AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 25th September 2025
Time 09.30 to 11.45
Venue Meeting Rooms 2 and 3, Farm Villa

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/25-26/62	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.00
TB/25-26/63	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/25-26/64	3.	Personal Experience – Standing Tall	FN	Verbal	DHS	09.05
TB/25-26/65	4.	Continuous Improvement Story - Minimal Risk Activity Packs (MRAP)	FN	Verbal	KMM	09.15
STANDING ITEMS						
TB/25-26/66	5.	Minutes of the previous meeting	FA	Paper	Chair	09.25
TB/25-26/67	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/25-26/68	7.	Chair's Report ▪ Board effectiveness review report	FN	Paper	JC	09.30
TB/25-26/69	8.	Chief Executive's Report	FN	Paper	SS	09.35
TB/25-26/70	9.	Board Assurance Framework	FA	Paper	AC	09.40
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/25-26/71	10.	Strategy Delivery Plan Priorities – Mid-Year Review	FD	Paper	SS	09.50
TB/25-26/72	11.	MHLDA Provider Collaborative Progress Report	FN	Paper	AR	10.00
TB/25-26/73	12.	Risk Management Framework	FN	Paper	AC	10.10
TB/25-26/74	13.	Getting the Basic Right paper	FD	Paper	DHS	10.15
OPERATIONAL ASSURANCE						
TB/25-26/75	14.	Integrated Quality and Performance Review	FD	Paper	SS	10.20
TB/25-26/76	15.	Communality Mental Health Framework programme	FD	Paper	DHS	10.30
TB/25-26/77	16.	Finance Report	FD	Paper	NB	10.40
TB/25-26/78	17.	Winter Plan 2025/26	FA	Paper	DHS	10.50
TB/25-26/79	18.	Medical Revalidation	FA	Paper	AQ	11.00
TB/25-26/80	19.	Business Continuity and Emergency Planning Report	FN	Paper	AC	11.10
TB/25-26/81	20.	Social Value and Net Zero Annual Report	FN	Paper	NB	11.15
TB/25-26/82	21.	Revised Standing Orders and Standing Financial Instructions	FA	Paper	TS	11.20
CONSENT ITEMS						
TB/25-26/83	22.	Register of interests	FN	Paper	SS	
TB/25-26/84	23.	Report from Quality Committee	FN	Paper	SW	
TB/25-26/85	24.	Report from People Committee	FN	Paper	KL	
TB/25-26/86	25.	Report from Audit and Risk Committee (Terms or Reference for approval)	FA	Paper	PC	
TB/25-26/87	26.	Report from Finance and Performance Committee	FN	Paper	MW	

TB/25-26/88	27.	Use of Trust Seal	FN	Paper	TS	
CLOSING ITEMS						
TB/25-26/89	28.	Any Other Business			Chair	11.35
TB/25-26/90	29.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 27th November 2025					

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

Members:		
Dr Jackie Craissati	JC	Trust Chair
Peter Conway	PC	Non-Executive Director (Deputy Chair)
Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Julius Christmas	JCh	Non-Executive Director
Sean Bone-Knell	SBK	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Non-Executive Director
Julie Hammond	JH	Associate Non-Executive Director
Pam Craven	PCr	Associate Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Kindra Hyttner	KH	Director of Communications and Engagement
Tony Saroy	TS	Trust Secretary
Daryl Judges	DJ	Deputy Trust Secretary
Jane Hannon	JHa	Programme Director
Kate Merlini-Moorcroft	KMM	Occupational Therapist Assistant -Continuous Improvement Story
Dan	Dan	Personal Story
Apologies:		

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.00 to 11.30 on Thursday 31st July 2025
Microsoft Teams Meeting

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Julius Christmas	JCh	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Sean Bone-Knell	SBK	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Pam Creaven	PCr	Associate Non-Executive Director
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Tony Saroy	TS	Trust Secretary
	Jane Hannon	JHa	Programme Director
	Daryl Judges	DJ	Deputy Trust Secretary
	Dr Tonye Ajiteru	TA	Consultant Psychiatrist (Continuous Improvement Story)
	Ben Francis	BF	
	Dr Olubunmi Olure	OO	Speciality Training (Continuous Improvement Story)
	Christine Hemmings	CH	Interim Director of Quality and Safety (Personal Experience)
	Julie	Julie	Personal Experience
	The Board was joined by members of the public and members of staff.		
Apologies:			

Item	Subject	Action
TB/25-26/37	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/25-26/38	**Declarations of Interest** No interests were declared.	

Item	Subject	Action
TB/25-26/39	**Personal Experience – Julie's Story** The Board watched a short video sharing a moving account of Julie's experience as a carer to her son and the tragic consequences of inadequate communication and care coordination. Her story highlighted systemic failures in supporting families and in responding to deteriorating mental health. The Board expressed deep appreciation for her candour and acknowledged the need to embed her feedback into ongoing service improvement. **ACTION: By November 2025, AC to provide an update to the Quality Committee on the improving family engagement as part of care and the progress which had been made.** The Board **noted** the Personal Experience – Julie's Story	
TB/25-26/40	**Continuous Improvement Story - Improving Timely Blood Test Collections** The Board received a presentation on a quality improvement project from Ruby Ward, aimed at increasing the completion rate of comprehensive blood tests on admission. A simple visual prompt system, using colour-coded posters, raised compliance from 50% to 96%. The Board praised the team's practical approach and endorsed wider rollout through training of resident doctors and multi-disciplinary teams The Board **noted** the Continuous Improvement Story - Improving Timely Blood Test Collections.	
TB/25-26/41	**Minutes of the previous meeting** The Board **approved** the minutes of the meetings held on the 29th May 2025 and the 12th June 2025. The Board query the next steps to resolve the feedback received in terms of getting the basics right and assurance was provided that a report on getting the basics was scheduled for consideration at the September 2025 Board meeting.	
TB/25-26/42	**Action Log & Matters Arising** The Board **approved** the action log, noting that all actions were completed or in progress, subject to the following. TB/25-26/8 – Chief Executive's Report – Provide a verbal update on the co-produced integrated clinical working plan that clearly incorporates the views of the clinical directors and the senior Nursing team: Engagement had commenced with clinical staff, which included North East London NHS Foundation Trust staff, with further engagement events planned to ensure a co-produced clinical working plan. The intention was to launch the clinical working plan in line with the Trust's new strategy.	
TB/25-26/43	**Chair's Report** The Board received the Chair's Report and the following items were highlighted:	

Item	Subject	Action
	• Hearing loss had been identified as a key determinant of dementia; this raised the possibility of an effective population health initiative. • The Medway Crisis House had been conducted by SW, rather than PC as listed in the report. The Board **noted** the Chair's Report.	
TB/25-26/44	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • The three key focuses of NHS 10-year plan; • Thanks to the Pears Foundation for their support in the development of the Medway Crisis House; and • Child and Adolescent Mental Health Services and the All Age Eating Disorders service will transition to the Trust in April 2026. The Board **noted** the Chief Executive's Report.	
TB/25-26/45	**Board Assurance Framework (BAF)** The Board received the BAF, noting the inclusion of new risks associated with CQC Regulatory Compliance, Cyber Attack and Industrial Action. The Board acknowledged the continued improvement in the BAF, and the further planned developments as the Trust's risk appetite was formalised. The Board sought assurance regarding the proposed closure of risk ID "04083 – Management of Environmental Ligatures" and was it was confirmed that the risk was well controlled and would continued to be monitored via the Quality Risk Register at the Quality Committee, with re-escalation to the BAF as required. A brief discussion was held as to whether the BAF accurately captured the high-level risks which had been identified by the Board and it was confirmed this was the case. High-level feedback on service disruption and the management of the resident doctors' industrial action was reported, with risk ID "04682 - Organisational Risk - Industrial Action" to continue to feature until the likelihood of further industrial action reduced. The Board **approved** the Board Assurance Framework.	
TB/25-26/46	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report** The Board received the MHLDA Provider Collaborative Progress report, and was informed of the further developments since the submission of the report, which included the refresh of the strategic approach to Dementia and the Community Mental Health Framework (CMHF). Discussions focused on the unwarranted variation in safe haven performance, with the need to achieve a similar performance at the William Harvey Hospital safe haven as had been achieved at Medway Hospital.	

Item	Subject	Action
	ACTION: By September 2025, JHa to ensure future MHDLA Provider Collaborative Progress Report highlighted progress against each of the programmes (e.g. via a RAG rating, or timeline illustrating intend progress and current position). The Board emphasised the importance of replicating the lessons learned and improvement from our services with higher memory assessment (MAS) to all our other MAS. There was also recognition of the vital contribution that our Voluntary Community and Social Enterprise (VCSE) partners play within the safe haven and dementia workstreams. The Board also queried whether we should have clinical directors for large scale transformation programmes. The Board **noted** the Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report.	
TB/25-26/47	**Trust's Digital Plan Refresh** The Board received the Trust's Digital Plan Refresh, noting that the two key areas of within the plan were the 'Business as usual' enablers; and the SolveIT approach, which was designed to identify how innovative technologies could be effectively deployed and utilised within the Trust. **ACTION: By September 2025, NB to circulate the key milestones for the Trust's refreshed Digital Plan.** The Board provided the following reflections on the Trust's Digital Plan refresh: ▪ Digital developments needed to be co-designed, and deliver reductions in workloads for clinicians; ▪ Prioritisation is essential for effective delivery of the key initiatives and to optimise return on investment; and ▪ The importance of quantifying the people impact of the digital developments, in terms of staffing numbers, financial savings, or productivity increases. Questions were raised as to how staff would be supported to build their digital confidence and assurance was given that the digital skills framework helped in this regard. The Board asked whether there was active involvement and engagement with the Information Governance Team as part of digital innovation, and assurance was provided that this took place at an early stage of any digital initiative. The Board expressed support for the SolveIT approach; although, suggested that further partnership working was required to deliver joint digital solutions. The Board **noted** the Trust's Digital Plan Refresh.	
TB/25-26/48	**Co-creation strategic plan and framework** The Board received the Co-creation strategic plan and framework which outlined a fundamental shift in how individuals will be involvement in service improvement at the Trust, with co-creation to become a part of standard practice across the Trust.	

Item	Subject	Action
	The Board commended the development of the co-creation strategic plan and framework and emphasised the importance of ensuring appropriate demographic representation. A brief discussion was held in terms of the need for SMART objectives, to measure the success of the programme of work, although currently there was a lack of benchmarking or baseline data. It was noted that oversight of the delivery of the co-creation strategic plan and framework resided with the Quality Committee. The Board **approved** the Co-creation strategic plan and framework.	
TB/25-26/49	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR), and was informed of the key areas of success within the reporting period, which included a reduction in the use of out of area beds and a reduction in the Mental Health Together patient waiting list by circa 1000 patients. **ACTION: By September 2025, AQ to circulate an update on the progress against each of the actions within the eight-week patient flow plan.** Discussions focused on the following areas: ▪ The challenges associated with out of hospital care funding, and the considerations which were required to support patient access, with early social worker involvement being key to support patient pathways; ▪ Timely discharge of patients was key to maintaining patient flow, with care packages to be identified as early as possible. Assurance was provided that there was on-going work with social care; ▪ Social Housing was being discussed at a system-wide level, supported by the Housing Associations' Charitable Trust, with a strategy intended to be developed by the end of Quarter 2 of 2025/26. All opportunities within the Trust were being explored, including appointing staff from the housing sector; but, it was important to ensure the correct infrastructure was in place. Clarification was sought as to the process for the triangulation of information, such as the impact of call abandonment on the rate of complaints and patient harm. It was agreed that further consideration should be afforded, by the Quality Committee, as to a process for the effective triangulation of data. **ACTION: By September 2025, DJ to refer to the Quality Committee consideration of how the Trust Board, and associate sub-Committees, can ensure effective triangulation of information.** The Board was informed of the discussions which had been held with Central and North West London NHS Foundation Trust, and noted the use of a Mental Health Assessment Centre and partnership working with the voluntary sector. The Board **noted** the IQPR.	

Item	Subject	Action
TB/25-26/50	**Memory Assessment Service System Delivery Plan** The Board received the Memory Assessment Service System Delivery Plan and noted the following: • There had been an improvement across all six standalone services in the first 12-months, with average waiting time reduced to 16.5 weeks, but there remained unwarranted variation across services; and • Phase 3 involved interdependencies with partner organisations to develop a three-level community clinical model to provide additional capacity. The Board emphasised the importance of the people impact of each delayed appointment, both in terms of the patients and their families. The progress to-date was commended but the best practice~~d~~ demonstrated in North Kent needed to be replicated county-wide. Clarification was sought regarding the 18% cancellation rate, with work on-going with primary care providers to improve the understanding of patients of the referral process and rationale for referral. Discussions focused on workforce supply and demand modelling; the need to embrace digital innovations, and the progress towards a neighbourhood teams operating model. **ACTION: By September 2025, AR to explore the demographics of appointment cancellations, to determine whether there were underlying health inequalities.** The Board **noted** the Memory Assessment Service System Delivery Plan.	
TB/25-26/51	**Finance Report for Month 3** The Board received the Finance Report and noted the following: • The inclusion of Key Performance Indicators (KPIs); and • Three primary challenges related to the use of external beds, year-to-date agency expenditure, and Inpatient Nursing. The Board reflected on the continued use of 2:1 observations despite the implementation of zonal observations and acknowledged further cultural work was required to increase clinical confidence of staff to operate in a different way. It was noted that increased observations were more likely to be used with complex patients with comorbidities. The Board was informed of the recent consultant psychiatrist interviews, noting that four consultants had been appointed with a range of high-quality applications applying to the Trust; although, there remained recruitment challenges in East Kent, so a virtual consultant initiative was scheduled to be piloted. Concerns were raised regarding those cost improvement schemes, including the system stretch, which currently had £0 identified to-date and assurance was sought regarding the delivery of the financial plan for 2025/26. There was on-going work in relation to rota management and additional assurance regarding delivery of the 2025/26 financial plan would be included in the September 2025 Finance Report.	

Item	Subject	Action
	The Board **noted** the Finance Report.	
TB/25-26/52	**Freedom to Speak Up Annual Report 2024/25** The Board received the Freedom to Speak Up Annual Report 2024/25 and thanked the Freedom To Speak Up Guardian. The Board was informed that the Trust's leadership programme was underway, with the programme expected to reduce the number of concerns across the Trust. Discussions focused on the following points: ▪ The need for a strategic approach to follow-up and feedback to become 'business as usual' to ensure those who raised concerns felt their voices had been heard, with a focus on early resolution; and ▪ Bullying and harassment had increased compared to previous years. assurance was provided that the Trust had a zero-tolerance approach. The Board was provided assurance that the appraisal process, and associated 360-feedback process, supported the monitoring of adherence to the Trust's values and behaviours and that management and leadership development training highlighting "what you walk past, you condone" to increase awareness of individual accountability. The Board **noted** the Freedom to Speak Up Annual Report 2024/25.	
TB/25-26/53	**Trust Green Plan Refresh** The Board received and **approved** the Trust Green Plan Refresh.	
TB/25-26/54	**Committee Terms of Reference** The Board received and **approved** the Committee Terms of Reference.	
TB/25-26/55	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/25-26/56	**Report from People Committee** The Board received and **noted** the People Committee Chair's report. The Board was informed of the concerns related to recruiting to a Female Psychiatric Intensive Care Unit (FPICU) and the options which should be considered in the event of significant vacancies. A discussion was held around the need for a full female pathway to ensure that posts were attractive and that patient flow was maintained. **ACTION: By September 2025, TS to discuss with JC and SS the scheduling of a report on the development and management of a female pathway, which included the specific FPICU risks.**	

Item	Subject	Action
TB/25-26/57	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/25-26/58	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/25-26/59	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/25-26/60	**Any Other Business** None.	
TB/25-26/61	**Questions from Public** Questions were invited from members of the Public, none were received.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 25th September 2025, meeting rooms 2 and 3, Farm Villa.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18.09.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2025								
27.03.2025	TB/24-25/137	Action Log & Matters Arising	Submit a report to the Quality Committee on the Trust's future clinical staffing model	DHS, AC and AQ	July 2025	November 2025	This will now come in November once consultations for various services have concluded.	**In Progress**
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework	NB	July 2025		The risks will be updated following the agreement of the Trust's Digital Plan.	**In progress**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Provide additional detail, as part of the IQPR, in regard to progress in address unwarranted variation between the six Memory Assessment Services	AR	September 2025		Closed- dementia variation has been added to IQPR narrative	**In progress**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Produce a separate report on the Mental Health Together (MHT) programme	DHS	September 2025		On the agenda. To be closed.	**In progress**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Schedule a Board Seminar on a one-year review of the Purposeful Admission Programme	TS	July 2025	Sept 2025	This has been added to the Board Seminar and Development Planner, for consideration with the Chair and Chief Executive.	**In progress**
29.05.2025	TB/25-26/15	Continuous Improvement Impact Report	Schedule a Board Seminar on the Continuous improvement programme in terms of its underlying activity and proposed outcomes.	TS	July 2025	Sept 2025	This has been added to the Board Seminar and Development Planner, for consideration with the Chair and Chief Executive.	**In progress**
31.07.2025	TB/25-26/46	Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report	Ensure future MHDLA Provider Collaborative Progress Report highlighted progress against each of the programmes (e.g. via a RAG rating, or timeline illustrating intend progress and current position)	JHa	September 2025		Closed – this is covered in the agenda	**In progress**
31.07.2025	TB/25-26/47	Trust's Digital Plan Refresh	Circulate the key milestones for the Trust's refreshed Digital Plan	NB	September 2025		Closed – information in the Diligent Reading Room	**In progress**
31.07.2025	TB/25-26/49	Integrated Quality and Performance Review	Circulate an update on the progress against each of the actions within the eight-week patient flow plan	AQ	September 2025		An update was circulated to all Board members on the 22nd August 2025. To be closed.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18.09.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
31.07.2025	TB/25-26/49	Integrated Quality and Performance Review	Refer to the Quality Committee consideration of how the Trust Board, and associate sub-Committees, can ensure effective triangulation of information	DJ	September 2025		The matter was duly referred to the September 2025 Quality Committee meeting for further consideration. To be closed.	**In progress**
31.07.2025	TB/25-26/50	Memory Assessment Service System Delivery Plan	Explore the demographics of appointment cancellations, to determine whether there were underlying health inequalities	AR	September 2025	January 2026	Appointment cancellations and underlying health inequalities is being addressed within the dementia programme board, would expect further analysis and any associated actions by end of Q3.	**In progress**
31.07.2025	TB/25-26/56	Report from People Committee	Discuss with JC and SS the scheduling of a report on the development and management of a female pathway, which included the specific FPICU risks	TS	September 2025		A verbal update will be given at the meeting.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
31.07.2025	TB/25-26/39	Personal Experience – Julie's Story	provide an update to the Quality Committee on the improving family engagement as part of care and the progress which had been made	AC	November 2025			**Not Due**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
30.05.2024	TB/24-25/16	Patient Survey Results	KH to bring an updated Patient and Participation Strategy to the Trust Board in November.	KH	November 2024	March 2025	On the agenda. To be closed.	**Closed**
27.03.2025	TB/24-25/145	Integrated Quality and Performance Review	Produce a standalone Memory Assessment Service Paper setting out the performance data across the Trust's Community Mental Health Teams, with unwarranted variation identified	AR	July 2025		On the agenda. To be closed.	**Closed**
29.05.2025	TB/25-26/7	Chair's Report	Provide an update to the People Committee on the revised operating model for the use of peer-support at the Trust	DHS	July 2025		A verbal update was provided at the July 2025 People Committee. To be closed.	**Closed**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18.09.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29.05.2025	TB/25-26/8	Chief Executive's Report	Provide a verbal update on the co-produced integrated clinical working plan that clearly incorporates the views of the clinical directors and the senior Nursing team	AQ	July 2025		This will be incorporated into the future clinical staffing model report to the Quality Committee in November 2025, once the consultations for various services have concluded. To be closed.	**Closed**
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Submit a review of the Trust's Digital Plan for consideration, which also include the potential use of AI Chatbots to support the patient experience	NB	July 2025		On the agenda. To be closed.	**Closed**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Circulate, via e-mail, clarification regarding the roles and responsibilities of social workers employed by the Trust and how this differed to social workers employed by local authorities	AC	July 2025		The requested information was circulated to Board members following the meeting on the 29th May 2025. To be closed.	**Closed**
29.05.2025	TB/25-26/13	Finance Report for Month 1	Provide an update on the impact of the use of external beds on the Trust's ability to achieve the financial plan for 2025/26 and associated next steps	NB	June 2025		Additional information was included as part of the Month 2 Finance Report to the Finance and Performance Committee in June 2025. To be closed.	**Closed**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th September 2025**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

In my role as Trust Chair, I present this report focusing on key matters of significance.

2. Kent & Medway system and national activity

This has been a relatively quiet period for the system and the national team, whilst providers focus on their operational performance and financial sustainability.

However, it was exciting to participate in the celebration of the first cohort of doctors to graduate from Kent & Medway Medical School, where I attended the inaugural ceremony at Canterbury Cathedral. This is the beginning of a long and fruitful relationship with the medical school which will enhance local services.

3. Board Self-Assessment

Recently the Board undertook a self-assessment of its performance against the Care Quality Commission's Key Line of Enquiries. Appended to my Chair's report is a paper setting out the results of the self-assessment and the proposed action plan. The action plan will need the Board's approval.

4. Trust Chair and NED visits

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

Where	Who
August 2025	
Health & Wellbeing meetings	Kim Lowe
Dover community teams (Coleman House)	Dr Jackie Craissati
Littlebrook Hospital	Julius Christmas
September 2025	
Allington Centre, Dartford	Kim Lowe and Stephen Waring
Long service awards	Jackie Craissati

Chair visits

I spent a morning at Coleman House in Dover, talking at length with the service manager, and then visiting the teams for Mental Health Together (MHT) and memory assessment. It was good to hear first-hand just how challenging it had been for local leaders to regroup and refresh team functioning after our transformation programme last year. I was also able to understand a little more about the context underpinning the freedom to speak up alerts from that team.

I was delighted to be harangued by passionate staff in MHT who were committed to the model but quick to point out the frustrations. I was left with three main thoughts:

- The outstanding practice demonstrated by our VSCE partners
- Uncertainty as to whether our staffing was sustainable in that part of the county, given the pressure of referrals.
- A realisation that we are placing enormous pressure on the wider range of VSCE services in the area, by frequently re-directing patients to a more appropriate service offer. If we had responsibility for the full MH budget, I would be raising questions about shifting funding towards this sector.

My visit to the memory assessment service was really encouraging, as I heard about the improved flow of patients, the 'one stop shop' model, and the high morale shown in the team.

Although not strictly speaking visits, I wanted to mention two very uplifting events. I, along with some of my fellow non-executives, was delighted to attend the long service awards, and to hand our sincere thanks and congratulations to around 100 staff who between them had served the public for more than 3000 years. It was a fun event, and a small gesture to acknowledge the outstanding commitment to caring from our staff.

Kim Lowe's visit to Health & Wellbeing meetings

A busy start to the year with a focus on innovative mental health support help for staff. There are many things happening, with good uptake from staff for these services. Sharing culture across the region is building at pace as NHSE reduces its focus in the area.

I was informed about the NHS Charities 'workforce wellbeing' bid. We have submitted a bid for £43,000 for a project to examine impact on 30 shift working nurses (sleep, food, movement). Sessions will be bought to the workplace around shift work. We currently await the outcome of the bid.

There is a new in-house staff support offer led by Dr Lona Lockerby (clinical psychologist). It is focussed on individuals who have been a victim of assault and/or abuse in the workplace. The aim is to reduce stress and anxiety in the workplace, and reduce sickness absence whilst promoting a culture of supportive practise. This will be a six-month trial.

New training package available to assist managers in making good Occupational Health referrals to save time and get better outcomes. There will be upcoming events for:

- Happiness at Work week 6-10th October.
- World Mental Health Day 10th October

Julius Christmas' visit to Littlebrook Hospital, Dartford

I recently visited Littlebrook Hospital. I was given a tour of the hospital, including spending time on one of the acute wards and meeting several staff who shared their experiences of delivering care in often challenging circumstances.

I was able to visit the section 136 suite and understand capacity challenges and how the team manage these. We also spent time talking about successes, such as the dementia diagnosis rate and its enablers, as well as challenges and opportunities in the digital space; particularly the opportunities to deploy AI to lighten the administrative burden on clinicians.

Stephen Waring and Kim Lowe's Visit to Allington Centre, Dartford

Kim Lowe and I visited the Allington Centre in Dartford. We felt warmly welcomed by staff and we interacted with many of the patients on the ward who responded positively to us and appeared well cared-for. The staff are running several quality improvement projects and making a real effort to find solutions themselves to issues.

The low secure facilities are modern and bright, and generally in a good condition and decorative state. It became apparent, however, that the building's PFI status can adversely impact getting simple repairs, as well as costlier (including health and safety) improvements completed quickly, and the details have been passed on to management.

The two spacious courtyards where patients access outside space would benefit from some 'greening' to match the lovely garden areas outside the building. We were concerned by reports that contract food quality had deteriorated recently. This is crucial to remedy as meals can be a key thing that patients look forward to.

Overall, we were impressed by the care that patients were receiving.

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BOARD SELF-ASSESSMENT RESULTS REPORT 2024/25

1. Introduction

The NHS Well-Led guidance, issued by the healthcare regulator NHS England, recommends that an annual self-assessment exercise is carried out by Boards of Directors of NHS organisations. In line with this guidance, the Trust Board has completed its review and the results are enclosed for Board discussion. The well-led framework is structured around eight key lines of enquiry (KLOEs) and Board members have been asked to undertake a self-assessment around these KLOE.

The NHS Well-Led guidance has been renewed from April 2024 however, updated guidance on developmental reviews and self-assessments has yet to be issued; therefore, all questions have remained the same as previous self-assessments, and future self-assessments will reflect the updated guidance once this has been issued.

2. Administration of the self-assessment

Board members were asked to provide a rating between strongly disagree to strongly agree for each question (1 = strongly disagree, 5 = strongly agree). The results have been analysed by averaging the scores for each KLOE and cross referenced with the NHSE well led rating framework. The results are laid out in the Appendix to this report. Where responses scored 3 or less, respondents were requested to provide some further information; all comments have been noted by the Chair, and where there were two or more lower scores, an action has been developed.

14 Board members responded of which 9 were non-executives and 5 executives.

3. Summary of responses

Overall, the rating and comments received from Board members demonstrated a positive response to the Board's function and performance. Most Board members scored four or five across all the KLOEs, with additional positive comments made regarding the Board's ability to respond to emerging issues and the development of the Trust's strategy. There were no areas of deterioration since 2023/24, and improved scores were particularly marked in terms of KLOE 4 and an additional question about Board administration and governance.

Areas for improvement were identified as follows:

1. KLOE 8 (robust systems and processes for learning, continuous improvement and innovation) remains the well-led area with the lowest score. Concerns were raised regarding our lack of progress in relation to quality improvement, and the need to refresh our approach, including the presentations to board. ***The Chair to discuss with the CEO, with a view to clarifying our strategic work plan in relation to quality improvement.***

2. Two items of relevance to Board subcommittees:
    a. With 'performance' moving from the Finance & Performance Committee to Quality Committee, there is a need to review how well this is embedded and the impact that it has.
    b. There is a need to ensure that matters of concern in subcommittees are flagged with sufficient clarity at Board. The committee chairs need to work with the Chair of the Board to ensure that the necessary time and focus is achieved.

3. The induction programme for new non-executive directors could be strengthened. ***The most recently recruited NEDs will work with the Trust Secretariat to refresh the approach.***

4. Engagement with stakeholders could be further strengthening. Initial work on this has commenced through the Involvement and Engagement Strategic Plan which was approved in July 2025; however, this has not yet been fully embedded to provide the assurance required.

5. Outcomes from last Action Plan

From this year's self-assessment, scores have either remained static or improved across all KLOEs. One action from the previous year was to gain further understanding of the performance of the Trust relative to other healthcare providers when appropriate, particularly through the use of additional benchmarking. The implementation of the NHS Oversight Framework has enabled comparison to other Trust's and the identification of those areas where the Trust benchmarks favourably, or adversely, with specific work undertaken in year to compare the Trust's performance to neighbouring trusts but also outstanding providers. However, it is acknowledged that there remains further room for improvement.

A further action from the previous year was to digital experience at Board level is improved and the diversity of the Board is more representative of the population KMPT serves, as new Board members are recruited. In the last year, a Non-Executive Director with specific digital and transformation expertise was appointed to Board level, and the diversity of the Board has been expanded through additional in-year appointments; however, further work is still required to ensure the Board is representative of the population KMPT serves.

The final action was to provide more focus at Trust Board meetings on the Committee Chair reports, with the Committee Chairs highlighting the concerns of the Committee. This has been supported through the revised format of the Chair reports to the Board, ensuring that areas of concern and escalation can quickly be identified; however, comments have highlighted that further improvements can be made to the time dedicated to the Chair reports, and the level of discussion associated with these.

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6. Proposed Action Plan (with comments)

The Trust Board will focus on the following five key areas in the forthcoming year:

1. To gain strengthen the systems and processes for learning, continuous improvement and innovation, particularly through improved utilisation of the Patient Stories and Continuous Improvement stories. ***Discussions at Board will be tied back to the patient story and continuous improvement story, to ensure that the understanding of the Board is cognisant with the lived experiences of patients and staff.***

2. To provide improve the focus on digital and performance across the senior governance forums of the Trust, with a particular focus on a holistic alignment between performance, quality and safety.

   The revised structure of the Quality Committee and Finance and Performance Committee, which are currently under development, will support an additional focus on digital and enable a holistic overview of performance, quality and safety.

3. To provide more focus at Trust Board meetings on the Committee Chair reports, with the Committee Chairs highlighting the concerns of the Committee.

   The Chair of the Board, in conjunction with the Trust Secretariat will ensure there is sufficient time left for partial assurance / escalation items as part of the Chairs reports.

4. To consider the implementation of a 'buddy' system as part of the induction process for Non-Executive Directors, to support their understanding of their roles, responsibilities and the function of the Trust.

   The Trust Secretariat, in conjunction with the Chair of the Board, will explore the allocation of one, or more, existing Non-Executive Directors to act as a 'buddy' to newly appointed Non-Executive Directors during their onboarding process.

5. To strength our engagement approach to stakeholders.

   This is already in train, with the Involvement and Engagement Strategic Plan approved in July2025; further embedding throughout 2025/26 should provide assurance to the Board.

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APPENDIX

Key Line of Enquiry (KLOE)		**Board's View 23/24 (Average scoring)**	**Board's View 24/25 (Average scoring)**	**Risk Rating**
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	4.1	4.1	
KLOE 2	Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	4.0	4.1	
KLOE 3	Is there a culture of high quality, sustainable care?	4.0	4.0	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.0	4.3	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance?	4.0	4.1	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	4.0	4.0	
KLOE 7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	3.9	4.0	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation?	3.8	3.8	
Additional question	Board operation/administration/governance	3.8	4.2	

Key:

4 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions.
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery.
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver.

Chief Executive's Board Report

Date of Meeting: 25 September 2025

Introduction

I wanted to open my report with saying how very proud I am to share that we have moved to segment one, the highest segment, and are ranked 9th across all the non-acute trusts in England.

This is a fantastic achievement and reflects the compassion, dedication and professionalism that our staff show on a daily basis – thank you to all our staff. The new oversight framework is part of the government's and NHS England's commitment to improve the transparency of trust performances and looks at a wide set of measures, including patient experience, clinical outcomes and financial sustainability.

This recognition presents the trust with a number of opportunities moving forward. These include additional capital spending, the scope to apply for Foundation Trust status and also taking steps to become an Integrated Health Organisation (IHOs). These are all important items for us to consider with our stakeholders as we develop our next trust strategy.

I also wanted to add that this will be my last report as CEO of KMPT and I am delighted that between now and our next Board meeting we will become Kent and Medway Mental Health NHS Trust. This milestone will help us deliver the final year of our current strategy and prepare for our new strategy, launching on the 1 April 2026, with a clearer ambition of the future we and our stakeholders want.

National and Regional Update

Meeting with Sir Jim Mackey, NHS England Chief Executive

Last month, I, along with Mairead McCormick, Chief Executive at Kent Community Health NHS Foundation Trust (KCHFT), met with Sir Jim Mackey, Chief Executive for NHS England, to discuss the opportunities presented in the NHS's new 10-year plan. This was a meeting we had requested as we strongly believe that community providers have a massive role to play in successfully implementing the 10-year plan. With the plan's focus on prevention, working closer with communities and the continued development of integrated neighbourhood teams, our trust and KCHFT are well positioned to be leading on this work together in Kent and Medway. The relationship between physical and mental wellbeing is so intertwined, and working together to make sure patients' needs in both areas are met will make a big difference to their care and recovery. Sir Jim was pleased to hear we are being so proactive and encouraged us to continue working closely together.

NHS Leadership Event – 16th September

Last week I attended the national CEO meeting in London. During the day we had feedback from the work that is happening regarding the ten-year plan and what we will be seeing over the autumn as we continue to shape the NHS for the future. There is definitely a clearer future emerging for the NHS and as I have said at the beginning of my report, I can see the important role that our trust can play locally and nationally. The plans are ambitious and rightly so, to ensure we deliver the patient outcomes our communities deserve.

System Provider Collaboratives

I am delighted to share that I have made the decision with the KCHFT CEO to bring together the Mental Health & Learning, Disability and Autism (MHLDA) provider collaborative and Community and Social Care provider collaborative into the Sustainable Community provider collaborative (PC). As per above it is going to be more important than ever before that we work closer with our community colleagues to share future healthcare and our clinical pathways. We had our launch workshop last month which was very well attended. You will be updated on progress going forward as part of the Board provider collaborative report.

Medway Recovery House Visit

On 28th August, myself and Andy Cruickshank, Chief Nurse made a further visit to the new Crisis House to meet with Sir Trevor Pears, Executive Chair of the Pears Foundation who through their philanthropy work, are helping to improve the lives of people needing support with their mental health.

We've being working closely with the foundation and Hestia to open the new Medway crisis and recovery house. Sir Trevor is a strong supporter of improving access to mental health care, and it was a good opportunity to share and discuss ideas of how we continue to work well together to help our communities. I am confident we will have a strong working relationship moving forward. I am extremely grateful to the generosity of the Pears Foundation for our patients.

House of Lords Committee on Autism Act 2009

We spoke to staff, patients, and members of our Transforming Neurodiversity Support (TNS) programme to provide written evidence to the House of Lords Committee on the 2009 Autism Act, the Government's autism strategy, and the statutory guidance. Our submission covered several areas, including:

- **Persistent delays and barriers** exist in autism diagnosis and access to services, with many needs still unmet despite the Autism Act 2009.
- The evidence advocates for **dedicated autism-specific services**, legally enforceable reasonable adjustments, and improved post-diagnosis support.
- The lack of adequate post-diagnostic care and **sensory-inclusive environments**, especially for adults, highlights the need for comprehensive, lifelong sensory support and accessible housing.
- High unemployment rates among autistic people result from biased recruitment practices, insufficient support, and environments that are not easily accessible. Proposed solutions include developing **autism-specific employment pathways**, modifying environments, and providing self-employment support.
- The submission emphasises the need for specialised, properly funded **support designed by and for autistic people**, supported by robust independent evaluation and enforcement.

Our Learning Disability and Autism Lead, George Matuska (RNLD), was also invited to meet with the committee alongside selected NHS and local authorities to discuss how effectively autistic people are involved in making decisions about NHS and local authority services and how this could be improved in the future. A record of the discussion can be found on the committee's webpages. I'd like to thank George for representing the views of our staff, patients and communities in this important forum.

Trust Update

New Trust Identity and Name to launch 13 October 2025

On 13th October, Kent and Medway NHS and Social Care Partnership Trust will become Kent and Medway Mental Health NHS Trust and launch its new co-created identity. We received approval from the Department of Health and Social Care in August. Our new identity is more than a name change – it reflects our commitment to making mental health care easier to find, trust and experience. It incorporates our new mission, vision, purpose and values, shaped by feedback and involvement from patients, staff and partners. I wanted to summarise our new identity here for clarity and show visually how it will look:

Mission (what we are here to do): We are an active, united mental health service for communities across Kent and Medway.
Vision (what we want to achieve): Creating communities where mental health care helps people not just live with mental illness, but live well.
Purpose (why we do this work): We believe communities live well when better mental health care is a part of everyday life - so we are here to: Make mental health care better, together with our communities
Values: We are caring, curious, inclusive and confident

Long Service Awards

On 11th September, the Board were joined by 161 colleagues who have each given between 20 to 35 years' service to the NHS. For the first time, we also hosted a table for our team of the year, Dartford Gravesham and Swanley Home Treatment Team, and employee of the year, Rebecca Bourne from our Rosebud Rehab unit, who were chosen from all of our Values in Practice award winners over the last year. It was a wonderful event and a fantastic way to celebrate the dedication of our staff and all the roles they have played in delivering care to our patients. Well done to everyone again. We are super proud and grateful for the dedication and care you have shown the NHS and our trust. I would also like to personally thank Juliette Bryant, one of our valued executive assistants, who single-handily organised the day with the support of the wider communications and marketing team.

Children's Young People and All Aged Eating Disorder services

I'm delighted that the public announcement of our role in taking over these services from NELFT has now been made, and we are actively planning for the transition together. The executive team has started visiting all of the services and sites that will be transferring to us to meet staff and get to know them. It is great getting out to meet our new colleagues and seeing these services in action. Two members of our executive team also joined colleagues from the Integrated Care Board at the recent Medway Health and Social Care session in late August. What was clear from the committee and our ongoing conversations with HASC is that it is vital we continue to work side-by-side with our stakeholders – including HASC members – as we transition and deliver these vital services in our communities, and ensure their experiences and feedback drives our improvement work for this service and beyond.

National Awards

We have once again been recognised for the work we are doing in several areas from across the trust:

Our support for veterans has received the Gold Awards in the Veteran Recognition Scheme. Gold Award is the highest level of this recognition, granted to organisations that are exemplars in their sector for actively supporting service leavers, veterans, reservists, and military families. The award recognises the effort and hard work our team has been doing to support veterans.

In August, we found out that we had achieved the NHSE Work Experience Quality Standard Bronze Award. The award, valid for two years, recognises the Trust's commitment to high-quality work experience provision, following a successful application led by Fiona Anderson in our People team. The Trust received formal recognition, including a certificate and feedback on strengths and areas for improvement. Well done to our teams for the national recognition.

Value in Practice Awards

We continue to receive lots of nominations for our Value in Practice Awards and the winners for July and August are included in the appendix to this report. Every month it makes me smile reading the nominations and the reason we and our staff should be very proud of themselves. Well done to all the winners in the last few months. Please do keep the nominations coming.

Summary and Conclusion

From reading my report I am sure it is obvious that there is a lot happening locally but also nationally that we have the opportunity to lead on within Kent and Medway.

I will keep the Board and our stakeholders updated as work progresses but an important focus for us now is being an active partner in shaping the integrated neighbourhood health (INH) work for our population. This will progress quickly in the coming months and it will be vital we take some time as a Board to shape our part of this exciting future.

Our segment ranking in the new National Operating Framework (NOF) will also enable us to actively pursue Foundation Trust (FT) status. This is a fantastic opportunity for us as an organisation and as soon as there is clarity from the national team regarding next steps I will update the trust Board.

Sheila Stenson
Chief Executive
25 September 2025

Executive Team Visits

Sheila Stenson:
Rosebud
Amberwood Ward
Crisis House, Medway
Medway and Swale Home Treatment Team
Liaison, Diversion and Resolution Service (LDR)

Donna Hayward-Sussex
Britton House

Nick Brown
Coleman House, Dover
Arndale House, Dartford : DGS CMHT, Mental Health Together, Early Intervention in Psychosis Service

Andy Cruickshank
Crisis House, Medway
Swale CMHT
DGS CMHT
Cherrywood Ward
Upnor Ward
Dover & Deal CMHT
SWK CMHT
LDR Service

Dr Afifa Qazi

Upnor, Boughton, Chartwell, Orchard Wards
Maidstone Pharmacy Team
MHT/MHT+ at Britton House
Clozapine/Depot Clinic at Britton House

Value in Practice Awards – July and August

Directorate		July	August
North	Individual	Darren Vigus, Community Psychiatric Nurse	Tracey Sutton, Senior Clinical Practitioner
	Team	Admin team in Medway & Swale MHT	Medway Liaison Psychiatry
East	Individual	Chrysalena Chioni, Psychologist	Debbie Manns, Lead Clinician, MAS, Canterbury & Ashford
	Team	Thanet MHT+	SKC EIP
West	Individual	Yasmin Moore, Clinical Team Leader	Gavin Jackson, Community Psychiatric Nurse
	Team	-	Memory Assessment Service
Forensic	Individual	Nicola Wells, Peer Support Worker	Victor Omotade, Healthcare worker
	Team	Brookfield Centre	Tarentfort Centre
Support services	Individual	Nigel Austen, Porter	Sabrina Glanville, Supervisor
	Team	Priority House receptionists	Clinical Systems Team – Katie Wheeler and Chris Gray
Acute	Individual	Molly Reid and Adebukola Jimoh	Marie Elliott, Health Care Assistant
	Team	Heather Ward	Sevenscore

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

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

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

Issues to bring to the Board's attention

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

New Risks:

One new risks have been added since the BAF was presented to Board in July

- **Risk ID 07960 – Self Harm incidents on Acute inpatient units (Rating of 20 – Extreme)**

Risk Movement:

No risks have changed their risk score since the Board Assurance Framework was presented to Board in July.

Risks recommended for Removal:

One risk is currently recommended for removal

- **Risk ID 04682 - Organisational Risk – Industrial Action (Rating of 4 (Moderate))**

Risk Appetite:

Following the Board session in April to describe the risk appetite for the Trust, this has now been incorporated into the Risk Management Framework and has being taken through the governance route for sign off. The Appetite statements have been applied to the BAF risks for the first time for this report.

Version Control: 01

Governance

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

Version Control: 01

The Board Assurance Framework

The BAF was last presented to Board on 31st July and ARC on 3rd September 2025. This report reflects further updates on risks since the beginning of September.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme)
- Risk ID 07960 – Self Harm incidents on Acute inpatient units (Rating of 20 – Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 16 – Extreme)
- Risk ID 04673 – Organisational Risk – Cyber Attack (Rating of 15 – Extreme)
- Risk ID 08174 - Delivery of Financial Targets (Rating of 15 - Extreme)

Risk Movement

No risks have changed their risk score since the Board Assurance Framework was presented to Board in July:

Risks Recommended for Removal

One risk is being recommended for removal at this time:

- **Risk ID 04682 - Organisational Risk – Industrial Action (Rating of 4 (Moderate))**
  This risk is being recommended for removal from the BAF as no current periods of Industrial Action are planned although the mandate is live until January 2026. This risk will remain open and tested processes to respond to periods of Industrial Action will remain in place.

New Risks

One risk has been added since the BAF was presented to Board in July.

- **Risk ID 07960 – Self Harm incidents on Acute inpatient units (Rating of 20 – Extreme)**
  This risk has been added the BAF following recent incidents on inpatient wards, and a review of incident data which shows self-harm is currently the top category for incident reporting. The risk score has been increased and there are multiple workstreams underway to review self-harm data, and pilot new approaches to reduce the number of incidents being experienced on the Acute inpatient units

Emerging Risks

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

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

Other Notable Updates

- **Risk ID 08157 – Implementing the Community Mental Health Framework to deliver high quality care and support through Mental Health Together**
  This risk has been reviewed and refreshed to refocus it on the current challenges. Actions continue to progress, and good progress has been made so far on moving towards this risk meeting its target risk score.

