1 AGENDA

Kent and Medway Mental Health NHS Trust

Title of Meeting Trust Board Meeting (Public)
Date 28th May 2026
Time 09.30 to 12.00
Venue MS Teams

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/26-27/01	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/26-27/02	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/26-27/03	3.	Personal Experience – The Acute ward and its patient's journey	FN	Verbal	DHS	09.35
TB/26-27/04	4.	Continuous Improvement Story - Improving Communication and Consultant Access for Patients and Carers	FN	Paper	AR	09.45
STANDING ITEMS						
TB/26-27/05	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/26-27/06	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/26-27/07	7.	Chair's Report	FN	Paper	JC	10.00
TB/26-27/08	8.	Chief Executive's Report	FN	Paper	SS	10.05
TB/26-27/09	9.	Board Assurance Framework	FA	Paper	JK	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/26-27/10	10.	Sustainable Communities Provider Collaborative Progress Report	FN	Paper	AR	10.20
TB/26-27/11	11.	Scope of Clinical Plan	FD	Paper	AQ	10.30
OPERATIONAL ASSURANCE						
TB/26-27/12	12.	Integrated Quality and Performance Report	FD	Paper	SS	10.40
TB/26-27/13	13.	Finance Report – Month 1	FN	Paper	NB	10.50
TB/26-27/14	14.	Workforce Deep Dive - Workforce Race Equality Standard and Workforce Disability Equality Standard	FD	Paper	ALS	11.00
TB/26-27/15	15.	Restrictive practice trends deep-dive	FD	Paper	JK	11.10
TB/26-27/16	16.	Safer Staffing Report (aka Nursing Establishment Review)	FD	Paper	JK	11.20
TB/26-27/17	17.	Governance Improvement Plan	FA	Paper	DJ	11.30
TB/26-27/18	18.	Co-creation strategic plan: implementation update	FN	Paper	KH	11.40
TB/26-27/19	19.	Standing Orders Amendment (CYP & All AED)	FA	Paper	DJ	11.45
CONSENT ITEMS						
TB/26-27/20	20.	Report from Quality Committee • Mortality Report (Executive Summary)	FN	Paper	SW	11.50
TB/26-27/21	21.	Report from People Committee	FN	Paper	KL	
TB/26-27/22	22.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/26-27/23	23.	Report from Audit and Risk Committee	FN	Paper	KC	
TB/26-27/24	24.	Report from Finance, Business and Investment Committee	FN	Paper	MW	

TB/26-27/25	25.	Report from Charitable Funds Committee	FN	Paper	SBK	
CLOSING ITEMS						
TB/26-27/26	26.	Any Other Business			Chair	11.55
TB/26-27/27	27.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 30th July 2026					

Members:		
Dr Jackie Craissati	JC	Trust 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
Kevin Corrigan	KC	Non-Executive Director
Margaret Dalziel	MD	Non-Executive Director
Julie Hammond	JH	Associate Non-Executive Director
Pam Craven	PCr	Associate Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Julie Kirby	JK	Acting Chief Nursing Officer
Nick Brown	NB	Chief Finance and Resources Officer
Ali Layne-Smith	ALS	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Kindra Hyttner	KH	Director of Strategy and Engagement
Daryl Judges	DJ	Deputy Trust Secretary
Vicky Fernandez	VF	Ward Manager (Continuous Improvement Story)
Andrew Simmons	AS	Lived Experience (Personal Story)
Apologies:		
Tony Saroy	TS	Trust Secretary

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

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Improvement Story - Improving Communication and Consultant Access for Patients and Carers
Author:	Vicky Fernandez , Bluebell Ward Manager
Executive Director:	Dr Adrian Richardson, Director of Transformation & Partnerships

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This paper outlines an improvement undertaken on Bluebell Ward to introduce a more structured and predictable ward-round process, improving communication and access for patients, families and carers. The work was frontline-led through the Trust's Improvement Management System and focused on reducing unwarranted variation, improving experience, and releasing clinical time. Early feedback is positive, with emerging evidence of improved consistency, staff efficiency and carer involvement, and potential for scaling the approach to other wards.

Issues to bring to the Board's attention

N/A

Governance

Implications/Impact:	Quality
Assurance:	Reasonable
Oversight:	Quality Committee

Version 2 - **Public**

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Improvement Story:

Title: Improving Communication and Consultant Access for Patients and Carers

Name: Vicky Fernandez - Ward Manager

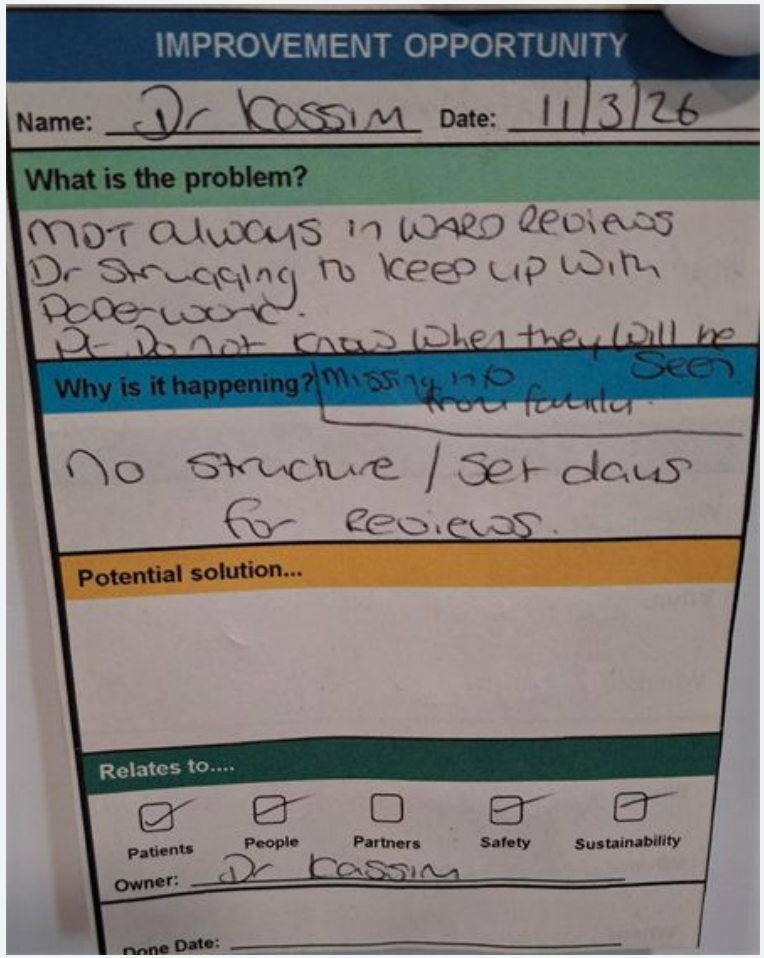
Caring | Inclusive | Curious | Confident

1. Problem:

The absence of a clear, structured ward-round schedule resulted in unpredictable consultant reviews for patients and carers. Patients did not know when they would be seen, contributing to frustration, increased risk of violence and aggression, and repeated disruptions to the MDT.

Carers were often unable to attend reviews or speak to consultants due to the lack of predictability, leading to missing critical background and contextual information. Unplanned and fragmented ward rounds meant the MDT was frequently in review activity, limiting time for clinicians to complete essential tasks such as paperwork, risk assessments, and medical reviews, and reducing overall efficiency of ward operations.

Improvement Management System (IMS) Improvement Ticket

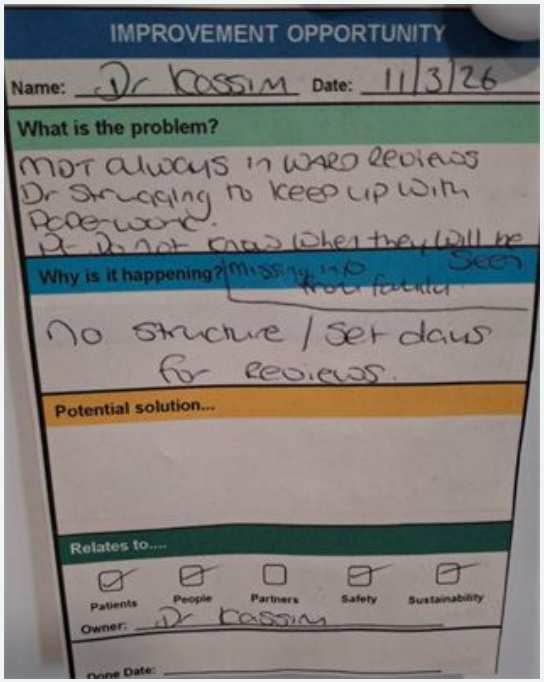


2. Approach:

Dr Kassim, a Locum Doctor for Bluebell Ward, raised an improvement ticket through the improvement huddle board to start to explore this problem. The first step was to reflect on current ward-round practice and understand the process and what and where things might be able to be improved.

The team agreed to protect dedicated time. Existing weekly meetings and consultant availability were reviewed to remove clashes. A structured timetable was introduced, prioritising patient reviews in the first three days of the week, with remaining time allocated to CPAs and professional meetings. The timetable was tested through a two-week PDSA cycle, reviewed and refined, and then adjusted to safely accommodate an increased caseload from 18 to 20 patients.

