports received, providing assurance and driving improvements in patient safety, prescribing practice, documentation quality and experience of care.	Assurance received via Quality Committee

Risks

Risk	Current Mitigation	What Board should expect next	Committee Route
Benefits are not consistently captured	Benefits framework being developed	Quarterly benefits report showing quality, workforce, productivity and financial impact	Quality / Finance, Business and Investment
Successful changes do not spread	Project examples identified	Spread tracker for MRAP, medicines administration and other proven changes	Quality / Transformation governance
Directorate ownership remains variable	Improvement Collaborative supports teams	Directorate-level improvement priorities and named owners	EMT / directorate governance
Work is not aligned to strategy	True North alignment planned	Dashboard mapping improvement work to strategic priorities	Board or relevant Board committee
Collaborative becomes a route-in rather than route-to-impact	Single access route established	Conversion rate from idea to delivery to measured benefit	Improvement Collaborative reporting

The significance for Board is that the Trust now has a clearer route for improvement, innovation, research, clinical audit and service evaluation. The next stage is to move from activity and examples of impact to a consistent organisational view of benefits, spread and sustainability.

Introduction

The Improvement Collaborative was established to bring together improvement, innovation, research, clinical audit and service evaluation into a single, coordinated approach that supports delivery of the Trust's strategic objectives. By creating one route for staff to access expertise, support and governance, the Collaborative reduces fragmentation, strengthens organisational learning and enables evidence-based improvement to be delivered at scale.

During 2025/26 the Improvement Collaborative moved from establishment into delivery. The focus has been to create a single route for improvement ideas, strengthen staff capability, support frontline teams to use improvement methods, and begin to evidence measurable benefit. The strongest examples of impact are now seen in patient safety, medicines administration, trainee experience and innovation projects. The next phase needs to strengthen benefits capture, directorate ownership and spread.

Activity at a Glance

Distribution of projects	Number of applications
Improvement Team	24
Clinical Audit & Effectiveness	86
Research & Innovation	10
Other*	9
Total	**129**

* - these include projects referred to digital, the innovation den and the Trust charity

The Collaborative is not yet able to report a complete conversion pathway from request through to measured benefit and spread. This is an identified assurance gap. During 2026/27 the reporting framework will be strengthened so that by the next update, the Board should expect to see a conversion dashboard showing the proportion of requests triaged, progressed, completed, delivering measurable benefit, spread across services, and closed with learning captured.

Improvement Team

The Improvement Team continues to play a central role in delivering Kent and Medway Mental Health NHS Trust's strategic ambitions through the Doing Well Together (DWT) programme. By building organisational capability, supporting frontline problem-solving, strengthening leadership behaviours and enabling innovation, the team is helping to create a culture where continuous improvement becomes part of everyday practice.

Importantly, the team is now beginning to demonstrate measurable benefits through structured benefits realisation. Yellow Belt projects have reported improvements in patient experience, reductions in defects, increased throughput, enhanced reputation and cost avoidance, demonstrating how improvement methodologies are translating into tangible outcomes for patients, staff and services.

Demonstrated Benefits and Benefits Realisation

Building Improvement Capability

The programme is developing a workforce equipped to apply structured improvement methodologies and data-driven decision making in day-to-day practice. Staff are being supported to understand customer experience, analyse performance, undertake structured problem solving and implement sustainable improvements. To date, 192 staff members have been trained in Yellow Belt (A3 Thinking) and have delivered or are delivering improvement projects aligned to the Trust strategy.

A further 591 staff members (18.63% of the organisation) have been trained in the basic principles of continuous improvement which is included in Trust induction.

Examples of Impact

The following examples demonstrate how Improvement Team support is translating improvement methodology into measurable benefits for patients, staff and services. The evidence shows emerging impact, with the next phase focused on strengthening quantification, spread and sustainability of benefits.

Improvement / Project	Measurable benefit demonstrated	Benefit type	Spread / sustainability
Trust-wide SMS appointment reminders across Memory Assessment Services (MAS), MHT and MHT+ services	Contributed to reduced Did Not Attends (DNAs) and client cancellations, increased throughput, enhanced patient experience and improved reputation. Early indication of benefit, but quantified reduction in DNAs/client cancellations is not yet available. This will be included in future benefits reporting.	Patient experience; productivity; operational effectiveness	Deployed across MAS, MHT and MHT+ services, however adoption is variable.
Mock Clinical Assessment of Skills and Competencies for membership to Royal College of Psychiatry	Achieved **100% trainee satisfaction, up from 56%** and reduced pass/fail marking variability from **44% to 29%**.	Staff experience; education quality; standardisation; reputation	Improved standardisation in marking and strengthened the quality of medical education processes.
Transition meeting effectiveness	Improved effectiveness through standardised documentation, updated contact arrangements, stronger multidisciplinary engagement and improved communication supporting better outcomes for young people moving into adult services.	Patient experience; care continuity; safety; communication	Standardised documentation and improved contact arrangements create a more sustainable process for future transitions.
Home Treatment Team intervention recording using SNOMED coding	Improved recording and visibility of interventions through more consistent use of SNOMED coding, creating a stronger foundation for future service evaluation and improvement.	Data quality; clinical effectiveness; service evaluation; assurance	More consistent coding supports future evaluation, audit and outcome reporting.
Allington ward medicines administration process	Reorganising the medicines cupboard and adding patient photos to medicines baskets reduced medicines-round time by releasing up to **eight hours of nursing time per month**.	Productivity; patient safety; staff time; operational effectiveness	Pharmacy is developing clear standards, informed by learning from Allington, for wards where this approach is not already in place.
Improvement capability through Yellow Belt / A3 Thinking	**192 staff** trained in Yellow Belt / A3 Thinking and delivering or developing improvement projects aligned to Trust strategy.	Workforce capability; cultural change; strategic delivery	Builds internal capability to identify problems, use structured improvement methods and deliver sustainable change.
Basic continuous improvement training	**591 staff**, representing **18.63% of the organisation**, trained in the basic principles of continuous improvement through Trust induction.	Organisational capability; culture; workforce development	Embeds improvement awareness at induction and supports a common language for continuous improvement across the Trust.

Impact Case Study – Releasing nursing time through ward-led improvement
Allington ward used improvement methods to redesign the medicines administration process. Changes included reorganising medicines storage and improving visual identification. The improvement on Allington alone delivered: • Approximately 8 hours per month saved • Clear identification and visual verification are believed to have reduced the risk of medication errors. • Improved visibility of medication stock enables more timely reordering, reducing over-ordering, excess stock, and associated costs. • Positive feedback from Pharmacy confirms that the new system is clear, effective, and safer for medication A standardised approach where this is not already in place is being drafted by pharmacy to ensure wards have a standard approach based on the learning from Allington.

Empowering Frontline Teams

The Improvement Management System (IMS) includes a training programme which spans 8 weeks for each cohort of frontline teams followed by 2 months of coaching from the improvement team. IMS supports teams to solve problems closest to where care is delivered through improvement huddles, visual management, performance boards and status sheet exchanges. This creates greater ownership, engagement and responsiveness to local challenges.

"My motivation in my role is when we can visually see the improvements that have been made with patients." –Ward Manager, Pinewood ward

"It's good to see a mixed bag of colleagues here [in training]. We are recognising the power and importance of input from everyone." – Lead Nurse.

We have completed 2 cohorts of IMS training, one in Dartford and one in Canterbury and we are currently training cohort 3 in West Kent which includes our first community team. We are seeing a greater level of staff engagement in improvement and several innovative improvements which have had an impact locally and some are being scaled across the Trust.

Medical Workforce Engagement

Medical workforce engagement has strengthened during the year, with improvement input now included in trainee development and consultant Continuing Professional Development (CPD). The next stage is to demonstrate how this engagement translates into completed improvement projects, measurable outcomes and stronger medical leadership within directorate improvement priorities.

Key activity to date includes:

- **Improved visibility and awareness:** Regular slots at consultant CPD sessions allow sharing of improvement approaches, completed work, and ongoing initiatives, alongside clear signposting to opportunities.
- **Enhanced capability and engagement:** Core trainee sessions, including White Belt training, build improvement skills while encouraging active participation in initiatives.

- **Early and sustained engagement:** Inclusion of information in resident doctor induction ensures the medical workforce is aware from the outset of team roles, involvement opportunities, and training pathways.
- **Increased participation:** Clear signposting and repeated engagement opportunities support wider involvement across the medical workforce.
- **Positive organisational impact:** Feedback from the Director of Medical Education highlights a noticeable and positive improvement in engagement levels within the medical workforce.

Overall, this structured, consistent engagement model is strengthening participation, awareness, and impact across the medical workforce.

Innovation Den

The Innovation Den provides a structured route for frontline staff to develop and test ideas that improve patient care, staff experience and service delivery. During 2025/26, projects supported through the Innovation Den have demonstrated measurable impact, while also creating opportunities to spread learning and innovation across the Trust.

Patient Impact - Innovation Den projects have delivered tangible improvements in patient outcomes and experience. The Minimal Risk Activity Packs (MRAPs) project demonstrated substantial reductions in incidents of self-harm, achieving reductions of 64% and 47% in the pilot areas. The project has subsequently been shortlisted for two HSJ Patient Safety Awards, providing external recognition of its impact. Other initiatives, including the Oakwood Nature Recovery Area and Courtyard Garden projects, have enhanced therapeutic environments, supporting patient wellbeing, recovery and engagement in care.

MRAP provides the strongest current evidence that the Innovation Den can support measurable patient safety improvement. The next stage is to assess whether successful innovations are being systematically adopted beyond their original setting, whether benefits are sustained over time, and how learning is shared across directorates.

Staff Impact and Engagement - The Innovation Den is helping to strengthen a culture where staff are encouraged to identify problems, generate ideas and lead change. By providing practical support, funding opportunities and a clear route for developing innovations, the programme enables staff to translate ideas into improvements that benefit patients and services. Feedback from participants highlights increased engagement, ownership and confidence in leading change, supporting the Trust's wider ambition to embed continuous improvement across the organisation.

Spread and Future Potential - Several Innovation Den projects have demonstrated potential for wider adoption across services. The success of the MRAPs project has generated interest beyond the initial pilot areas, while environmental improvement initiatives and therapeutic resources are providing models that can be adapted in other settings. Collectively, these projects demonstrate how frontline innovation can generate measurable benefits, support organisational learning and contribute to the Trust's strategic objectives. The next phase will focus on systematically evaluating outcomes, sharing learning and accelerating the spread of successful innovations across the Trust.

Looking Forward

The next phase of delivery will focus on:

- Expanding improvement capability across the organisation with a focus on ensuring that all projects capture measurable benefits
- Increasing IMS maturity across teams and directorates, ensuring directorate ownership of improvement within their services and a focus on building a coaching culture.
- Embedding leadership behaviours that support continuous improvement as part of the cultural change Trust initiative.
- Scaling successful innovations/ improvements and creating a community of improvement champions so that we can learn from what works well
- Delivering sustainable improvements aligned to Trust strategic priorities and True North objectives.

Improvement Team Conclusion

The Improvement Team is helping to build a learning organisation that empowers staff, aligns improvement activity with strategy, strengthens problem-solving capability, supports innovation and enables sustainable improvements for patients, staff, partners and communities. Through the combined delivery of the Doing Well Together programme, the Improvement Management System and the Innovation Den, the team is establishing the foundations for long-term organisational improvement and transformation.

Alongside capability building and cultural change, emerging benefits realisation evidence now demonstrates measurable improvements in patient experience, workforce engagement, service efficiency, training quality and operational performance, providing increasing assurance

Research & Innovation (R&I)

Investment in R&I has increased opportunities for people served by the Trust to take part in research studies, embed a research culture in the Trust, and improve visibility of Trust research and innovation through the region, nationally and internationally. This growing culture of research is improving patient care, staff retention and morale, and long-term capability across our workforce.

People who work for us

Individual Staff Development

- **Hannah Wise, Research Delivery Lead** – successfully applied for a National Institute for Health and Care Research (NIHR) Funded Health & Social Care Research MSc at the University of Kent
- **Alison Welfare-Wilson, A Research Nurse/ CRP** successfully applied for an NIHR research development award for new researchers, project on training for trauma informed approach to research delivery
- **Maddie Bridges, a Nurse/ Matron** submitted an application for a NIHR Pre-Doctoral Award to complete a Master's at King's College London while remaining in clinical practice.
- **Eromona Whisky (Pharmacy)** successfully applied for an NIHR Senior Clinical Practitioner Research Award to consider equity of Clozapine prescribing across all racial populations

- **KMMH Secondment Opportunity -** successfully applied for NIHR RDN contingency funding to support research activity and workforce development through internal secondments. Three staff members, one Research Assistant and two Nurses—joined the R&I team to develop valuable research skills and knowledge. Upon completion, these staff members can return to their substantive roles equipped with enhanced research capabilities, thereby strengthening the Trust's overall research capacity and expertise.

- **Early Career Researchers** – KMMH has provided numerous early-career researchers and Resident doctors with the opportunity to enhance their research competencies by actively supporting ongoing research initiatives, including clinical trials. This experience serves to prepare them for future Principal Investigator roles.

- There have been over 50 publications by 40 KMMH staff this year.

Patients we care for

- KMS SDE: We have been successful in obtaining funding from the NIHR Secure Data Environment to contribute to a secure research dataset using information recorded during mental health care provided by Kent and Medway Mental Health NHS Trust. Our aim is to use the electronic health records and digital technology to make it easier for researchers and NHS teams to understand what helps people recover, where services are under most pressure, and how care can be improved for different communities.
- Scanning (Advanced Imaging Access): We have been successful in obtaining NIHR capital funding for KMMH to purchase two ultra-low field MRI scanners in situ at CCCU, and Maidstone. The scanners are currently being used for several research projects and will soon be starting a brain health clinic study, following successful funding by the centre for advanced diagnostic development. This will seek to improve memory assessment through local integration of brain scan, blood biomarkers and cognitive testing done closer to people's homes.
- We have been successful in obtaining funding to look at how health technology can support Trust strategy and implementation. Projects include how AI could enable triage of patients on waiting lists, to allow for collection of initial information/ symptoms and monitor wellbeing prior to initial appointment and subsequent clinics; phone app development to support teams identify non-epileptic attack disorder; and use of AI in teaching and disseminating information for patients.

We host up to 30 national, multi-site, NIHR Portfolio studies each year. Here is a small example of some of the recent benefits to our patients;

- **ADAPT:** Supporting improved diagnostic accuracy in patients with suspected dementia, enabling clinicians to differentiate between dementia subtypes more confidently and the potential for earlier diagnosis.

- **COBALT:** Clinical trial of novel memory interventions in service users living with dementia. Its launch at KMMH has allowed Resident doctors to join the Associate PI scheme, fostering early-career researchers and preparing them for future PI roles, which will help KMMH deliver more clinical research studies in the future.

- **SPACES:** Physical Activity Intervention for individuals with Severe Mental Illness (SMI) aimed to increase movement by offering patients within the intervention arm access to an 18-week group activity program. Patients have expressed many personal benefits from taking part in the study and furthermore multiple KMMH staff have been trained up as Physical Activity Coordinators to successfully deliver the program.

- **CHIPD:** This study explores the dynamic relationship between circadian biomarkers, sleep, cognition, and mental health. Our shift workers as well as patients with psychosis and depression could receive an in-depth sleep report, which will help us understand the impact of sleep on their mental health and daily functioning using brain scans and cognitive assessments.
- **Pharmacogenetics** - provides doctors individualised insights on how a patient's metabolism responds to specific medications, which in turn allows doctors to make an informed decision about changing medication or doses.
- **CADDA Knowledge Exchange Award – Kent and Medway Brain Health Clinic -** The Kent and Medway Brain Health Clinic (KMBHC) pilot will test an innovative approach to dementia diagnosis that combines cutting-edge technologies to provide faster, more accessible assessments. The KMBHC model integrates three emerging technologies: blood-based biomarker testing (pTau217) that can identify Alzheimer's disease pathology without invasive procedures; low-field MRI scanning that provides portable, accessible brain imaging; and computerised cognitive testing that standardises assessments whilst reducing clinician time requirements.

Partners we work with

- We have developed close links with partner organisations – with many joint staff working at the new Kent and Medway medical school and the allied universities.
- Research funding applications have developed close links with regional universities and NHS Trusts. These include successful recruitment to the NIHR integrated training programme for clinical academic doctors, support for medical students to undertake research, and working closely with partner NHS Trusts in Kent and Medway, MTW and D&G, EKHUFT, and KCHFT and primary care.
- The Living with Dementia Research Group was created to ensure lived experience directly shapes dementia research, building on existing Trust involvement by promoting and recruiting through the Co-creation Community.
- Centre for Advanced Diagnostic Development and Application (CADDA) have approached and offered to fund a sandpit event to bring university and Trust clinical staff together to explore research ideas.
- We have been working with **system partners** across Kent and Medway examining the suicide risk factors in areas of health inequalities in Kent. This has developed excellent links with partners in the Kent and Medway System but also led to KMMH becoming partners of the **National Suicide Prevention Alliance**.
- There are now 10 medical school academics with KMPT honorary contracts to further strengthen our collaborative working.

Clinical Audit and Effectiveness Team

Clinical Audit and Service Evaluation Projects (1st April 2025 – 31st March 2026)

Between 1st April 2025 and 31st March 2026, the Clinical Audit and Effectiveness (CAE) programme continued to support assurance, improvement and learning across the Trust. During this period, 191 new Clinical Audit and Service Evaluation (CASE) projects were initiated, 40 projects were completed and 55 interim reports were received, demonstrating sustained and increasing engagement from clinical and corporate teams. A small number of projects were cancelled. These incomplete projects were typically closed due to staff role changes, service transformation or where the audit question was no longer relevant or proportionate.

The CASE programme is reported through CEOG, the Quality Committee and the Trust Quality Account, and is available to the Care Quality Commission (CQC) and Integrated Care Board (ICB) on request. The completed programme provides assurance against Trust policy, national guidance and best practice, while also evidencing measurable improvements in care delivery.

Themes and impact from local directorate-level projects

Across all directorates, the following themes emerged from completed and interim project reports:

1. Physical health and medication safety
A large proportion of projects focused on improving physical health monitoring and safer prescribing, particularly in Acute and Forensic & Specialist services. Recurrent audit themes included antipsychotic monitoring, anticholinergic burden, clozapine safety, VTE assessment, falls risk, nutrition and metabolic monitoring. Many projects demonstrated improved compliance at re-audit, for example:

- Increased completion and timeliness of admission physical examinations, blood tests and ECGs.
- More consistent use of structured tools to review anticholinergic burden, side-effects (e.g. GASS) and falls risk.
- Safer, more judicious use of antipsychotics in older adults and people with dementia, with clearer documentation of indication, review and deprescribing plans.

2. Documentation, communication and continuity of care
High volumes of projects across all directorates addressed the quality and reliability of documentation on RiO, discharge communications and handover processes. Improvements were demonstrated in:

- Recording and validation of progress notes, diagnoses and risk assessments.
- Quality and person-centredness of discharge and care plan letters written directly to service users.
- Safer transitions between services, including acute wards, A&E, community teams and primary care, reducing the risk of missed follow-up, duplication or medication error.

3. Safeguarding, risk management and least-restrictive practice
Forensic & Specialist Directorate projects provided assurance and improvements in safeguarding compliance, restrictive practice monitoring, AWOL review processes and post-incident documentation. These projects strengthened risk visibility, MDT oversight and consistency of escalation, supporting safer, rights-based care within secure and specialist settings.

4. Person-centred care, experience and equity
Many service evaluations collected patient and carer comments, including surveys in inpatient wards, community teams, forensic services and specialist pathways. Findings consistently highlighted the value of compassionate communication, shared decision-making, and trauma-informed approaches. Projects

addressing menopause care, neurodiversity, reasonable adjustments, veteran pathways and sensory environments supported more inclusive and personalised care.

Overall, completed local projects demonstrated improvements across prescribing practice, monitoring, timeliness of assessments, documentation quality, patient experience and staff confidence, with learning embedded into local action plans and shared through governance structures.

Key actions from national clinical audit participation

The CASE Team continued to support full participation in all mandatory national clinical audits and oversaw action planning arising from findings. Significant actions during this period included:

- Embedding updated NICE-aligned approaches to suicide and self-harm risk assessment, including removal of categorical risk labels in line with NG225 and NCISH findings.
- Establishing a Trust wide task and finish group following the National Audit of Falls, leading to revised falls risk assessment, clearer management plans and improved staff training.
- Strengthening clozapine safety through education, improved side-effect monitoring (including bowel and myocarditis awareness), and clearer prompts for baseline and ongoing physical health checks.
- Improving data quality and diagnostic recording, including work to support implementation of SNOMED coding to underpin national audits and outcome reporting.

Clinical Audit and Effectiveness Overall assurance

Taken together, activity during 2025/26 demonstrates that the CASE programme continues to make a significant contribution to patient safety, effectiveness, experience and equity, while promoting consistency of practice and frontline-led improvement. The flexible, staff-driven project proposal process, supported by the CASE Team and Improvement Collaborative, ensures the programme remains responsive to emerging risks and priorities identified in clinical practice.

A full summary of the impact of individual projects by directorate is provided in the appendix to the Clinical Audit and Effectiveness Annual Report.

Conclusion

Improvements to the functioning of the Improvement Collaborative during the year have included developing the reporting process, refining the ideas submission questionnaire and reviewing customer feedback through the introduction of a feedback questionnaire. This will enable us to understand which professional groups and services are using the Improvement Collaborative, and to further develop the offer during 2026/27.

Those within the Improvement Collaborative provide regular cross-team support to ensure projects are directed to the most appropriate route and that governance is applied consistently. As an example, while Research does not receive many cases directly related to transformation or clinical audit, there is clear overlap between Service Evaluation and Research, and cases can appropriately flow from one to the other where scope changes or questions evolve. Of the 10 projects allocated to Research, at least three involved joint discussions between the Research and Service Evaluation teams to confirm best practice, clarify classification, and ensure proportionate governance arrangements were in place. Two of the 3 projects came in as research and turned out to be service evaluation and one came in as a service

evaluation, but work is underway to develop the topic as a research project. Some of the current service evaluation work may also develop into research over time.

Staff involved in the Improvement Collaborative have also benefited from greater understanding of each team's role and stronger joint working.

Overall, the Improvement Collaborative is making a significant contribution to the Trust's strategic objectives by creating the conditions for continuous improvement, innovation, research excellence and evidence-based practice. Through the combined efforts of the Improvement Team, Research & Innovation service, and Clinical Audit & Effectiveness function, the Trust is strengthening its capability to identify opportunities, generate and apply evidence, test new approaches and sustain meaningful change.

The evidence presented in this report demonstrates tangible benefits across patient care, workforce development, operational performance, service quality and organisational learning. Staff are increasingly equipped with improvement skills, research opportunities have expanded, innovation is delivering measurable outcomes, and clinical audit activity continues to provide assurance while driving quality improvement. Importantly, the Collaborative is fostering stronger joint working and creating clear pathways between improvement, service evaluation, clinical audit and research, ensuring that ideas and learning can be developed, evaluated and spread effectively across the organisation.

As the Trust continues its transformation journey, the Improvement Collaborative provides a strong foundation for delivering sustainable improvements aligned to strategic priorities and True North objectives.

The Board can take moderate assurance that the Improvement Collaborative has moved from establishment into early measurable delivery. The strongest assurance is in improvement capability, innovation outcomes, staff engagement and specific examples of local measurable impact.

Assurance remains moderate because benefits capture is not yet being consistently applied, there is variable spread and there is a need to strengthen directorate ownership. During 2026/27, the focus should move from proving the model to demonstrating sustained impact. This will require standardised benefit reporting, clearer alignment to strategic priorities and true north measures and systematic spread of successful changes across directorates.

The Board is asked to support this direction of travel and receive further assurance through agreed committee routes during 2026/27.

2026/27 priority	Why it matters	Board assurance route
Benefits realisation	Ensures improvements are measurable	Quarterly report to relevant committee
Spread of innovation	Avoids isolated improvement	Directorate oversight
Research growth	Supports care quality and staff development	R&I governance route
Audit action completion	Converts audit into improvement	Quality Committee oversight

NHS
Kent and Medway
Mental Health
NHS Trust

Title of Meeting	**Quality Committee**
Meeting Date	**30th July 2026**
Title	**Quality Committee Chair's Report (June and July 2026)**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Julie Kirby, Acting Chief Nursing Officer**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Violence and Aggression/Restrictive Practice Report	• Chief Nurse's Report • Risk Register • Community CQC Survey • Patient Safety Incident Response Report • CQC Report • Quality Impact Assessments • IQPR • Annual Controlled Drug Report • Medical Device Biannual Report • Mortality Report • Comments, Complaints and Compliments Report • Safeguarding Annual Report	• Quality and Patient Safety Assurance Group Terms of Reference

NHS
Kent and Medway
Mental Health
NHS Trust

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse's Report	The Committee received the Chief Nurse's Report and noted that all CQC warning notices have been lifted. Progress against the Quality Improvement and Governance Framework was noted. The Committee received assurance regarding actions to manage patient flow pressures and associated risks.	**Reasonable**	The Committee approved the Quality Account for submission to NHS England.
Risk Register	The Trust Risk Register was reviewed and noted. Limited assurance remains appropriate whilst the Board Assurance Framework and risk management arrangements are being refreshed. The Committee noted the number of risks outside risk appetite and the need for greater consistency in risk reporting.	**Limited**	Further updates will be provided as revised arrangements are implemented.
Patient Safety Incident Response Report	The Committee reviewed the Patient Safety Incident Response Report and noted improved Duty of Candour compliance. Recurring themes relating to medication management, communication and safety culture continue to feature in investigations. Workforce capacity pressures are affecting investigation timeliness. Whilst improvement actions are in place, evidence of sustained impact is still required.	**Limited**	The Committee will continue to monitor delivery of the improvement programme and the outcomes of external reviews

Quality improvement Plan	The Committee received assurance that the Quality Improvement Plan continues to progress under appropriate governance arrangements. Improvement actions remain in place across key quality priorities. Environmental risks associated with extreme heat are being managed through operational controls.	**Reasonable**	While the Committee received reasonable assurance that development of the plan was on track, further work to embed actions and to fully triangulate qualitative and quantitative data would be needed. Future reports will provide clearer evidence of progress and impact.
IQPR	The Committee reviewed the IQPR and received assurance regarding actions to improve patient flow and reduce delays. Positive performance was noted across several quality indicators. Work continues to strengthen the use of patient experience data to support improvement.	**Reasonable**	Trends and improvement actions to enhance assurance and scrutiny. Future reports will focus on key risks, trends and improvement actions.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Quarterly Mortality Report 2026/27 (Q1)
Author:	Frances Lowrey, Mortality Review Manager
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The Mortality Review report includes patient mortality incidents reported in Q1 2026/27 and compares to previous data reports. The data includes natural causes and unexpected deaths, including suspected suicides.

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

Note to the reader: *Overall mortality data has been pulled by reported date and therefore will include deaths that may have occurred prior to Q1. The report does however include some data that has been pulled by date of death. This includes suspected suicides to provide a near to real time suicide surveillance overview.*

Issues to bring to the Board's attention

- There has been a marked reduction in deaths reported in Q1 compared to the previous quarters. While this may be linked to a lower number of death notifications received, assurance has been obtained that the Business Intelligence (BI) reporting process to identify unreported deaths from the NHS National Spine remains operational. The reduction in deaths is most evident in West and East Directorates. As Trust activity and referral levels have remained stable, there is currently no clear explanation for this change. Whilst it remains possible that external factors, such as delays or changes in deaths being recorded on national systems, may be contributing to the variation, there is currently no evidence to substantiate this. Further investigation is therefore ongoing, including engagement with Integrated Care Board (ICB) colleagues to explore whether

additional insight can be obtained from primary care records. The Trust will continue to monitor the position closely and provide a further update as the investigation progresses.

- Despite the overall reduction in reported deaths, suspected suicides have increased in Q1. This increase mirrors trends identified through the Kent and Medway Real Time Suicide Surveillance (RTSS) system and returns to reporting levels seen in earlier quarters (Q4, Q3, Q2 2025/26). A thematic review of suspected suicides occurring within six months of service discharge is underway to better understand contributory factors, identify opportunities for improvement, and to explore post-discharge safety measures.

- Structured Judgement Reviews (SJRs) continue to identify recurring themes relating to risk assessment, physical health monitoring, and multi-agency/joint working. These themes are evident in both examples of good practice and areas requiring improvement, indicating opportunities to strengthen consistency across services.

- Opportunities have been identified to improve organisational learning from deaths. A revised Learning from Deaths process has been submitted to the Quality Committee for approval. The proposed changes are intended to strengthen the Trust's mortality review framework and maximise learning and improvement arising from patient deaths.

Governance

Implications/Impact:	Patient Safety
Assurance:	Reasonable
Oversight:	Oversight by Quality Committee

1. INTRODUCTION

1.1 The purpose of the report is to fulfil the expectations in relation to reporting, monitoring and the Board's oversight of mortality incidents, as set out in the National Quality Board's 'Learning from Deaths' guidance (March 2017). This builds on the recommendations made by the MAZARS investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is managed by NHS England. This is further reflected in our local policies and procedures to ensure we discharge our duties effectively, and as such the Committee would be familiar with the report history and purpose.

2. LEARNING FROM DEATH IN KMMH

2.1 The Patient Safety Incident Reporting Framework (PSIRF) was introduced by the NHS to improve how we learn from patient safety incidents or events. We'll also learn from good practice when things go well.

2.2 The PSIRF sets out how the NHS responds to these patient safety events so we can learn from them and improve patient safety.

2.3 There are national and local PSIRF priorities that the Trust are guided by. Local priorities can be amended dependant on our what our data tells us.

2.4 A Patient Safety Incident Decision Panel takes place weekly. The purpose of the group is to review incidents (including mortality) that may require further exploration, such as a Thematic Review (TR), After Action Review (AAR) or Patient Safety Incident Investigation (PSII).

2.5 In addition to the PSIRF processes, the Trust has a monthly Mortality Review Group meeting, where mortality data and learning from death reviews are shared with the group. The Trust are currently in a period of transition, moving learning from deaths to the portfolio of psychiatry, from nursing. This will enable stronger medical oversight and learning from deaths outcomes.

2.6 The Trust also has embedded the Structured Judgement Review process. This is a method used to review and learn from deaths. Findings of completed SJRs are shared with the Trust, and are featured in this quarterly report.

2.7 In addition, each death is reviewed by Governance daily to identify opportunities for learning and highlight good practice. This follows an escalation process, whereby incidents can be referred for a PSIRF response if concerns about the care are raised.

2.8 The Trust also links in with other agencies/ organisations to jointly review mortality incidents, identify learning, and strengthen effective partnership working. This includes close collaboration with the Learning from the Lives and Deaths of People with a Learning Disability and/or Autism (LeDeR) programme, acute trusts and the police.