- **Risk ID 08337 – Organisational Culture impact on Change Programmes**
  There is a lot of good work being undertaken to influence culture across the organisation; however the results can be slow to show through in survey results. The 2025 Staff survey will take place before the culmination of all the planned actions, so it will need to be considered alongside the results from last year and the ongoing pulse survey results to show a direction of travel.

- While BAF risks are regularly reviewed over the year to keep them up to date, they are currently undergoing a review and sense check as we reach the halfway point in the year. Some updates have been included in this report, while others will be included in the next report at the end of November.

- The Risk Appetite statements set by the Board earlier in the year have been applied to the BAF risks according to the table below. This will feed into the ongoing discussion about risk scores and actions to move risks into an appetite position. This will be applied primarily to the BAF risks and be cascaded to all risks through the organisation over time.

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

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

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

Risk ID	Title	Current Risk Score	Appetite	Appetite Status
00580	Organisational Inability to meet Memory Assessment Demand	20	Cautious	Outside of Tolerance

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02290	CQC Regulatory Compliance	12	Averse	Outside of Tolerance
04673	Organisational Risk – Cyber Attack	15	Averse	Outside of Tolerance
04682	Organisational Risk – Industrial Action	4	Cautious	In Appetite
07557	Trust Agency Usage	9	Seek	In Appetite
07891	Organisational Management of Violence and Aggression	12	Minimal	Outside of Tolerance
07960	Self Harm Incidents on Acute inpatient Units	20	Minimal	Outside of Tolerance
08065	Inpatient Flow	16	Cautious	Outside of Tolerance
08146	Maintenance of a Sustainable Estate	8	Cautious	In Appetite
08157	Community Mental Health Framework Achieving outcomes to evidence success	12	Minimal	Outside of Tolerance
08173	Delivery of a fit for purpose estate	9	Cautious	In Tolerance
08174	Delivery of Financial Targets	15	Minimal	Outside of Tolerance
08175	Delivery of Underlying Financial Sustainability	12	Minimal	Outside of Tolerance
08337	Organisational Culture impact on Change Programmes	9	Seek	In Appetite

Recommendations

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

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

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Updated: 12 September 2025

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Board Assurance Framework

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

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

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

12/06/2024 — Risk Opened

ID 00065	Jun 2024	Chief Medical Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	4	20	Patient flow team jointly working with Liaison Psychiatry, Home Treatment and community services on case by case basis to ensure each admission is purposeful, and inappropriate admissions are avoided. At the same time, we are ensuring that the clinically ready for Discharge patients get the right support in a timely manner so that they spend the least amount of time, beyond what is clinically relevant, in hospital. twice daily reports including the Place of Safety Breaches [1d] daily system calls [1d] business case approved through ICB to move to CORE 24 across all acute hospitals liaison teams [1a] CRFD programme of work underway to release capacity within the KMPT bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review [1f] CRFD Programme is a system wide programme in conjunction with the ICB Local Authority and supported through the Provider collaborative.[1f] review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts to be able to accurately measure patients wating in EDs for Beds.[1a] Use of VCSE partners to support CRFD onward transition. Currently 5 patients have gone through this pathway.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	4	4	16	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Accurate recording and reporting of 12 hour breaches — Director of Digital — Completed — G Countywide Safe Haven Provision — Deputy Chief Operating Officer — 02/06/2025 — A Kent and Medway MH Summit with Social Care — Chief Medical Officer — Completed — G Implementation of CORE 24 across all Hospital Liaison Services — Deputy Chief Operating Officer — 30/06/2025 — A Recovery Houses across the County — Deputy Chief Operating Officer — 28/07/2025 — A Virtual ward Model for People with Dementia — Chief Medical Officer — 31/12/2025 — A	Chief Medical Officer	Outside of Tolerance	1	3	3	30/09/2025

				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)
12/06/2024 Risk Opened																			
ID 08157	Aug 2024	Chief Operating Officer	**Implementing the Community Mental Health Framework to deliver high quality care and support through Mental Health Together** IF we don't complete enough paired DIALOG+ as a partnership to understand people needs and improvement and are not able to deliver an responsive access to care and support THEN we will a) not be able to assess outcomes for our service users and will b) delay commencement of treatment, RESULTING IN poor patient experience.	5	5	25	Daily review of waiting lists at service level, weekly review of waiting list at operational level and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. Amendments to the front door are underway as part of the Community Mental Health Programme refresh, the interface with GP's is undergoing improvement and the voluntary sector are moving resources to entry points to enable improved triage. Team level daily management. Tactical groups in all localities monitoring waits and clinical risk to patients (1c). Monthly deep dive by programme management to each locality (1a) Dashboard in place (1d) BI Team reviewing weekly MHT report to align to waits and patient flow to enable patient level data at service level. (1d) DNA policy has been reviewed and updated to support effective and safe discharge from MHT for people who do not want the service (1f) Rio updated to include ability to record onward referral to alternative provision (such as Talking Therapies). (1f) Fortnightly partnership interface meeting to identify pathway challenges and response to this. Refresh of Community Mental Health Programme to refine	Robust team level management Dashboards Caseload management tool Partnership Forums	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of Mental Health Together Front Door Processes — Deputy Chief Operating Officer — 30/11/2025 — A Review of Mental Health Together and Mental Health Together + Interventions — Director of Psychological Therapies — Completed — G Recruitment of 35 Assistant Psychologists on a 6 month contract to support the management of waiting lists. — Deputy Chief Operating Officer — Completed — G Capacity Planning — Deputy Chief Operating Officer — 30/11/2025 — A	Chief Operating Officer	Outside of Tolerance	3	3	9	31/12/2026
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 BAF Risk Opened — 20/07/2023 Risk returned to BAF																			
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF KMPT do not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance the Continuous Improvement Approach Violence Reduction Strategy PSS Strategy Use of Force Act Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy Safer Staffing	Incident reporting via InPhase Quality Improvement Data	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. — Chief Nurse — 30/03/2026 — A New Violence and Aggression Policy 2025 — EPR Lead — 15/11/2025 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2026
03/04/2014 Risk Opened — 15/06/2025 Risk escalated to BAF																			
ID 02290	Apr 2014	Chief Nurse	**CQC Regulatory Compliance** IF we don't have effective means for assessing, measuring, monitoring and reviewing the regulations as set out in the Health and Social Care Act 2008 required to evidence compliance with fundamental standards and to uphold CQC registration THEN inspections may highlight areas of poor quality of care RESULTING IN avoidable harm, legal claims, regulatory breaches, enforcement action from our regulators and damage to the confidence in the Trusts reputation as a provider of choice.	4	4	16	QPRs held within the Directorates and audits that identify areas of concern for further action Learning Review Group (LRG) – learning is identified from patient safety incidents and lessons shared to prevent reoccurrence CQC MHA Reviews for inpatient areas – provider action statements generated, reports to Mental Health Legislation Operational Group (MHLOG) and Mental Health Act Committee (MHAC) Regulation, Compliance and Quality Group (RCQG) – meets monthly and reports to Quality Committee (QC) Quarterly engagement meetings with CQC whereby areas of concern are discussed and assurance provided against quality statements and the five key questions Support tools and evidence lists for staff based on CQC quality statements and five key questions. This is available on staffroom. Quality improvement plans following inspection activity - these are monitored via RCQG and QC Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month).	QPR minutes and audit results within the Directorates identify areas of concern and actions are then generated to rectify these Learning Review Group minutes identify learning shared from patient safety incidents Quarterly engagement meeting with CQC mirites The provider action statements from MHA inpatient reviews and quality improvement plans from inspection activity are reviewed for oversight and assurance purposes at the Regulation, Compliance and Quality Group, with points of escalation/concern highlighted to Quality Committee and Mental Health Act Committee Workplan for Regulation, Compliance and Quality Group which has set items that are regularly reported to these meetings i.e. Rapid tranquilisation data, supervision/training data, complaints, serious incidents etc. Quality statement presentation slides have been shared within directorates so that staff are aware of what evidence would be required under each quality statement. Quality improvement plans – when actions are complete, these move to the assurance check phase and are monitored via the Regulation, Compliance and Quality Group. Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month). Quarterly Performance and Quality Meeting (PQM) with the ICB Minutes.	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Place of Safety Quality Improvement Plan — Chief Nurse — 30/07/2025 — A Delivery of Community Teams Quality Improvement Plan — Chief Nurse — 30/10/2025 — A	Chief Nurse	Outside of Tolerance	2	3	6	31/03/2026

				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)
	02/04/2024 Risk Opened — 08/09/2025 Risk escalated to BAF																		
ID 027960	Apr 2024	Chief Nurse	**Self harm incidents on Acute inpatient units** IF the inpatient wards do not have adequate knowledge and safety structures in place to assess, prevent, review and respond to incidents of self harm, THEN incident frequency and severity will increase, RESULTING IN compromised patient safety and wellbeing and actual harm coming to patients, compromised staff wellbeing, increased oversight from regulatory bodies, negative impact on Trust reputation.	5	4	20	Trauma informed approach to Therapeutic Observations and clinical risk management Clinical risk assessment and management (1a, 2e) Person centred care plans (1d) Therapeutic observations (1d, 1e, 1f, 2e) Therapeutic interventions (1d, 2a, 2e) Staff support: reflective practice and debrief (1a, 1d, 1f, 2e, 2a) Safety huddle/bundle (1f) Search procedures (2e) Staff training in self harm and trauma informed care (1f) Environmental Ligature risk management (1d, 1f) Matrons skills workshops and emergency walk throughs (1f) learning bulletins (1f) matrons weekly environmental walk arounds (1f) Rescue kits (1d) Clinical Handover (1f) Red2Green (1f) Rapid review learning (1f) Designated Senior Responder (1f) Clinical risk forum Acute and trust wide (1d) Trust wide self harm steering group (1d) High intensity user pathway Purposeful admission protocol	Incident reporting- identifying trends and themes per area. New BI dashboard to support data analysis. Matrons daily huddle Governance Huddle Clinical risk forum minutes Trust wide self harm steering group meeting records Yearly environmental ligature audit	5	4	20	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Re establish the clinical risk forum for cases of frequent self harm and High intensity users — Clinical Director for Acute — 30/09/2025 — A Self harm data analysis on wards — Head of Nursing and Quality, Acute — 03/11/2025 — A Collaborative discharge planning with community teams — Clinical Director for Acute — 01/12/2025 — A Social Media awareness — Lead for Psychological Practice, Acute — 01/12/2025 — A New Style Person Centred Care Planning — Head of Allied Health Professionals, Acute — 29/12/2025 — A Alternative to Self Harm Pilot Project — Head of Allied Health Professionals, Acute — 19/01/2026 — A Minimal Risk Activity Pack Pilot Project — Head of Allied Health Professionals, Acute — 19/01/2026 — A Enhanced Therapeutic Observations and Care (ETOC) — Head of Nursing and Quality, Acute — 02/03/2026 — A Clinical Handover Process Review — Corporate Head of Nursing & Quality — 18/03/2026 — A CAPLET training for all inpatient staff — Head of Nursing and Quality, Acute — 01/04/2026 — A	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																
2 - We are a great place to work and have engaged and capable staff living our values																			
2.1 - Creating a culture where our people feel safe, equal and can thrive																			
	30/01/2025 BAF Risk Opened																		
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Change Programmes** If KMPT's current interventions do not successfully build its capability and capacity to deliver effective change, Then change efforts are unlikely to succeed and engagement will deteriorate, Resulting in poor organisational culture, impact on our people, patients and population, reduced ability to deliver key strategic ambitions	4	3	12	Work to introduce and embed new and coherent organisational values Delivery of leadership development programme Delivery of equality, diversity and inclusion interventions Delivery of 'Doing Well Together' and improvement capability building	Staff Survey results Pulse Survey results	3	3	9	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Leading Well Together programme — Deputy Chief People Officer — 31/12/2025 — A Delivery of Management Development Programme — Deputy Chief People Officer — 31/12/2025 — A Roll out and embedding of New Organisational Values — Deputy Chief People Officer — 31/03/2026 — A Embedding of staff voice initiatives — Deputy Chief People Officer — 31/03/2026 — A	Chief People Officer	In Appetite	2	3	6	31/03/2026
2.2 - Building a sustainable workforce for the future																			
			No Risks Identified against this Strategic Objective																
2.3 - Creating an empowered, capable and inclusive leadership team																			
			No Risks Identified against this Strategic Objective																
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																			
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																			
			No Risks Identified against this Strategic Objective																

				Initial rating				Current rating					Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	L	C	Rating	Target Date (end)
3.2 - Working together to deliver the right care in the right place at the right time																			
04/12/2014 Risk Opened 04/06/2021 — Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over disatisfaction over the national pay award — 03/11/2021 — Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing. — 13/03/2023 — So far there has been little impact from Industrial action. Business continuity plans and Command and control arrangements are in place and have so far proved adequate. This is being kept under review. — 15/05/2024 — This risk is recommended for removal from the BAF. It will remain open and be managed on the EPRR risk register. — 15/05/2024 — This risk has been escalated to the BAF due to the announcement by the BMA of Industrial Action in July by Resident Doctors.																	
ID 04682	Jan 2019	Chief Nurse	**Organisational Risk - Industrial Action** IF industrial action is enacted within KMPT by Unison, Unite, BMA, RCN etc, or any external service affected by industrial action, which may have an effect on the business continuity of the Trust THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services and a backlog of delivery due to cancellations.	3	3	9	Industrial Action SOP inclusive of Command and Control [2e] Unique operational order/s. Significant Incident Plan [2e] Business Continuity Plans [2e] Workforce and OD Industrial Action Monitoring Group EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side Situation Reporting to ICB via OCC	Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance Strikes are planned and therefore mandates are known in advance when they overlap or and concurrent. Operational Directorate backlog monitoring against demand and capacity risk.	2	2	4	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**	Chief People Officer	In Appetite	2	2	4	29/07/2026
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																
4 - We use technology, data and knowledge to transform patient care and our productivity																			
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																			
22/07/2015 Risk Opened 15/06/2025 — Risk escalated to BAF																			
ID 04673	Jul 2015	Chief Finance and Resources Officer	**Organisational Risk - Cyber Attack** IF KMPT is the victim of a successful cyber attack THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation.	4	5	20	Omitted for security reasons	Omitted for security reasons	3	5	15	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Omitted for security reasons	Chief Finance and Resources Officer	Outside of Tolerance	2	3	6	29/03/2026
4.2 - Enhance our use of IT and digital systems to free up staff time																			
			No Risks Identified against this Strategic Objective																
4.3 - Effective digital tools are in place to support joined-up, personalised care																			
			No Risks Identified against this Strategic Objective																
5 - We are efficient, sustainable, transformational and make the most of every resource																			
5.1 Achieve financial sustainability																			
22/08/2023 Risk Opened																			
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Sign off of Medical Agency spend at exec level. [3a] Sign off for above cap rate posts at CEO level [3a] Reporting to Trust Board [3a] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend Medical lead for recruitment appointed to support areas which are challenging to recruit to. All non medical vacant posts are reviewed at the weekly vacancy control panel. No retrospective approval of Agency shifts	Monthly IQPR (reported to each public board) Monthly statements to budget holders [1a] Monthly Finance Report [1h] Internal audit [3d]	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Reduce Nursing Agency Spend by 50% to meet the National ask — Chief Medical Officer — 30/10/2025 — A	Chief Medical Officer	In Appetite	3	3	9	28/03/2026

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
	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	5	15	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Forecast of the Trust Agency spend (signed off by Service Directors) — Associate Director of Finance — 31/03/2026 — A Forecast of the Trust Bank spend (signed off by Service Directors) — Associate Director of Finance — 31/03/2026 — A Review of the use of temporary staffing and identify appropriate mitigations and controls — Associate Director of Finance — 31/03/2026 — A Review of Trust Reporting Pack — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Officer	Outside of Tolerance	2	4	8	31/03/2026
	25/06/2024 Risk Opened																		
ID 08175	Jun 2024	Chief Finance and Resources Officer	**Delivery of Underlying Financial Sustainability** IF the Trust fails to maintain financial sustainability THEN this could lead to an inability to deliver core services and health outcomes, and financial deficit, RESULTING IN intervention by NHS England and insufficient cash to fund future capital programmes.	3	4	12	Long term sustainability programme [1g] Cost Improvement Programme [1d]	Monthly external reporting to ICB and NHS England	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Separate workstream for Corporate Savings to monitor delivery to include system stretch requirement — Associate Director of Finance — 31/03/2026 — A Agreed Cost Improvement Plan programme of work with agreed timeframes — Associate Director of Finance — 31/03/2026 — A Review of Trust controls on Non Pay — Associate Director of Finance — 31/03/2026 — A Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising — Associate Director of Finance — 31/03/2026 — A Refresh and review underlying position at service and commissioner level. — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Officer	Outside of Tolerance	3	2	6	31/03/2026
5.2 Exceed the ambitions of the NHS Greener programme																			
			No Risks Identified against this Strategic Objective																
5.3 Transform the way we work																			
			No Risks Identified against this Strategic Objective																
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
	29/03/2024 Risk Opened																		
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** To complete the Annual ERIC Return — Deputy Director for Estates — 29/09/2025 — A Tender for 6 Facet Survey — Deputy Director for Estates — 30/03/2026 — A	Chief Finance and Resources Officer	In Tolerance	2	3	6	31/03/2026
	01/04/2020 Risk Opened																		
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Services Business Continuity Plans	Reporting to FPC TIAA Audit Contract Monitoring Minutes	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**	Chief Finance and Resources Officer	In Appetite	2	3	6	31/03/2026

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Year 3: 6-month Strategy Delivery Review
Author:	Sarah Atkinson, Deputy Director of Transformation and Partnerships
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This six-month review provides an update on the delivery of Year 3 of the 2023–26 Trust Strategy, focusing on the Trust's ambitions for Patients, People, and Partners, and supported by strategic enablers. The paper seeks to provide assurance against all strategic metrics providing an update on progress whilst also identifying actions to meet strategic ambitions

Issues to bring to the Board's attention

Key Achievements:

- Significant progress has been made in reducing long waits for dementia diagnosis, with waiting times and backlog numbers falling well below national averages.
- The new Co-creation Framework for patient engagement has been approved and is being implemented, shifting towards a values-led, outcome-focused approach.
- Staff empowerment and leadership development are advancing, with more staff trained in improvement methodologies and leadership behaviours embedded in training programmes.

Ongoing Challenges:

- Some metrics remain off track, notably in equitable access to services, staff engagement, and discharge processes. Bed occupancy and length of stay for clinically ready for discharge patients continue to present challenges.
- Digital transformation is progressing, but some solutions (such as electronic prescribing for community services) are still in development.

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Strategy Deployment Group, IQPR and Board Sub-Committees

Version Control: 01

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Background

The 2023-26 trust strategy sets the direction, with specific outcomes, what will need to be delivered by the organisation. The strategy is based on three strategic ambitions (our Patients, our People and our Partners) and three strategic enablers. Overall the strategy includes 73 outcomes across all domains.

It has been acknowledged the significant challenge of improving 73 outcomes all at once, and therefore, in March 2025, the board agreed a new approach to the delivery of the strategy.

This approach follows our Doing Well Together improvement methodology and prioritises the metrics in 4 categories:

True Norths – our long-term ambitions which in themselves do not represent improvement effort but by which all other metrics should align to,

Breakthrough Objectives – these are the top contributors to our true norths, according to our data and will be our priority focus over the next year. In time, through the rollout of Doing Well Together, these metrics will largely be delivered by frontline services through the improvement management system.

Trust Initiatives – our long-term programmes which significantly impact the operational delivery of the organisation. These initiatives are owned and delivered with our daily business and should not represent siloed improvement work.

Key Projects – these are large scale projects with clear deliverables which are delivered using a traditional task/ finish project management approach.

Governance

Whilst the strategy continues to be governed via iQPR and directorate performance meetings. The format of these directorate meeting; previously QPR meetings will change from September to reflect the new approach to strategy deployment. As these become embedded, there will be a more data driven approach to reporting; by way of business rules which indicted which metrics should be reported against. This will include a standardised approach to reporting and the use of improvement methodology to drive all strategic improvements. This new approach will be gradually introduced between September and December 2025

Year Three Operational Delivery Review

Overview against operational plan

Progress across our outcome measures is summarised in the following pages. We have provided specific details on the work to date, acknowledging that whilst there has been great improvement on many of the metrics, there is still work to do against some metrics which will continue in the last 6 months of this year. While some metrics show as ‘off target’ this indicates progress against delivery plans/ trajectories rather than performance and does not detract from the great progress made against may of our metrics.

The table below captures progress against our priorities and their associated driver metrics.

Version Control: 01

Strategic Theme	Obj Typ	Outcome/ Driver Measure	Exec Spon	Status	Comment	Aligned Watch Metrics
Patient - We provide equitable, timely access for all	TN	85% of community (Community Mental Health Framework (CMHF) and Memory Assessment Service (MAS) patients' needs met within timeframes	Donna hayward - Sussex	Off track	We are maintaining good progress with rapid to response to urgent referrals. Though we have not yet met the four-week waiting standard for Mental Health Together. The current is an average wait of 15 weeks with: Of the 5,918 waiting 82% are waiting under 18 weeks 32% are within the 4 weeks There is some variation in this, with North Directorate nearer 7 weeks. The wait time standard is being reviewed in line with national expectations.	• See 85% urgent referral in 24hrs • See 85% of routine referrals within 4 weeks
	TN	Equitable access: less than 1% variation in waiting times (CMHF/MAS) between most deprived and least deprived	Adrian Richardson	Off track	Work is continuing to identify areas of concern and is being addressed within the planned health inequalities within KMPT and in partnership with KCHFT. MAS data suggests that there is a difference in 6-week diagnosis between ethnicities, this is forming part of the ongoing health inequalities work and will utilise our new involvement and engagement team and future alignment of our health inequalities work at system level. This is being reviewed during Q3 and the results are necessary countermeasures will be prioritised by the dementia programme board in Q4.	• Improve social mobility and inequality through our commitment to deliver 14 levelling up goals
	BO	95% of Dementia diagnosis within 6 weeks	Adrian Richardson	On Track	Phase 1 of standardised model has been completed and is embedding across all MAS services A continuous improvement approach has been rolled out across the MAS services focused on reducing the number of patients waiting over 52 weeks for a diagnosis. There are currently (12/9/25) 54 patients who have been waiting over 52 weeks, down 79.2% from a baseline of 260. The impact of this has been a reduction in waiting time from 189.9 days in July 24 to 98 days in August 2025, a 51.6% drop Performance is now 65% below the national average of 151 days.	

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					Whilst 95% has not yet been achieved across all MAS. At a trust level, performance was at 7.7% in April 2024 and was 29.2% in July 2025 and reached a peak of 33.8% in February 2025 the reduction is due to concentration on the long waits. Locally, North Kent regularly achieved diagnosis rates over 50%, peaking at 85.7% w/c 11/8/25. Focus is now on East and West Kent to increase diagnosis rates. Work is underway to understand the variation in practises between each MAS service and to identify the individual improvements needed in each locality, this is referenced within September IQPR and also forms part of the sustainability programme. In May, a community model for dementia diagnosis was agreed with system partners. Whereby only the most complex patients would be referred to KMPT MAS services. Working groups are in place to mobilise the model	
	BO	90% of community (CMHF/MAS) referrals have ethnicity recorded	Adrian Richardson	On track	Current performance is 84%, it is anticipated that further improvement will be made with the launch of the patient portal to allow for easier data recording as well as being reinforced in directorate QPR's	
	TI	Children and Adolescent Mental Health Services and All Aged Eating Disorders	Donna Hayward-Sussex	On track	A programme of work is underway to transition services from the previous provided into KMPT. A governance structure has been implemented for the programme and regular reporting to board and other stakeholders is underway. Anticipated timeframes are on track for transition.	
	KP	Patient Engagement & Involvement	Kindra Hyttner	On Track	In July '25, the Board approved our new Co-creation Framework and strategic plan, marking a shift in how we approach involvement and engagement across the Trust. The new department is now in place and mobilising into the implementation phase.	• 90% of transformation projects have service user involvement • Increase service user and public participation in local led research by 10%

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					We are moving away from the 90% project engagement fixed target and instead adopting a values-led and outcome focused approach to embedding co-creation across the Trust. We will focus on two new outcome measures: 1. improved experience from being involved; and 2. improved quality and equity of services because of improvement. This approach supports meaningful, inclusive involvement and ensures co-creation becomes a core part of how we work.	
	KP	Trust Identity	Kindra Hyttner	On Track	We are pleased to confirm that our new name and identity will officially launch on Monday, 13 October 2025. From this date, we will legally become Kent and Medway Mental Health NHS Trust. To ensure a smooth transition, we are prioritising updates to critical items first, including higher football inpatient areas, followed by an 18-month trust wide embedding programme. This will include: - A sustained period of staff engagement to embed our new identity, supported by updated materials, templates, and training on voice, tone, style and accessibility. - Ongoing conversations with staff around our new organisational strategy, reinforcing our new mission, vision, purpose, and values. We anticipate full embedding of the new identity across the Trust to take 12–18 months.	
People - We support and empower our staff	TN	Staff Engagement score from 6.9 to 7.1	Sandra Goatley	Off Track	Engagement score decreased last year from 6.9 to 6.8, leaving a greater improvement to be made this year. Such significant changes are rarely seen in-year.	• Increase raising concerns sub score from 6.6 to 6.9 • Increase our burnout sub score from 5.2 to 5.5 • Reduce vacancy rate to 14% • Reduce agency spend to 3.7% of pay bill
	BO	Staff feel able to make improvements in their workplace	Sandra Goatley	On Track	Improvement from 54.8% to 58.7% between Q1 and Q2, moving towards target of 60.3%	

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	TI	Leadership Development & Culture	Sandra Goatley	On Track	Leading Well Together programme on track to have completed delivery across all of TLT by end March 2026, with system module designed	• 90% of B7+ leaders have attended leadership training • Reduce the number of minority ethnic staff involved in conduct and capability to 0% variance • Our staff feel KMPT is supportive and compassionate employer • 95% supervision & appraisal rate • Increase minority ethnic staff B7+ • Increase staff satisfaction with their line managers
	TI	Doing Well Together Improvement Programme	Adrian Richardson	On Track	The Doing Well Together Programme launched in March 2025; delivering KMPT's continuous improvement approach across 5 pillars Capability Building – to date; 46 staff become certified in Yellowbelt (A3 training) and have delivered improvement projects with a further 32 still in the coaching phase of their training. 232 staff have also received awareness training (whitebelt) IMS – the first wave of training is near completion with 4 wards embedding frontline continuous improvement. Wave 2 is due to commence in Nov. Improvement Projects – the improvement team are support the 7 breakthrough objectives and beginning to initiate the use of A3 thinking to drive improvements Strategy deployment – Acute and Forensic & Specialist directorates have completed DWT training. With another 2 directorates undertaking training from October. A new format of directorate QPR will launch in Sept to incorporate improvement methodology. Leadership Behaviours – improvement leadership behaviours have been incorporated in the trust leadership programme with webinars being delivered in Sept/ Oct. EMT have also attended 3-days of improvement training and are receiving improvement coaching.	• Have leaner more efficient processes • Overhaul organisational governance • Devise new model for transformation

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Partners - We create healthier communities together	TN	Reduce clinically ready for discharge (CRfD) length of stay (LoS) by 25%	Afifa Qazi	Off Track	Bed Occupancy remains high at 97.1% in August. Housing remains one of the biggest contributors to CRfD LoS and work is continuing to build relationships with system partners at operational and strategic levels. Internally, work is underway to ensure patients have a purposeful admission to identify therapeutic outcomes to reduce their in-patient stay The use of OOA bed has also been a focus and is seeing positive results. In August, a total of 28 OOA bed were used, compared to 43 in May; a reduction of 35%. Of the 28 used in August, 12 were for acute patients and 16 were for PICU.	• Reduce the LoS for patients waiting onward transfer • Decrease bed occupancy to 85%
	BO	Eliminate all CRfD over 100 days	Afifa Qazi	Off Track	In May, a short-term plan to improve CRfD was agreed by the board. Whilst CRfD remains high, those who have been awaiting discharge for more than 100 days has fallen significantly, from 46 in February to 18 (10/9/24), a reduction of 61% whilst this is positive CRfD remains a challenge and work is continuing to identify and address root causes.	• Eliminate all specialist out of area beds • Reduce OOA PICU beds
	TI	Community Mental Health Framework (CMHF)	Donna Hayward-Sussex	Off Track	Focus remains on: • Reducing long waits and prioritising patients that have been waiting between over 18+ weeks. Current average wait is 15 weeks • Clinical model refinement at proposal stage with the aim to finalise by end of the September. Now we are working at pace to agree how we deliver the refined model. This will then be subject to running through the demand capacity model developed by finance. Aim to have a pathways product that can be the basis wider stakeholder engagement and communication. This will be guided by a communication and engagement workstream, which includes a primary care member. • Activity oversight to ensure capacity is utilised appropriately across all teams This is in place and led by the service directors for each directorate. Any issues are escalated to the deputy COO for monitoring and appropriate action. • Improvement of data quality Collaboration with partners and those with lived experience is excellent with good engagement from staff working in all elements of the services. There are	• Increase the number of patients accessing care in MHT • 85% of people with SMI presenting to MHT have a physical health check • 85% of people with learning disabilities are referred for a physical health check

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					review packs completed by MHT leadership to best utilise resource and respond to any people who have become outliers. Over the coming months and in addition to model refinement, focus will centre on data, digital solutions and workforce. As part of the refreshed community mental health programme, data and digital and workforce workstream are being established a led by a subject expert and service director. The group are starting to form and there first priority is to respond to the needs of the clinical and delivery model refinement, to support its readiness. The impact of this approach has reduced the MHT waiting list from 6,949 at the end of March 2025 to 5,918 in early September 2025. This equates to a 15% reduction. This has also led to an improvement in average clock stop from 20 weeks in March 2025 to 15 weeks in September 2025.	
Safety - We work with our community to provide safe and harm free care	TN	Reduce the number of patient harms by 10%	Andy Cruickshank	On Track	Whilst there have been some increases in the number of incidences of V&A in NK and F&S directorates, the Acute directorate has seen a decrease in incidence and the overall trajectory is in a positive direction with a 1% decrease overall in the last reporting period.	• Decrease V&A on our wards by 15% • Fulfil our role to deliver joint initiatives to reduce suicide and self-harm
	BO	Reduce self-harm in female acute in-patients by 10%	Andy Cruickshank	On Track	A target reduction of 10% in self-harm in female acute in-patients has been agreed. This would bring incidences on acute wards to 60 per month. Performance in August ’25 was 70 incidences, down from 141 in March ’25. A number of interventions are in progress: • Inphase self-harm custom report dashboard launched February 2025 and accessible to all individuals with inphase logins. This provides data on both service level and directorate self-harm incidents and types of self-harm over a rolling 12-month period. • Monthly self-harm cross-directorate interprofessional steering group established March 2025. • Minimal Risk Activity Pack (MRAP) pilot launched on Upnor and Chartwell in March 2025. The pilot will be evaluated 6 months post-launch for review of effectiveness / impact. • Alternatives to Self-Harm (ASH) pilot training carried out on Foxglove in April 2025 and on Fern in July 2025. The pilot will be evaluated at the 6-month post-training point for each ward.	

					• Staff survey to collect baseline views regarding experiences of working with those who self-harm ran from May to July 2025. Feedback from the survey was taken to the July 2025 steering group. • BI dashboard launched July 2025 and accessible to all teams. This provides service level and directorate data about self-harm incidents with gender breakdowns and age of client, and allows for drill down to data on individual incidents. • Changes made allowing for inphase to pull through Rio information to improve data quality in both inphase and BI dashboards implemented in September 2025. • Baseline survey for views of those with lived experience of self-harm devised. This is anticipated to launch at the end of September 2025 and to run until end of November 2025. • A3 engagement work led by the improvement business partners will start with the East Kent women's acute wards in October 2025. • Meeting with external training provider specialising in working with individual with high risks, self-harm and suicidality scheduled for October 2025, following staff feedback via survey that they feel they lack skills and knowledge when working with this clinical population. • Self-harm data to be incorporated into acute safety huddles as of November 2025 (in line with timeframes identified by improvement team in line with training and review around tiered accountability huddles and sustainability).	
Sustainable care - We invest wisely in our resources to improve our services	TN	Attendee contact time per week per FTE	Nick Brown	On Track	The Trust is moving to change its metric on the Sustainable care True North, with further guidance being provide from NHS England around how improvements in clinical time will be monitored. The metrics have shifted for a revised focus on increase in activity vs increase in cost. This approach better supports the sustainable care ambition which seeks to maximise how we use the trust resources. Looking at YTD delivery this approach is supported by work on-going with community teams with a focus on demand and capacity within services. We can see activity is increasing both in terms of dialog assessments being completed and more generally in terms of appointments outcomed vs attended contract, which year on year indicate a growth of approximately 10%	• Reduction in time spent capturing and revalidating data by 25% • Reduce unwarranted variation in services • Forecast mental health capacity and demand
	BO	Number of consultant and psychologist clinical contacts		On Track		

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	TI	Getting the Basics Right	Donna Hayward-Sussex	On Track	There are two main workstreams in GTBR: The admin improvement project which has begun to look at administrative processes with a view to standardise these across services. A value stream mapping session is due to commence in September to identify opportunities for standardisation. Admin staff are leading the work in this area with key links to the e-referrals and patient portal digital projects. The second workstream is focussing on clinical processes including reducing the number of unoutcomed appts, reduce DNA's by 15% and reducing cancellations. Actions are underway to identify the areas with the largest room for improvement to implement text message reminders for appointments. Further data analysis has shown greater DNA's on Monday's and Fridays and potential countermeasures are being discussed with input from patient engagement to identify root causes.

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In addition to the strategic outcomes above, the 2025/26 delivery plan is underpinned by strong foundations which are fundamental to our success.

	Outcome	Exec Sponsor	Status	Update
Digital	Clinical staff report that our Electronic Patient Records System is quicker and easier to use.	Nick Brown	Off Target	Over the last 12 months, the Rio Dev team have released over 400 staff requested Rio Changes, and pushed out Rio change releases for enhancements and improvements 40 weeks out of the last 52. • Highlights would be a new Physical Health and Risk Portals for clinicians as a much easier way to both view and capture Physical Health and Risk Info. • We have also implemented direct links between Rio and EMIS and our own InPhase reporting system, making it easier to access EMIS information directly within Rio as well as moving significant dual entry between Rio and InPhase in many cases, and should significantly improve data quality. Automation is being used to augment existing resources and do more with what we have We have used the bot to add 4000+ emails to Rio to allow for QPR reports to link Rio and ESR data. It is estimated that this would have taken 2 weeks if done manually, however, the bot is able to do it in 2 days. The bot is also now removing leavers from Rio automatically, something that helpdesk did sporadically as and when they could spare the time, approx 10 hours across a month give or take.
	Sharing information and data internally is smoother and quicker and we have one version of the truth		On Target	The past 12 months has seen the delivery of a new suite of Power BI reports. These dashboards are being actively used on a daily basis to improve data quality and assist in the management of waiting lists particularly in relation to the Memory Assessment Service and community mental health services.
	Electronic solutions have been deployed for medicines, ordering		Off Target	. Medicines Management has been implemented for inpatient settings. The Civica Prescribing product still does not have the functionality to enable electronic prescribing for community services and we are currently assessing our options. Ordering investigation is

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	investigations, patient safety alerts and bed management			progressing at system level and work is in progress to deliver a bed management solution utilising Rio and Power BI to provide near real-time reporting of planned admissions.
	Electronic solutions have been delivered for referrals and consultations		Off Target	This outcome is partially delivered in that electronic solutions have been delivered for video consultations. Work is progressing well in relation to referrals following a visit to another Trust.
	A service user portal has enabled access to personalised information and freedom to control their own care		On Target	A project is in-flight to implement the Patient Knows Best which provides patients with access to a portal to access information about their care including appointment letters. The product will be trialled by Perinatal and EIP services in November with a planned trust-wide roll out in February '26
Estates	Embed hybrid working		Off Target	The Hybrid working policy was reviewed last year and has now been fully implemented and embedded in the organisation. We are monitoring the utilisation of room/desk bookings and bookable space as part of the criteria for any new accommodation.
	Secure shared clinical spaces with our partners		Off Target	KMPT accesses shared clinical space across Kent alongside healthcare partners through NHSPS Open Space and the use of Healthy Living Centres in the Rochester and Swale area Further and future opportunity of shared clinical accommodation with our partners will derive from the Health Care Partnerships (HCPs) identifying specific opportunities in a locality together with the Integrated Neighbourhood Teams initiative identified in the NHS 10-year Plan.

In addition to the strategic driver/ watch metrics there were 25 metrics which are considered 'business as usual'. These are monitored and reported through the Trust Leadership Team (TLT) or as part of the Integrated Quality & Performance report (iQPR) or the Directorate Quality Performance Reviews (QPRs), without the need for an improvement approach. These are listed in Appendix One

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Wider progress and issues

Doing Well Together Improvement Programme

In May, we started the rollout of the Doing well Together Improvement Programme with 4 wards; 2 in the Acute directorate and 2 in Forensic and Specialist. During the training teams are learning about the importance of measuring for improvement, how we demonstrate the impact and the value of improvement. In the coming weeks, the teams will be identifying key metrics to support local improvement and will measure their success. Whilst relatively small at this stage, frontline teams feeling empowered to take ownership of their own improvement will, in time, create a culture of using data, valuing it and recognising the importance of ensuring data quality.
These pilot wards have also started using improvement huddles which enable anyone; either staff or patients/ their loved ones can to an idea for improvement or to identify a problem. The teams then come together for 15 minutes to discuss the problem and identify potential solutions. These small acts of continuous improvement are beginning to have meaningful impact on challenges faced within these departments.

Developing a new strategy for 2026/27

We remain committed to our Doing Well Together methodology and will be developing a new strategy using the same strategy planning framework as this year. Whilst our True North metrics remain our 3-5-year commitments we will be using a data driven approach to review our breakthrough objectives and identifying our top contributors to agree our priorities for the coming year.

We will also use our strategic filter to identify our focused key projects and strategic initiatives, taking into consideration the changing landscape of the organisation following the transition of CAMHS services as well as opportunities to work with system partners to support the NHS 10-year plan and the focus on neighbourhood health.

Plans are being developed to start the strategy planning process following the launch of the new trust identity in October. Plans to engage with the wider leadership of the organisation as well as frontline teams, those with lived experience and other system partners.

High-level timelines indicate a draft strategy to be shared with board members in December wither further refinement in the new year ahead of the strategy launch in April 2026.

Conclusion

As we reach the midpoint of Year 3 in delivering the 2023–26 Trust Strategy, it is evident that meaningful progress has been made across many of our strategic ambitions and enablers. The adoption of the Doing Well Together methodology has provided a structured and inclusive framework for prioritising and delivering improvements, with frontline teams increasingly empowered to drive change through data-informed decision-making.

Notable progress has been made in the long waits for dementia diagnosis, the development of the co-creation and strengthening leadership development.

While several metrics remain off track, particularly in areas such as clinically ready for discharge, using a more focused, targeted approach to improvements is beginning to show some progress in this area.

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The embedding of leadership behaviours, the rollout of improvement training, and the strengthening of governance through the Trust Leadership Team have all contributed to a more cohesive and responsive delivery of improvements whilst acknowledging that there is still a way to go.

Looking ahead, the development of the 2026/27 strategy will build on these foundations, using a refined data-driven approach to identify breakthrough objectives and align our efforts with system-wide priorities, including the NHS 10-year plan and neighbourhood health initiatives. Continued engagement with stakeholders and a commitment to transparency and learning will be key to sustaining momentum and achieving our long-term ambitions.

Appendices

Appendix One – List of 'business as usual' metrics

Domain	Metric
Patient - We provide equitable, timely access for all	95% of people presenting to ED with a mental health crisis will be triaged within 1 hour
	95 % of mental health patients within Eds will be admitted to a psychiatric bed within 12 hours
	Work with partners to assess 95% of people in crisis within 4 hours
	Increase service users experience of receiving care
	Improve patient outcome measures
	Increase satisfaction for in-patient experience by 10%
	Decrease V&A on our wards by 15%
	reduce
	All staff are trained in autism awareness and service users report friendlier wards
People - We support and empower our staff	95% of staff receive annual appraisal
	Reduce racist incidence of Violence and aggression by 15% in line with the national average
	Reduce sickness rates to 3.5%
	Increase work life balance sub score
	Reduce vacancy rate
	Joint working with K&M Medical School, University of Kent and Canterbury Christ Church University will be formalised
	We will be ready to apply for formal teaching status
Partners - We create healthier communities together	10% of women with severe perinatal mental health needs in community services will have access to specialist care
	Introduce agreed outcome measures to monitor patient care and experience
Sustainable care - We invest wisely in our resources to improve our services	Our leaders have increased access to reliable data and knowledge to help decision making
Strategic Enablers	
Digital	All digital solutions are co-designed by clinical and digital staff
	Increase digital literacy of our workforce
	Reduce the number of serious incidents, complaints and investigations associated with information sharing across the system and wider NHS
Finance	Achieve recurrent annual break-even financial position
	Eliminate underlying deficit

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Estates	Reduce carbon emissions from energy consumption by 80% by 2035
	Cut emissions associated with transport by 25% by 2025
	Reduce overall waste volume by 5%
	Reduce water consumption by 5% every year
	Increase the environmental quality of our green spaces by 2025
	Release office space footprint and increase clinical space
	Increased staff satisfaction with estates maintenance of office and clinical space
	Improve the efficiency of our estate and invest more in maintenance
	Prioritise patient safety and backlog maintenance
	Repurpose our estate to recycle back into our existing buildings

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Update
Author:	Jane Hannon, Programme Director Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an update on the work of the Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA PC). It includes:

- An update on the mental health urgent and emergency care programme with a focus on the East Kent area
- An evaluation on the out-of-area placement repatriation project for people with autism
- A red, amber, green rating for the programme milestones, indicating milestones completed, expected to be completed and where delays are expected, as requested at the July Board. This is at the end of the report.

Issues to bring to the Board's attention

The work of the review and resettlement team to help autistic people live more independently has had a positive impact for patients and financial sustainability.

There has been a further increase in the Dementia Diagnosis rate to 62%

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board and Provider Collaborative Board

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

Programme	2025	2026	
	27 Nov	29 Jan	26 Mar
Community Mental Health Framework			
Dementia Diagnosis Pathway			
Urgent and Emergency Care			
New joint board with community			
Joint Mental Health Pathways			
Physical and Mental Health Ward			

2. Programme updates September 2025

2.1 Mental Health Urgent and Emergency Care

Background and Vision

The Urgent and Emergency Care (UEC) Transformation Programme is led by the ICB Adult Mental Health Commissioning Team and guided by NHSE's Long Term Plan (2019) and 10-Year Plan (2025).

Its purpose is to enable timely, evidence based and high-quality therapeutic care and support for people in mental health crisis, in the least restrictive setting possible and close to home.

It continues to focus on:

- Reducing primary mental health self-presentations and ambulance conveyance to Emergency Departments
- Provision where appropriate of an alternative to a psychiatric inpatient admission
- Reducing the use of Section 136 of the Mental Health Act (1983) through early intervention
- Provision of Right Care by the Right I Person, in line with the Home Office, Department of Health and Social Care (DHSC), and National Police Chiefs' Council (NPCC)
- Most importantly, improved patient experience and empowerment through person-centred community crisis alternatives that promote social inclusion and a strengths-based approach

The team is investing in alternative crisis support services that offer more therapeutic and person-centred interventions. Interventions include: safe havens, crisis recovery houses, mental health bespoke conveyance and sit-and-care service, hear and treat / see and treat – 836 service (urgent police & ambulance response), expansion of liaison psychiatry and introduction of front-door triage.