Improvement Management System (IMS) Improvement Ticket



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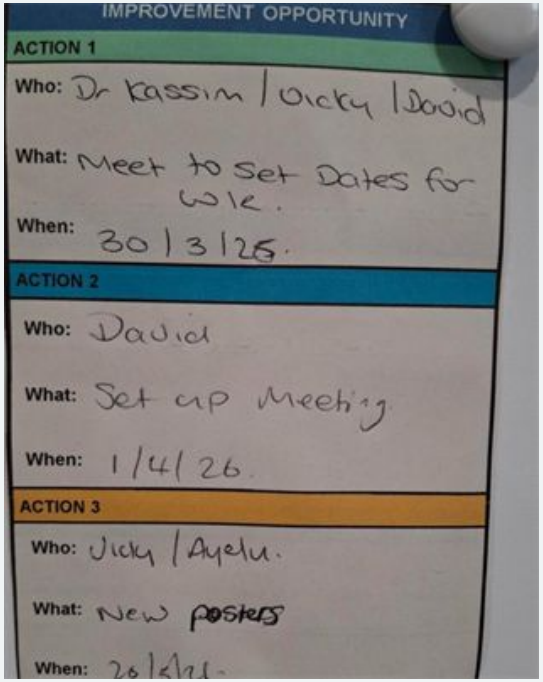


Back

3. Current State:

- Ward reviews were conducted without a defined structure
- Visit dates and times decided ad hoc
- Some patients were reviewed multiple times per week, while others were not seen for extended periods
- Patients experienced frustration and confusion about consultant access, even when reviews had occurred
- Visibility of who had been seen relied on informal tracking (e.g. a board in the doctors' room)
- The lack of structure resulted in ward reviews frequently extending into the late afternoon, reducing time for other clinical duties

4. Goal / Aim:

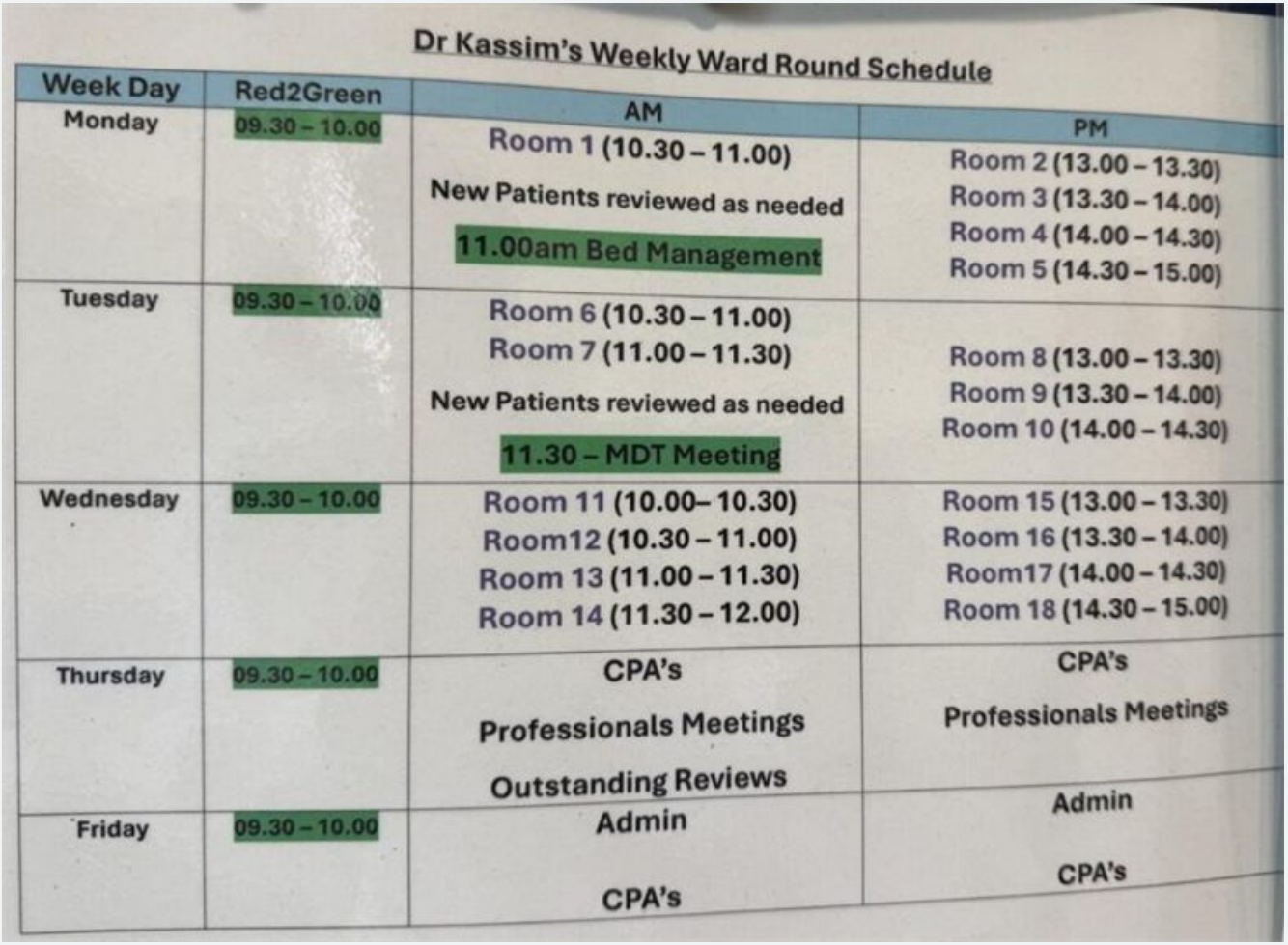
Goal:

To provide a more organised and predictable ward-round process that strengthens therapeutic relationships with patients and families while reducing unnecessary complaints.

Aim:

To implement a structured approach to ward rounds that releases clinical time for direct patient care, improves communication and involvement of families and carers, and reduces complaints related to access and information.

5. Implementation / Change:



Dr Kassim's Weekly Ward Round Schedule

Week Day	Red2Green	AM	PM
Monday	09.30 – 10.00	Room 1 (10.30 – 11.00) New Patients reviewed as needed 11.00am Bed Management	Room 2 (13.00 – 13.30) Room 3 (13.30 – 14.00) Room 4 (14.00 – 14.30) Room 5 (14.30 – 15.00)
Tuesday	09.30 – 10.00	Room 6 (10.30 – 11.00) Room 7 (11.00 – 11.30) New Patients reviewed as needed 11.30 – MDT Meeting	Room 8 (13.00 – 13.30) Room 9 (13.30 – 14.00) Room 10 (14.00 – 14.30)
Wednesday	09.30 – 10.00	Room 11 (10.00– 10.30) Room12 (10.30 – 11.00) Room 13 (11.00 – 11.30) Room 14 (11.30 – 12.00)	Room 15 (13.00 – 13.30) Room 16 (13.30 – 14.00) Room17 (14.00 – 14.30) Room 18 (14.30 – 15.00)
Thursday	09.30 – 10.00	CPA's Professionals Meetings Outstanding Reviews	CPA's Professionals Meetings
Friday	09.30 – 10.00	Admin CPA's	Admin CPA's

Standard work defines Dr Kassim's schedule and is clearly visible on the ward, ensuring staff have a shared understanding of expected attendance and availability.

This information feeds into each patient's room visual management (slide 7), confirming when ward round visits can be expected.

This clarity enables carers and family members to plan their time on the ward to engage effectively in the process.

5. Implementation / Change:

- Introduced standardised bedroom posters to improve visibility and communication.
- Following learning from a complaint, process was enhanced to ensure families and carers are consistently invited to ward meetings.
- Standardised door signage to use bed numbers rather than patient names
- Shared the approach with the Trust Carers Lead to support consistent communication with families and carers (full engagement plan in place moving forward)
- Improvement highlighted in the Bluebell team newsletter as part of wider IMS work to raise awareness
- Changes implemented mid-March.

6. Results / Benefits:

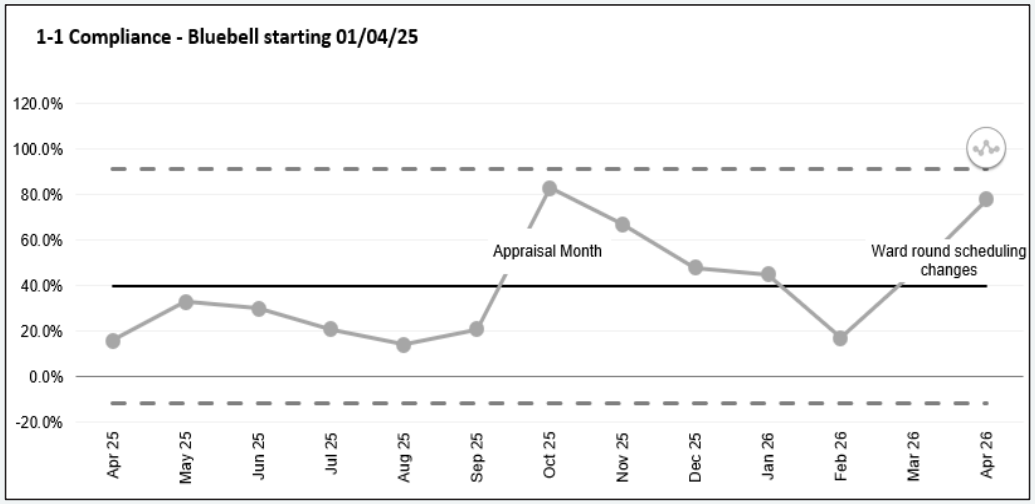
A number of patients (5), carers (2), and staff (5) on Bluebell provided their feedback via a post-implementation survey, providing an indicative view from each group:

100% of staff surveyed 'prefer the new structured ward review timetable compared to the previous ad-hoc system'.

92% of everyone surveyed believe the change has had a 'positive effect' on either care, communication, or awareness of scheduled ward review

100% of patients surveyed responded that 'knowing when ward reviews happen' helped them feel at least 'a little' more prepared or informed.

80% of patients surveyed felt the change has had 'a positive effect on [their] experience of care on the ward'.



- Improved staff and patient feedback. Resident doctors now have clear time with consultant for learning
- Ward round visits rebalanced across all patients to reduce unwarranted variation in review frequency
- Supervisions / 1:1 compliance has increased due to improved time management.

7. Scalability:

Dr Kassim feels that this approach could be scaled and adopted across other wards. The model is transferable and has received strong endorsement from the Carers Champion.

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Kent and Medway Mental Health NHS Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.15 on Thursday 26th March 2026
At Farm Villa, Hermitage Lane, Maidstone, Kent. ME16 9PH

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Kim Lowe	KL	Non-Executive Director
	Julius Christmas	JCh	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Pam Creaven	PCr	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Julie Kirby	JK	Chief Nursing Officer (Interim)
	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 Strategy and Engagement
	Tony Saroy	TS	Trust Secretary
	Hazel Garnham	HG	Lived Experience (Personal Story)
	Shannon Paine	SP	Corporate Head of Nursing & Quality (Continuous Improvement Story)
	Kevin Corrigan	KC	Incoming Non-Executive Director (Observing)
	The Board was joined by members of the public and members of staff.		
Apologies:			

Item	Subject	Action
TB/25-26/143	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and noted no apologies had been received. All written reports were taken as read.	
TB/25-26/144	**Declarations of Interest** No interests were declared.	
TB/25-26/145	**Personal Experience – The difference that accessing the right care can make** The Board welcome Hazel who had been a patient in community services. She is now a Community Involvement Coordinator. She has also helped in the rollout of the Community Mental Health Framework. Hazel highlighted that she has been open to secondary mental health services since childhood. She explained the difficulties she had when she did not receive the	