3. ANALYSIS OF INFORMATION

Figure 1: Mortality reported cases

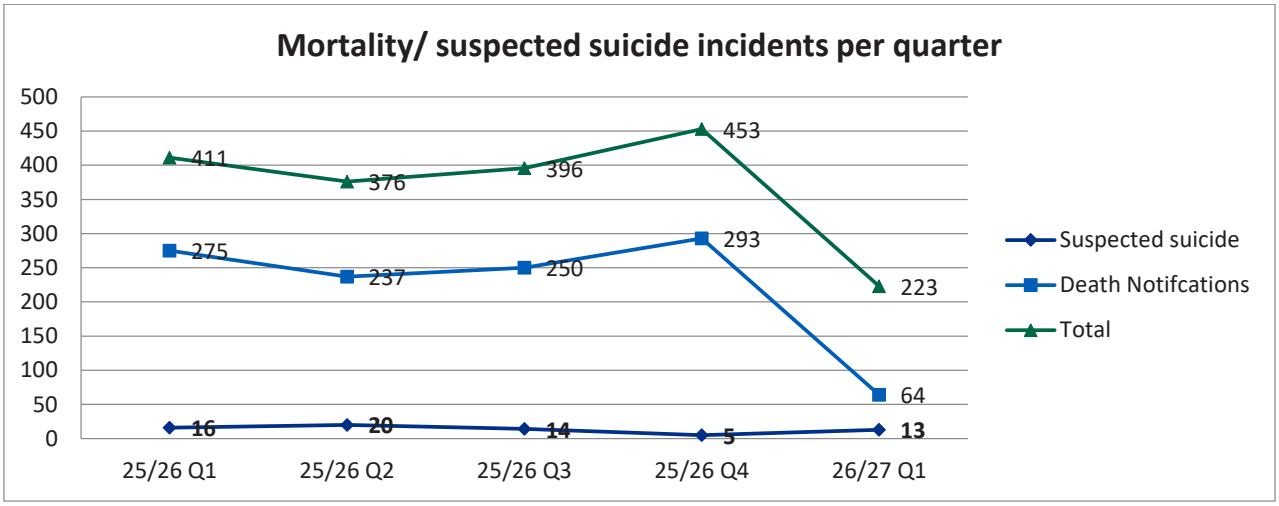


Figure 2: Mortality SPC

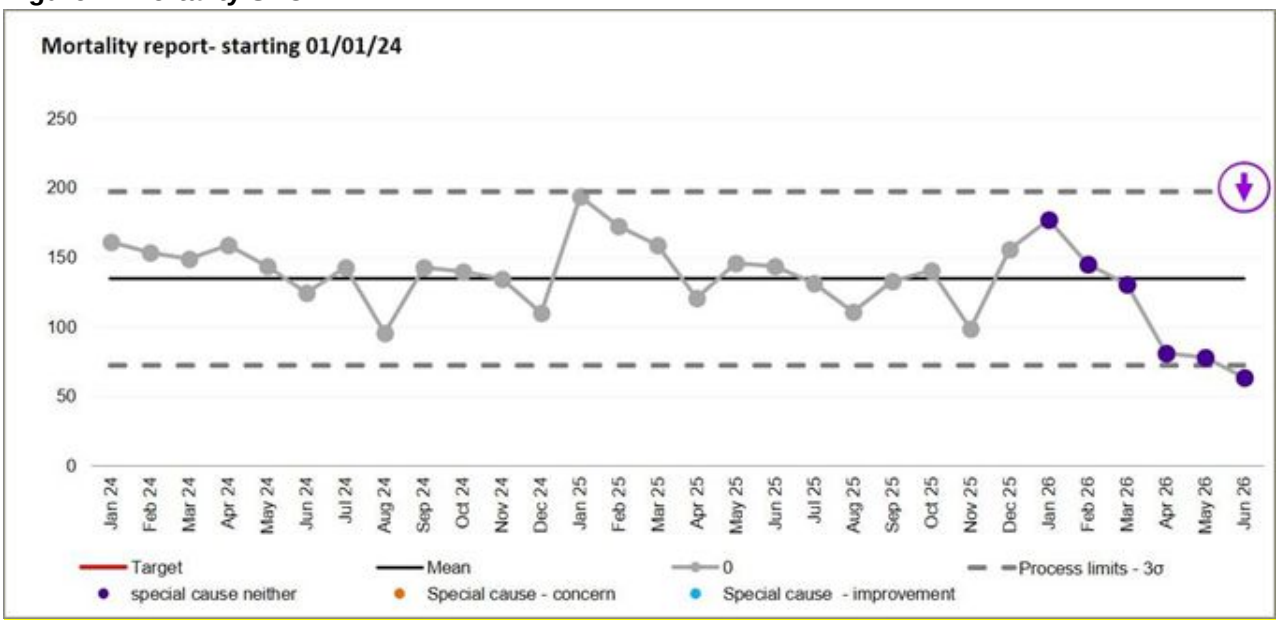


Figure 3: Death/unexpected death in Q4 2025/26

Death (Expected Death)	**124**
Expected death within an Acute Trust unrelated to mental health	38
Natural causes	11
On end of life / palliative care unrelated to mental health	75
Death (Unexpected Death)	**99**
Cause of death unknown, care and service delivery issues identified	4
Cause of death unknown, no care and service delivery issues identified	54
Homicide	2
Natural causes	12
Pending investigation	14
Suspected or actual suicide	13
Total	**223**

3.1 The number of deaths reported in Q1 was significantly lower than in previous quarters. As shown in Figure 1, this reduction may be associated with a lower number of death notifications received during the reporting period. Historical data indicates that death notifications typically sit in the 200s per quarter. Monthly figures (Figure 2), show that mortality numbers reported have consistently reduced from February 2026, with special cause variation highlighted.

3.2 A review of deaths reported across each directorate over time demonstrates an overall downward trend. The most notable changes have been observed in West and East Kent. While the number of deaths reported in West Kent has increased slightly, East Kent has seen a further reduction. As there has been no significant change in Trust activity levels or referral rates, the reasons for this overall decrease are unclear and warrant further investigation to better understand the underlying factors.

3.3 An unexplained reduction in reported deaths has been identified within the data, most notably within the West Directorate, while North and East Kent figures remain more consistent with expected levels of natural variation. A comprehensive review has been undertaken by both the Business Intelligence and RiO teams to verify the integrity of data flows, recording processes and reporting mechanisms. This has included repeated checks of the relevant systems and supporting processes, with no issues identified to date. Analysis of service activity, including referrals and contacts, has not identified any corresponding reduction in activity that would explain the decrease in reported deaths. Whilst it remains possible that external factors, such as delays or changes in deaths being recorded on national systems, may be contributing to the variation, there is currently no evidence to substantiate this. Further investigation is therefore ongoing, including engagement with Integrated Care Board (ICB) colleagues to explore whether additional insight can be obtained from primary care records. The Trust will continue to monitor the position closely and provide a further update as the investigation progresses.

3.4 In recent months, the number of expected deaths has continued to exceeded the number of unexpected deaths, where previously, the rate of unexpected deaths was higher. This change does not necessarily indicate that more patients have died from a natural cause. It could mean that information relating to the circumstances of death, through third party, or shared care records for example, have been more easily accessible. There was 1 inpatient death of a patient on a KMMH ward. The national criteria is for a PSII has been met and a PSII will commence.

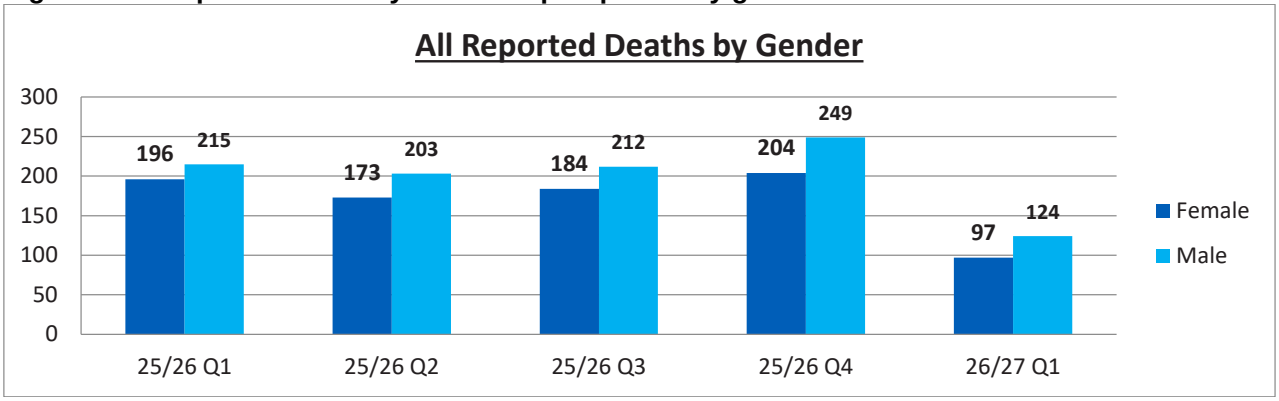
3.5 During the reporting period, 11 deaths have been subject to a PSIRF response. This includes 4 Swarm Huddles (previously known as Rapid Reviews), 2 After Action Reviews (AAR), 2 Thematic Reviews (TR), and 3 Patient Safety Incident Investigations (PSII), One PSII relates to the death of patient, where the perpetrator was known to KMMH.

3.6 The Thematic Reviews are to explore:

- Mental Health Together (MHT) referrals, which will include two incidents
- A review of 6 suspected suicides that occurred within 5 months of KMMH discharge.

3.7 58% of all deaths reported in Q1, were of patients who were over the age of years old. The percentage of deaths of older patients has been higher in previous reports. 13% were under the age of 50, 11% were 50-59 years, and 11% were 60-69 years. 61% of all deaths reported in Q1 are recorded as expected, or natural causes deaths, which includes end of life care and deaths in the acute hospital that were unrelated to mental health.

Figure 4: All reported mortality incidents per quarter by gender.



3.8 Gender for the two victims of homicide, where the perpetrators were the patients, are not known, and therefore are not recorded in Figure 5. The higher rates of male mortality are consistent with national findings through the ONS report.

Mortality review by ethnicity

Figure 5: Deaths by ethnicity

	25/26 Q1	25/26 Q2	25/26 Q3	25/26 Q4	26/27 Q1	Total
Asian or Asian British - Any other Asian background	1	2	1	1	0	5
Asian or Asian British - Bangladeshi	0	0	0	1	0	1
Asian or Asian British - Chinese	1	0	0	0	0	1
Asian or Asian British - Indian	3	4	3	2	2	14
Asian or Asian British - Pakistani	0	0	0	0	0	0
Black, African, Caribbean or Black British – African	3	0	0	1	0	4
Black, African, Caribbean or Black British – Caribbean	0	0	0	2	1	3
Black, African, Caribbean or Black British - Any other Black, African or Caribbean background	0	2	0	0	0	2
Mixed or Multiple groups - White and Asian	0	1	0	0	0	1
Mixed or Multiple groups - White and Black Caribbean	1	1	1	1	0	4
Mixed or Multiple groups - Any other mixed or multiple ethnic background	2	0	3	6	1	12
Not stated / Unknown	88	77	85	79	39	368
White - British	294	275	287	346	171	1373
White - Irish	1	1	1	2	0	5
Any other ethnic group	3	5	2	1	3	14
White - Any other White background	14	8	13	11	6	52
Total	411	376	396	453	223	11859

Figure 6: Ethnicity recording compliance- InPhase

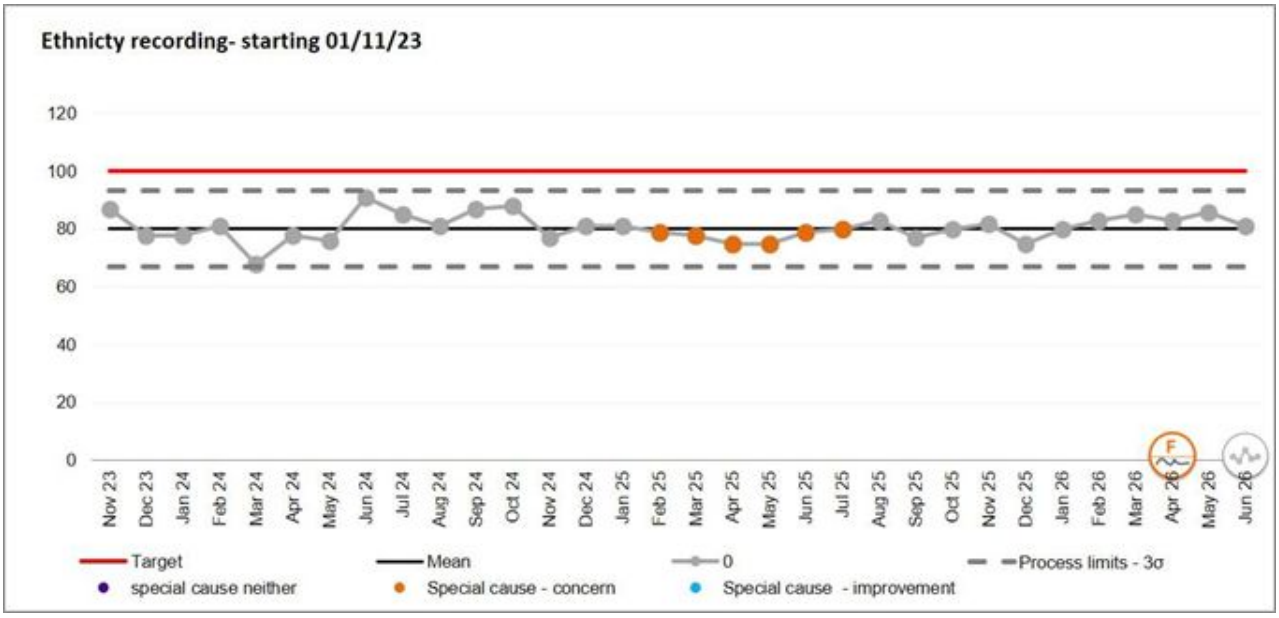


Figure 7: Equality, Diversion and Inclusion, Business Intelligence report

Compliance with recording of Protected Characteristics

Directorate	Acute		Forensic and Specialist		East Kent		North Kent		West Kent		Total	
Characteristics	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total
Gender	100.0%	276	100.0%	3,368	99.9%	11,929	99.9%	7,133	99.9%	6,436	**99.9%**	29,142
Ethnicity	95.2%	276	90.2%	3,368	83.5%	11,929	94.7%	7,133	84.5%	6,436	**87.4%**	29,142
Marital status	81.5%	276	70.4%	3,368	48.4%	11,929	54.2%	7,133	58.1%	6,436	**54.8%**	29,142
Religion	71.7%	276	52.8%	3,368	36.4%	11,929	43.8%	7,133	47.4%	6,436	**42.9%**	29,142
Nationality	55.0%	276	32.9%	3,368	28.0%	11,929	35.0%	7,133	32.8%	6,436	**31.6%**	29,142
Sexual orientation	43.1%	276	12.8%	3,368	10.9%	11,929	11.8%	7,133	22.7%	6,436	**14.3%**	29,142

Compliance with recording of Other Demographics

Directorate	Acute		Forensic and Specialist		East Kent		North Kent		West Kent		Total	
Characteristics	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total	% Complete	Total
Settled accommodation	80.0%	276	55.7%	3,368	48.1%	11,929	50.4%	7,133	52.1%	6,436	**50.7%**	29,142
Employment status	75.7%	276	58.5%	3,368	47.2%	11,929	50.3%	7,133	51.8%	6,436	**50.6%**	29,142
Accommodation status	74.6%	276	57.6%	3,368	46.0%	11,929	48.9%	7,133	49.6%	6,436	**49.1%**	29,142
Ex BAF status	29.3%	276	14.6%	3,368	8.0%	11,929	8.5%	7,133	18.1%	6,436	**11.3%**	29,142

3.9 76% patient were of White ethnicity. This compares to a similar number of 77% in Q4 2025/26. 3% of all deaths reported in Q1 were of patients of ethnic minority (this mirror Q4 data), and like previous reports, there does not seem to be any intelligence of emerging themes. The trust continues to address health inequalities, by exploring barriers to people in Kent and Medway accessing mental health support, and to ensure that the needs of the local population are met.

3.10 There continues to be gaps in ethnicity recording, with 17% where the patient's ethnicity was not known (Figure 6). The Equity For All Assurance Group are working to improve compliance with recording protected characteristics. A Business Intelligence, EDI report is in place to monitor rates of compliance (Figure 7). As of June 2026, overall compliance for ethnicity recording is at 87% (1% improvement since

the Q4 report). Other protected characteristics have lower rates of compliance, such as sexual orientation, which is being addressed through the EDI Assurance Group.

Figure 8: Breakdown of mortality responses

	Apr-26	May-26	Jun-26
Number of patients with an open referral	33080	32388	31911
Total number of deaths (reported date)	81	78	64
Mortality rate per 10,000 open referrals*	25.0	24.4	20.1
Percentage of SJRSs allocated	9.8%	6.4%	9.3%
Percentage of PSIRF (SH, TR, AAR, PSII)	3.7%	7.6%	3.1%
Percentage of LEDER	2.4%	1.2%	1.5%
Percentage referred by the ME	0%	0%	0%
Percentage of deaths judged more likely than not due to problems in care (from SJR)	0%	0%	1.5%
Number of deaths with family concerns raised (SJR)	1.2%	3.8%	3.1%
Percentage of SJRs completed within 60 day timeframe	100%	100%	87.5 (1 SJR)

*****Based on data for 2024, the crude death rate in the Kent County Council area was approximately **130 deaths per 10,000 residents**.

Figure 9: Deaths by incident date/ open/ closed referrals

Deaths by date of death	April 26	May 26	June 26
Total number of deaths (date of death)	92	61	32
How many were open to services at the time of death	75	50	24
How many were closed to services before death	17	11	8
If closed, how many died within 6 months of discharge	15	8	5

3.11 Figure 9 shows how many people died each month, as opposed to how many deaths were reported, and whether they were still receiving services at the time they died or had already been discharged. Most patients who died (around 75-80%) were still receiving services at the time of death. Among those discharged, a high proportion died within 6 months of discharge.

3.12 Current KMMH process is that we report and review all deaths of patients who died within 12 months of last contact/ discharge. This is not a national requirement, and other organisations have adopted a 6 months review timeframe approach. The mortality group will consider if amendments need to be made to reporting timescales.

4 KMMH SUSPECTED SUICIDES

Figure 9: Suspected suicide by month

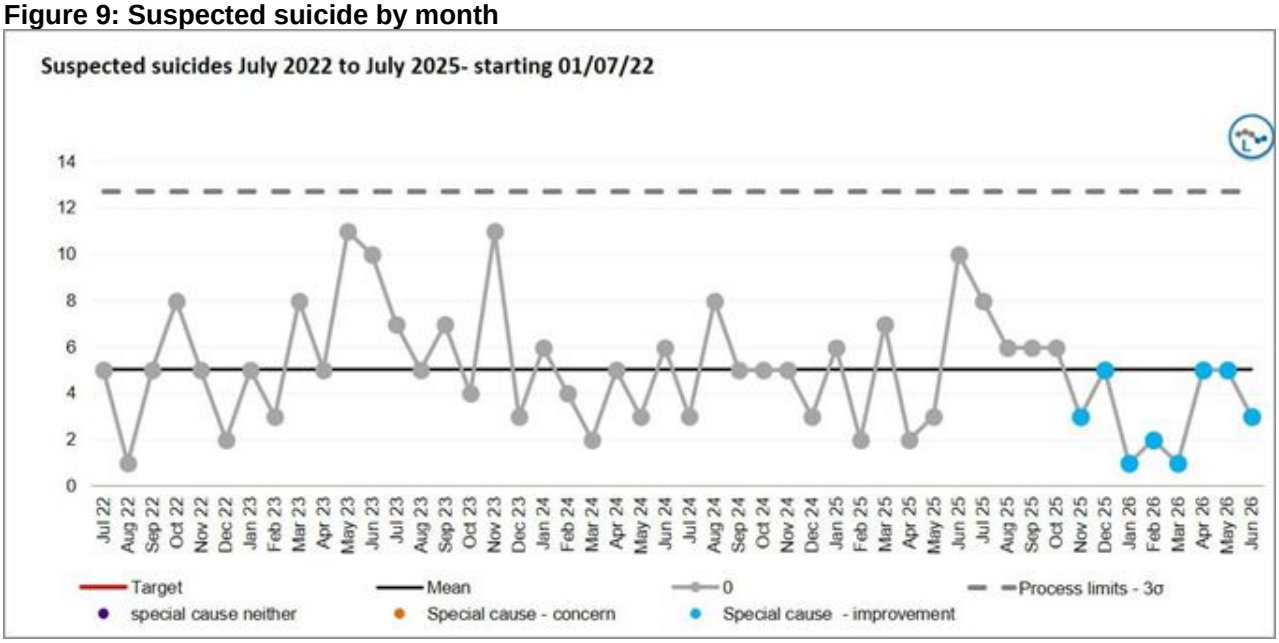
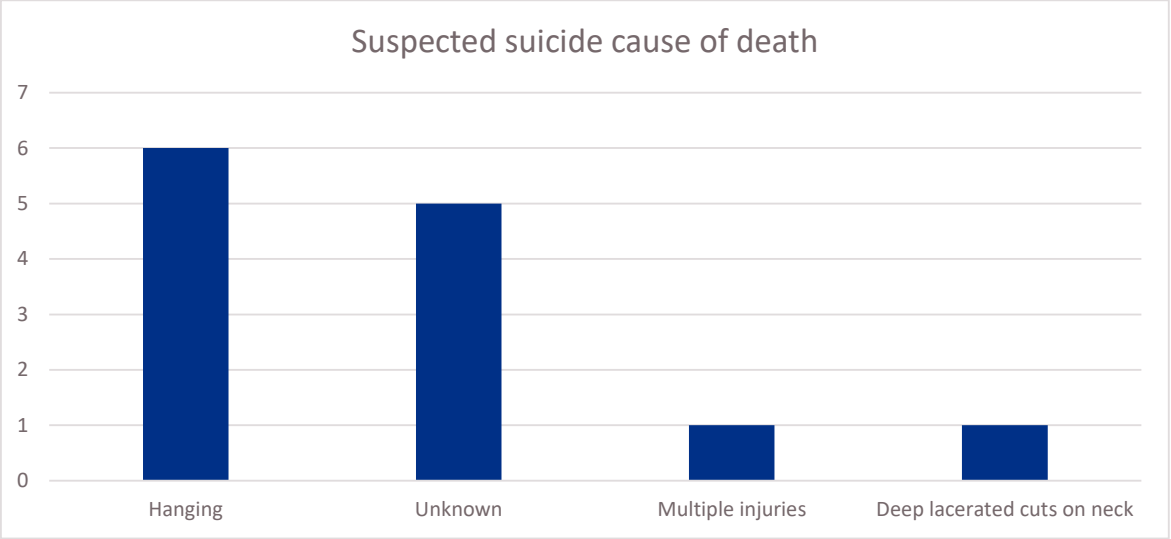


Figure 10: Suspected suicides by age

SUS SUICIDES - Age Band	Apr-26	May-26	Jun-26	Total
100+	0	0	0	**0**
90 - 99	0	0	0	**0**
80 - 89	0	0	0	**0**
70 - 79	0	0	0	**0**
60 - 69	0	0	0	**0**
50 - 59	2	4	2	**8**
40 - 49	0	0	0	**0**
30 - 39	3	1	0	**4**
20 - 29	0	0	1	**1**
18 - 19	0	0	0	**0**
Total	**5**	**5**	**3**	**13**

Figure 11: Suspected suicide cause of death



4.1 Figure 9 shows special cause improving variation in suspected suicide rates. And although the longer-term data shows a reduction, higher numbers did occur in both April and May 2026.

4.2 A review of the suspected suicides has shown that:

- There no team that is an outlier
- Cause of death was mostly hanging (some pending toxicology) This aligns to the national data. Where cause of death is unknown (5), contact has been made with the coroner to request this information
- The increase in April and May 2026 is also reflective in the Kent and Medway real time suicide surveillance data, which indicates this is not isolated to KMMH patients. National data shows that roughly 30% of all people who died by suspected suicide were known to mental health services.
- Number of suspected suicides was higher for patients (mostly male) in their 30s and 50s
- 9 patients were open to services at the time of their death. 4 patients were discharged, between 1 and 7 months before they died.

4.3 National Confidential Inquiry into Suicide and Safety in Mental Health (NCiSH) annual reports have consistently reported higher rates of suspected suicide among patients, predominantly males, in their 40s, followed by patients in their 50s and 30s. Recent KMMH data suggests a shift towards patients in their 30s and 50s. This emerging trend will continue to be monitored. Suspected suicides rates remain higher in male patients, which is consistent with the national picture.

5 STRUCTURED JUDGEMENT REVIEW

5.1 **25** Structured Judgement Reviews were completed in Q1 2026/27.

Figure 12: ratings of care

Allocation and initial assessment or review (entry into services)	**22 in total** 1. Potential Patient Safety Event: 0 2. A Learning Opportunity: 4 3. Expected Practice/ Process: 8 4. Good care: 10 5. Exemplary Practice/ Process: 0
Ongoing care	**20 in total**

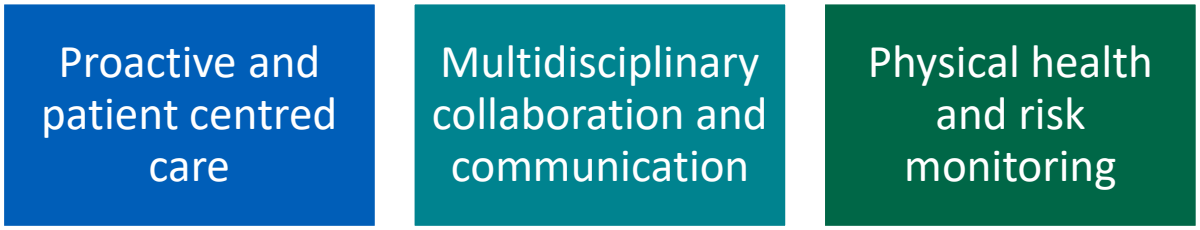
	1. Potential Patient Safety Event: 2 2. A Learning Opportunity: 9 3. Expected Practice/ Process: 5 4. Good care: 4 5. Exemplary Practice/ Process: 0
Psychiatric inpatient care	**2 in total** 1. Potential Patient Safety Event: 0 2. A Learning Opportunity: 1 3. Expected Practice/ Process: 1 4. Good care: 0 5. Exemplary Practice/ Process: 0
Discharge	**6 in total** 1. Potential Patient Safety Event: 0 2. A Learning Opportunity: 4 3. Expected Practice/ Process: 1 4. Good care: 1 5. Exemplary Practice/ Process: 0
Overall care	**25 in total** 1. Potential Patient Safety Event: 2 2. A Learning Opportunity: 8 3. Expected Practice/ Process: 8 4. Good care: 7 5. Exemplary Practice/ Process: 0

5.2 The common criteria met for SJR is diagnosis, where most patients had a diagnosis of schizophrenia and were treated by their local MHT/MHT+ team.

5.3 Overall care was rated good and above in 45% of the cases reviewed. This compared to 31% in the previous reporting quarter. 35% of the SJRs completed rated the overall care as a learning opportunity, however, the death was not thought to be likely due to problems in care, and therefore there were no reviews that were progressed through the PSIRF. Areas of learning have been listed in Figure 15 and section 5.7 of this report and have been shared at Directorate Governance level to action accordingly.

5.4 Themes of good care and areas for learning have been highlighted from Structured Judgement Reviews have been highlighted.

Figure 13: Areas of good care



5.5 Proactive and patient centred care

- Timely actions and flexibility in response to concerns (e.g. bringing forward appointments, same-day reviews, rapid escalation).
- Persistent engagement with patients despite challenges.
- Tailored care delivery (e.g. home visits, facilitating depot administration during hospital admission).
- Active follow-up (including after DNAs).
- Plans developed *with* patients (e.g. safety plans in patient's own words, identifying stressors).

5.6 Multidisciplinary collaboration and communication

- Effective liaison across services (MHT, GP, cardiology, social care, hospice, housing, care homes).
- Clear communication between professionals, patients, and families.
- Good interdisciplinary working (including pharmacist–doctor collaboration).
- Evidence of shared decision-making, including carer involvement.
- Transfer summaries and documentation supporting continuity of care.

5.7 Physical health and risk monitoring

- Regular and thorough monitoring of mental and physical health (e.g. observations, ECGs, bloods, GASS scores, Clozapine monitoring).
- Comprehensive, well-documented assessments and reviews.
- Appropriate risk assessment and escalation.
- Adherence to clinical guidelines and policies (e.g. depot protocols, annual checks).
- Clear documentation, including risk plans, safety plans, and physical health records.

5.8 Overall, the reviews found that services are responsive, adaptable and focused on the patients needs, with personalised and timely care provided.

Figure 14: Areas for improvement

5.9 Timeliness of reviews and clinical response

- Long delays in medical reviews (1–5 months, overdue reviews).
- Delays in referrals being screened, triaged, or followed up.
- Failure to meet expected timeframes (e.g. 4-hour LPS assessments).
- Delays in investigations (e.g. ECGs, bloods, admission bloods).
- Slow or absent follow-up on abnormal results or clinical deterioration.

5.10 Gaps in physical health, risk and care planning

- Incomplete or absent physical health monitoring (e.g. ECGs, GASS, blood tests).
- Poor follow-up of abnormal findings (e.g. prolactin, weight loss, glucose).
- Risk assessments, safety plans, and CRAM not updated or incomplete.
- Lack of clear, detailed, and individualised care plans.
- Missed opportunities to assess key issues (e.g. nutrition, medication side effects, occupational risk).

5.11 Communication, coordination and documentation

- Unclear responsibility (e.g. who follows up GP requests).
- Poor MDT communication and lack of consultant oversight.
- Inadequate liaison with external partners (GPs, care homes, other services).
- Documentation issues (missing records, duplication, inconsistencies).
- Lack of clarity for patients (e.g. pathways, appointment confirmation, consent for remote care).
- Lack of involvement of carers and a lack of gathering collateral information in some cases.

5.12 Overall the reviews highlighted learnings in relation to responsiveness, clinical quality, and joint working.

5.13 Opportunities exist to enhance organisational learning from SJRs by strengthening the development of actions from review findings and recommendations, and by aligning learning with complaints, risks, inquests, governance activities, and local reviews to identify themes and drive improvement.

6 CLINCIAL RISK ASSESSMENT AND MANAGEMENT (CRAM) UPDATE

6.1 The Trust has continued to demonstrate sustained improvement in CRAM compliance throughout 2026. Following the implementation of the new risk assessment and safety planning processes in May 2025, the initial target of 50% compliance by the end of February 2026, was achieved and exceeded, reaching 52%.

6.2 Whilst the subsequent target of 90% compliance by the end of May 2026 has not yet been achieved, a steady month-on-month improvement continues to be seen across the organisation. Data as of June 2026, indicates overall compliance of 61.5% for new risk assessment completed, and 47,2% for risk assessment completed with the required timeframe.

6.3 Progress is also evidence within safety planning, with compliance increasing from 33% to 39.4% for safety plans completed and from 26.6% to 47.7% for safety plan completed within the required timeframe. This evidences an increasing adoption of the new process across clinical services. It should be noted that the safety planning process was designed to be completed collaboratively with patients and, where appropriate, families and carers. As this often requires completion over several clinical contacts, safety plan compliance figures are not expected to reach their optimal level until approximately six months post-implementation (August–September 2026).

6.4 Improvement activity continues to be support through the work of the Clinical Risk and Suicide Prevention Lead, Risk Champions, and Directorate Heads of Nursing, who are providing targeted support to services and monitoring progress through local governance arrangements.

6.5 In addition, while some services are excluded from reporting, there remain cohorts of patients within included services who do not routinely require a risk assessment or safety plan (for example, some patients within the Living Well with Dementia pathway in MHT+ services). These patients are currently included within the denominator and may therefore adversely affect reported compliance rates. Work is planned to refine the reporting methodology over the coming months to better reflect the clinical applicability of risk assessments and safety plans.

7 LEARNING FROM DEATHS PROCESS

7.1 A Learning from Deaths Proposal has been developed, which sets out a programme of improvement to strengthen the Trusts mortality review processes and ensure closer alignment with NHS England Learning from Deaths requirements.

7.2 While the Trust has established governance structures and can provide assurance that all deaths receive an appropriate level of review, the paper identifies several areas requiring further development, including increasing the number of SJRs completed to enhance learning, learning from deaths mechanisms such as engagement with medical examiners, and a change of learning from deaths oversight from nursing to medical leadership (to sit within the Chief Medical Officer portfolio).

7.3 The paper will be presented to the Quality Committee in July 2026, and changes to processes will begin once approval has been issued.

Title of Meeting	**Public Board Meeting**
Meeting Date	**20th July 2026**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Ali Layne-Smith, Interim Chief People Officer**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• HR Helpdesk • Freedom To Speak Up (FTSU) 6-month Report • People Committee Main Report • People Plan Update • Culture Transformation • Band 5 Nursing Review • Guardian for safe working	• Response to Lord Mann Review	• Board Assurance Framework and Corporate Risk Register including Emerging Risks • HR Policies and Procedures • Review of Terms of Reference

Agenda Items by Exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another Committee.
HR Helpdesk	The Committee received a positive update on the HR Helpdesk, which has now been operational for seven months and continues to experience growing utilisation across the Trust. The service has been well received by managers and staff and is providing valuable insight into workforce themes and policy improvement opportunities.	**Reasonable**	The Committee supported further work to develop quality measures, user feedback mechanisms and targeted interventions arising from enquiry trends
Freedom To Speak Up (FTSU) 6-month Report	The Committee reviewed the annual Freedom to Speak Up report and welcomed the continued increase in concerns being raised, viewing this as evidence of a strengthening speak-up culture and improved psychological safety across the Trust. Management behaviours remain the predominant theme, with concerns identified regarding the quality and timeliness of feedback provided to staff following the raising of concerns.	**Limited**	The Committee supported recommendations to strengthen managerial capability, improve organisational learning and embed actions within the Cultural Transformation Programme. The launch of Staff Voice across the Trust is another opportunity to triangulate Staff Experience Recommendations to be incorporated into the Cultural Transformation Programme.
People Committee Main Report	The Committee reviewed workforce performance metrics including sickness absence, turnover, vacancies, recruitment activity, employee relations cases and agency expenditure. Positive trends were noted in turnover and retention measures. Opportunities remain to improve sickness absence performance and recruitment timescales. Attention was given to agency expenditure. The Committee noted the continued risk relating to agency expenditure associated with medical vacancies, particularly within Children and Young	**Reasonable**	The Committee welcomed ongoing development of workforce reporting, including plans to strengthen data triangulation and benchmarking arrangements.