Key Successes and Challenges

Successes include:

- A clear impact on the number of people with a primary presentation of mental health attending or being conveyed to A&E across Kent & Medway from **10,110** (**2.6%** of presentations) in **2021-2** to **8,640** in **2024-25** (**2.1%** of all presentations). (The **2025-6** percentage of presentations for a primary mental health reason has been consistently well **below 2%.)**

- A sustained reduction in incidence of Section 136, from **1,137** in **2021-22** to **777** in **2023-4.** (Unvalidated figures for 2024-5 and **year to date figures for 2025-6** are in line with this level.)
- **Safe haven attendances have increased** from **300 in April 2023** to around **500 in April 2024** and now **over 1500 in July 2025**.
- More people are being **discharged from KPMT psychiatric liaison services to a safe haven - increasing from 20 in April 2024** to now **consistently over 60 a month from December 2024 to July 2025.**
- **Crisis house occupancy is increasing** as new crisis houses are opened with Medway and Ashford crisis houses showing at **around 90% for July 2025**.

Mental health clinicians are being supported to work more confidently with voluntary community and social enterprise sector (VCSE) partners and to adopt a more positive approach to risk-taking in decision-making.

The most sustained challenge is the marked difference between the impact of crisis alternatives in different parts of the county. At the July Board, the Provider Collaborative Team were asked to review the differences between the East Kent and Medway and a summary informed by KMPT and ICB colleagues is shown below.

East Kent Crisis Pathway

East Kent UEC services face disproportionate mental health demand and challenges with 5.3% of A&E attendances being for primarily mental health related compared to 0.7% at Medway in quarter 1 of 2025- 2026.

Context

In 2021, East Kent had a 1% prevalence of severe mental illness compared with 0.9% for England and 0.7% for Medway and Swale.

East Kent also covers a large geographical area, particularly compared with Medway, which is more compact. East Kent is also impacted by the Coastal Effect.

KEY ELEMENTS OF VARIATION IN OFFER BETWEEN SITES	
Medway	**East Kent**
Rapid Response and Liaison Psychiatry Team on site in the same building	Rapid Response Team not on site (Canterbury based)
Community safe haven is not far away	Community crisis café further away in Ramsgate
24/7 co-located safe haven since November 2023	Co-located Safe havens are newer and Ashford haven is not yet open 24/7
Underlying prevalence of severe mental illness is below average (0.7%)	Underlying prevalence of severe mental illness is above average (1%)
Compact geographical area	Large geographical area and coastal effect

Uptake of crisis alternatives

There has also been a lower uptake of crisis alternatives to date. Drivers for this include the fact that the Thanet co-located safe haven mobilised in January 2024 compared to Medway which went live in July 2023 and the Ashford co-located safe has only recently opened in March 2025 on a part time basis for 5 hours, 7 evenings per week. Once an appropriate venue is identified the collocated Ashford Safe Haven will move to a 24/7 model of operation. Challenges for those reliant on public transport is also a factor.

The ICB is convening a series of **engagement events** with Mental Health Professionals and VCSE Providers with the aim of strengthening clinicians' confidence and trust in working with VCSE partners, with the goal being fuller utilisation of Safe Havens and Crisis Recovery Houses.

A broader **communication strategy** is in development to:

- Increase awareness of Safe Havens and Crisis Recovery Houses.
- Ensure all stakeholders – especially service users – understand the benefits of these community crisis alternatives.
- Expand VCSE provision in the **Urgent and Emergency Care space** will provide greater choice and flexibility for people in crisis. This does require a cultural shift for both clinicians and service users who have traditionally viewed crisis care as the sole responsibility of statutory NHS services.

Additional enablers include:

- Moving the Thanet co-located safe haven from the first to the ground floor in September 2025 as part of a range of measures to tackle security concerns and maximise its ability to support people in crisis.
- The William Harvey Ashford safe haven is increasing its opening hours and is expected to be open 24 hours a day by April 2026.
- There will also be access to dedicated mental health triage space, assessment room and office on the William Harvey site for the Psychiatric Hospital Liaison Team.
- Teams are working to increase awareness of bus routes
- A new crisis recovery house is planned for Margate in partnership with the Pears Foundation.

Service configuration

There are differences in the way services are configured. In Medway, rapid response, liaison, home treatment and safe haven staff are all located in the same place.

In East Kent it is not felt to be feasible to permanently co-locate rapid response services at the two A&E sites. This is due to the size of the geographical patch and the requirement of the rapid response team to meet four-hour response target for people in crisis, which will be moving to a two-hour target. However, KMPT leaders are instigating a programme of work to improve how the teams link.

Improving consistency in thresholds for admission

It has been observed that the Rapid Response Team (RRT), who undertake urgent assessments of patients experiencing a mental health crisis in the community, generally apply a higher threshold when deciding whether an admission to an inpatient mental health bed is required than the Liaison Psychiatry Team (LPT), who assess patients in Emergency Departments (ED).

This difference arises because the RRT have direct, practical experience of supporting people with mental health needs in community settings, which forms a core part of their role. As a result, they are often more confident in identifying safe alternatives to admission. In contrast, liaison colleagues have less day-to-day exposure to community-based care, and therefore may be more likely to recommend hospital admission.

To promote greater consistency in decision-making, KMPT leaders are developing a programme of work to strengthen liaison colleagues' understanding of rapid response thresholds for safe

discharge and community management. This will include joint workshops, shadowing opportunities, and access to rapid response colleagues for telephone advice when making crisis decisions. Progress will be monitored closely with teams to understand the impact of these changes.

In parallel, work is also underway to strengthen the interface with acute hospital staff, particularly at the Queen Elizabeth Queen Mother site in Margate.

Agreed actions

Objective	Action	Timescale	Lead
Increase accepted referrals to Thanet safe haven	Implement actions agreed at workshop 18 August 2025 to improve safety for staff and patients, including move to the ground floor.	Q2 2025-6	KMPT
Improved pathways Increased diversion to safe havens, crisis houses and community treatment (including home treatment)	Realignment of matron responsibilities to strengthen the clinical leadership / positive risk taking across both Liaison teams	Q2 2025-6	KMPT
	Increase liaison team confidence by: • shadowing rapid response and home treatment staff • recruiting to new senior crisis roles • show progress towards Royal College of Psychiatry Psychiatric Liaison Accreditation Network (PLAN) approval (date for accreditation will be informed by progress and may be in 2026-27)	Q4 2025-6	KMPT
	Regular interface meetings and ICB engagement events with VCSE, service users and across agencies, to include awareness raising of bus routes	Q4 2025-6	KMPT/ ICB
	Expand VCSE provision in the Urgent and Emergency Care space	Q1 2025-26	ICB
	William Harvey co-located safe haven at Ashford to go live 24/7	Q1 2026-7	ICB
	Dedicated mental health triage space, assessment room and office on the William Harvey site for the Psychiatric Hospital Liaison Team	Q2 2026-7	KMPT/ EKUHFT
	New crisis recovery house in Margate	Q1 2026 - 27	ICB

2.3 Out-of-area complex autism placements evaluation

Introduction:

The ICB commissioned a pilot project to reduce reliance on distant placements for autistic adults with complex needs, moving out of area patients back to the community or home setting in Kent Duration: June 2024 – May 2025. The project was delivered by the KMPT Review and Resettlement Team.

The Aim:

By the end of the pilot (April 2025), to reduce the number of autistic in-patients unsuitably placed outside the Kent and Medway geographical location by 25% and reduce the number of all autistic

in-patients by 10%, through a comprehensive review and resettlement program that includes clinical reviews of every patient and quality review of every provider.

2024-25 Objectives:

- To reduce the out of area (OOA) cohort by 25% and the entire cohort by 10% by the end of the 12-month pilot
- To reduce the unsuitable admission of Autistic people
- To reduce the length of stay for Autistic people admitted to mental health in-patient settings
- To realise any identified savings and reinvest them into community services.

For the project trial to succeed three additional roles (complex care coordinators for autistic people) were recruited by the end of July 2024.

Reflection

With delays in recruiting, the project started in earnest in July 2024. The starting caseload was 15 patients, but following some due diligence conducted from the information received from the ICB, the caseload was amended to 19 people including one person who was in the process of transition.

Of the 19 patients, 7 can be considered as being placed outside of Kent and Medway although 3 were placed in London Boroughs previously part of Kent.

During the life of the project, there were 22 admissions (including 3 re-admissions) and 25 discharges (including 3 re-admissions) with one discharge pending after the life of the project. Every new admission was to a bed in Kent whether KMPT, Cygnet Maidstone or Cygnet Godden Green. The team acted as gatekeeper for prospective new admissions ensuring that if a placement was requested it was confirmed that it was appropriate before it was established; 29 were declined.

All but one of the discharges was to a property in Kent at the patient's request. Discharges were mainly to a home address under the umbrella of the CMHT or received S117 aftercare to a residence in the County. The Board is asked to note the good work carried out by the team.

Performance Measures against Objectives

1. **To reduce the OOA cohort by 25%** - OOA cohort reduced from 7 to 4, **a reduction of 43%.**
2. **To reduce the entire cohort by 10% by the end of the 12-month pilot** – Cohort reduced from 19 to 15, a **reduction of 21%**
3. **To reduce the unsuitable admission of Autistic people** – **29 referrals declined as being inappropriate.**
4. **To reduce the length of stay for Autistic people admitted to mental health in-patient settings**. **Average Length of Stay (LOS) reduced from 459 days to 287**
5. **To realise any identified savings and reinvest them into community services.** Realised savings for 2024-25 from the out of area placements outside of Kent have been assessed, net of S117 aftercare costs. The team were able to demonstrate savings of 800k for the cohort, including the saving from the newly discharged patient in July 2025.

   There are other savings from reducing length of stay, discharging from KMPT acute beds to home under the care of our own CMHT as well as stepping down patients within our own bed capacity. However, these are more difficult to quantify, as costs avoidance is challenging to evidence. Capturing these figures was outside the scope of the programme.

Conclusion

Whilst the life of the project was only 9 months, the project positively impacted patient experience, patient flow, appropriate admissions and discharge of patients from beds outside of Kent and outside of KMPT. The team was able to demonstrate the benefits of working with complex cases resulting in improved health and wellbeing and quality of life, married with financial savings that can be reinvested into our community services. The ICB is considering how it can best use this learning to inform next steps in enabling people to live as independently as possible.

3. Sustainable Community Care Collaborative

The Sustainable Community Care Provider Collaborative was launched on 13 August 2025 with a face to face workshop, attended by a wide range of partners. This collaborative brings together the work of the Community Social Care Collaborative with the Mental Health, Learning Disability and Autism Provider Collaborative.

The purpose of joining these two collaboratives together is to:

- Deliver the ten-year plan focus on care shifting from hospitals to communities
- Optimise resources and deliver joined up care both at scale and locally
- Reduce overheads and duplication
- Maximise opportunities to manage workforce supply
- Enable a single model for physical and mental health proactive and prevention-based care – delivered through Integrated Neighbourhood Teams with primary care
- Underpin a more coherent relationship with local authorities and social care, particularly for vulnerable groups
- **Most importantly a coherent provision of high-quality whole person care**

At the workshop we began the process of bringing together our existing workstreams and identifying new areas of work. Partners met in groups to scope our work under the following headings

- Learning Disability, Autism and ADHD pathways
- Children's Services
- Ageing well Including Dementia
- Mental Health Urgent and Emergency Care
- Neighbourhood Health (Integrated Neighbourhood Teams)

In addition to the above we will also be continuing together the successful community Better Use of Beds work, reviewing how our corporate services can work better together and scoping joint work for women's services. We will be updating our reporting to the KMPT Board as we further develop this new Collaborative.

Abbreviations in this report:

A&E – Accident and Emergency
ED - Emergency Departments
ICB – Integrated Care Board
INTs – Integrated Neighbourhood Teams
Liaison Psychiatry Team - LPT
Mental Health – MH
Mental Health Learning Disability and Autism - MHLDA
OOA – Out of Area
Rapid Response Team - RRT
Urgent and Emergency Care – UEC
VCSE – voluntary community and social enterprise (sector)

4. Current performance data

Measure	Agreed trajectory	Current data						Trend
		Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	
Programme: Dementia Pathway Transformation								
Increase dementia diagnosis rate	66.7% by March 2026	60.5%	60.9%	60.8%	61.1%	61.4%	62%	↑
Programme: Mental Health Urgent and Emergency Care								
Reduced MH A&E attendance and increase in attendance at safe havens	Reduction	*% MH A&E presentations against total presentations*						↓
		1.89%	1.92%	1.64%	1.11%	1.25%	1.29%	
	Reduction	*A&E attendances for adult patients with primary MH need*						↑
		824	902	772	810	901	976	
	Increase	*Safe Haven attendance*						↓
		1522	1585	1525	1623	1572	1526	
Crisis house bed occupancy	85%	*Medway bed occupancy*						↑
		63%	54%	71%	70%	26%	92%	
		Ashford bed occupancy						
		77%	43%	64%	74%	81%	89%	
Reduced mental health in ambulance/ police conveyances to A&E	Reduction	*Primary MH A&E presentation - Ambulance conveyance*						↑
		320	433	336	329	380	428	
		Primary MH A&E presentation - Police conveyance						↓
		49	32	33	34	51	37	
Reduction in incidence of Section 136	Reduction	81	63	55	57	75	58	→

Exception reporting on performance

- The number of people with a primary mental health presentation conveyed to A&E by ambulance has reduced over the last 24 months. June and July 2025 have seen numbers increase. This is in keeping with the overall increase in A&E attendance.
- While overall numbers of people presenting to A&E has increased, the percentage of these presentations that are primarily driven by mental health remains low. This increase in numbers has lasted beyond the expected Spring surge. East Kent presentations make up a high proportion of these presentations and the section above outlines drivers for this and actions being put in place.
- Police conveyance remains low.
- The Medway Crisis Recovery House was closed between 9th and 17th June, while it relocated to new premises. This explains the low occupancy during that month. July data shows 92% occupancy rate.

5. Programme milestones for 2025-2026

Milestone Tracking Key

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

Community Mental Health Framework			
Milestones	**Q2**	**Q3**	**Q4**
Milestones for CMHF being refreshed as per separate Board report			
Dementia Pathway Transformation			
Milestone	**Q2**	**Q3**	**Q4**
Go live with level 1 pilots (care homes)	X		
Finalise GPwER and GP capacity increase (level 1)	X		
Design MDT model for levels 2 and 3			
Review MDT model to inform continuation and scaling opportunities		X	
Expand pilot and scale up		X	
Continue expansion of pilots and scale across system		X	
Finalise reflections on pilots and new model and communicate			X
Mental Health Urgent & Emergency Care			
Milestone	**Q2**	**Q3**	**Q4**
Publication of MH Housing Strategy		X	
Publishing of revised Crisis 136 Standards		X	
Centralised HBPOS Go Live		X	
William Harvey Safe Haven increase to 24-hour service			X
Bespoke Conveyance (to include sit and wait) go-live			X
Procurement of Thanet and Medway Crisis Houses			X
Joint Working Programme			
Milestone	**Q2**	**Q3**	**Q4**
Working group established to deliver on mental health pathways development	X		
Mapping of existing programmes of work and meetings to ensure alignment across KMPT and Local Authorities	X		
KMPT Social Workers commence internal secondment	X		
Obtain and assess contracting data for current services across health and social care, identifying overlaps/gaps	X		
Proposed workshop surrounding prevention across health and social care takes place		X	
Embedding joint working practices and culture of inter-organisational collaboration			X
Evaluation of KMPT Social Worker secondment work takes place			X

We are here

Exception reporting on milestones

Dementia

- Dementia will commence level 1 pilots from w/c 15 September 2025, so is expected to be delivered within Q2 as planned.
- Due to complexity of implementing a new dementia diagnosis model, the delivery timeframe for the level 2 element is now expected to take place through Q3 and Q4 instead of full delivery in Q3.

Urgent and Emergency Care

- Local elections led to a delay in the housing symposium, which has caused the Housing Strategy publication date to slip from Q1 to Q3. This was factored in in the updated milestones shared in July 2025, so is shown here as amber.
- Centralised Health Based Place of Safety (HBPOS) will now be delivered in Q1 2026. This has slipped from Q3 2025 due to delays in the capital programme.
- Revision of S136 standards will now be implemented in Q4 2025-26, in line with the changed HBPOS go live date.
- The Ashford co-located Safe Haven was due to increase to 24/7 opening in Q4 2025. This is now expected to take place in April 2026, so early Q1 of next year.
- Margate and Medway crisis house opening will be delayed from Q4 2025 to Q1 2026. The Thanet delay is due to difficulties procuring a suitable building.

Joint working programme

- Work to obtain and assess contracting data is expected to be completed by the end of Q2 as planned.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Risk Management Framework (Risk Strategy and Risk Policy Review 2025)
Author:	Jessica Scott, Emergency Preparedness and Resilience Lead
Executive Director:	Andy Cruikshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Statutory

Overview of Paper

The 2025 Risk Management Framework aligns with NHS England and HM Treasury guidance, introducing an agreed Board Risk Appetite Statement and domain-specific ratings.

Issues to bring to the Board's attention

Governance now centres on appetite-based reporting via the Board Assurance Framework and Trust Risk Register. The Risk Manager leads reporting changes; with sub-committees monitoring risks outside tolerance. The Policy and Standard Operational Procedure updates clarify appetite verses tolerance and InPhase is being adapted for 129 risk owners to be trained to implement this approach across the whole risk profile of the Trust in a phased roll out in 2025/26.

This change closes Deloitte KLOE5, recommendation 10, and supports consistent risk governance, informed decision-making, and resource prioritisation. Compliance is tracked through InPhase actions, sub-committee oversight and the TIAA audit.

Governance

Implications/Impact:	-
Assurance:	Substantial
Oversight:	Audit and Risk Committee.

Version Control: 01

Risk Management Framework.

The 2025 Risk Framework builds on KMPT's evolving governance, aligning with NHS England's updated Risk Management Framework, adapted from the HM Treasury's *Orange Book* and other sector-specific guidance.

It incorporates:

- A refreshed Risk Appetite Statement developed in collaboration with the Board and informed by the Leeds Teaching Hospital model and training delivered to Board in April 2025 by NHS Professionals.
- A shift to risk appetite-based governance, with domain specific appetite ratings is aligned to sub-committees and executive staff roles, in the Risk Appetite Guideline as appended.

Assurance:

This change closed Deloitte KLOE5, recommendation 10, as reported within the Risk Assurance Paper (May 2024).

Embedding change in 2025/26:

The roll out of the move to risk appetite-based governance commences with the Board Assurance Framework and Trust Risk Register.

The Risk Manager is key in the provision of reports reflecting the Board Risk Appetite for the Board Assurance Framework and Trust Risk Register.

Once the Board Assurance Framework and Trust Risk Register are established and feedback received on the reporting table change, this will then move down into sub-committees of the Board via the Risk Manager before widely moving to all risks on the InPhase App via a change in the form, training and application of that change to each risk owner (n129 owners) in 2025/26.

In preparation for that change for all risk owners, the InPhase Steering Group has been informed to allow for consideration of the application of the change and impact on the Business Information report downloads.

Risk tolerance:

The information reported against the Board appetite will be monitored via the sub – committees to ensure risks are in a tolerable risk position, influence control review/new controls for those which are outside of tolerance and be used for:

- Supporting informed decision-making
- Reducing uncertainty;
- Improving consistency across governance mechanisms and decision making;
- Supporting performance improvement;
- Focusing on priority areas within the Trust; and
- Informing spending review and resource prioritisation processes.

Non-Clinical Risk Management Policy.

Sections Updated:
1.2, 4, 13.3, 6.1.4, 10.4.2, 10.5.2, 10.6.2

Addition of risk appetite clarification across multiple sections, reinforcing how risks will be assessed, tolerated, or brought within appetite in line with strategic objectives.

Changes to the Non-Clinical Risk Management Policy in 2025 focus on and reinforce alignment of the Board risk appetite with governance and operational processes. These changes once embedded support consistent risk assessment and escalation practices across the sub-committees.

Risk Management Process Standard Operating Procedure.

This document has been changed to reflect the Risk Appetite Guidance appended to the Framework document.

For staff it distinguishes between:

Risk Appetite: The level of risk the Trust aims to operate within.
Risk Tolerance: The level of risk the Trust is willing to accept.

The **Risk Appetite Scale** referenced is actively being embedded in the Trust's Board Assurance Framework, governance documents for sub-committees and operational tools, including the InPhase Risk App.

Monitoring the changes:

Risks outside tolerance are monitored via sub-committees.
Actions are tracked in the InPhase system.
Compliance is audited through the Risk Quality Audit.
TIAA audit review.

The documents have been supplied to the Reading Room and are currently active on StaffRoom for direct staff access and will be part of the TIAA call for evidence.

Version Control: 01

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Getting the Basics Right
Author:	Victoria Stevens – Deputy Chief Operating Officer
Executive Director:	Donna Hayward-Sussex – Chief Operating Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The paper summarises the work being undertaken within the Getting the Basics Right Programme. It highlights progress to date and the approach being taken to deliver against the overall aims.

Issues to bring to the Board's attention

The focus of the programme is to improve processes, standardise tasks and utilise digital options where possible. In addition, the programme seeks to identify opportunities to reduce inefficiencies and improve quality. A key driver of the programme is to create an operational model for service administration. Currently no such model exists across the organisation. This is complex and requires significant engagement and consultation with a large number of administration staff. This is likely to generate concern amongst our staff with involvement and co-production being critical to success.

Governance

Implications/Impact:	Staff confidence due to scale of change.
Assurance:	Reasonable
Oversight:	Trust Board and Leadership Team

Context & Background

The Trust is seeking to improve processes across clinical services to eliminate waste by standardising tasks and utilising digital options where possible. Re-engineering where achievable both procedures and systems to identify opportunities to reduce inefficiencies and improve quality. We call this programme 'Getting the Basics Right'.

'We're simplifying the everyday tasks that take up time – from documentation to admin processes – to be more consistent, efficient and focused on what matters most, patient care'. This is our vision for Getting the Basics Right.

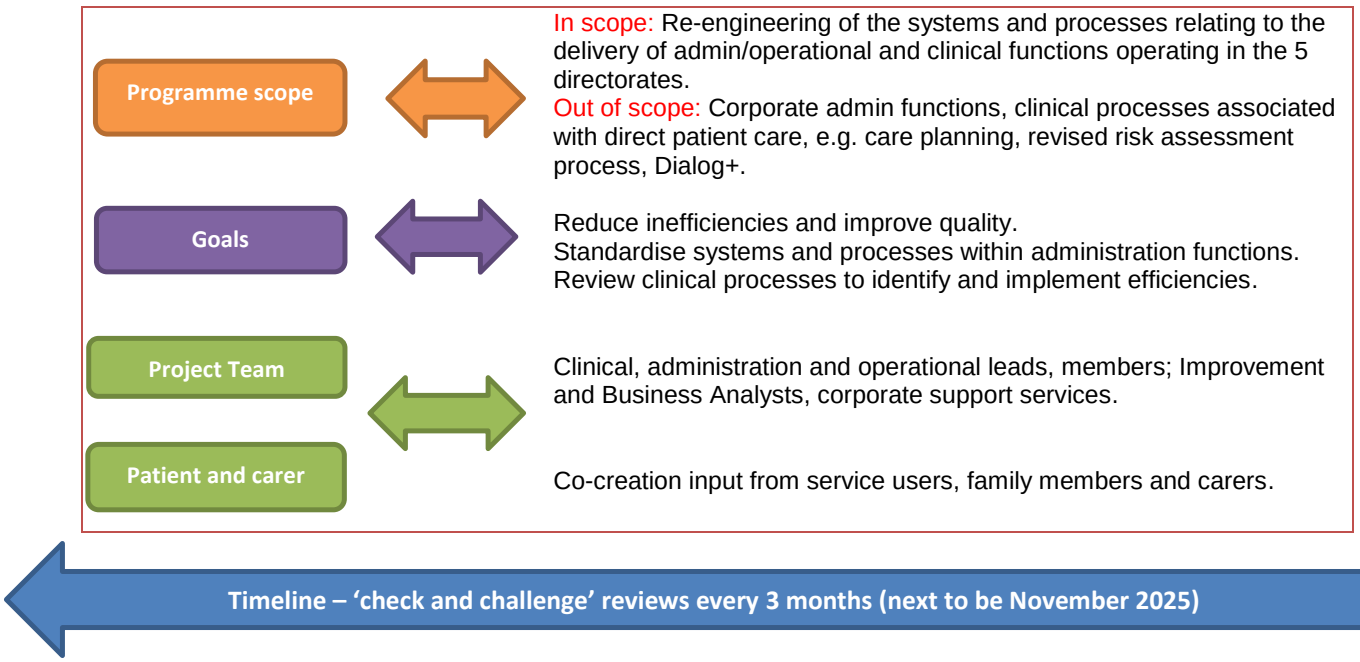
Across all clinical services the administrative functions play a critical role in supporting teams to deliver care. It is widely recognised that some tasks that are undertaken by both clinicians and administrators take too long, are over burdensome and in some cases add little value to our patients. We have heard directly from staff that change is needed and never more so as we increase our focus on ensuring we are sustainable.

During the discovery phase of the programme we have learnt about the inconsistent approaches adopted with notable variation in staffing levels and roles across our administration functions. In some teams this has led to unnecessary pressure on both clinical and administration staff. Moreover, limited digital solutions are clearly hampering efficiency. The absence of a fair, standardised, and sustainable administrative model is clearly indicated.

The programme seeks to simplify everyday tasks via standardisation and utilisation of digital enablers; working closely with the Digital Team to implement new technologies. This will be done alongside designing a new operational model for administration.

Programme Scope

The Getting the Basics Right programme will run over several years due to the scale of the work involved and the size of the organisation. In order to ensure that progress can be monitored, goals have been established to help drive the programme in the scope and defining stage. Programme details are below:



The scope of the project as outlined above, has two distinct areas 1) the clinical effectiveness group and 2) the administration effectiveness group.

Clinical Effectiveness Group

The group are focused on the improvement of clinical systems and processes which include appointment management and reducing non-attended appointments.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
Reducing Trust Cancelled Appointments	On average 11.8% per month of appointments are cancelled by the Trust. This leads to admin staff having to rebook appointments for patients, often at short notice. The impact of this is poor quality of service and patient experience.	Scoping of the issues is currently underway. This will identify specific services and professions who have the largest cancellations. A targeted improvement project will be implemented in North Kent and learning from this will be used to inform other localities.	Evaluation of the A3 in North Kent with a view to roll out across the Trust.	The North Kent project will commence in October 2025 with completion in February 2026. Learning shared and implementation commencing for other directorates March 2026.	Reduction in administration time and Improved service user experience.	Reduction in Trust cancelled appointments from current average of 11.8% per month.
Reducing non-attended appointments by patients	On average 16.3% per month of appointments are either recorded as did not attend or cancelled by patients. This accounts for a significant amount of resource and is likely to have an impact on the quality of care	DNA policy revised, ratified and published. Daily DNA huddle introduced. Text message reminders live from January 2025. Noted that text reminders were in place prior to this date but	Opt out (rather than Opt in) planned for September 2025. Additional information via the Patient Information webpage, to provide signposting to support and information. Evidence demonstrates that patient access to robust information	Aim to reduce Did Not Attend Incidents to 5% by March 2026. (Exceptions - MHT have a target of 10% as they have a much higher DNA and Client cancellation rate (currently	Improved information for patients. Reduction in the number of missed appointments.	No. of hits/views of the webpage. Reduction in total number of DNAs monitored via trend information.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	provided to our patients. There is considerable variation in numbers of DNA across services, for example, groups aligned to MHT currently have a DNA rate between 20% to 30%. Whereas the early intervention service (as of March 2025) had a DNA rate of 5.2% but a cancellation rate of 10%. Likewise, some of our services have a high missed appointment rate for reasons external to the clients control e.g. CJLADS (based within custody). This makes it difficult to achieve a standard Trust-wide target. The focus of the project will therefore be on areas where the DNA rate, client cancellation and client population are higher (see	continuous improvement has standardised the process. An outlook rules pilot will be implemented to provide tools for admin to ensure adherence to the DNA policy.	supports a reduction in DNAs (NHS reducing DNA's guidance & Nice Guidance). Reducing Barriers to Engagement Training – provided to colleagues conducting Dialogue/ Dialogue+, to improve follow up appointment rates.	between 10% and 20% dependent on locality). September 2025 – March 2026.		

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	appendix). However, some countermeasures (Text Message Reminders, Outlook Rule & Information webpage are aimed at supporting all services).					
Improving un-outcomed appointments	Not outcoming appointments occur when a patient has received an appointment but the clinician has not confirmed the appointment on RiO. This leads to under reporting of activity and wider data quality issues associated with recording patient activity.	In the period from April 24 to March 2025, 3,749 un-outcomed appointments were reported across the Trust. On average (Mean) this equates to 250 a month. Confirmation of current state as part of the A3 included Root cause analysis Survey of staff to ascertain their understanding of the outcome process, identify issues and time taken. Data workshops provided for all community directorates to help	Prioritise counter measures identified to enable a focus on 'quick wins' e.g. ensure staff are provided with tablets to enable completion of admin/outcoming of appointments when working away from base. Develop specific screen saver reminders and improve inductions to emphasise the importance of good quality data.	Counter measure and quick wins will be completed as identified. The A3 will be completed by December 2025.	Improved data quality and recording of activity.	Total number of un-outcomed appointments reduced by 85% per team. (This is based on reviewing all appointments from April 2022 onwards.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
		develop staff understanding. Introduction of data huddles at directorate level.				
Standardisation of Operational Policies & Standard Operating Procedures (SOP) Governance	To date the review of the current SOP's within the Trust shows that there are 68 clinical SOPs. Further review is needed to confirm which of these are combined with policies. Work is ongoing to clarify accurate numbers and the breakdown of SOPs and policies. Policies and SOPS are in place to provide guidance to staff on a range of services. The review process for these documents is not clearly identified within all services and there is no clear governance process to ensure that all documents have owners and are	Standard template for Operational Policy and SOP's developed for use in MHT and MHT+. In depth analysis regarding the volume of SOP's and policies that require review across the Trust. Policy Group membership changed and new governance process under way.	The new standard format for the documents is being tested for effectiveness with key stakeholders. If the outcome of the evaluation is positive, the standard template will be rolled out on a wider basis across all services. This will include the development of guidance to clarify what constitutes a SOP and what constitutes a policy. Survey all staff to ascertain level of satisfaction and understanding of SOP's.	March 2026	Increased staff satisfaction and understanding of both operational policies and SOP's. Streamlined number of both policies and SOP's to aid compliance.	Decrease in total number of SOPs and policies. Approved and refined governance processes in place – less burdensome and more clarity. Improved compliance against SOP audit process.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	reviewed and ratified as required.					
Capturing patient information and Improving Data Quality	Identifying health inequalities amongst services provided by KMPT is challenging due to the significant variance in completeness of protected characteristics data across services and directorates.	A baseline for completeness of data has been provided by BI as part of the Equity for all project. This shows percentage of completeness. Baseline data is shown in Appendix 3.	Alignment with Equity for all project as a significant interdependency. RiO form being developed for staff to use to simplify recording of protected characteristics. BI dashboard available to monitor recording of data for protected characteristics.	Ongoing but progress will be reviewed December 2025	Improvement in data capture to better inform work related to inequalities.	Increased rates of completion for protected characteristics.

Administration Improvement Group

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
Minute taking policy	Administrators in community and inpatient services can spend a significant amount of time attending meetings and subsequently writing up detailed minutes from the meeting. This has been estimated as 127 hours per week	CQC compliance has been clarified in relation to legislative requirements to record minutes of meetings. Draft Minute Taking Policy being developed to be ratified September 25.	Exploration of the use of Co-Pilot, voice recognition tools and other AI options which have the potential to eliminate the need for typing up minutes and actions for both clinical and admin staff. Action logs implemented saving approximately 60% of administration	Completion November 2025.	Reduction in admin and clinical time reading notes Improved staff experience.	Staff feedback exploring levels of satisfaction pre and post implementation.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	across all directorates.		time previously spent taking minutes. Trust wide comms informing all staff of the changes in minute taking and replacement with action logs.			
Admin access to progress notes	Policy constraints restricting administrators from entering notes on RIO leading to protracted processes for communicating updates with the clinical team.	May 2025 agreement reached that supports administrators to directly record their contact with patients on progress notes without need for a clinician to validate the RiO entry. Guidance developed and submitted to Information governance policy review group. Information Governance Policy is being amended and circulated for agreement.	RiO team to update permissions once policy changes are agreed. Trust wide comms to inform all staff of the changes to policy.	30 September 2025.	Improved use of admin time. Support effective caseload management and Improve communication and continuity across services. Improve patient safety and experience.	Improved caseload management and patient experience.
Operational Model for Service Administration	KMPT has no Operational Model for Service Administration	Productivity analysis of all tasks completed. This shows a	Senior administrators digital and improvement specialists will work together to undertake a	Value stream mapping undertaken across all	Definable operational model for administration.	Reduction in non-value add tasks to demonstrate efficiency

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	leading to a lack of a framework for how administrative tasks are organised, managed, and integrated with clinical operations. This has an impact on patient experience and service performance. There are many processes / procedures and systems in place (many varied) across our teams. There is no standardisation of these including patient letters, GP responses and job planning which is needed to ensure consistency of workload and function across all clinical services. The lack of standardisation has made it difficult to automate routine processes.	breakdown of tasks, time taken and relevance to admin role. This analysis will act as the foundation for the value stream mapping work which will follow. Robotic automation software has been deployed within Rio.	value stream mapping exercise. It will help identify inefficiencies and areas for improvement by analysing the current state and designing a future state alongside our staff working in administration. Full development of an Operational Model with appropriate agreements followed by additional engagement across the Trust, job description reviews, job planning, staff 'customer' training with patient involvement and formal consultation.	services over a 3-month period – complete by December 2025. Timeline refresh thereafter to allow full engagement and enhanced scoping. End state for new operational model March 2027.	Improved patient and staff experience. Financially sustainable.	(application of LEAN). Reduction in variation across teams with standardisation of roles and responsibilities. Sustainable support to front line service delivery.

Projects	Problem Statement	Progress to date	Future Developments	Timeline for Completion	Benefits	Measures
	This leads to inconsistency along with not providing the best quality and standards we wish to provide. It is confusing for staff and is inefficient.					

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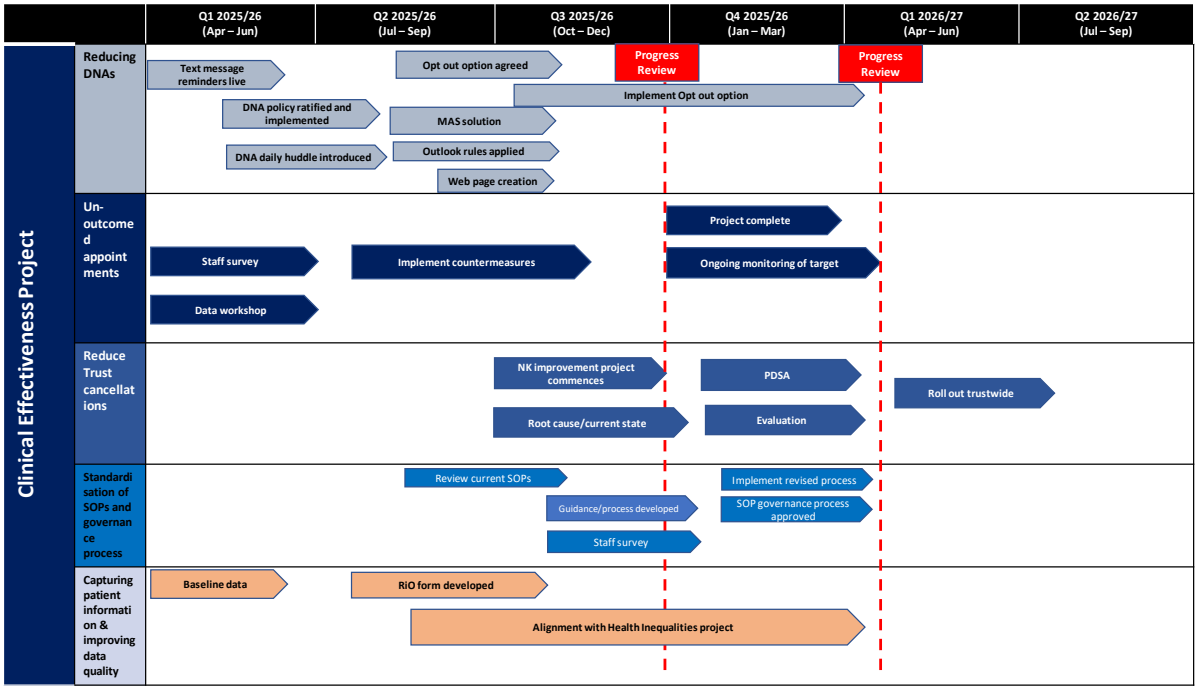
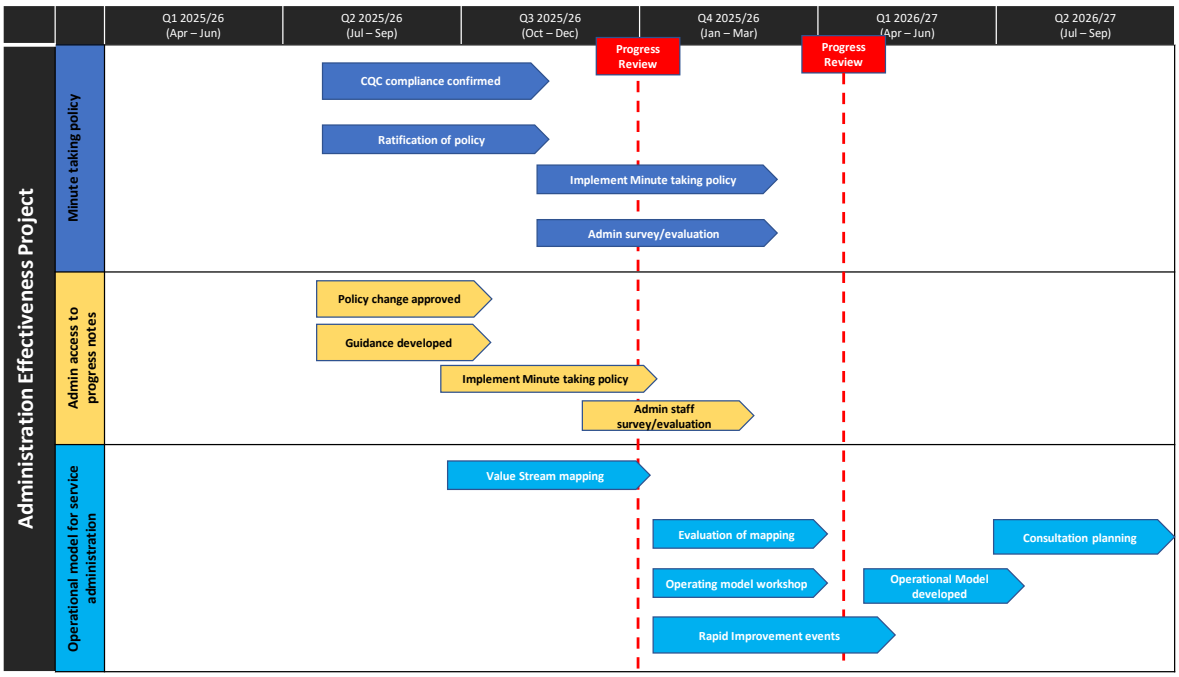
Programme Timeline

The timeline for the projects/task and finish groups are detailed in the diagram below:



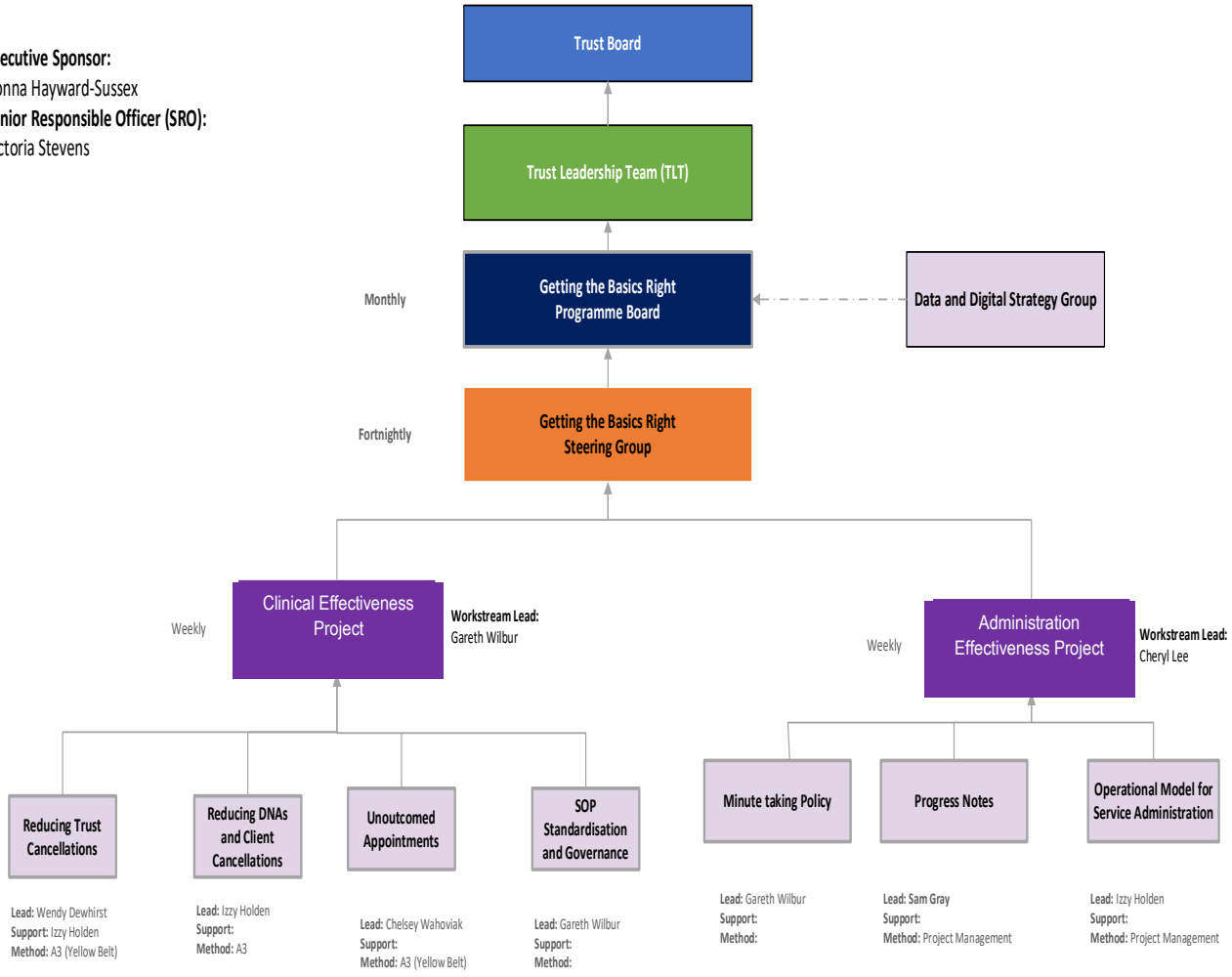


The programme has taken time to identify key areas of focus. This is largely due to a variety of independencies. The introduction of 'Doing Well Together' has helped delineate between this programme, the digital programme and what will be undertaken as improvements without the need for a programme approach as is being adopted in GtBR.