Item	Subject	Action
	correct diagnosis. She had been open to the crisis team frequently, and she described how well she was looked after by that team. Following successful intervention by the crisis team clinicians, she was approved for an out of area assessment. She received the correct diagnosis, and effective treatment was received in 2020. Since then, she has been working and is engaged in psychological support. The Board thanked Hazel and **noted** the Personal Experience Story.	
TB/25-26/146	**Continuous Improvement Story – Physical Health Monitoring – For Newly Prescribed Anti-Psychotics** The Board received the improvement story describing the Trust's response to the CQC Section 29A Warning Notice in April 2025, including: • introduction of a RIO antipsychotic initiation tab, • early evidence of improved compliance (February 2026 audit), • scaling across teams, and • remaining challenges relating to workload, physical space and pathway ownership. The Board **noted** the Continuous Improvement Story.	
TB/25-26/147	**Minutes of the previous meeting** The Board **approved** the minutes of the meeting held in November 2025.	
TB/25-26/148	**Action Log & Matters Arising** The Board reviewed the action log: • TB/24-25/137 – Clinical staffing model to Quality Committee: To be closed as there will be a new Trust strategy • TB/25-26/9 – Review of the risks within technology risk statement: The Trust will receive a restructured BAF in May 2026 • TB/25-26/99 – Suicide and self-harm risks: To be closed • TB/25-26/101 – Partnership Working report to include partnership register: To close • TB/25-26/102 - Use of Clarendon Hotel Age UK: To close • TB/25-26/118 – Occupational Therapy access: OT is available in all mental health together. To close. • TB/25-26/121 – Refresh of clinical staffing model timeline: Not completed. To close. • TB/25-26/121 – Action plan to improve ethnicity recording: To be combined with ethnicity data improvement plan action. • TB/25-26/126 – Digital plan: This is now in the new Trust Strategy. • TB/25-26/128 – Complains improvement trajectory: This will now come part of future IQPRs. Due date to be adjusted to May.	
TB/25-26/149	**Chair's Report** The Board received the Chair's report, including: • system-level developments,	

Item	Subject	Action
	• Board activity and visits, • Board member changes and recruitment. The Chair thanked MAF and PC for their work with the Trust during their NED appointments. The Chair highlighted that during a site visit, it appeared that staff members were not aware that preventing racist incidents was a Board priority, and had not received the expected advice regarding new measures in place to respond to racist abuse. The executive team confirmed that it will ensure that the new measures are robustly communicated to staff, including timely feedback when incidents are reported. The Board **noted** the Chair's Report.	
TB/25-26/150	**Chief Executive's Report** The Board received the Chief Executive's report covering: • national and regional updates, • executive changes, • CYP and All-Age Eating Disorder service transfer, • CQC Well-Led inspection feedback, • partnership working and external recognition. The Chief Executive updated the Board on the appointment of the new national Mental Health Director, and thanked SG for her work with the trust as this was her final board meeting before her retirement. The Board **noted** the Chief Executive's Report.	
TB/25-26/151	**Board Assurance Framework (BAF)** The Board received the updated Board Assurance Framework, noting: • no new risks or removals since January 2026, • unchanged risk scores, • key risks remaining outside tolerance, including regulatory compliance, inpatient flow, self-harm and cyber risk. The Board highlighted that a significant number of risks were outside of tolerance and the Board needed to be informed in future iterations as to when the risks will fall into risk appetite. It was recommended that the table within the report be adjusted with the inclusion of a column to detail that information. The Board also raised that system finance risks and the Children & Young Persons Mental Health Services matters are not on the BAF. The Board highlighted that there needed to be better triangulation of data to inform risks. **Action: By May 2026, TS to adjust the Board development and seminar planner to include a seminar on data triangulation for the BAF. The precise date for the seminar will be agreed by the Chair and SS.** The BAF was **approved**.	

Item	Subject	Action
TB/25-26/152	**Strategic Delivery Priorities – Closing Report** The Board received a report reviewing delivery of the Trust's 2023–2026 Strategy. The report highlighted progress despite operational pressures, including reductions in inpatient harm, improved dementia diagnosis waiting times, strengthened leadership and improvement capability, improved crisis response performance, and the maintenance of financial stability. The Board noted a number of areas requiring continued focus, including Mental Health Together, patient flow and bed occupancy, self-harm reduction and embedding the Quality Plan. The Board also noted the key learning from delivery, including the need for a reduced number of priorities, stronger data quality and governance, and continued investment in leadership and culture, which have informed the development of the new five-year strategy. The Board **noted** the Strategic Delivery Priorities – Closing Report.	
TB/25-26/153	**Five-year trust strategy 2026-2031** The Board received the proposed Five-Year Trust Strategy for 2026–2031, together with the staff and public engagement findings, delivery framework and digital improvement plan. The Board noted that the strategy sets a clear long-term direction grounded in extensive engagement and organisational learning, with five True North priorities focused on access, safety, experience, resources and prevention. The Board noted the emphasis on disciplined delivery, measurable outcomes and strengthened governance, with the Doing Well Together improvement programme providing the mechanism for translating the strategy into year-one breakthrough objectives, trust initiatives and key projects, supported by digital enablement. The Board requested more detail regarding the strategic workplans at a future Board seminar session. **Action: At its June seminar, SS to present the strategic workplan which shows how the strategy will have operational effect.** The Board **approved** the Five-Year Trust Strategy.	
TB/25-26/154	**Sustainable Communities Provider Collaborative Progress Report** The Board received and noted the update on the Sustainable Communities Provider Collaborative, including progress across the Community Mental Health Framework, dementia pathways and neighbourhood models. In discussion, the Board emphasised the need for greater clarity on scope and intended outcomes for the dementia care home pathway. It was confirmed that approximately 90% of care homes have now been reached through training, with a clear ambition to achieve 100% coverage. The Board noted the intention to reduce	

Item	Subject	Action
	routine referrals into the Trust, with future referrals limited to complex presentations only, supported by strengthened system capability. The Board also highlighted the importance of ensuring that neighbourhood models, including those supporting people in Jonn Hopkins Clinical Groups 10 and 11 ('High Need'), are fully addressed, recognising that these needs must be met even where individuals are supported at home. The Board **noted** the Sustainable Communities Provider Collaborative.	
TB/25-26/155	**Trust Partnership Working** The Board received a proposal for a Structured Partnership Framework, setting out a formal definition of partnership working, agreed principles and a proportionate, risk-based governance model across System, Place and Neighbourhood tiers. The Board noted that the Trust does not currently operate within a consistent partnership framework and that the proposed approach responds to national guidance, CQC Well-Led expectations and organisational learning from recent collaborative working. In discussion, the Board noted that the current state of partnerships set out at Appendix 5 will be subject to further review once the framework is implemented, to ensure appropriate classification, proportional governance and clarity of accountability. Members emphasised the importance of ensuring that governance arrangements, particularly at sub-Board level, are explicit and clearly articulated, including lines of accountability, reporting and escalation. The Board **approved** the Structured Partnership Framework, subject to clarification and strengthening of governance arrangements for the proposed sub-Board/committee oversight model.	
TB/25-26/156	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Report, which provides an overview of Trust performance against the Doing Well Together True North priorities and Breakthrough Objectives, alongside regulatory oversight measures. The Board noted that the Trust remains in Segment 1 of the NHS Oversight Framework and that the report is a core component of the Trust's performance management and assurance framework. In discussion, the Board focused on patient flow and bed state, with particular concern regarding the ongoing use of corridor care in East Kent as a symptom of sustained operational pressure across the system. Members sought assurance that the scale, drivers and impact of corridor care were clearly understood and visible within Board-level reporting, including how this links to flow, liaison services and system-wide urgent and emergency care pressures. The Executive Team outlined the actions underway to address flow challenges in East Kent, including step-down capacity, liaison support and system escalation arrangements. The Board emphasised the importance of transparent and consistent reporting of corridor care to support effective oversight and assurance.	

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Item	Subject	Action
	Action: By 31.05.26, SS must ensure that the next iteration of the Integrated Quality and Performance Report includes a dedicated page setting out corridor care in East Kent, including scale, drivers, risks, mitigating actions and trajectory. The Board **noted** the Integrated Quality and Performance Report.	
TB/25-26/157	**Independent Quality and Safety Governance Review** The Board received the findings of an independent Quality and Safety Governance Review commissioned following a CQC warning notice, and serious incidents in community services. The review assessed the Trust's quality governance maturity as 'Developing', with significant Lagging features', and concluded that a consistently reliable, end-to-end assurance system from frontline services to the Board is not yet in place. Key weaknesses were identified in safety-critical controls, governance discipline, data quality, regulatory readiness and the use of patient, family and carer experience in assurance. The review recognised existing foundations, including the refreshed Strategy, Quality Plan, Doing Well Together improvement model and emerging PSIRF capability. The Trust will be carrying out further works in terms of the Trust-wide Quality and Corporate Governance Development Programme, and a review of the Board Assurance Framework. The Board requested that it be updated on the progress of those workstreams in six months' time. **Action: By May 2026, JK to provide an update on progress against plan for the Trust-wide Quality and Corporate Governance Development Programme.** The Board **approved** the Development Programme and sharing the information with the CQC.	
TB/25-26/158	**Finance Report for Month 11** The Board received the Month 11 Finance Report and noted that the Trust continues to deliver its financial plan, reporting a £2.02m surplus, in line with plan. The Board noted the capital position, including that the programme remains slightly behind plan due to project timing, with mitigating actions in place to maximise year-end delivery. The Board noted that there are currently two patients in out-of-area beds, both of whom are expected to be repatriated to in-area provision within the next month, subject to clinical readiness. In discussion, the Board commended the Trust for maintaining strong financial grip and for continuing to deliver on its financial commitments despite ongoing operational pressures. The Board **noted** the Finance Report for Month 11 (February 2026).	
TB/25-26/159	**Workforce Deep Dive – Staff Survey**	

Item	Subject	Action
	The Board received the report presenting the National Staff Survey 2025 results and noted the overall position. The Board discussed the continued decline in overall engagement, together with reductions in advocacy, confidence in care quality and psychological safety, and the widening variation in staff experience across the organisation. Members recognised that these results present a clear leadership challenge for the Trust. The Board noted that the Trust has entered a new strategic period and that employee experience and engagement are explicitly addressed within the 2026–2031 Trust Strategy, providing a clear framework for improvement. The Board emphasised that improving staff engagement must be treated as a core leadership responsibility, and that delivery will be driven through Directorate Strategy Deployment Reviews (SDRs), with clear ownership and accountability at directorate and team level. The Board discussed the need for targeted support in East Kent, recognising the sustained impact of transformation and operational pressure in this area. The Board also emphasised the importance of using data more effectively and closer to real time to support timely intervention. There was also a challenge to the number of actions arising from the staff survey, with a request to prioritise these for maximum impact. The Board **noted** the National Staff Survey 2025 results and endorsed the management approach to improving engagement through the Trust Strategy and Directorate-level accountability.	
TB/25-26/160	**Children and Young Persons Mental Health and All Age Eating Disorders** The Board received a report setting out the proposed governance arrangements and associated legal documentation, including the commercial, operational and digital components required to support delivery. The paper described the scope of the agreement, the anticipated benefits to the Trust, and the key dependencies that must be resolved prior to completion. In considering the proposal, the Board noted that a small number of matters remained subject to final resolution, namely: 1. outstanding issues relating to NHS Professional Staffing, 2. the position regarding the residual lease for the adolescent inpatient unit, and 3. finalisation of the Digital Service Level Agreement (SLA) with NELFT. The Board was assured that these issues were well understood, actively being progressed, and would be fully resolved prior to execution of the Legal Agreement. The Board noted that the proposed arrangements were otherwise consistent with the Trust's strategic, operational and financial objectives, and that appropriate due diligence and governance oversight had been applied. The Board **approved** the proposals set out in the paper, subject to the Legal Agreement being finalised and signed.	