	People's Services following service transfer arrangements.		
People Plan Update	The Committee received the refreshed People Plan and welcomed its alignment to the Trust Strategy and strategic objectives. Assurance was provided regarding delivery arrangements covering leadership and talent, workforce planning, inclusion, staff wellbeing and future workforce requirements.	**Reasonable**	The Committee supported proposed arrangements for monitoring delivery, accountability and programme oversight, whilst recognising the need for continued simplification and alignment of reporting across corporate directorates.
Culture Transformation	The Committee recognised the scale of change required and noted that cultural improvement will require sustained leadership focus over several years. Further evidence is required to demonstrate measurable improvement and impact.	**Limited**	Whilst encouraged by the scale of staff engagement undertaken, the Committee concluded that further evidence is required to demonstrate measurable improvement outcomes and sustainable cultural change across the organisation.
Band 5 Nursing Review	The Committee received an update on the nationally mandated Band 5 Nursing Job Evaluation Review and noted the progress made in establishing governance arrangements and preparing for implementation. Assurance was received that the Trust is well positioned to meet national requirements and has completed key preparatory work, including the review of nursing job descriptions.	**Reasonable**	The Committee noted that national funding and implementation arrangements continue to evolve and will require ongoing oversight. This is a huge piece of work that could have wide implications
Lord Mann Review (Including Equality, Diversity and Inclusion)	The Committee reviewed progress relating to Equality, Diversity and Inclusion, including the Trust's response to the Lord Mann Review. Assurance was received regarding existing governance arrangements, leadership accountability and development of the EDI improvement programme. The Committee noted that further work is required in relation to data collection, reporting mechanisms and implementation of national recommendations.	**Reasonable**	Actions arising from the review have been incorporated within the People Plan and Cultural Transformation Programme and will continue to be monitored through established governance arrangements.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th July 2026**
Title	**Mental Health Act Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance items**
• MHA/MCA Training Report	• Chief Medical Officer's Report • Report from MHLOG • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • CQC MHA Monitoring Visits Report • Bi-annual CTO Lapses report • Bi-Annual DoLs Audit Report • Health Inequalities • HBPoS / Section 136 Quarterly Update (incl. risk of prolonged length of stay) • Legislation Update	

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Medical Officer's Report	The Committee noted continued improvement in Mental Health Act governance, including successful recruitment of Associate Hospital Managers and removal of the Health-Based Place of safety warning notice. Ongoing concerns remain regarding delays in access to inpatient beds, prolonged stays within Health-Based Places of Safety and compliance with consent to treatment requirements. The introduction of a dedicated Mental Health Act register strengthens oversight of these risks.	**Reasonable**	Continued monitoring through the Mental Health Act risk register and routine reporting.
Report from MHLOG	The Committee noted continued improvement in Mental Health Act compliance, including reductions in Community Treatment Order lapses and strengthened monitoring of Section 58 consent-to-treatment requirements. Additional controls have been implemented to support compliance and reduce the risk of future lapses.	**Reasonable**	Progress to continue to be monitored through MHLOG and MHAC.
CQC MHA Monitoring Visits Report	The Committee noted positive feedback on compassionate care and patient involvement and recognised recurring concerns relating to Mental Health Act compliance, including patients' rights, consent to treatment, capacity assessments, and governance indicate that compliance is not yet fully embedded across all services.	**Limited**	Next Steps: Delivery of actions through the Quality Improvement Plan to continue, with a focus on evidencing implementation and sustainability of improvement.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th July 2026**
Title	**Finance, Business and Investment Committee Chair's Report**
Author	**Mickola Wilson, Non-Executive Director**
Presenter	**Mickola Wilson, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance items**
•	• Strategic Transformation Programmes-Dementia Update	• Chief Finance and Resources Officer Report including BAF • Finance Report for Month 12 • Sustainable Services Update • Digital Update • Anti-Fraud, Bribery and Corruption Policy • Business Cases Annual Review • Business Case - Winthrop Hall • Business Case – Estates Safety Fund

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Strategic Transformation Programmes- Dementia Update	The Committee supported the proposed transition to Business as Usual (BAU) as assured had been provided regarding the elimination of the majority of patients waiting over 52 weeks, with sustained performance in the percentage of patients diagnosed with six weeks. The Committee supported the use of 'watch-metrics' via the Integrated Quality and Performance Report to alert the Board to any deterioration. Challenge was provided around the quality of diagnosis with assurance provided that the Trust had a robust diagnosis process which exceeded national standards in some areas due to the dedication of clinicians.	**Substantial**	The Committee emphasised the importance of a six-month review process, to provide assurance that the improvements which had been delivered remained embedded across the Trust. The Committee acknowledged that commissioning discussions were on-going to ensure patients were referred to, and received care in, the appropriate services, and to enable complex patient cohorts to receive specialist expertise.
Chief Finance and Resources Officer Report including BAF	The Committee noted the focus on productivity and efficiency across Kent and Medway, with assurance provided that regular updates would be provided as the programme of work developed. The committee were advised that the step-down beds contract was being wound down, with an expectation that the Kent and Medway Integrated Care Board (ICB) would commission a recurrent solution. Current	**Reasonable**	The Committee was informed of the request from NHS England for enhanced board scrutiny of cyber security arrangements and was assured this would be addressed by the Audit and Risk Committee, with any specific issues cross-referred.

	planning assumptions indicate that the seasonal variation in demand should enable this transition to be managed within existing capacity.		
Finance Report and Forecast	The Committee was informed of the programme of work to bring the Trust's agency expenditure within the national agency cap and confirmed this would continue to be monitored. The Committee was updated on the position on the better practice payment codes, and provided assurance the position in month reflected a once off issue, with the position monitored in future months. As part of on-going monitoring of the Trust's cash position it was confirmed there was a favourable position against plan, with sufficient cash reserves to cover the 9.5 operating days of expenditure target.	**Reasonable**	The Committee requested that additional narrative was provided around the use of bank spend. This will be included as part of the September report. Further triangulation of the Clinically Ready for Discharge position, due to the potential for significant impact on the Trust's financial position was requested from the Chief Finance and Resources Officer.
Digital and IT Update	The Committee were informed of the improvements delivered by the case-load management tool which provided both clinical and operational benefits; although, noted further work was required in relation to the Business Intelligence Dashboard.	**Reasonable**	Concerns were raised regarding the number of areas within the delivery plan that were rated "amber" and "red" with it confirmed these would continue to be monitored, and action taken if the position did not improve.
Business cases:	Winthrop Hall The Committee endorsed the Business Case for approval, subject to provision of the Montagu Evans evaluation report to the Non-Executive Director members. Estates Safety Fund	**Reasonable**	The Committee queried the length of the contract arrangement; although received assurance regarding the suitability of the break clauses contained within the contract.

	The Committee endorsed the Business Case for the Estates Safety Fund; noting the patient, staff and system-wide benefits. Business Cases Annual Review The Committee supported the content of the report.		
The Committee endorsed the Anti-Fraud, Bribery and Corruption Policy, subject to the feedback provided, for approval by the Audit and Risk Committee.			

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th July 2026**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quarterly Impact Report	• Charity Risk Register • Chairty Operational Plan • Charity Name Change Engagement Paper • Finance Report (incl. an update on Microhive) • Annual Report Draft • Approval for Requests over £5000 • NHS Lottery Ethical Exploration Paper

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another Committee.
Chairty Operational Plan	The Committee noted continued improvement against charitable income, community partnerships, corporate volunteering and charity rebranding objectives. Positive progress was also noted in grant applications and community engagement initiatives. The Committee sought further assurance regarding the geographical reach of volunteering activity and governance arrangements for charity challenge events.	**Reasonable**	A review of corporate volunteering activity, including geographical spread and health and safety assurance, is to be presented to a future Committee meeting. Consideration to be to inclusion of any associated reputational risks within the Charity Risk Register.
Charity Name Change Engagement Paper	Stakeholder engagement demonstrated support for adopting **Kent and Medway Mental Health Trust Charity** as the Charity's operating name. Members supported progression, through the Trust's governance process, and noted the opportunity to strengthen public engagement and future fundraising.	**Reasonable**	The recommendation to be progressed for formal approval by the **Board of Trustees** branding development to commence following approval
NHS Lottery Ethical Exploration Paper	The Committee considered the ethical and governance implications associated with participation in the NHS lottery. Subject to appropriate governance and due diligence arrangements, participation was recognised as a potential opportunity to support future fundraising and income generation for the charity.	**Reasonable**	Further work to progress NHS Lottery proposals through established Charity governance arrangements.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th July 2026**
Title	**Children and Young People's and All Age Eating Disorders (CYPMHS & All AED) Committee Chair's Report**
Author	**Stephen Waring, Committee Chair**
Presenter	**Stephen Waring, Committee Chair**
Executive Director Sponsor	**Donna Hayward-Sussex, Chief Operating Officer and Deputy Chief Executive**
Purpose	**Assurance**

Agenda Items

People items	**Patient items**	**Finance items**
• Workforce & Capacity Report:	• Quality & Safety Dashboard • Safeguarding Assurance Report • Integrated Quality & Performance Report (IQPR) • Operational Resilience / Service Continuity Update	• Service Transfer Programme Update & Milestones. • Phase 2 Digital Full Transfer Programme Assurance.

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Workforce & Capacity Report:	Committee noted successful TUPE transfer of 624 staff and positive feedback from welcome/listening events (92% positive face-to-face). Challenges raised regarding low staffing levels, recruitment delays, agency reliance (particularly in adolescent unit and crisis services), administrative gaps, and mandatory training burden.	Reasonable	Committee challenged pace of recruitment and clarity of risk alignment.
Quality & Safety Dashboard	Received. 201 incidents reported (156 clinical, 45 non-clinical); key themes include self-harm, violence/aggression, and safeguarding. Daily risk huddles and learning review processes provide improved oversight.	Reasonable	Committee requested clearer benchmarking, targets, and enhanced narrative in future reporting.
Safeguarding Assurance Report:	Transition to KMMH safeguarding processes underway with improved alignment of training and reporting. Committee noted low referral rates and recognised need for embedding new processes and improving data maturity.	Reasonable	
Integrated Quality & Performance Report (IQPR):	Limited assurance due to incomplete and inconsistent data during digital transition; Committee explicitly noted no assurance can be provided for Q1. Updated position includes 947 active referrals <18 weeks and 89.3% crisis assessments within 4 hours.	Limited	Committee requested close attention to digital transition and asked to be alerted should there be delays to implementation.
Operational Resilience/Service Continuity Update	Transition delivered safely with no disruption to patient care or complaints; strong patient experience maintained. Residual risks include workforce pressures, digital dependency, estates issues, and system maturity.	Reasonable	

Service Transfer Programme Update & Milestones	Day 1–90 milestones achieved with high confidence; ongoing risks relate to workforce, estates, financial recovery (CIP), and governance alignment.	Reasonable	
Phase 2 Digital Full Transfer Programme Assurance	Programme rated Amber. Critical dependencies include central tenant migration (expected August 2026), infrastructure, and resourcing capacity.	Reasonable	Committee challenged potential delays and impact on assurance and operations.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of paper

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

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

Issues to bring to the Board's attention

The board are asked to note

- This month the quality aspect of the report has been developed to give a more structured position. This remains a work in progress with further updates planned for the September Board.
- The wider report has also been updated to provide a clearer oversight on the key metrics under each true north, with further work around data maturity and triangulation to be done. The board can take assurance that the right areas are being highlighted, with management actions in train. Further assurance will depend on clearer evidence over the next reporting cycles.
- Access and flow remain the most material operational challenges, the 38-week waiting position has improved, which is positive, but the 18-week access standard remains below ambition and recovery is not yet sustained. Flow remains under pressure, with high occupancy, out-of-area placements and adjusted length of stay increasing from below 40 to 44 days once Clinically Ready for Discharge (CRFD) is excluded.

Governance

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

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Integrated Quality & Performance Report

(IQPR)

July 2026

Contents

1. Performance Overview

Overall assurance assessment

The Trust continues to experience sustained operational, workforce and flow pressures. This is therefore causing our performance to be mixed (internal variation exists): there are improvements in some access, workforce and productivity measures, but community access and patient flow remain the principal risks to delivery of the Trust's strategic ambitions. Recovery actions are in place; however, the pace of improvement remains variable with a number of interdependences.

At this stage, the executive team are continuing to develop the assurance measures we have in place and seeking clarity with regards to understanding the gap to the ambition and that we have credible breakthrough objectives and actions in place to deliver the ambition. The Board at this stage, should therefore take partial assurance, with gaps remaining in access recovery, flow, workforce capacity and productivity, data maturity and data triangulation.

National Oversight Framework (NoF)

The Trust's overall segmentation moved from 1 to 3 based on quarter 4 performance (25/26), with an average metric score of 2.31 (down from 2.02 in Quarter 3). This is primarily driven by the Trust's benchmarking position in the national Community Mental Health Survey and ranks the Trust 33rd nationally for community and mental health trusts, down from 13th in Quarter 3. We have a paper on the Board agenda today that sets out clearly the change and the actions we are taking in response to this.

Across the NOF domains, the Trust scored as high performing in access to services and finance and productivity; below average in patient safety and people and workforce; and low performing in effectiveness and experience.

True North Assurance Summary

The True North domains show a varied assurance position. Improvement work is active across all areas, but performance remains below ambition in Access, Experience and Staying Well; Smarter Working is still developing as an assurance framework; and Safe Care requires continued focus on embedding stronger clinical practice beneath stable headline harm indicators. All a focus for the trust quality improvement plan (QIP).

Taken together, the report supports partial assurance, with clear ownership and defined improvement activity. Stronger assurance depends on sustained delivery, improved data quality and triangulation of data and clearer evidence that actions are reducing variation in the highest-risk areas.

An assessment by each area is provided below.

True North Area	Status	Trend	Board Assurance Message	Assurance Gap
Access	Partial assurance	**Improving** from the January position, Performance remains significantly below the required level, with long waits concentrated in Mental Health Together (MHT) services, particularly East Kent and parts of West Kent.	Access remains a material risk with the Trust seeing 76.5% of patients within 18 weeks. The position has seen a significant improvement in month, but sustained delivery is not yet evident, this will be monitored closely in the coming months.	18-week standard not achieved and sustained recovery not yet demonstrated
Safe Care	Partial Assurance	**Stable**, with incidents reduced between February and June 2026.	Partial assurance can be provided on the safety improvement work with performance in female self-harm below the average (127 incidents) since July 2024. Further work is required to ensure the improvement is embedded in clinical practice.	Improvements are consistently embedded into clinical practice at this stage.
Experience	Off track / partial assurance	**Variable,** patient experience is below the 95% ambition, with the new your experience baseline at 81%. Staff recommendation has improved but the latest pulse survey (50.7%) remains below the 60% target, and confidence is limited by low response rates.	Patient and staff experience should be viewed together. The Board should note improvement activity is in place, but assurance is limited by the low level of response rates and a lack of consistency across services. Surveys to continue to monitor impact of improvement work.	Low response rates and service variation limit confidence in the experience position.
Smarter Working	Developing / limited assurance	**Baseline being established**. Productivity reporting and workplan adherence measures are not yet mature, and current data should be treated as baseline intelligence rather than confirmed performance.	The Board should treat current productivity data cautiously. Smarter Working is a key enabler for access, safety, experience and flow, but stronger data quality is required before an assessment can be taken.	Data quality, validation and methodology not yet mature
Staying Well	Off track / limited assurance	**Material Pressure**, with assurance constrained by data maturity and triangulation. Flow, bed occupancy and patients awaiting beds remain below the Trust's intended position, current reporting is reliant on manual data capture.	Assurance is limited until improvement work demonstrates impact on out of area placements, discharge delays and bed availability. This work is being supported by improvements in digital bed management to improve assurance with regards to live data capture.	Impact of flow improvement actions on patient flow, discharge timeliness and bed availability not yet evidenced.

2. Quality Focus

The Trust can take **partial assurance** regarding the overall quality and safety of services. There is evidence of improvement activity, stable performance in several headline safety indicators and increasingly structured quality improvement arrangements, through the Trust's Quality Plan. However, assurance remains constrained by variation between services, flow pressures, data maturity in some areas and the need to demonstrate that improvements are consistently embedded within clinical practice rather than reflected solely in performance indicators.

This overview should be read as an executive assessment of the Trust's quality and safety position, informed by the IQPR, the Quality Improvement Plan, and detail presented to the Quality Committee. The purpose is to bring together the key quality risks to provide an assessment to the board.

1. Safety & Risk

<table>
<tr><td colspan="2">Present position
Incident reporting remains an important safety surveillance signal, but should not be interpreted in isolation. The Quality Focus data shows 1,258 reported incidents in June (up from 1,183 in May), alongside 149 patient harms (down from 160 in May), 141 self-harm incidents (compared to 145 in May).

Female self-harm remains one of the Trust's most significant quality surveillance measures. The SPC position demonstrates normal variation, with a long-term mean of 127 incidents since July 2024. Acute services saw a reduction in incidents between February and June 2026. However, service-level variation remains evident: Foxglove Ward continues to contribute the highest volume of incidents across the previous 12 months and Fern Ward increased from 6 incidents in May to 22 in June.</td></tr>
<tr><td>Assurance position
Headline safety indicators remain broadly stable and there are encouraging signs of improvement in some areas, particularly female self-harm within inpatient services. However, the Board should not view stability in harm indicators alone as evidence of safe care. The stronger test of assurance remains whether risk assessment, care planning, medication safety, incident learning and clinical practice controls are reliably embedded across services.</td><td>Future steps
Actions underway include implementing safety cards, psychoeducation materials, self-harm formulation tools, alternative to self-harm (ASH) and Minimal Risk Activity Pack (MRAP) rollout, Assist & Embrace, ward training, targeted review of higher-reporting areas and development of a community self-harm objective for Quarter 2 2026/27. Future reporting will seek to strengthen oversight on these actions and provide clearer evidence around delivery.</td></tr>
</table>

2. Quality of Care and Clinical Effectiveness

Present position
The Quality Improvement Plan (QIP) remains rated Amber with moderate confidence. Risk assessment compliance remains below target, with North Kent at 51%, West Kent at 39.3% and East Kent at 50% against an 80% target. Clinical Risk Assessment and Management (CRAM) reporting shows overall compliance of 61.5% for new risk assessments completed and 47.2% completed within the required timeframe. Safety planning is improving, with safety plans completed increasing from 33% to 39.4% and safety plans completed within the required timeframe increasing from 26.6% to 47.7%.

Mandatory training remains a quality enabler and an assurance gap. The QIP reports Safeguarding Adults Level 2 at 82%, Safeguarding Children Level 2 at 82%, Immediate Life Support at 80%, Adult Basic Live Support at 89% and Personal Safety at 84%, with pressure in CYP/AAED where the training position was below trust standards at the point of transfer. These indicators should be treated as core controls for safe practice, rather than workforce metrics alone.

Assurance position	**Future steps**
The Trust is increasingly focusing on the clinical controls that underpin safe and effective care, but evidence remains variable across pathways and services. The most important assurance questions are whether patients have up-to-date risk assessments, up-to-date care plans, appropriate follow-up after discharge, high-quality formulations and timely physical health reviews where required.	Further reporting should strengthen the evidence that core clinical controls are reliably embedded across pathways and services, including risk assessment, care planning, follow-up after discharge, high-quality formulations, timely physical health reviews and mandatory training compliance.

3. Access & Waiting Times

Present position
Mental Health Together performance remains below ambition, with 76.5% of patients commencing intervention within 18 weeks against the 85% ambition. There are 197 patients waiting more than 38 weeks against the ambition of zero by March 2026 (this position has improved from 305 in January, so good progress is being made). Directorate variation is material: East Kent has 87 patients waiting over 38 weeks, West Kent has 90 and North Kent has 20. Although the 38-week position has improved from the January peak, sustained recovery is not yet demonstrated.

The flow position also remains under pressure. Bed occupancy remains above the Trust's 90% ambition (to be delivered over the life of its strategy). In June, 437 out-of-area placement bed days were reported, of which 203 related to female PICU contracted beds due to the absence of female PICU provision in Kent and Medway. The adjusted Trust-controllable position is therefore 234 bed days. Current reporting for patients awaiting beds is based on manual Patient Flow Team data, with a RiO bed management form expected to improve visibility and data quality in Quarter 2 2026/27.

Assurance position	Future steps
Patient Flow remains a significant operational and quality risk within the organisation. Delays in access, delayed discharge, prolonged lengths of stay and out-of-area placements are quality issues as well as operational issues because they affect safety, deterioration risk, patient experience and continuity of care.	Future reporting should demonstrate sustained recovery in the 38-week position, clearer oversight of directorate variation and improved visibility and data quality for patients awaiting beds through the RiO bed management form expected in Quarter 2 2026/27.

4. Patient Experience and Outcomes

Present position

The new Your Experience Matters survey reports that 81% of respondents rated the Trust as good or very good in relation to involvement in decisions about care, based on 239 responses. This should be considered a baseline position rather than evidence of sustained improvement. The annual complaints report shows 1,267 contacts in 2025/26, including a 17% increase in formal complaints, partially driven by an increase in reopened complaints. Benchmarking has been undertaken and this indicates that the Trust's position is consistent with national changes. At the same time, responsiveness improved, with 96% acknowledged within three working days and 91% responded to within agreed timeframes.

The main complaints' themes remain communication with patients and carers, access to services and waiting times, care planning and clarity of treatment, discharge and continuity of care. These themes triangulate with the wider quality risks in risk assessment, care planning, patient flow and clinical coordination. Positive assurance is provided by 1,774 compliments received during 2025/26, most commonly recognising staff compassion, professionalism, teamwork and positive therapeutic relationships.

Assurance position	Future steps
Patient experience remains below ambition, although new data sources provide improved visibility. Assurance remains constrained by response rates, the maturity of the new Your Experience Matters survey and variation between services.	Future reporting should strengthen the use of new experience data sources, demonstrate whether survey findings are improving over time and show how complaints themes are being used to inform action on risk assessment, care planning, patient flow and clinical coordination.

Overall Conclusion

The Board can take partial assurance from the current quality and safety position. There are positive signals around structured quality improvement activity, self-harm improvement work, safeguarding compliance, complaints responsiveness and increased executive focus on safety. However, the most significant risks remain patient flow, access delays, variation in practice, clinical control reliability and demonstrating that quality improvements are consistently embedded across services. Further work will take place over the next quarter to ensure as a Trust our IQPR includes all the relevant quality and safety metrics that allow us as a Board to take better assurance around the safety of our services.

3. Trust Wide Integrated Quality and Performance Dashboard

Access	Executive Sponsor: Donna Hayward-Sussex, Chief Operating Officer & Deputy CEO	Off track / partial assurance

True North

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Acc.001: % Mental Health Together patients receiving treatment in 18 weeks	85.0%	76.3%	80.0%	76.7%	81.2%	79.6%	81.5%	73.5%	65.9%	63.5%	59.9%	61.4%	76.5%	74.6%	73.7%

Access remains off track. The Trust is currently seeing 76.5% of Mental Health Together patients commencing intervention within 18 weeks against the 85% ambition, and 197 patients remain waiting 38 weeks or more. Although the 38-week position has improved from the January (305 patients), sustained recovery is not yet demonstrated.

The waits are varied. East Kent is the largest volume contributor, with pathway bottlenecks in individual interventions and further work required to understand the impact of recent pathway or data-definition changes. West Kent has patients with no future appointment or awaiting first clinical contact, indicating triage, allocation, capacity and pathway variation as key drivers. North Kent has lower absolute numbers but remains off target, with root cause analysis underway.

The access challenge is therefore a community pathway management issue, not solely a waiting-list issue. Actions are focused on reducing the longest waits, improving clock-stop and caseload management, strengthening triage and pathway grip, and supporting people through waiting-well arrangements. The digital Improving Caseload management tool for Mental Health Together Plus is a key enabler.

Partial assurance can be taken from directorate-level Doing Well Together improvement (A3) work, named owners, root cause analysis and countermeasure plans. Assurance will strengthen when future reporting demonstrates sustained reduction in 38-week waits, improvement in the 18-week position, clear directorate trajectories and consistent application of waiting-well and pathway controls.

Key Metrics

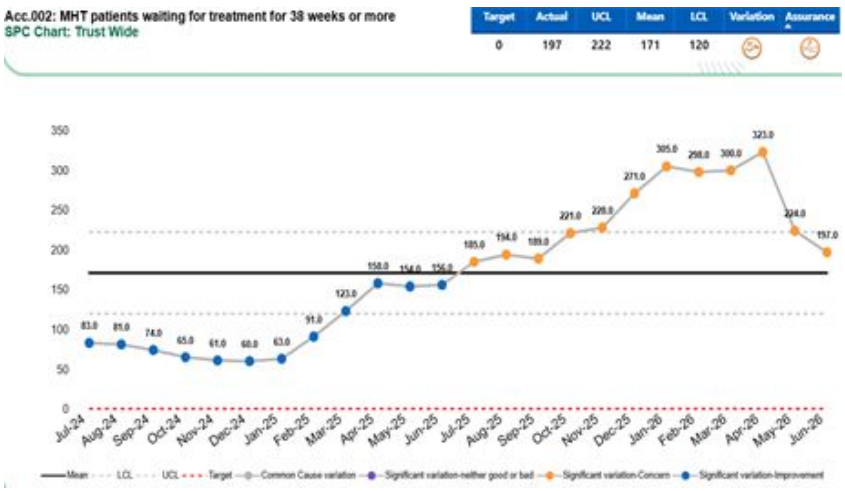
Metric	Trust-wide performance	SPC / direction of travel	East Kent	West Kent	North Kent
Acc.001: % MHT patients commencing interventions within 18 weeks	**76.5%** against 85% target	Below target; recent deterioration requires review. Performance remains below ambition and the recent downturn is not yet confirmed as an SPC trend or special cause change.	**76.2%** — below target. Broadly mirrors the Trust position and should be read alongside East Kent's higher long-wait volume and pathway bottlenecks.	**71.8%** — weakest directorate position. Supports concern around first clinical contact, triage, allocation and pathway grip.	**81.4%** — strongest directorate position but still below target. Lower long-wait volume but continued local grip is required.
Acc.002: MHT patients waiting 38 weeks or more	**197** against the ambition of zero (126 improvement in the quarter)	Improving from the January peak but still off track. Sustained recovery is not yet demonstrated, and the position remains materially above the intended level.	**87** — material volume pressure. East Kent remains one of the two main contributors, with pathway bottlenecks and clock-stop discipline requiring focused action.	**90** — highest volume contributor. Reinforces the need for active management of patients with no future appointment or awaiting first clinical contact.	**20** — lower absolute volume but still above ambition. RCA and local countermeasures remain required to prevent persistence or escalation.

Breakthrough Objectives

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Acc.002: MHT patients waiting for treatment for 38 weeks or more	0	185	194	189	221	228	271	305	298	300	323	224	197	245	171

Focus on Breakthrough Objectives

Acc.002: MHT patients awaiting Intervention waiting to date 38 weeks or more.



Data Source	RiO	Data Quality Confidence	

What is being measured?

Number of patients waiting for a treatment clock stop at month end who have been waiting for 38 weeks or more from Spell Start Date for an appropriate Clinical or Social Intervention.

What is the data telling us and key actions in place

In terms of people waiting well for services. We have had in place for over a year a methodology to review and respond to people waiting over 18 weeks, which is led by community directorates senior leadership team. This approach has improved our real time tracking of people waiting. We are also exploring with a local charity about how they can support waiting well as a potential pilot in East Kent. In addition, we have now launched the digital Caseload Management tool for people under the care of Mental Health Together Plus. This tool enables multi-disciplinary teams to understand, track and respond to all aspects of caseload management – risk management, care planning, contacts, waiters etc. The tool is an exemplar of good practice, which is subject to project oversight to ensure implementation and improvement.

Regarding people waiting, we have in place a standard operating to procedure to ensure people are waiting well. For several people, whilst they might be waiting for specific intervention, they are also being seen for other support, for example, stabilisation. For people who have not been seen other than for their assessment and planning session, a process is in place to speak to people once they have triggered over 18weeks. At this contact it is agreed how regularly contact is made and what to do if things change or they are concerned about their safety. All people waiting a review in regular huddles throughout the week and escalated to the service director on a weekly basis. We are also exploring ways in which the VCSE can further help with waiting well. Finally, we also use a patient experience questionnaire for people waiting, which is led by our Chief AHP and share this data regularly.

We are currently reviewing waiting lists to examine the recent downturn in the number of people receiving treatment with 18 weeks for the last two months. Although this is not a yet a trend or significant SPC change, we are ensuring we have a robust approach and responsiveness.

Watch Metrics

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Acc.003: % Mental Health Together patients receiving an assessment in 4 weeks	65.0%	70.1%	68.2%	61.7%	66.7%	65.1%	70.0%	57.2%	64.4%	57.7%	51.5%	55.2%	51.30%	61.9%	59.1%
Acc.004: Open Access Crisis Line: Calls received	3,274	3,383	3,047	2,976	3,227	2,794	2,968	3,174	3,070	3,159	2,848	3,068	3,112	3,069	3,197
Acc.005: Open Access Crisis Line: Abandonment Rate (%)	12.00%	37.1%	38.9%	40.2%	28.3%	21.2%	25.0%	22.4%	25.7%	24.3%	20.2%	20.7%	25.1%		27.6%
Acc.006: Assess people in crisis within 4 hours	90.0%	93.7%	91.4%	93.6%	91.0%	90.9%	84.9%	91.4%	85.1%	73.0%	88.1%	84.9%	83.8%	87.7%	87.9%
Acc.007: People presenting to Liaison Services: triaged within 1 hour		92.1%	89.4%	90.8%	90.9%	89.2%	93.9%	92.3%	89.6%	90.0%	92.6%	93.4%	90.6%	91.2%	88.1%
Acc.008: Liaison Psychiatry referrals closed within 12 hours	95.0%	84.6%	82.1%	81.8%	82.8%	81.5%	82.6%	82.8%	81.6%	85.8%	84.7%	85.3%	84.9%	83.4%	66.9%
Acc.009: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	29.6%	12.3%	10.4%	6.5%	16.2%	15.7%	8.3%	8.5%	16.3%	18.0%	13.9%	12.0%	13.9%	16.3%
Acc.010: Place of Safety Length of Detention: % under 24 hours	75.1%	80.0%	78.7%	86.9%	86.4%	89.8%	90.5%	85.2%	89.8%	93.3%	100.0%	100.0%	100.0%	88.7%	82.8%
Acc.011: MAS diagnosis within 6 weeks	95.0%	31.1%	25.3%	21.3%	22.5%	27.2%	23.2%	20.0%	17.7%	31.5%	29.1%	21.6%	21.5%	24.2%	24.1%
Acc.012: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%	70.0%	85.7%	92.3%	87.0%	76.5%	76.9%	50.0%	80.0%	68.2%	83.3%	52.9%	47.1%	71.6%	68.9%
Acc.013: % MHLD referrals commencing treatment in 18 weeks	86.1%	92.9%	84.8%	83.8%	83.7%	70.7%	95.8%	87.7%	87.5%	87.5%	75.5%	72.2%	84.8%	83.7%	83.8%
Acc.014: Perinatal assessments (against annual target)	2,000	183	163	177	180	161	144	174	150	175	603	193	190	208	
Acc.015: DNA Rate – All Appointments	8%	10.7%	10.1%	10.5%	10.4%	9.8%	10.0%	10.6%	10.5%	10.2%	10.1%	10.1%	10.0%	10.3%	10.4%
Acc.016: Number of Active Referrals waiting less than 18 weeks to first contact (MHSCYP)		1,339	979	1,072	946	1,176	1,042	1,101	1,076	1,179	1,098	1,327	944	1107	
Acc.017: CYP Crisis Assessments within 4 hours (Referral to Contact)		81.2%	88.4%	77.6%	77.1%	76.0%	76.1%	79.3%	76.7%	67.8%	81.6%	90.7%	61.1%		
Acc.018: % Routine Eating Disorders Activity-Based Clock Stop Achieved Within 4 Weeks Aged 0–18		87.9%	91.1%	92.0%	100.0%	97.1%	93.0%	98.2%	96.8%	93.1%	78.0%	89.3%	92.5%		

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

Acc.012 The numbers remain very low monthly, denominator of 17 trust wide. Performance should be viewed over a longer period of time and target achieved over last 12 months.

Acc.017: CYP Crisis Assessments within 4 hours (Referral to Contact): Challenges exist in accessing NHSP cover at night due to vacancies within the service, a root cause analysis for further exploration is being completed.

Safe Care | Executive Sponsor: Julie Kirby, Chief Nurse | Partial Assurance

True North

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Safe.001: Number of patient harms		178	149	146	152	105	127	116	232	153	142	121	117	145	169

Safe Care remains a significant improvement priority with partial assurance being provided on delivery. Inpatient female self-harm remains within normal cause variation, with a mean of 127 incidents since July 2024. The key assurance question is whether stable harm indicators are supported by stronger practice in formulation, safety planning, risk review, medication safety and learning from incidents.