Programme Governance

The governance framework for the programme is as detailed below.

Executive Sponsor:
Donna Hayward-Sussex
Senior Responsible Officer (SRO):
Victoria Stevens



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Delivering the Change

The programme will utilise Kotter's 8-Step Change Model as a framework to deliver the changes as described above. It provides a clear and structured approach with specific emphasis on employee engagement.

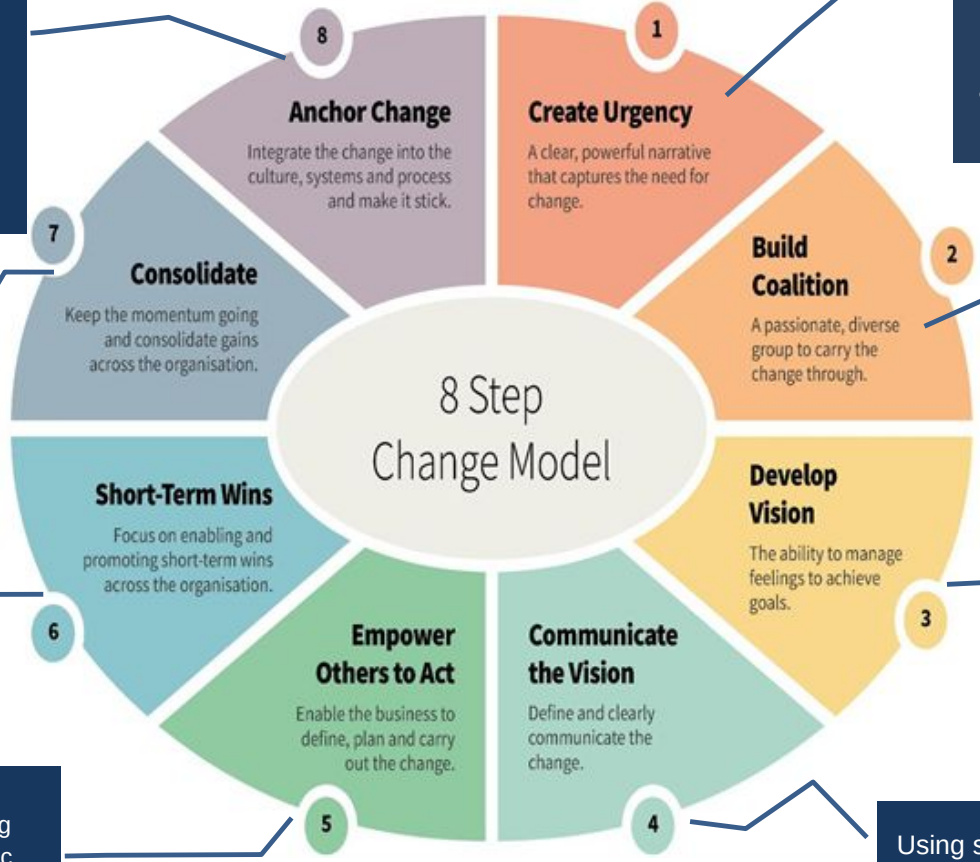
We will reinforce small actionable changes to daily routines to reinforce the new ways of working.

We will be caring, inclusive, curious and confident.

We will use stepping stones to continue the journey to achieve outcomes. We will do this by continuing to leap!

We will celebrate improvements (no matter how small) to compound over time and build momentum.

We will 'dig deep' into root causes of barriers, surfacing obstacles including systemic issues that need addressing. The programme will be supported by the Exec to resolve these issues.



We have shared both the experience of staff and patients to help create the narrative as to why change is important and why now. For example, the reduction in MHT DNA appointments has resulted in efficiencies due to a reduction in missed appointments for patients

Project team; patients, families and carers involved through co-creation; admin and clinical staff in each of the directorates; HR, BI, IG and finance.

We're simplifying the everyday tasks that take up time, from documentation to admin processes, to be more consistent, efficient and focused on what matters most, patient care'.

Using storytelling and the involvement of patients we will communicate the vision.

Summary

The GtBR programme currently consists of the 2 workstreams outlined above. Each workstream has a number of projects. These are monitored regularly to ensure closure and movement to 'business as usual' enabling future areas of focus to be added to the programme.

The interdependency with the Digital Transformation programme (appendix 1) is essential to the success of the programme and timelines for delivery. An example of this is the development of Artificial Intelligence solutions that enable our administration functions and the patient portal supporting improved communication with our patients and anticipated further reductions in not attended appointments.

The scale of change related to the development of an operational model for administration is significant and should not be underestimated. It will require significant engagement across the organisation with both our staff and patients. The workstream will utilise the principles of Kotter's change model to aid progress and engage widely with circa 400 wte staff directly involved with service administration.

Appendix 1

Dependencies between GtBR and Digital Transformation

There are several digital projects currently underway that have a direct synergy with the programme. These are outlined below. It is noted that this will not be an exhaustive list and will be added to as the digital transformation develops.

Patient portal	Purpose: To provide a secure digital solution for patients and service users to access their healthcare records, correspondence, and treatment plans , to communicate with their care team and to access a library of self-help materials. Expected Benefits: ▪ Improved patient experience resulting in reduced DNA rates as a result of patients receiving timely appointment information. ▪ Reduced printing and mailing costs with added benefits of reducing administration time (printing letters / care plans and sending via the post) where patients have opted-in to receiving correspondence electronically. ▪ Seamless capturing of Patient Rated Outcome Measures resulting in time saved for clinicians.
E- referrals	Purpose: To implement an electronic referral management system to support the management of GP referrals into KMPT. Expected Benefits: Currently being defined.
E-prescribing	Purpose: To improve inpatient safety and experience of staff, by introducing a new electronic system to prescribe and administer medication. Expected Benefits: ▪ Consent to treat documentation visible electronically resulting in improve patient safety and compliance with legislation, regulations and policies. ▪ Improved compliance with documentation when prescribing visible electronically resulting in improve patient safety and compliance with legislation, regulations and policies. ▪ Improved checking of documentation when administering resulting in improve patient safety and compliance with legislation, regulations and policies.
Health Inequalities/equity for all	Purpose: to reduce healthcare-based inequalities for our service users, and more widely to support the Trust in reducing health inequalities within the local population. The Group will provide central oversight of health inequalities information and activities to reduce inequality. • Increase staff awareness of and confidence in identifying health inequalities through learning opportunities delivered via a range of methods i.e. virtual training, face to face sessions, thematic information sessions etc; • Oversee continued development and utilisation of the health inequality dashboard; • Identify opportunities to improve protected characteristic recording and data quality; • Identify opportunities to access to services in line with the Trust 2026 objective; • Review healthcare-based inequality information to better understand the areas of inequality and determine areas for prioritisation;

	• Oversee current KMPT improvement activity to reduce health inequality and share areas of good practice and innovation within and outside of the Trust; • Integrate health inequalities into the 'Doing Well Together' Improvement programme to ensure that staff are provided with the opportunities and capability to deliver sustainable change; • Develop joint EDI/HI leads and champion roles; • Develop partnership opportunities with KCHFT and NELFT; • Build a more equitable offering for our staff and patients through the delivery of PCREF raising any risks, issues via governance and finding mitigations.

Appendix 2 – Did Not Attend

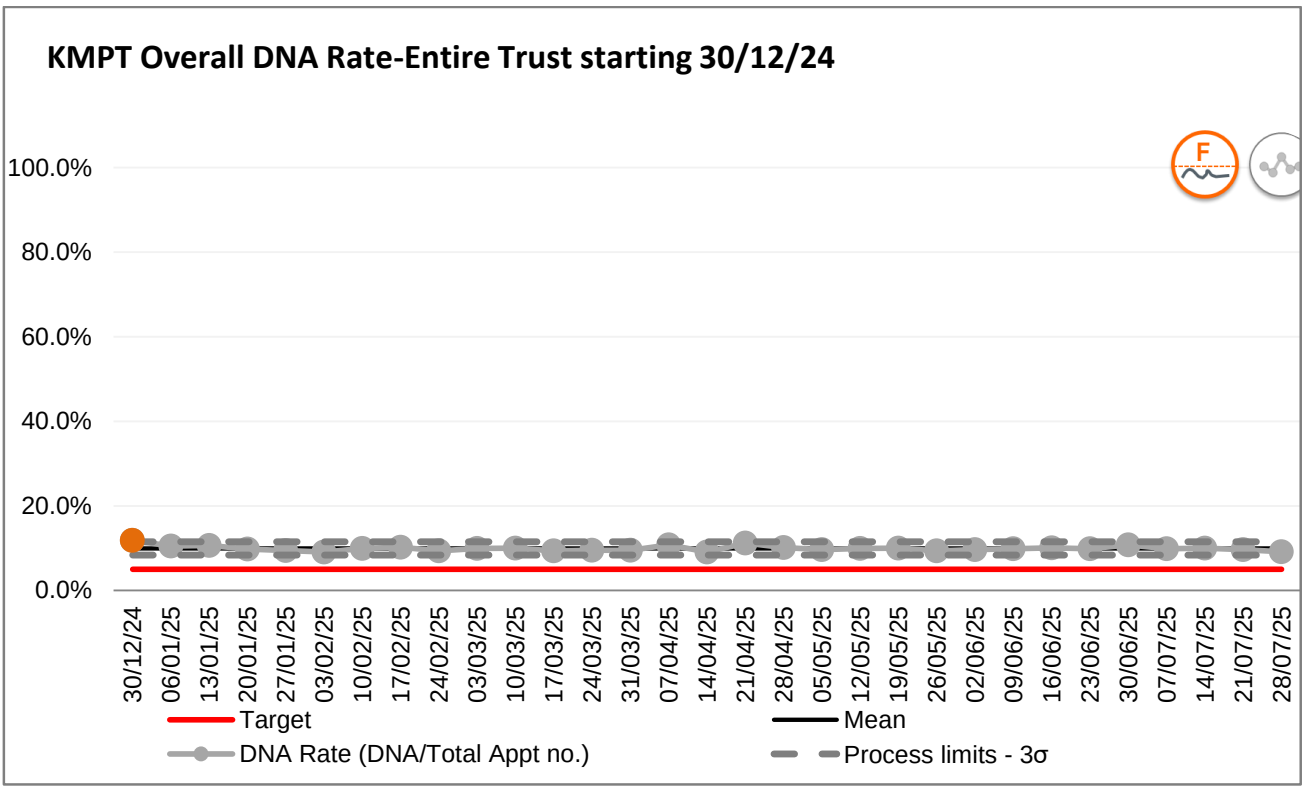
Mental Health Together were the first service to take part in the Did Not Attend (DNA) pilot as they demonstrated particularly high numbers of missed appointments. A key element of the project has been the introduction of SMS Text Reminders. These will be rolled out across the trust in 2 stages.

The first stage is 'switching on' reminders, and adding team email addresses to allow service users to contact teams (to cancel an appointment as opposed to missing it for example). The second will commence when the 'opt out' process is agreed and implemented. The 'opt out' process means that patients will opt out of receiving text message reminders, rather than having to opt in to this service.

A pilot of the new automated opt-out system will include the development of the content for the service user text, potentially a change to RIO Information sharing and consent forms and completion of the Patient Information Webpage (where patients will be able to find information relating to opting out).

The Graph below shows KMPT's current DNA rate (overall) – currently at approximately 10%. As previously outlined different services will have a different DNA rate, such as MHT and EIP but the trust overall DNA rate sits at 10%.

Graph 1

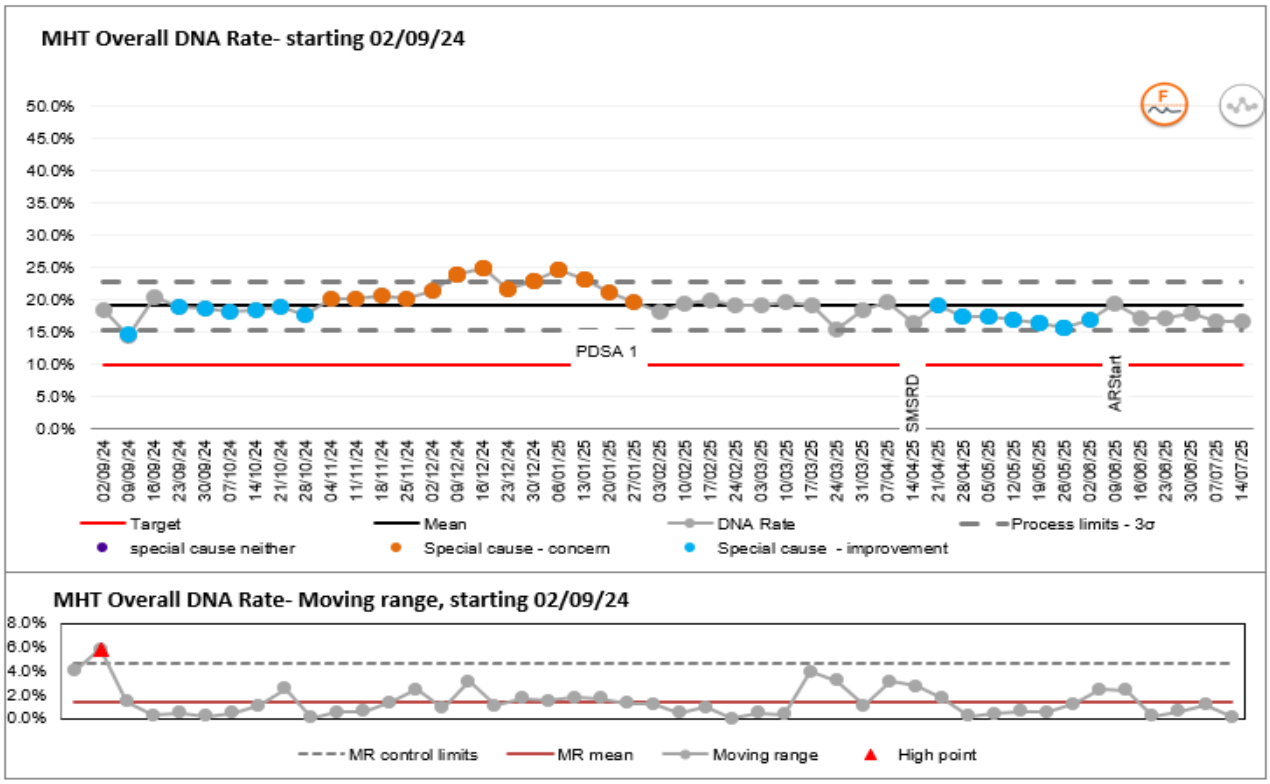


The graph below details the number of DNAs in Mental Health with the reduction over time following the implementation of the countermeasures detailed in the report – introducing text message reminders.

Labels on the graph indicate specific pieces of work starting and the impact. ARStart shows a dip which related to reduced admin capacity for setting up text reminders.

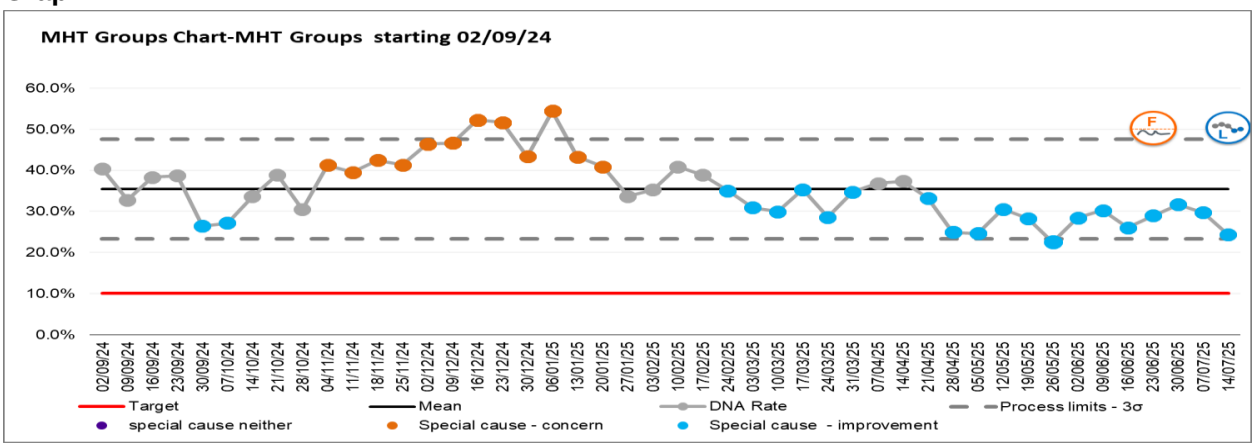
Currently the DNA rate is consistently falling below the mean across the county.

Graph 2



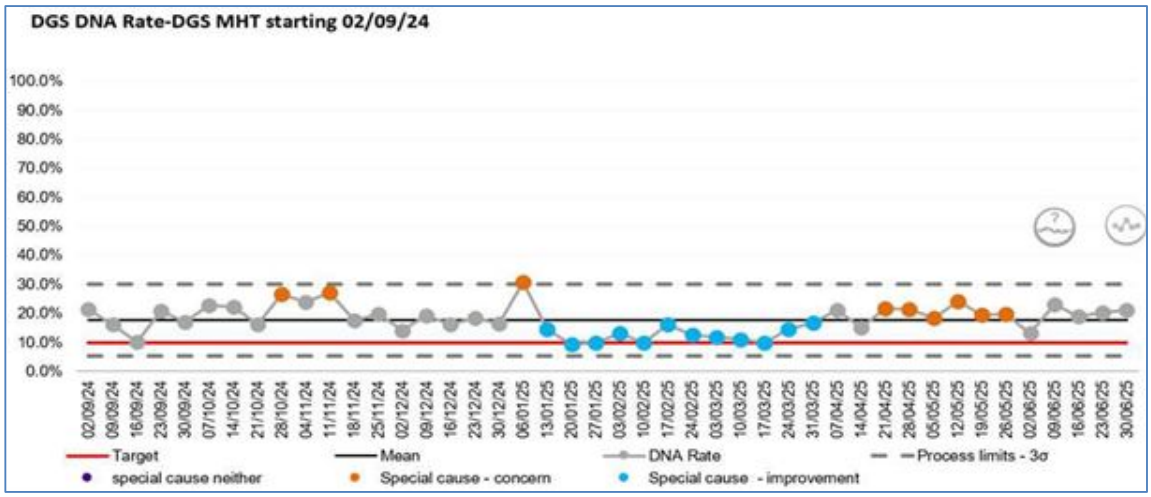
Graph 4 shows the variation in DNAs for group appointments. This is a significant issue for the trust. One of the countermeasures in place to help resolve this is the introduction of specific training for staff to help them better engage with patients when booking them into groups and how they are describing the offer available.

Graph 4



Graph 5

This shows the Did not Attend Reduction at one of the 2 Pilot sites of DGS (the second pilot site was in Thanet), where standardised Text Message Reminders were first rolled out. A sustained reduction is observed from the 20th of January 2024 (when the Pilot commenced), until the end of the Pilot (31st March 2025). At this point the Did not Attend Rate increased – feedback from the Pilot Team highlighted this as being due to the increased number of Group Appointments.



Appendix 3

Directorate	Acute	Forensic and Specialist	East Kent	North Kent	West Kent	Total
Characteristics	% Complete	% Complete	% Complete	% Complete	% Complete	% Complete
Accommodation status	80.3%	57.3%	48.4%	50.7%	48.5%	**50.4%**
Ex BAF status	32.7%	13.6%	8.1%	8.1%	18.0%	**11.4%**
Employment status	71.1%	58.2%	49.6%	51.7%	50.7%	**51.7%**
Ethnicity	95.9%	92.2%	83.6%	87.3%	73.5%	**83.3%**
Gender	100.0%	100.0%	100.0%	99.9%	99.9%	**99.9%**
Marital status	76.9%	67.7%	51.1%	52.8%	54.7%	**54.7%**
Nationality	57.8%	32.6%	29.7%	35.6%	34.5%	**32.8%**
Religion	69.4%	46.3%	39.0%	42.5%	43.0%	**42.0%**
Settled accommodation	88.1%	56.5%	50.4%	52.9%	50.8%	**52.3%**
Sexual orientation	51.0%	12.4%	10.9%	9.7%	21.3%	**13.7%**
Disability flag	30.6%	15.3%	4.0%	2.6%	4.6%	**5.6%**
Total	**68.5%**	**50.2%**	**43.2%**	**44.9%**	**45.4%**	**45.3%**

*Baseline Data for protected characteristics

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

A paper setting out the Trust's performance aligned the targets and metrics from the trusts Doing Well Together Programme.
The report focuses on the True North and Breakthrough Objectives in order to deliver the key strategic aims.

Issues to bring to the Board's attention

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

The IQPR provides an overview of trust services across numerous indicators, this represents one element of the trusts Performance Management Framework and is supported by monthly Executive led Directorate Quality Performance Review meetings.
The Chief Executives Overview at the start of the report highlights the key areas of focus: patient flow and bed state along with dementia services and mental health together waiting times. Key areas of improvement in recent months are also noted.
The reporting against each domain additionally includes a focus on the relevant Breakthrough Objective.

Governance

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

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Integrated Quality & Performance Report

(IQPR)

September 2025

Contents

1. Chief Executive Overview

I wanted to open my introduction to this report to share how very proud I am that we have moved to segment one in the new oversight framework which reviews trusts performance looking at a wide set of measures, including patient experience, clinical outcomes and financial sustainability. We are in the highest segment (segment 1), and are ranked 9th out of 61, across all the non-acute trusts in England.

This is a fantastic achievement and reflects the compassion, dedication and professionalism that our staff show on a daily basis.

As usual, this report highlights the trust performance for August, focussing on where performance is improving, areas of concern and what actions we are taking to address these. This month I have focussed my overview on our inpatient beds, the work we are undertaking in our community mental health teams (MHT), dementia and a number of areas we are making positive progress.

Patient flow / Bed state

We continue to manage our beds with an un-relented focus. Bed occupancy across our acute beds was the highest since March at 96.8% for August, our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 60.6 days (15 discharges) in August, higher than July but a reduction from quarter one. The position remains higher than in late 2024 where there was consistent achievement of under 50 days. We enacted our 8-week bed plan last month which includes the use of a VCSE provider for Step-down beds for patients whose onward transfer is delayed.

Key actions and improvements:

- The established caseload 'Patient Flow - Step Down Bed' (Clarendon House) remains a critical element of the patient flow pathway and currently 9 people have been transferred to the facility, awaiting onward transition to their long-term placement.
- Up until September 11th, 4 OOA patients have been repatriated to a KMPT bed (discharged from OOA bed and admitted to an Acute ward within 48hrs of discharge).
- Reduced our CRFD cohort of patients to 55 in acute beds as at early September compared to a high of 70 in January
- Reduced our CRFD Length of Stay (LOS) at discharge to 60.6 days in August compared to 90+ in April and May

- Reduced our CRFD over 100 days patients from a high of 12 in February to 2 in August – this has been a breakthrough objective for the trust since the start of April and we have seen real progress made against this objective. In the coming months we need to re-define our breakthrough objective to ensure continued progress is made for our CRFD patients.

We recognise the need to continue to achieve a reduction in those people waiting over 12 hours in an emergency department for admission to an acute bed. In August 8.8% of those identified as needing a bed where discharged from liaison teams within 12 hours, whilst challenges remain this is the highest percentage of the previous 12 months. Work is underway to procure a digital solution to provide more transparency of how beds are assigned for those identified as requiring one in any setting.

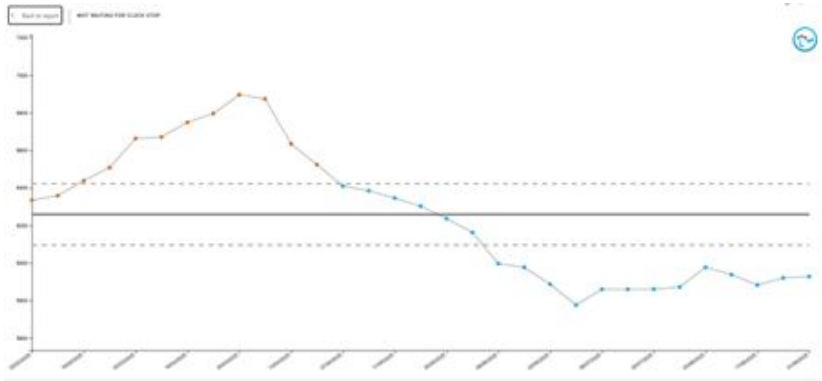
Community Mental Health, Mental Health Together (MHT)

Good progress is being made within the Community Mental Health Programme. The refinement of the model is underway with good engagement from staff, our patients and partners.

I am pleased to report that for Mental Health Together we have seen a reduction in wait times. The MHT waiting list has reduced from 6,949 at the end of March to 5,918 in early September, which is a 15% reduction. This has been achieved through:

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

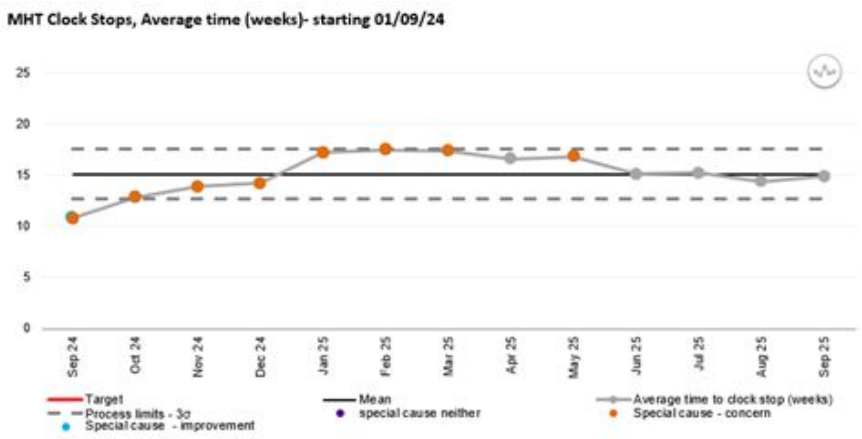
MHT Waiting list size 01/02/25025 – 12/08/2025. Showing special cause variation of an improving nature overall and in 4 of 7 teams



- Of the 5,918 waiting 82% are waiting under 18 weeks
- 32% are within 4 weeks

Our focus in the next month is to eliminate those waiting over 52 weeks which is reported as 45 patients as at 9th September. However, almost exclusively all of these are patients were previously open to a Community Mental Health Team prior to the implementation of MHT and have been receiving treatment prior to stepping down to receive a different support offer. All patients reported as waiting over 52 weeks are reviewed weekly to ensure plans are in place. in addition, all teams reviewing those waiting longer than 12 weeks.

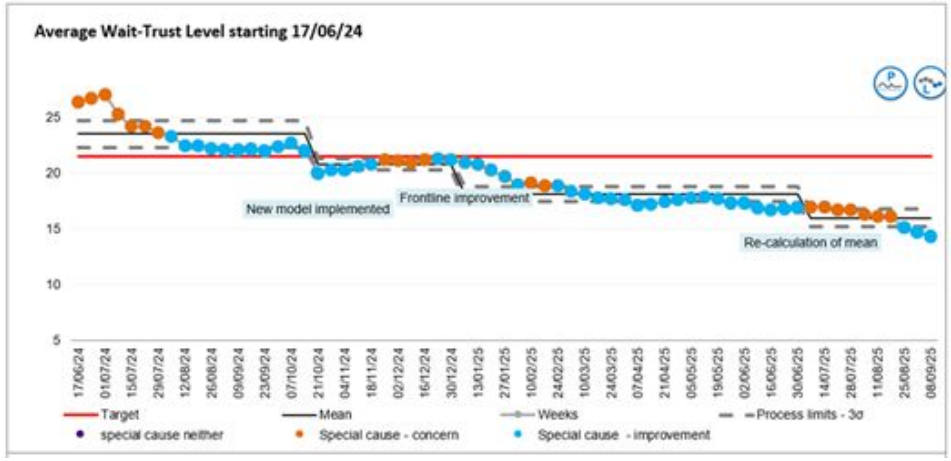
In 2025 to date there has been an average of 3,695 referrals received by MHT each month, there is common cause variability month to month. The graph below shows a reduction from 17.5 weeks wait in February 2025 to 14.9 weeks in August 2025. This is the time in weeks from referral to commencement of treatment. Further work is being explored to test analysis of expected level of waiting lists and number of clock stops per month, now that the service has been operating long enough to generate trend data.



Dementia

We have made significant progress internally in the last 6 months with our performance, below are the positive steps that have been taken:

- We have seen an improvement from 8.8% in May 2024 to consistent performance of over 25% since November 2024. This is above both the national performance (16.6% for May 2025) and south-east England performance of 3.4%.
- Increased the dementia diagnosis rate to the highest it has ben in Kent & Medway ever to 62%, moving closer to the national ambition to 66.7%
- An average of 374 diagnosis have been recorded each month in 2025/26 to date, an increase from 352 on average for the second half of 24/25.
- We have focussed on reducing long waits, with patients waiting over 52 weeks for a diagnosis reducing by 80.8% from 260 in February to (50 week commencing 15th September 2025). Work is continuing to eliminate non-clinically necessary waits over 52 weeks in September.
- Average waiting time has reduced by 47.9% in the past year from 190 days to 99 days (15th September 2025) and continues to reduce. Average waits at KMPT are below the national average wait reported in the national dementia audit of 151 days



Progress continues to reduce unwarranted variation within the six Memory Assessment Services with the key areas of focus being: Our focus is in the following teams, West Kent due to the highest active caseload and demand versus capacity. South Kent Coast has the second highest caseload and we are reviewing with the team current practices. Ashford & Canterbury where we have seen clinical practice of repeated reviews for patients, that is not happening in other teams and nor does it need to happen clinically.

Further areas I'd like to note;

- 91.4% of those in crisis were assessed within 4 hours in August, this is the twelfth successive month the above target (85%) showing sustained improvement
- % MHLD referrals commencing treatment in 18 weeks continues to demonstrate sustained improvements, achieving 84.8% in August against a target of 80% and above the mean of 79.8% over the last 24 months
- Agency spend as a % of the trust total pay bill was 2.0% in August, below the mean of the last 24 months for nine successive months demonstrating variation of an improving nature
- Workforce metrics for vacancies, training and turnover continue to show sustained improvements and attainment of the targets set.

2. Trust Wide Integrated Quality and Performance Dashboard

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

Executive Sponsor: Adrian Richardson, Director of Transformation & Partnership

True North

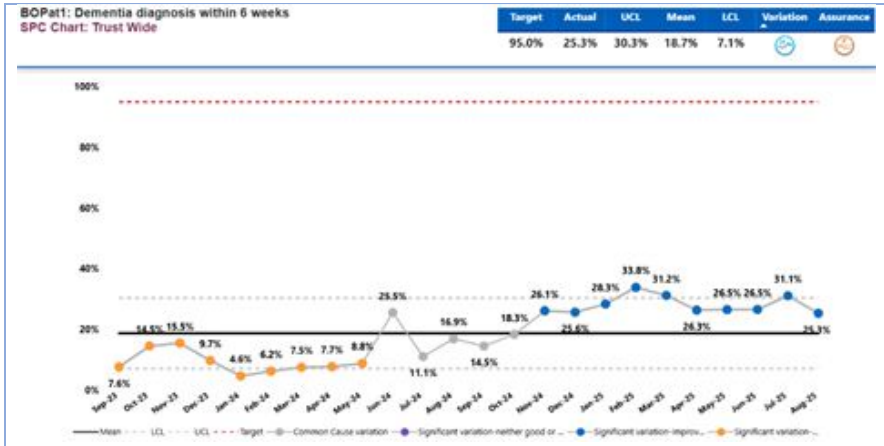
Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
TNPat1: Timely access: Community (CMHF/MAS) patients needs are met within timeframes	85.0%	12.0%	15.0%	18.7%	19.9%	15.5%	16.2%	17.5%	13.9%	12.7%	15.5%	16.5%	17.3%
TNPat2: Equitable access: <1% variance in waiting time (MHT/MAS) between most deprived and least deprived.	1.0%										(3.5%)		

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

Breakthrough Objectives

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
BOPat1: Dementia diagnosis within 6 weeks	95.0%	14.5%	18.3%	26.1%	25.6%	28.3%	33.8%	31.2%	26.3%	26.5%	26.5%	31.1%	25.3%
BOPat2: Community (CMHF/MAS) referrals have ethnicity recorded	90.0%	86.3%	85.3%	84.8%	84.5%	84.2%	84.1%	84.0%	83.8%	83.9%	84.0%	83.9%	84.0%

Focus on Breakthrough Objectives



Data Source	RiO	Data Quality Confidence	

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

What is being measured?

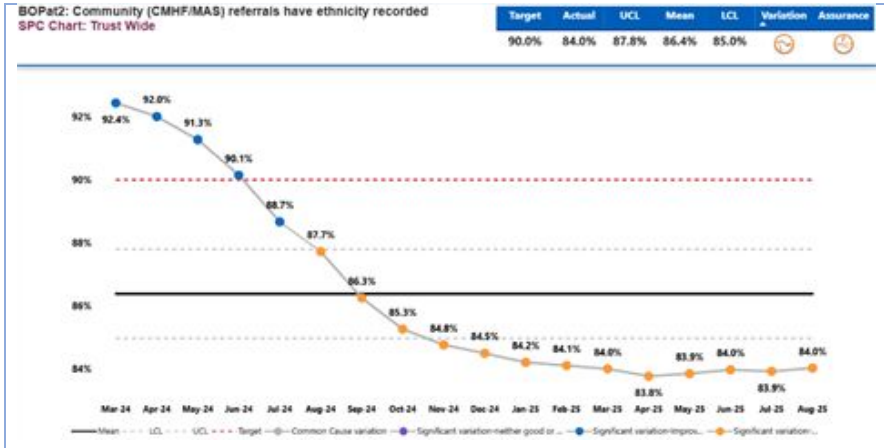
Time between a referral into the Memory Assessment Service and a confirmed diagnosis.

What is the data telling us and key actions in place

The SPC chart shows that the Trust is consistently failing the 95% target for compliance with the mean for compliance since July 2023 being 18.7%. However, the last ten months' compliance has been above the mean triggering an SPC rule that signifies special cause variation of improved performance.

Since February there has been a focus on eliminating non-clinically necessary waits of over 52 weeks. This has seen a reduction in patients waiting over 52 weeks from 260 to 57 (9th September). Work continues to eliminate these non-clinically necessary waits

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



Data Source	RiO	Data Quality Confidence	

What is being measured?

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

What is the data telling us and key actions in place

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

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

Watch Metrics

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
1.1.01: Open Access Crisis Line: Calls received		3,607	3,509	3,195	3,287	3,373	2,920	3,362	3,229	3,110	3,266	3,383	3,048
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		23.2%	24.1%	20.4%	22.1%	26.8%	30.9%	33.6%	31.5%	34.3%	36.9%	37.1%	38.9%
1.1.03: Assess people in crisis within 4 hours		86.6%	90.7%	92.5%	90.7%	90.9%	89.5%	86.9%	94.9%	94.7%	86.9%	93.7%	91.4%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		81.1%	81.5%	88.3%	87.6%	90.6%	83.4%	88.0%	88.6%	90.7%	92.3%	92.1%	89.4%
1.1.05a: Liaison Psychiatry referrals closed within 12 hours	95.0%	29.4%	23.3%	27.7%	39.2%	53.0%	61.9%	78.1%	80.4%	80.0%	81.6%	84.6%	82.1%
1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	4.8%	0.0%	0.0%	6.3%	6.1%	3.3%	5.4%	6.8%	6.7%	2.0%	5.7%	8.8%
1.1.06: Place of Safety Length of Detention: % under 24 hours		74.5%	70.0%	60.0%	77.1%	76.2%	76.6%	77.6%	75.0%	75.0%	79.0%	80.0%	78.7%
1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%	61.9%	59.1%	85.0%	66.7%	58.3%	75.0%	61.5%	52.6%	69.6%	72.2%	70.0%	85.7%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		75.0%	72.1%	83.3%	87.1%	85.4%	94.1%	92.1%	88.6%	100.0%	81.3%	92.9%	84.8%
1.1.10: Perinatal assessments (against annual target)	2,000	127	155	166	146	193	136	158	514	216	182	183	163
1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab)		1,263	1,362	1,543	1,389	1,563	1,371	1,819	2,035	2,205	2,053	2,281	1,861
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	88.5%	88.8%	87.3%	89.4%	88.1%	88.7%	87.9%	87.7%	88.7%	91.2%	90.8%	88.4%
1.3.02: Complaints - actuals		35	31	37	32	51	44	60	45	61	58	51	53
1.3.03: Compliments - actuals		141	140	130	151	147	122	122	131	122	159	174	118
1.3.04: Compliments - per 10,000 contacts		42.2	37.8	37.2	48.9	40.7	37.5	34.5	35.5	32.8	41.0	40.8	31.8
1.3.05: Patient Reported Experience Measures (PREM): Response count		478	580	510	594	540	529	563	513	626	605	577	424
1.3.06: Patient Reported Experience Measure (PREM): Response rate		3.2	3.6	3.3	4.1	3.7	3.6	3.6	3.2	3.7	3.5	3.2	2.6
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.2	8.5	8.2	8.3	8.5	8.6	8.5	8.5	8.5	8.4	8.4	8.5
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	92%	85%	97%	95%	100%	98%	97%	96%	94%	93%	93%	95%
1.3.09: Complaints responded to within 30 days (or agreed timeframe)	100%	70%	60%	66%	87%	92%	82%	81%	89%	76%	81%	86%	80%
1.4.05: Decrease violence and aggression on our wards	(7.5%)	2.5%	37.3%	9.0%	(1.3%)	14.8%	28.3%	12.2%	34.1%	23.8%	23.8%	21.9%	0.6%
1.4.06: Medication errors		49	32	54	46	50	39	54	46	62	50	54	45
2.1.01: Referrals to MHT commence treatment within 4 weeks		8.4%	10.6%	11.0%	10.7%	4.0%	4.6%	9.0%	5.5%	4.2%	8.2%	7.6%	11.5%
2.1.02: MHT waiting list size		5,072	5,595	5,704	6,007	5,995	6,243	6,573	6,186	5,687	5,472	5,590	5,468
2.1.03: MHT 2+ contacts		16,602	16,833	17,246	17,866	18,507	19,137	18,987	19,797	20,600	21,641	22,623	23,316

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

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

Executive Sponsor: Sandra Goatley, Chief People Officer

True North

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

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

Breakthrough Objectives

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

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

Focus on Breakthrough Objectives

BOPeo1: Staff feel able to make improvements in their workplace

Insufficient data points to analyse by SPC

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

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

What is being measured?

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

What is the data telling us and key actions in place

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

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

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

The two programmes of work expected to drive improvements in these results relate to the roll out of the Staff Council, and the delivery of the Doing Well Together programme. The Staff Council has been piloted in Forensic and Specialist services and is anticipated to be rolled out across the organisation in the Autumn. The Doing Well Together programme launched in March 2025; delivering KMPT's continuous improvement approach across 5 pillars

- Capability Building – to date; 46 staff become certified in Yellowbelt (A3 training) and have delivered improvement projects with a further 32 still in the coaching phase of their training. 232 staff have also received awareness training (whitebelt)
- Improvement Management System (IMS) – the first wave of training is near completion with 4 wards embedding frontline continuous improvement. Wave 2 is due to commence in Nov.
- Improvement Projects – the improvement team are support the 7 breakthrough objectives and beginning to initiate the use of A3 thinking to drive improvements
- Strategy deployment – Acute and Forensic & Specialist directorates have completed DWT training. With another 2 directorates undertaking training from October.
- A new format of directorate QPR will launch in Sept to incorporate improvement methodology.
- Leadership Behaviours – improvement leadership behaviours have been incorporated in the trust leadership programme with webinars being delivered in Sept/ Oct
- The second Innovation Den has also just closed for bid submission, and capability building is taking place with directorates and local teams.

Watch Metrics

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
3.1.01: Staff Sickness - Overall	3.5%	4.8%	5.1%	4.6%	5.1%	5.2%	5.0%	4.6%	4.3%	4.3%	4.1%	5.0%	5.2%
3.1.02: Vacancy Gap - Overall	14.0%	11.8%	12.0%	11.0%	11.1%	10.8%	10.7%	9.8%	10.0%	10.1%	10.3%	10.2%	10.3%
3.1.03: Essential Training For Role	90.0%	93.8%	94.3%	94.7%	95.1%	95.0%	95.2%	95.5%	95.4%	95.4%	94.8%	95.4%	95.6%
3.1.04: Leaver Rate	15.0%	14.3%	14.1%	13.4%	13.3%	13.4%	13.4%	12.5%	12.8%	12.6%	12.6%	11.9%	11.9%
3.1.05: Leaver Rate (Voluntary)	14.0%	9.5%	9.5%	9.3%	9.3%	9.3%	9.3%	9.1%	9.2%	8.9%	9.0%	8.2%	8.1%
3.1.06: Safer staffing fill rates	80.0%	108.2%	112.0%	116.1%	108.7%	109.6%	110.1%	108.8%	110.7%	112.1%	109.6%	110.2%	109.2%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	20.0%	26.7%	27.0%	27.0%	27.1%	28.1%	28.4%	28.5%	28.5%	27.0%	27.5%	29.8%	30.6%
3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%	0.63%	0.02%	0.27%	0.18%	0.35%	0.21%	0.21%	0.05%	0.17%	0.32%	0.44%	0.39%

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

Executive Sponsor: Dr Afifa Qazi, Chief Medical Officer

True North

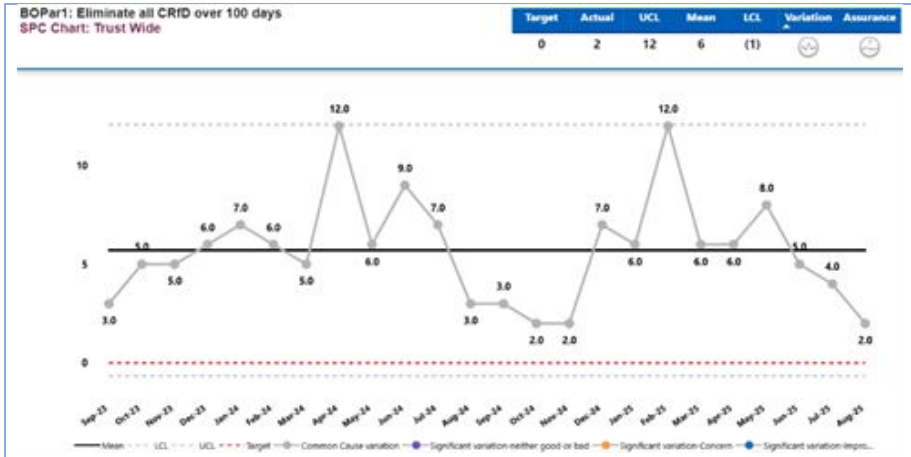
Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
TNPar1: Reduce clinically ready for discharge (CRfD) length of stay (LoS) by 25% by 2030	71.8	46.8	46.7	47.0	67.8	62.0	112.6	69.0	90.6	93.1	75.3	50.0	60.6

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

Breakthrough Objectives

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
BOPar1: Eliminate all CRfD over 100 days	0	3	2	2	7	6	12	6	6	8	5	4	2

Focus on Breakthrough Objectives



Data Source	RiO	**Data Quality Confidence**	

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

What is being measured?