Kent and Medway Mental Health NHS Trust

Item	Subject	Action
	The Board **delegated** authority to sign all necessary legal and contractual documentation to the Chief Executive Officer and the Chief Finance and Resources Officer.	
TB/25-26/161	**Quality Priorities** The Board received an update on delivery of the Quality Account Priorities for 2025/26 and noted that although progress was made across Women's Health, Working with Families, and Self-Harm, there was an absence of impact measures in the plan which made it difficult to discern whether the programmes had been effective. The Board noted that further work will focus on embedding and sustaining improvements through existing governance arrangements. The Board considered the proposal for the 2026/27 Quality Account Priority, which will focus on implementation of the Quality Plan through a structured programme of work aligned to the Trust's strategy. The Board **noted** progress against the 2025/26 Quality Account Priorities and the proposed Quality Account Priorities for 2026/27.	
TB/25-26/162	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/25-26/163	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/25-26/164	**Report from Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee Chair's report.	
TB/25-26/165	**Report from Finance, Business and Investment Committee (Estates Strategy)** The Board received and **noted** the Finance, Business and Investment Committee Chair's report.	
TB/25-26/166	**Register of Interests** The Board received and **noted** the Register of Interests	
TB/25-26/167	**Any Other Business** None.	
TB/25-26/168	**Questions from Public** None.	
	Date of Next Meeting	

Kent and Medway Mental Health NHS Trust

Item	Subject	Action
	The next meeting of the Board will be held on Thursday 28th May 2026, via Microsoft Teams.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 05/2026

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN MAY 2026								
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework	NB	July 2025	May 2026	Closed – This will be captured in the wider work on the BAF.	**Over due**
29.01.2026	TB/25-26/121	Action Log & Matters Arising	Provide an action plan to improve ethnicity recording, to be combined with ethnicity data improvement plan action.	AR	March 2026	May 2026	This has been incorporated into the IQPR narrative: Ethnicity recording has improved to 88.2% of community (MHT/MAS) referrals through clear, practical changes. Since January 2026, 176 staff have completed protected characteristics training, reporting increased confidence to ask for information, explain Trust data and use data to inform practice. Patients can now see why we collect this information on the Trust website, with additional information sheets in development. New processes have also been introduced to make ethnicity easier to record. Targeted work in West Kent using the Doing Well Together methodology increased recording from 76.1% to 86.2% in 2025/26. In all, this has been an important first step, with further improvement still needed. With these foundations in place, the Ethnicity, Diversity and Inclusion PowerBI report is now being used to support improvement, and focused work on Restrictive Practices, Mental Health Act detentions and MAS access shows how data is being put into action to improve care.	**In progress**
29.01.2026	TB/25-26/128	Integrated Quality and Performance Review	Provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis	JK	March 2026	May 2026	A verbal update to be given at the meeting.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 05/2026

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29.01.2026	TB/25-26/121	Action Log & Matters Arising	Present a Trust wide ethnicity data improvement plan to address gaps in the Trust's ethnicity data for both staff and patients (Quality Committee)	ALS/ AR	May 2026		Closed – covered on the IQPR paper.	In progress
29.01.2026	TB/25-26/123	Chief Executive's Report	Strengthen the stakeholder engagement plan, including targeted communication to Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) and local councillors	KH	May 2026		Closed – a planned and proactive approach will be in the final communications and engagement strategic plan that is being developed now.	In progress
29.01.2026	TB/25-26/124	Board Assurance Framework (BAF)	Reconcile inconsistencies in inpatient flow data with update provided to Quality Committee	JK / AQ	May 2026		Closed- This was provided to QC.	In progress
29.01.2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Provide a verbal update as part of the Sustainable Communities Provider Collaborative Progress Report regarding the Health Inequalities Improvement Plan and collaboration with Kent Community Health NHS Foundation Trust	SS	May 2026		A verbal update to be given at the meeting by AR.	In progress
29.01.2026	TB/25-26/126	Digital Progress Against Plan	Present the mapping of system-level digital responsibilities and dependencies	NB	May 2026		The Trust's digital plan is presently being developed locally with emerging joint working with KCHFT. National funding is anticipated to support our work in AVT, with the trust part of one of the national pilots in this area. We anticipate this is an emerging picture and will include further detail into the board strategy session in June.	In progress
29.01.2026	TB/25-26/127	Trust Quality and Safety Agenda	Finalise the NED Visit Insight Framework	TS	May 2026	July 2026	A new system of NED visit feedback will be implemented over the next quarter, with digital submission of NED visit feedback	In progress
29.01.2026	TB/25-26/127	Trust Quality and Safety Agenda	Produce a plan to address fear of reprisals and strengthen leadership behaviours	ALS	May 2026		Closed - a series of actions have been agreed through People Committee at the end of 2025 and throughout this year are in place to address these and other cultural and behaviour issues and risks. These include continued monitoring and reporting through FTSU, launching the "Staff Voice" (like a staff council) for every directorate, strengthening staff networks, and the	In progress

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 05/2026

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							continued roll out of a new leadership development programme for Band 7 and above. In addition, we are planning a Trust Wide cultural transformation programme through our "Doing Well Together" methodology. A BAF risk related to culture is being drafted so these sorts of issues are monitored at Board level. .	
29.01.2026	TB/25-26/128	Integrated Quality and Performance Review	Lead a Trust-wide audit of waiting-well arrangements, incorporating patient experience data	DHS	May 2026		Closed – covered on the IQPR paper.	**In progress**
29.01.2026	TB/25-26/128	Integrated Quality and Performance Review	Deliver a deep-dive report on restrictive practice trends, drivers and mitigation plans	JK	May 2026		A verbal update to be given at the meeting.	**In progress**
29.01.2026	TB/25-26/132	Freedom to Speak Up 6 Month Report	Report to the People Committee the: • Implementation of the principles-based Change Management Framework; and Embedding of closed-loop reporting back to staff	ALS	May 2026		A verbal update to be given at the meeting.	**In progress**
26.03.2026	TB/25-26/151	Board Assurance Framework (BAF)	TS to adjust the Board Development and Seminar Planner to include a seminar on Data Triangulation for the BAF. The precise date for the seminar will be agreed by the Chair and SS.	TS	May 2026		Closed – this has been completed.	**In progress**
26.03.2026	TB/25-26/156	Integrated Quality and Performance Review	By 31.05.26, SS must ensure that the next iteration of the Integrated Quality and Performance Report includes a dedicated page setting out corridor care in East Kent, including scale, drivers, risks, mitigating actions and trajectory.	SS	May 2026		Closed – covered in the IQPR.	**In progress**
26.03.2026	TB/25-26/157	Independent Quality and Safety Governance Review	By May 2026, JK to provide an update on progress against plan for the Trust-wide Quality and Corporate Governance Development Programme.	JK	May 2026		Closed – this is covered CEO report.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 05/2026

NHS
Kent and Medway
Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS NOT DUE OR IN PROGRESS								
29.01.2026	TB/25-26/119	Continuous Improvement Story – Standardising Medication Storage in Allington Centre	Produce a Trust-wide scale-up plan with measurable safety metrics and report it to the Finance, Business and Investment Committee	AR	July 2026			**Not Due**
29.01.2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Present a 'broader health inequalities' update for the Board	AR	July 2026			**Not Due**
26.03.2026	TB/25-26/153	Five-year trust strategy 2026-2031	At its June seminar, SS to present the strategic workplan which shows how the strategy will have operational effect.	SS	June 2026			**Not Due**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29.01.2026	TB/25-26/121	Action Log & Matters Arising	Refresh the clinical staffing model timeline with oversight by the Quality Committee	DHS, AQ and JK	March 2026	September 2026	Clinical plan is due for completion in September 2026. Work force plan will follow, no dates for completion agreed at this stage. Will need to be agreed with new Chief People Officer. With presentation at Quality Committee and People Committee before Board	**CLOSED**
25.09.2025	TB/25-26/72	Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report	Bring a report to Board showing all partnership working within the Trust	SS	November 2025	March 2026	The partnership approach will be discussed at the March 2026 Board meeting.	**CLOSED**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 05/2026

NHS
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Mental Health
NHS Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
27.11.2025	TB/25-26/99	Board Assurance Framework (BAF)	Bring back an update to Board on both the suicide and self-harm risks to the Trust, and how these may link	JK	March 2026		This will be covered within the Quality Priorities paper on the agenda. Recommended to close the action.	CLOSED
27.11.2025	TB/25-26/101	Trust Partnership Working	Revise the Trust Partnership Working report to include a partnership register, a maturity matrix, principles for working with the voluntary sector and a governance model. This should come back to the Board in March 2026	AR	March 2026		A verbal update to be give, as this is being picked up in the new strategy charters and the revision of the trust SDR process	CLOSED
27.11.2025	TB/25-26/102	Integrated Quality and Performance Review	The Board to receive a report on the use of the Royal Clarendon Hotel Age UK residential service, and what would be needed to further pursue this model across the county, at the March 2026 Board meeting.	AQ	March 2026		This was discussed at the February 2026 Board Development Day. Recommended to close the action.	CLOSED
29.01.2026	TB/25-26/118	Personal Experience – My Occupational Therapy Journey	Explore options to strengthen early Occupational Therapy access, including primary-care referral routes (Quality Committee oversight)	DHS / AQ	March 2026		A verbal update to be given at the meeting	CLOSED
29.01.2026	TB/25-26/121	Action Log & Matters Arising	Refresh the clinical staffing model timeline with oversight by the Quality Committee	DHS, AQ and JK	March 2026	September 2026	Clinical plan is due for completion in September 2026. Work force plan will follow, no dates for completion agreed at this stage. Will need to be agreed with new Chief People Officer. With presentation at Quality Committee and People Committee before Board	CLOSED
29.01.2026	TB/25-26/124	Board Assurance Framework (BAF)	Revise the reputational risk wording within the BAF for review by the Audit & Risk Committee	KH	March 2026		A verbal update to be given at the meeting	CLOSED
29.01.2026	TB/25-26/126	Digital Progress Against Plan	Provide an updated Digital Plan, including the accelerated Ambient Voice Technology (AVT) plan with clarified milestones and resource requirements	NB	March 2026		The digital plan has been updated and taken for discussion to the FBI committee in March. This includes clinical leadership and research. The outline plan is outlined in the Trust Strategy and will be refined once agreed.	CLOSED

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28th May 2026**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For noting**

1. Trust Board meetings

At the April Board development day, the Board had a productive session with the directorates, which were represented by Service Directors, Heads of Nursing, and Clinical Directors. It was a very helpful session with the directorates who presented on strengths, weaknesses, opportunities, and threats.