Service-level variation remains important and is being monitored. Acute incidents reduced between February and June 2026. Foxglove remains the highest contributor to self-harm incidents over the rolling 12-month period, while Fern increased from 6 incidents in May to 22 in June. Medication safety also remains a practice-quality signal, with reporting fluctuating month to month and higher reporting in Fern Ward and Rivendell. Daily safety huddles support directorate leaders to identify early hotspots and support accordingly.

The trust is implementing safety cards, psychoeducation materials, self-harm formulation tools, alternative to self-harm (ASH) and Minimal Risk Activity Pack (MRAP)rollout, Assist & Embrace, ward training, targeted review of higher-reporting areas and development of a community self-harm objective for Quarter 2 2026/27.

Safe Care triangulates directly across the quality lens, and these indicators are enabling us to test whether headline stability is supported by embedded practice improvement.

Key Metrics

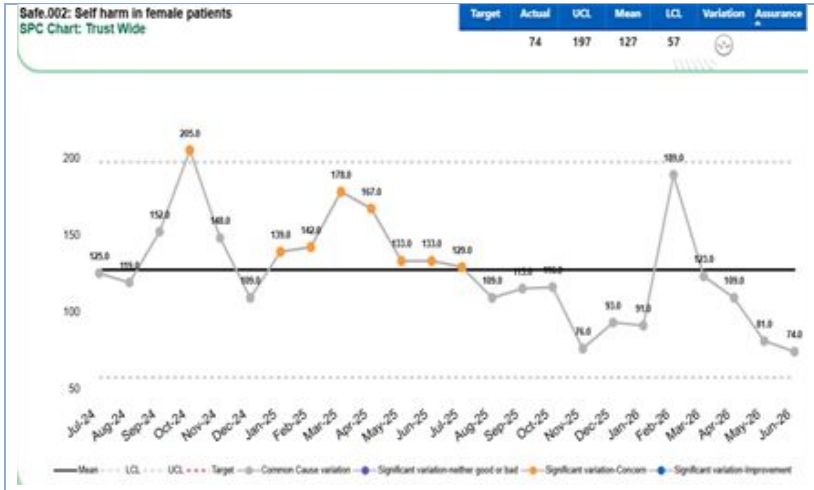
Metric	Trust-wide position	SPC / direction of travel	Variation / hotspot	Executive Assurance Focus
Safe.001: Number of patient harms	Headline harm position should be read alongside incident themes and Quality Focus triangulation.	Direction to be interpreted through SPC and severity review, not count alone.	Variation should be assessed through incident themes, mortality, medication safety, safeguarding and quality audits.	Harm counts provide an important signal but are not sufficient assurance on their own. Assurance depends on learning, severity review, practice improvement and triangulation with Quality Focus themes.
Safe.002: Female self-harm incidents	Mean of 127 incidents since July 2024; around 2,300 recorded self-harm incidents, c80% involving women.	Normal cause variation. Acute incidents reduced between February and June 2026.	Foxglove remains the highest contributor over the rolling 12 months. Fern increased from 6 incidents in May to 22 in June.	The data does not indicate special cause deterioration, but service-level variation requires focused review. The Board should seek assurance that ward-level actions improve formulation, safety planning, staff confidence and patient support.
Medication safety	Latest month above the 12-month average but within the recent reporting range.	Month-to-month variation; no clear sustained deterioration or improvement.	Higher reporting in Fern Ward and Rivendell.	Medication safety is a practice-quality signal. Assurance depends on understanding severity, contributory factors, local variation and evidence that learning is being embedded.
Risk assessment / care planning	Reported through watch metrics and quality assurance activity.	Direction to be confirmed through compliance, audit quality and evidence of active review. Important that quality is driven alongside compliance.	Variation should be highlighted where risk, formulation or care plan compliance is inconsistent across teams or pathways.	This is a core assurance layer beneath harm reduction. Reduced harm should not be treated as assurance unless risk assessments, formulations and care plans are timely, person-centred and actively reviewed.

Breakthrough Objectives

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Safe.002: Self harm in female patients	36	129	109	115	116	76	93	91	189	123	109	81	74	109	127

An additional Breakthrough Objective to reflect **improving the management of self-harm in the community** is under development with data collection to commence in Quarter 2 of 2026/27.

Focus on Breakthrough Objectives



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

What is being measured?

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

What is the data telling us and key actions in place

SPC is showing normal cause variation, the mean since July 2024 is 127.

Incident numbers for acute services decreased between February and June 2026. When reviewed on a rolling 12 month period, Foxglove has the highest reported incidence of self-harm in the organisation, although incident numbers have been reducing gradually since February. Fern ward showed an increase in incidents from 6 in May to 22 in June.

The self-harm formulation support tool for staff and patients that was developed by the self-harm steering group remains with communications team awaiting update before this can then be shared with teams. Psychoeducation leaflets for patients and their families, friends and carers are in the process of being developed. A task and finish group is being established to develop a bitesize training offer for ward staff, and another group is currently developing a plan to pilot the use of “safety cards” on the ward.

Watch Metrics

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Safe.004: Risk Compliance	90%	9.5%	12.3%	15.0%	17.3%	19.2%	19.5%	21.3%	26.4%	31.5%	35.6%	38.2%	41.2%		16.4%
Safe.005: Care Plan Compliance	90%	0.0%	0.0%	0.0%	0.0%	0.8%	0.9%	2.1%	15.4%	25.6%	32.9%	39.9%	46.5%		9.1%
Safe.006: Patients receiving follow-up within 72 hours of discharge	90%	91.3%	85.8%	88.5%	87.0%	88.7%	85.9%	90.8%	86.7%	88.2%	85.6%	86.8%	81.8%	87.4%	85.8%
Safe.007: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Safe.008: All Deaths Reported And Suspected Suicide		136	112	137	146	104	161	177	145	133	91	80	66	124	134.2
Safe.009: Restrictive Practice - All Restraints		100	87	111	163	170	141	99	140	131	104	88	89	119	99.5
Safe.010: Restrictive Practice - No. Of Prone Incidents	0	8	4	7	16	12	4	10	3	10	7	7	2	8	7
Safe.011: Care Plan in date for patients in treatment (CYP & AAED)		76.1%	75.4%	75.9%	77.3%	78.1%	77.7%	77.7%	77.8%	79.0%	79.6%	79.1%	73.0%		
Safe.012: Risk assessment in date for patients in treatment (CYP & AAED)	90%	86.5%	85.1%	84.4%	84.3%	84.6%	84.7%	83.6%	83.9%	84.7%	85.2%	84.7%	79.2%		

Safe.008 – Data under review to understand reasoning for improvement. Potential changes in reporting being explored.

Experience

Executive Sponsor: Julie Kirby, Chief Nurse & Ali Layne-Smith, Chief People Officer

Off track / partial assurance

True North

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Exp.001: % of patients feel that the overall experience of our services was good/ very good (FFT % Positive)	90.0%	90.8%	88.4%	88.8%	87.4%	83.6%	86.9%	87.4%	88.3%	87.4%	80.1%	80.0%	79.0%		87.2%
Exp.002: Trust Staff Engagement Score	6.8									6.7					

**EXP.002 Data reported annually in line with national staff survey*

Experience remains off track with partial assurance. Patient experience and staff experience are both below ambition, and assurance is constrained by low response rates.

The new YEM baseline shows 81% good or very good for being included in decisions about care, based on 239 responses.

Staff experience has improved but remains below the breakthrough objective: 50.7% of staff recommend KMMH as a place to work against the 60% target. The Pulse response rate of 487 responses, or 12.3%, limits confidence in representativeness. Therefore, the ambition to increase national staff survey participation to 65% should be treated as both an engagement and data quality objective.

Patient and staff experience should be read together and triangulated with complaints, compliments, discharge communication, waiting experience, leadership behaviours and staff voice.

To address this position there is ongoing work around the patient experience objective, focused on staff experience plans, the introduction of Staff Voice forums, extending the use of staffroom and various staff development initiatives.

Key Metrics

Metric	Trust-wide position	SPC / direction of travel	Variation / hotspot	Executive Assurance Focus
Exp.001: FFT % positive overall experience	Below the 95% ambition.	Direction to be interpreted through trend and response volume.	Should be triangulated with compliments, complaints, YEM results and response rates.	Positive experience remains below ambition. Assurance will depend on improved response rates, service-level consistency and triangulation with complaints and compliments.
Exp.003: Patients feel included in decisions about care	81% good / very good, based on 239 responses.	New baseline; insufficient data points for trend analysis/ SPC.	Directorate and service variation to be developed as YEM matures.	This is the patient experience breakthrough objective. The baseline is useful, but assurance is limited until response rates improve and consistent involvement is demonstrated across services.
Exp.004: Staff would recommend KMMH as a place to work	50.7% against 60% target.	Improved since last Pulse survey, but insufficient data points for trend analysis/ SPC.	Wide directorate variation; low response rate limits confidence.	Staff advocacy remains below ambition. Assurance depends on representative participation, directorate action plans and evidence that leadership and culture interventions affect day-to-day experience.
Staff survey participation / response rate	Pulse response 487 / 12.3%; ambition to increase national staff survey participation from 51% to 65%.	Data quality / representativeness issue.	Variation by directorate and staff group to be tracked.	Response rate is both an engagement measure and a data quality risk/limitation. Low participation limits confidence in the staff experience assessment and weakens the evidence base for WRES, WDES and NoF.
Complaints / compliments responsiveness	Compliments increased; complaints should be treated as an early warning signal.	Direction to be confirmed through responsiveness and theme analysis.	Links to communication, discharge, responsiveness and service variation.	Compliments provide a positive signal, but must be triangulated with complaints, response timeliness and themes. Assurance depends on whether learning is improving responsiveness and communication.

Breakthrough Objectives

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Exp.003: % of patients feel that we are good/ very good at including them in decisions about their care	95.0%										80.0%	79.6%	79.4%		
Exp.004: % of staff would recommend KMMH as a place to work	60.0%	44.8%						33.0%		54.0%	50.7%				

**Exp.004: March data reflects annual staff survey results. All other results are taken from the pulse survey which is administered during Quarters 1,2 and 4 each year. There may be variation in the results between the two sources due to differences in survey format and response rate.*

Focus on Breakthrough Objectives

Exp.003: % of patients feel that we are good/ very good at including them in decisions about their care.

Insufficient data points to analyse by SPC

Data Source Your Experience Matter **Data Quality Confidence**

What is being measured?

Measure moving forward

We will use patient experience measure from the new launched survey on 1st April 2026 'Your Experience Matters'. We will use the question:

- Being included in decisions about the care provided

Measure baseline (prior)

Prior to 'You Experience Matters' (YEM) we used the Patient Related Experience Measures' (PREM). We will use the question:

- Did we involve you as much as you wanted in agreeing what care you receive

Although the survey measure has changed, these 2 questions are very similar in nature of what is being asked. Therefore, this is an appropriate comparative measure moving forward.

What is the data telling us and key actions in place

The first month of the YEM shows an overall score 81% being very good/good. This was out of a total of 239 responses.

Next steps

- Map out A3 improvement methodology for the BO
- Engage wider key stakeholders in moving forward with the BO
- Further think about communication around the importance of the YEM and driving up response rates

Exp.004: % of staff would recommend KMMH as a place to work
Insufficient data points to analyse by SPC

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

What is being measured?

Staff recommend KMMH as a place to work (staff survey) from 54% to 60% as a Trust

What is the data telling us and key actions in place

Wide variation exists across directorates with targets set as relative increases to the Staff Survey results 2025 as shown below:

True North:
Staff engagement score – target 7.3 (by 2030)

	Target	Mar-25	Mar-26	Mar-27	Mar-28	Mar-29	Mar-30
Acute	7.3	7.1	7				
Children/AAED	7.3	No data	No data				
Forensics and Specialist	7.3	7.0	6.9				
East	7.3	5.9	5.7				
North	7.3	6.8	6.7				
West	7.3	6.6	6.3				
Support Services	7.3	7.0	7				
Trust total	7.3	6.8	6.7				
Data Source	Staff Survey	Staff survey 24	Staff survey 25	Staff survey	Staff survey	Staff survey	Staff survey

Breakthrough:
Would recommend organisation as a place to work

	Target 26/27	Mar-25	Jul-25	Jan-26	Mar-26	Apr-26	Jul-26
Acute	66%	60.9%	50.0%	no data	60.0%	57.8%	
Children/AAED	60%	no data	no data	no data	55.7%*	No data	
Forensics & Specialist	66%	61.7%	36.6%	27.0%	60.0%	46.7%	
East	45%	41.3%	26.7%	7.1%	37.0%	46.0%	
North	60%	56.8%	53.3%	30.0%	50.0%	55.8%	
West	52%	50.2%	41.7%	35.0%	44.0%	48.3%	
Support Services	65%	63.0%	59.5%	51.0%	62.0%	55.8%	
Trust	60%	56.7%	44.8%	33.0%	54.0%	50.7%	
Data Source		Staff Survey 24	Pulse	Pulse	Staff Survey 25	Pulse	Pulse

April 2026 shows the data from the latest Pulse survey for the breakthrough objective. Response rates remain low with only 487 (12.3%) completing, however, results since last Pulse survey in January are showing improvements across all directorates. Children/AAED will be added to surveys from July 2026.
Key Actions:

- **Day-to-day Experience** - The approach to improving Staff Experience and Engagement has evolved for 2026. All directorates are producing an action plan which are tied into the True North and Breakthrough objectives of the 2026-2031 Trust strategy. Directorates will be sharing their results, holding staff focus groups and developing these plans. Actions will be regularly reviewed during SDR or as per directorate review process as applicable.
  Alongside this a short trial of creating a Staffroom Community (East directorate) will take place and be subsequently rolled out across all directorates. This will enable stronger narrative control and leaders feeling more empowered to drive local conversations and build trust with their people. This should support improved communication and transparency within the directorates.
- **Staff Voice** – Following the successful trial in Forensics, Staff Voice forums are currently being established for each directorate. The aim is to reach a wider range of staff feedback and contribution across the directorate in addition to other listening/response

	mechanisms. All forums are expected to be established with their elected representatives and first meetings taking place by late July 2026. Meetings will then take place quarterly. • **Leadership behaviours** – improvement leadership behaviours are incorporated in the trust leadership programme – Leading Well Together. Behaviours were assessed to gain a personal benchmark through the creation of a new 360 tool; this is currently being repeated in line with 2026 appraisal timelines for the Trust Leadership Team. Leadership behaviours are being incorporated as a focus in the Culture (strategic initiative) – behaviours, expectations, how we work, how decisions are made, how teams are led and managed. This group has been set up, and actions will follow once agreed. • **Talent Toolkit** – Trial talent toolkit with EMT and Deputies to see how process works and what is working well/ not before rolling out into Trust. • **Positive Experience** – a focus in how it feels to work here; engagement, involvement, belonging is an additional focus and currently being explored in terms of key action areas. This also sits alongside the True North objective to increase engagement to 7.1 by 2030. **Health and Wellbeing** – The new 3-year plan is drafted and will be finalised by July 2026.

Watch Metrics

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Exp.005: Complaints - actuals		49	52	66	43	46	38	71	49	72	70	54	52	55	50.3
Exp.006: Compliments - actuals		174	118	139	153	150	178	124	135	117	147	141	132	142	138.2
Exp.007: Compliments - per 10,000 contacts		40.8	31.8	34.5	35.8	37	46.7	29.4	35.1	28.3	36.3	36.1	31	35	36.8
Exp.008: Your experience matters: Response Count		577	424	456	507	353	434	405	501	478	427	621	744	494	530
Exp.009: Your experience matters: Response Volume		3.20%	2.60%	3.10%	2.80%	2.00%	2.50%	2.20%	2.80%	2.70%	2.40%	3.60%	4.00%		3.2%
Exp.010: Your experience matters: Achieving Regularly, % good/very good											81.0%	81.0%	80.1%		
Exp.011: Complaints acknowledged within 3 days (or agreed timeframe)	100%	92.0%	95.0%	89.0%	84.0%	95.0%	98.0%	97.0%	94.0%	96.0%	97.0%	98.0%	88.0%		94.0%
Exp.012: Complaints responded to within 30 days (or agreed timeframe)	100%	86.0%	80.0%	83.0%	88.0%	75.0%	81.0%	79.0%	72.0%	86.0%	78.0%	80.0%	93.0%		80.2%
Exp.013: Decrease violence and aggression		462	392	462	456	469	371	386	363	384	352	344	343	399	316
Exp.014: Medication errors	27	54	45	55	54	36	40	31	52	45	38	37	50	45	47
Exp.015: Increase percentage of BAME staff in roles at band 7 and above	20.0%	29.8%	30.6%	30.9%	30.9%	30.7%	30.5%	31.1%	31.0%	31.0%	31.1%	31.1%	32.6%		29.2%
Exp.016: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%	0.4%	0.4%	0.2%	0.1%	0.1%	0.3%	0.4%	0.2%	0.2%	0.4%	0.4%	0.4%		0.3%

Smarter Working | Executive Sponsor: Nick Brown, Chief Finance and Resources Officer | Developing / Limited Assurance

True North

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Res.001: Productivity Increase Year on Year	2.0%	4.7%	5.5%	4.0%	4.6%	4.3%	4.4%	5.8%	7.2%	6.1%					

Reported data is national NHSE data which is 3 months in arrears. In a healthcare context, productivity can be summarised as the amount of activity the NHS delivers relative to the resources used to deliver that activity. Work is underway locally to shadow national reporting to enable local reporting.

Smarter Working remains a developing domain with limited assurance. Productivity and workplan adherence data should be treated as baseline intelligence rather than confirmed performance while methodology, data integration and validation are still being developed.

Initial recordable patient facing clinical contact time data shows an average of 0.40 per WTE in May 2026, with medical staff at 0.21 and psychology at 0.58. This is not yet suitable for assurance judgement because recording, methodology and denominator issues are still being resolved. In particular, this work has identified a substantial level of activity which isn't presently recorded (this includes unplanned activity, MDT meetings and family contacts).

Smarter Working is a key enabler for access, safety, experience and flow. The priority is to stabilise methodology, validate staff lists, improve ESR and RiO integration, and develop local shadow reporting for national productivity assessment.

Future reporting should show when the data is sufficiently mature to support productivity assurance and whether clinical capacity is improving in a way that supports the wider performance framework.

Key Metrics

Metric	Trust-wide position	SPC / direction of travel	Variation / data quality	Executive Assurance Focus
Res.001: Productivity increase year on year	National data reported three months in arrears; local shadow reporting in development.	Trust baseline is being established; insufficient local data maturity for SPC interpretation.	Directorate breakdown not currently reported; local methodology is being developed to shadow the national assessment.	This is as a developing assurance measure. Stronger assurance depends on timely local reporting, agreed methodology and evidence that productivity improvement is supporting access, safety, experience and flow. Progressed is anticipated in the next month.
Medic and psychologist workplan adherence	Target 90%; reporting nearing conclusion but not yet sufficiently validated for performance assessment.	Insufficient data points and validation for SPC.	Significant data validation and integration required across ESR and RiO; staff lists being validated with clinical leads.	This is the breakthrough objective, but assurance is limited until the measure is validated. The Board should expect future reporting to demonstrate clinical workplan delivery.
Clinical contact time per WTE	Average 0.40 in May 2026; medical staff 0.21 and psychology 0.58.	Directional only. June changes are affected by methodology corrections and therefore should not be treated as deterioration.	Data is solely based on recorded activity, so shouldn't be read in isolation. Further validation is required before comparisons are reliable.	Current results are materially affected by recording practice, methodology changes, including previously unrecorded activity. The Board should not draw conclusions until the measure has been further validated.
Workforce capacity indicators	June position indicates deterioration in key workforce measures.	Direction requires further review to determine whether this is normal variation or emerging deterioration.	Sickness, vacancy, mandatory training and leaver rates should be reviewed by directorate and staff group.	Workforce stability is a key dependency for productivity, access, safety and experience. The Board should expect future reporting to show whether workforce pressures are constraining delivery of the productivity ambition.

Breakthrough Objectives

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

Work to finalise reporting for this measure is nearing conclusion in conjunction with clinical leads to validate all data prior to publication.

Focus on Breakthrough Objectives

<table>
<tr><td rowspan="5">% of Medics and Psychologists adhering to patient facing workplan (Target 90%)</td><td>Data Source</td><td>ESR & RiO</td><td>Data Quality Confidence</td><td></td></tr>
<tr><td colspan="4">Significant data validation and increased data integration required to acquire a higher degree of confidence in the outputs of this new measure, ongoing refinement will build confidence in outputs</td></tr>
<tr><td colspan="4">What is being measured?</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td colspan="4">What is the data telling us and key actions in place</td></tr>
<tr><td colspan="4"></td></tr>
</table>

Watch Metrics

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Res.002: Psychology & Medic contact time per FTE		0.38	0.36	0.38	0.4	0.39	0.34	0.39	0.36	0.35	0.37	0.4	0.27		
Res.003: Staff Sickness - Overall	4.5%	5.0%	5.2%	4.9%	4.9%	5.5%	5.9%	5.1%	5.2%	5.1%	5.1%	5.1%	5.5%		4.9%
Res.004: Vacancy Gap - Overall	11.5%	10.2%	10.3%	10.2%	10.2%	10.3%	10.2%	10.4%	10.4%	10.3%	10.4%	10.6%	10.5%		10.7%
Res.005: Mandatory Training For Role	90.0%	95.4%	95.6%	94.8%	95.4%	95.3%	95.6%	95.7%	95.5%	94.9%	94.6%	94.4%	94.3%		95.00%
Res.006: Leaver Rate	12.3%	11.9%	11.9%	11.4%	11.2%	11.7%	12.1%	12.3%	12.6%	12.3%	11.8%	11.9%	12.4%		12.7%
Res.007: Leaver Rate (Voluntary)	13.0%	8.2%	8.1%	7.8%	7.7%	7.4%	7.4%	7.5%	7.6%	7.3%	7.2%	7.5%	8.4%		8.5%
Res.008: Safer staffing fill rates	80.0%	110.2%	109.2%	110.3%	109.0%	108.6%	109.6%	109.4%	110.8%	109.0%	111.0%	110.3%	108.0%		110.5%
Res.009: In Month Budget (£000)	0	-15,303	-17,957	-15,725	-15,710	-15,553	-15,537	-15,537	-15,514	-15,536	-15,911	-15,994	-15,930		-15,466
Res.010: In Month Actual (£000)		-15,469	-17,979	-16,362	-16,355	-16,094	-16,332	-15,992	-16,128	-16,100	-15,997	-16,548	-16,961		-15,914
Res.011: In Month Variance (£000)		-166	-23	-637	-645	-541	-795	-455	-614	-564	-85	-554	-1,031		-448
Res.012: Agency spend as a % of the trust total pay bill	3.20%	1.9%	2.0%	1.8%	2.2%	1.7%	2.2%	1.3%	1.8%	0.4%	1.3%	1.0%	1.3%		2.2%
Res.013: Clinician Contact time per FTE		0.32	0.32	0.35	0.33	0.34	0.32	0.34	0.34	0.32	0.36	0.37	0.24		

Res.002: Psychology & Medic contact time per FTE & Res.013: Clinician Contact time per FTE*: Until now, the methodology contained a known issue relating to the treatment of Group contacts which had been highlighted to stakeholders. The contact time recorded for these appointments was being multiplied by the number of attendees, resulting in an overstatement of the total contact time. This known issue has now been corrected so that contact time reflects the actual duration of the session, regardless of the number of attendees. As the previous approach was inflating the reported figures, it is not unexpected that the results for June are significantly lower than those reported in earlier months. The June figures provide a more accurate reflection of the actual clinical contact time delivered.*

There has also been an adjustment in June regarding the staff included in the calculation for Medics – until now, all staff flagged as Medics in Rio (circa 180 staff) were being included in the calculations which included Specialty Registrars. Specialty Registrars (i.e. junior Medics) have now been excluded from the calculation leaving circa 120 staff classed as Medics for the purpose of this exercise.

Staying Well

Executive Sponsor: Afifa Qazi, Chief Medical Officer

Off track / limited assurance

True North

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Prev.001: Bed Occupancy (Net)	92.0%	95.3%	96.8%	97.7%	96.4%	97.9%	97.0%	97.7%	97.7%	95.0%	97.9%	97.8%	96.2%		96.5%

Staying Well remains off track with limited assurance. Bed occupancy significantly above target, despite a 1.6% reduction in month. The breakthrough objective focuses on reducing the number of people waiting for beds as the clearest indicator of the wider flow position, and the wider impact on the patients (with delays in care having a direct correlation to length of stay and potential clinical risk).

Current reporting is based on manual Patient Flow Team data, so the Board should treat the position as directional until digital capture is fully embedded. Adjusted length of stay has increased over six months from below 40 to 44 days, once CRFD patients are excluded. This indicates a wider flow issue beyond CRFD, requiring grip on admission management, treatment progression and discharge planning.

The improvement programme is structured around admission avoidance, Clinically Ready For Discharge (CRFD) reduction and discharge process improvement. Community directorates are undertaking RCA on admission drivers, while dedicated clinical and discharge capacity supports CRFD and standardised discharge processes.

Operational governance is being strengthened, and the new RiO bed management form is expected in Quarter 2 2026/27 to improve visibility of demand and capacity and improve data quality.

Flow is now a focus of wider system discussions, particularly in relation to corridor care and quality of care for patients waiting to be seen in a number of settings. Delays in accessing beds, out of area placements and discharge delays can impact safety, risk profile whilst the patient is waiting and patient/carer experience.

The principal watch metric is out of area placements. In June, there were 437 out of area placement bed days, of which 203 related to female PICU patients in contracted beds due to the absence of a female PICU provision in Kent and Medway (unit due to open in the Autumn). Excluding this structural capacity requirement, the adjusted position is 234 bed days, which provides a more meaningful measure of Trust performance.

Key Metrics

Metric	Trust-wide position	SPC / direction of travel	Variation / data quality	Board assurance interpretation
Prev.001: Bed occupancy (net)	Ambition is to reduce net occupancy to 90%; current position remains above the intended level.	Material pressure remains. Movement should be considered alongside patients awaiting beds, OAPs and discharge delays.	Bed occupancy should primarily be interpreted as a Trust-wide flow and capacity measure	High occupancy constrains flow, access and safety. Assurance depends on whether admission avoidance, CRFD reduction and discharge improvement actions reduce pressure over time.
Prev.002: Number awaiting bed at period end	Baseline being formulated; current reporting is manual.	Directional only until data capture is embedded digitally and the baseline is confirmed.	Manual Patient Flow Team data limits assurance; RiO bed management being implemented in Quarter 2 2026/27.	This is the breakthrough objective. The Board should expect future reporting to show a reliable baseline, trajectory and evidence that actions are reducing waits for beds.
Out of area placement bed days	437 OAP bed days in June; 203 related to contracted female PICU beds, giving an adjusted Trust-controllable position of 234 bed days.	Adjusted position provides a more meaningful view of Trust-controllable flow pressure.	Structural female PICU capacity should be separated from avoidable flow constraints when assessing performance.	The adjusted OAP position is an important watch metric for whether flow actions are working. Assurance depends on sustained reduction in bed days.

Breakthrough Objectives

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	12 Month Average	24 Month Average
Prev.002: Number awaiting bed (monthly average)											19	20.4	17	19	

Data reflects manually collected information from the Patient Flow Team. The new RiO bed management form is in the final stages of testing and is expected to improve data visibility and quality.

Focus on Breakthrough Objectives

Prev.002: Number awaiting bed (at period end)	**Data Source**	Manual	**Data Quality Confidence**	
	Some potential data completeness issues due to lack of digital data collection and limited oversight.			
	What is being measured?			
	Count of patients identified as awaiting a bed on final day of the month			
	What is the data telling us and key actions in place			
	Baseline being formulated and analysis will occur once this is in place			

Watch Metrics

Measure Name	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	A
Prev.003: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	608	625	608	574	590	561	482	407	453	316	
Prev.004: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	21	19	17	22	18	17	14	13	17	5	
Prev.005: CRFD Bed Days Lost (Acute beds)		1,551	1,827	1,690	1,565	1,723	1,717	1,647	1,712	1,657	1
Prev.006: Clinically Ready for Discharge (CRfD) length of stay (LoS)	64.7	46.3	82.2	81.9	92.9	45.8	69.9	116.1	53.7	74.9	5
Prev.007: Clinically Ready for Discharge (CRfD) over 100 days at period end	0	14	17	16	15	17	19	20	22	14	
Prev.008: Clinically Ready for Discharge (CRfD): YA Acute	7.0%	14.4%	17.5%	17.9%	15.2%	20.3%	22.0%	19.9%	22.0%	17.1%	1
Prev.009: Clinically Ready for Discharge (CRfD): OA Acute	12.0%	31.9%	36.2%	31.8%	30.6%	28.7%	23.6%	24.6%	29.6%	31.3%	2
Prev.010: Average Length Of Stay (Younger Adults Acute)	34	36.2	32.8	42.6	50.9	27.5	31.5	61.3	44.1	46.0	5
Prev.011: Average Length Of Stay (Older Adults - Acute)	77	71.4	69.1	104.3	79.7	76.0	81.6	71.1	120.4	115.3	9
Prev.012: Adult acute LoS over 60 days % of all discharges	16.0%	14.5%	12.2%	14.4%	22.9%	12.9%	13.3%	20.4%	15.6%	19.7%	2
Prev.013: Older adult acute LoS over 90 days % of all discharges	37.7%	30.3%	30.0%	43.3%	31.3%	24.0%	42.9%	25.9%	29.6%	50.0%	4
Prev.014: Readmissions within 30 days (YA & OP Acute)	8.8%	10.4%	16.7%	12.6%	12.0%	10.3%	12.2%	12.3%	11.8%	9.9%	7
Prev.015: Average Length of Stay in C&YP Mental Health wards (Days)		200	91	46	63	41	80	98	0	111.3	5

Prev.003 and Prev.004 Out of Area Placements: these figures include female PICU contracted beds due to the absence of female PICU provision in Kent and Medway. In June 2026, 437 out of area bed days were used, of which 203 related to female PICU contracted beds. The adjusted Trust-controllable position is therefore 234 bed days.

4. Appendices

NHS Oversight Framework

NHS England » NHS Oversight Framework 2025/26

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

As of Q4 2025/26 KMPT is in segment three: *The organisation and/or wider system are off-track in a range of domains or are in financial deficit.* The trust's benchmarking position in the national Community Mental Health Survey which has changed the trusts position in the Effectiveness and experience of care domain from segment 1 in Q3 to segment 4 in Q4. A new framework will be launched for 2026/27

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q4 2025/26	3	NOF Score	Provider value	
Average metric score			Q4 2025/26	2.31	NOF Score	Provider value	
Unadjusted segment			Q4 2025/26	3	NOF Score	Provider value	
Financial override	Q4 2025/26	No	Yes		Yes	Provider median	

2026/27 Scoring

The table below sets out the Trust's provisional 2026/27 scoring view, using the NoF domains as an additional assurance lens. Scores should be read as indicative until the 2026/27 technical rules and final metric definitions are confirmed.

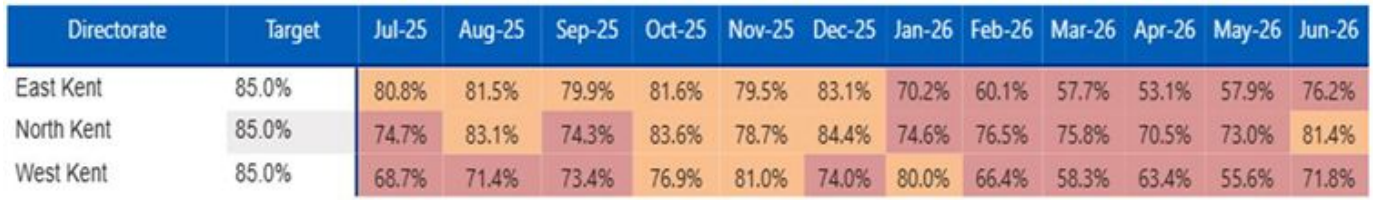
Domain	Metric	Quarter Scores			NoF Scoring				Status	Estimated Quarter 1	Direction	Board Focus
		March	April	May	1	2	3	4				
Access to Services	Percentage of people discharged from community MH with a paired outcome score (all ages)		5 0	25 1	CYP 27 Adult 12	19 7	12 3	<12 <3	Scoring	3.0	Improving	Focus on paired outcomes data quality
	Percentage of total Children and Young People mental health waits for help over 104 weeks		No data	No data	<5%	11%	29%	30%	Scoring	2.0	Unknown	Initial due diligence indicated zero activity in this area (2 conservative estimate due to lack of confirmed information)
Effectiveness of Care	% of acute and rehabilitation adult discharges followed up within 72 hours	81	78	73	79	70	62	<60	Scoring	2.0	Worsening	Recover follow-up and understand deterioration drivers.
	Mental health 14-day readmission rate				<5%	10%	17%	>18%	Scoring			Confirm reporting and identify discharge or community support gaps.
Experience of care	CQC community mental health survey satisfaction rate	4			*Relative from better or much better, through somewhat better to somewhat worse and worse*				Scoring	4.0		Address community experience drivers and evidence service-level action.
	NHS staff survey advocacy rate				*Relative Score*				Scoring	tbc		Improve staff advocacy through directorate action and staff voice.