Total number of patients with a CRfD that have been discharged in the month with a CRfD Length in days over 100 *(this is not the number of patients currently on wards with CRFD LOS to date greater than 100 days)*

What is the data telling us and key actions in place

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

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

Watch Metrics

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	36.3	34.0	34.6	40.3	35.0	51.5	49.4	36.9	38.9	35.1	36.2	32.8
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	82.5	85.8	95.2	103.2	63.3	124.4	125.8	87.7	102.4	88.8	71.4	69.1
1.2.03: Adult acute LoS over 60 days % of all discharges		12.9%	13.9%	13.9%	16.5%	19.1%	17.3%	22.6%	18.4%	17.0%	14.9%	14.5%	12.2%
1.2.04: Older adult acute LoS over 90 days % of all discharges		37.9%	42.3%	41.4%	31.3%	28.0%	57.1%	48.0%	35.1%	40.0%	33.3%	30.3%	30.0%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	12.7%	18.0%	11.7%	13.1%	12.2%	8.8%	11.9%	11.5%	6.3%	11.4%	10.4%	16.7%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		454	373	303	264	467	596	926	1,026	875	775	625	608
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	0	17	11	9	9	27	24	36	31	28	28	19	17
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	19.8%	20.9%	21.3%	20.6%	19.6%	24.3%	21.7%	22.0%	18.9%	15.2%	14.4%	17.5%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	27.4%	37.7%	32.2%	29.9%	37.6%	36.1%	32.9%	29.3%	21.3%	25.4%	31.9%	36.2%
4.1.01: Bed Occupancy (Net)	92.0%	96.4%	97.2%	96.8%	92.6%	97.4%	97.7%	97.4%	94.2%	94.0%	95.8%	95.3%	96.8%

1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 608 bed days were used in August 2025, 198 were female PICU patients within contracted beds resulting in 410 out of area placement days as an accurate reflection of trust performance. As at 15th September there are 17 patients in external placements of which 5 are female PICU placements.

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

Executive Sponsor: Andy Cruickshank, Chief Nurse

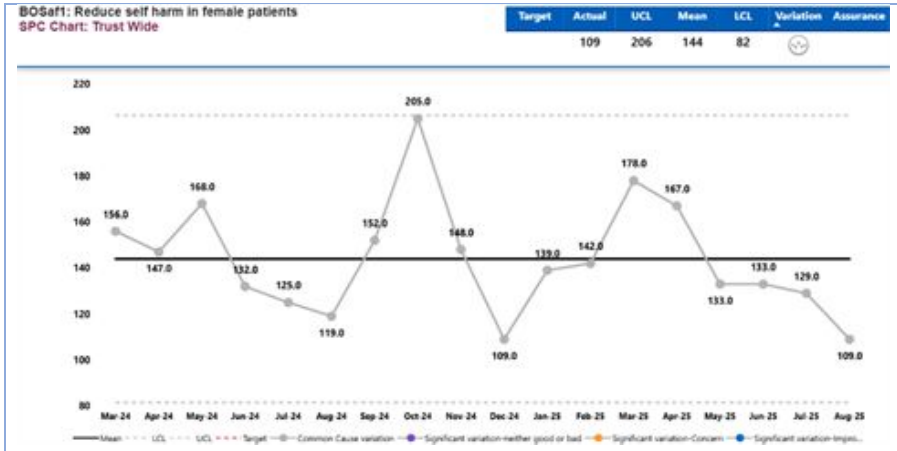
True North

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
TNSaf1: Reduce the number of patient harms		225	269	200	147	177	172	232	207	165	175	178	149

Breakthrough Objectives

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
BOSaf1: Reduce self harm in female patients		152	205	148	109	139	142	178	167	133	133	129	109

Focus on Breakthrough Objectives



Data Source	InPhase	Data Quality Confidence	

Some potential data completeness issues being investigated within community services

What is being measured?

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

What is the data telling us and key actions in place

SPC is showing normal variation but there is a lot of variation in the number of female self-harms from month to month. The mean since March 2024 is 144.

The acute directorate accounted for 70 incidents in August 2025 and have adopted a target of 60 by March 2026. It should be noted that Chartwell's recent switch from female to male patient care provision is likely to impact the data in terms of the overall number of incidents of self-harm by a female patient.

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

BI and Inphase reports have been created to improve accessibility of self-harm data for individual teams. There have historically been some data quality issues in terms of Rio ID not being included in the Inphase reports, positively a technical solution has been deployed which will help address this issue.

A survey has been completed to collect staff views of what is working well, what isn't working and where the gaps are in terms of supporting individuals who present with self-harming behaviours. Preliminary analysis of the responses of has been undertaken and initial outcomes have been shared with the self-harm steering group. Direct engagement work with the staff on the female wards, starting in East Kent is due to start within the next month. A monthly cross-directorate, interprofessional steering group has been established to oversee this work. A survey has also been designed to gather the views of those with lived experience of self-harm, to understand amongst others, how they feel mental health services supported them or impacted on their self-harming behaviours, their views on what drives their self-harming, how they feel that the offer of mental health services could be improved to support them more effectively in the future.

Watch Metrics

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
1.2.05: Patients receiving follow-up within 72 hours of discharge		86.9%	82.3%	85.5%	78.2%	84.3%	85.0%	84.5%	82.8%	83.9%	89.9%	91.3%	85.8%
1.2.10: %Patients with a CPA Care Plan	95.0%	82.5%	80.6%	82.4%	80.0%	87.1%	90.1%	89.3%	89.5%	90.7%	89.7%	84.7%	81.8%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	72.3%	71.4%	72.2%	72.1%	72.4%	71.4%	70.7%	71.6%	71.9%	70.4%	74.1%	74.7%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	64.0%	62.3%	60.1%	55.8%	58.6%	62.4%	61.1%	56.4%	54.7%	57.1%	53.1%	48.7%
1.4.01: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
1.4.02: All Deaths Reported And Suspected Suicide		144	142	137	113	198	174	159	121	148	153	134	100
1.4.03: Restrictive Practice - All Restraints		70	97	87	67	63	77	109	103	95	57	100	87
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	6	6	6	7	3	7	8	5	2	12	8	4
4.1.02: DNAs - 1st Appointments		10.5%	10.4%	10.7%	11.6%	10.2%	10.3%	10.7%	10.9%	10.7%	10.7%	10.5%	10.4%
4.1.03: DNAs - Follow Up Appointments		9.5%	9.5%	10.1%	10.9%	10.7%	9.9%	10.0%	10.5%	10.4%	10.5%	10.5%	9.8%

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

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

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

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

Breakthrough Objectives

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

Focus on Breakthrough Objectives

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

Watch Metrics

Measure Name	Target	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
4.1.04: In Month Budget (£000)	0	(14,233)	(19,323)	(14,814)	(15,042)	(14,756)	(14,708)	(14,742)	(15,122)	(15,315)	(15,413)	(15,303)	(17,957)
4.1.05: In Month Actual (£000)		(13,822)	(18,717)	(14,756)	(14,960)	(15,863)	(15,637)	(15,488)	(16,169)	(16,064)	(15,684)	(15,469)	(17,979)
4.1.06: In Month Variance (£000)		411	606	58	82	(1,107)	(930)	(746)	(1,047)	(749)	(271)	(166)	(23)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	3.5%	2.9%	3.2%	2.8%	2.6%	2.5%	1.9%	2.7%	2.5%	2.6%	1.9%	2.0%

5. Appendices

NHS Oversight Framework

NHS England » NHS Oversight Framework 2025/26

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

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

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

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

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

Extract as at 09/09/2025

Report Guide

True North

The guiding direction of the organisation

Timeframe: 3-5 years

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

Breakthrough Objectives

The improvement focus of the organisation

Timeframe: 0-12 months

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

Watch Metrics

Important metrics to understand department performance

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Community Mental Health Framework programme
Author:	Neil Robertson (Interim Deputy Chief Operating Officer)
Executive Director:	Donna Hayward-Sussex (Chief Operating Officer)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

In response to NHS England's Community Mental Health Framework (CMHF), published in September 2019, KMPT and its partners embarked on an ambitious transformation of community based mental health care and support. The vision was, and remains, to join up community mental health services so that people in Kent and Medway get the right support, from the right team at the right time; helping people with mental illness to live well.

Funding from the Mental Health Investment Standard has been targeted at 4 key areas of community mental health transformation:

- Development of Mental Health Together (MHT); community based mental health services delivered by a partnership of providers for low to severe mental illness.
- Community Rehabilitation.
- All Age Eating Disorder Services (AAEDS).
- 18-25 Pathway.

This paper focuses on the Mental Health Together element of the community mental health transformation; providing insight into the many improvements that have been made since the initial implementation and setting out the current programme of work that will bring further improvements to the offer we jointly deliver with our partners. Our model of care, and how that care is delivered, is being refined; we know that we can make further improvements to what we provide, how we provide it and where we provide it. Our goal is always to ensure greater ease of access to safe, high quality, effective services that are tailored to enabling each client to live well.

Whilst we celebrate what has been achieved to date in transforming community mental health services, we also need to learn the lessons from previous implementations. This programme of improvement rightly focuses on ensuring that all our stakeholders are fully engaged in the co-design, implementation and communication of any changes. It has also been designed to ensure that the skills, expertise and experience of the delivery partners are used to greatest effect, recognising that the broad nature of services and support offered by Mental Health Together rely on mature relationships between all partner organisations. This update highlights the improvements that will be made and details the programme structure and plans that will ensure they are successfully implemented.

Issues to bring to the Board's attention

The Board is asked to note:

- The ambition of the Trust and its partners in developing the delivery partnership that underpins Mental Health Together, recognising that this is pioneering work.
- That there is commitment across the delivery partnership to build and further improve.
- That Mental Health Together will be on a continuous journey of improvement and that this is the latest iteration.
- That the programme of improvement has been designed and structured to ensure that the lessons, about communications and engagement and developing the enablers to support the change, have been learnt.

Governance

Implications/Impact:	The refinement of the model and subsequent demand and capacity modelling requires agreement across multiple partners. This will take time to be finalised. Improving communications and engagement with our staff and stakeholders and ensuring we have the right workforce and digital support in place to improve the quality of our service delivery is critical.
Assurance:	Reasonable.
Oversight:	Oversight by KMPT Board and Provider Collaborative Board.

Introduction

This paper and the accompanying programme management pack, will provide a *holistic* view of the community mental health transformation programme. It is intended to provide the Board with assurance about the programmes progress, since the Attain review and recommendations for the programme. The paper will also outline next steps in reaching our ambition to deliver a partnership approach to providing the right support in the right place and at the right time for the people of Kent and Medway.

Context

For a number of years, the trust, in partnership with Invicta Health, Porchlight, Shaw Trust, and Kent and Medway Integrated Care Board (ICB) set out to undertake an ambitious transformation of community mental services, in line with the NHSE Community Mental Health Framework (CMHF). The framework sets out an approach to providing seamless person-centred care for younger and older adults, which ideally is delivered through a partnership model. Since its inception, there has been some roll back in regard to some of the ambitions, such as, four week waits; however, the central tenets of providing evidenced based care and support closer to home remains the priority.

The Board have been updated about the journey of the programme and the challenges that led to commissioning an independent review. Since April of this year, consolidating improvements with other initiatives have been considered and acted upon. These include addressing areas highlighted by the Care Quality Commission (CQC) linked to caseload and risk management and projects associated with the Getting the Basics Right programme including improving efficiency and productivity. It is critical that learning from all of these initiatives are brought together into a coherent programme of work to improve the care we provide.

In late May 2025, we refreshed the programme with the explicit aims of:

- **Providing safe and excellent care - refining, simplifying and, where appropriate, realigning the model of service delivery**. This will ensure that people are receiving support in the right place, based on the level of need and risk. It is also critical that the trust strengthen its role as a lead provider, ensuring that it offers our partners the leadership to deliver care to the right people in a way that is commensurate to the skills and knowledge of their respective workforces.
- **Supporting staff to understand and deliver care - driving consistent and coherent implementation of Community Mental Health (CMH) through effective communication and engagement**. Engagement, and the development of spaces to co-create with service users and the workforce, were not previously fully optimised. This meant that people who receive and deliver care were not fully involved.
- **Building partnerships – strengthening and developing the partnership offer we provide to the people of Kent by effectively working with a network of providers across the county to improve access and outcomes.** There is a strong base of VCSE network providers across Kent and Medway, who can significantly support improving outcomes for service users in the right place at the right time, which will mean working effectively beyond our core base of provider partners. In addition, a strategic partnership approach is critical to realising the Ten-Year Plan ambition for neighbourhood working and integrated teams.

Background – the scope of Community Mental Health and our wider environment

The Community Mental Health programme of transformation has focused in these four areas:

- Community Rehabilitation.
- All Age Eating Disorder Services (AAEDS).
- 18-25 Pathway.
- Development of Mental Health Together (MHT); community based mental health services delivered by a partnership of providers for low to severe mental illness.

The following provides a summary update of improvements across Community Rehabilitation, All Age Eating Disorder Services and the 18-25 Pathway:

- The existing **Community Rehabilitation** offer has been developed to ensure the service is effectively resourced, is clear about purpose and provision is equitable across the Trust. There has been a recruitment and onboarding programme to support this with 70% of clinical posts now filled. Policies and procedures have been completed. The enhanced model includes social workers and partnership working with VCSE; the recruitment and contracting for this is in progress, with implementation being phased across the Directorates with East Kent being the most advanced. Close working arrangements are being developed with the Mental Health Together (MHT) teams in localities to support service users with intensive needs.
- In **All Age Eating Disorder Services,** several pathways have been developed and launched, including:
    - The all-age Intensive Care (admission avoidance) pathway, launched in January 2025.
    - The Intensive Care Pathway for Avoidant/Restrictive Food Intake Disorder (ARFID), launched for CYP in 2024 and due to go live for adults in autumn 2025.
    - The Support and Stability Pathway for chronic presentations is now firmly established and embedded as business as usual.
    - National benchmarking of services continues for First Episode Rapid Early Intervention (FREED). In addition, the Centre for Research for Binge-Eating Disorder (BED) patients pilot reported in February 2025; North East London Foundation Trust (NELFT) are considering how to mobilise digital funds to offer this app to adult patients.
- The **18-25 Pathway** has been jointly developed by KMPT and NELFT and rolled out across all localities: this is supported by 2 dedicated Link Workers per locality, one each based in Children and Young Peoples Mental Health Services (CYPMHS) and Adult Mental Health Services. The pathway has been benchmarked against national quality standards. In addition, direct access to Talking Therapies is now available for young people. A pilot trialling the use of Dialog+ for young people has been successful; this is being rolled out across all localities and supported with a programme of training for NELFT staff. A clinical focus group is being established to review the

clinical offer for 18-25 yr olds and new SOPs will be developed for young people moving from CYPMHS to adult services when CYPMH services are transferred from NELFT.

The focus of this report is on the improvements made to **the Mental Health Together offer** since the establishment and roll out of the delivery partnership; this is in a context of a programme of ongoing improvement work and examples are included in the Innovation and Improvement section below.

Finally, in the last year, there has been a change in strategic priorities of the NHS, which has led to a new NHSE Ten Year Plan. It proposes 3 radical shifts: from hospital to community; analogue to digital; and sickness to prevention. This does not change the work we are undertaking in our community service; rather provides an opportunity for our community services to develop and evolve for integrated neighbourhood working.

What next - programme delivery focus, governance and workplan

The community mental health programme has remained live and, since the Attain review, a refresh of our approach to CMH has been undertaken to optimise the delivery of the recommendations. The overarching aim is to learn from the programme roll out to date, simplifying and clarifying the offer. **The refreshed delivery focus** of the programme is to:

- Engage, support and involve our communities and staff across the partnership;
- Align our services to improve access to care at the right place and time, closer to home;
- Embed safe, effective and quality care through the next iteration of community services;
- Build a platform for ongoing continuous improvement.

The **overarching governance structure has been modified** to ensure work is focused on the key priorities, assurance is sought through monitoring delivery, and senior leaders from the partnership come together to have oversight and influence the programme of work undertaken.

The **workplan** is across three phases taking us to March 2027.

These phases will focus on building on all the work delivered over the life of the programme, but specifically will prioritise:

- Phase 1: Now to December 2025: Operational safety
- Phase 2: January to June 2026: Service improvement
- Phase 3: July 26 to March 2027: System working

The work will be structured under five pillars – model of care and service delivery; affordability, productivity and commissioning; data and digital improvement; workforce development; and communication and engagement.

We are clear that the programme should be as agile as possible to prevent process getting in the way of rapid improvement and learning in practice.

What has been delivered so far - progress and improvements

This section of the paper focuses on the progress and improvements that have been made over the last six months. This includes local innovation that will support wider system change and improvements in waiting times.

Model of care and service delivery and population need

At pace and led by our Director of Psychological Therapies, the original model of care has been refined using a co-creation approach. The model of care provides a framework for delivering the best possible care. The first phase was defining the evidenced based interventions we can provide that will meet the needs of the majority of people who access our services. The workstream included our partners and we received feedback and the views of 104 service users; frontline staff have engaged in the model refinement through a combination of membership of the working group, consultation via operational cascade routes and a dedicated workshop. In addition to the type of intervention we have proposed, thought has been given about which of our partners will provide these.

The refined clinical model proposal has identified five clusters of evidence-based interventions. The specific interventions will be delivered according to need and severity. The proposed model assumes that low to medium severity of need are delivered by our partners, with medium to severe provided by KMPT. The model also assumes easier access and improved use of care navigation. We are beginning to socialise the proposed interventions, so that we get feedback to finalise the model. This is currently with our provider partners and not subject to wider distribution.

Having completed this work, the workstream will now flip to focus on how we need to deliver the interventions and what we need to do it. At the time of writing this paper, the focus of this work is on access, which needs to be responsive and agile. Once we have finalised the 'how we deliver', we will triangulate this with the internal demand and capacity work for Mental Health Together plus, which will be a quick process due the advanced development of this framework.

In addition, we have completed some analysis of population health data to inform current and future planning of our delivery models; ensuring we have the right resource allocation to meet population need across all our communities.

Communication and engagement

The Attain review, based on wide-ranging feedback, highlighted the need for more meaningful and agile communication and the effective implementation of an agreed engagement strategy. The impact on service users, our workforce and key stakeholders of rushed or incomplete communications and engagement in the past has resulted in them feeling confused and unclear about implementation. It has left people feeling unhappy about not being involved, able to support delivery of the previous model and their views on deliverability unheard.

Moving forward, communication and engagement is a central pillar of the work we are undertaking. As mentioned above, we have included a large number of service users, our community workforce and leaders in the clinical model refinement, which has been well received. Whilst we are developing a communication and engagement plan, at the time this paper is presented, we are engaging with our CMH operational and clinical leaders to reflect on the CQC feedback to enable them to provide feedback, express concerns and identify solutions. Up to December 2025, a series of other face to face engagement events have been provisionally scheduled to include frontline staff, primary care, service users and carers, and other stakeholders.

Learning from previously, a specific communication and engagement group is currently being established to oversee the developments and delivery of key messages, provide expertise in ways to communicate and engage (both internally and externally), and hold the programme to account about the effectiveness of this work pillar. The group will include service users, our partners and general practice and is being co-

led by a community service director. Check and challenge about effective communication and engagement will be a golden thread in the programme structure.

Partnership

The programme is making incremental change in strengthening the provider partnership and has a real opportunity to improve its strategic leadership as a lead provider. Since the Attain review, the engagement across the delivery partnership has matured and all partners are committed to improving the Mental Health Together offer based on learning to date. As part of the clinical model refinement our partners provided leadership in understanding the interventions that they will provide and are now supporting the delivery modelling.

In terms of programme governance, partners are at the centre of improvement and decision making. There is an opportunity to further respect their sovereignty and build advance on the things that they do well that mental health trusts generally do not. The partners have also been instrumental in the recent improvements made and testing learning undertaken that is discussed later in the paper. It has been agreed that very senior staff from the partnership will have a regular informal protected space to deal with issues and further improve partnership working.

Finally, looking beyond our main partners, scoping and development will be undertaken to strengthen and improve working with the rich landscape of network providers in Kent and Medway to meet the needs of the people we serve as we will achieve more together.

Supporting workstreams

Two other pillars of work under development are data and digital and workforce. The workstreams are on standby to meet when the work above has progressed to a sufficient level of maturity. We agreed that staggering these group is important because their remit will be to respond to the needs of the clinical and operational delivery model. In addition, there is work we need to do with our other partners or network providers to support the appropriate sharing of information that will need a digital solution. As we move further into the detail, we will be able to scope the focus of these workstreams.

Waiting Time Management

A decision had been made previously for all referrals and waiting times to be centralised in KMPT. This means that an average of 3200 referrals per month are processed through our electronic patient record, with a large percentage of these seen by our delivery partners. This has led to larger than expected caseloads with patients waiting too long to receive an intervention.

Since April 2025, considerable progress has been made in the reduction in the number of people waiting and ensuring effective referral and waiting list management. The Deputy Chief Operating Officer led the development of a robust process to manage waits and referrals in each community directorate. The approach enables more effective use of data to be responsive in offering assessment, providing treatment and the management of DNA's. The impact of this approach has reduced the MHT waiting list from 6,949 at the end of March 2025 to 5,918 in early September 2025. This equates to a 15% reduction. This has also led to an improvement in average clock stop from 20 weeks in March 2025 to 15 weeks in September 2025. This approach required a change in culture with support offered to frontline staff in the overall improvement of caseload management with huddles introduced with good effect. The process for overseeing this has established an effective 'battle rhythm' and is being experienced as an example of good practice allowing the devolvement to community directors for weekly management and oversight with escalation processes established.

One of the ambitions originally set for the transformation was meeting 4 weeks waiting standard to treatment, as proposed by the Community Mental Health Framework. However, this requirement has not been mandated by NSHE and in the coming weeks national guidance is expected about the community mental health standard.

We remain committed to further reducing the number of people on our waiting list to levels that are commensurate with the large number of referrals each month. We are reviewing the options in relation to how referral and waits are managed in the context of a provider partnership, and a proposal is expected in the next two months.

Other dependencies

The community mental health programme cannot be seen in isolation. The improvements being made following feedback from the Care Quality Commission and the projects within the Getting the Basics Right programme are being threaded through the programme to prevent parallel processes. For example, the role of the named worker, streamlining community triage/assessment and care planning through embedding Dialogue+. These requirements are at the centre of how we operationalise the refined clinical model, so people are clear about role and responsibility and co-created care plans illustrate and measure the impact of the intervention a person requires.

Innovation and improvement

Since the initial implementation of Mental Health Together, the delivery partnership has continuously reviewed it's offer and delivery model, always with the goal of ensuring that people in Kent and Medway get the right support, from the right team at the right time. Examples of some of the improvements that have been made include:

- Streamlining of the assessment and care planning process.
- Reducing the number of people waiting and the time they need to wait.
- Development of the named worker role.
- The Medway Pilot, where the capacity for urgent referrals has been increased and the utilisation of wider community resources has been realised.
- Improved data usage to enhance clinical quality and productivity.
- The Drug & Alcohol Pilot.
- User and staff informed refinement of the Model of Care.
- Improved culture and cohesion between MHT and MHT+ teams.
- The Physical Health and Prescribing Pilot in East Kent.
- A refinement of the Red Board methodology to improve patient safety.
- Ongoing psychological skills training.
- Improved completion of Dialog+.

Outward View

Benchmarking ourselves against community mental health improvements elsewhere is important to both challenge our assumptions and approach, and validate the work undertaken and ambition.

Across the country, areas have taken different approaches to implementing the Community Mental Health Framework, some are advanced with others refining. Achieving the four week waits standard, implementing Dialogue+ and delivering services through a partnership platform are at different stages.

To sense check the improvements and understand other approaches to delivery, the provider partnership has two events planned in September 2025. Firstly, we have invited a senior specialist advisor from the National NHSE mental health team, who were the architects of the Framework. The advisor has agreed to spend the day in North Kent to see the work we have been doing in Mental Health Together and share with him the Medway Pilot. The day will consist of information sharing and observing the service in operation. This will be an opportunity to get meaningful feedback about our approach. The second visit is from a senior director and medical lead from a London Mental Health Trust. They will be sharing how they are managing waits, DNA's, embedding Dialogue+ and their approach to being data driven with their teams.

Finally, we are in conversations with NHSE region about being involved in a data pilot, which is a national initiative. Initial conversations have taken place after being asked by region to be involved in recognition of some of the work we are undertaking and the advancement of the model.

Risks and mitigations

The 4 key risks for this programme of work are:

Ensuring the right support is provided in the right place at the right time – We need to provide the right intervention dependant on need, ensuring easy access for the least amount of wait time to improve the outcome for the people we serve. This is mitigated by the programme putting the service user at the centre of the improvements we make, effective communication and engagement, embedding the feedback from the CQC, driving through productivity to work in an agile way and a relentless focus on reducing waiting times.

Communications and engagement – critical to delivery is learning from previous engagement with the people we serve, our staff, partners and wider stakeholder, this will ensure we get the next stage of programme development right and is the foundation of moving to continuous improvement. This will be mitigated by the development of a communication and engagement group, which will consist of service users, staff and partners, including primary care.

Relationships with partners and primary care – we need to further strengthen our partnership to effectively deliver our ambition for community mental health care, and be inclusive of all network providers. This is being mitigated by being fully inclusive of relevant partners in design, building and delivering the refreshed model, making sure we play to our strengths.

Resource utilisation – until we complete the work to understand what we need to do to deliver the refined clinical model and process this through our demand and capacity modelling, we do not fully understand the resource implications of the refreshed model. This work is being done at pace and we will mitigate accordingly on completion.

Next steps

1. Deliver the workplan.
2. Communication, communication, communication with staff and partners - to build a shared understanding of what is going to happen next.

3. Developing the transformation and continuous improvement skill set of the team who will deliver this new phase of the programme - to underpin its effective delivery and build a 'Programme Team' culture and a group of people that speak as one to the broad range of stakeholders.
4. Build a critical path and detailed programme plan with localities and workstreams to underpin the work of the programme team.
5. Work through the localities to tailor the communication and solutions to meet the individual needs of those populations and staff teams.
6. Align the capture, mitigation and escalation of risks to KMPT's new risk framework (being approved by the Audit & Risk Committee) – developing this with the localities and workstreams.
7. Develop a benefit tracking tool to closely review our impact and the delivery of outcomes for our population and staff.
8. Develop with partners an integrated neighbourhood teams' model that is aligned with community-based services across the County.

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Community Mental Health Framework

September Board Update

25.09.25

Contents – in this pack you will find…

Introduction and background

- The Community Mental Health Framework (CMHF) was published by NHS England in September 2019. Since its inception some of the original ambitions have been modified, although right care in the right place at the right time, delivered through a partnership of providers, is a central tenet.
- It describes the vision for place-based community mental health services that are focused on the whole person, with an emphasis on partner organisations working together to address the wider determinants that impact on a person's life outcomes, well-being and mental and physical health.
- Implementation of the CMHF was supported by investment through the Mental Health Investment Standard (MHIS); a commitment by NHS England for ICBs to spend an increasing proportion of their budget on mental health. The ICB has used this funding to support the following CMH transformation programmes:

    - **Community rehabilitation**
    - **Eating disorder services**
    - **18-25 pathway**
    - **Development of Mental Health Together.**

- **This paper provides a detailed update on the Mental Health Together element of the CMH transformation programme, a review of which was completed in April 2025 and the findings from that presented to the Board.**

CMH programmes scope and overview

- KMPT and NELFT have jointly developed and rolled out an 18-25 pathway across all localities: this is supported by 2 dedicated Link Workers per locality, one each based in Children and Young Peoples Mental Health Services (CYPMHS) and Adult Mental Health Services (AMHS). The pathway has been benchmarked against national quality standards. In addition, direct access to Talking Therapies is now available for young people.
- A pilot trialling the use of Dialog+ for young people has been successful; this is being rolled out across all localities and supported with a programme of training for NELFT staff.
- A clinical focus group is being established to review the clinical offer for 18-25 yr olds. New SOPs will be developed for young people moving from CYPMHS to AMHS when CYPMH services are transferred from NELFT.

- The existing offer has been developed to ensure the service is effectively resourced, is clear about purpose and is equitable across the Trust. There has been a recruitment and onboarding programme to support this with 70% of clinical posts now filled. Policies and procedures have been completed.
- The enhanced model includes social workers and partnership working with VCSE; the recruitment and contracting for this is in progress, with implementation being phased across the Directorates with East Kent being the most advanced.
- Close working arrangements are being developed with the Mental Health Together (MHT) teams in localities to support service users with intensive needs.

A number of pathways have been developed and launched, including:

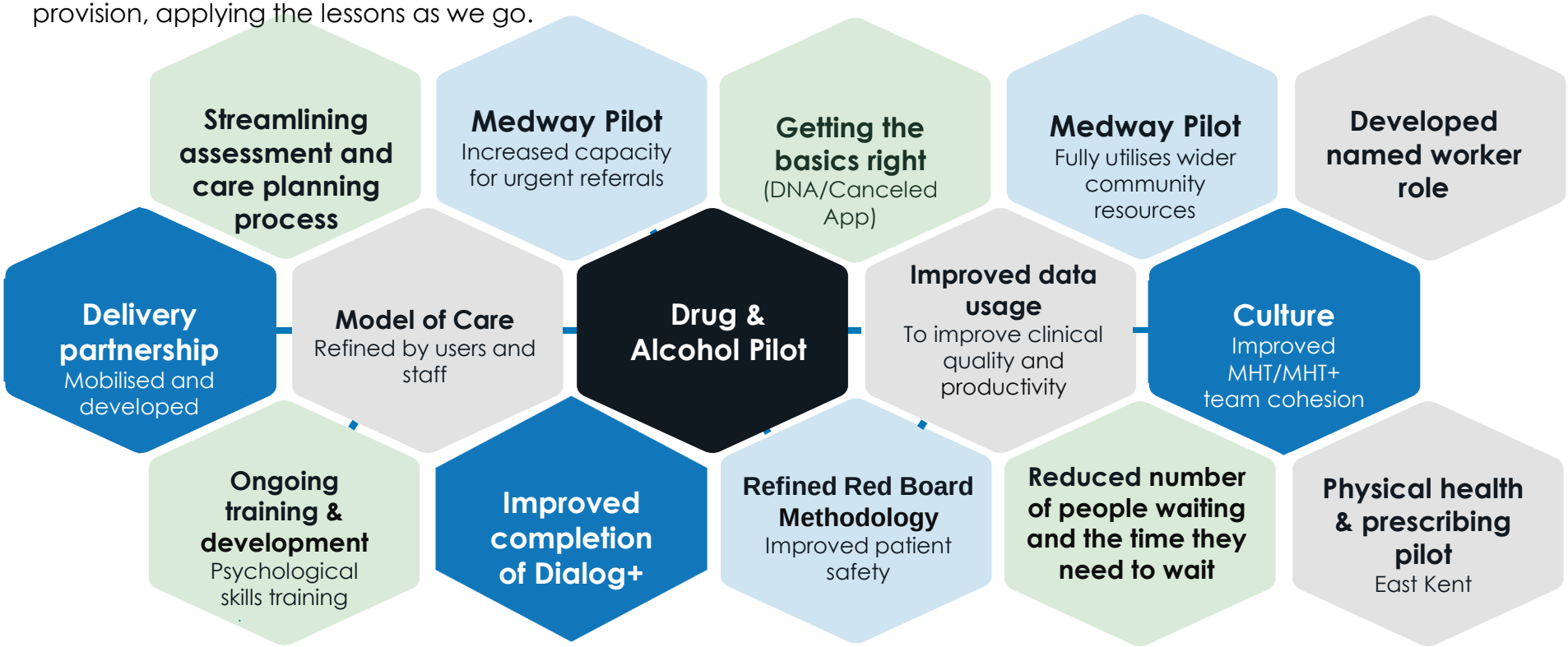
- The all-age Intensive Care (admission avoidance) pathway, launched in January 2025.
- The Intensive Care Pathway for Avoidant/Restrictive Food Intake Disorder (ARFID), launched for CYP in 2024 and will go live for adults in autumn 2025.
- The Support and Stability Pathway for chronic presentations is now firmly established and embedded as business as usual.

National benchmarking of services continues for First Episode Rapid Early Intervention (FREED). In addition, the Centre for Research for Binge-Eating Disorder (BED) patients pilot reported in February 2025; NELFT are considering how to mobilise digital funds to offer this app to adult patients.

Details of improvements in the services provided via Mental Health Together are included in the next slide.

We're building on lots recent great work to improve MHT services

- Significant progress has been made in developing a community based mental health service in line with the CMHF; a central pillar of this is the delivery partnership developed between KMPT, Porchlight, Shaw Trust and Invicta Health which jointly provides community based mental health services to people with low to severe levels of mental illness.
- The model is ambitious and there is much to celebrate and learn from.
- Since the initial implementation, the delivery partnership has been on a journey of continuous improvement to refine and develop our provision, applying the lessons as we go.



Mental Health Together Programme – plans for further improvements

Building on the work to date

The graphic summarises the planned next steps for Community Mental Health services - aligning with the national ambition of the Ten-Year Plan and recognising that this is part of a continuous improvement cycle. The subsequent slides provide more detail of our immediate and medium-term plans.

Strategy	Co-Design	Build	Implement and embed
2025/26 and 2026/27			
Refreshing the population data Revisiting the national framework & national ambitions strategy	Refining the model of care and ensuring this is clinically and operationally deliverable.	Aligning the workforce and enabling functions Realigning partner arrangements to reflect refinements Continuously strengthening users, staff and partnership engagement Strengthening our role as lead provider	Building on the original to implementation and embedding the refined care model, workforce model and enabling functions

Underpinning principles:

Balancing the competing demands of implementing at pace and ensuring comprehensive communication and engagement

Embedding programme management discipline and employing Kotter's Change Model

Programme scope

Our vision

This is a once in a lifetime change - we're joining up community mental health services so that people in Kent and Medway get the right support, from the right team at the right time. We're not just helping people live with mental illness, but live well

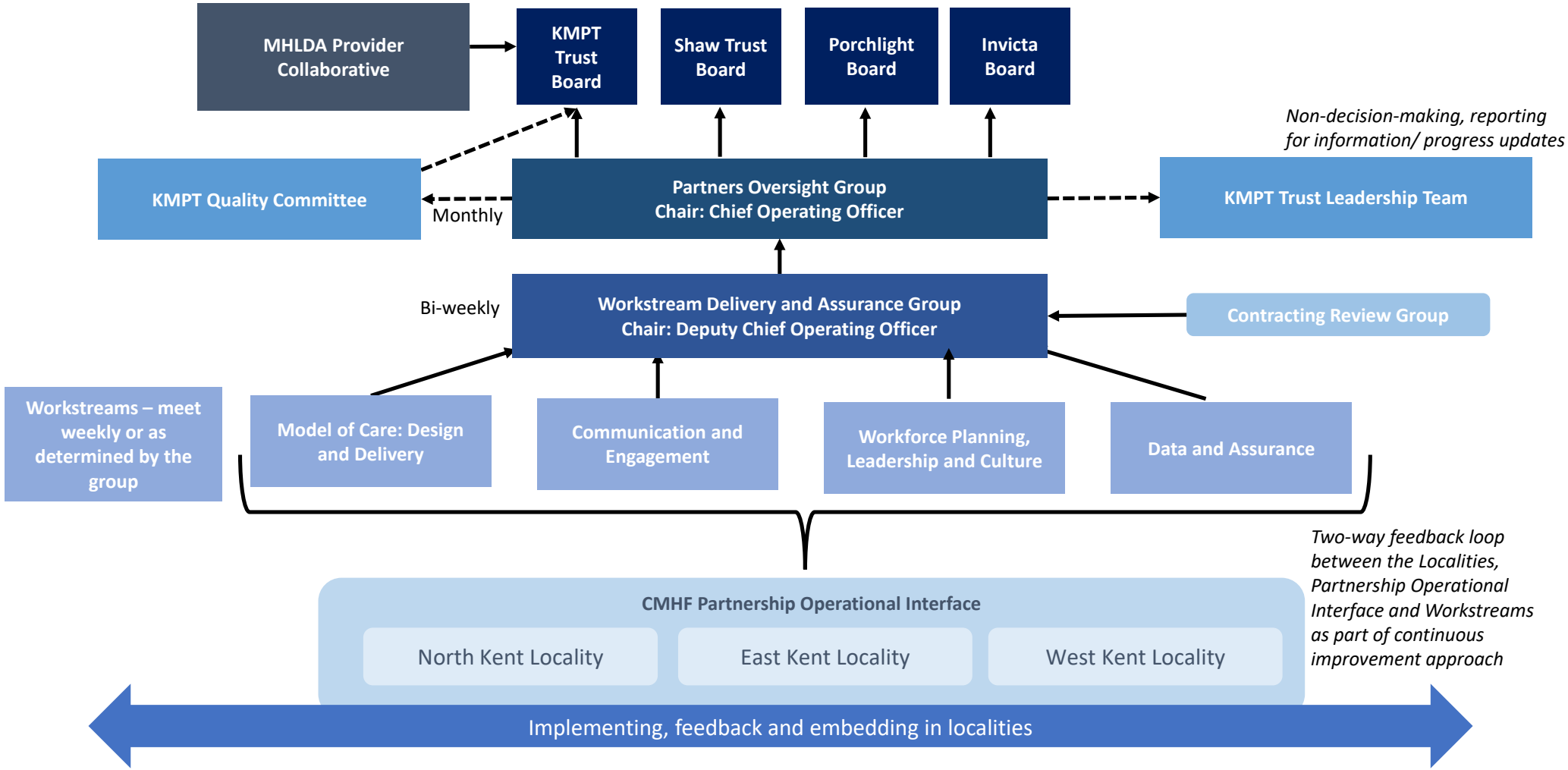
Our aim

We are building on the learning and feedback from the community services roll-out so far to simplify and clarify our offer and to improve the safety, quality and responsiveness of our care

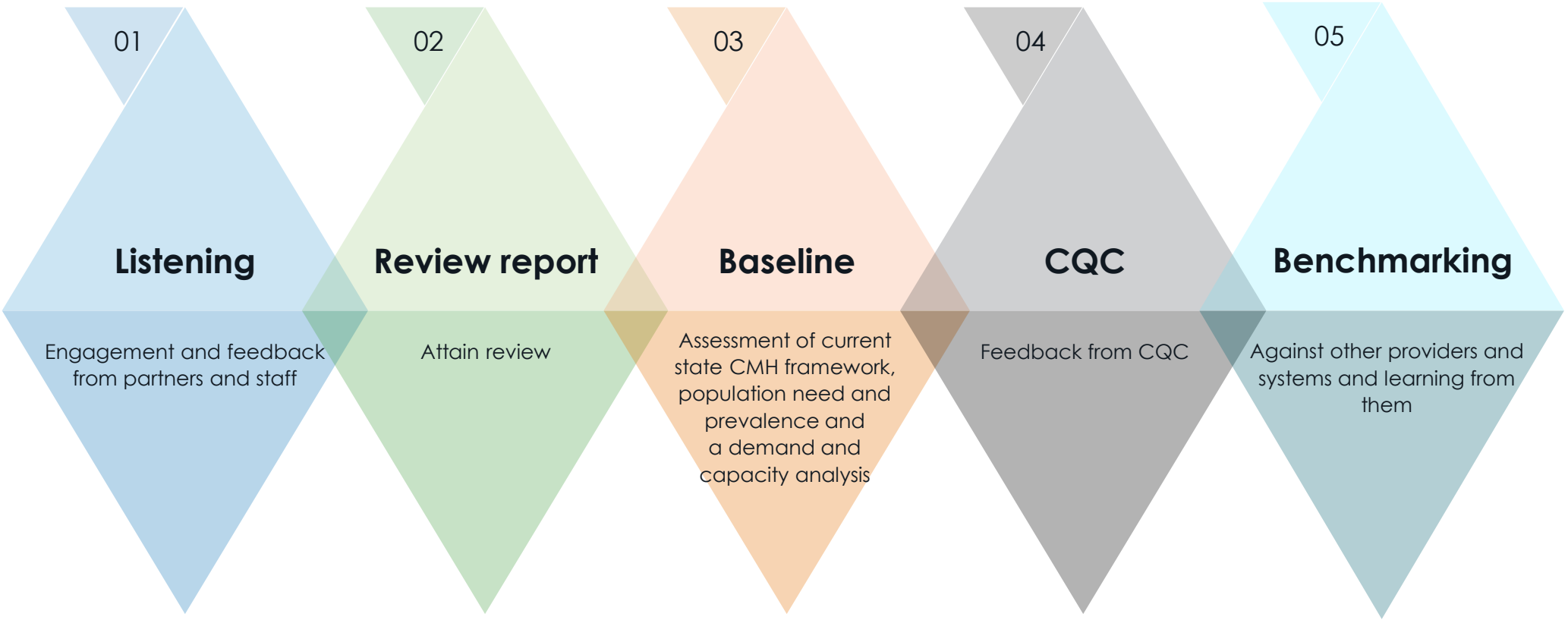
Our delivery focus

- *Engage, support and involve our communities and staff across the partnership*
- *Embed safe, effective and quality care through the next iteration of community services*
- *Align our services to improve access to care at the right place and time, closer to home*
- *Build a platform for ongoing continuous improvement*

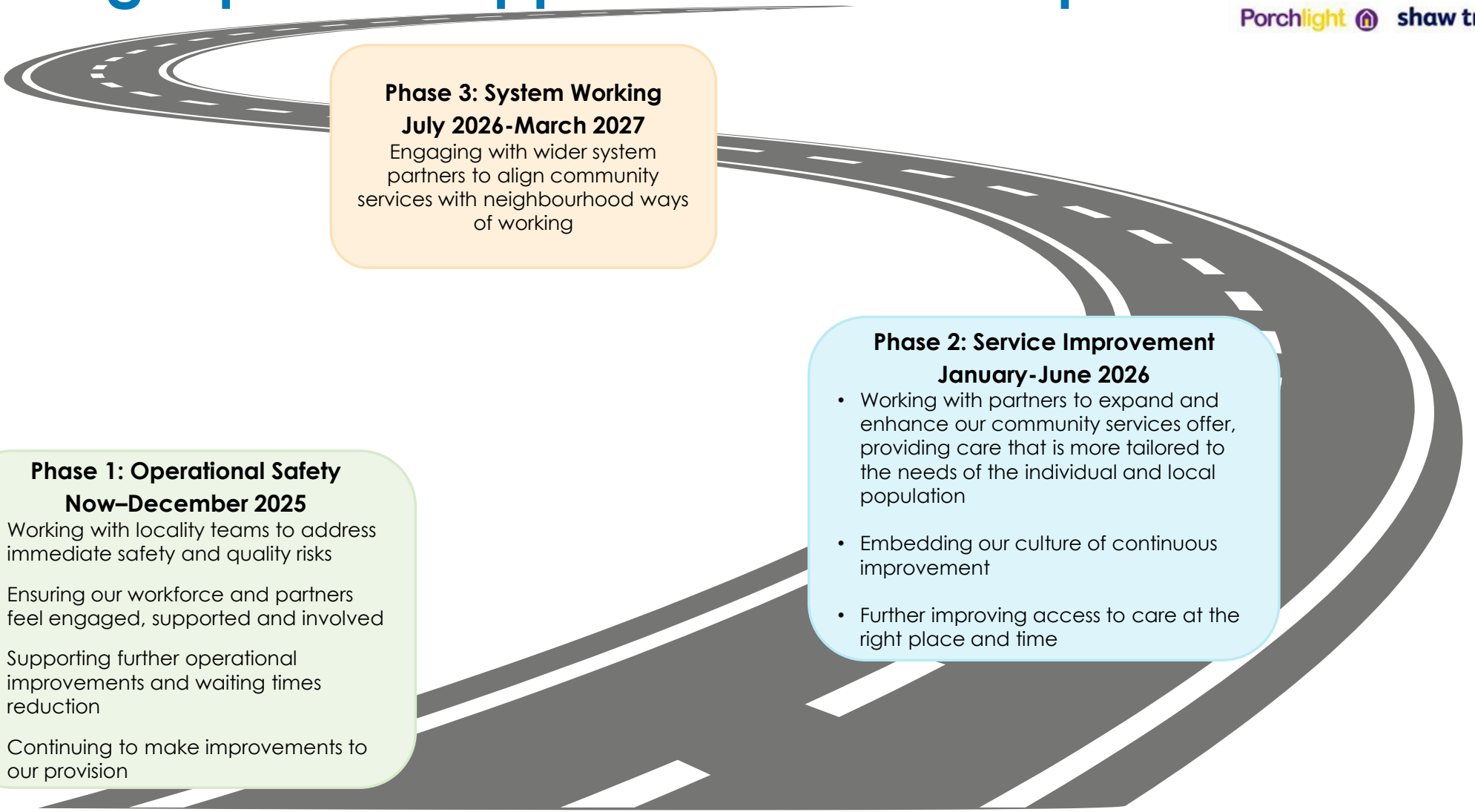
Programme governance



What has informed the programme workplan?