2. Board Member Updates

This Board meeting will be my last board meeting as Chair of Kent and Medway Mental Health NHS Trust, it has been a great pleasure leading the Board.

Following a successful recruitment exercise, in partnership with Dartford and Gravesham NHS Trust, for a non-executive with a clinical background, I'm pleased to announce the Board will welcome Margaret Dalziel on 25 May 2026 and this will be her first board meeting.

This will also be the first formal board meetings for Kevin Corrigan, Non-Executive Director and he is the trust's Chair of the Audit and Risk Committee. On 11 April, Ali Layne-Smith joined the Board as the Chief People Officer.

3. Trust Chair and NED visits

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

Where	Who
March 2026	
Orchards and Chartwell wards, Priority House, Maidstone	Stephen Waring
April 2026	
People with Complex Emotional /Personality Disorders Training	Mickola Wilson
May 2026	
Littlebrook Hospital	Julie Hammond and Jackie Craissati
Mental Health Learning Disability Service	Julie Hammond

Non-Executive Directors

Stephen Waring NED Visit – Orchards and Chartwell wards at Priority House

I was delighted to visit Orchards and Chartwell wards at Priority House. The acute matron was an excellent host, clearly enjoyed her job and took pride in the care and support she and her colleagues provided to the patients.

Orchards is a modern, pleasant environment, with plenty of space – good sized communal lounge, dining space and a range of facilities including quiet rooms and chill-out room. The garden spaces were also well laid out with attractive garden furniture and plenty of green shrubs – excellent for patient wellbeing. There was a sense of calm on the ward. Of sixteen beds, however, eight of the patients were 'clinically ready for discharge'.

Chartwell, on the other hand, though in good decorative order, is significantly more cramped with less generous communal spaces, and a much less inviting outside space. The staff have still worked hard to make it welcoming with some personalised touches. The ward manager has clearly had a positive impact with more permanent recruitment and establishing a positive culture in the ward, including a focus on involving families and loved ones in care.

There appeared to be a lot of manual form-filling required (with a checklist of checklists). I was told that this, together with increased acuity and complexity of some patients, reduced staff ability to spend time with patients.

Mickola Wilson's NED Visit - People with Complex Emotional /Personality Disorders training

This course is run through iLearn and is designed for non-clinical staff who wish to gain a greater understanding of these conditions. The one-day course was attended by a group of staff who all work in this field and one of the students from the university who is doing work experience at St Martins.

It was extremely informative and helpful session, and the members shared their experiences as to how to identify someone with these conditions and how to respond to an episode. In general discussions their comments reinforced what we already know about the lack of feedback and inconsistences in practices and procedures in different locations. They were very surprised to learn what we discuss at Board level including the suicide watch and problems with getting the patients back into the community.

Dr Julie Hammond NED Visit - Littlebrook Hospital

It was positive to hear about stable staffing, low turnover and confidence in the leadership of the two matrons. The new Deputy Head of Nursing described using Copilot to support minute-taking, which is helping to reduce administrative pressure, and an activity tracker is being developed to better understand ward manager workload and identify tasks that could

be delegated. Recruitment for the new female PICU is progressing well, with all roles filled apart from five HCA posts.

Key areas for ongoing focus include documentation, particularly risk assessments and care plans, patient flow and the impact of delayed step-down on staff and patient experience. The PICU team also raised concerns that zonal observations cannot currently be delivered due to staffing constraints, despite previous positive experience with this model. The visit highlighted several estate issues, particularly on Pinewood ward, where the environment is compact. Outdoor therapeutic spaces across parts of the site also appeared limited and would benefit from further consideration.

Overall, the visit identified positive leadership and workforce stability, alongside areas requiring continued oversight around documentation quality, flow, staffing and the safety and therapeutic quality of the estate.

Julie Hammond NED Visit - Mental Health Learning Disability Service

The service is a small multidisciplinary team providing specialist support for people with mental health conditions who require reasonable adjustments and personalised care due to learning disabilities. It was positive to hear about the team's work supporting mainstream services, particularly around autism, reasonable adjustments and education for other teams. The service described a manageable workload, clear referral criteria and good links with the community learning disability team and KCHFT colleagues. Waiting times were reported as 28 days for assessment and 3 to 6 months for psychological input, with shorter waits for urgent referrals.

The main concerns raised related to reduced local authority provision and the loss of their dedicated learning disability social care support, which the team felt had affected patient experience, community support and the quality of some capacity assessments. Estates were also highlighted as a challenge, particularly the difficulty of accessing suitable, consistent clinic space for patients who may need predictability and structured appointments. Overall, the visit highlighted a committed specialist team with strong multidisciplinary working, alongside ongoing concerns around social care provision, the quality of capacity assessments, estates and assurance around commissioned care providers.

Kent and Medway Mental Health NHS Trust

Chief Executive's Board Report

Date of Meeting: 28th May 2026

Introduction

It has been a busy and varied few weeks for me since we last met as a Board. I have spent time with health and social care leaders talking about what our local population needs, and where the opportunities and gaps are across Kent and Medway. I have also spent time with many of our staff in our clinical services, seeing first-hand the reality of the care we provide and hearing what our staff are experiencing every day. What those two perspectives keep reminding me is that our overarching strategy is critical to ensure we provide safe and effective services for our population and if it makes work easier, safer and more rewarding for our staff delivering care.

I also wanted to note that we have now entered a period of transition for the trust board as in the coming months our Chair and some of our long standing Non-Executive Directors (NEDs) tenures come to an end. I refer to this later in my report.

It is going to be critical for us as a trust along with the change we are facing as a Board that we remember across all the all those conversations I may be having, the message has been consistent. We need to work better together, move more care into communities - where it's right to do so, make sensible use of digital, and focus much more on prevention. All which are a big focus in our new five-year strategy.

National and Regional Update

National Chief Executive Officer (CEOs) Meeting

The national CEOs met with the national NHS England (NHSE) team in London last month. It was clearly set out that we need to sustain the improvements the NHS have delivered in quarter 4 of the last financial year, with regards to operational performance and financial grip. There will be a continued focus as we move into the new year on urgent and emergency care, the work on developing neighbourhood health and the "left" shift with particular focus on outpatient follow ups within the acute sector. We also received an update on the national quality strategy that is likely to be published in June.

National CEO meeting with new National Director for Mental Health, learning disability and autism

Our Deputy Chief Executive and Chief Operating Officer, Donna Hayward-Sussex attended a meeting on my behalf in April with the new National Director for Mental Health, learning disability and autism. The meeting was attended by the National NHS England Chief

Executive Sir Jim Mackey. NHSE have encouraged the mental health sector to agree our areas of focus for this coming year. There is strong recognition that a focused improvement plan, underpinned by robust evidence, improved data quality, and reduction of unwarranted variation in access and productivity is required in mental health services nationally. Structural challenges remain significant, including ageing estates, rising Children and Young People (CYP) demand, and extremely low access to psychological therapies for people with severe mental illness (SMI), which was consistently reinforced as the overriding priority for all trusts.

We sadly know that variation exists across providers in length of stay, bed occupancy and clinical productivity, with benchmarking expected to be increasingly utilised. Discussions have also started to take place with an explicit expectation to move away from block contract arrangements in the future. Trusts have also been asked to prepare for forthcoming Mental Health Act reforms, including consultations on Sections 135 and 136, with clear communication and readiness for clinicians.

Throughout the day, there was a consistent emphasis on maintaining a sharp focus on SMI, ensuring mental health is fully integrated within Integrated Neighbourhood Teams (INTs), and avoiding parallel system structures. Digital innovation was highlighted as a significant area of opportunity to improve access and reduce waiting times, particularly for psychological therapies, with strong consensus that investment should drive quality and access improvements rather than assumptions around workforce reduction.

The direction of travel was clear: trusts are expected to demonstrate focused delivery for SMI, improved productivity and access, stronger use of data and benchmarking, readiness for legislative change, and a proactive approach to digital and commissioning reform.

This has further been supported with the launch of the new Call for Evidence to shape a new cross-government Mental Health Strategy. The Call for Evidence will be open for eight weeks, closing on 10 July, and I will be encouraging as many of us as possible to engage with this so we can help use our knowledge and experience to shape the future of mental health care for our patients.

Kent and Medway Members of Parliament (MPs) Meeting

The Kent and Medway CEOs met with the Kent and Medway MPs last month to update them on the progress we are making as a wider health system and discuss how they can support us in shaping the future of health services in our system. I look forward to meeting the MPs in a few weeks when they visit our organisation to discuss our vision and future for mental health services.

Kent and Medway System Architecture

We are developing a new system architecture for Kent and Medway to operate within. The architecture is designed to support a system that is operationally, clinically and financially challenged. There will be the following in place moving forward.

- Provider Alliance (all providers within the system including primary care) – chaired by myself

- Neighbourhood Alliance – chaired by Mairead McCormick
- Acute Alliance – chaired by Miles Scott

The two alliances will report into the overarching Provider Alliance meeting, and this forum will provide assurance to the Joint Committee, chaired by the ICB Chair. The Joint Committee is attended by all system Chief Executives and Chairs. In addition, there will be a System Leadership Group (SLG) that is chaired by the ICB CEO that will be attended by all system CEOs. In my role as Chair for the Provider Alliance, I will be deputy chair of SLG. I will keep the Board updated on the programmes of work for each alliance in the coming months.

The Kent and Medway Provider Alliance ("the Alliance") has been established to provide a formal forum for provider chief executives to work collectively on behalf of the Kent and Medway provider system, with a shared focus on delivery, alignment and system improvement.

The Alliance exists to:

- Provide collective provider leadership across Kent and Medway
- Support system delivery of agreed priorities, including financial recovery, service transformation and improved outcomes
- Enable providers to work together at pace on areas where collaboration delivers greater benefit than individual organisational action
- Act as a key component of the Kent and Medway NHS system leadership and governance architecture, working in partnership with the ICB while recognising distinct commissioning and provider roles

Trust Update

Transitioning Trust Board

I wanted to recognise formally today that our longstanding Chair Dr Jackie Craissati will be leaving us at the end of June. I wanted to formally thank Jackie for her incredible leadership of the Trust Board and her outstanding commitment and service, which has made a lasting contribution to the Trust. Jackie will be sorely missed by us all. I want to wish Jackie well for the future.