	Mean length of stay for adult acute mental health and psychiatric intensive care unit patients	51	49	52	41	50	70	>70	Scoring	3.0	Worsening	Reduce length of stay through discharge, CRFD and flow grip.
	Mean length of stay for older adult acute mental health patients	104	112	107	74	94	125	>125	Scoring	3.0	Variable	Understand variation and strengthen discharge and system actions.
Finance productivity and innovation	Planned surplus or deficit	0.75			0%	-1%	-2%	>-2%	Contextual			
	Variance to plan year-to-date	0.01			On plan	0.5% adverse	1.0% adverse	>1% adverse	Contextual			
	Combined finance score	1							Scoring	1.0	Same	Impact of breakeven plan to be considered
	Relative cost difference (National Cost Collection Index)	87.71%			<100%	*Relative Scoring*			Scoring	1.0	Same	Use benchmarking to identify productivity and value opportunities.
	% of clinical trials set up within 90 days				95%	*Relative Scoring*			Scoring			Confirm applicability, data availability and any required action.
	Implied productivity growth				Tbc				Contextual			
Patient safety	Urgent crisis response within 24 hours	73%	82%	81%	>80%	71%	45%	<44%	Scoring	1.0	Improving	Sustain crisis response and reduce variation across pathways.
	NHS staff survey raising concerns sub-score	6.31							Scoring			Strengthen speaking-up culture and triangulate staff feedback.
	% of safety incidents resulting in harm				tbc				Scoring			Interpret harm rates with severity, themes and learning.
	Crude rate of restrictive interventions per 1,000 bed days								Contextual			
People and workforce	Healthcare worker flu vaccination rate								Contextual			

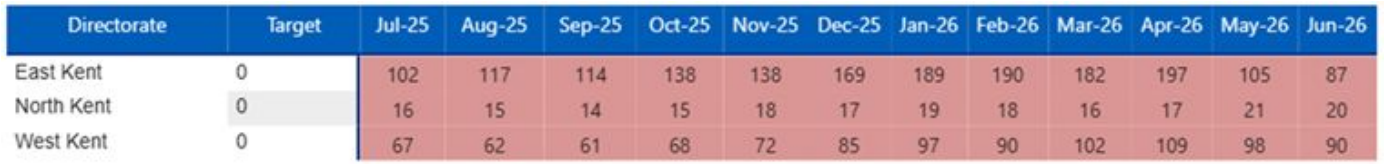
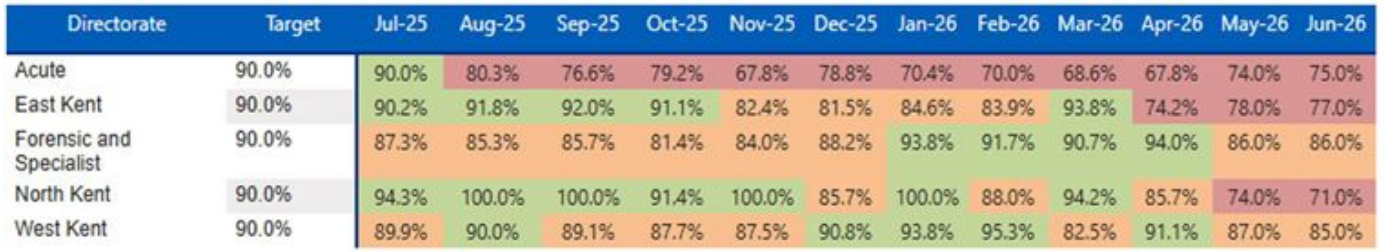
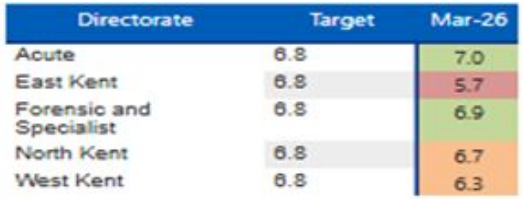
	National education and training survey satisfaction rate								Scoring			Confirm reporting
	NHS staff standards score								Scoring			Confirm reporting
	NHS staff survey engagement theme score	6.65			*Relative scoring*				Scoring			
	Sickness absence rate	5.63%			*Relative scoring*				Scoring			
	Temporary staffing cost relative band				Below average	Above average but on plan	Below average but off plan	Above average and off track	Scoring	4.0		Assurance on reduction to bank and agency spend. Trust submitted a non-compliant plan

Directorate Reports: True North and Breakthrough Objectives

The directorate reports provide the supporting layer beneath the Trust-wide Integrated Quality and Performance Dashboard. They should be used to understand where performance variation sits, whether Trust-wide performance is masking material directorate-level outliers, and where local improvement plans or data quality actions are required. The table below summarises the key directorate-level data available in the report, alongside relevant reporting caveats.

Domain	Metric	Directorate Detail
Access	Acc.001: % Mental Health Together patients commencing intervention within 18 weeks	

Directorate	Target	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
East Kent	85.0%	80.8%	81.5%	79.9%	81.6%	79.5%	83.1%	70.2%	60.1%	57.7%	53.1%	57.9%	76.2%
North Kent	85.0%	74.7%	83.1%	74.3%	83.6%	78.7%	84.4%	74.6%	76.5%	75.8%	70.5%	73.0%	81.4%
West Kent	85.0%	68.7%	71.4%	73.4%	76.9%	81.0%	74.0%	80.0%	66.4%	58.3%	63.4%	55.6%	71.8%

Access	Acc.002: MHT patients awaiting intervention waiting 38 weeks or more	
Experience	Exp.001: FFT % positive overall experience	
Experience	Exp.002: Trust Staff Engagement Score	
Experience	Exp.003: Patients feel included in decisions about their care	
Experience	Exp.004: Staff would recommend KMMH as a place to work	

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Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	CQC Community Mental Health Survey
Author:	Rachael Sanderson, Strategic Lead for Allied Health Professions
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of paper

This paper sets out the Trust's position on the 2025 CQC Community Mental Health Survey benchmark results, the six-year trend behind them, and the actions in response.

The headline is a clear deterioration. Overall experience is now rated 'worse than most trusts', having been 'about the same' in 2024, and 16 questions fall below the expected range compared with a position within range the year before. The overall experience score is 6.1 out of 10, the second lowest in six years, and the Trust is one of only two nationally rated 'worse than expected' across the survey as a whole.

Triangulation with complaints, Patient Advice and Liaison Service (PALS), Patient Reported Experience Measure (PREM) and Friends and Family Test (FFT) gives a consistent message. Individual care from staff is experienced well, but the surrounding system (continuity, access, communication, crisis response and support with wider life needs) is experienced as unreliable, and it is this that is driving the position.

The paper offers reasonable assurance on why performance has fallen and limited assurance on the response, which largely continues existing work that is not yet showing measurable improvement. The weakest and least-addressed area is support with employment, finances and physical health; however, the Trust should not frame this as solely within its ownership, but as an area requiring closer work with the ICB through the mental health commissioning review to ensure the right support, pathways and commissioned services are in place for patients.

Issues to bring to the Board's attention

The Trust's benchmarking position has deteriorated markedly. Overall experience is rated 'worse than most trusts' and 16 questions fall below the expected range (13 'worse', 3 'somewhat worse'), up from a position within range in 2024. Six-year analysis shows 2025 is an outlier rather than part of a gradual decline: one question fell below the range in 2024 against 16 in 2025.

Version control 02

The cause is consistent across every source. Feedback on individual staff is strongly positive, with compassion, professionalism and therapeutic relationships the Trust's clearest strengths. The problems are system-level: continuity of care, access to timely support, communication between services, crisis responsiveness, and support with employment, finances and physical health, which is the weakest and most persistent area (employment scores 1.4 out of 10).

Internal measures remain strong (PREM 8.4 out of 10, FFT 88% positive) because they capture the immediate contact rather than the whole journey; complaints and PALS align closely with the survey.

Most themes already sit within the Trust's strategy and Quality Improvement Plan, but that work predates the result and is not yet evidencing improvement. Support with wider life needs is the least developed area and should be progressed with the ICB as part of the mental health commissioning review, rather than presented as solely a Trust-owned gap. The paper therefore offers reasonable assurance on diagnosis and limited assurance on response.

The Board is asked to:

- **NOTE FOR IMPORTANT CONTEXT** the deterioration and the level of assurance
- **AGREE** monitoring through existing governance supported by defined metrics and regular reporting
- **DECIDE** whether the Board wishes to request a specific improvement plan and timescale for the least developed area (employment, finances and physical health), developed with the ICB through the mental health commissioning review to clarify the right support, pathways and commissioned services for patients.

Governance

Implications/Impact:	Impact on patient experience
Assurance:	Assurance received from Trust Wide Patient Experience Group Level of assurance: this paper offers reasonable assurance on diagnosis and limited assurance on response. It sets out clearly why the Trust's position has deteriorated and triangulates the evidence well, which supports reasonable assurance that the problem is understood. Assurance on the response is limited, because the actions described largely continue existing programmes and are not yet supported by milestones, success measures or timescales against which improvement can be judged before the next survey. One key area, support with employment, finances and physical health, requires clearer joint work with the ICB through the mental health commissioning review to confirm the appropriate response, pathways and commissioned services.
Oversight:	Quality Committee and Quality and Patient Safety Assurance Group

1. Context and Methodology

The published benchmark data rates the Trust against other trusts as better, about the same or worse, and gives a score for each question.

The survey was run by the Survey Coordination Centre at the Picker Institute. Across 50 NHS trusts, 67,127 community mental health service users were invited and 12,319 responded, an adjusted response rate of 19% (undelivered questionnaires are removed from the calculation).

Since 2023 the survey has used a 'push-to-web' method. Service users are first offered the questionnaire online, and those who have not responded are later sent a paper copy. Postal and text-message reminders include a direct link, and QR codes on the invitation and multi-language sheet let people complete it on a phone or tablet.

The survey uses a nationally standardised method. Around 1,250 patients per trust are randomly sampled: those aged 16 or over who received treatment for a mental health condition at least once between 1 April and 31 May 2025 (the sampling period) and had at least one other contact at any other time.

The Trust received 259 responses to the 2025 survey, a response rate of 22% (21.2% after CQC weighting), close to its 22.6% in 2024. Of the trusts that use IQVIA for response analysis, 26 had a rate of 20–24% (including this Trust), 22 were at 15–19%, and 2 at 10–14%.

Each survey is named by the year it is run, not by a January to December calendar year of care. The 2025 survey sampled patients treated between 1 April and 31 May 2025 (with at least one other contact at any time); fieldwork ran later in 2025, and the results were published the following year. Comparisons with the previous year therefore compare one survey cycle with the next, not adjacent calendar years.

The paper also draws on other patient experience data: Trust-wide PREM, FFT, complaints and PALS.

2. Benchmarking Position

The Trust's benchmarking position has deteriorated from 2024 to 2025. Overall experience is now rated 'worse than most trusts', having been 'about the same' in 2024. Sixteen questions fall below the expected range, 13 rated 'worse' and 3 'somewhat worse', with none above it. This is a marked shift from 2024, when only one question fell below the expected range.[1]

Looking across all scored questions in the survey, the Trust has fewer of the most positive responses (47%) and more of the most negative responses (33%) than the trust average (52% and 27%). The gap with comparator trusts is widening, particularly on overall experience. National outlier analysis identified the Trust as one of only two rated 'worse than expected' across the survey as a whole. This reflects a statistically significant excess of negative responses overall, not a few isolated questions.[2]

3. Overall Experience and Six-Year Trend Analysis

Overall experience has fallen from 6.3 out of 10 in 2024 to 6.1 in 2025. Over six years the score has stayed within a narrow band (6.4 in 2019 to 6.1 in 2025), but 2025 is the second lowest in that period, and the benchmarked position has moved from within the expected range to 'worse than most trusts'. Improvement in overall experience is not yet showing in the results.

Findings by question and section

[1] All trust-level scores, question bandings and response figures in this paper are taken from the published CQC Community Mental Health Survey 2025 benchmark report for Kent and Medway Mental Health NHS Trust (RXY), Care Quality Commission and the Survey Coordination Centre, Picker Institute.

[2] Source: Care Quality Commission, 2025 Community Mental Health Survey – Variation in trust results (trusts where patient experience is better or worse), NHS Patient Survey Programme, published March 2026. This report gives the Trust's overall proportion of 'most positive' (47%) and 'most negative' (33%) responses across all scored questions, against the trust average of 52% and 27%, and identifies Kent and Medway as one of only two trusts rated 'worse than expected' across the survey as a whole.

The Quality Committee asked for analysis of longer-term trends. The 2019 to 2025 dataset has been reviewed at section and question level. The main points are set out below and in Figures 1 to 4.

Overall experience (Q38) has stayed within a narrow band: 6.4 in 2019, a high of 6.7 in 2020, a low of 5.9 in 2023, 6.3 in 2024 and 6.1 in 2025 (Figure 1). The 2025 score is the second lowest in six years. The larger change is in the Trust's position relative to other trusts. The number of questions rated below the expected range was one in 2024 and 16 in 2025, a sharp break from the previous five years (Figure 2).

Several areas have declined steadily rather than in a single year (Figure 4). Support to make decisions about care (Q18) has fallen from 7.2 in 2019 to 5.5 in 2025, choice about care (Q16) from 6.7 to 5.9, and the time taken to reach crisis support (Q28) from 5.3 in 2022 to 3.5 in 2025. These point to structural pressure on involvement, choice and crisis access that predates 2025.

Some questions have stayed low throughout and are the Trust's weakest scores in any year (Figure 3): help with finding or keeping work (1.4 in 2025), help with money or benefits (1.9), being asked for feedback on care (2.7), and support with physical health needs (3.9). At section level the lowest areas are Feedback (2.7), Support with other areas of life (3.3), Support in accessing care (3.8) and Crisis care support (4.4). Support with the wider aspects of life and with access is structurally the weakest part of the survey and receives limited attention in the current narrative. Proposed actions for this area are set out in Section 6.

Four questions fell significantly from 2024: involvement in a care plan (Q15), time to reach crisis support (Q28), whether crisis support gave the help needed (Q29), and whether support meets needs (Q37). One caution on Q15: it fell 1.7 points (7.3 to 5.6), but 2024 was an unusually high year against a longer range of about 5.5 to 6.5, so 2025 is closer to a return to trend than a new fall. This is worth flagging so the figure is not over-read.

The data also shows areas of steady improvement that should be protected (Figure 4). Discussion of medication side effects (Q21.3) has risen from 4.9 in 2019 to 6.5 in 2025, and asking how people are getting on with their medication (Q22) from 6.8 to 8.2. Psychological therapies (8.4) and respect and dignity (7.5) remain the highest-scoring sections and match the positive feedback about staff.

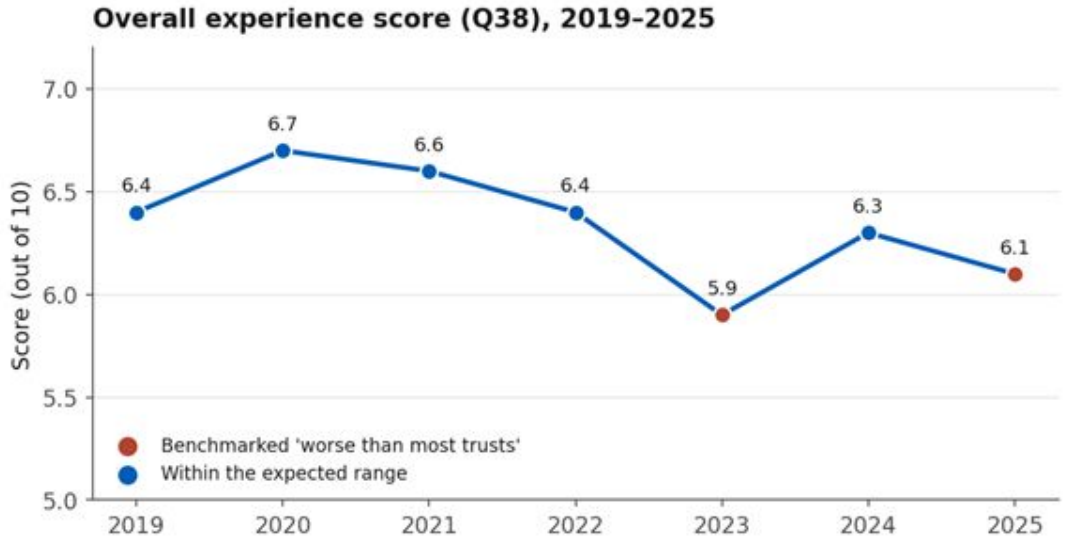

Figure 1: Overall experience score (Q38), 2019 to 2025. Red points mark years benchmarked 'worse than most trusts'.

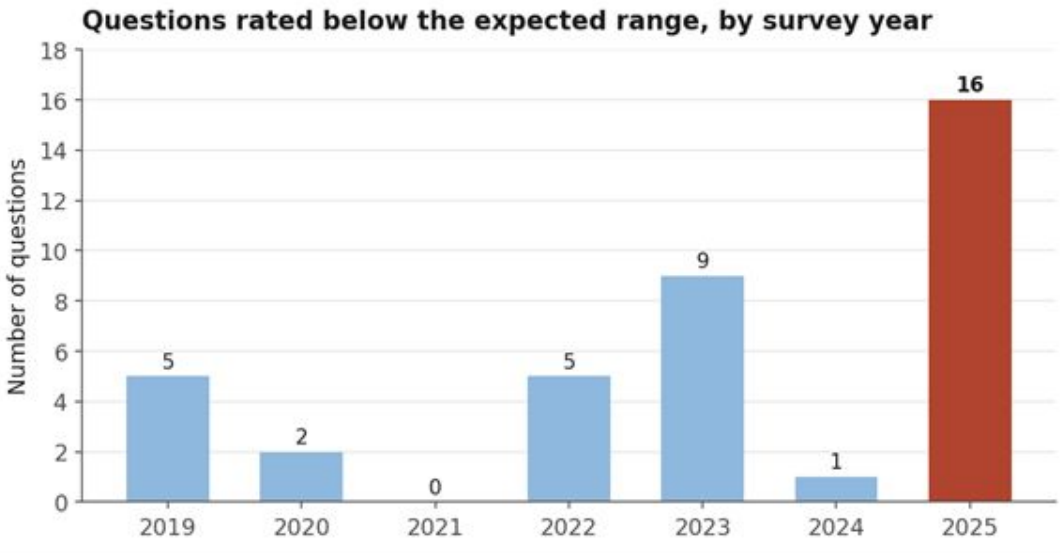

Figure 2: Number of questions rated below the expected range, by survey year.

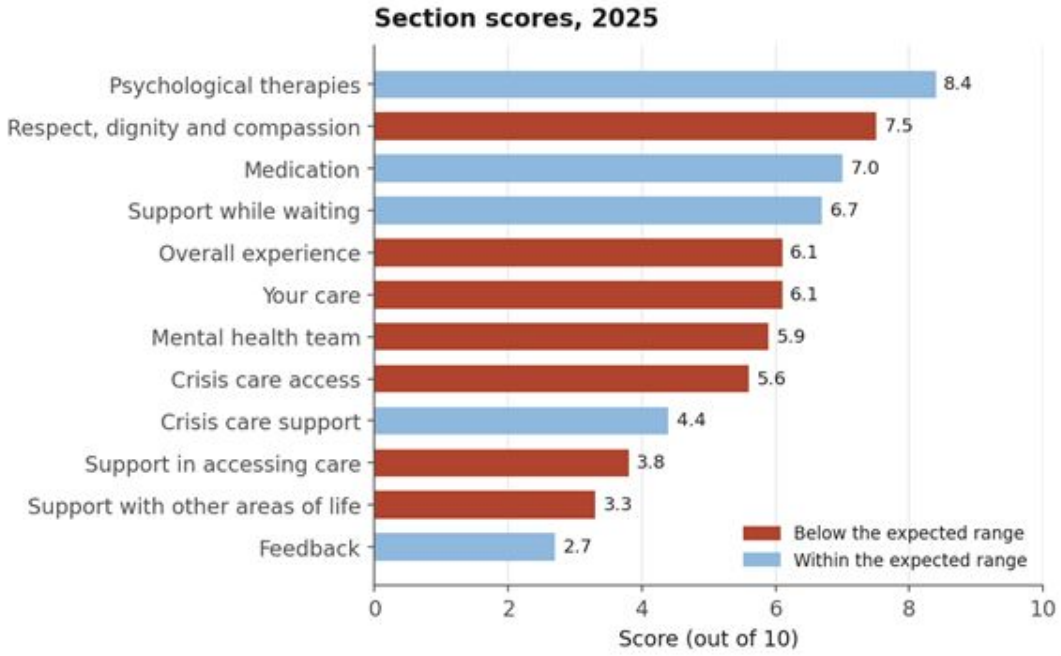

Figure 3: Section scores for 2025. Red bars fall below the expected range.

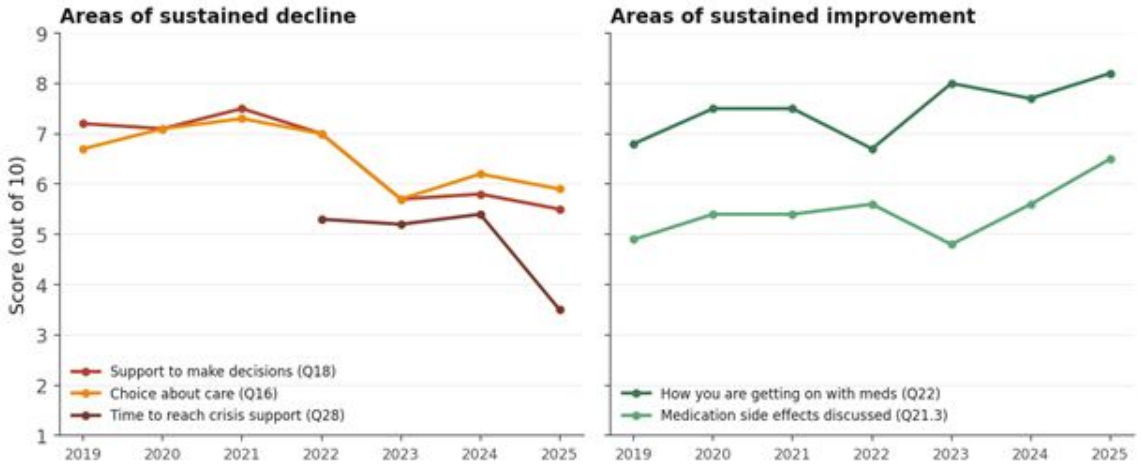

Figure 4: Selected questions with sustained decline and sustained improvement, 2019 to 2025.

4. Patient Feedback

The free-text survey responses show how services are experienced and echo the themes from the other data sources.

Positive feedback is clear and strongly expressed. The strongest theme is the compassion and kindness of staff. Patients describe staff as empathetic and invested in their wellbeing, and many link their sense of safety and their recovery to these relationships. Gratitude for individual staff and teams is common, and some patients describe their care as life-changing or as keeping them stable at times of real distress.

A related theme is being listened to and understood. Patients value time and space to explain how they feel without judgement, and describe feeling respected and validated, particularly when vulnerable. Where there is continuity of clinician, rapport and trust, patients see the therapeutic relationship as central to their care and recovery.

Professionalism and clinical expertise also feature strongly. Patients describe confidence in staff's skills, including clear diagnosis, good medication management and therapy. Many value specific treatments such as CBT, psychotherapy and group work. Patients also value holistic care that takes account of physical health, family and wider circumstances.

Flexibility is also valued. Patients highlight remote consultations, home visits and adaptable appointments, which they say reduce anxiety and improve access, particularly for people with complex needs or difficulty attending in person.

The feedback also points clearly to areas for improvement. The main concern is continuity of care. Patients describe frequent changes of clinician and care coordinator, having to retell their history, and losing established relationships. Some are unsure whether they are still under the service at all, which reflects gaps in communication and coordination.

A further theme is whether the team is actively holding a patient's care. Many describe feeling unsupported or 'cast adrift', with little timely or meaningful help. This includes delays in treatment, too little contact between appointments, and gaps in physical health monitoring. The overall effect is that care feels unresponsive to individual need.

Communication and information sharing are also concerns. Patients report late, inaccurate or missing correspondence and poor communication between services. Carers and families, particularly in dementia care, describe unclear processes and too little involvement in decisions.

Crisis care is a further challenge. Support is often reactive rather than preventative, with little help until a patient reaches crisis. Crisis services are seen as hard to reach, with long waits, inconsistent responses and little continuity of staff. This reduces confidence and, for some, makes them reluctant to seek help in a future crisis.

A notable feature is how many respondents said there was nothing good about their care when asked. This is a clear signal of dissatisfaction and disengagement and is strongly linked to poorer overall experience.

The picture is consistent. Patients receive high-quality, compassionate care in individual contacts with staff, but this is not sustained across the wider pathway. Problems with continuity, access, communication and responsiveness undermine confidence in the system and feed directly into the Trust's overall experience scores.

5. Triangulation of Patient Experience Data

Wider patient experience data helps to explain what is driving performance.

The survey method matters for interpretation. It reflects a representative sample of patients over a 12-month period, so it captures experience across the whole pathway rather than at a single point, including patients who have disengaged or had inconsistent care. The national outlier analysis is complementary: it assesses all questions together rather than one by one.

The themes are consistent across all sources. Complaints and PALS show high volumes of concern about access to therapy, communication with patients and carers, and discharge, including premature or unsafe discharge. PREM feedback points to unmet need: not being seen often enough, delays, cancelled appointments and unclear pathways. These match the survey, where patients describe fragmented care, a lack of timely support, and difficulty getting help before crisis.

Continuity of care is a consistent and significant issue: frequent changes of clinician, repeating histories, and lost relationships, all reinforced by complaints data. Communication is a mixed picture. Face-to-face communication with staff is often warm and effective, but there are recurring concerns about communication between services, delays in correspondence and unclear pathways. Communication remains one of the most common subjects of complaint.

By contrast, feedback on staff is consistently positive. Analysis of the survey free text identified compassion, kindness and professionalism as the Trust's main strengths. Compliments data shows the same, with recurring themes of support, teamwork and practical help. Quality of staff, involvement in care and feeling listened to are also the most cited positives in PREM feedback.

While the survey shows poor overall experience, the Trust's own measures are more positive. The Friends and Family Test shows 88% reporting a positive experience, a 'very good' rating, and PREM averaged 8.4 out of 10 across February and March 2026 from over 900 responses. This suggests individual contacts are often experienced well. The likely reason for the gap is timing: PREM and FFT are usually collected close to the point of care and capture the immediate contact, rather than the whole-journey experience the survey reflects.

The findings point to one interpretation. Relational care, including compassion, professionalism and therapeutic engagement, is experienced well. The wider system of care is experienced as less reliable, with problems in continuity, access, coordination and responsiveness over time. It is this system-level experience, built up across the pathway, that appears to be driving the Trust's benchmarking position.

6. Current Actions

A range of actions are underway to address the areas the survey highlights. Under the Trust's new strategy there is a True North objective to improve overall experience, and a Breakthrough Objective on involving patients in decisions about their care.

A new Trust-wide survey, 'Your Experience Matters', launched in April 2026 to give more targeted insight into the main drivers of experience, including feeling understood, involvement in care and confidence in services. Its questions link to the Trust's values and to questions in the CQC survey, so these areas can be monitored between surveys:

- how caring are our staff (related to question 14 of the CQC Community Mental Health Survey)
- are you included in decisions about care being provided (relates to questions 13, 16 and 18 of the CQC Community Mental Health Survey)
- are staff taking the time to understand you (related to questions 8 and 9 of the CQC Community Mental Health Survey)
- how confident you are about the care we provide (question 38 of the CQC Community Mental Health Survey)
- in addition to mandated FFT question (also related to question 38 of the CQC Community Mental Health Survey).

The Trust Quality Plan focuses on aspects of patient experience identified through CQC inspection reports, including better patient information and improving the experience of neurodivergent people in community mental health services. It also covers clinical risk assessment and access and waiting times, which both affect experience directly and align with the survey's domains. Several Quality Plan workstreams will include patient experience metrics, and a clear governance structure oversees their delivery and whether those metrics are improving.

Refinement of the Community Mental Health Framework is also expected to improve the access and therapeutic provision the survey identifies as problems.

Financial support information is being addressed through Recovery College courses such as 'Living Well on a Budget', and the communications team is updating the Trust website, so this information is easy for service users to find.

Healthwatch Kent and Healthwatch Medway attend the Trust-wide Patient Experience Meeting, so their insights feed directly into the Trust. Work is also underway with Healthwatch to map their thematic coding against the codes used for PREM, compliments and complaints, to improve triangulation and make the data more usable for teams.

The digital team is developing Power BI dashboards for patient experience, making the data easier to reach and helping teams review and act on feedback.

Work is underway to bring patient experience data together, as it is currently held in several systems. This includes how the co-creation team records service-user insight, and discussions at directorate and Trust level on integrating patient experience, PALS, complaints and patient safety data for joint analysis.

The communications team is supporting the sharing of patient experience data internally and with external stakeholders. It is also promoting the 2026 CQC survey to staff and patients, to raise awareness and improve the response rate next time.

The Trust is contacting organisations rated 'better' or 'much better than expected' to learn from them.

Strengthening support with wider life needs (employment, finances and physical health)

The six-year analysis identifies support with the wider aspects of people's lives as the weakest and most persistent area. In 2025, help with finding or keeping work scored 1.4, help with money or benefits 1.9, and support with physical health needs 3.9; the 'support with other areas of life' section scored 3.3. These scores have stayed low across the whole period. The response should not be framed as solely Trust-owned, particularly where employment and financial support depend on wider system provision and commissioning. The Trust should work more closely with the ICB through the mental health commissioning review to confirm the appropriate support, pathways and commissioned services for patients, and to test any proposed actions against current provision.

Employment: work with the ICB to review access to employment support, including whether Individual Placement and Support or equivalent provision is available, sufficient and consistently linked to community mental health pathways. Employment is the single lowest-scoring question in the survey and an area where the response is likely to require both provider action and commissioning clarity.

Physical health: continue to strengthen Trust delivery of annual physical health checks for people with serious mental illness, ensuring they are offered and recorded consistently, using the Dialog+ rollout to prompt the conversation, and reporting completion rates alongside experience data.

Finances and benefits: work with the ICB and wider partners to clarify the pathway for welfare, benefits and debt advice, building on the Recovery College 'Living Well on a Budget' course and Trust website information. The Trust can strengthen routine enquiry and signposting, but the wider response should be agreed with system partners, so patients have access to appropriate specialist support.

Social connection and measurement: strengthen links to social prescribing and voluntary-sector activities, and use Dialog+ data on employment, finances and physical health as the measure through which the Trust-wide Patient Experience Group tracks progress before the next survey. Where gaps relate to availability or consistency of wider support, these should be fed into the ICB mental health commissioning review.

These are options rather than settled plans and should be checked against services already in place, clinical priorities and commissioning priorities. A named Trust lead should coordinate the work with the ICB, with a clear timescale for confirming current provision, identifying gaps and agreeing the appropriate response.

The Trust-wide Patient Experience Meeting will remain the governance group for survey-related actions, with regular updates to Quality Committee for assurance.

7. Conclusions and Board Considerations

The published results show a clear deterioration in the Trust's relative position. Overall experience is now rated worse than most mental health trusts, with 16 questions below the expected range compared with a position within range in 2024. The Trust does not seek to minimise this.

Triangulation across the survey, complaints, PALS, PREM and FFT points to the same conclusion. Individual contact with staff is experienced well: compassion, professionalism and therapeutic relationships are the Trust's clearest strengths, and psychological therapies and respect and dignity are its highest-scoring domains. The problems lie in how care is organised across the pathway: continuity, access to timely support, communication between services, crisis responsiveness, and support with the wider aspects of people's lives.

Most of these themes are already the subject of work: continuity and access to a named worker through the refined Mental Health Together and Community Mental Health Framework model; crisis responsiveness through the Quality Improvement Plan; involvement in care decisions through the 'Your Experience Matters' breakthrough objective and clinical risk work; and access and waiting times through the Mental Health Together standards. Two qualifications matter. First, most of this work predates the survey result and is not yet showing improvement in experience, so it should be treated as promising rather than proven. Second, support with employment, finances and physical health, the weakest and most persistent area in the survey, requires closer work with the ICB through the mental health commissioning review to clarify the appropriate support, pathways and commissioned services for patients.

Section 6 sets out proposed areas for development for this weakest area, including employment support, physical health checks and welfare and benefits advice. The Board is asked to treat this as an area requiring joint Trust and ICB consideration, rather than a solely Trust-owned improvement gap.