Taking a phased approach to next steps



Phase 3: System Working
July 2026-March 2027
Engaging with wider system partners to align community services with neighbourhood ways of working

Phase 2: Service Improvement
January-June 2026

- Working with partners to expand and enhance our community services offer, providing care that is more tailored to the needs of the individual and local population
- Embedding our culture of continuous improvement
- Further improving access to care at the right place and time

Phase 1: Operational Safety
Now–December 2025

- Working with locality teams to address immediate safety and quality risks
- Ensuring our workforce and partners feel engaged, supported and involved
- Supporting further operational improvements and waiting times reduction
- Continuing to make improvements to our provision

Programme workplan – the five pillars of our work plan

	Communication and Engagement	Model of care and service delivery	Affordability, productivity commissioning	Workforce	Data and digital
	Significant priority				
Phase 1 Now – Dec 25	**All phases:** • Ongoing stakeholder mapping to understand gaps and/or areas for focused engagement - by geography and at all layers across organisations • Develop and deliver a live communications and engagement plan to involve stakeholders, support any changes, and ensure effective two-way communication • To include staff, MHT/+ partners, primary care colleagues, wider system partners, service users and communities **Phase 1:** • Autumn series of engagement events – including with primary care • Use of Staff Room for internal comms **Phase 2:** • Focused engagement with primary care and wider partners to explore opportunities to improve access to services **Phase 3:** • Engage with the wider system and partners to align with neighbourhood models	• Finalise and implement the refined Model of Care, including changes to accessing care • Refine the processes, systems and pathways to deliver the model of care • Understand and reduce unwarranted variations in service offers across localities • Address safety priorities	• Finalise demand and capacity planning aligning to resources • Develop partner contract requirements and opportunities across activity, quality and outcomes • Strengthen KMPT's role as Lead Provider and seek stability of the model beyond the pilot period	• Complete workforce modelling to align demand / capacity / resource with the refined model of care • Understand gaps and develop a partnership workforce delivery plan at locality level to close them • Scope training and development needs and develop a training plan	Ensure processes and systems are in place which: • Enable the collection and reporting of high-quality, reliable and real-time data across partners • Facilitate safe, timely and efficient delivery of agreed clinical and care pathways

Phase 2 Jan-Jun 2026		• Strengthen the offer across partners / wider system and across different delivery settings, including primary care
		• Align with NELFT transfer on transition / 18-25 year old offer and Eating Disorders
		• Roll out next steps for Drug and Alcohol services.
		• Integrate new assertive outreach model with community rehab
			• Confirm contracts for 26/27
			• Establish effective contract monitoring processes, underpinned by data on quality and productivity
			• Strengthen KMPT's role as Lead Provider and seek stability of the model beyond the pilot period
				• Implement and embed workforce model
				• Implement training and development programme
				• Engage with the system to develop neighbourhood working.
					• Interface with Trust wide transformation:
					  • Electronic referrals
					  • Patient-led booking
					  • Approaches to automation and getting the basics right

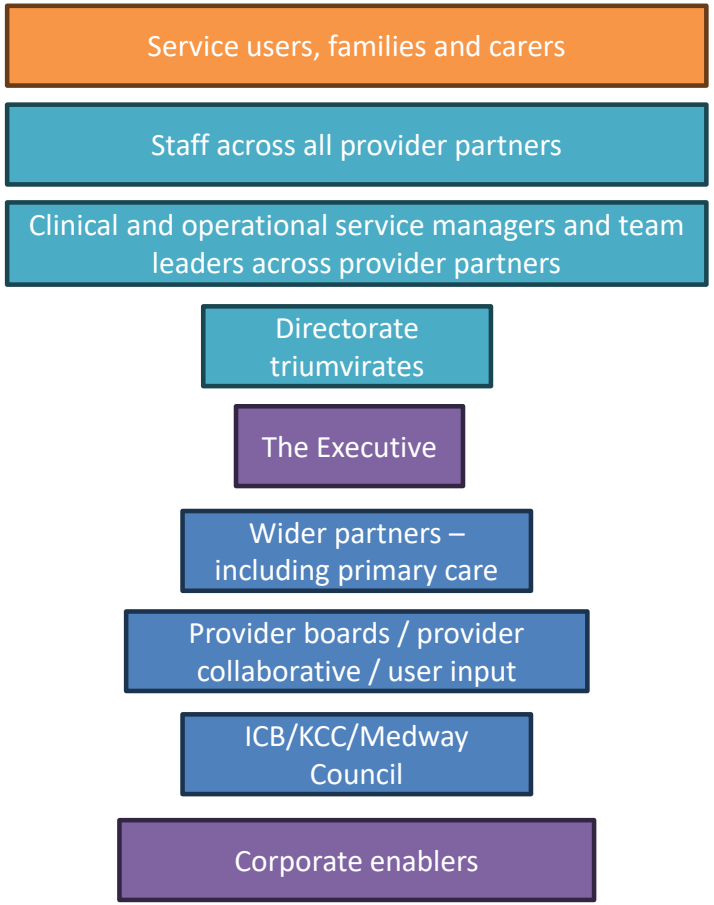
Phase 3 Jul 26 – Mar 27		• Review and strengthen community rehab roll-out • Align care delivery as part of the system approach to neighbourhood models	• Embed contract monitoring processes • Lead strategic development of CMH with wider partners • Ongoing certainty and stability to support longer-term planning and service development	• Support alignment with neighbourhood teams through workforce delivery models	• Support alignment with neighbourhood teams through data-sharing, interoperability and ongoing performance reporting

Communication and engagement

How we are working with our stakeholders

- Establishing a Communications & Engagement working group to develop a Communication and Engagement plan informed by stakeholder mapping
- Maintaining regular engagement with all internal and external stakeholders and using feedback loops
- Ensuring clinical and operational triumvirates are used for internal messaging, at all levels
- Developing programme management capability in delivery teams and building in checks to ensure understanding

Our key stakeholders:



Next steps

Deliver the workplan.

Communication, communication, communication with staff and partners - to build a shared understanding of what is going to happen next.

Developing the **transformation and continuous improvement skill set of the team who will deliver this new phase of the programme** - to underpin its effective delivery and build a 'Programme Team' culture and a group of people that speak as one to the broad range of stakeholders.

Build a **critical path and detailed programme plan** with localities and workstreams to underpin the work of the programme team.

Work through the **localities to tailor the communication and solutions to meet the individual needs** of those populations and staff teams.

Align the **capture, mitigation and escalation of risks to KMPT's new risk framework** (being approved by the Audit & Risk Committee) – developing this with the localities and workstreams.

Develop a **benefits tracking tool** to closely review our impact and the delivery of outcomes for our population and staff.

Take **develop with partners an integrated neighbourhood teams model that is aligned with community based** services across the County.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Finance Report for Month 5 (August 2025)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 5 (September 2025).

Issues to bring to the Board's attention

The attached report provides an overview of the Trust's financial position for Month 5 (August 2025). The Trust continues to deliver a position in line with plan, reflecting robust local controls and proactive management of key pressures.

Items of focus:

- The Trust has reported a pre-technical adjustment surplus of £0.55m, and a post-technical adjustment surplus of £0.92m. This is in line with the financial plan.

- The trust continues to managed a pressure within its external bed usage with 10 Acute and 7 PICU beds used in month and a year to date budgetary pressure of £3.03m. This pressure was identified during planning and mitigations have been put in place with non-recurrent slippage offsetting the pressure. The run rate has reduced during Quarter 2, following the introduction of step-down bed capacity.

- The trust has spent £2.22m on agency to Month 5, which would equate to a £4.98m in year spend. This position is being closely monitored with measures in place to reduce this position further and deliver a position in line with the agency cap of £4.27m.

- The Trust's Acute Inpatient wards have continued to utilise additional Nursing staff (both registered and unregistered) over and above established levels. This position is mostly offset by vacancies elsewhere within the trust, with overall staffing numbers are 6.11wte above plan (4,409.7 wte). The August position is due to annual leave and staffing levels are predicted to reduce in Month 6.

Governance

Implications/Impact:	If the Trust fails to deliver on its 2025/26 financial plan then this could impact on the long-term financial sustainability agenda.
Assurance:	Reasonable
Oversight:	Finance and Performance Committee

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Finance Board Report
August 2025
(Month 5)

Brilliant care through brilliant people

Contents

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1. Executive Summary

Key Messages

For the period ending 31st August 2025, the Trust has reported a pre-technical adjustments surplus of £0.55m and a surplus of £0.92m post technical adjustments, this is in line with the financial plan.

Key pressures for the Trust are:

External beds

- The Acute beds usage increased over July levels, with an average of 10 beds utilised costing £0.23m. The Trust doesn't hold a budget for external acute beds.
- External PICU bed usage decreased with an average of 7 external Female PICU beds (9 in July) and an average of 3 external Male PICU beds (2 in July) being utilised at a cost of £0.49m. The Trust holds a budget for 7 PICU beds.
- The Trust has introduced step-down capacity to facilitate the repatriation of patients from external acute beds to KMPT beds. ptake is increasing, with nine beds utilised (£0.07m per month).

Acute Inpatient staffing

- The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels.
- On average this financial year, usage is 86.5 WTE above establishment. In August, 91.2 WTE above budgeted levels were utilised, representing an 11.6 WTE (11.3%) reduction compared to April.
- Additional controls were implemented in June and work is on-going in this regard, however levels of staffing rose in August to compensate for increased Annual Leave. Staffing levels are expected to decrease in coming months.

Agency spend

- In month spend remained £0.38m, consistent with July levels. Year to date agency spend is £2.22m, with East Kent medical agency and West Kent nursing agency being key areas of pressure.
- In month spend levels were highest in East Kent, with 47.4% of overall agency spend, due to medical vacancies, but also West Kent (30.6%) due to pressures within Liaison services, CMHTs and Crisis teams.
- For 2025/26 an agency spend limit has been set for the Trust of £4.27m. Based on current forecasts, the Trust would spend £4.98m, £0.71m over the cap. Actions are in place to reduce current run rates.

At a Glance - Year to Date	
Income and Expenditure	
Efficiency Programme	
Agency Spend	
Capital Programme	
Cash	

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

Capital Programme

- As at 31st August the overall capital position is £0.66m under plan. This is due to delays in the delivery of doors for Estates projects and IFRS 16 lease remeasurements, which have not yet taken place.
- The forecast spend position is £17.30m which recognises the outcomes of the Public Sector Decarbonisation and Estates Safety Fund bids.

Cash

- The closing cash position for August was £13.81m which was an increase in month of £0.96m and is £3.80m higher than the July forecast. This is the result higher levels of receipts in relation to LVA (low volume activity) and VAT reclaims, delays in paying trade payables predominantly due to the lack of access to the finance system and the timing delays on payments relating to the pay award (relating to pension and national insurance payments) which will come through in September.

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2. Finance KPIs

I&E YTD position

M5 YTD actual	**£0.92m surplus**
Forecast outturn	£2.20m surplus

Year to date position on plan with a reported £0.92m surplus. Key pressures include Acute Inpatient staffing and External beds and are mitigated with non-recurrent benefits and pay slippage.
The Trust is forecasting an outturn position of a £2.20m surplus as per plan.

Efficiency delivery

M5 YTD actual	**£5.14m**
Full year identifed	£13.62m

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

Capital spend

M5 YTD actual	**£1.70m**
Forecast outturn	£17.88m

The Capital position is £0.66m behind plan. This is due to two Estates projects relating to anti ligature door replacement slipping in month along with IFRS 16 lease remeasurements which have not yet taken place. The forecast spend position is £17.88m which recognises the outcomes of the Public Sector Decarbonisation and Estates Safety Fund bids and donated funding for medical equipment.

Bank spend

M5 actual	**£1.79m**
Planned Run Rate	£1.67m

Bank spend increased in month by 7.0%. Usage increased across Acute wards to support staff training and increased levels of Annual Leave.

Agency spend

M5 actual	**£0.38m**
Planned Run Rate	£0.36m

Agency spend in August remains the same as July. The current forecast pre mitigations for agency is £4.98m, which against a cap of £4.27m results in the annual cap being exceeded by £0.71m.

WTEs utilised

M5 actual	**4,000**
Planned Staffing	4,060

WTEs utilised are monitored by NHSE against the Trust's workforce plan and are monitored to ensure there is no workforce growth. A decrease of 12 WTE is reported in month, and 44 WTE reduction since April 25.

External beds spend

Year to date overspend	**£3.03m**
Average Beds in Month	20

External beds utilised remained an average of 20 beds, consistent with July usage. This remains a key area of financial pressure for the Trust as only 7 PICU beds are funded. Mitigations are in place including step down beds to relieve the pressure from CRFD patients.

Cash position

M5 cash balance	**£13.81m**
Operating Expenditure Days	18.1

The closing cash position for August was £13.81m which was an increase in month of £0.96m and is £3.80m higher than the July forecast of £10.00m. This is the result of delays in paying trade and capital payables due to the lack of access to the finance system.

Principles

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

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

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

3. Primary statements

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£'000	£'000	£'000	£'000	£'000	£'000
Income	295,294	24,608	24,992	384	123,039	125,679	2,640
Employee Expenses	(229,166)	(19,097)	(18,887)	210	(95,486)	(94,367)	1,119
Operating Expenses	(59,038)	(4,920)	(5,624)	(704)	(24,599)	(28,821)	(4,222)
Operating (Surplus) / Deficit	**7,090**	**591**	**480**	**(111)**	**2,954**	**2,491**	**(463)**
Finance Costs	(4,892)	(408)	(297)	110	(2,039)	(1,576)	463
System control Surplus / (Deficit)	**2,199**	**183**	**183**	**(0)**	**915**	**915**	**(0)**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	(192)	(10)	(10)	0	(512)	(370)	142
Surplus / (deficit) for the period	**2,006**	**173**	**173**	**(0)**	**403**	**545**	**141**

The Trust is reporting a surplus of £0.92m at the end of August, in line with plan.

Employee expenses

The Trust is reporting a year to date underspend on employee expenses of £1.12m. This consists of an underspend on substantive pay of £1.35m with an additional underspend of £0.22m on bank (where bank is planned to support rotas), offset by overspends on agency of £0.45m.

The Trust spent £0.38m on agency in-month, representing 2.0% of pay spend. In staff group terms, spend within the Medical and Nursing staff groups accounted for the majority of the spend equating to 49.0% and 45.6% of overall agency spend, respectively.

Operating expenses

In month operating expenses are over budget by £0.70m which is heavily driven by external bed spend. The Trust utilised 10 external PICU beds (7 PICU beds funded) and 10 external Acute beds, all of which are unfunded, and this presents a financial pressure to the end of August of £3.03m.

Statement of Financial Position

	30th April 2025	31st July 2025	31st August 2025
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	174,192	172,933	172,246
Current assets	20,105	22,140	22,698
Current liabilities	(30,182)	(30,885)	(30,669)
Non current liabilities	(39,058)	(38,456)	(38,370)
Net Assets Employed	**125,057**	**125,732**	**125,905**
Total Taxpayers Equity	**125,057**	**125,732**	**125,905**

Total assets

Total assets for the month decreased by £0.13m. This limited movement is due to capital changes being offset by increases in cash, resulting from delays in trade payable payments.

Total liabilities

Overall, total liabilities increased by £0.30m in-month. Current liabilities increased by £0.22m, primarily due to increases in trade payables resulting from system delays. There was a small reduction in non-current liabilities due to the ongoing payments of lease liabilities.

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APPENDICES

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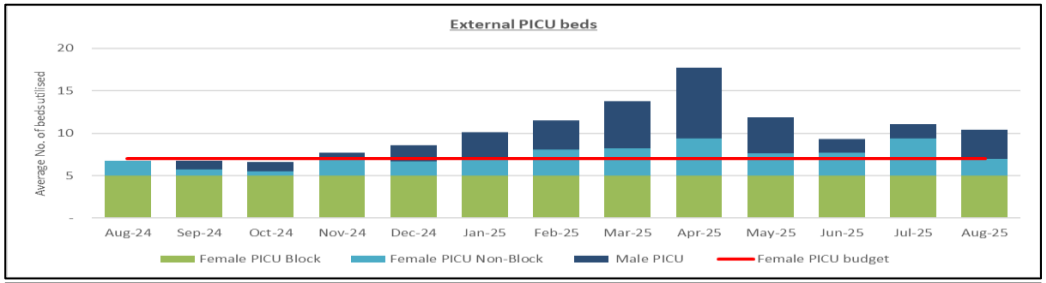
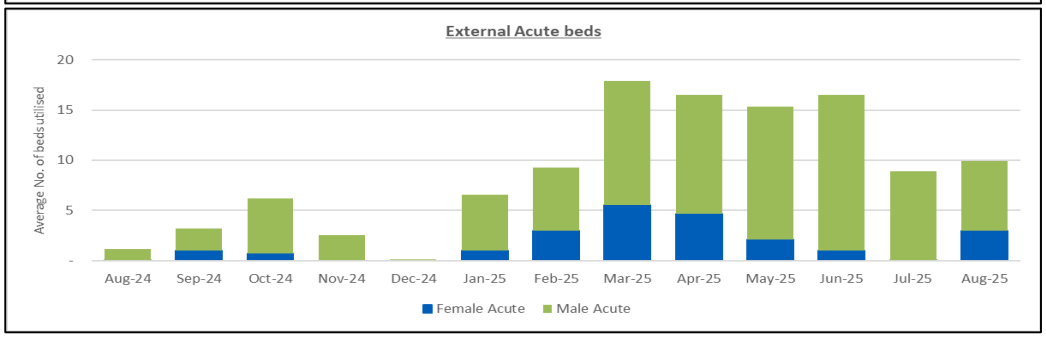
4. Exception Report – External Beds





Commentary

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

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

In August, usage of external Acute beds increased, from average 9 beds to 10. Female PICU usage is within the funded level of 7 beds but male PICU usage has increased from 2 to 3 beds. By the end of the month, external PICU usage had reduced to 7 beds total and this is continuing into September.

The Trust has undertaken a number of steps to reduce this pressure, including the implementation of step down beds, with the expectation that this would improve patient flow. 9 patients are currently placed in step down beds, supporting a reduction in external Acute beds used.

Exception report – Inpatient Staffing

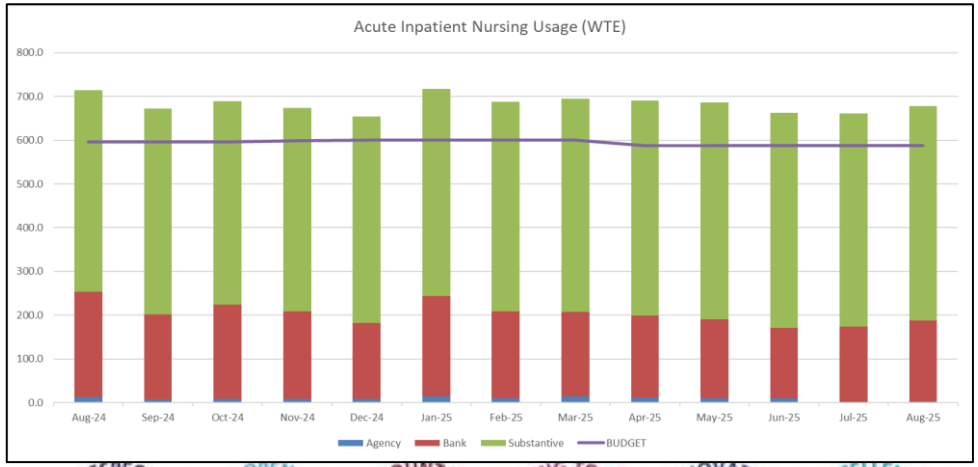
Commentary

The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels. On average, usage over establishment equates to 86.5 additional WTEs and £0.35m per month.

The following steps have been identified to mitigate the pressure:

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

Temporary staffing usage increased in August to cover higher levels of Annual Leave and training.



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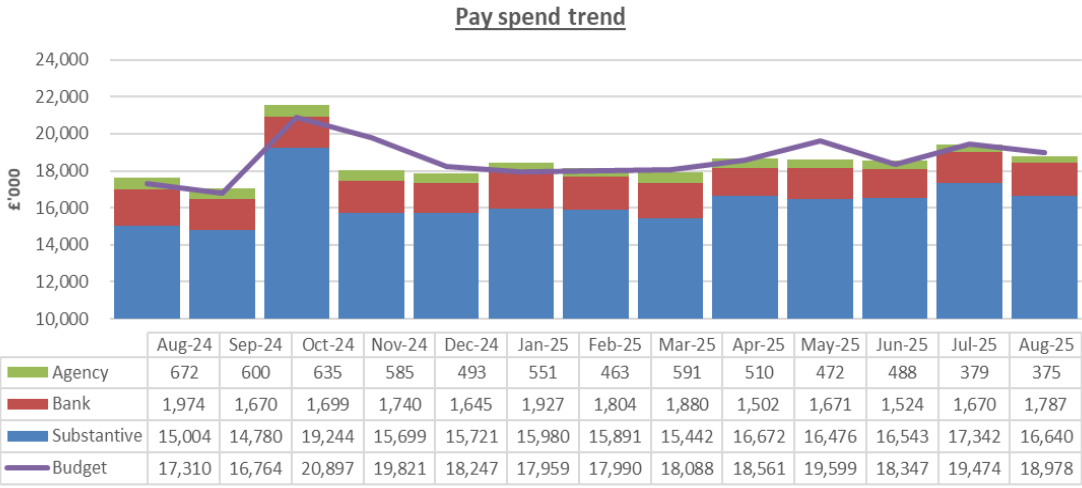
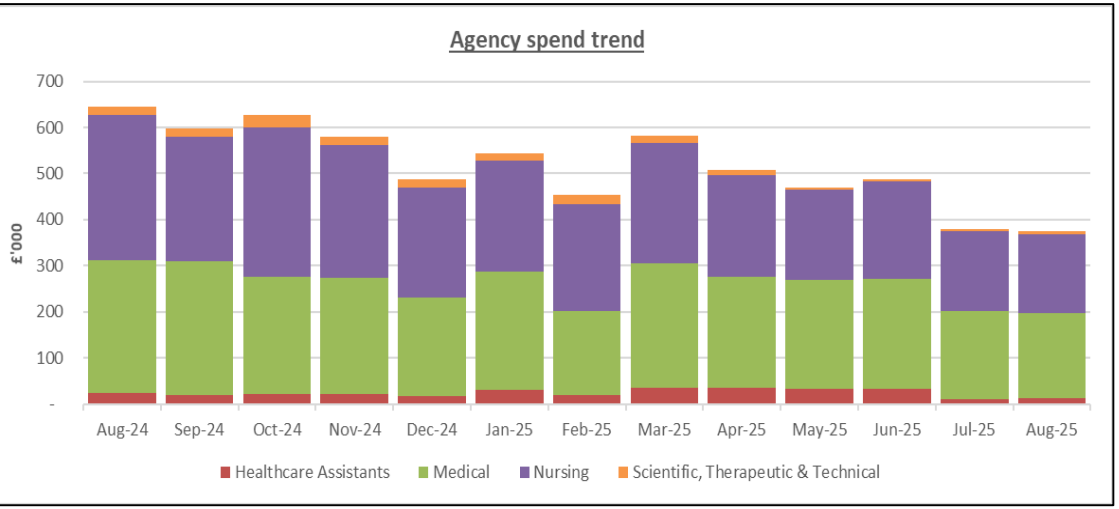
5. Exception Report – Pay Trend



	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
Agency	672	600	635	585	493	551	463	591	510	472	488	379	375
Bank	1,974	1,670	1,699	1,740	1,645	1,927	1,804	1,880	1,502	1,671	1,524	1,670	1,787
Substantive	15,004	14,780	19,244	15,699	15,721	15,980	15,891	15,442	16,672	16,476	16,543	17,342	16,640
Budget	17,310	16,764	20,897	19,821	18,247	17,959	17,990	18,088	18,561	19,599	18,347	19,474	18,978



Commentary:

At the end of August the Trust reported a year to date underspend on pay of £0.61m, including the impact of the pay award for the year to date for all substantive staff.

Substantive pay decreased in month after the agreed pay award for 2025/26 was recognised in July, as per national guidance.

The unadjusted current forecast for agency spend is £4.98m, which is £0.71m above the cap of £4.27m. Further work is planned to bring spend back in line with the cap.

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 slightly above plan due to seasonal pressures in inpatient staffing. This is anticipated to recover in Month 6.

Bank spend increased in month by 7.0%. Usage increased across Acute wards to support staff training and increased levels of Annual Leave.

Agency spend in August totalled £0.38m which represents a 55.8% reduction on spend seen for the same period in 2024/25; and a 1.2% reduction on spend in July.

- Medical agency WTE was 9.6 WTE in August, 7.1 WTE of which were in East Kent. This is likely to continue for the rest of this financial year though a focus on medical recruitment remains.
- Nursing agency increased 4.8WTE in month. Of the Nursing agency utilised, 42% is supporting community teams covered by CMHF and most of the remainder is supporting Liaison and Homecare teams. Agency recruited to cover vacancies in Mental Health Together in North Kent has now been recharged to the 3rd sector provider responsible for the recruitment. Recruitment continues to these teams and agency is forecast to reduce in coming months.
- HCA agency increased by 1.3 WTE to 4.7 WTE, the biggest user being West Kent Crisis & Homecare team. Implementation of Golden Key controls with NHSP has significantly reduced the use of HCA agency with the aim of stopping entirely.

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

6. Cost Improvement Plan

Savings plans

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

Efficiency maturity	Fully developed	Plans in progress	Opportunity	Unidentified	Total
	£'000	£'000	£'000	£'000	£'000
Plan submission (April 2025)	1,000	13,700	2,900	-	17,600
	5.68%	77.84%	16.48%	0.00%	
Month 5 reported	11,860	1,764	-	-	13,624
	67.39%	10.02%	0.00%	0.00%	

Commentary

The Trust submitted a surplus plan of £2.20m for 2025/26 and this is predicated on delivery of a 5% efficiency target (£15.4m) plus an additional £2.20m stretch target to achieve the required surplus. Overall, schemes fully developed and in delivery now represents 67% of the overall target for 2025/26.

Schemes underway:

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

Plans under development:

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

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7. Capital Position

	Annual			In month			Year to Date		
	Plan	*Forecast*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
System Capital expenditure									
Capital Maintenance and Minor Schemes	4,164	3,964	(200)	211	155	(56)	1,778	1,404	(374)
Information Management and Technology	1,299	1,699	400	0	(76)	(76)	0	26	26
Section 136 development	3,462	3,462	0	0	442	442	0	693	693
Public Decarbonisation	200	0	(200)	0	0	0	0	0	0
IFRS 16 Leases	3,375	3,375	0	0	8	8	384	11	(373)
Total system expenditure	**12,500**	**12,500**	**0**	**211**	**529**	**318**	**2,162**	**2,134**	**(28)**
External expenditure									
Out of Area Placement (Female PICU)	3,940	3,940	0	0	3	3	0	37	37
PFI 2025/26	461	461	0	38	38	0	190	194	4
Public Decarbonisation	629	0	(629)	0	0	0	0	0	0
Estates Safety Fund	0	400	400	0	0	0	0	0	0
R&D - Hyperfine Swoop Imaging System	0	578	578	0	0	0	0	23	23
Section 136 development	2,250	2,250	0	0	0	0	0	0	0
VAT Reclaim	(2,250)	(2,250)	0	0	(442)	(442)	0	(693)	(693)
Total external expenditure	**5,030**	**5,379**	**349**	**38**	**(401)**	**(439)**	**190**	**(439)**	**(629)**
Total Capital Expenditure	**17,530**	**17,879**	**349**	**249**	**128**	**(121)**	**2,352**	**1,695**	**(657)**

Commentary:

As at 31st August the overall capital position is £0.66m behind plan. This is due, mainly, to two anti-ligature door related schemes in Estates which are expected to recover by October in addition to the IFRS 16 underspend noted in previous months.

The forecast spend position remains unchanged from July at £17.88m

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NHS
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NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th September 2025
Title of Paper:	Winter Planning Board Assurance Statement
Author:	Neil Robertson (Interim Deputy Chief Operating Officer)
Executive Director:	Donna Hayward-Sussex (Chief Operating Officer)

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

In line with NHSE mandate, KMPT is required to plan for winter pressure that can impact on the demand on and delivery of ours services. NHSE now require boards to sign off a ***Board Assurance Statement*** about our winter readiness and associated mitigations.

For KMPT winter plan objectives are:

- Ensure that we have realistic and measurable plans in place to effectively manage the pathways for people using crisis services.
- Ensure that we increase our uptake of the influenza vaccine, specifically target our clinical workforce.
- Respond to adverse weather through effective mobilisation of resources in line with our winter resilience plan to ensure patient safety and business continuity.
- Provide appropriate support to system partners to mitigate demand in key hotspots of known service users.

The KMPT plan consisted of action cards, which include risks and mitigation for 4 targeted areas relevant to mental health service delivery - strengthening pandemic, seasonal flu and vaccination plan; mental health flow and crisis alternatives; supporting vulnerable high intensity users, and; emergency planning, resilience and response to adverse weather. Associated critical policies and plans are incorporated into the actions cards, including pandemic planning and the emergency planning for extreme adverse weather.

The plan critically considers maintaining business continuity, accessible leadership, bolstering key services that can be subject to increased demand or may need to support the wider system in mitigating their demand. Service user and workforce wellbeing is a feature of the plan and has been subject to an Equality Quality Impact Assessment.

The plans also consist of a series of metrics to provide further assurance about the health of the organisation during the winter period. Risks and the mitigation of these will be reviewed weekly, unless this is required sooner. At this time, the status of each plan is mainly rated amber given the stage of planning. The Winter Plan will be reviewed and updated regularly.

Version Control: 01

The Board Assurance Statement is to be submitted to NHSE England on the 30th September 2025. Sign off is required by the Chief Executive and Chair.

Issues to bring to the Board's attention

The 5 big risks at the point of completing this document are:

- Not optimising alternatives to acute care and failing to reduce clinical ready for discharge leading to high levels of 12-hour Emergency Department breaches and high use of out of area beds.
- Due to a summer surge in the number of people clinically ready for discharge when compared to this time last year, this could impact on our winter bed capacity.
- Adverse weather impacting on business continuity in delivering core inpatient, community and crisis services.
- Failing to achieve uptake of influenza across our clinical workforce, which could impact on patient safety and business continuity.
- Seasonal illness impacting on our workforce sickness and absence.

Mitigations for the risks have been identified and incorporate previous learning. Risks are currently score between 8 and 12 in relation to impact and likelihood. Risk will be reviewed weekly from this point forwards with escalations in place for swifter review if required.

Governance

Implications/Impact:	Delayed onward transfer of care for patients in our Acute Wards are our highest risk for winter with the Patient Flow Programme seeking to address these in a variety of ways.
Assurance:	Reasonable assurance.
Oversight:	Trust Board.

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Winter planning 2025/2026

September 2025

Winter Planning (1)

NHS
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NHS and Social Care Partnership Trust

Purpose

- The purpose of this plan is to ensure that we are proactive and responsive to the needs of the people we service over the winter period due to seasonal demand and potential adverse weather.
- Play our part in support our system due the likely extraordinary demands placed on acute and community partners.
- Ensure that our board are assured about our preparation and response to the winter period.

Objectives for 2025/26

- Ensure that we have realistic and measurable plans in place to effectively manage the pathways for people using crisis services.
- Ensure that we increase our uptake of the influenza vaccine, specifically target our clinical workforce.
- Respond to adverse weather through effective mobilisation of resources in line with our winter resilience plan to ensure patient safety and business continuity.
- Provide appropriate support to system partners to mitigate demand in key hotspots of known service users.

Headlines on last years position

- The start of winter pressures **fluctuates from year to year** and is usually quantified by an increase in acute demand in the Autumn period.
- For the trust we do see variation when demand for our crisis and acute system occurs in winter. The data for 2024/25 shows that **November 2024 and March 2025 saw a significant increase in demand across our acute and crisis system**. Out of area bed use also **significantly increased** in March 2026; however this can be accounted by other variables, especially for the number of people clinically ready for discharge.
- Initial modelling as of August/September 2025 indicates that we are **in a worse position with the number of people clinically ready for discharge than this time last year,** so as we enter into winter **we run the risk of reduced bed capacity** than in the same period in 2024. This means that we are going into winter with **a risk of our Clinically Ready for Discharge increasing.**
- From a sickness and absence perspective, we **did not see any material episodes** in 2024/25.
- For **uptake of flu vaccination, 2024/25 saw only a 40% uptake by our staff**, though the national uptake was 37%.
- The UK experienced a mild winter in 2024/25, with **no material adverse weather issues impacting on our business continuity**.

Winter Planning (2)

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Key Policies and resources	• KMPT Winter Resilience Plan – update for 2025/26. • Trust Pandemic Plan. • Trust Infection Control Policy. • Kent Local Resilience Forum. • GOV.UK resource website for winter pressures. • Cabinet Office Resilience Direct. • NHSE 10 High Impact Interventions.
Risk	**The top five risks for KMPT this winter are:** • There is a risk that we could have less bed capacity due to an increase in clinically ready for discharge this year we compared to the same time last year. • Not optimising alternatives to acute care and failing to reduce clinical ready for discharge leading to high levels of 12-hour Emergency Department breaches and high use of out of area beds. • Adverse weather impacting on business continuity in delivering core inpatient, community and crisis services. • Failing to achieve uptake of influenza across our clinical workforce, which could impact on patient safety and business continuity. • Seasonal illness impacting on our workforce sickness and absence.
Organisational Assurance	This organisational plan for responding to winter will be subject to the completion of a Board Assurance Statement, which provide a checklist for readiness. This includes a QEIA. It is due to be signed off in September 2025 Board.

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INDIVIDUAL PLANS 2025-26

Winter Planning: Strengthening pandemic, seasonal flu and vaccination plan

Overall Status

Amber

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NHS and Social Care Partnership Trust

Action	Key Activities
• **Increase the uptake of staff seasonal flu vaccination to 80% in 25/26.** • **Ensuring that all areas adhere to the Trust Infection Prevention and Control guidance.**	• Mobilisation plan being overseen by a task and finish group in readiness for vaccine issue. This will be supported by vaccination campaign that includes myth busting. • Vaccination clinics will be established, as well as well as attending clinical teams, such as, community and inpatient service. • Last year KMPT vaccinated 40% of the workforce (national avg. 37%), we are committed to achieving 45% as per national expectations and are currently finalising the trajectory for vaccine uptake. • From a mental health perspective, we will manage flu outbreak in inpatient services in line with our IPC policy and will cohort based on numbers of people effected. • Physical health screening forms for hospital admission will be used to assess risks in relation to virus and infection to support admission management inline with our IPC policies. • The Trust pandemic plan is updated https://app.joinblink.com/#/hub/01910972-7078-7950-8766-0af1abb51464 • IPC Staff Room Link https://app.joinblink.com/#/hub/018fc4e0-023d-79cf-b547-52c6fcdc8b56 • Trust IPC Policies Link https://app.joinblink.com/#/hub/018fda1d-7dfe-71bd-869b-de365246ac3c

Keys Issues / Risks	Impact	Likelihood	Status
Inadequate uptake of flu vaccination by our workforce could impact on high sick rates impacting on business continuity, inpatient flow and increases the risk of our inpatient being exposed to influenza.	5	2	10
Failing to adhere to Infection Prevention and Control guidance increases the risk of both services user contracting seasonal flu and other viruses, impacting on sickness and increased risk of serious illness to vulnerable patients.	5	1	5

Mitigations	Metrics
• Targeted communication and engagement with the workforce, which includes myth busting and effectively reaching our ethnically diverse workforce. • We are working with pharmacy and procurement to ensure we have suitable storage for vaccines stored off our hospital sites. • Adhering to infection control policy. • Ensuring agility with in our bed base to managed flow challenges as a result of influenza outbreak.	• An achieved weekly trajectory to staff vaccinated in line with this years target. • Confirmed inpatient cases of influenza and other seasonal are appropriately isolated and managed to reduce the risk of bed closures. • Minimal bed closure due to unmanageable viral outbreaks. • Weekly sickness returns are in line with previous baseline for 2024/25

Winter Planning: Mental health flow and crisis alternatives (1)

Overall Status

Amber

NHS
Kent and Medway
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Action	Key Activities
Rapid assessment through crisis pathways will continue to be provided by rapid response and with in 4 or 24 hours dependent on need.	• Critical to the plan is admission avoidance and using alternative to admission. The following service responses are to work in an integrated way to ensure people are provided with least restrictive care. This will ensure that acute admission flow is prioritised for the greatest need, reducing 12 hour breaches where we can. • A recent increase in clinically ready for discharge in August/Sept 2025, means that we are at risk of going into the winter with more beds blocked than this time last year – our CRFD is 5% higher for younger adult than when compared to this time last year. We are now working on mitigating this. • Rapid Response Teams in each locality with respond with in 4hr, 24hr and 72hr based on needs and risk. The service is 24 hours. Last years data showed a good response rate, however, peaks in referral to the service were seen in September and October 2024 and March 2025. • Now, Core 24 standards and funding now embedded across all acute hospital in Kent, meaning that we will be responsive both in the context of ED and acute hospital ward admissions. Last winter data correlated with Rapid Response increased referral with the increase in footfall in ED's. KMPT also achieved over 80% in one hour response rate between September 2024 and March 2025. • In the event of an Emergency Department critical surge, the departments front door will be strengthened with additional staffing for triage. • Both Rapid Response and Liaison Teams work directly with KMPT Home Treatment Team to provide alternatives to admission. • The system have access to recovery house and safe havens to support alternatives to admission or ED presentations. We will work with providers and commissioners to continue to optimise this resource and be agile where we can to support system pressures. • The Trust will adhere to the NHSE OPEL action card for 2024-2026 (see attached document) • It is unclear if industrial action will be held over the winter period, which could impact of crisis service delivery. We will continue to use our current business continuity plan for previous action, which has been reviewed.

Winter Planning: Mental health flow and crisis alternatives (2)

Overall Status

Amber

NHS
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Keys Issues / Risks		Impact	Likelihood	Status
Sickness due to winter illness could impact on team responsiveness during the winter period		5	2	10
Not using alternatives to admission effectively due to risk aversion.		4	3	12
Increase in the use of out of area acute beds because of lack of system cohesion, which increases the risk of poor care and is not affordable.		4	3	12
KMPT social workers are working to find ways to address the issue of not having devolved responsibility to from KCC, which will support faster discharge preparation.		4	3	12
Due to a summer surge in the number of people clinically ready for discharge when compared to this time last year, this could impact on our winter bed capacity if we do not act now.		4	3	12
Future industrial action could impact on the safe and effectively delivery of crisis services.		3	3	9

Mitigations	Metrics
• Sickness monitoring, deploying staff resource to challenged area and uptake of the flu vaccination. • Working to ensure we the a suite of metrics from existing data sources to support data driven responses. • Undertake a piece of work to engage and communicate the workforce to "think alternatives" and provide check and challenge through our flow team. • Continue with progress made in reducing acute out of area and ensure existing structures are strengthened. • Leadership conversation taking place with KCC to explore devolvement. • Early work to ensure recent high bed demand does not impact on increasing clinically ready for discharge numbers. • Stand up current medic industrial action business continuity plan when required. • Increase Emergency Department triage resourcing at the front if there is a surge in mental presentations.	• Maintaining minimum staffing levels in ALL services. • Business continuity is maintained across the winter for all services. • An increase in the use of crisis alternative based on previous winters demand. • Crisis plans for people known are updated leading up to the winter period. • Winter demand remain in line with November December 2024 and January 2025. • Responding with alternatives to emergency care in October 2025 and March 2026. • Out of Area bed usage remains in line with numbers of patients admitted in October and December 2024. November and March shown as a hotspot based on last winter. • Clinically ready for discharge numbers to be no more than 17% of total young adult beds • Crisis services fully staffed in the event of industrial action. • Emergency Department ED presentation surge of more than 50%

Winter Planning: Supporting vulnerable high intensity users (HIU).

Overall Status

Amber

NHS
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Action	Key Activities
Proactively identify high intensity users to reduce readmissions	• The HIU project is underway and the first data set shows reductions in contacts across KMPT and some patients improving to an extent to facilitate a discharge from the service (5 out of 28 HIU patients in the first quarter January-April 2025). • The system wide part of this project has great representation from our partnering agencies and is supporting better working relations across Kent and Medway. • In October 2025 we will conduct an analysis of the second data set to assess the impact of this work on re-admissions, triangulating the data with service users and clinician's voice. (Ongoing BAU work). • This work has also identified another group of patient readmissions who don't meet the HIU definition criteria of 5 + contacts in 90 days but instead have 3 or 4 contacts. Work is then happening at pace to address this cohort who are hard to engage relationally, but do need some intensive psychotherapeutic support. • We are exploring options currently within our existing psychotherapeutic offer, as part of the CMHF revisions to look at alternative interventions for this cohort. This is underway with a view to achieve KMPT agreement with these developments, clinical work commencing and then our first evaluation of this work on 30th November 2025.

Keys Issues / Risks		Impact	Likelihood	Status
Demand and capacity issues for staff (time and resources), which is currently be reviewed and will be updated at a later date.		4	3	12
Over use of beds by people deemed a high intensity user impacting in the use of out of area beds		5	2	10

Mitigations	Metrics
• Undertake a piece of work to engage and communicate the workforce to "think alternatives" and provide check and challenge through our flow team. • Continue with progress made in reducing acute out of area and ensure existing structures are strengthened.	• Reduction in the number of people in identified needing a regular requirement for admission over a year. • Out of area beds used remains at December 2024 levels.

Winter Planning: Emergency planning, resilience and response to adverse weather

Overall Status

Green

NHS
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Action	Key Activities
Effective interventions for the management of adverse weather to support business continuity.	• Clinical services and relevant corporate services to implement the winter resilience plan and cold weather action card

Keys Issues / Risks		Impact	Likelihood	Status
Extreme cold weather can cause: transport disruption; increased cases of slips/trips; cardiovascular or respiratory illnesses and hypothermia; increased hospital admissions, especially among vulnerable individuals; and power and telecom outages.		5	2	10

Mitigations	Metrics
• The Truest Action Card for responding to adverse weather. 2BB85473.pdf **Adverse Weather and Health Plan - GOV.UK** https://www.gov.uk/government/publications/cold-weather-plan-action-cards-for-cold-weather-alert-service	• Maintaining minimum staffing levels in ALL services • All sites are accessible for staff, service users and the public. • All site that are operating have sufficient heat, electricity and a water supply. • Effective use of command structure as required. • All patients deemed physically vulnerable have a support plan. • All teams have access to a reviewed business continuity plan meaning no service fully closes

Kent and Medway NHS and Social Care Partnership Trust

Winter Planning 25/26

Board Assurance Statement (BAS)

Kent and Medway NHS and Social Care Partnership Trust.