I also want to take this opportunity to welcome our new joint Chair, Colin Lynch to the Trust. Colin will be the chair of our trust and Kent Community Health Foundation Trust (KCHFT), he will commence his role on the 1st of July. We look forward to the leadership, insight and direction Colin will bring to the trust as we work more closely with KCHFT.

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

I am delighted to confirm that the transfer of Children and Young People's (CYP) Mental Health Services and All-Age Eating Disorder Services (AAED) to KMMH took place on 1 April 2026. The transition was delivered successfully against the success criteria we had agreed with North East London Foundation Trust (NELFT), safely, and with no disruption to

clinical services. I would publicly like to take this opportunity to thank everyone involved in this safe transition of services and to welcome our new colleagues to the trust. We look forward to working more closely with you all and shaping the future of CYP and AAED services in Kent and Medway.

CQC Well-Led Inspection

Following the Care Quality Commission (CQC) Well-Led Review in March, the trust as planned has received a formal follow up letter from inspectors. While we can expect the full and formal report to be shared with us later this year following CQC's internal quality assurance, inspectors have provided high-level feedback confirming themes which were shared verbally with the Executive team, at the end of the inspection.

It is testament to our dedicated workforce that the CQC recognised the strength of leadership commitment across the trust, the openness and honesty with which leaders articulated the challenges we face, and the transparency that CQC experienced throughout the inspection. CQC reflected on our motivated and dedicated workforce, emerging leadership capability, and the progress being made in research and quality improvement. They also recognised areas of excellence in delivery, thoughtful preparation for major service transfers, CYP, and improvements in the experience of colleagues from the global majority. As well as the trust's commitment to co-creation.

At the same time, CQC were clear about the work we need to continue to strengthen governance, risk management, and assurance, and to build greater consistency in how decisions are planned, assessed and implemented. These messages strongly align with the findings of the Moorhouse Review, which we have previously shared with the Board, our staff and partners, and the improvement work already underway, including our Doing Well Together approach.

Overall, the feedback reflects where we are at this stage in our journey to improvement - a trust with clear strengths and direction, making progress on an improvement journey, with further work required to ensure our systems and processes are as strong and consistent as our values and intent. We will provide the Board with a further update ahead of the publication of the full report later this year.

Quality and Safety Update

In a paper to our January Board, I set out very openly about the past year for the trust and stated to the public that while the Trust has always been focused on quality and patient safety, sadly we did not consistently evidence the assurance needed to our communities. I agreed to bring back to the May Board a short **"**what we learned / what we changed**"** public update. Please find attached to my report an update.

Senior Leaders Day

On Friday the 15th May I held our quarterly leaders' event which was attended by 80 of our senior leaders. We used the day as an opportunity to reflect at the start of the day on our recent CQC well led inspection and to plan for taking our new 5-year strategy forward in the

organisation. It was a well energised day with our leaders being open and honest that the well-led inspection had given us time to reflect, be proud of, provide mutual support be open and transparent with each other and CQC, be confident and most importantly tell our story of what we have delivered in the past few years.

LSC Accreditation

We have recently been successfully re-accredited by the Lean Competency System (LCS) to deliver our Yellow Belt training. Yellow Belt forms a key component of our Doing Well Together improvement programme, equipping staff to work on more complex, strategic trust priorities with a structured approach to problem-solving, from clear problem definition and root-cause analysis through to sustainable improvement. This is an internationally recognised qualification certified through LCS and Cardiff University, to date 179 colleagues have completed the training, with 54 formally accredited. This reaccreditation reinforces our commitment to building internal capability and embedding a strong, continuous improvement culture.

Volunteers Week

Volunteers' Week takes place next week, providing an opportunity to recognise the critical contribution volunteers make across the NHS. National reporting introduced in 2024 shows that between September and December last year we recorded the highest number of volunteers and volunteer hours of any provider across Kent and Medway, and the highest volunteer hours of any mental health trust nationally.

This position is further strengthened by our status as the only mental health provider partnered with the Duke of Edinburgh Award, enabling structured, safe, non-clinical volunteering opportunities for young people aged 14–24. This partnership supports early intervention and prevention, strengthens community engagement, and reinforces the Trust's leadership in volunteering and partnership working. I want to say a massive thank you to our volunteers who give their own time and make a difference every day for our patients.

External recognition and awards

As Chief Executive, it continues to be a source of pride to see colleagues recognised for excellence beyond the trust, reflecting both the quality of our work and our wider contribution colleagues make to the system. This month, several colleagues and partners have received prestigious awards:

- Daryl Judges, Deputy Trust Secretary, was awarded the Beatrice Reid Award by the Chartered Secretaries' Charitable Trust
- Jayne Carey, Cognitive Behavioural Therapist, received the Medway Health Care Professional SEND Award

- Dr Ishaq Pala, Consultant Liaison Psychiatrist, was named College Tutor/Departmental Education Lead of the Year at the Medical Education Leaders UK Awards
- Canterbury Christ Church University, our key research and education partner and provider of nursing apprenticeships, was recognised as Nursing Apprenticeship Provider of the Year at the Student Nursing Times Awards 2026

These achievements demonstrate the strength of our clinical leadership, education partnerships, and commitment to delivering high-quality care.

Sharing our story

As a trust, we remain committed to showcasing the impact of our colleagues' work in delivering innovative, high-quality care for the communities we serve. Since the Board last met, there has been strong local, regional and national media interest in our work. Colleagues have contributed to a range of broadcast and print coverage, including the *Daily Telegraph*, BBC Kent, ITV's *This Morning*, and local press.

This coverage has highlighted our innovative approaches, including the use of AI-enabled tools and therapeutic interventions such as reptile therapy, alongside our continued focus on improving performance and patient outcomes. It reflects growing external recognition of both the quality of our services and our commitment to continuous improvement.

I would like to thank colleagues who have supported this work by sharing their expertise and experience. Their contribution—often alongside their core roles—plays an important part in strengthening our reputation, building confidence in our services, and ensuring the positive difference we are making is visible to patients, partners and the wider public.

Value in Practice Awards

We continue to receive lots of nominations for our trust Value in Practice Awards. Please see the appendix for the latest winners – a massive congratulations to you all, it is always the highlight of my week reading the reasons to celebrate our staff and all the fantastic care they provide for our patients.

Summary and Conclusion

As I have said at the start of my report today, the next 6 months for us will be about us transitioning as a Board, what I do know is this will not impact on the determination and ambition myself and my team have for the organisation and the population we serve. I look forward to us welcoming new colleagues and to us formally launching our new five-year strategy in June. Receiving the high level CQC well-led inspection letter has re-enforced for my team and I that we have built a solid foundation for us to move forward on over the next few years. We have a strong position in the wider health system within Kent and Medway and the contribution we can make to the future vision of the system is widely recognised.

Sheila Stenson
Chief Executive
28th May 2026

Executive Team Visits

Sheila Stenson:
Canterbury Wards : Bluebell, Fern, Foxglove
West Kent Memory Assessment Service
West Kent EIP and Neuropsychology
Briton House

Donna Hayward-Sussex
Albion Place – Maidstone - MHT, MHT+
Dartford CYP
Dartford MHT/MHT+ and EIS
Ashford and Canterbury MHT+
Canterbury CYP

Julie Kirby

Canterbury wards
Woodchurch and Sevenscore ward in Thanet and Rivendell Rehabilitation Unit
PICU, Dartford
Ashford and Canterbury Memory Assessment Service (MAS)

Kindra Hyttner
East Kent, Mental Health Plus, Old Age
Occupational Therapy at Broadview, Dartford

Nick Brown
Canterbury wards : Bluebell, Fern, Foxglove

Adrian Richardson
Liaison, Diversion and Reconnect
Rosebud Rehabilitation
111 Tonbridge Road

Value in Practice Awards

Directorate	February	March
North	Caroline Joseph, Administrator	Shannah Hall, Advanced Clinical Practitioner
East	Lisa Jones, Administration Assistant	Sarah Potter, Liaison Psychiatry, Thanet
West	Yee Ping Chan, Call Handler	David Torto, Community Psychiatric Nurse
Forensic	Eleanor Green, Healthcare Assistant	Maria Court, Administrator
Support services	Anne Clark, Post Graduate Administrator, Medical Education	Nathan Lucas, Workforce Information Manager
Acute	Jennifer Wheeler, Acute Matron	Thomas Turbefield, Ward Manager

What we learned / What we changed

Public update – May 2026

Key area	What we learned	What we changed
Independent scrutiny and assurance	We recognised that further independent scrutiny was needed to strengthen learning and assurance, particularly in relation to patient safety, liaison services, and deaths where substance use was a contributing factor.	We have started three independent external reviews focusing on psychiatric liaison services, the patient safety team (including how learning is embedded), and patient deaths over the past two years where drug or alcohol use was relevant. All three reviews are underway and are expected to be completed by the end of July 2026.
Leadership oversight, escalation and accountability	We identified the need for clearer and more consistent leadership oversight, communication and escalation routes to support timely assurance and shared understanding of patient safety risks.	We have introduced Executive patient safety briefings and a clear communication pathway from the patient safety team, through the Chief Nurse, to Executive and Board colleagues. We have also held workshops with directorate leadership triumvirates to strengthen leadership, clarify accountability and responsibilities, and reinforce expectations for safety, quality and learning.
Consistency of practice and documentation	Learning showed variation in the quality, clarity and consistency of meaningful documentation that supports safe care.	Our Quality Improvement Plan (QIP) focuses on four themes: safety and risk; access and waiting; environment, equity and experience; and

		leadership, governance and culture. Within the safety and risk theme, we have focused on improving the quality, clarity and consistency of risk assessments and care plans, emphasising standardisation and meaningful documentation rather than simple completion. We have introduced clear quality oversight by matrons, supported by regular audits focusing on formulation and safety planning. Governance of the QIP has been strengthened with a revised governance structure, providing clearer assurance routes and improved feedback loops.
CQC findings and regulatory feedback	We learned that many of the themes identified by the Care Quality Commission were consistent with findings from independent reviews, particularly in relation to governance and quality oversight.	We are working closely with our CQC colleagues and underwent a Well-led inspection in March. Initial findings were aligned with the Moorhouse independent review. Areas for strengthening include governance and quality oversight, which we are addressing through the QIP and refreshed corporate governance arrangements including committee workplans and the Board Assurance Framework. One element of the Section 29A warning notice issued after the

		March 2025 community inspection has been lifted. We remain in discussion regarding the element relating to the Health Based Place of Safety; however, there have been no reported Mental Health Act breaches for two consecutive Mental Health Act Committee meetings. We also received positive initial high-level feedback following inspection of our community mental health learning disability services earlier this year.
Embedding learning from patient safety incidents	We recognised the need for a consistent, Trust-wide approach to sharing learning from patient safety incidents and ensuring this learning informs improvement.	We have embedded our Patient Safety Incident Response Framework (PSIRF) Learning Review Group (LRG). This is an Executive-led forum with representatives from each directorate, where learning is shared across the Trust. It acts as the approval forum for all After Action Reviews (AARs) and Patient Safety Incident Investigations (PSIIs).
Managing change within the organisation	We learned from previous change programmes, including community transformation work, that we needed to improve how change is planned and supported across the organisation.	We applied this learning and staff feedback to the transition programme for Children and Young People's Services (CYP) and All-Age Eating Disorder Services (AAED). These services transferred safely to the Trust as the new provider on 1 April, and the transition went smoothly and safely. Initial

CQC Well-led feedback recognised that learning from previous change programmes had been applied effectively and viewed the transfer programme positively.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	The Board Assurance Framework – Current Position and Developmental Programme
Author:	Louisa Mace, Risk Manager (with input from Andrew Hughes, ANHH Consulting)
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Assurance and Approval
Submission to Board:	Regulatory Requirement

Overview of paper

This paper presents the current iteration of the Trust's Board Assurance Framework as an interim position, pending the development of a new, strategy aligned BAF.