In assurance terms, this paper offers reasonable assurance that the Trust understands why its position has deteriorated, but limited assurance on the response. The actions described are largely a continuation of existing programmes and are not yet supported by milestones, success measures or timescales against which the Board can judge progress before the next survey. Setting these out would raise the assurance the next report can give.

It is proposed that improvement continues through the Trust's strategy and Quality Improvement Plan, monitored by the Trust-wide Patient Experience Group, rather than through a separate survey action plan. To make this credible, the Group will track a defined set of experience metrics, including the relevant 'Your Experience Matters' and Dialog+ measures, and report progress, and any deterioration, to Quality Committee on a regular basis.

The Board is asked to:

- **NOTE FOR IMPORTANT CONTEXT** the deterioration and the level of assurance
- **AGREE** monitoring through existing governance supported by defined metrics and regular reporting
- **DECIDE** whether the Board wishes to request a specific improvement plan and timescale for the least developed area (employment, finances and physical health), developed with the ICB through the mental health commissioning review to clarify the right support, pathways and commissioned services for patients.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Finance report for Month 3 (June 2026)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The attached report provides an overview of the financial position for month 3 (June 2026).

Issues to bring to the Board's attention

For the period ending 30th June 2026, the Trust has reported a marginal surplus position (post technical adjustments) against a breakeven financial plan. The year-to-date position shows a small underlying deficit, offset by non-recurrent mitigations.

The key financial challenges for the Trust are:

- Use of external beds remains a pressure, with 4 Acute, 11 Psychiatric intensive Care Unit (PICU) beds and 17 stepdown beds used in month and a year-to-date budgetary pressure of £0.82m.
- Year to date agency spend is £2.08m. The current agency forecast pre-mitigations is £7.16m against an NHS England (NHSE) cap of £6.46m.
- The Trust's Acute Inpatient wards pay pressures have continued to utilise additional Nursing staff (both registered and unregistered) over and above established levels. The year-to-date pressure totals £0.88m.

Governance

Implications/Impact:	Risk of delivery of finance targets may result in sanctions from NHSE.
Assurance:	Reasonable
Oversight:	Finance, Business and Investment Committee

NHS
Kent and Medway
Mental Health
NHS Trust

Finance Reporting Pack

Trust Board
June 2026

Contents

1. Executive Summary

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

YTD financial position
£0.01m surplus
Plan: breakeven

External beds
£0.82m pressure
PICU up; step-down full

Inpatient staffing
£0.88m pressure
37.7 WTE above budget

Agency spend
£0.70m over cap
Forecast £7.16m vs £6.46m

What the Board needs to know

GREEN/ AMBER

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

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

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

Forecast assumes delivery; confidence depends on Quarter 2/ 3 traction.

Priority risks and controls

External beds: Step-down fully utilised; PICU above funded levels. Need reduction trajectory and ICB capacity from October

Acute staffing: Staffing down from May but still 37.7 WTE over establishment. Controls need sustained benefit.

Agency: June £0.80m, mainly CYP/ AAED and medical vacancies. Forecast £0.70m above agency cap.

Area of focus for July

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

Control
Track staffing controls, observation reductions and agency reductions.

Note
Capital is £14.05m above plan, mostly non-CDEL lease recognition; cash is £8.32m but will tighten as payments progress.

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2. Finance KPIs

FINANCIAL POSITION

£0.01m Surplus YTD

Plan: Breakeven

On plan overall

Pressures in Acute staffing and external beds

Supported by non-recurrent benefits

CASH POSITION

£8.32m
Cash balance

8.9 days
of expenditure

Above plan position Impacted by delayed invoicing for new CYP costs

Forecast to be lower in future months as capital programmes progress

CAPITAL PROGRAMME

£17.36m YTD Spend

Plan: £3.31m

Operating capital on plan

Major schemes (Female PICU and Section 136) CDEL pressures due to CYP transfer being worked through with NHSE

TOTAL WORKFORCE ~

4,475 WTE

Plan: 4,627

26 WTE decrease in month due to reduced bank

Substantive increases driven by targeted recruitment

ACUTE WORKFORCE

637 WTE ↓

Plan: 596

Above plan in month. Decreases due to bank reduction

Driven by annual and study leave and enhanced care

COMMUNITY WORKFORCE ~

1,559 WTE ↑

Plan: 1,753

Vacancies driving underspends; net recruitment increase 1wte in month

Demand and capacity review being finalised

AGENCY SPEND

£0.80m in month ↑

Last month spend £0.68m

Forecast £7.16m against cap of £6.46m

Increase in month as CYP agency costs fully embedded

Remain below plan YTD but exceeding NHSE Cap

BANK SPEND

£1.63m in month ↓

Last month spend £1.86m

Forecast £21.79m against cap of £16.90m

Above planned spend

Main drivers of over spend being Acute inpatient staffing

Over NHSE cap for bank

EXTERNAL BEDS

15 beds
(↑ from 11)

Increased PICU bed usage in month (7 to 11 in month)

Step down beds in addition; 17 beds used in month

On-going cost pressure partly driven by CRFD

CYP RUN RATE

£3.35m

average run rate vs budget £3.60m

Below plan levels of spend

Costs still under review post transfer

High vacancies drive underspend

CORPORATE COSTS

£3.98m

average run rate vs £3.72m plan

Professional fees remain a pressure. Run rates are not reducing as per Plan

CYP posts being recruited to as per transition plan

Excludes Faciliteis and Estates costs

KEY MESSAGES

- Breakeven achieved but reliant on non recurrent mitigations
- Acute staffing and external beds driving cost pressures
- Capital programme above plan driven by CYP leases and being managed with NHSE
- CYP & AAED costings mostly known and CYP deep dive presented this month
- Cash reasonably strong but will be more pressured in year as capital programmes are finalised

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3. Primary statements

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Budget	Budget	Actual	Variance	Budget	Actual	Variance
	£000	£'000	£'000	£'000	£'000	£'000	£'000
Income	355,344	29,926	29,996	70	90,036	89,774	(262)
Employee Expenses	(282,838)	(23,992)	(23,757)	234	(72,003)	(70,323)	1,680
Operating Expenses	(65,799)	(5,370)	(5,388)	(18)	(16,077)	(17,548)	(1,472)
Operating (Surplus) / Deficit	**6,707**	**564**	**850**	**286**	**1,956**	**1,902**	**(54)**
Finance Costs	(6,264)	(482)	(529)	(47)	(1,953)	(1,999)	(46)
Surplus / (deficit) for the period	**444**	**82**	**321**	**239**	**3**	**(97)**	**(100)**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	**(443)**	**(82)**	**(319)**	**(237)**	**(3)**	**103**	**106**
System control Surplus / (Deficit)	**0**	**(0)**	**2**	**2**	**(0)**	**6**	**6**

Statement of Financial Position

	31st March 2026	31st May 2027	30th June 2026
	Actual	*Actual*	*Forecast*
	£000	£000	£000
Non-current assets	183,623	191,580	197,914
Current assets	21,129	23,747	22,719
Current liabilities	(31,756)	(39,683)	(34,078)
Non current liabilities	(37,757)	(38,910)	(50,904)
Net Assets Employed	**135,240**	**136,734**	**135,651**
Total Taxpayers Equity	**135,240**	**136,734**	**135,651**

The Trust is reporting a small surplus position at the end of June against a breakeven Plan.

Income
Year to date there is an adverse variance to plan due to a revision of assumptions regarding income for CYP. This will be net to pay underspends. Most other areas are showing minimal variances only.

Employee expenses
The Trust is reporting a year-to-date underspend on employee expenses of £1.68m.

Substantive pay increased by £0.41m over May spend levels. Of this, £0.33m relates to the medical pay award which was paid in month and backdated to April as per the national pay award agreement.

Pay underspends are due to vacancy slippage across East, North and West Kent Community Directorates total £0.95m, including funds reserved for extending services under CMHF. This slippage will reduce through the year as recruitment continues, as per the plan, to increase Community pay run rate by £2.5m across the year by filling vacancies..

Operating expenses
Non pay includes spend on external placements compared to budget, with additional Acute and PICU beds utilised resulting in an overall year to date pressure of £0.82m, including spend on stepdown beds.

In June, usage of external Acute beds decreased, from average 4.5 beds to 3.6. PICU usage increased from 7 beds to 11 and Step-Down beds at Ticehurst were fully utilised, totalling 17 beds. 31 external beds were used in month against a commissioned base of 7 external female PICU beds.

Total assets
Total assets increased by £5.30m in the month. This mainly relates to further updates in relation to the properties transferring from NELFT.

Total liabilities
Total liabilities have increased by £6.39m in the month. This mainly relates to further updates in relation to the properties transferring from NELFT. Trade Payables has also increased in month, the largest being £0.46m with our Facilities Services provider for Capital programmes. It is expected that these will be paid by the end of July.

Appendices

4. Income and Expenditure Forecast

Forecast Position

The Trust continues to forecast delivery of its agreed financial plan. Month 3 is breakeven, but current run rates indicate a £4.5m underlying gap, mainly from external beds, community investment, seasonal utilities and other operational pressures.

The forecast assumes delivery of the approved plan, CIP trajectory and operational mitigations to reduce external bed use and strengthen staffing controls. Early traction is visible in inpatient nursing numbers, and phasing of community investment is under review. The plan remains deliverable, but further progress is required on beds.

Principal Forecast Assumptions

The forecast depends on the following assumptions:

- External acute bed use reduces to planned levels, reaching c. two beds from October 2026; current step-down arrangements support flow until longer-term ICB capacity is in place.
- ICB-funded step-down capacity is operational from October 2026.
- PICU pressures reduce and prove non-recurrent; planned staffing reductions, temporary staffing controls and non-pay efficiencies are delivered to trajectory.
- Community mitigations, vacancy controls and wider corporate controls are implemented as planned.

Forecast Risk Range

Scenarios reflect uncertainty in external bed use, acuity, complex care costs and CIP delivery. The worst case assumes no improvement in current run rate. Executive review of assumptions, risks and mitigations remains part of monthly financial governance. On this basis, the Trust continues to forecast delivery in year.

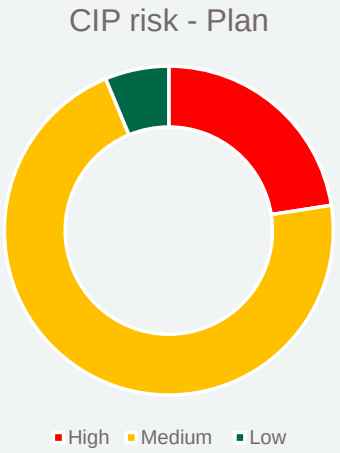
Forecast summary

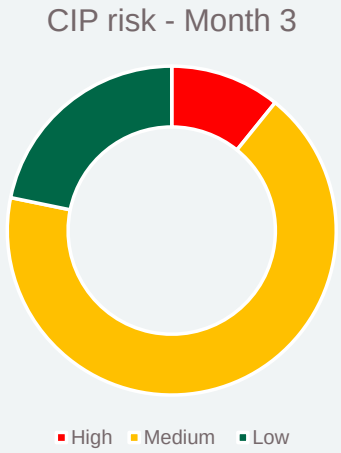
	£'m
Unadjusted position to month 3	(0.5)
Non recurrent mitigations	0.5
Reported position at month 3	0.0
Unadjusted Forecast	(1.6)
Planned Community recruitment	(2.4)
Community mitigations	1.2
Bed pressures and other cost pressures	(1.3)
Season impacts (utilities)	(0.4)
Total forecast pre CIP	(4.5)
Planned CIP	4.5
Likely Forecast	**0.0**
Best case	0.2
Worst Case (CIP non delivery)	(4.5)

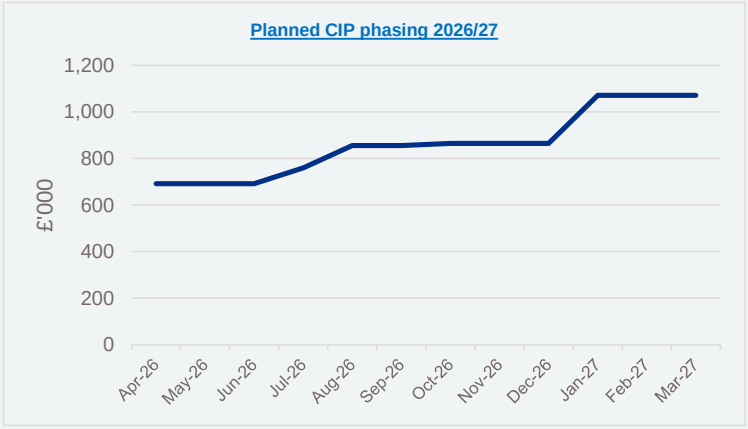
5. Cost Improvement plans 2026/27

Savings plans

Scheme	Plan	Forecast 2026/27	Progress made
Acute Inpatients pay reductions	1,600	1,180	Savings behind plan but deep dives being undertaken on Acute Inpatient staffing and controllable spend
Corporate and Support CIP schemes	1,000	667	Plans underway
Inpatient Rehabilitation	620	620	Plans being worked up
Depreciation - devices	160	160	Plans being worked up
Agency VAT	1,000	667	Plans underway
Female PICU	39	39	Plans underway
External placements reductions PICU	500	500	Savings behind plan but Flow and bed spend under close Executive review with a trajectory for expected reduction being finalised in June
External placements reductions Acute	1,670	1,114	
External placements reductions step down	450	450	
CYP planned run rate reductions	1,100	1,100	Plans underway
Non pay review	1,000	1,000	Non pay review to be completed July 2026
Agency premium	600	600	Plans underway
AHP resource utilisation	-	500	Plans underway
Admin review	-	150	Plans underway
NR Community controls	-	1,606	Delivering
Unidentified	613	-	
Total	**10,352**	**10,352**	







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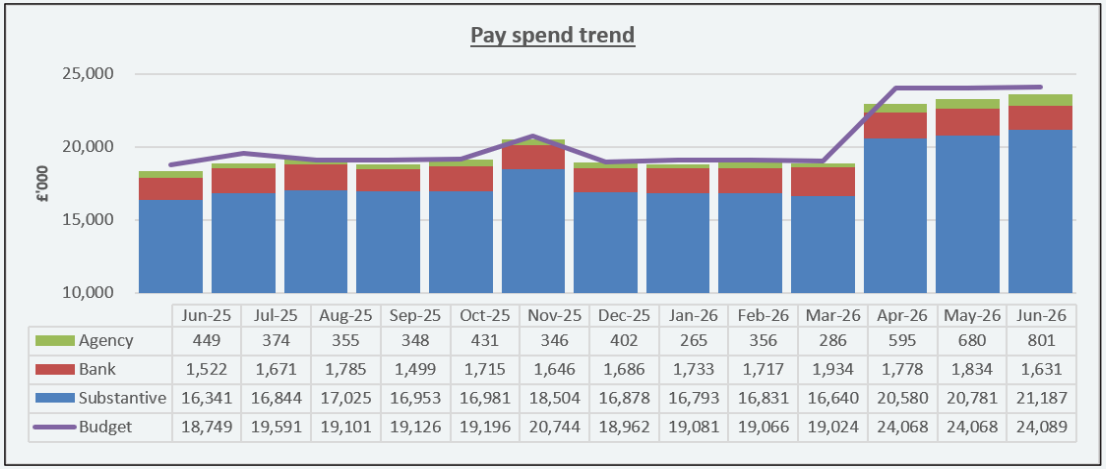
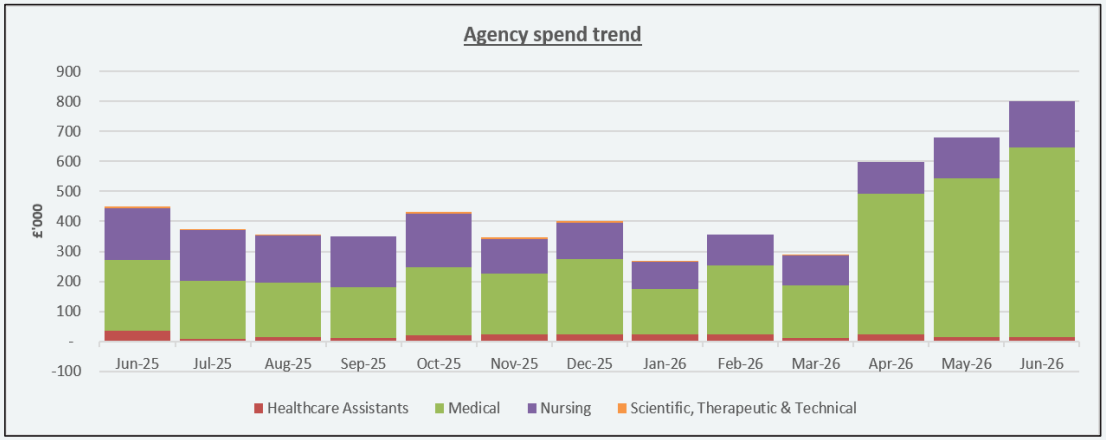
6. Exception report – Pay trend



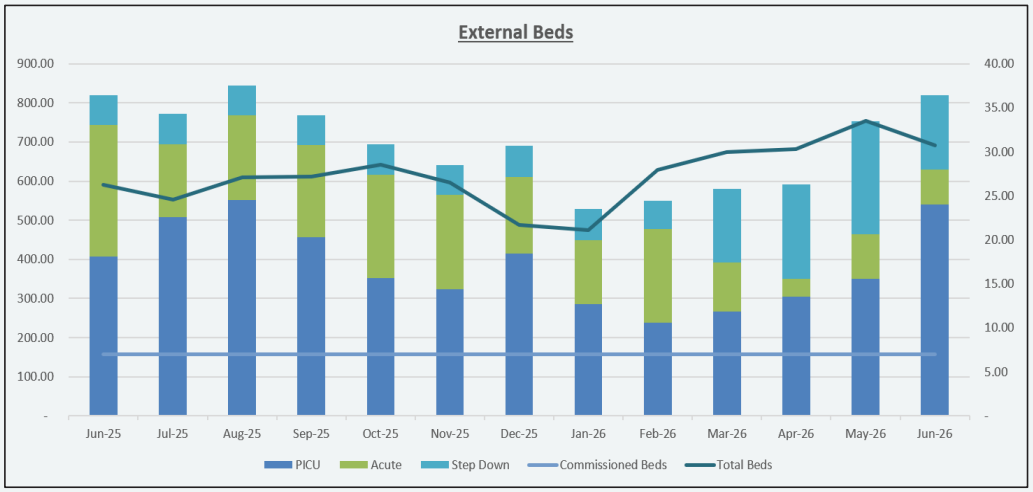
	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Agency	449	374	355	348	431	346	402	265	356	286	595	680	801
Bank	1,522	1,671	1,785	1,499	1,715	1,646	1,686	1,733	1,717	1,934	1,778	1,834	1,631
Substantive	16,341	16,844	17,025	16,953	16,981	18,504	16,878	16,793	16,831	16,640	20,580	20,781	21,187
Budget	18,749	19,591	19,101	19,126	19,196	20,744	18,962	19,081	19,066	19,024	24,068	24,068	24,089



As at the end of June the Trust reported a year-to-date underspend on pay of £0.75m.

- There is a high level of focus from the system and NHS England to ensure pay run rates and WTEs are not increasing in year. The Trust is presently 25.8 WTE below plan.
- Pay run rates increased overall at the start of the financial year due to the CYP & AAED service transfer.
- Substantive pay increased by £0.41m over May spend. Of this, £0.33m relates to the medical pay award which was paid in month and backdated to April. Community and Female PICU recruitment also caused small increases in substantive pay, offset by reductions in additional sessions worked by medics (higher in May to cover Industrial Action).
- Bank spend has reduced by £0.20m, £0.06m relates to fewer working days in month. £0.13m reduction is due to reduced observations on Acute wards and Rosewood MBU. £0.03m reduction in East Kent Crisis was noted as due to lack of availability of NHSP staff, leaving some shifts unfilled.
- Agency spend in June totalled £0.80m, of which £0.49m relates to agency staff used in CYP/AAED services. There are 5.5 wte Consultants in East Kent and 0.5 WTE Consultants in West Kent, all covering vacancies in MAS or MHT+ teams. 1 WTE Consultant in Acute is covering a vacancy in East Kent. A further 11.5 WTE medical agency have been used in CYP/AAED services in June at a cost of £0.38m in month. There are currently 17.7 WTE medical vacancies for Consultants, Specialists or Specialty Doctors in this Directorate.
- Of the Nursing agency utilised, 30.1% (£0.05m) is supporting CYP/AAED services with additional staff required in Inpatient and Crisis teams. A further £0.11m is used in Community services across East, North and West Kent. This is £0.04m in Crisis & Homecare services, £0.06m in MHT/MHT+/MAS teams and £0.01m in Liaison services.
- The current agency forecast is a spend of £7.16m against the cap of £6.46m. This is lower than planned as CYP agency is reduced against expected levels but will still exceed the cap by £0.70m unless further reductions are achieved.

7. Exception report – External beds



Commentary

In June, usage of external Acute beds decreased, from average 4.5 beds to 3.6. PICU usage increased from 7 beds to 11. The Trust is funded for the equivalent of 7 Female PICU beds, which is predominantly used to fund a block contract for 5 Female beds. 4 Male PICU beds were utilised in month at a cost of £0.12m, these are not funded.

Levels of Clinically Ready for Discharge (CRFD) patients held on Acute Inpatient wards remain exceptionally high (33%), leading to both external PICU beds being required to increase bed base.

To help alleviate this pressure, the Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to Trust beds.

The external beds graph shows the continuing increase in external beds usage since January. PICU usage has increased month on month and now exceeds commissioned levels. Acute usage decreased as Step Down provision was extended but usage is increasing, with Step Down capacity at Ticehurst now fully utilised (17 beds). This presents a risk to the financial position.

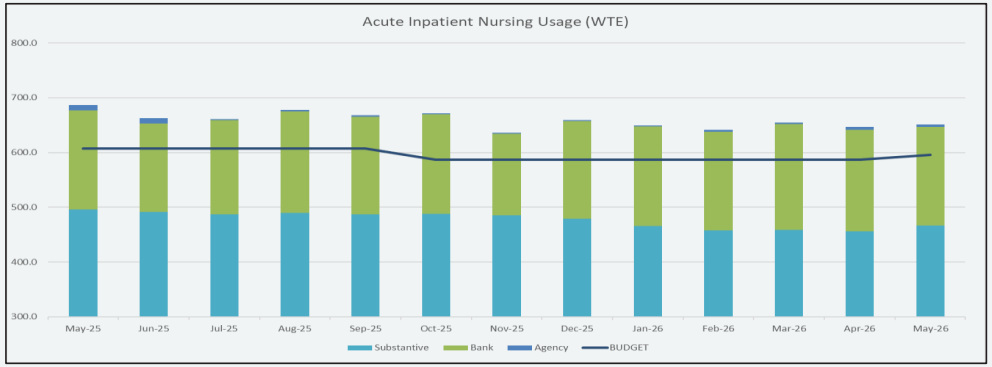
Exception report – Inpatient staffing

Commentary

In June, 37.7 additional WTE above establishment were utilised, decreasing from 55.1 WTE in May. The year-to-date pressure totals £0.88m.

In month changes

- Levels of additional observations decreased in month, costing approximately £0.09m in additional staffing reduction mostly due to a long-term complex patient being discharged on Foxglove ward
- Annual leave cover reduced due to some reductions in leave taken and covered.
- Sickness cover increased from £0.20m to £0.24m
- Study leave cover increased from £0.15m to £0.17m
- Other cover cost £0.15m in month and includes £0.07m cover for staff who are supernumerary or working off ward, £0.02m cover for staff management days and £0.06m described as “other leave”, all of which are in line with May levels.



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8. Capital position

	Annual			In month			Year to Date		
	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
System Capital expenditure									
Capital Maintenance and Minor Schemes	3,247	3,247	0	32	105	(73)	79	364	(285)
Information Management and Technology	350	350	0	0	(12)	12	0	155	(155)
Section 136 development	2,250	2,250	0	209	680	(471)	680	1,445	(765)
Public Decarbonisation	0	0	0	0	0	0	0	0	0
Out of Area Placement (Female PICU)	2,539	2,539	0	500	375	125	1,200	549	651
Solar Installation	138	138	0	0	0	0	138	9	129
IFRS 16 Leases	585	585	0	0	0	0	535	30	505
IFRS 16 Leases - CAMHS	70	1,809	(1,739)	0	0	0	7	1,665	(1,658)
Total system expenditure	**9,179**	**10,918**	**(1,739)**	**741**	**1,148**	**(407)**	**2,639**	**4,217**	**(1,578)**
External expenditure									
PFI 2025/26	236	236	0	20	20	0	60	59	1
R&D - Hyperfine Swoop Imaging System	578	578	0	332	(189)	521	578	2	576
Thanet Crisis Assessment Service	50	50	0	0	0	0	0	0	0
Estates Safety Fund	0	4,451	(4,451)	0	2	(2)	0	2	(2)
Total external expenditure	**864**	**5,315**	**(4,451)**	**352**	**(167)**	**519**	**638**	**63**	**575**
Total Capital Expenditure against CDEL	**10,043**	**16,233**	**(6,190)**	**1,093**	**981**	**112**	**3,277**	**4,280**	**(1,003)**
Intra DH expenditure									
Winthrop Hall	0	8,958	(8,958)	0	2,436	(2,436)	0	8,958	(8,958)
Dover Health Centre	0	331	(331)	0	13	(13)	0	331	(331)
Cherry Tree House	33	1,019	(986)	0	987	(987)	33	1,019	(986)
Georges Turles Clinic	0	1,876	(1,876)	0	1,876	(1,876)	0	1,876	(1,876)
Unit 1, Gillingham Business Park	0	324	(324)	0	318	(318)	0	324	(324)
Maidstone Studios M2	2	229	(227)	0	228	(228)	2	229	(227)
Courtyard, Pudding Lane	0	340	(340)	0	340	(340)	0	340	(340)
Total Intra DH expenditure	**35**	**13,077**	**(13,042)**	**0**	**6,198**	**(6,198)**	**35**	**13,077**	**(13,042)**
Total Capital Expenditure	**10,078**	**29,310**	**(19,232)**	**1,093**	**7,179**	**(6,086)**	**3,312**	**17,357**	**(14,045)**

Commentary:
As of 30th June, the overall capital position is £14.05m over the planned position submitted to NHSE, driven primarily by the recognition of assets associated with the CYP and AAED service transfer.

The majority of this (£13.04m), does not score against the Trust's CDEL as it relates to intra DoH leases are excluded.

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

Excluding these leases the position is £0.58m behind plan; this is due to an IFRS16 remeasurement linked to the pending rent review for the Eureka Medical Centre which is yet to be finalised, along with an underspend on the Female PICU project and Hyperfine Scanner, These are partially offset by an overspend on the Section 136 project.

Funded by	£k
Operational Capital	9,214
Public Dividend Capital	4,501
Grant	578
PFI funding	236
Intra DH Leasing	13,077
Total Capital Limit	**27,606**
(Over)/Under Spend	(1,704)

9. Glossary — acronyms and key terms

AAED — All Age Eating Disorders

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

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

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

CYP — Children and Young People services.

DoH / DH — Department of Health.

FT — Foundation Trust.

HCA — Healthcare Assistant.

I&E — Income and Expenditure statement or position.

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

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

MAS — Memory Assessment Service.

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

NHS / NHSE — National Health Service / NHS England.

PICU — Psychiatric Intensive Care Unit.

PO — Purchase Order.

RAG — Red, Amber, Green status rating.

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

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

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

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

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

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

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

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

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

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

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

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

Non-pay — Operating costs that are not employee expenses.

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

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

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

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

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

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

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Workforce Deep Dive: Strategic Workforce Planning Proposal
Author:	Ali Layne-Smith, Chief People Officer
Executive Director:	Ali Layne-Smith, Chief People Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Boards Request

Overview of paper

Following the transfer of the Children and Young People and All Age Eating Disorder services to The Trust, KMMH is now the provider of mental health services for the entirety of Kent. Having published the 5-year "Doing Well Together" strategy, there is a timely imperative to model and plan for the "right" workforce to deliver our services for the future.

A strategic workforce plan has been commissioned to establish the baseline (as-is) position of the skills mix, roles, locations, and tenure of colleagues in patient facing roles and services; and to forecast and model future workforce requirements for the next 3 and 5 years.

New clinical and quality plans are being drafted, and alongside the NHS 10-year plan and Mental Health strategy it is expected that the Trust will require some new and different skillsets, and ways of working, to deliver for the future.

A strategic workforce plan for 2026 – 2031 will provide the Trust with insight and analysis derived from internal and external data sets (including population health information), to inform discussions and decision making about our future workforce and talent requirements.

It is anticipated that the plan will be brought to Board in November 2026, having progressed through the required governance stages.

Issues to bring to the Board's attention

This is the first time that the Trust has commissioned a strategic workforce plan to align with strategy and population health dynamics.

NB: Data relating to current and future workforce profiles are not included in this paper but has been used to provide indicative themes and areas for focus.

Governance

Implications/Impact:	Planning to identify workforce requirements to meet future population health needs
Assurance:	Reasonable
Oversight:	People Committee

1. Background

The Trust recently published the “Doing Well Together” strategy for 2026 – 2031 and is drafting clinical and quality plans which will be reviewed at Board later in the year. When considered alongside the NHS 10-year plan and the Mental Health strategy, it is timely to establish the baseline of skill sets and role mix of the colleagues who work in patient facing roles and services.

Once the baseline is established, internal and external data sets will be used to model options for workforce requirements in 3 and 5 years’ time. Strategic workforce plans usually extend to 10 years but as this is the first time of commissioning a plan, and to accelerate planning to support our 5-year strategy, the plan will focus on establishing the as-is baseline, 3 years and 5 years.

2. The case for a strategic workforce plan

The purpose of a strategic workforce plan (SWP) is to ensure that we have the right people, with the right skills, in the right roles, at the right time. The PESTLE (political, economic, social, technological, legal, and environmental) analysis below highlights some of the key drivers that signal the need to review the skills sets and skill mix of our colleagues.

3. Internal starting point

The workforce analytics team within the People Directorate designed a modelling tool to test the feasibility of using existing data to model future workforce requirements. The initial data set included:

- Staff type (Nurse, AHP etc)
- Banding
- Location
- Budgeted and Actual WTE
- Vacancies
- Turnover / Attrition
- Known retirements

With this limited data set analysis highlighted:

- Areas with high vacancy rates for specific bands
- Areas of oversupply of certain bands
- Forecasted erosion between Band 6 and 7 roles
- Increased consultant vacancy rates

Whilst the internal data set highlighted the need for focus in these areas, there was a lack of context to inform actions that would be needed – e.g. bank and agency usage, sickness absence data, demand data, and safe staffing benchmarks. In addition, there was a need to relate the internal data to external data such as the trajectory for mental ill health in the region over the next 5 years.

The initial modelling exercise was used to inform the commissioning of the SWP.

4. Scheme of work

A strategic workforce plan has been commissioned to provide a documented analysis of the Trust's current workforce position including:

- Staffing establishments by staff group, role type and location.

- Workforce demographics and workforce profile.
- Vacancy, turnover and workforce trend analysis.
- Key workforce strengths, risks and challenges.

An assessment of future workforce requirements informed by:

- The Trust's organisational strategy.
- National and regional workforce strategies.
- Population health needs and demographic projections.
- Relevant system and partner workforce plans.

A comprehensive 5-year Strategic Workforce Plan including:

- Workforce forecasts for 1, 3 and 5-year horizons.
- Workforce modelling scenarios and options.
- Workforce risks, opportunities and dependencies.
- Strategic recommendations and proposed actions.

A report identifying:

- Existing and future workforce skills gaps.
- Emerging workforce capability requirements.
- Recommendations for workforce development, talent management and succession planning.

Facilitation of stakeholder engagement activities including:

- Workshops.
- Interviews.
- Focus groups and consultation sessions as agreed.

Preparation of:

- Final Strategic Workforce Plan.
- Executive Summary.
- Workforce modelling outputs and supporting analysis.
- Board presentation pack.