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	QEIA in draft and scheduled for next QEIA session 7th October.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The Trust has worked closely with the ICB, UEC and South East Region.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Attended 8th September 2025.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Donna Hayward Sussex
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	Our plan will - • Ensure that we have realistic and measurable plans in place to effectively manage the pathways for people using crisis services. • Ensure that we increase our uptake of the influenza vaccine, specifically target our clinical workforce. • Respond to adverse weather through effective mobilisation of resources in line with our winter resilience plan to ensure patient

Provider:	Double click on the template header to add details

		safety and business continuity. • Provide appropriate support to system partners to mitigate demand in key hotspots of known service users. The plans we have developed consider the actions and activities for readiness and responsiveness, risk assessed for impact and likelihood, mitigations and metrics for success.
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	The top four risks this winter are: • Not optimising alternatives to acute care and failing to reduce clinical ready for discharge leading to high levels of 12-hour Emergency Department breaches and high use of out of area beds. • Due to a summer surge in the number of people clinically ready for discharge when compared to this time last year, this could impact on our winter bed capacity if we do not act now. • Adverse weather impacting on business continuity in delivering core inpatient, community and crisis services. • Failing to achieve uptake of influenza across our clinical

Provider:	Double click on the template header to add details

		workforce, which could impact on service user safety and business continuity. • Seasonal illness impacting on our workforce sickness and absence.
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	We have considered priorities about 12 hour breaches following a decision to admit.

Provider CEO name	**Date**	**Provider Chair name**	**Date**

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	KMPT are aiming to achieve the previous national target of 45%
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Critical time for responsiveness will be October/November/March 25/26
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Daily staffing huddles are in place and we will mobilise staff from other clinical areas to ensure minimum staffing.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	N/A	N/A
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	N/A
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	IPC policies are fit for purpose.
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Systems for fit testing in place and will be able to respond to aerosol generating procedures.
8. A patient cohorting plan including risk-based escalation is in place and	Yes	High intensity users programme remains in

	understood by site management teams, ready to be activated as needed.		place. In addition, we are launching a communication campaign about the reviewing of crisis plans for known service users.
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	All appropriate systems in place and this was last subject to a testing exercise on 17th July 2025
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	We are adhering to the NHSE OPEL Mental Health Action 2024-26
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	Yes	Specific plan for Mental Health Flow and Crisis Alternative has been devised for 2025/26.
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	Specific ongoing plan in place for supporting vulnerable high intensity users for 2025/26

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Equality Impact Assessment (EqIA) template 2025 (Reviewed Feb 2025)

Equality Impact Assessment (EIA) is a tool designed to identify whether an existing or proposed (new) policy, procedure, project or service (the activity) affects people from minority groups[1] differently, and whether it affects them in an adverse way. The EIA will guide the lead of the activity to understand whether people from protected characteristic groups[2] are disadvantaged by the activity. It is also a way of identifying where we might better promote equality of opportunity.

As an NHS Trust, KMPT needs to ensure that proper consideration has been given to equality, diversity and inclusion in relation to all strategies, policies, services and functions, both current and proposed.

An EIA is a risk assessment tool that helps to examine whether different groups of people are, or could be, disadvantaged by the decisions that are made. It involves using equality information, and the results of engagement with people from protected groups and others, to understand the actual effect or the potential effect of our functions, policies or decisions. It can help to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations.

For further support or advice please contact the Equality, Diversity & Inclusion Team at kmpt.equalityteam@nhs.net

Contents

[1] Minority groups as defined by the Equality Act 2010 as protected characteristics
[2] Age, Disability, Gender Reassignment, Marriage/Civil Partnership, Pregnancy & Maternity, Race, Religion & Belief, Sex (assigned at birth), Sexual Orientation

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Section 1 – Engagement

Project title/Activity/Action: Winter Plan2025/26 Lead Name: Neil Robertson Lead Role: Deputy Chief Operating Officer	1. Is this a: • Change to an existing strategy or policy ☐ • Change to a service or function ☐ • A new strategy or policy ☐ • A new service or function ☐ • A new project ☐ • Other ☒

2. Does this affect a particular Directorate, Service or Workforce Group? Tick all that apply:

Directorate **(please indicate the Directorate affected)**	**Workforce Group** **(please indicate the workforce group affected)**	**Who**
All ☒ (if all directorates are affected) Acute ☐ Forensic & Specialist ☐ Support Services ☐ East Kent ☐ North Kent ☐ West Kent ☐ Please indicate which service in affected Click or tap here to enter text.	All ☒ (if all workforce group is affected) Consultants ☐ Doctors ☐ Nurses ☐ HCA ☐ AHP ☐ Corporate ☐ Information Management and Technology ☐ Support staff* ☐ *Please indicate specifically which group is affected	Patients ☒ Carers ☒ Staff ☒ Families ☒ Trade unions ☐ Suppliers ☐ Other (describe below) ☐ Click or tap here to enter text.

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3. Checklist

All the KMPT's policies, programmes, strategies, services and major developments affect patients, carers, service users, employees and the wider community. These will have a greater or lesser relevance to quality and equality.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation, pregnancy and maternity and any other relevant characteristics (for example socio-economic status, social class, income, unemployment, residential location or family background and education or skills levels).

Make notes to assist with the completion of the EqIA.

Questions	**Yes**	**No**
Is there any indication or evidence (including from consultation with relevant groups) that different groups have different needs, experiences, issues and priorities in relation to the proposed policy or proposal?	☒	☐
Is there potential for or evidence that the proposed policy or proposal will affect different population groups differently (including possibly discriminating against certain groups)?	☐	☒
Have there been or are there likely to be any public concerns (including media, academic, voluntary or sector specific interest) about the policy or proposal?	☐	☒
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	☐	☒
Could the proposal affect our workforce or employment practices?	☒	☐
Is there potential for or evidence that the proposed policy or proposal will not promote equality of opportunity or promote good relations between different groups?	☐	☒

Notes

Summarise the strategy, policy, service(s) or function(s) being assessed. Describe current status followed by any changes that stakeholders would experience.

In line with NHSE guidance, KMPT, like any other NHS provider are required to plan for winter pressure that can impact on the demand on and delivery of services. NHSE now require Boards to sign off a Board Assurance Statement about their winter readiness and associated mitigations. For KMPT winter plan objectives are:

- Ensure that we have realistic and measurable plans in place to effectively manage the pathways for people using crisis services.
- Ensure that we increase our uptake of the influenza vaccine, specifically target our clinical workforce.
- Respond to adverse weather through effective mobilisation of resources in line with our winter resilience plan to ensure patient safety and business continuity.
- Provide appropriate support to system partners to mitigate demand in key hotspots of known service users.

KMPT plans consisted of action card, which include risks and mitigation for 4 targeted areas relevant to mental health service delivery- strengthening pandemic, seasonal flu and vaccination plan; mental health flow and crisis alternatives; supporting vulnerable high intensity users, and; emergency planning, resilience and response to adverse weather. Associated critical policies and plans are incorporated into the actions cards. Pandemic planning and the emergency planning for extreme adverse weather.

The plan requires consideration of maintain business continuity, accessible leadership, bolstering key services that can be subject to increased demand or can support the wider system in mitigating their demand.

The 4 big risks at the point of completing this document are:

- Not optimising alternatives to acute care and failing to reduce clinical ready for discharge leading to high levels of 12-hour Emergency Department breaches and high use of out of area beds.
- Adverse weather impacting on business continuity in delivering core inpatient, community and crisis services.
- Failing to achieve uptake of influenza across our clinical workforce, which could impact on patient safety and business continuity.
- Seasonal illness impacting on our workforce sickness and absence.

Mitigations for the risks have been identified and based on previous learning.

4. Engagement/Consultation

A key principle for completing impact assessments is that they should not be done in isolation. Consultation with groups and stakeholders[3] needs to be conducted from the start, to enrich the assessment and develop relevant mitigation. Detail here who you have involved with completing this EqIA. The EDI team along with Network representatives and representatives for vulnerable groups have formed an EQIA consultation review group. To present/attend the next meeting, please contact: kmpt.equalityteam@nhs.net
To present at the Trust Wide Patient Experience Group or the Trust Wide Carer Experience Group, please contact: tracy.neilson@nhs.net
Please note, this is to support your consultation piece and is not part of the Governance approval process.

Meeting/Group/Governance	Organisation	Role of assessment team e.g. service user, manager of service, specialist (which area)
Clinical Services: *EIP* *MHT* *MHT+* *HTT* *Neuropsychology/ psychiatry* *Community Brain Injury* *Specialist Personality Disorders* *CJLaDS* *Crisis Line/ NHS 111press 2* *MAS*	*KMPT*	Clinical Directorate Service Director and their deputies
Patient Safety Team	*KMPT*	Director of Patient Safety and Deputy Chief Nurse
Business Intelligence	*KMPT*	Chief Digital Officer
Estates and Facilities	*KMPT*	Director of Estates and Facilities

[3] Stakeholders include but not limited to: JNF, staff networks, service users, carers

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Section 2 – Impact

5. Impact

This looks at the scheme as a whole and asks how it will impact patients, staff and the organisations involved and how any identified risks or negative impacts could be mitigated.

Patient/Staff Safety – will the scheme have a positive/negative or neutral effect on the aim to treat and care for people in a safe environment and protect them from avoidable harm?

Clinical Effectiveness – will the scheme have a positive/negative or neutral effect on the aim to apply knowledge that is based on research, clinical experience and patient preferences, to achieve optimum processes and outcomes of care for patients? (The purpose of clinical effectiveness is to use evidence to improve the effectiveness of clinical practice and service delivery.)

Patient/Staff/Organisation Experience/Families/Friends/Carers – will the scheme have a positive/negative or neutral effect on patients' experience of care, based on all interactions, before, during and after delivery of the care? How will it affect staff experience and the portrayal of the organisation as a whole?

The following assessment requires judgement against the listed areas of risk above in relation to quality. Each activity/action will need to be assessed to identify whether it will impact adversely on patients / staff / organisations. In the table below, identify whether there will be a positive/negative or neutral effect on each of the areas. Record your reasons for arriving at that conclusion in the comment's column. If any area is identified as having a potential negative effect, you must calculate the overall risk score for this by multiplying the score for level of impact and the score for likelihood of occurrence together, using the risk matrix. Insert the total in the appropriate box. If a negative effect is identified, please also provide any suggested mitigations.

Area	Positive/Negative or Neutral Impact	Comments:	Suggested Mitigations	Updates
Patient Safety	Positive impact as this plan is intended to support business	Patient safety team and quality leads consulted about plan.		

	continuity, staff wellbeing and patient safety Negative – poor staff uptake of vaccination could impact on business continuity due to winter sickness.		**Vaccination campaign beginning and will support engagement about vaccination uptake.**	
Staff Safety	Positive impact by ensuring staff are protected from influenza and will be supported with clear actions when business continuity affected by unprecedented demand and adverse weather. Negative – staff not engaging with vaccination uptake.	Specific groups of staff outing themselves at risk of ill health by not getting vaccinated.	**Vaccination campaign beginning and will support engagement about vaccination uptake.**	
Clinical Effectiveness:	Positive- maintaining business continuity.		**Vaccination campaign beginning and will support engagement**	

	Negative – staff winter sickness impacting on service delivery		**about vaccination uptake.**	
Patient Experience:	Positive- maintaining business continuity. No plans to change service delivery unless triggered by adverse weather. Negative – adverse weather, winter sickness and high demand on crisis service could impact on patients' experience.	**This is in relation to patients not being seen in a timely way if in crisis, not getting continuity of care due to sickness and struggling to get to appointments if weather extreme.**	**OPEL response** **Business continuity plans** **Staff flue vaccination programme.**	
Staff Experience:	Positive- Staff have a clear plan how to respond to winter challenges including winter Negative – some staff could struggle to get to work due the ruralness of the county and some individual poor		**Business continuity plans** **Staff flue vaccination programme.** **Extreme weather plan**	

	engagement with vaccination programme			
Organisation Experience:	Positive- assurance that we have plan that consider most eventualities. Negative – failing to deliver safe levels of service due to surge in demand, staff winter sickness and extreme weather.		**Business continuity plans** **Staff flue vaccination programme.** **Extreme weather plan**	

6. Equality Impact Assessment

6.1 Who may be affected by this activity?

Protected characteristics (Equality Act 2010)	**In addition, consider the following vulnerable groups (external):**
Age ☒ Disability ☒ Gender reassignment ☒ Marriage & civil partnership ☒	Armed forces ☒ Carers ☒ Digital exclusion ☒ Domestic abuse ☒ Education (literacy) ☒

Pregnancy & maternity ☒ Race ☒ Religion & beliefs (including no belief) ☒ Sex (male or female) ☒ Sexual orientation ☒	Homeless ☒ Looked after children ☐ Rural/urban areas ☒ Socioeconomic disadvantage ☒ People with addiction or substance misuse problems ☒ People on probation ☒ Prison population ☐ Undocumented migrant, refugees, asylum seekers ☒ Sex workers ☒ Other (describe below) ☐

6.2 Assessment Team Discussions – between **Click or tap to enter a date.** and **Click or tap to enter a date.**

Protected equality characteristic	Describe here the considerations and concerns in relation to the programme/policy for the selected groups.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Age	Older people's access to service in adverse weather. Older people's vulnerability to the impact of flu and other winter illness in hospital-based settings. Older people risk of isolation.	Team awareness of vulnerable and isolated service users and ensuring a review of care where appropriate. Identifying alternative to hospital admission Crisis plan provide different alternative, not just A and E. Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users. Increase physical health screening where appropriate. Encouraging flu vaccination where patient identified as not receiving this.
Disability	Reduced mobility, hearing or visual impairments may affected in accessing services, increased isolation and vulnerability to winter illness	Team awareness of vulnerable and isolated service users and ensuring a review of care where appropriate. Identifying alternative to hospital admission Crisis plan provide different alternative, not just A and E.

		Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users. Increase physical health screening where appropriate. Encouraging flu vaccination where patient identified as not receiving this.
Gender reassignment	No impact identified	
Marriage & civil partnership	No impact identified	
Pregnancy & maternity	No impact identified	
Race	No impact identified	No impact identified
Religion & beliefs	No impact identified	No impact identified
Sex	No impact identified	No impact identified
Sexual orientation	No impact identified	No impact identified

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Armed forces	No impact identified	No impact identified
Carers	Carers could become isolated during extreme weather when caring for a loved one at home. Caring for somebody who is suffering from winter illness or they themselves are ill impacting of caring duties.	Team awareness of vulnerable and isolated service users and ensuring a review of care where appropriate. Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users. Encouraging flu vaccination where patient identified as not receiving this.
Digital exclusion[4]	Older adults may not have access to or be able to use digital solutions if extreme weather impact on contact with service.	Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users.
Domestic abuse	Risk of being isolated in an abusive environment due to extreme weather and the seasonal holidays	Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users.
Education (literacy)	No impact identified	No impact identified

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Homeless	Consideration needs to be given to this vulnerable group during extreme weather	Teams where appropriate review care and seek support for temporary housing through the local authority.
Looked after children	N/A	**N/A**
Rural/urban geographies	**Risk of isolation due to extreme weather**	Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users.
Socio-economic disadvantage	If a person struggles financially to get to appointments as they may not have a car, or are able to afford costs of transport or do not have access to digital solutions and are also experiencing fuel poverty.	Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users. Team awareness of vulnerable and isolated service users and ensuring a review of care where appropriate.
People with addiction or substance misuse problems	As per socially disadvantage and homelessness section	**As per socially disadvantage and homelessness section**
People on probation	No impact identified	**No impact identified**
Prison population	N/A	**N/A**

Vulnerable groups/existing inequity	Describe here the considerations and concerns in relation to the programme/policy for the selected groups.	Describe here suggested mitigations to inform the actions needed to reduce inequalities.
Undocumented migrants, refugees, asylum seekers	As per socially disadvantage and homelessness section	Use of trust transport and taxi's where appropriate to safely support appointments and admission for the most vulnerable users. Team awareness of vulnerable and isolated service users and ensuring a review of care where appropriate.
Sex workers	No impact identified	No impact identified
Other	No impact identified	No impact identified

[4] Digital Exclusion can be linked to the following key root causes:

- Connectivity access to the internet – can include financial barriers as well as suitable broadband speeds/connectivity
- Digital Skills the ability to use digital tools such as email, online shopping, digital healthcare - also includes having confidence in online safety, and how to utilise particular services or apps
- Technology and Accessibility access to appropriate devices to suit their individual needs – includes access to devices suitable for use with a certain disability as well as financial and location barriers
- Not wanting to use digital platforms simply not wishing to utilise digital services – this could be due to distrust of providers, online security, privacy etc.

Kent and Medway
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Section 3 – Actions and decisions

7. Action plan and monitoring arrangements

Insert your action plan here based on the mitigations recommended.

Involve your assessment team[5] in monitoring progress against the actions.

ACTIONS & DECISIONS TRACKER						
Item	**Initiation Date**	**Action/Item**	**Person Actioning**	**Target Completion Date**	**Update/Notes**	**Open/ Closed**
1	01/09/25	Monthly reviews	Neil Robertson	04/04/2026		
2						
3						
4						
5						
6						

[5] Assessment team – this can be the group set up to work on the EqIA and the activity

8. Recommendation

Based on your assessment, please indicate which course of action you are recommending to decision makers. You should explain your recommendation in the blank box below.

Outcome No.	Description	Tick
Outcome One	**No major change to the service/function required.** This EQIA has not identified any potential for discrimination or negative impact, and all opportunities to promote equality have been undertaken. Proceed with the programme and review EQIA mid-programme.	X
Outcome Two	**Adjust the service/function** to remove barriers identified by the EQIA or better advance equality. Are you satisfied that the proposed adjustments will remove the barriers you identified? Proceed with adjustments, amend programme and review EQIA mid-programme.	
Outcome Three	**Continue the service/function** despite potential for negative impact or missed opportunities to advance equality identified. You will need to make sure the EQIA clearly sets out the justifications for continuing with it. You need to consider whether there are: • Sufficient plans to stop or minimise the negative impact • Mitigating actions for any remaining negative impacts plans to monitor the actual impact. Proceed with programme. Monitor and evaluate. Discuss with SRO.	
Outcome Four	**Stop and rethink** the service change/proposal when the EQIA shows actual or potential unlawful discrimination. Review with the SRO for this area of work within 28 days of completion of EQIA.	

Please use the box on the right to explain the rationale for your recommendation:	

9. Governance

Sign off	Director (name and job title)	Date:

10. Version Control

Version Number	Purpose/Change	Author	Date

The above provides historical data about each update made to the EqIA. Please include the name of the author, date and notes about changes made – so that you are able to refer back to what changes have been made throughout this iterative process.

11. Publish

All approved EqIAs should be published on KMPT's intranet. Send the final ratified copy to: kmpt.policies@nhs.net & kmpt.equalityteam@nhs.net

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Designated Body Annual Board Report and Statement of Compliance (2024/2025)
Author:	Dr Mohan Bhat, Deputy Chief Medical Officer for Workforce
Chief Medical Officer:	Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

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

Overview of Paper

Annual Organisation Audit Report and Statement of Compliance to Board for approval prior to submission to NHS England (2024/25).

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

Issues to bring to the Board's attention

1) We have in total 158 doctors who have prescribed connection to KMPT as their designated body. 99% (152/154) will have completed their appraisal in the year. There were 4 who had approved exemptions for the appraisal year, 1 on a career break and 3 on long term sickness. In line with GMC requirement and Responsible Officer Protocol, KMPT has a robust process in place to ensure recommendations to the GMC are timely and our doctors are revalidated in line with GMC requirements.

2) All actions raised from 2023/2024 Annual Board Report have been completed.

Governance

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

Version Control: 01

Briefing Note:

Revalidation and appraisals are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop, so care continuously improves. All Responsible Officers, who are the people responsible for helping doctors with revalidation are required to complete the Annual Organisational Audit (AOA) on behalf of their organisation or 'designated bodies'. The collective results from the exercise provides a level of assurance about the consistency of the appraisal process supporting medical revalidation to patients, the public and to doctors, Responsible Officers and the organisations in which they work; to higher level Responsible Officers in NHS England's regional teams, the General Medical Council and Ministers on the value that medical revalidation brings.

Our Annual Organisational Audit (AOA) was completed in January 2025 which concluded that as an organisation we have fit for purpose processes in place to ensure our doctors are appraised and revalidated in a timely manner in line with RO Regulation. We are assured that all our doctors are fully engaged with the appraisal and revalidation process.

Version Control: 01

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

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

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

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

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of: Kent and Medway NHS and Social care Partnership Trust.
can confirm that:
1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

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

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

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

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

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

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

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

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

Y/N	Yes
Action from last year:	None
Comments:	TIAA audited our appraisal and revalidation processes in January 2025 and all the recommendations were completed with no further recommendations
Action for next year:	None

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

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

1B – Appraisal

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

Y/N	Yes
Action from last year:	To agree the layout of the version 7 MAG on the IT system SARD by end of this year
Comments:	Version 7 Layout completed on SARD 2025

Action for next year:	None

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

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

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

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

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

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

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

Action for next year:	None

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	None
Comments:	Appraisers participate in an annual appraisal refresher training
Action for next year:	None

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

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

1C – Recommendations to the GMC

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

Y/N	Yes
Action from last year:	None

Comments:	
Action for next year:	None

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

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

1D – Medical governance

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

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

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

Y/N	Yes

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

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

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

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

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

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of

concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	
Comments:	We are now in the process of collating this data
Action for next year:	We will report these figures annually from this year (2025-26) to the People Committee in the “Managing concerns around doctors”.

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

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

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

Y/N	Yes
Action from last year:	None
Comments:	This is will be monitored by the annual report on “Managing concerns around doctors” to the People Committee

Action for next year:	None

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

Y/N	Yes
Action from last year:	To continue processes.
Comments:	This is supported by Medical Education and Clinical Effectiveness and Outcome Group (NICE guidance, research, clinical audit and clinical policies are monitored via this group)
Action for next year:	None

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

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

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	None
Comments:	This is maintained by the Medical Staffing Department
Action for next year:	None

1F – Organisational Culture

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

Y/N	Yes
Action from last year:	None
Comments:	Job planning is used to ensure consistency and delivery of expectations for clinical activity, ensuring high professional standards with a culture of transparency and collaboration. The Trust implemented monthly excellence awards called 'Values in Practice Awards' since May 2024 which supports recognising excellence in care. We have also implemented the Patient Safety Incident Response Framework meeting the four key aims the framework sets out to provide.
Action for next year:	None

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

Y/N	Yes
Action from last year:	None
Comments:	We have had a focus on EDI and have substantive plans and actions across the trust to reduce violence, aggression and racism
Action for next year:	None

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

Y/N	Yes
Action from last year:	None
Comments:	The Trust Behaviour Framework provides our values and behaviours. We are supported by a Freedom to Speak up Guardian (external service) who helps colleagues to raise concerns safely when they do not feel they can use the local mechanisms we provide and encourage. Learning from concerns is key to improving patient safety and quality of care. Our CEO provides regular 'Speak to Sheila' sessions for all staff who are able to raise and discuss any topics they feel of relevance, ask questions and discuss matters of importance to them.
Action for next year:	None

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

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

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

Y/N	Yes
Action from last year:	As below in comment.
Comments:	This will be reported annually to the People Committee via the "managing concerns around doctors" report
Action for next year:	This will continue

1G – Calibration and networking

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

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

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

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

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	158
Total number of appraisals completed	152
Total number of appraisals approved missed	4
Total number of unapproved missed	2
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	58
Total number of late recommendations	0
Total number of positive recommendations	55
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	3
Total number of concerns received by the Responsible Officer[2]	9
Total number of concerns processes completed	7
Longest duration of concerns process of those open on 31 March (working days)	1200 working Days
Median duration of concerns processes closed (working days)[3]	289 Working Days

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

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

Total number of doctors excluded/suspended during the period	1
Total number of doctors referred to GMC	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	23
Total number of new employment checks completed before commencement of employment	20
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	0

Section 3 – Summary and overall commentary

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

General review of actions since last Board report
At KMPT in the last year we had a total of 152 doctors who had their appraisals. Four doctors who did not have the appraisal had agreed exceptions. A total of 2 Doctors had missed their appraisal without an agreed exception. We support the doctors in process and also ensure appraisers are trained to continue to improve our appraisals, refresher training remains an annual event for all the appraisers in the Trust in support of standardising the quality of appraisals. Monitoring of performance, concerns and remediation are managed under the Trust's Decision-Making Units, meetings are held monthly with the Chief Medical Officer and Deputy/Responsible Officer and Chief People Officer and Deputy in attendance, the Responsible Officer and Deputy meet with the GMC Employer Liaison Advisor quarterly. A number of quality assurance mechanisms are in use in relation to medical appraisal. Each appraisal in a revalidation portfolio is checked for key items against the GMC's 5 domains and the Trust's local requirements. Discrepancies are notified to the doctor and, if necessary, an action plan prepared to rectify omissions to ensure a recommendation to revalidate can be made. The Medical Staffing Team in HR is responsible for ensuring that all necessary pre and post-recruitment checks are completed in full and for taking any required action, including

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

dealing with start dates or withdrawing offers of employment, where the responses to these checks are not satisfactory. This process is complaint.
Actions still outstanding
None
Current issues
None to report
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
Provide an annual report to the People's Committee about "Managing concerns around doctors."
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We have had another successful year with regards to Doctors having their annual appraisals completed. We have also taken steps to support the doctors in this process and also ensured that the current appraisers are trained to improve the quality of appraisal experience of our doctors. We are committed to maintain and continually improve this overall process

Section 4 – Statement of Compliance

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

Signed on behalf of the designated body

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

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Emergency Planning, Resilience and Response (EPRR) Annual Report, Compliance Self-Assessment Statement, EPRR Policy and 2024/25 Work Plan.
Author:	Jessica Scott, Emergency Preparedness & Resilience Lead
Executive Director:	Andy Cruikshank, Chief Nurse (Accountable Executive Officer, EPRR)

Purpose of Paper

Purpose:	Noting
Submission to Board:	Statutory Compliance

Overview of Paper

This paper has been submitted to give assurance that the Trust is assured against the Civil Contingencies Act (CCA) 2004 and fully aligned to the NHS England and Emergency Preparedness, Resilience and Response Framework/Core Standards Assurance Programme of 2024/25.

Issues to bring to the Board's attention

The Board are requested to accept this annual report and re-affirm its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) and:

- Note the closing of the 2024/2025 EPRR work plan.
- Note the EPRR 2024/25 Statement of Compliance (Appendix 1)
- Ratify the EPRR Improvement Plan 2025/26 (Appendix 2).
- Note the EPRR Policy (Appendix 3)
- Note the content of the 2025/2026 EPRR work plan commencing 1 September 2025 (Appendix 4).

As requested by NHSE Board are requested to share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Kent and Medway NHS and Social Care Partnership Trust

Governance

Implications/Impact:	The EPRR Policy is owned by the Board. The portfolio of EPRR has an accountable Executive Officer: The Chief Nurse. Independent of the trust, to confirm compliance with the Civil Contingencies Act, 2004 the Trust is audited against the NHS EPRR Core Standards on an annual basis via a Kent and Medway Integrated Care Board (ICB) submission to NHSE The NHSE 2024 audit assurance confirmation was received in Q4 denoting that the trust had maintained a status of 'substantially compliant'. The 2025 NHS EPRR Core Standards self-assessment process, which was conducted in July 2025, will be again validated via ICB audit and the results ratified by NHSE and submitted to ARC in Q4 2025/26.
Assurance:	Reasonable
Oversight:	This paper has been supported by the Audit and Risk Committee.

The EPRR work plan runs annually from 1 September, following the July self-assessment and adheres to the governance principle; that the work is undertaken via a trust-wide EPRR working group chaired by the Accountable Emergency Officer. The work plan is assured in its delivery to the Audit and Risk Committee (ARC) via the Trust-wide Health, Safety and Risk Group.

Kent and Medway
NHS and Social Care Partnership Trust

Emergency Preparedness, Resilience and Response – Annual Report to Board (Period September 2024 – August 2025)

Background and context

1. The Civil Contingencies Act (2004)

1.1 The Civil Contingencies Act (2004), requires the trust to put in place the following duties with fellow Category 1 responders:

- Risk Assessment
- Develop Emergency Plans
- Develop Business Continuity Plans
- Warning and Informing
- Sharing Information
- Co-operation with other local responders.

1.2 This annual report provides assurance to the Board that the Trust has embedded plans and processes that will ensure that it is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response (EPRR) as defined within the duties above.

2. Assessing and documenting compliance

2.1 The NHS EPRR Core Standards Framework is the mandated method for assessing compliance and giving assurance across the NHS in the subject of Emergency Preparedness, Resilience and Response.

2.2 Assessment is undertaken firstly by all NHS providers using an NHSE predetermined set of data, as part of a self-assessment which aligns to the duties held within the Civil Contingencies Act 2004.

2.3 In 2024 KMPT was requested to submit evidence within the self-assessment for the audit against 58 lines of inquiry. Of those 58 the Trust was fully compliant with 57 and scored 98.3%.

2.4 The 2024 self-assessment data sets were audited by the ICB and the regional results collated and submitted for ratification by NHSE. NHSE confirmed the ratified position via a confirmation letter. In March 2025 the letter was received and presented to the Audit and Risk Committee, where it was noted as receiving 'Substantial' rating.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

2.5 The gap in assurance, set out in the EPRR Improvement Plan was addressed via the agreed EPRR Work plan for 2024/25.

2.6 For 2025 KMPT have been requested to submit evidence within the self-assessment for the audit against 58 lines of inquiry. Of the 58 the Trust is fully compliant with 58 and has self-assessed at 100%.

3. Risk assessment

3.1. The Trust EPR Lead is the co-chair of the Kent and Medway Resilience Forum Risk Assessment Group. As a member of the Local Health Resilience

Partnership and the Kent Resilience Forum the Trust fully supports the review of the Community Risk Register against the National Security Risk Assessment held by the Cabinet Office.

3.2 Annually, or as a new risk or threat emerges the Trust reviews its position using its own internal risk management process. The Emergency Preparedness, Resilience and Response Risk Register is managed to ensure risks are escalated to the Trust Risk Register and additionally submitted to the Board Assurance Framework for assurance against the Trust Strategic Objectives.

4. Develop emergency plans

4.1 Within 2024/25 all existing plans due for review have been republished or reformatted as required, one briefing document is ready for the port Entry and Exit System and one new plan has been created on the subject of the Isle of Grain in response to the off-site plan held for the industrial activity and siren in that area. This will be tested as part of exercise Combine held by Medway Council every three years.

5. Develop business continuity plans (aligned to ISO 22301)

5.1. The EPRR Policy defines the scope of the Business Continuity programme. The management of business continuity is detailed within the trust Management of Business Continuity Policy and template documents.

5.2 The Audit and Risk Committee have reviewed the rolling audit work plan and listed a business continuity audit for 2025/26; to confirm that the trust is conforming with its own business continuity programme, outside of the Annual EPRR Core Standards Framework audit, where is currently is rated at fully compliant on Business Continuity.

6. Warning and informing

6.1 Via the Trust Communications Team, arrangements are in place to make available information on resilience and response to the public and staff. Examples of this in the 2024/2025 work plan have in in relation to summer and winter preparedness, planned and unplanned Information Technology down time potentially requiring IT System Business Continuity Plan activation, planned motorway closures, Met office forecasts, South East Water outages and the continued mitigation changes from European legislation culminating in the Entry and Exit System reforms in 2024/25.

7. Sharing information

7.1. The Trust as part of the Kent Resilience Forum has processes in place to share information with other local responder organisations to enhance co-ordination both ahead of and during an incident.

7.2 The KMPT page on Resilience Direct is in place as a resilient EPRR repository; this has given on call staff a designated point of truth for plans,

templates and briefings as the 'Master on call file' and allows for sharing of information in response across the Kent Resilience Forum such as common information pictures.

7.3 Throughout any national level 4 and regional level 3 Industrial Action planning and response the trust has been fully compliant with command and control arrangements. Situation Reports (SITREPs) flowed to the Kent and Medway Operational and Incident Control Centres and briefings, instructions and information has been received; as briefings and items for action.

8. Co-operation with other local responders.

8.1. The Trust as part of the Kent and Medway Resilience Forum, KMPT has processes in place to co-operate with other local responder organisations to enhance co-ordination both ahead of and during an incident. To support this approach the Joint Emergency Services Interoperability Principles are embedded into the EPRR Policy, Significant Incident and Major Incident Plans.

9. Training programme

9.1. During 2024/25 and to date, training has been given to KMPT staff by EPRR Team on:

- Induction via eLearning
- Loggist training
- Staff entering onto the Director on call rota, Manager on call rota and Clinical Leads and refresher training sessions.
- Those requiring support with writing and reviewing Business Continuity Plans.
- Management of self-referrals with a hazardous material contamination, at reception areas across the Trust via eLearning

9.2 EPRR Team members

- No formal courses in year

9.3 Externally EPRR Team members have provided training

- In conjunction with the ICB for Border Force on Loggist Training
- In conjunction with the Kent and Medway Resilience Team on Risk Assessment for members of the Risk Assessment Group.

10. Exercise programme and Incidents

10.1. The duty placed on the Trust within the NHSE Core Standards is that it performs a communications cascade bi-annually and a table top exercise annually with a live exercise tri-annually. These elements have all been achieved in the 2024/25 work plan.

10.2 Internally communication and multiple exercises were undertaken, to allow for learning in support of service business continuity plans and incident plans:

Communication

Exercise Toucan National NHS Communication Exercise - 12/05/2025
Exercise Activate1 Communications Exercise 12/03/2025
Exercise Activate2 Communications Exercise (postponed in July due to error on designated incident phone, resolved)
Exercise Activate 2.1 Communications Exercise -17/07/2025

Table Top

- Exercise Arrow3 – Tarentfort Unit 26/09/2024
- Exercise Globe – Trevor Gibbens Unit 03/10/2024
- Exercise Willow – 08/11/2024
- Exercise Marvel (Cyber Exercise) – 28/02/2025

Live Exercise

- Joint Exercise Powder, Hazardous materials (KMPT and South East Coast Ambulance with Hazardous Area Response Team) 11/07/2025

10.3 Externally the trust has attended regional and local exercises and specialist briefings which have allowed for the review, validation and adaptation of response plans:

- National LRF briefings on risk including Drones and Invasive mosquitoes 16/09/2024
- Webinar, Cold Weather Preparedness Programme 26/09/2024
- Briefing, Isle of Grain Industry – Off site Plan 23/10/2024
- Webinar, Adverse weather and Health Plan launch 27/03/2025
- Seminar, National LRF briefing on risk 16/04/2025
- Seminar, Kent and Medway Resilience Forum 08/05/2025
- Briefing, Kent Fire and Rescue, Wildfire risk 22/05/2025
- Briefing, Kent Fire and Rescue briefing, Derelict Building risk (structure risk, rough sleepers, safeguarding including modern slavery) 22/05/2025
- Pathology Cyber-attack 09/07/2025, Exercise Beech, Regional Exercise 11/07/2025

10.4 Within 2024/2025 the trust responded to the following Business Continuity/ Regional Incident declarations which have allowed for further validation of current plans and procedures where recommendations are project managed via a corrective action database:

- Ash Eton, Improvised explosive device 18/09/2024

11. Methodology on opening of the 2025/2026 EPRR work plan

11.1. Duties, Core Standards and NHS Contract have been reviewed for change against a refresh of the corporate EPRR Policy.

11.2 The NHS Core Standards Framework self-assessment has been undertaken and is used to generate the EPRR Improvement Plan, if required (2025/26).

11.3 The process of monitoring and managing risks to a level of appetite is a continuous process and will move seamlessly from one plan year to the next.

11.4 Identification of Plans, Policies and Standard Operating Procedures for 2025/2026 is set against master index held by the Trust Policy Manager.

11.5 Identification of new plans is set against risk methodology to close assurance actions and provide further risk controls.

11.6 Trust Business Continuity Programme baselines at 31 August 2025 and is forward planned against the priority of a plan and the transformation agenda.

11.7 Exercises which are mandated against the NHS EPRR Core Standards Framework.

11.8 Training to be set against an EPRR Training programme and Training Needs analysis aligned to the EPRR National Occupational Standards, 2022.

12. Workforce Resource 2024/25

12.1. The current resource available to EPRR for a substantive team is:

Chief Nurse	Accountable Emergency Officer
Deputy Director of Quality and Safety	Deputy Accountable Emergency Officer
Emergency Preparedness and Resilience Lead	Subject Matter Expert (RGN, DipN, DipHep, CBCI)
Emergency Preparedness and Resilience Officer	Non-Clinical Subject Matter Expert (DipHEPRR)
Resilience and Risk Administrator	Office functions

13 Action required from the Board

13.1. The Board are requested to accept this annual report and re-affirm its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) and

- Note the closing of the 2024/2025 EPRR work plan.
- Note the EPRR 2024/25 Statement of Compliance (Appendix 1)
- Ratify the EPRR Improvement Plan (Appendix 2).
- Note the EPRR Policy (Appendix 3)
- Note the content of the 2025/2026 EPRR work plan commencing 1 September 2025 (Appendix 4).
- Share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Appendix 1.

Emergency Preparedness, Resilience and Response 2024/25 Statement of Compliance.

EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2024/25**, Kent and Medway Social Care Partnership Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 58 of the core standards which are applicable to the organisation, Kent and Medway Social Care Partnership Trust

- is fully compliant with 58 of these core standards;

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

- The overall rating is: Fully Compliant

Andy Cruickshank

Kent and Medway Social Care Partnership Trust

12/08/2025

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 2.

Emergency Preparedness, Resilience and Response 2025/26 Improvement Plan

EPRR Improvement Plan:

Version: 1.0

Kent and Medway Partnership Trust (KMPT) has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2023/2024. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
N/A for 2024/25 outcome of self-assessment. Check NELFT 2024/25 outcome of self-assessment for any areas of improvement for services transitioning in 2025/26 and include that in transition plan.					

Appendix 3

Emergency Preparedness, Resilience and Response Policy

(In Diligent Reading Room)

Appendix 4

Emergency Preparedness, Resilience and Response 2025/26 Work Plan

(In Diligent Reading Room)

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING - PUBLIC

Date of Meeting:	25th September 2024
Title of Paper:	Social Value and Net Zero Annual Report
Author:	Jake Fisher, Procurement and Contracts Manager
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Noting
Submission to Committee:	Board requested

Overview of Paper

This paper provides the Trust Board with an update on the delivery of social value and net zero outcomes through KMPT's procurement activities. It outlines key achievements, supplier engagement efforts, and progress made across the supply chain, while highlighting areas for continued development and strategic focus.

Items of focus

Key successes and challenges in delivering social value and net zero through KMPT's procurement strategy, and proposed forward approach to enhance strategic outcomes across the supply chain.

Governance

Implications/Impact:	Engagement and consultation
Risk recorded on:	N/A
Risk IDs:	N/A
Assurance/Oversight:	Finance & Performance Committee

Contents

1. Executive Summary

1.1.1. As part of KMPT's and the NHS' strategic commitment to sustainability and community impact, the Procurement Team is embedding carbon reduction and social value objectives across all contracting activity. This approach ensures that our procurement decisions deliver enhanced outcomes for Kent and Medway communities, while safeguarding patients and staff through a supply chain that is both ethical and accountable.

1.1.2. Since August 2023, the Procurement Team has implemented a structured assessment model to evaluate supplier contributions to social value and net zero objectives. This report outlines the team's progress in embedding this model throughout 2024/2025 financial year, evidencing its impact on procurement outcomes. It also sets out our forward strategy to further integrate these principles into future procurement planning, in alignment with the Cabinet Office's changing policy themes through the updated Social Value Model.

2. Assessment Model

2.1. Strategic Priorities

2.1.1. The Trust's current assessment model is guided by a clear overarching ambition and a set of supporting themes that align with KMPT's strategic priorities and national NHS sustainability and social value goals:

To work collaboratively with our supply chain to reduce health inequalities

- Fighting climate change
- Healthier and more resilient communities
- Being a fair and responsible employer with a diverse workforce
- Tackling economic inequalities and supporting business growth

2.2. Evaluation and Supplier Commitments

2.2.1. The themes are systematically embedded within procurement processes and contract management through the application of clearly defined assessment criteria. For contracts that are subject to a formal competitive tender process, a minimum evaluation weighting of 10% is assigned to the delivery of net zero and social value outcomes. These outcomes are expected to represent additional value generated specifically as a result of the Trust's contractual relationship with suppliers (distinct from standard business operations), and must be delivered at no additional cost to the Trust.

2.2.2. Recognising the unique nature of each procurement, key focus areas are selected based on the scope and proportionality of the contract. Suppliers are evaluated against their proposed commitments using a detailed set of criteria.

2.3. Accountability and Performance Monitoring

2.3.1. Upon contract award, supplier commitments become binding obligations within the contract. These are linked to key performance indicators and reporting mechanisms to ensure transparency and accountability throughout the contract lifecycle.

3. Supplier Engagement and Market Development

3.1. Strategic Review and Focus Areas

3.1.1. Following the last report to the Trust Board in November 2024, the Procurement Team undertook a comprehensive review of its approach to embedding social value and net zero within procurement activities. This review placed particular emphasis on strengthening contract management practices and enhancing data reporting mechanisms to ensure greater transparency, accountability, and alignment with KMPT's strategic priorities.

3.2. Supplier Engagement and Feedback

3.2.1. To support this work, the team conducted engagement meetings with 16 key suppliers to assess progress against contractual deliverables and explore their broader organisational commitments to social value and sustainability. These sessions were designed to foster collaborative relationships, improve the quality and consistency of reporting, and gain insight into the challenges suppliers face in delivering meaningful social value outcomes.

3.2.2. Common challenges identified across the supplier base when tendering for public sector contracts included:

- The scope, nature, and value of contracts affecting the proportionality of commitments
- Unrealistic or overly prescriptive requirements
- Limited awareness of local opportunities and delivery partners
- Difficulty implementing local initiatives when operating outside of Kent
- Limited capability to capture and report contract-specific carbon emissions, with most data reflecting broader organisational estimates

3.2.3. Feedback was also sought from suppliers on the Procurement Team's reporting approach, including suggestions for more effective methods of consolidating data across a diverse supply chain. Feedback from suppliers was overwhelmingly positive, with several noting that KMPT stands out as one of the few NHS organisations actively engaging its supply chain to monitor and enhance the delivery of social value and net zero outcomes. KMPT was recognised as a leader in adopting best practice approaches through its procurement and contract management activities.

3.2.4. As a direct result of supplier engagement, the Procurement Team developed a new data reporting schedule aimed at standardising data sets linked to social value and net zero deliverables. This schedule is designed to align with KMPT's strategic priorities and improve consistency across contracts.

3.2.5. Refinements were also made to the tender evaluation process, ensuring that supplier challenges are considered while maintaining ambition for tangible, measurable outcomes. In parallel, the team collaborated with KMPT's volunteering and charity teams to identify opportunities for suppliers to contribute directly to the Trust's services and community initiatives.

3.2.6. An information pack is currently in development to support suppliers in identifying local opportunities, partners, and possible outcomes. Early results from this initiative include both monetary and in-kind contributions to KMPT's charity, volunteering programmes, and material support for Trust services.

4. Progress and Impact

4.1. Supplier Reporting and Assessment Process

4.1.1. As part of its annual reporting obligations, the Procurement Team requested data from suppliers to monitor the delivery of contractual commitments and evaluate the impact of social value and net zero initiatives across the Trust's supply chain.

4.1.2. Sixteen key suppliers with active contracts (each subject to formal assessment of social value and net zero through competitive tendering) were invited to submit relevant information. Submissions were received from 14 suppliers.

4.2. Performance Highlights and Observations

4.2.1. A number of excellent social value and net zero initiatives were reported across the supply chain. **Appendix 1 - Annual Impact Report** highlights key achievements aligned to KMPT's social value and net zero themes, based on supplier self-reported data. While the current dataset is limited, it provides a valuable baseline for future improvement.

4.2.2. The most substantial delivery of social value and net zero outcomes was reported by two of the Trust's largest suppliers:

- Morrison Facilities Services Ltd – Hard facilities maintenance supplier
- ISS Mediclean Ltd – Catering services supplier

4.2.3. These suppliers are recognised as leaders in the Trust's supply chain, particularly due to the scale and workforce intensity of their contracts. Larger contracts naturally offer greater scope for delivering meaningful social value and environmental benefits.

4.2.4. However, submissions received from the wider supplier base also revealed a need for further market development. Some suppliers showed limited understanding of deliverable outcomes and struggled with data reporting requirements. Notably, data specific to the Trust's contracts (particularly in relation to the "Fighting Climate Change" theme) remains difficult to capture. Suppliers are often able to report organisation-wide metrics, but lack the granularity to isolate Trust-specific impacts.

4.2.5. Further engagement will be undertaken with suppliers who did not submit data, to understand the barriers and improve future compliance.

5. National Policy Updates

5.1. NHS Social Value Playbook

5.1.1. In July 2025, NHS England published the NHS Social Value Playbook, providing updated commercial guidance on embedding social value into the procurement of NHS goods and services. This release reflects significant changes in public procurement policy, most notably the

transition to the Social Value Model 2025 (Procurement Policy Note 002), which supersedes the previous PPN 06/20.

5.1.2. The updated model aligns NHS procurement with five strategic government missions:

- kickstarting economic growth,
- making Britain a clean energy superpower,
- taking back our streets,
- breaking down barriers to opportunity, and
- building an NHS fit for the future.

5.1.3. These missions represent a structured framework for integrating social value into procurement decisions, ensuring that contracts deliver measurable benefits beyond their commercial scope.

5.2. KMPT Strategic Alignment

5.2.1. In response to these national policy developments, KMPT has undertaken a review of its strategic priorities and procurement assessment model to ensure alignment with the NHS Social Value Playbook and the Social Value Model 2025.

5.2.2. As part of this alignment, the Procurement Team is developing a revised Social Value and Net Zero Charter which incorporates the new policy requirements, and integrates them into the Trust's approach to evaluating and delivering social value and sustainability outcomes through procurement. While the overarching ambition remains unchanged, the supporting themes have been updated to reflect current national priorities and local delivery opportunities.

To work collaboratively with our supply chain to reduce health inequalities

- Make Britain a Clean Energy Superpower
- Break-down Barriers to Opportunity
- Build an NHS Fit for the future
- Kickstart Economic Growth

5.2.3. Many of the strategic priorities outlined in the previous version of the charter continue to be relevant, and will be reviewed and mapped against the updated themes.

6. Forward Strategy and Next Steps

6.1.1. Following a comprehensive review of progress and impact during the 2024/2025 financial year, the Procurement Team has identified the following strategic priorities for 2025/2026 and beyond to further embed social value and net zero principles across KMPT's procurement activities:

i. **Strengthen Data Maturity and Reporting Standards**

Continue to enhance the centralised supplier reporting framework by developing standardised templates and guidance aligned with KMPT's strategic objectives and national policy requirements. This will aim to support improved data consistency, granularity, and transparency across the supply chain.

ii. **Deepen Supplier Collaboration and Capability Building**

Expand supplier engagement efforts to build understanding and capability in delivering social value and net zero outcomes throughout the contract lifecycle. This includes addressing common challenges, promoting best practice, and ensuring alignment with the Trust's strategic goals.

iii. **Integrate KMPT volunteering, charity and sustainability opportunities into assessment model**

Develop a supplier toolkit to raise awareness of local opportunities for contributing to KMPT's volunteering, charity, and sustainability initiatives. This will aim to support improved evaluation criteria, strengthen tendered commitments, and drive tangible community and environmental impacts.

iv. **Embed Strategic Themes into Procurement Lifecycle**

Develop and operationalise the revised Social Value and Net Zero Charter across all procurement stages, from market engagement to contract expiry. This includes refining the integration of key performance indicators into standard procurement documentation, contract terms, and performance review mechanisms.

7. Recommendations for Board Consideration

7.1.1. The Trust Board is invited to:

i. Acknowledge the Procurement Team's progress since November 2024 in embedding social value and net zero principles across the Trust's procurement and contract management activities.

ii. Endorse the continued strategic direction and approve the proposed next steps for advancing the delivery of social value and sustainability outcomes through future procurement initiatives.

Appendix 1

ANNUAL IMPACT REPORT

Social Value & Net Zero 2024/2025

Introduction

The NHS has committed to achieving net zero emissions; eliminating direct emissions by 2040, and emissions it influences through its supply chain by 2045. With approximately 66% of NHS emissions arise from purchased goods and services, procurement plays a pivotal role in delivering this ambition. With a supply chain of over 80,000 suppliers, the scale presents both a challenge and a unique opportunity to drive environmental and social progress.

This commitment reflects the NHS's evolving role as a driver of social and environmental progress, aligning procurement with national priorities outlined in the 10-Year Health Plan, and supporting the delivery of Integrated Care Systems objectives and the Trust's Green Plan. Embedding social value into procurement enables the NHS to act as an anchor institution, improving population health by addressing social, economic, and environmental determinants. Through responsible purchasing and contract management, the Trust can stimulate local economic growth, reduce health inequalities, and promote inclusive employment.

The Trust is committed to working with ethical suppliers who contribute positively to the wellbeing of Kent and Medway. This **Annual Impact Report** outlines some of the key achievements in social value and net zero delivery during the 2024/2025 financial year, structured around strategic priorities and thematic areas. By highlighting supplier initiatives, this report aims to promote best practice, foster innovation, and encourage continued progress across the supply chain.

Reporting Scope and Broader Impact

The data and examples presented in this report are directly attributable to the Trust's contractual arrangements with suppliers and reflect outcomes specifically driven by its social value and net zero procurement strategy, rather than routine operations. These achievements would not have occurred without the awarding of contracts by the Trust, and as such, even modest contributions are considered meaningful. Importantly, these outcomes have been delivered at no additional cost to the Trust.

The ability of suppliers to deliver social value and net zero outcomes is generally proportional to the scope, nature, and value of individual contracts. Larger contracts typically offer greater opportunities to generate substantial and measurable outcomes. The data presented in this report is self-reported and based on a limited number of supplier submissions. It is therefore likely that actual delivery exceeds what is currently captured, with further work required to improve data maturity, consistency, and reporting standards.

Many suppliers are also delivering impactful initiatives at a national level that, while aligned with the Trust's values, are not directly attributable to its contracts and therefore fall outside the scope of this report. We have started to capture this information, and future reporting will seek to highlight these broader contributions where appropriate.

It is also worth noting that social value and net zero outcomes are being achieved through partnerships with organisations outside the formal supply chain, including collaborations with the Trust's volunteering and charity teams. Although these activities are not formally included in this report, an illustrative example is provided below:

Case Study

Webb's Garden Summer House

Through collaboration between the Charity and Procurement teams, Lisa Barrett, Procurement and Contracts Manager, supported Kirsty McInnes, Charity and Volunteer Manager, and Sarah Atkinson, Deputy Director of Transformation & Partnerships, in leading an initiative to install a therapeutic summer house in Webb's Garden at St Martin's Hospital, Canterbury.

Lisa helped to shape and advance the project, identifying an opportunity to align the Trust's objectives with the social value ambitions of Redrow Homes Ltd. Despite not being part of the Trust's supply chain, Redrow generously agreed to support the build both financially and operationally. This resulted in the Trust's largest cash donation to date; £10,000 in funding, and an estimated £30,000 in materials and labour.

> **The impact this will have on our charity, the wider Trust, and most importantly, on the wellbeing of our patients, is immeasurable.**
> Kirsty McInnes, Charity & Volunteer Manager

The 'Redrow Shelter' is designed to be a quiet, sustainable retreat for patients, supporting mindfulness, emotional regulation, and private conversations. Construction is underway, with completion expected in the coming months.

Fighting Climate Change

Our key priorities for fighting climate change through procurement activities are to:

- Reduce carbon emissions
- Reduce air pollution to protect the environment
- Avoid the creation of waste (especially single use plastics) and promote reuse and recycling supporting circular economy principles
- Reduce water consumption
- Protecting natural habitats and biodiversity

Contractual Social Value & Net Zero Achievements

April 24 to March 25

35,838
Car miles saved through green transport programmes

50.12
Tonnes of hard to recycle waste diverted from landfill or incineration

448
Volunteering hours to support green spaces and wildlife projects in Kent

14
Trees planted at Trust sites

27.6
Tonnes of carbon dioxide equivalent saved through decarbonisation

3
NHS Evergreen Self-Assessments completed

£7,149
Invested in staff time and resources in measures to safeguard the environment

£1,600
Donations or in-kind contributions to local Kent community green space projects

Examples

Green transport programmes

ISS Mediclean Ltd implemented two electrical vehicles at Maidstone and Dartford sites, installed charging points, and recruited a local workforce

Morrison Facilities Services Ltd use management portal to optimise routes, track mileage and mpg, and offers an EV and hybrid car salary sacrifice scheme

Waste diversion

Morrison Facilities Services Ltd recycles 98% of its waste, diverting 26.85 tonnes of hard to recycle waste from landfill or incineration

Teal diverted 23.24 tonnes of hard to recycle waste

Decarbonisation

Morrison Facilities Services Ltd delivered a year-on-year 16.3% reduction of tCO_2e compared with 2023/2024 baseline through decarbonisation of its diesel fleet

Volunteering

Morrison Facilities Services Ltd' staff are allocated 16 hours' volunteering leave to participate in social value initiatives, logging 446 hours to date
Morrison Facilities Services Ltd made a meaningful contribution to the upkeep of Walmer Lake for the ward

Morrison Facilities Services Ltd planted 12 trees at Deal Hospital

ISS Mediclean Ltd planted 2 trees at Greenacres in Dartford

Donations

Morrison Facilities Services Ltd Foundation awarded £1,000 Green Space Grant to the Trust for its Just Grow Campaign

Morrison Facilities Services Ltd donated £150 to the Trust's 'Spring has Sprung' campaign

Healthier and more resilient communities

Our key priorities for supporting healthier and more resilient communities through procurement activities are to:

- Provide programmes to support physical or mental wellbeing for communities and staff
- Provide volunteering in the community
- Support local community projects
- Make a local impact by enhancing facilities / open spaces
- Deliver initiatives to support those who have experienced mental ill health, or long-term health condition to build stronger community networks

Contractual Social Value Achievements

April 24 to March 25

£3,144
Donations and in-kind contributions to support local mental health organisations and initiatives

£6,849
Invested in staff time and resources to enhance local facilities and open spaces

£1,500
Donations and in-kind contributions to local Kent community projects

81
Volunteering hours to support community enrichment organisations and projects

£1,362
Invested in staff time and resources to support disabled and vulnerable people to build stronger community networks

£2,748
Invested in staff time and resources to support health interventions and wellbeing initiatives

Examples

Support of local mental health organisations and initiatives

Morrison Facilities Services Ltd and ISS Mediclean Ltd in partnership with its suppliers donated goods to KMPT's charity at Christmas with a view to bringing joy to service users during the festive period

Morrison Facilities Services Ltd donated toys to Demelza Hospice, supporting care for children facing serious or life-limiting conditions

Word360 delivered training sessions for Kent-based linguists focused on interpreting and its impact on mental health, and dementia awareness. These included tools and strategies to safeguard wellbeing and support local communities consistently and sustainably.

Community enrichment

ISS Mediclean Ltd hosted an art-exhibition with the Trust to display and promote artwork created by service users

ISS Mediclean Ltd hosted Macmillan Coffee morning to raise awareness and donations for charity

Enhancement of local facilities and open spaces

Morrison Facilities Services Ltd have supported a wide range of projects in collaboration with the Trust, including:

- a 'Spruce Up Day' at the Rivendell NHS site, which included donating PPE, painting fences, and clearing overgrown hedges and vegetation around the Emmetts and Walmer wards

- construction of a log cabin, staining benches in the Archery House courtyard, and repainting the perimeter fence at Rivendell. Supplies such as wipes, paintbrushes, and coveralls donated by their supplier Travis Perkins.

Local Kent community projects

Morrison Facilities Services Ltd delivered a pond project in for a primary school in Tonbridge and Malling, and awarded a £900 grant to develop green spaces at a school in Maidstone

Support disabled and vulnerable people to build stronger community networks

ISS Mediclean Ltd provided unpaid work experience at the Dartford to support a current service user gain confidence and skills required in the workplace

Being a fair and responsible employer with a diverse workforce

Our key priorities under this theme are for suppliers to:

- Demonstrate action to identify and manage the risk of modern slavery including within the supply chain
- Operate fair, transparent and inclusive recruitment and working processes and practices that safeguard users
- Adhere to ethical and responsible sourcing practices.
- Increase the workforce representation of disabled people or those with long-term health conditions
- Provide fair and equitable wages for staff and support in-work progression

This area generally offers limited scope to influence existing supplier practices through procurement, and is therefore typically assessed on a Pass/Fail basis against minimum Trust standards. Substantial achievements are also difficult to capture, as many initiatives are delivered organisation-wide and cannot easily be attributed specifically to the Trust's contracts.

Contractual Social Value Achievements

April 24 to March 25

£1,897
Invested in staff time and resources for professional development initiatives

£380
Invested in staff time and resources for modern slavery and unethical work practices training

£4,099
Invested in staff time and resources to engage staff in health interventions and wellbeing initiatives

3
Suppliers pay 100% of their workforce assigned to the contract at or above the 'Real Living Wage'

7
Full time equivalent employees with declared disabilities hired or retained

4
Suppliers paid 100% of supply chain invoices within 30 days

Examples

Professional Development

OHWorks invested £1,140 in engaging staff assigned to the contract in professional development, offering internal and external mentoring and support.

Morrison Facilities Services Ltd delivered over 1,528 training courses across the contract to over 40 staff members.

Wellbeing Initiatives

Morrison Facilities Services Ltd led a six-hour wellness workshop.

Randstad partnered with the NHS to provide all-day staff wellbeing check service.

ISS Mediclean Ltd ran a mental health awareness day campaign across all Trust sites.

Real Living Wage

ISS Mediclean Ltd, Morrison Facilities Services Ltd, and Tiaa Ltd pay 100% of staff assigned to the Trust's contracts at or above the 'Real Living Wage' as specified by the Living Wage Foundation

Supporting supply chains

Morrison Facilities Services Ltd, ISS Mediclean Ltd, OHWorks Ltd and Tiaa Ltd paid 100% of sub-contractors within 30 days, helping to support cashflow for small business and local supply chains

Tackling Economic Inequalities and supporting business growth

Our key priorities for tackling economic inequalities and supporting business growth through procurement activities are to:

- Provide employment opportunities, particularly for those who face barriers to employment and/or who are located in deprived areas
- Provide apprenticeship and training opportunities, particularly for those who face barriers to employment and/or who are located in deprived areas
- Ensure a diverse and resilient supply chain by providing opportunities to local businesses (where possible), SMEs and third sector organisations.
- Raise career aspirations within the community and help to ensure people are equipped with the right skills to match the labour market.

Contractual Social Value Achievements

April 24 to March 25

71
Local FTEs directly hired or retained for the duration of the Trust's contracts

44
Local FTEs hired or retained for the duration of the Trust's contracts through sub-contractors

5
Local FTEs hired who were long-term unemployed

4
Apprentices hired or retained for the duration of the contract

1
Local FTE hired who were not in employment, education or training

89
Hours spent supporting pupils through local Kent school and college initiatives

£646,684
Spent with Voluntary, Community and Social Enterprise sector organisations within contract supply chains

£9,393,422
Spent with Kent based suppliers through contract supply chains

17
Local FTEs directly hired who were unemployed

51
Micro, Small, and Medium Enterprises within contract supply chains

Examples

Employment Opportunities

Of the 44 full time equivalent (FTE) local employees hired or retained by Morrison Facilities Services Ltd for the Trust's contract:

- 3 are former armed forces members
- 1 was formerly not in employment, education or training (NEET)
- 2 were unemployed and in receipt of benefits, joining following a recruitment campaign

ISS Mediclean Ltd works closely with the Job Centres in Dartford, Canterbury and Maidstone to hire local employees who were previously unemployed. Of the 50 staff hired or retained for the duration of the contract:

- 15 local individuals were hired or retained who were previously unemployed
- 3 local individuals were hired during contract mobilisation who were previously long term unemployed (out of work for 12 months or more), and another 2 in 2025

Training Opportunities

Morrison Facilities Services Ltd has hired or retained 3 apprentices for the Trust's contract. They also held a two-day apprenticeship focussed job fair, investing c. £500 and 80 hours of staff time.

Diverse Supply Chain

Morrison Facilities Services Ltd sub-contracts a number of services under the Trust's contracts to 36 micro, small and medium enterprises.

Community Careers Development

Morrison Facilities Services Ltd invested 64 hours of staff time to attend careers fairs at King Ethelbert School and Ashford College to promote awareness of the Trust's contract, the range of roles and opportunities available, and the organisation's apprenticeship programme.

Tiaa Ltd offered a work experience placement to a pupil of Trinity School, Seven Oaks, offering insight into the role of an Anti-Crime Specialist

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Changes to Standing Orders and Standing Financial Instructions
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive, and Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

A paper setting out proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Items to bring to the Board's attention

A review has been undertaken of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation. A copy of the full document, with tracked changes, has been uploaded to the Board Reading Room within Diligent.

Changes include:

- changing the name of the Finance and Performance Committee;
- transferring responsibility of performance oversight to Quality Committee; and
- amending the reporting requirements of the Remuneration and Terms of Services Committee.

If approved by the Board, the Trust Secretary will work with the relevant Committee Chairs to amend their respective Terms of Reference to reflect the above changes, with the Board's approval for the amended Terms of Reference to be sought in October 2025 by virtual means.

Governance

Implications/Impact:	This policy is a statutory requirement for all NHS Organisations, and it is important that this document is up to date, hence annual reviews have been scheduled.
Assurance:	Significant
Oversight:	Oversight by Audit and Risk Committee, approval by the Board.

Key Changes Requested for Approval

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

SO/SFI number	Current wording	New wording	Reason
Throughout	Finance and Performance Committee	Finance, Business and Investment Committee	Change of name of Committee
SO 8.12.4	*Quality Committee* Primary Role: To provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. To assure the Board that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. To assure the Board that where there are risks and issues that may jeopardise the Trust ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.	*Quality Committee* Primary Role: To provide the Board with assurance concerning all aspects of quality, safety **and performance** relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. To assure the Board that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. To assure the Board that where there are risks and issues that may jeopardise the Trust ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.	The word 'performance' has been added. The Trust's operational performance will now be overseen by the Quality Committee. Please note, financial performance remains the remit of the Finance, Business and Investment Committee.
SO 8.12.5	*Finance, Business and Investment Committee* Primary Role: To provide the Board with assurance concerning all aspects of finance **and performance** relating to the provision of care and services in support of getting the best value for money and use of resources. To assure the Board that structures, systems and processes are in place and functioning to	*Finance, Business and Investment Committee* Primary Role: To provide the Board with assurance concerning all aspects of finance relating to the provision of care and services in support of getting the best value for money and use of resources. To assure the Board that structures, systems and processes are in place and functioning to support broad and long term	The word 'performance' has been removed. The Trust's operational performance will now be overseen by the Quality Committee. Please note, financial performance remains the remit of the

SO/SFI number	Current wording	New wording	Reason
	support broad and long term Financial, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively, to assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets, that these are being managed in a controlled and timely way.	Financial, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively, to assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets, that these are being managed in a controlled and timely way.	Finance, Business and Investment Committee.
SO 24.1.4	The Remuneration and Terms of Service Committee shall report to the Board the basis of its decisions. Minutes of the Board's meetings should record such decisions.	**Where deemed appropriate by the Committee Chair, the Remuneration and Terms of Service Committee** shall report to the Board the basis for its decisions. Minutes of the Board's meetings should record such decisions.	Due to the number of matters related to individuals, the Trust must balance compliance with GDPR with the need for transparency of the Trust's decisions. Accordingly, the SO has been reworded to include a discretion so that the balance can be achieved.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th September 2025
Title of Paper:	Register of Board Members Interests
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

This paper sets out the Trust's Register of Board members' interests, which are published on the Trust website.

Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

It is the Trust's practice to formally submit the Register of Interests to the Board twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board is attached.

All Board members have made declarations to the Trust Secretary who has the responsibility of maintaining the Register of Interests including where the member had no interests to declare.

This information is publicly available on the Trust website.

Governance

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable
Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee

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Register of Board Members Interests – September 2025

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS
September 2025

Director	Position	Interest declared
Dr Jackie Craissati	**Trust Chair**	Jackie is Director of Psychological Approaches CIC, which is on the NHS England framework for Independent Serous Incident Investigations. However, the company does not undertake investigations relating to KMPT. Jackie is chair of Crohn's & Colitis UK. The charity works closely with the NHS but is not commissioned to deliver services. Jackie is Independent Governor on the Board of the University of East London. There is the unlikely possibility that a particular serious safeguarding incident in relation to Lasting Power of Attorney has links to Kent & Medway. Jackie is Chair at Dartford and Gravesham NHS Trust
Kim Lowe	**Non-Executive Director**	Non-Executive Director and Deputy Chair at Kent Community Health Foundation Trust. Ad Hoc unpaid consultancy work with University of Kent
Mickola Wilson	**Non-Executive Director**	Director of Seven Dials Fund Management and advisor to private investors in Real Estate. Former CEO of Teesland plc and MD of Guardian Properties.

		Non-Executive director of Mailbox Investment Company. Member of the Property Committee of the Mercers Livery Company. Member of the Council for Essex University Non-Executive Director BBRC (NFP Residential Company specialising in Key Worker Housing Member of the Chartered Surveyors Livery Company
Sean Bone-Knell	**Non-Executive Director**	Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services
Peter Conway	**Non-Executive Director** (Deputy Chair)	Independent Member of the West Kent Housing Association Audit Committee (until 24/09/24) Non-Executive Director of the West Kent Housing Association (from 25/09/24) Non-Executive Director and Chair of the Audit Committee for Medway NHS Foundation Trust
Stephen Waring	**Non-Executive Director** (Senior Independent Director)	Employed (on a part-time basis) at Greater London Authority, Health and Wellbeing Team
Dr MaryAnn Ferreux	**Non-Executive Director**	Trustee - Royal College of Physicians Edinburgh Company Director - Health Innovation Kent Surrey Sussex Founder M&K Consulting services Non-Executive Director at Kent Community Health Foundation Trust.
Julius Christmas	**Non-Executive Director**	Non-Executive Director at Dartford and Gravesham NHS Trust Technology Advisor, Lantern UK
Pam Creaven	**Associate Non-Executive Director**	None declared.
Julie Hammond	**Associate Non-Executive Director**	Health Governor for Kent Community Health NHS Foundation Trust GP for Dartford East Health Centre
Sheila Stenson	**Chief Executive Officer**	Chair of the South East Finance Academy Partner Non-Executive Director to the Kent and Medway Integrated Care Board and one of their Board Sub-Committees
Donna Hayward-Sussex	**Chief Operating Officer & Deputy CEO**	None declared
Dr Afifa Qazi	**Chief Medical Officer**	None declared

Andrew Cruickshank	**Chief Nurse**	On the Board of Directors for the Council of the National Mental Health Nursing Directors forum Visiting Professor on the Faculty of Medicine, Health and Social Care at Canterbury Christchurch University
Nick Brown	**Chief Finance and Resources Officer**	Spouse is an employee of KCHFT

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th September 2025**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Andy Cruickshank, Chief Nurse**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quality Digest • Inpatient Deaths Report • TGU External Review of Security • Section 29 Warning Notice Report • Clinical Audit and Effectiveness Annual Report • Clinical Accreditation Report • Quality Impact Assessments • Annual Ligature Audit Report – 6 Month Update • DPIC Annual Report and Declaration	• Chief Nurse's Report • Quality Risk Register • CQC Report

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse Report	Inpatient deaths: The Committee was assured that appropriate reviews are taking place and that learning will be shared as soon as available. Work is ongoing to identify preventative steps. Nurse call alarms: Assurance was received that testing regimes are being strengthened following the discovery of intermittent faults. The Committee noted the challenges of balancing assurance with ward disruption, particularly for autistic patients. Capital investment may be required to achieve consistency with alarm systems across all sites. Improvement Plan: The Committee took assurance that improvement actions are progressing well, with staff engagement through workshops, swift responses to issues as they arise, and positive progress in community services regarding waiting times.	**Reasonable Assurance**	Next Steps: The Committee will continue to monitor the effectiveness of the new CQC enquiry process and the revised alarm testing arrangements, seeking evidence of improvement at future meetings.
Quality Digest	Restrictive practices: Although prone restraint use has seen a gradual increase, assurance was provided that refresher training is underway, with senior leadership oversight to ensure alternative interventions are prioritised.	**Reasonable Assurance**	Next Steps: • Monitor the impact of refresher training on restraint use.

	Seclusion and neurodiversity: The Committee was assured that demographic data, including neurodiversity flags, is now being captured. A future report will enable a review of restrictive practices through a health inequalities lens. Duty of Candour: Assurance was received that current compliance issues are linked to recording processes rather than practice. Patient safety improvement facilitators are now embedded in directorates, expected to strengthen assurance and reporting quality. Patient safety structures: The Committee was assured that a restructured patient safety team is now in place, focused on real-time identification of themes. Governance teams will be supported through A3 methodology training to embed the new approach.		• Receive future report on restrictive practices with a health inequality focus. • Track improvements in Duty of Candour compliance following structural changes.
Risk Register	The Committee reviewed the risk register, including the severity charts by directorate. While their current value was debated, it was agreed that aligning risks with the revised risk appetite would provide clearer assurance on whether risks sit within or outside tolerance. Cyber risk was given particular attention. Although currently rated below the “serious” threshold, the Committee acknowledged the inevitability of attempted breaches and the potential for significant impact if systems were compromised. Assurance was received that: technical resilience planning is in place, but recommended that future work should	**Reasonable assurance**	Next steps: • Risks to be set against revised risk appetite in future reporting. • Further assurance to be sought on digital governance, with a possible deep dive session to explore clinical and patient safety aspects. The Committee was assured that risk management processes remain robust, with targeted areas for further focus identified.

	consider digital governance from a patient safety perspective. This may form the basis of a future deep dive session.		
Director of Infection Prevention and Control (DIPC) Annual Report and Declaration	As part of the DIPC report, the Committee received an update on the 2024/25 Flu campaign. The CQUIN target was set at 90% uptake, but delivery has been highly challenging this year. Uptake currently stands at 40%, a decrease from the 2023/24 level. Staff have reported barriers such as concerns about side effects, needle aversion, and allergies or medical issues. While the InFLUencers team has worked hard to promote uptake, the Trust recognises that performance remains significantly below target. On this basis, the Committee can provide limited assurance.	**Limited Assurance**	Next steps: • A renewed focus is required to increase uptake across all Directorates. • Further work should be done to address staff concerns and explore alternative approaches to improve confidence and accessibility. • Progress to be closely monitored, with updates reported back to the Committee.
Free Text -			

Title of Meeting	**Public Board Meeting**
Meeting Date	**25th September 2025**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Sandra Goatley, Chief People Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• People Committee Main Report • People Risk Register • EDI Deep Dive: Annual Report • Guardian of Safe Working Hours Report • Annual report on safe working hours: Doctors in training, August 2024 to July 2025 • Safe Learning Charter		• HR Policies and Procedures

Agenda Items by Exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
People Story	The Committee welcomed the People Story from Tara Lister, which provided valuable insights into the experience of working parents in KMPT and highlighted the importance of flexibility, trust, and supportive management. Members reflected on the positive impact of the Working Parents Conversation Café and discussed the potential development of a formal staff network.	**Reasonable Assurance**	Action for the Board to consider: Whether future presentations from staff with caring responsibilities should be received at the Board level or remain within the People Committee.
Main Report	The Committee received an overview of current workforce issues and system developments. Nationally, the NHS 10 Year Plan has been published with new provisions to support resident doctors, while the Nursing and Midwifery Council is preparing a review of its code of conduct and revalidation in 2026. The system remains above plan on substantive workforce spend, and pay cost improvement delivery is behind plan with associated risks. At the Trust, vacancy, recruitment, and turnover measures remain positive, but sickness absence is above target and culture change continues to be a challenge.	**Reasonable Assurance**	The Committee was assured that appropriate actions are being taken. Consultations are underway across Trusts to support planned workforce reductions, and a Trust consultation will begin shortly. Work is progressing to embed new agency rate ceilings, strengthen compliance with Oliver McGowan training, and finalise system leadership design principles. Focus also remains on staff wellbeing, engagement, and culture, with HR and line managers proactively managing sickness and supporting staff impacted by stress or workplace incidents.
People Risk Register	The Committee reviewed the People Risk Register and was assured that appropriate management and oversight are in place. Progress was also reported on agency and temporary staffing, with positive improvements in	**Reasonable Assurance**	Overall, the Committee was assured that people risks are being actively managed, with clear actions in place to reduce exposure and strengthen controls.

	medical staffing. Culture risk work is progressing, and a new risk has been added relating to the People Team structure changes following the conclusion of consultation. The Committee requested that learning from this and other consultations be captured and shared to strengthen future processes.		
EDI Deep Dive	The Committee reviewed the statutory EDI report and noted year-on-year improvement, particularly in disability equality, workforce representation, and disciplinary processes. However, challenges remain around recruitment outcomes for the global majority staff, under-representation in senior roles, and rising reports of violence and aggression, with underreporting and system limitations still a concern. The Committee was partially assured, recognising progress made but emphasising the need for continued focus and stronger visibility of EDI at the Board.	**Reasonable Assurance**	The Committee agreed actions to strengthen reporting systems, clarify the Trust's sponsorship policy, and support staff networks to have greater influence on organisational change. Members also highlighted the importance of raising EDI prominence at the Board level, recommending a sharper focus on two to three priority areas for next year.
AOB: The Committee discussed concerns regarding mandatory training compliance rates, with 275 staff outstanding in one area. While training places are available, challenges remain around course length and volume. The Committee Chair will discuss next steps with the Chief Nurse and report back, with **limited assurance** noted.			

Title of Meeting	**Board of Directors (Public)**
Meeting Date	25th September 2025
Title	Audit and Risk Committee Chair's report
Author	Peter Conway, Non-Executive Director
Presenter	Peter Conway, Non-Executive Director
Executive Director Sponsor	N/A
Purpose	Noting

Agenda Items

Finance and Regulatory items
• Board Assurance Framework • Trust Risk Register • Risk Strategy and Risk Policies Review • Internal Audit Report • Anti-Crime Report • Director of Finance Items • Trust wide Health, Safety and Risk Bi-Annual Review • Fire Safety Report • Emergency Preparedness and BRP Reviews • Information Governance Assurance (including data quality and cyber security) • Gifts and Hospitality Registers • Review of Terms of Reference • Committee Effectiveness Review (incl. HFMA Committee Checklist)

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Risk Management	<u>Board Assurance Framework (BAF)</u> The risk ‘’spine’’ of Framework, Strategy and Policy have been updated including risk appetite following the Board Away Day. ARC endorsed these documents. Further training and coaching of staff will enhance ownership and accuracy of reporting <u>Trust Risk Register</u> The number and severity of risks appear to have increased. Consideration would be given to tracking these over time and benchmarking with other providers.	Reasonable Reasonable	1) Board will receive the new risk appetite framework for approval by September 2025. 2) It is recommended that at the next Board Away Day, 15 minutes is set aside for all Board members to individually write down their top 5 worries. These will be taken away and compared against the BAF
Audit and Assurance	<u>Internal Audit Report</u> Assurance was provided regarding the outstanding audit recommendation, which related to implementation of the new PAM solution and the internal audit reviews conducted within the reporting period, with the following assurance ratings received: ○ ICT review of Cyber Security – Reasonable ○ Assurance Framework and Risk Management – Reasonable ○ Patient Safety Incident Response Framework – Substantial ○ Cyber Assessment Framework-Aligned Data Security and Protection Toolkit – All minimum achievement levels met, HIGH independent assessment confidence <u>Anti-Crime Report</u> TIAA are undertaking an assessment of our compliance with the new Failure to Prevent Fraud Offence under the	Reasonable Reasonable	

	Economic Crime and Corporate Transparency Act. The outcome is likely to be positive		
Internal Controls - Trust	<u>Trust wide Health Safety and Risk Bi-Annual review</u> The increase in Dangerous Occurrences Regulations (RIDDOR) reportable incidents related to violence and aggression was discussed and will be considered by Quality Committee and the Chief Nurse. Assurance was positive in the meantime. <u>Fire Safety Report</u> An overarching fire risk, which covered all the Trust's sites, had been developed; however, further review of the allocated rating was required. <u>Emergency Preparedness and BRP Reviews</u> The Committee commended the achievement of a Fully Compliant" rating against the self-assessment.	Substantial Reasonable Substantial	A review. by the Chief Finance and Resources Officer, of the arrangements at Private Finance Initiative (PFI) locations was requested to ensure timely resolution of maintenance requests.
Terms of Reference	The Committee endorsed the Terms of Reference for approval by the Trust Board	N/A	
Free Text - No additional comments			

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Terms of Reference

Name of Committee	**Audit and Risk Committee (ARC)**	
Date	**141 August ~~July~~ 20254**	
Version	**V~~23.~~14**	
Approval	**ARC**	*~~10th~~-2nd September 20254*
	Trust Board	*2~~6~~5th September 20254*
Next review due	~~2nd~~-1st September 202~~6~~5	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1.0	Draft	29.07.11	Val Woodin	
V1.0	Draft	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11for implementation January 2012
V1.1	Draft	21.11.11	Simon Muir Internal Audit	Review requested by IAC re NHS Trust Audit Handbook requirements for incorporating Risk element
V1.2	Draft	15.03.12	Val Woodin	Minor amendments mainly related to the name of the Committee
V1.3	Approved	27.09.12	Val Woodin	Additional duty to oversee strategic objective
V1.4	Approved	04.09.14	Val Woodin	Minor amendments agreed by IARC
V1.5	Approved	03.03.16	Rosanna Roughley	Addition of role of Panel for Appointment of External Auditors
V1.6	Approved	18.04.17	Sheila Wilkinson	Annual review – no changes recommended
V1.7	Approved	08.03.18	Sue Manthorpe	Annual Review – Addition of EPRR
V1.7	Approved	28.06.18	Trust Board	Approved by the Trust Board 28.06.18
V1.8	Draft	05.09.19	IARC	Review and approve
V1.9	Draft	02.07.20	IARC	Addition of explicit reference to review of Board Assurance Framework twice a year
V1.9	Approved	30.07.20	Trust Board	Approved by Trust Board 30.07.20
V2.1	Draft	08.01.21	TS/PC	Amended to reflect HM Treasury Audit and Risk Assurance Committee Handbook
V2.1	Approved	25.02.21	Trust Board	Approved by Trust Board
V2.1	Approved	01.03.22	ARC	Reviewed by the Committee and agreed no changes required.

V2.1	Approved	02.03.23	ARC	Reviewed by the Committee and agreed no changes required.
V3	Draft	11.07.24	Trust Secretary	Updated in line with HFMA Guidance and the Trust's internal governance refresh
V3	Approved	26.09.24	Trust Board	Approved by Trust Board
V4	Draft	14.08.25	Deputy Trust Secretary	Annual Review process
V4	Approved	25.09.25	Trust Board	Approved by Trust Board

1. Constitution

The board hereby resolves to establish a committee of the board to be known as the audit (and risk/ risk assurance) committee (the committee). The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

Any amendments to these Terms of Reference can only be approved by the Trust Board. The Terms of Reference will be reviewed annually.

2. Purpose

The Audit and Risk Committee provides assurance to the Board that governance, risk management, financial reporting and internal controls are effective across the Trust.

3. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

4. Membership

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The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the ~~three~~ independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.

The Chief Finance and Resources Officer, Chief Nurse, and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.

The trust secretary may attend meetings.

The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.

Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.

A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.

At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

5. Quorum

A quorum shall be two members.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's standing orders, and standards of business conduct policy.

7. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The chair of the committee, board, accountable/ accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

8. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist (where they do not report elsewhere).

9. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control

The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to

these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the Qeuality Ceommittee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan

- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

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Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

System for raising concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence*, *NHS code of governance* and the fit and proper persons test.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

10. Accountability and Reporting

The committee shall report to the board on how it discharges its responsibilities. The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or

require executive action.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements
- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any material changes to the board, for approval.

NHS
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7. Secretariat and Administration

The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

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Terms of Reference

Name of Committee	**Audit and Risk Committee (ARC)**	
Date	**11 July 2024**	
Version	**V23.1**	
Approval	**ARC**	*10th September 2024*
	Trust Board	*26th September 2024*
Next review due	2nd September 2025	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1.0	Draft	29.07.11	Val Woodin	
V1.0	Draft	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11for implementation January 2012
V1.1	Draft	21.11.11	Simon Muir Internal Audit	Review requested by IAC re NHS Trust Audit Handbook requirements for incorporating Risk element
V1.2	Draft	15.03.12	Val Woodin	Minor amendments mainly related to the name of the Committee
V1.3	Approved	27.09.12	Val Woodin	Additional duty to oversee strategic objective
V1.4	Approved	04.09.14	Val Woodin	Minor amendments agreed by IARC
V1.5	Approved	03.03.16	Rosanna Roughley	Addition of role of Panel for Appointment of External Auditors
V1.6	Approved	18.04.17	Sheila Wilkinson	Annual review – no changes recommended
V1.7	Approved	08.03.18	Sue Manthorpe	Annual Review – Addition of EPRR
V1.7	Approved	28.06.18	Trust Board	Approved by the Trust Board 28.06.18
V1.8	Draft	05.09.19	IARC	Review and approve
V1.9	Draft	02.07.20	IARC	Addition of explicit reference to review of Board Assurance Framework twice a year
V1.9	Approved	30.07.20	Trust Board	Approved by Trust Board 30.07.20
V2.1	Draft	08.01.21	TS/PC	Amended to reflect HM Treasury Audit and Risk Assurance Committee Handbook
V2.1	Approved	25.02.21	Trust Board	Approved by Trust Board
V2.1	Approved	01.03.22	ARC	Reviewed by the Committee and agreed no changes required.

V2.1	Approved	02.03.23	ARC	Reviewed by the Committee and agreed no changes required.
V3	Draft	11.07.24	Trust Secretary	Updated in line with HFMA Guidance and the Trust's internal governance refresh
V3	Approved	26.09.24	Trust Board	Approved by Trust Board

1. Constitution

The board hereby resolves to establish a committee of the board to be known as the audit (and risk/ risk assurance) committee (the committee). The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

Any amendments to these Terms of Reference can only be approved by the Trust Board. The Terms of Reference will be reviewed annually.

2. Purpose

The Audit and Risk Committee provides assurance to the Board that governance, risk management, financial reporting and internal controls are effective across the Trust.

3. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

4. Membership

The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.

The Chief Finance and Resources Officer and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.

The trust secretary may attend meetings.

The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.

Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.

A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.

At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

5. Quorum

A quorum shall be two members.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's standing orders, and standards of business conduct policy.

7. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The chair of the committee, board, accountable/ accounting officer,

external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

8. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist (where they do not report elsewhere).

9. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control

The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and

any work undertaken outside the annual audit plan, together with the appropriateness of management responses

- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th September 2025**
Title	**Finance and Performance 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	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
• Salary Sacrifice – Vehicle Solutions	• IQPR • Dementia	• Chief Finance Officers Report • Digital • Estates • Finance Report Month 5 • SLR • Finance, Digital and Estates Risks 2025/26 • Cyber Assurance • Cost Improvement Plans – update • IT Hardware Services Recommendation Report

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Finance Officers' Report	The Chief Finance Officer's report highlighted several key pressures facing the system, including rising inpatient staffing costs in August due to holiday cover, ongoing risks around outpatient spend, and worsening system cash flow. Estates developments are progressing, with the female PICU project on track, though delays are anticipated for the centralised place of safety due to foundation issues. The digital programme continues to advance, with a focus on service impact and cyber risk oversight.	**Reasonable Assurance**	A full breakdown of the financial forecast will be brought to the next committee meeting for discussion.
IQPR	The Committee reviewed the developing IQPR, which is showing positive progress. Key issues noted: • Ongoing pressures with patient flow and bed availability, affecting timely admissions. • Liaison services are performing well; delays remain only for those requiring beds. • Mental Health Together is showing improvement, though further progress is needed if shorter targets are introduced.	**Reasonable Assurance**	Next steps: 1. Oversight of the IQPR to transfer to the Quality Committee from November, with continued sight by the Finance and Performance Committee. 2. Demand and capacity analysis to be completed to support resource alignment. 3. Further discussion on targets and trajectories at the Quality Committee and Board.

	• Regional variation remains, particularly in East Kent, with demand and capacity work underway. • Suggestion to review long-term targets to ensure momentum in the short term.		
Dementia	Progress has been made on reducing long Clinically Ready for Discharge (CRFD) waits, now down to just a handful of complex cases. Attention will shift to other cohorts where quicker progress can be achieved. East Kent remains an outlier, though it has been chosen as a pilot site for integrated neighbourhood health. This offers promising opportunities, but prevention work and the use of voluntary/community support must be strengthened. Waiting lists have reduced significantly: average waits are now under 100 days, and the diagnosis rate has reached its highest level at 62%. The remaining 52+ week waits are expected to be cleared shortly. Strong leadership in East Kent and improving performance in West Kent were noted, although cultural and system challenges persist.	**Reasonable Assurance**	Next steps: monitor East Kent's integrated neighbourhood pilot, maintain focus on prevention and crisis alternatives, and continue oversight of dementia pathway progress.
Cyber Assurance	The Trust is meeting and exceeding NHS England's new Cyber Assurance Framework standards. Key risks remain around ransomware, phishing, insider threats, and supplier vulnerabilities. Immediate priorities are to strengthen real-time monitoring, build cyber expertise, and complete the Windows 11 upgrade before October 2025.	**Reasonable Assurance**	Next steps include enhancing incident response planning, formalising third-party assurance, and exploring AI/ML tools to improve threat detection.

Digital	A Full report on project progress was received and noted; the highest risk areas related to the integration of CAMS. The Committee congratulated the team on their achievements to date	**Reasonable Assurance**	It was noted that the Committee would be looking at innovation and the use of AI. Jules Christmas was requested to consider the best approach to driving this forward.
Business Case Approval	IT Hardware Services Recommendation Report: The proposal to enter into the hardware supply contract.	**Limited Assurance**	The committee requested further information to support the approval process.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 25th September 2025

Title of Paper: Trust Sealing Report

Author: Nicola Legge, Legal Services Manager

Executive Director: Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose: Noting

Submission to Committee: Standing Order

Overview of Paper

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

Issues to bring to the Committee's attention

Two documents have been signed and sealed as a deed during from Q1 25/26 This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact: No risks/impact

Risk recorded on: No risks

Risk IDs: No risk

Assurance/Oversight: Substantial Assurance

Version control: 1

Number	Date of Sealing	Description	Signatures	Comments
164	19.06.25	Agreement for Lease of Barrier Road Crisis House	Sheila Stenson Jackie Craissati	
165	28.06.25	Lease of Barrier Road Crisis House	Sheila Stenson Jackie Craissati	

Version control: 1