5. Indicative timeline and milestones

Milestone	Description	Target Date
Project Initiation	Kick-off meeting, confirmation of scope, methodology and governance arrangements	July 2026
Baseline Workforce Assessment	Workforce data gathering and baseline analysis	July – August 2026
Stakeholder Engagement	Stakeholder interviews, workshops and consultation activities	August – September 2026
As -Is Position Sign-off	Baseline report agreed by steering group	September 2026
Workforce Modelling and Analysis	Development of workforce demand, supply and scenario modelling	September 2026
Modelling outputs signed off	Gap analysis and assumptions agreed by steering group	Oct – Sept 2026
Draft Strategic Workforce Plan	Submission of first draft plan and findings	October 2026
Review and Refinement	Stakeholder review and incorporation of feedback	October 2026
Final Strategic Workforce Plan	Submission of final plan and supporting documentation	October 2026
Governance Preparation	Preparation of committee and Board papers and presentations	October – November 2026
Trust Board Presentation	Presentation of final workforce plan to Trust Board	November 2026

The Board is asked to note and support the commissioning of a strategic workforce plan for 2026 - 2031

	Key Drivers	Workforce Implications	Emerging Risks / Opportunities
Political	Alignment to NHS national priorities Medium term planning requirements integrating finance and workforce Increased / partnership regulatory scrutiny	Redesign of skills mix and roles to enable shift from inpatient to community settings Requirements for a multifunctional workforce – AHPs, pharmacy, psychology, nursing integration Increased accountability for workforce planning at Trust, system and national level Expectation to demonstrate workforce contribution to national targets – productivity, access, and outcomes	Risk: misalignment between service redesign pace and workforce readiness Opportunity: system collaboration, talent pipeline building (build, buy, borrow, bot..)
Economic	Requirement for financial sustainability and productivity gains Pressure to reduce agency spend and reliance on temporary staffing System and national level financial constraints and efficiency expectations	Continued drive to reduce agency and bank reliance, right-sized substantive workforce, improved productivity Tight controls on workforce growth and establishment increases Demand for skill mix optimisation, role substitution, workforce modelling to inform decision making	Risk: staffing gaps if recruitment pipeline does not keep pace with agency reduction targets Risk: Burnout if productivity expectations outpace staffing capacity and / or capability Opportunity: efficiency via digitalisation and automation e.g. smarter rostering
Social	Changing workforce expectations - hybrid / flexible working Increased focus on wellbeing, retention and engagement Population demand growth and complexity of mental health needs	Increased expectations for career pathways and progression – crucial for retention, and improved employee experience Need to address wellbeing, sickness absence, and burnout, improve retention in key shortage groups, consider attrition trends, retirements and changing workforce demographics	Risk: Inability to compete with other trusts for flexibility and / or career progressions. Opportunity: strengthen retention strategies – development pathways, wellbeing engagement

	Key Drivers	Workforce Implications	Emerging Risks / Opportunities
Technological	Expansion of digital enablement, workforce systems, and BI reporting Use of business intelligence, for operational and strategic decision-making NHS shift from analogue to digital models of care	Requirement for digital skills across all staff groups, data literacy for managers and clinicians Use of automation to reduce administrative burden, digital pathways impact on clinical workflows New workforce requirements, digital specialists, analysts, informatics workforce	Risk: digital skills gap slowing transformation Risk: workforce resistance to new technologies Opportunity: release of clinical capacity through automation and improved systems
Legal	Workforce compliance requirements – GMC, NMC, DBS Information governance and workforce data submission requirements Equality, diversity, and inclusion requirements	Increased governance in recruitment processes, workforce data, education and training compliance Maintain safe staffing levels, fair and equitable employment practices EDI implications of workforce planning and culture	Risk: non-compliance impacting regulatory or reputational outcomes Opportunity: strengthen inclusive workforce culture and compliance frameworks
Environmental	NHS shift to prevention and community-based care models Estate, service transitions, and organisational change - integration with partners, service migration, co-location	Workforce models must adapt to community delivery, integrated system working across organisations Need for flexible workforce, cross-organisational roles and pathways Impact of estate on workforce distribution and accessibility, co-location	Risks: workforce mobility challenges – travel, estate constraints Opportunity: develop placed-base workforce models aligned to population need

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Freedom to Speak up Annual Report
Author:	Rebecca Crosbie, The Guardian Service (Cover sheet authored by Sheila Stenson, Chief Executive)
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

This paper provides an update for the Board on the annual performance (1 April 2025 to 30th March 2026) of the Freedom to Speak Up (FTSU) Guardian Service.

Issues to bring to the Board's attention

The report covers the period 1st April 2025 to 30th March 2026.

During this period, 128 cases were raised to the Guardian Service 5 were rated as Red, 21 were rated as Amber and 101 rated as Green. There was one white case which required no action or discernible risk within the organisation. Of these 128 cases 99 were closed within this period. 80 of these resolved with a verbal or written outcome, 4 chose not to pursue and 15 made no further contact following initial engagement.

The primary themes for this period were; Management Issue (46), System/Process (35) and Behaviour/Relationship (20). These were also the top three multi-theme occurrences.

Administrative and Clerical remains the most prominent job group raising concerns (42), following by Additional Clinical Services (26) and Nursing (21). During this period the most cited reason for staff to use The Guardian Service has been for Impartial Support (42%). 66% of cases have been escalated to the trust in some capacity. The remaining 34% of cases used the service to build confidence to escalate their own concerns or as an impartial sounding board.

There have been 2 anonymous cases for this period and 2 cases where staff reported a perception of detriment because of speaking up.

Version 2 - **Public**

The Trust agreed four areas of focus at Trust Board in February. This is being managed by the People Team with oversight by myself as lead for the Guardian service. Updates will be provided to the trust People Committee. The four areas include:

1. Directorates to close the loop when concerns are raised in a timely manner. It should also be noted that a new escalation pathway was agreed in year and implemented from January, encouraging local ownership of concerns raised via freedom to speak up.
2. Formal communication plan for FTSU guardian – set up a, you spoke up, we did campaign.
3. Guardian to roll out escalation training to all managers across the trust
4. Ensure staff do not suffer detriment when raising concerns within the trust

During this period, it is also important to note that the Guardian engaged with over 200 promotions, briefings and meetings relating to promoting service visibility.

Governance

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

NHS
Kent and Medway
Mental Health
NHS Trust

The Guardian Service
Here to listen

Annual Report
1 April 2025 to 31 March 2026

Circulation: **Public Board**

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

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

Date: June 2026

The Guardian Service
Here to listen

Contents

1. Executive summary

The report presents the annual data from FTSU cases raised with The Guardian Service for the reporting period 1st April 2025-31st March 2026. During this period 128 cases were raised with the Guardian.

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During this period the most cited reason for staff to use The Guardian Service has been for Impartial Support (42%).

66% of cases have been escalated to the trust in some capacity. The remaining 34% of cases used the service to build confidence to escalate their own concerns or as an impartial sounding board.

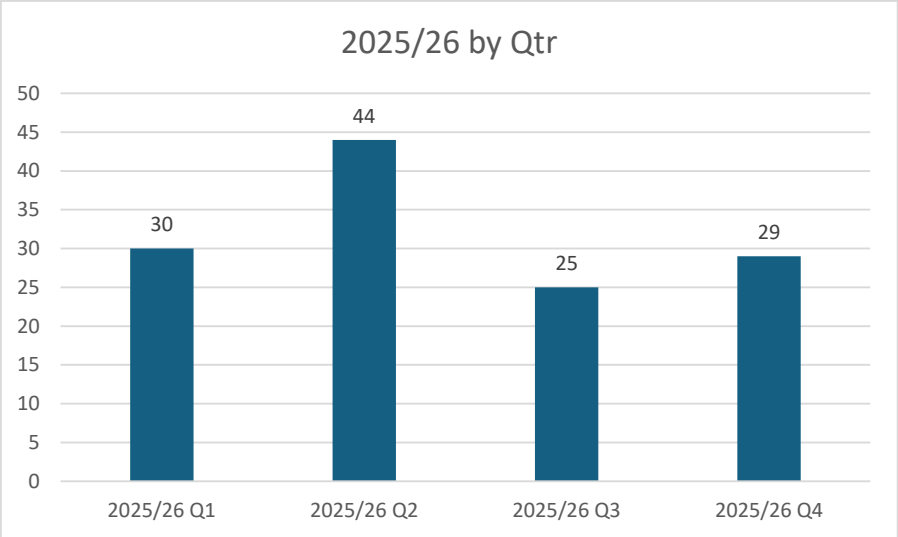
2. Purpose of the paper

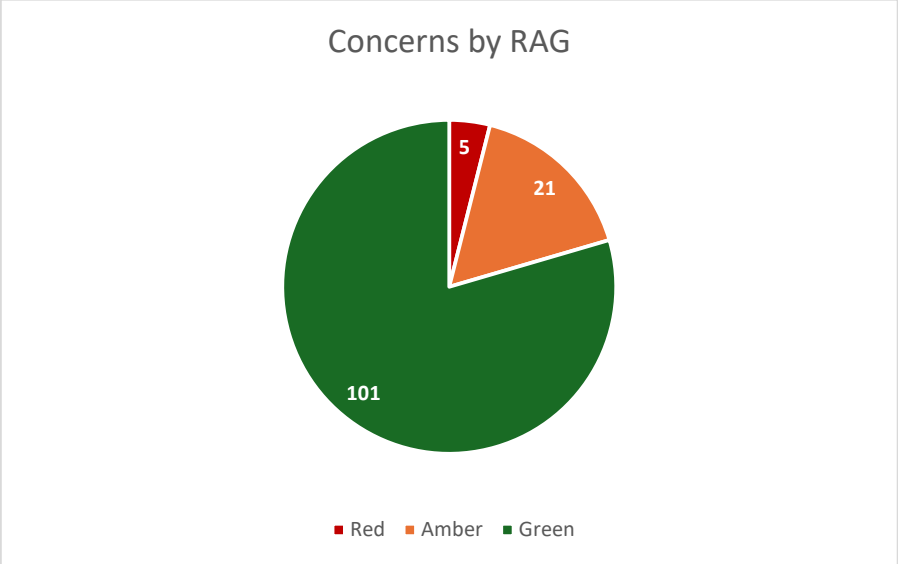
The purpose of this paper is to give an overview of the cases raised at Kent and Medway Mental Health Trust (KMMH) to the Freedom to Speak Up Guardian employed by The Guardian Service Limited (GSL) during the full reporting year of 2025/26. This reporting period begins on 1st April 2025 and ends on 31st March 2026.

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

3. Number of concerns raised

During this period there were 128 concerns raised via the FTSU Guardian.





4. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	44	34.38
Permission to escalate with names	52	40.63
Permission to escalate anonymously	1	0.78
Permission to escalate without name	31	24.22
Total	**128**	

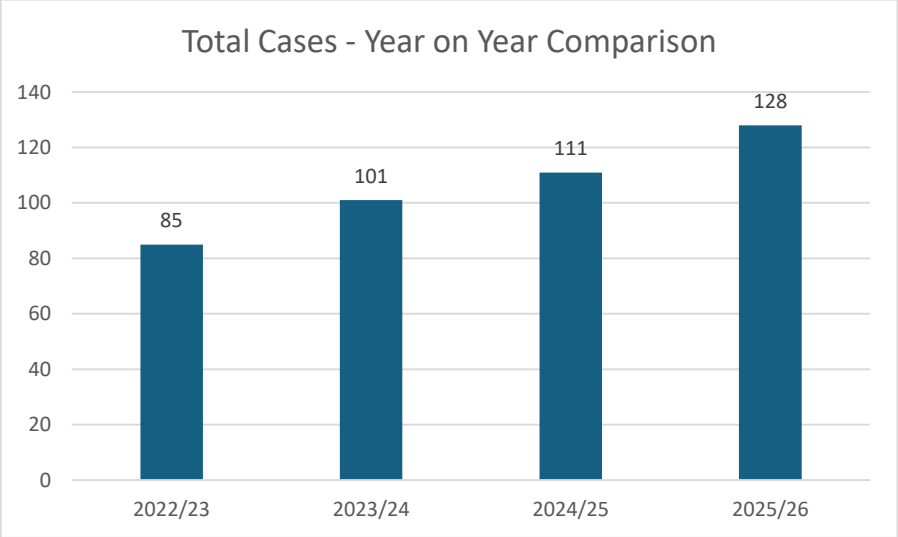
5. Themes

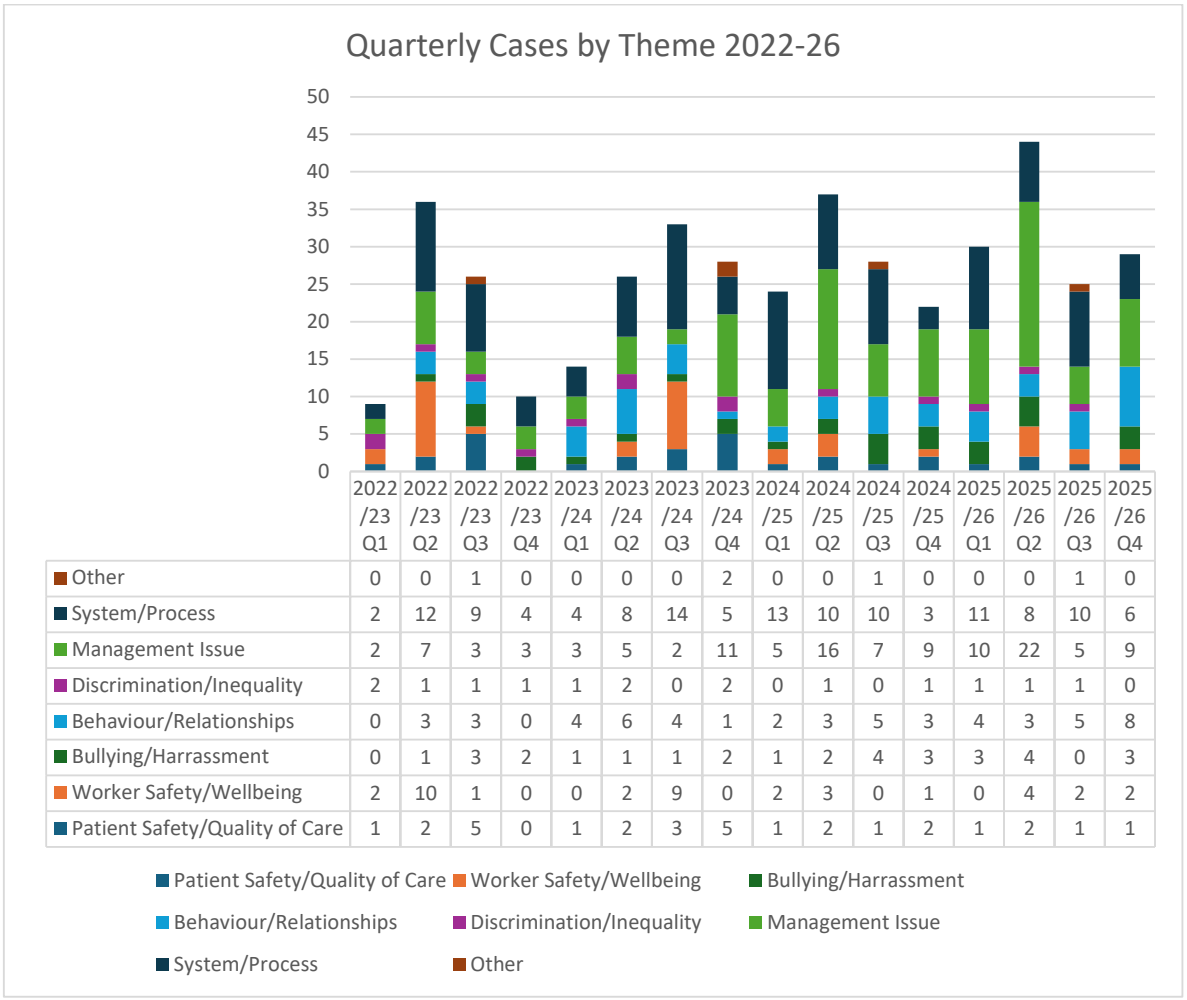
Concerns raised are broken down into the following categories;

Cases by Primary Theme	Total
Patient and Service User Safety / Quality	5
Management Issue	46
System Process	35
Bullying and Harassment	10
Discrimination / Inequality	3
Behavioural / Relationship	20
Other (Describe)	1
Worker Safety	8
Sexual Misconduct	0
Grand Total	**128**

Cases by multi-theme occurrence	Total
Patient and Service User Safety / Quality	10
Management Issue	84
System Process	71
Bullying and Harassment	24
Discrimination / Inequality	17
Behavioural / Relationship	54
Other (Describe)	1
Worker Safety	34
Sexual Misconduct	1

6. Trends in Cases





	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2	2024/25 Q3	2024/25 Q4	2025/26 Q1	2025/26 Q2	2025/26 Q3	2025/26 Q4
Other	0	0	1	0	0	0	0	2	0	0	1	0	0	0	1	0
System/Process	2	12	9	4	4	8	14	5	13	10	10	3	11	8	10	6
Management Issue	2	7	3	3	3	5	2	11	5	16	7	9	10	22	5	9
Discrimination/Inequality	2	1	1	1	1	2	0	2	0	1	0	1	1	1	1	0
Behaviour/Relationships	0	3	3	0	4	6	4	1	2	3	5	3	4	3	5	8
Bullying/Harrassment	0	1	3	2	1	1	1	2	1	2	4	3	3	4	0	3
Worker Safety/Wellbeing	2	10	1	0	0	2	9	0	2	3	0	1	0	4	2	2
Patient Safety/Quality of Care	1	2	5	0	1	2	3	5	1	2	1	2	1	2	1	1

7. Assessment of Cases

The top three themes have been assessed as follows:

Management Issue

During this period over 50% of cases were reported as having an element of the theme of Management Issue. Within these cases the most prominent experiences reported were perceptions of:

-Poor leadership behaviour and culture

-Preferential treatment or staff feeling treated differently to colleagues

-Leadership behaviour not aligning with trust values

-Leadership not responding to or minimising concerns

Within this theme we see three teams appear as hot spots. Ongoing conversations have been had with both the Executive Lead and Service Directors about the concerns raised. Although plans have been put in place to address the concerns and improve leadership culture the Guardian will continue to be visible until positive change is observed. In all cases there is reflection around the initial response to concerns and whether this was both objective and meaningful enough.

The Guardian has noted that in these cases there was often a focus on the staff members emotions or frustration when communicating their concerns. Whilst it is important to consider professional

communication it is also important to reflect on the impact of not feeling heard. Some staff who spend a considerable period trying to raise their concerns may end up in a state of heightened emotion or frustration. In some cases, this has remained the focus rather than what has led to the frustration. This has then impacted the response or actions taken.

There have also been cases where staff members have reported significant impact to their psychological wellbeing due to perceived work-related experience. In some of these cases the focus has been on the staff members psychological state rather than what has led to this. Staff report feeling as though they are being gaslit or that concerns are minimised with emphasis made on their lack of resilience to situations. This has a negative impact on psychological safety and prevents concerns from being effectively resolved.

System and Process

System/Process continues to remain a top theme with over 50% of cases reporting an element of this. This theme sees a broader range of processes raised as follows:

-Removal of the hybrid working policy: some staff report impact because of this and feel it has made elements of their work inaccessible due to personal circumstances.

-Sickness and Return to Work: staff have reported a lack of support and check in during sickness absence. Some staff report being absent for extended periods with no communication from management. Where this absence resulted from perceived work-related stress some staff report a feeling that no actions or mitigations for the stress were explored with an expectation to return to the same situation that they feel caused the absence. In addition, some staff reported returning to work with no clear return to work plan which they feel caused further stress. In cases where a work-related stress risk assessment had been undertaken some staff reported hearing no follow up from this and felt the process to be a tick box exercise.

-Payroll – Several concerns related to errors which occurred within payroll. Staff reported that communication relating to these was lacking and caused stress during times of increased financial pressure. Some staff reported struggling to get clear responses and understanding around how the errors had occurred.

-Local inductions – New staff reported that they felt local inductions were lacking leaving a perception that teams and managers did not have the capacity to welcome and induct new starters. New starters reported feeling unsure about their role, responsibilities and support from colleagues/managers.

-Flexible Working requests relating to health needs – Staff felt that these were not being considered objectively. In some cases, the appropriate centralised process had not been followed. The guardian was able to ensure managers were aware of this and escalated for the process to be engaged.

-Consultation – consultation process has been raised with a feeling that this has lacked compassion from management in some areas. Staff have reported feeling that decisions relating to change had been made prior to the process being engaged and felt that their input was futile. Some long-standing employees also report feeling that their long service wasn't valued.

Behaviours/Relationships

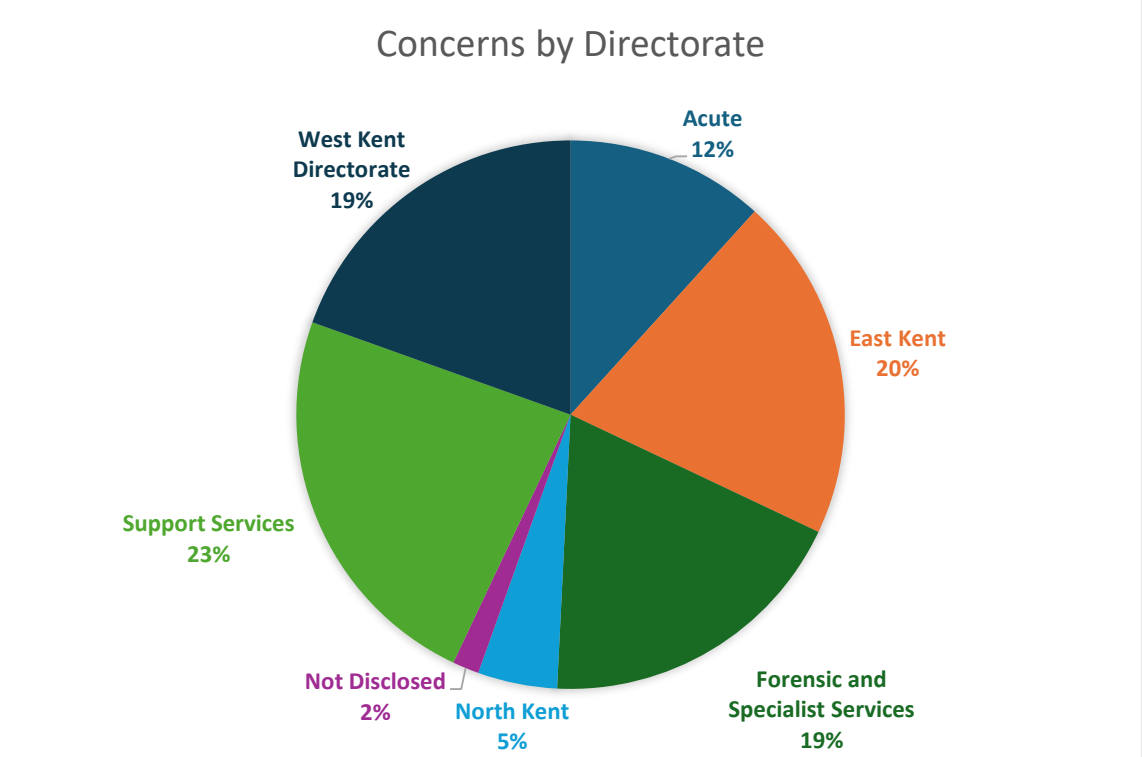
Behaviour/Relationships in the workplace is the third most prominent theme for this reporting period. These cases predominantly resulted from staff reporting a perception of incivility from colleagues. Similarly to that of the theme Management Issue staff felt that colleagues were not acting in line with trust values and that this was impacting individuals' wellbeing, culture within teams and overall morale.

Within this theme there is an overlap on the cases raised from the three hot spot areas mentioned within the theme of management issue. In many of these cases staff felt that they had raised their experiences with management and reported that these had either been minimised or that management were complicit in the behaviour. In some cases, staff felt managers were not equipped to have uncomfortable conversations to resolve the concerns or avoided this all together.

8. Statistical Graphs

Concerns raised by Directorate

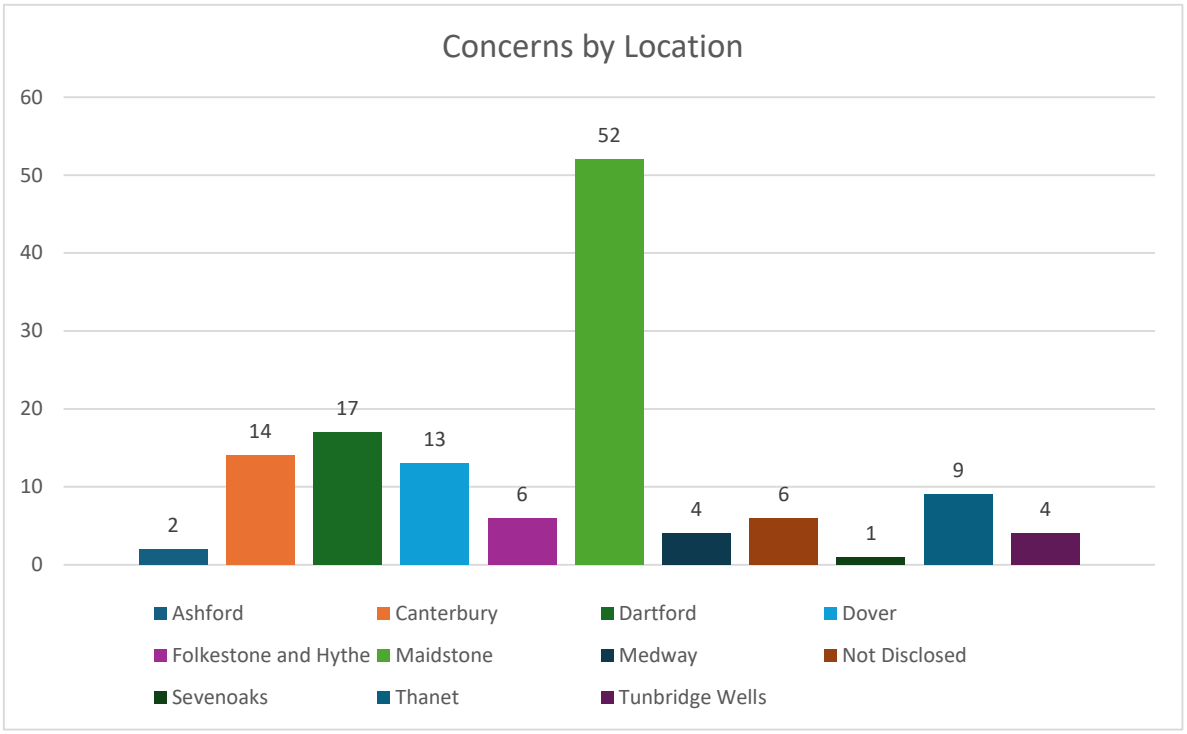
Directorate	Head Count	Concerns	% of staff raising concerns
Acute Directorate	706	15	2.1%
East Kent Directorate	679	26	3.8%
Forensics and Specialist Directorate	748	24	3.2%
North Kent Directorate	507	6	1.1%
Support Services	900	30	3.3%
West Kent Directorate	483	25	5.2%

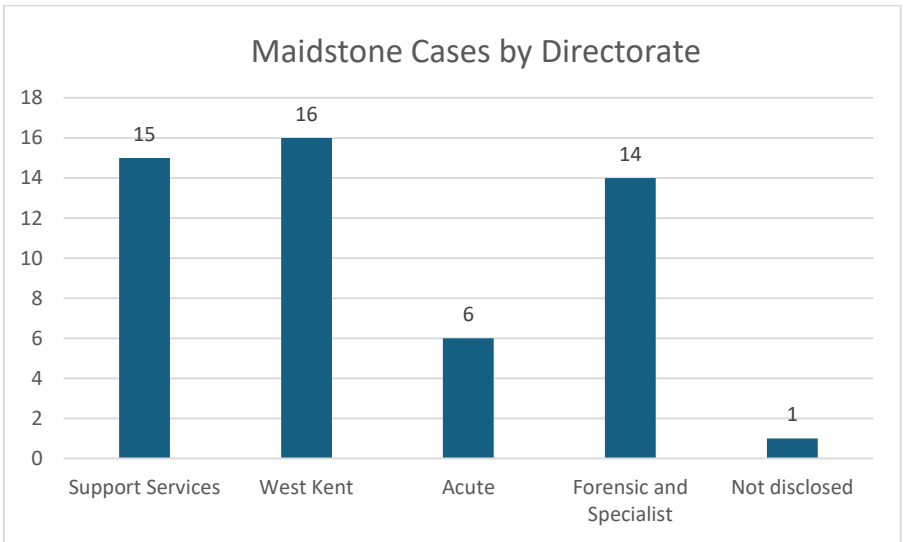


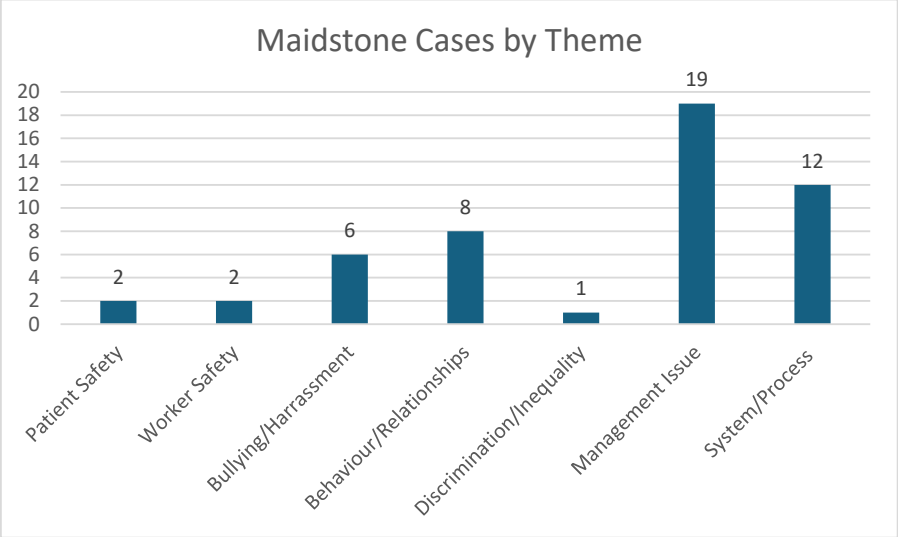
Concerns raised by Location

Location	Head Count	Concerns	% of staff raising concerns
Dartford & Gravesham	777	17	2.1%
Sevenoaks	23	1	4.3%
Tonbridge and Malling	27	0	0
Maidstone	1201	52	4.3%
Tunbridge Wells	128	4	3.1%
Swale	124	0	0
Ashford	115	2	1.7%

Canterbury	770	14	1.8%
Folkstone and Hythe	97	6	6.1%.
Dover	93	13	13.9%
Thanet	292	9	3%
Medway	336	4	1.2%
Unspecified	42		
Not disclosed		6	
Grand Total	4025	128	



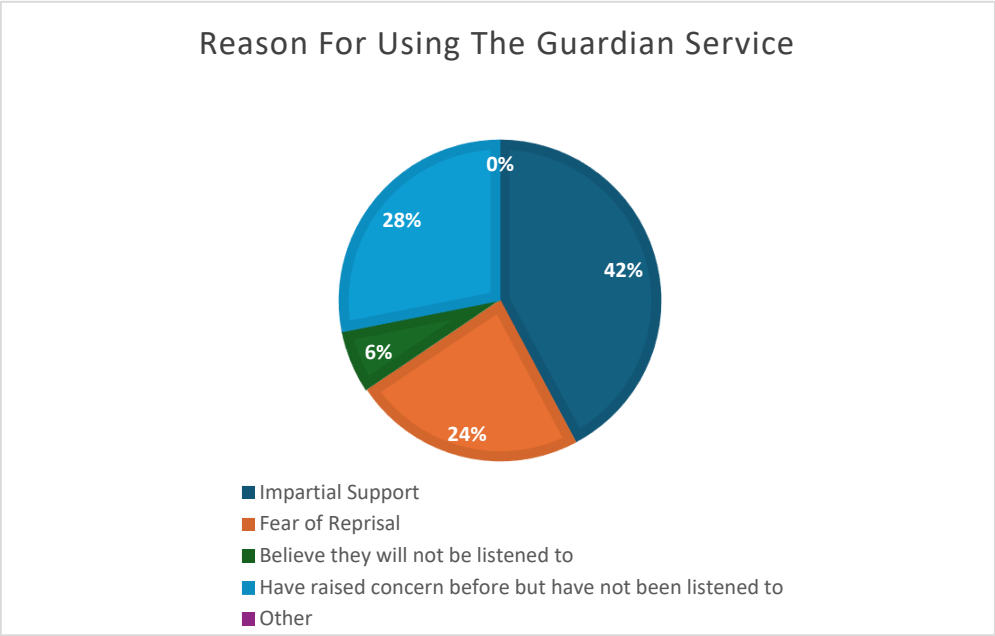




Concerns raised by Job Group

Job group	Head Count	Concerns	% of staff group
Add Prof Scientific and Technic	383	10	2.6%
Additional Clinical Services	975	26	2.6%
Administrative and Clerical	948	42	4.4%
Allied Health Professionals	247	7	2.8%
Estates and Ancillary	167	0	0
Medical and Dental	242	6	0
Nursing and Midwifery Registered	1062	21	1.9%
Students	unknown	0	
Not disclosed		16	
Misc	1		
Total	4025	128	

9. Why do staff use The Guardian Service?



10. Detriment

Two cases of detriment were reported within this period. In one case an individual felt they were treated differently following speaking up. They believe this led to their concerns worsening and impact on their wellbeing. Senior management are engaging directly with this individual to explore their ongoing concerns and the behaviour of those alleged to be behaving outside of trust values.

A second case of detriment from speaking up was logged which relates to a historic case. In this case confidentiality was breached by HR. An apology was shared at the time, but the staff member felt due to this they faced negative treatment from a colleague. The staff member expressed impact on their wellbeing because of this experience. The Guardian and Deputy Director of Workforce have worked together to ensure that there is clear process and understanding around confidentiality when speaking up. As this experience happened several years ago the trust feel confident this would not happen with the current awareness and improvements around FTSU. Feedback has been shared with the staff member to offer assurances.

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

The trust has recently reviewed the FTSU Reflection and Planning tool to ensure this is up to date in line with national guidelines. The action plan for FTSU has been incorporated into the high-level actions within the planning tool.

The Guardian continues to meet monthly with the Executive Lead and senior members of the workforce team to ensure themes, data and any barriers are shared for learning and improvement.

12. Learning and Improvements

The escalation pathway for FTSU has been updated and this includes a back to basics guide for responding to concerns. This document has been embedded within the managers induction and shared with senior leaders to cascade to their respective management teams.

13. Comments & Recommendations

Below are three recommendations for the board's consideration based on concerns that have been raised with the Guardian.

Recommendation 1:

There is still a notable challenge in gaining what staff would consider to be meaningful feedback following concerns being raised. In some cases, leaders spend time with staff with good intention to support them feeling heard but without clear feedback and follow up; staff report this feels like a tick box exercise.

In addition, there have been many cases when managers or leaders have set out time frames to meet with or respond to staff, and these not been met. This can exacerbate a sense of futility and staff report feeling that their concerns are not seen as valid. It is important to ensure that expectations set are achievable and the impact it can have when these are not met.

Consideration is welcomed on defining what satisfactory feedback looks like and ensuring all managers and leaders understand this standard. It is also important to reinforce the need to set realistic expectations and avoid commitments that cannot be met.

Recommendation 2:

During this period a concern was raised relating to patient safety and culture within the Acute Directorate. The staff member had been raising concerns prior to using The Guardian Service and felt these were being minimised. The patient safety elements of this concern were investigated by someone with a clinical background, but this took an extended period to conclude with many delays and limited updates. In addition, expectations were set that were repeatedly not met and this caused additional distress to the staff member who was impacted by how they were being perceived by raising such concerns.

It is important to note that when investigations into concerns happen an extended period following the event this can impact the quality and outcomes of the investigation. Due to an individuals' ability to accurately recall or opportunity to create a counter narrative to minimise concerns it can compromise the process.

Consideration is welcomed on setting clear timeframes for clinical investigations and ensuring timely feedback and updates are provided throughout the process.

Recommendation 3:

There have been several cases where concerns relating to behaviour in the workplace have been investigated and allegations have been upheld. Recommendations have been made as part of these processes but in some cases, these have not been followed through. In addition, if the behaviour or experience persists and the process has not seen meaningful change the staff member has had to raise further concerns. In one area there has been repeated formal process with upheld allegations regarding one individual.

Consideration is welcomed on how monitoring can be strengthened to ensure recommendations from these processes are implemented and lead to meaningful outcomes. Where formal processes repeatedly evidence that an individual is having a negative impact, the organisation should consider what further action is needed to mitigate the impact on culture, staff wellbeing and quality of care.

14. Staff Feedback

- Rebecca was incredibly supportive and raised my concerns to relevant people. The trust did not respond to concerns in an appropriate time scale

- The FTSUG was quite diligent and very helpful but the Trust did not attend to issues as should be expected given relevant obligations.
- Without speaking to the Guardian, my problem would not have resolved.
- The Guardian was calm and knowledgeable and clearly explained my options. The Guardian made me feel that I was in control of the process - I didn't feel rushed or pressurised to go in any particular direction.
- I would raise concerns regarding client safety only
- Although the main concern seemed to be getting stuck in limbo with the managers, I was kept informed and the anxiety of feeling powerless was lessened.
- The FTSUG was objective in advancing the issues raised with her.
- The Guardian was very professional yet also kind and compassionate. I felt that she was doing everything she could to get a resolution for myself.
- The Guardian was amazing. She was kind and supportive, always professional and measured in her responses. I felt very safe and that my concerns were important.
- It came across that the guardian had been prepped by management on the situation before meeting with staff.
- I would not raise concerns again as it turned on me, i became the problem which pushed me to having to leave my job. Speaking with The Guardian was helpful.
- I have already recommended to my colleague who is having similar problems.
- I am grateful for this service as it made me feel less alone.
- The guardian service is highly valuable service
- Through using the guardian process, I've become more aware of limitations in the communication between the higher-ups in my trust, which I now feel empathy for.
- The interventions as provided by the FTSUG are very much appreciated.
- I did actually recommend the Guardian service to several of my colleagues, who did go on to use the service. Very satisfied.
- This was not helpful and although the guardian was open to our concerns, the response given felt regurgitated from management; causing us to feel dismissed
- The Guardian was great, compassionate and supportive. She understood where i was coming from and i found her advise helpful.

Appendix

15. Background to Freedom to Speak Up

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

16. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust

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

as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in KMMH on 6th June 2022.

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

17. Access and Independence

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

18. Categorisation of Calls and Agreed Escalation Timescales

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

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

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

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

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	System Governance: Joint Committee Board Report
Author:	Sheila Stenson, Chief Executive Officer
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Approval
Submission to Board:	Joint Committee requested

Overview of paper

This paper presents the Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture, for onward consideration by partner provider Boards. The intention is to provide a single, consistent system narrative following Joint Committee, ensuring alignment across organisations on the agreed direction of travel and expectations for delivery.

Issues to bring to the Board's attention

The proposed Joint Committee arrangements are supported by the statutory and regulatory framework that allows NHS bodies to work collaboratively and, where appropriate, delegate specified functions through formal governance arrangements.

Any participation in the Joint Committee will be subject to agreed Terms of Reference and supporting delegation arrangements, and will operate in accordance with each organisation's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Delegation (or equivalent governance framework).

The arrangement does not remove the statutory responsibilities of the participating organisations, each of which will remain accountable for the discharge of its legal duties and regulatory obligations

Version 2 - **Public**

Governance

Implications/Impact:	No direct legal implications are identified within the report No direct quality or patient safety implications arise from this report, which relates to governance, reporting, and system alignment arrangements. No direct financial implications arise from the report however delivery of the agreed system direction is linked to the wider objective of improving system financial sustainability and addressing financial pressures across Kent and Medway. No direct patient or public engagement implications arise from this report.
Assurance:	Reasonable Assurance received from the NHS Kent and Medway Joint Committee and System Leadership Group regarding the proposed approach to consistent Board reporting, governance alignment, and system-wide communication.
Oversight:	Oversight through the NHS Kent and Medway Joint Committee.

NHS Kent and Medway

Report to	NHS System Leadership Group
Meeting date	26 June 2026
Report Title	System Governance and Joint Committee Alignment: Joint Committee Board Report
Key question	Is the System Leadership Group content with the proposed approach to issuing a consistent Joint Committee update to all Boards, including the phasing and supporting arrangements?
Executive Lead	Adam Doyle, Chief Executive Officer, NHS Kent and Medway
Author	Adam Doyle, Chief Executive Officer, NHS Kent and Medway

Which of the organisation's strategic objectives does the report support:	
☐ Commission the right services each year	☐ To ensure financial sustainability over three years
☒ Lead strategy and ensure commissioning levers deliver impact	☐ Develop into a high-performing Commissioning Organisation
☐ Renew our culture for long-term sustainability	

Recommendation (outcome / action requested):

Meeting action required:

☒ Seek assurance ☐ Decision/approval required ☐ For noting/information

Recommendation(s) to the Meeting:

The Meeting is asked to:

1. **NOTE** the contents of this report
2. **SUPPORT** the approach to co-ordinated circulation across partner organisations
3. **NOTE** the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

Executive summary:

This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture, for onward consideration by the ICB Board and partner provider Boards.

NHS Kent and Medway

The intention is to provide a single, consistent system narrative following Joint Committee, ensuring alignment across organisations on the agreed direction of travel and expectations for delivery.

The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the phasing of Board discussions, ensuring coordinated timing and alignment of governance processes. The Director of Communications will support the approach to ensure clarity and consistency of messaging.

The System Leadership Group is invited to note the proposed approach and provide assurance that it is appropriate.

Proposed next steps:

- Finalise the Board report following SLG feedback
- Agree phasing and timing of Board presentations with partner Company Secretaries
- Support coordinated communication and messaging across organisations
- Issue report to all Boards in line with agreed approach

Governance pathway to date:

Meeting name:	Date:	Outcome:
N/A		

Contact for further information	Adam Doyle, adam.doyle5@nhs.net

COMPLIANCE NOTES:

Equality, health inequalities, and quality impact assessment

If this report is presented for decision/approval, please complete:
Has an assessment been undertaken?
☐ Yes (please attach the action plan as an appendix to this paper)
☒ No/Not applicable (please indicate why an assessment was not required)

An Equality and Health Inequalities and Quality Impact Assessment has not been undertaken as this paper is a strategic update on agreed system direction and proposed Board reporting, and does not introduce any direct changes to services, access or delivery.

Conflicts of Interest

NHS
Kent and Medway

COMPLIANCE NOTES:

Are there any conflicts associated with authors or reporting officers?

☐ Yes ☒ No

If yes, please confirm how the conflict has been managed.

FOI Status

Is this report disclosable under FOI?

☒ Yes ☐ No

If no, please specify why:

Financial Implications

Are there financial implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Legal Implications

Are there legal implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Quality and Safety Implications

Are there quality or safety implications associated with this report?

☐ Yes ☒ No

If yes, please describe:

Patient and Public Engagement

Are there patient and public engagement implications associated with this report?

☐ Yes ☒ No

If yes, please describe. If no, please specify why:

There are no patient and public engagement implications as this paper communicates an agreed system position and approach to Board reporting; any future service changes arising from this work will be subject to appropriate engagement.

NHS
Kent and Medway

SYSTEM GOVERNANCE AND JOINT COMMITTEE ALIGNMENT: JOINT COMMITTEE BOARD REPORT

1. INTRODUCTION

This paper presents the draft Board report summarising the outcome of the Joint Committee discussion on system transformation, care models and commissioning architecture. It is intended for onward consideration by the ICB Board and partner provider Boards, providing a single, consistent system narrative and ensuring alignment on the agreed direction of travel and expectations for delivery.

2. STRATEGIC ALIGNMENT

This report supports delivery of the agreed system transformation programme, including the move to a more integrated, population-based model of care, strengthened provider alliances and the transition to strategic commissioning. It enables a consistent understanding across Boards, supporting collective leadership, coordinated decision-making and alignment to system priorities, including improved outcomes, reduced inequalities and financial sustainability.

3. JOINT COMMITTEE BOARD REPORT

The attached report reflects the outcome of the Joint Committee discussion, confirming areas of agreement and setting out clear expectations for the next phase of delivery. It is designed to be issued to all Boards as a consistent account of system direction, supported by coordinated phasing of discussions across organisations. The ICB Company Secretary is working with Company Secretaries across partner organisations to agree the timing and sequencing of Board consideration, with support from the Director of Communications to ensure clarity and consistency of messaging.

4. KEY RISKS, MITIGATIONS, AND CONTROLS

There is a risk that, without a coordinated approach, differing timing or interpretation of the Joint Committee outcomes across organisations could lead to inconsistency in understanding, messaging or organisational response. This is being mitigated through a structured, system-wide approach led by the ICB Company Secretary in collaboration with partner Company Secretaries to align Board cycles and phasing. In addition, communications support will ensure consistent messaging and narrative across organisations, reducing the risk of misalignment and supporting collective ownership of the agreed direction.

5. OTHER CONSIDERATIONS

There are no other considerations relevant to this report.

NHS Kent and Medway

6. REQUIRED OUTCOMES AND NEXT STEPS

The Meeting is asked to:

- **NOTE** the proposed Board report content following Joint Committee
- **SUPPORT** the approach to coordinated circulation across partner organisations
- **NOTE** the proposed phasing, with the ICB Company Secretary working with partner organisation Company Secretaries and Director of Communications to support messaging and consistency of communications

7. SUPPORTING DOCUMENTATION

There are no supporting documents relevant to this report.

Appendices:

Appendix 1: Joint Committee Board Report

NHS Kent and Medway Joint Committee
System Transformation, Care Models and Commissioning Architecture
Report for Noting – Following Joint Committee Discussion

1. Purpose

1.1. This paper brings together the previously circulated system architecture and care model proposals and provides an update following discussion at the Joint Committee.

1.2. The purpose of this report is to confirm the areas of agreement reached, clarify the expectations arising from that discussion, and provide a consistent system narrative for consideration by the ICB Board and partner provider Boards.

1.3. The Joint Committee confirmed that there is now a shared understanding of both the direction of travel and the scale of change required across Kent and Medway.

2. Context and Rationale for Change

2.1. The context set out in the original paper remains unchanged. The system continues to operate under sustained financial, operational and workforce pressure, with variation in access and outcomes and a delivery model that remains overly reliant on hospital-based care.

2.2. The Joint Committee explicitly confirmed that:

- The current model has reached its limits and is no longer sustainable
- Incremental change will not deliver the scale of improvement required
- A more fundamental shift in how care is organised and delivered is necessary

2.3. There was a clear and consistent articulation from provider organisations that their current models are both clinically and financially unsustainable in their present form. This was recognised collectively as a critical driver for change across the system.

3. The System Model: Four Layers of Care

3.1. The Joint Committee confirmed agreement with the four-layer model of care as the organising framework for the system:

- Primary care
- Neighbourhood care
- Intermediate care at scale
- Acute care

3.2. here was strong support for this structure as the right foundation for future delivery. However, the discussion emphasised that the models within these

layers must remain deliberately fluid and adaptive, rather than fixed end-states.

3.3. The Committee recognised that:

- The overall framework is now clear and widely understood
- Clinical models within each layer are at varying stages of development
- Further clinically led work is required to define how care will be delivered in practice

3.4. Importantly, the discussion highlighted that stronger clinical leadership across the health and care economy is now essential to progress this work. The scale of change required cannot be delivered solely through organisational or managerial leadership. It will require:

- Visible and credible clinical leadership at system level
- Greater alignment of clinical leaders across organisations and care settings
- Clinically led design and ownership of future service models

3.5. It was therefore agreed that strengthening clinical leadership capacity and coherence across Kent and Medway is a critical enabler of the next phase, alongside the continued development of detailed clinical models, particularly within acute care.

4. Implications for System Architecture

4.1. The system architecture described in the original paper, with neighbourhoods as the core unit of delivery supported by alliance-based working, was supported by the Joint Committee.

4.2. The discussion reinforced the expectation that:

- Organisations will operate within a clearly defined system framework
- Decision-making will be taken at the appropriate level with shared accountability
- Behaviour will shift from organisational optimisation to system-wide outcomes

4.3. There was a clear acknowledgement that this represents not only a structural change but a significant shift in leadership behaviour across the system.

5. Provider Alliances and Delivery Expectations

5.1. The Joint Committee confirmed the central role of provider alliances in leading delivery and transformation across the system.

5.2. There was a clear and consistent view that acute providers will need to work significantly more closely together, particularly in relation to:

- Clinical service lines
- Workforce utilisation
- Cost management
- Productivity and efficiency

5.3. This shift will require strong and aligned clinical leadership across acute providers, ensuring that decisions on service configuration and delivery are clinically led, evidence-based and collectively owned.

5.4. The Committee agreed that the Neighbourhood Health Alliance must now accelerate its development and delivery role at pace.

5.5. In particular, it will need to move quickly to a position where it is:

- Clinically led, with clear models of care
- Operationally effective at scale
- Financially accountable for delivery

5.6. This again reinforces the requirement for consistent clinical leadership within and across neighbourhoods, bringing together primary, community and specialist expertise.

6. Strategic Commissioning and Commissioning Intentions

6.1. The Joint Committee reaffirmed support for the transition to strategic commissioning, with commissioning intentions as the primary mechanism for translating strategy into delivery.

6.2. The discussion also clarified more explicitly how the ICB's role will evolve in practice.

6.3. There was a clear expectation that the commissioning function will be increasingly focused on securing the best possible value from contracts and ensuring that every pound spent delivers demonstrable benefit for population outcomes. This represents a shift towards a more rigorous and outcomes-focused approach to commissioning, with greater scrutiny of value, productivity and impact.

6.4. It was recognised within the discussion that this approach may create individual organisational pressures for providers, particularly where existing contracts, cost bases or service configurations are not aligned to the emerging model.

6.5. However, there was a clear and shared view that these challenges must not be addressed in isolation. Instead, they will need to be worked through collectively across the system, with the provider alliances acting as the primary mechanism for resolving these issues.

6.6. This reinforces the expectation that:

- Financial and contractual challenges will be overtly addressed at a provider and system level
- Providers will work together through alliance arrangements to redesign services and manage consequences
- Commissioning and provider collaboration will be essential to ensure a coherent transition to the new model

6.7. The Committee also emphasised that this transition must be managed in a way that maintains delivery grip during 2026/27.

7. Financial Context and System Imperative

7.1. A central theme of the discussion was the scale of the system's financial challenge.

7.2. The Joint Committee agreed that the system financial position is now paramount in shaping decisions and priorities. This reinforces the need for:

- Rapid progress on productivity and efficiency
- Alignment between financial plans and clinical models
- Collective ownership of financial sustainability across organisations

7.3. The clinical and quality outcomes and financial context was recognised as a major driver of urgency in implementing the new model.

8. Governance and System Leadership

8.1. The Joint Committee confirmed agreement with the proposed governance arrangements, including the role of the Joint Committee as the primary forum for system-level decision making and accountability. There was explicit agreement that:

- A formal report will be produced following each Joint Committee meeting
- This report will be shared with all partner Boards in public
- This will provide a single, consistent narrative of system decisions and progress

8.2. This paper constitutes part of that agreed reporting approach.

9. Organisational Development and Leadership

9.1. The discussion reinforced that delivery of the model will require a step change in leadership capability, relationships and behaviours across the system.

9.2. The Joint Committee supported the proposed organisational development approach, recognising that:

- Building trust and collective leadership is essential to success
- Leadership behaviour must align with system expectations
- Clinical leadership must be strengthened alongside managerial leadership, with a clearer and more consistent voice for clinicians in system decision-making and service design
- This programme is a core enabler of transformation rather than a supporting activity

10. Key Risks and Focus for the Next Phase

10.1. The risks outlined in the original paper were endorsed, with particular emphasis on:

- The pace of clinical model development
- Clarity of accountability for delivery
- The ability of organisations to operate collectively

10.2. The Joint Committee was clear that progress over the next six months will depend on maintaining clarity of direction, strengthening system leadership and ensuring that delivery is not compromised during the transition.

11. Conclusion

11.1. The Joint Committee discussion confirmed that Kent and Medway has reached a clear point of alignment on its future model. There is now:

- Agreement on the overall structure and direction of travel
- A shared recognition that the current model is unsustainable
- Clear expectations for greater collaboration, particularly within acute services
- A requirement to accelerate neighbourhood delivery
- A clear need to strengthen clinical leadership across the system
- A collective understanding that financial sustainability is central to all decisions

11.2. The focus now moves from agreement to delivery, with pace, discipline and collective leadership critical to success.

12. Recommendation

12.1. The ICB Board and partner provider Boards are asked to:

- Note the outcome of the Joint Committee discussion
- Confirm their continued support for the agreed direction of travel
- Consider the implications for their organisations, particularly in relation to collaboration, clinical model development, leadership capacity and financial sustainability

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	30th July 2026
Title of paper:	Governance Improvement Programme
Author:	Tony Saroy, Trust Secretary Julie Kirby, Chief Nurse
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Approval
Submission to Board:	Board requested

Overview of paper

A paper setting out the Trust's response to external reviews of its governance

Issues to bring to the Board's attention

The Board is asked to consider and approve a revised committee-level governance architecture as part of the Trust's response to the recent external governance reviews.

Key proposed changes are the creation of a new Partnership Committee, the standing down of the Mental Health Act Committee with its business moving to the Quality Committee quarterly.

The Board should particularly confirm whether quarterly Mental Health Act oversight within Quality Committee provides sufficient scrutiny, given the previous CQC finding. The Board is also asked to note progress on strengthening the Board Assurance Framework, including the establishment of a weekly BAF Revival Group, draft revised risk articulations, and a planned Board Development session on BAF and risk appetite.

Subject to Board approval, the revised committee chairing arrangements will take effect from 1 September 2026 unless otherwise stated.

Governance

Implications/Impact:	Legal and Regulatory impact
Assurance:	Reasonable assurance
Oversight:	Trust Board

Version 2 - **Public**

Background

This paper focuses on the two areas of the Governance Improvement Programme (GIP) that require the Board's attention at this meeting: the Trust's committee-level governance architecture, and the Board Assurance Framework (BAF). The GIP remains the Trust's response to the March 2026 CQC Well-Led inspection and the preceding independent governance review. The programme is monitored weekly by a GIP working group comprising the Chief Executive, the Acting Chief Nurse, the Trust Secretary and external support. The Board will receive its first full progress report in September 2026.

1. Governance architecture

Three changes to the Trust's committee-level governance architecture are proposed: the creation of a new Partnership Committee, the standing down of the Mental Health Act Committee (MHAC) and absorption of that Committee's work into the Quality Committee.

These are in addition to the establishment of a time-limited CYPMH & AAED Services Committee to support the safe transition of services into KMMH, which has already had its first meeting.

The table below sets out the Board-level committee structure as it stood at the February 2026 baseline and as now proposed. The wider structure of Trust-wide groups and sub-groups that sits beneath these committees will be reviewed next.

Board-level committee	Current	Future	Chair	Nature of change
Trust Board	✓	✓	Colin Lynch	Unchanged
Audit and Risk Committee (ARC)	✓	✓	Kevin Corrigan	Unchanged
Quality Committee (QC)	✓	✓	Margaret Dalziel	Assumes Mental Health Act business on a quarterly basis (see below)
Finance, Business and Investment Committee (FBI)	✓	✓	Julius Christmas (From 1 Sept 26)	Unchanged
People Committee (PC)	✓	✓	Pam Creaven (From 1 Sept 26)	Unchanged
Remuneration and Terms of Service Committee (Rem Com)	✓	✓	Kim Lowe	Unchanged
Charitable Funds Committee (CFC)	✓	✓	Susan Baker (From 1 Sept 26)	Unchanged
Mental Health Act Committee (MHAC)	✓	—	N/A	Stood down. Business moves to the Quality Committee, quarterly
Partnership Committee	—	✓	Kim Lowe	New. Commissioner/provider separation; shadow form from October 2026
CYPMH & AAED Services Committee	—	✓	Stephen Waring	New. Time-limited, up to 12 months, post-transfer assurance

"Current" = February 2026 baseline; "Future" = proposed structure. Shaded rows indicate committees affected by the proposed changes: rows shaded blue are existing committees undergoing change; rows shaded green are new committees.
"CYPMH & AAED" = Children and Young People's Mental Health and All-Age Eating Disorders.

Headlines and rationale

Performance Oversight

As part of the Governance Improvement Programme, consideration has been given to the most effective committee structure for performance assurance.

One option is for performance reporting to be reviewed through the Finance, Business and Investment Committee, creating a single committee-level forum that considers organisational performance alongside operational delivery, finance and strategic priorities. This approach would provide an integrated view of organisational performance and reduce duplication of reporting across committees.

The IQPR will continue to be received by all relevant Board committees, with each committee expected to focus on and provide assurance on the areas that fall within its remit. Trust Board will retain oversight of the full IQPR and the overall performance of the organisation.

The Board is invited to consider the advantages of this approach and agree the preferred model for committee-level performance scrutiny.

A new Partnership Committee

The Trust holds a lead-provider role as part of the Community Mental Health Framework implementation, and it is imperative that there is a governance forum to provide oversight independently of the Trust's provider responsibilities.

The new committee separates the Trust's role as *commissioner* from its role as *provider*. As commissioner, the Trust can then hold all providers to account, including itself, and the Board gains assurance on how well the Trust works as a partner. Communications and Engagement will also fall within the committee's responsibilities.

The Committee will start to operate from October 2026 in shadow form for three to six months. A joint committee-in-common with KCHFT was expected in 2027/28 and it has been decided that this will not be taken forward now.

Standing down the Mental Health Act Committee

The Mental Health Act Committee is proposed to close, with its business moving to the Quality Committee on a quarterly basis. Mental Health Act compliance, including record-keeping, was a CQC finding from several years ago, so the Board should confirm that quarterly oversight within the Quality Committee provides sufficient scrutiny before the change takes effect.

The CYPMH & AAED Services Committee

A time-limited committee has been established to give the Board assurance on the transitional risks arising from the transfer of Children and Young People's Mental Health (CYPMH) and All-Age Eating Disorder (AAED) services from NELFT to KMMH on 1 April 2026. These risks cover quality, safety, performance, workforce stability, and financial and operational resilience.

The committee holds no executive powers and is constituted for up to 12 months, ideally to be stood down at the end of March 2027, if not before. Membership comprises two Non-Executive Directors, one of whom chairs, together with the relevant executives and service leads. It meets monthly and its Chair reports to the Board after each meeting. This gives the Board direct oversight of the transfer while the risk is highest, after which oversight returns to the Trust's normal governance arrangements.

Next steps

Giving effect to the proposed changes requires two immediate pieces of governance work:

- **Amending and creating Terms of Reference:** new Terms of Reference for the Partnership Committee and the CYPMH & AAED Services Committee, amended Terms of Reference for the Quality Committee to take on Mental Health Act business, amended Terms of Reference for the Finance, Business and Investment Committee to take on performance reporting, amended Terms of Reference for the Board to encompass these changes, and the formal standing down of the Mental Health Act Committee's Terms of Reference.
- **Amending the Scheme of delegation:** to reflect the revised committee structure and the reporting lines of the new and closing committees.

2. Board Assurance Framework (BAF)

The BAF is Theme 6 of the programme, led by the Acting Chief Nurse. Both the CQC and preceding independents reviews found the BAF and Corporate Risk Register underdeveloped, with some significant risks not on the register, and that risk mitigations lacked detail and did not show clear ownership. Theme 6 responds with a new BAF format, refreshed strategic risk articulations, and alignment of the Corporate Risk Register.

Current position: a new format and refreshed risk articulations are in draft but not yet agreed or in use, and the current BAF still reflects the previous strategy. Committee Chairs have been briefed on the proposed format of the revised BAF, with a second progress meeting scheduled for later this month. A Board Development workshop on 6 August will focus on the BAF and risk appetite.

A separate commissioning risk view is under consideration, which would be addressed either via the partnership strategic risk or through a separate Commissioning BAF.

Weekly BAF Revival Group

A weekly BAF Revival Group has been established to take this work forward, comprising the Acting Chief Nurse (CNO), the Chief Finance Officer (CFO), the Risk Manager and external support. It oversees redesign of the BAF, refresh of the strategic risk articulations and alignment of the Corporate Risk Register, before the revised format is brought to the Board. This group is separate from the weekly GIP working group, which oversees the programme as a whole, and reports alongside it.

Recommendations

The Board is asked to:

1. **UNDERSTAND** that this paper concerns changes to the Trust's governance architecture and the Board Assurance Framework, and that the first full progress report will follow in September 2026.
2. **AGREE** the purpose and remit of the proposed Partnership Committee.
3. **AGREE** the standing down of the Mental Health Act Committee, with its business moving to the Quality Committee on a quarterly basis.
4. **CONFIRM** that quarterly oversight of Mental Health Act compliance within the Quality Committee provides sufficient scrutiny, given the related CQC finding.
5. **NOTE FOR ASSURANCE** the establishment of the time-limited CYPMH & AAED Services Committee, which provides post-transfer oversight for up to 12 months.
6. **APPROVE** the revised governance architecture at Board Committee level, as shown in the appended organogram.
7. **APPROVE** the next steps set out above: amending and creating Terms of Reference and amending the scheme of delegation.
8. **NOTE FOR ASSURANCE** the establishment of the weekly BAF Revival Group, and the focus of the6 August Board Development workshop on the BAF and risk appetite.
9. **ENDORSE** the resequencing of the programme so that the committee structure is settled first, with revised dates brought back to the Board for the deadlines at risk.
10. **CONFIRM** the expectation of quarterly progress reporting.

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Appendix: Board committee structure

A. February 2026 baseline

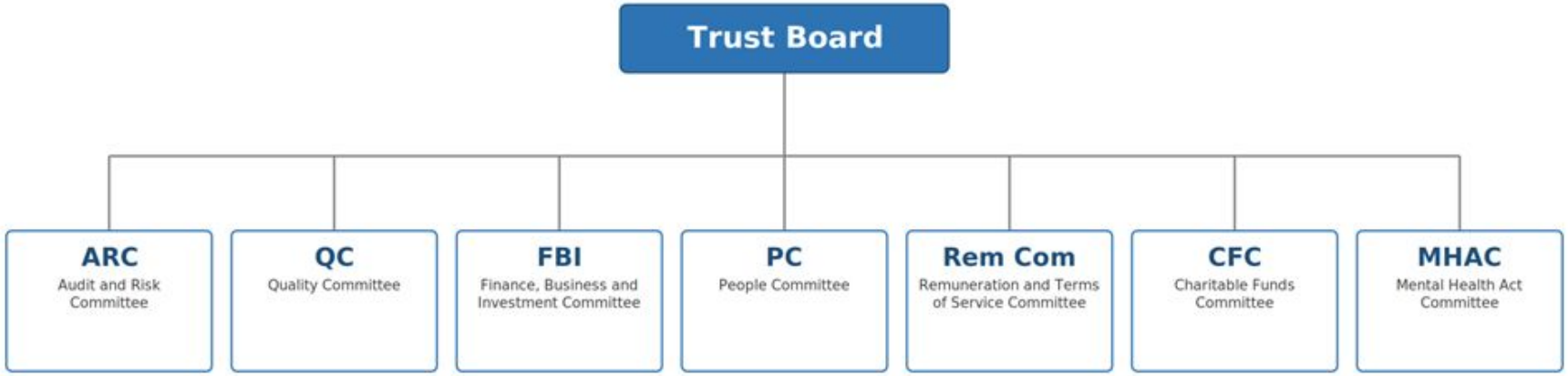


Figure A — The Board-level committee structure as it stood at the February 2026 baseline. All committees report directly to the Trust Board.

B. Proposed structure

Version 2 - **Public**

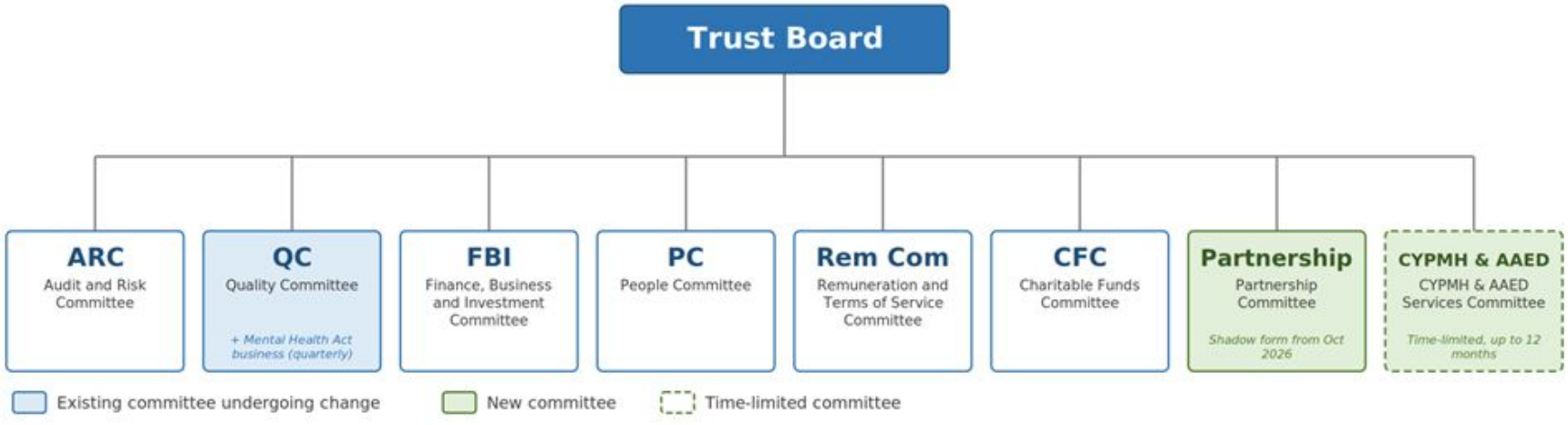


Figure B — The proposed Board-level committee structure. Colour coding follows the table in Section 1: committees shaded blue are existing committees undergoing change; those shaded green are new. The Mental Health Act Committee (MHAC) is stood down and therefore does not appear here; its business moves to the Quality Committee on a quarterly basis. The CYPMH & AAED Services Committee is time-limited (up to 12 months, to be stood down by the end of March 2027).