The BAF continues to set out the principal risks to delivery of the Trust's pre-April 2026 strategic objectives and provides the Board with a view of risk exposure, controls, and ongoing management action. The current version reflects the position as reported to Board in March 2026, with updates to narrative and assurance.

The Executive Team has reviewed the position and agreed that it remains important for the Board to receive the BAF at this time to ensure continuity of oversight of strategic risk, whilst recognising that the framework itself is work in progress and will be substantively and substantially redesigned.

The current BAF therefore acts as a bridging position, maintaining visibility of the Trust's key risks while the new model is developed. This development is part of the overall trust governance improvement plan

Issues to bring to the Board's attention

The existing BAF was received by the Audit and Risk Committee on 11 May. The Committee expressed concern that it was not yet aligned to the new Strategy.

This report provides the existing position with the BAF noting it needs development. The report describes the process that will be followed in the coming months to coproduce and implement a new BAF and reporting process.

Version 2 - **Public**

Governance	
Implications/Impact:	Patient safety/legal
Assurance:	Limited Assurance
Oversight:	Audit and Risk Committee

What the current BAF is telling the Board

The Trust faces a sustained set of high-level strategic risks, with multiple areas outside appetite

The BAF highlights a concentration of “extreme” risks (scores 15–16) affecting core areas of service delivery, including demand (memory services), patient safety (self-harm), flow, regulatory compliance, and delivery of key transformation programmes. In addition, cyber risk and financial sustainability remain significant pressures.

A large proportion of these risks are formally outside the Trust’s agreed risk appetite, indicating a high level of residual exposure across several strategic domains.

The overall risk profile is stable but largely unchanged, with limited evidence of downward trajectory

Since the last Board review in March 2026, there have been no changes in risk scores, no new risks added, and none removed. While some risks show incremental management progress, they have not yet translated into reduced risk ratings, suggesting that either controls are still maturing or they are not yet having sufficient impact or worst, that they are the wrong controls.

The BAF therefore presents a static risk position, with limited visibility of movement toward target states.

Key pressures are well understood and actively managed at operational and programme level

Narrative updates demonstrate that actions and controls are in place across major risks, including programme reviews (e.g., community transformation), targeted safety interventions (self-harm), cyber resilience testing, and financial planning. Emerging risks are also being actively horizon-scanned, including digital transformation, leadership capacity, and service transfer risks.

This indicates that management focus and operational grip are present, even where strategic risk exposure remains high.

Financial and transformation risks are being actively managed but remain structurally challenging

The Trust has delivered its in-year financial plan and submitted a compliant medium-term financial strategy, albeit with conditions and ongoing pressures (notably inpatient costs and out-of-area placements). Similarly, major transformation programmes (e.g., Community Mental Health Framework) are described as having credible plans in place while still carrying high risk due to scale and complexity, reinforcing the longer-term nature of risk reduction in these areas.

Diagnosis of the current BAF

The Board should understand that the current BAF:

- Is aligned to the previous strategic framework, and not yet fully aligned to the emerging strategy
- Contains a mix of strategic and operational risks, which dilutes Board-level focus

- Provides broad coverage and regular reporting, but is stronger as a risk register than as an evaluative assurance tool
- Does not yet consistently demonstrate the “golden thread” from strategy through to risk, assurance, and impact

Notwithstanding these limitations, the BAF provides baseline assurance that:

- Key risks are identified and visible
- Management actions are in place
- Emerging risks are being horizon scanned and will be incorporated as appropriate

The framework continues to capture a comprehensive set of risks, align them to risk appetite, and provide regular reporting to Board and committees, supported by executive oversight. The absence of risk movement, combined with the breadth of risks included, suggests that the BAF is currently stronger as a reporting and tracking mechanism than as a driver of strategic prioritisation or decision-making.

Development of a new BAF

Work is now underway to develop a new Board Assurance Framework, based on the risk–cause–effect model aligned to NHS England and CQC well-led guidance.

This will:

- Define a clear set of enduring strategic risks and describe the changing causations that could result in the risk occurring. At this early stage initial proposals suggest 7 strategic risks.
- Strengthen the linkage between strategy, risk, controls, assurance, and impact
- Introduce evaluative assurance and control effectiveness measures
- Provide a more focused and Board-driven approach to risk management

The intention is to bring forward a redeveloped BAF for Board consideration in the July 2026, following Executive, Committee Chair, and Committee engagement, and a dedicated Board seminar to confirm the architecture and risk set. The aim is to have a full finalised revision for September 2026 board.

The output will be a strategic delivery tool that drives prioritisation, investment, and transformation, while meeting regulator expectations for high performing organisations. The visualisation and format of the BAF will align with the KCHFT model but will be populated with a spine of KMMH-relevant content.

Success in outcome will depend less on design and more on discipline of use: a Board that actively owns, interrogates, and acts on its principal strategic risks and causations.

For information at this stage, the proposed seven core strategic risks are:

SR1. There is a risk that the Trust will not consistently deliver safe, high-quality, and compassionate care.

SR2. There is a risk that the Trust will not achieve financial sustainability or deliver value for money.

SR3. There is a risk that the Trust will not maintain secure, resilient, and interoperable digital systems.

SR4. There is a risk that the Trust will not maintain a safe, therapeutic, and fit-for-purpose estate.

SR5. There is a risk that the Trust will not attract, recruit, retain, and develop a sustainable, engaged workforce.

SR6. There is a risk that the Trust will not maintain effective governance, leadership, and organisational culture.

SR7. There is a risk that the Trust will not effectively collaborate with system partners to deliver integrated care.

These proposed risks are in early stages of development and will aim to provide a stable and enduring strategic framework, with all emerging issues treated as causes within these risks, not new risks Included in the redevelopment will be the alignment to the new recently launched strategy.

Level of assurance provided

The current BAF provides **moderate assurance** that the Trust has visibility and management oversight of its principal risks.

However, assurance is constrained by the maturity of the framework, particularly:

- Limited evidence of risk movement
- Variable clarity on control effectiveness and impact
- Incomplete alignment to the refreshed strategy

The redevelopment programme is intended to address these limitations and strengthen the BAF as a core strategic tool for decision-making and assurance.

Recommendations for Board decision

The Board is asked to approve the board assurance framework as per the risk management framework section 5:

The Trust Board on receipt of the Board Assurance Framework reviews the content and prescribes corrective action where a risk falls outside of the agreed risk appetite. The Board Assurance Framework presents an assessment of the strength of internal controls in place to reduce the likelihood and impact of a key risk materialising and it defines the

main sources of internal and external assurance regarding the effectiveness of those internal controls.

Conclusion

In receiving the current BAF, the Board retains visibility of the Trust's most significant risks during a period of transition, but it should be regarded as an interim mechanism rather than the end-state assurance framework.

The priority is to move to a more strategically aligned, evaluative, and decision-focused BAF, consistent with regulatory expectations and the Trust's development trajectory.

Updated: 18 April 2026

Board Assurance Framework

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

Kent and Medway Mental Health NHS Trust

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMMH remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment or services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years.	5	5	25	System wide response to achieve improved Memory Assessment services across Kent and Medway through the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative and Ageing Well Board. □ - BI Functionality to drive performance at team, directorate and organisational level - Stand alone assessment model formed, currently being optimised through Tiered Accountability work - Completing the Demand and Capacity for the multi-disciplinary model for memory assessment within KMMH (to be rolled out across the organisation) - Community Model Task Force formed comprising KMMH and wider NHS and VCSE partners.	Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team Highlight reports to Trust Leadership Team, FBI and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	4	4	16	⟷

Actions to reduce risk	Owner	Target Completion (end)	Status
Phase 2: Launch of multi-disciplinary assessment model within KMMH	Director of Partnerships and Transformation	Parked (To review in 6 months)	
Optimisation of phase 1 stand-alone model	Director of Partnerships and Transformation	29/05/2026	A
Phase 2 resourcing and implementation	Director of Partnerships and Transformation	Parked (To review in 6 months)	
Resourcing and roll-out of community model alongside ICB and community services	Director of Partnerships and Transformation	29/05/2026	A
Scoping impact of Improved DDR rate on Dementia pathways	Director of Partnerships and Transformation	06/04/2026	R

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

12/06/2024 — Risk Opened

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend
ID 08065	Jun 2024	Chief Medical Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	4	20	Patient flow team jointly working with Liaison Psychiatry, Home Treatment and community services on case by case basis to ensure each admission is purposeful, and inappropriate admissions are avoided. At the same time, we are ensuring that the clinically ready for Discharge patients get the right support in a timely manner so that they spend the least amount of time, beyond what is clinically relevant, in hospital. Twice daily reports including the Place of Safety Breaches Daily system calls Daily bed flow call chair by the Deputy Chief Operating Officer to examine demand, capacity, escalations, 7-day discharge trajectory and complex case review. This can increase twice a day if OPEL 4 is triggered. Daily bed flow meeting is clarifying reasons for admission and alternative to admission to support purposeful admission. Winter plan underpinned by NHSE Mental Health OPEL Framework. Local and system escalation of delayed discharge as required. CORE 24 rolled out across all acute hospital's liaison teams CRFD programme of work underway to release capacity within the KMMH bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review CRFD Programme is a system wide programme in conjunction with the ICB, Local Authority and supported through the Provider collaborative. Review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts to be able to accurately measure patients waiting in EDs for Beds. Use of VCSE partners to support CRFD onward transition. As at January 2026, 25 patients have used this pathway. Clarendon House commissioned 13 beds to support people who are Clinically fit for Discharge with onward pathway thus improving capacity in Acute Psychiatric bed stock. This has saved 1374 bed days so far (January 2026). Working with the ICB to explore additional step-down capacity. Red to Green and purposeful admission methodology in	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
Recovery Houses across the County	Deputy Chief Operating Officer	BLOCKED	
Expand Step Down and Community Capacity for those patients with a higher risk profile currently as CRFD on the wards.	Chief Medical Officer	30/04/2026	R
Maximising Crisis and Home treatment team support to wards for early discharge	Chief Medical Officer	30/04/2026	R
Trusted assessment model with social workers released from KMMS to support CRFD discharge	Chief Medical Officer	30/04/2026	R
Improving proactive early discharge processes on the ward with support from the Acute Directorate.	Chief Medical Officer	30/06/2026	A
Increased use of VCSE providers for ongoing support, housing, and social inclusion	Chief Medical Officer	31/07/2026	A
Enhanced social care presence on the wards	Chief Medical Officer	31/07/2026	A

Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
Chief Medical Officer	Outside of Tolerance	1	3	3	30/03/2027

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)
							operation on all wards to support discharge. Temporary employment of 2 social workers to support discharge and high levels of CRFD at Littlebrook Hospital and Priority House.						Directorate based beds	Chief Medical Officer	31/01/2027	A						
													Shared discharge pathways	Chief Medical Officer	31/01/2027	A						
	12/06/2024 Risk Opened																					
ID 08157	Aug 2024	Chief Operating Officer	**Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.** If we do not provide the right intervention to the right people due to extraordinary demand that matches the right capacity to provide accessible and responsive treatment and/or support THEN we will a) not be able to understand and meet peoples need in a timely manner b) delay commencement of treatment and/or support RESULTING IN poor service user experience, a potential risk to safety and a delay in meeting the outcome that are important to them.	5	5	25	Community Mental Health Programme milestone plan to implement change to service, which will support access, waiting times and case load management. - Daily review of waiting lists at service level, weekly review of waiting list at operational level (led by service directors) and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. - Actions in place to reduce the overall caseload for MHT and MHT plus, which will support transition to a new approach, which will be completed by April 2026. - Review of the front door are underway as part of the Community Mental Health Programme refresh, and it is agreed that we will launch the Medway Approach. - The COO agendas referrals, waiting times and caseload at their operational report meeting, to understand exception reporting. This is also scheduled regularly at the Quality Improvement Plan CQC Huddles on at least a monthly basis. - Review underway to simplify the mechanism for managing contacts and waits, this includes the DIALOG plus being launched as the initial assessment, care plan and baseline outcome at the point of triage in Q4 2025/26. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse. - A new approach to managing people waiting over 15 weeks is being developed with the service directors to ensure there is a consistent approach to waiting well system. - Referrals, waiting lists and caseload are subject to review and action at the directorate and trust wide SDR process. - Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse.	Robust team level management Dashboards Caseload management tool Partnership Forums	4	4	16	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer	Outside of Tolerance	3	3	9	**31/12/2026**
													Effective waiting time management of people waiting over 18 weeks	Deputy Chief Operating Officer	COMPLETED	G						
													Implementation of Demand and Capacity Modelling	Deputy Chief Operating Officer	30/04/2026	R						
													Risk Assessment compliance *All teams to deliver the Trust Quality Improvement Plan for Risk Assessment compliance*	Deputy Chief Operating Officer	15/06/2026	A						
													Implementation of Care Navigation at the Point of Access (East and West Kent)	Deputy Chief Operating Officer	05/10/2026	A						
													Compliance with DIALOG plus at initial contact	Deputy Chief Operating Officer	31/12/2026	A						
1.2 - Creating safer and better experiences on our wards																						
	04/12/2014 BAF Risk Opened; 20/07/2023 Risk returned to BAF																					
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** **<u>Risk Statement</u>** If the Trust does not effectively manage violence and aggression, staff and patients may be exposed to physical and psychological harm. **<u>Impact</u>** This may result in: Increased use of restrictive interventions (including restraint and seclusion) Prolonged recovery for patients Reduced staff confidence in managing and reporting incidents Increased staff sickness absence and reduced workforce capacity Challenges in delivering safe, high-quality care Reduced staff retention and recruitment difficulties Reputational damage Reduced willingness of agency/bank staff to work in high-risk environments Lower staff engagement in violence reduction initiatives	5	3	15	Key Controls (Current Position) Restrictive Practice Framework (policy, guidance and oversight) Violence Reduction Strategy with aligned Trust workstreams (including inpatient and racial incident reduction) Continuous Improvement Approach supporting QI methodology and local interventions Personal Safety and Security (PSS) and Security Strategy, including CCTV where available Compliance with Use of Force Act and Operation Cavell Supporting clinical policies (e.g. therapeutic observations, ligature risk, safer staffing) Incident reporting and monitoring via InPhase, supported by Quality Improvement data	Incident reporting via InPhase Quality Improvement Data / Staff surveys	4	3	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Nurse	Outside of Tolerance	2	3	6	**31/03/2027**
													Improvement project is in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. Now testing directorate level assurance phrase.	Deputy Chief Nurse	30/07/2026	A						
													Enhance data-driven oversight and learning - Develop integrated reporting and thematic review of violence and aggression incidents, using InPhase and workforce data to identify hotspots and ensure learning is fed back to teams.To report into new Patient Safety and Quality Assurance group	Deputy Chief Nurse	31/08/2026	A						
													New Violence and Aggression Policy 2025	EPR Lead	COMPLETED	G						
													Violence and Aggression Listening Sessions to be held with Community Teams	Diversity and Inclusion Manager	COMPLETED	G						
													Allyship Training for Community and Children and Young People Teams	Diversity and Inclusion Manager	12/04/2027	A						

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
2 - We are a great place to work and have engaged and capable staff living our values																			
2.1 - Creating a culture where our people feel safe, equal and can thrive																			
30/01/2025 → BAF Risk Opened																			
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Delivery of Strategic Ambitions** If there is an inconsistent culture across the trust, with pockets of excellence alongside areas of closed and poor culture, then phycological safety, openness and willingness to learn and improve are not consistently embedded. Resulting in the potential for reduced staff engagement and retention, weakened speaking up, further inconsistent practice, increase incidents and complaints, and increase regulatory scrutiny impacting the delivery of safe, effective and equitable care and the Trust strategic ambitions.	4	4	16	Leadership and Management development programmes Work to introduce and embed new and coherent organisational values Delivery of leadership development programme Delivery of equality, diversity and inclusion interventions Delivery of 'Doing Well Together' and improvement capability building Prioritisations and regular review of Strategic Priorities and capacity	Staff Survey results Pulse Survey results	3	3	9	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Leading Well Together programme — Deputy Chief People Officer — 29/05/2026 — A Embedding of staff voice initiatives — Deputy Chief People Officer — 14/12/2026 — A Improving Change Management Processes — Deputy Chief People Officer — 31/03/2027 — A	Chief People Officer	In Appetite	2	3	6	31/03/2027
2.2 - Building a sustainable workforce for the future																			
			No Risks Identified against this Strategic Objective																
2.3 - Creating an empowered, capable and inclusive leadership team																			
			No Risks Identified against this Strategic Objective																
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																			
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																			
			No Risks Identified against this Strategic Objective																
3.2 - Working together to deliver the right care in the right place at the right time																			
			No Risks Identified against this Strategic Objective																
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																
4 - We use technology, data and knowledge to transform patient care and our productivity																			
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																			
22/07/2015 → Risk Opened → 15/06/2025 Risk escalated to BAF																			
ID 04673	Jul 2015	Chief Finance and Resources Office	**Organisational Risk - Cyber Attack** IF the Trust is the victim of a successful cyber attack THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation.	4	5	20	Robust security firewalls in place [1d] Cyber Resilience and Response plan [2e] Disaster Recovery Plan [2e] End point devices are patched [1d] Horizon scanning [1h] Link with National Alerting and Notification systems (1h) 'Nexthink' alert system [1h] Links to HSCN/KPSN [2f] Annual Pen Test and Audit [3d] DSPT [2c] ISO 27001 [3f] Evidence gathering from suppliers (stored in Spoint) [1c] IT Health [1h] Pentera [1h] Automatic driver and firmware updates [1d] Moving systems on to Same Sign On [1d] Single sign through OKTA [1d] Business Continuity Plans - Service and IT Systems Annual Audit of IT systems Business Continuity Plans Cyber Resilience Exercises Cyber Essentials Multi-Factor Authentication Varonis MDDR [1d] DHCP snooping [1d] Understood Controls Diagram (2025) [1d] Overarching Records Management Policy - uplift for protracted incident on paper mitigation [2e]	ISO27001 Internal Audit Cyber Essentials (2025) DSPT CAF EPRR Annual Assurance Programme	3	5	15	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Completion of short term actions from the Cyber Exercise and further exercise planned for Spring 2026 — EPR Lead — COMPLETED — G Completion of medium term actions from the Cyber Exercise — EPR Lead — 02/10/2026 — A Implementation of the Cyber Action Plan — Deputy Director of Digital — 31/03/2027 — A	Chief Finance and Resources Office	Outside of Tolerance	2	3	6	29/03/2027
4.2 - Enhance our use of IT and digital systems to free up staff time																			
			No Risks Identified against this Strategic Objective																
4.3 - Effective digital tools are in place to support joined-up, personalised care																			
			No Risks Identified against this Strategic Objective																

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Risk Appetite	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5.3 Transform the way we work																			
19/01/2026 Risk Opened																			
ID 08480	Jan 2026	Director of Communications and Engagement	**Risk to stakeholder confidence** If heightened scrutiny following CQC activity and political / regulatory engagement leads to renewed attention on Trust performance and historic themes, Then media and stakeholder challenge may increase and escalate rapidly, particularly where complex issues are misunderstood or reported without context, Resulting in loss of confidence among patients, carers, staff and partners, increased regulatory and political scrutiny, workforce impacts, and reduced capacity to focus on and deliver improvement.	4	4	16	Executive-led issues management, escalation process and stakeholder management for sensitive matters Routine media monitoring and issues horizon scanning Coordinated handling of enquiries and reputational issues across communications, quality/safety, safeguarding, HR and legal Established governance for incidents, complaints and duty of candour Reactive briefing materials maintained for high-risk themes and external milestones A structured comms approach ahead of known scrutiny milestones. Proactive strategic storytelling to evidence improvement and learning, supported by updated briefings for senior leaders and services. Crisis Communications Plan Business Continuity Management Policy	Board oversight through formal committee and assurance reporting routes	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Development of a Media Training Plan — Deputy Director of Communications and Engagement — 31/03/2026 — R Development of a media and communications dashboard to enable thematic reviews — Head of Communications and Marketing — 01/06/2026 — A Development of a new process for responding to Out of Hours Media contacts — Head of Communications and Marketing — 30/09/2026 — A Improved process for the triangulation of data to include consideration of an ICB approach, potentially through the purchase of a media monitoring system — Deputy Director of Communications and Engagement — 30/09/2026 — A	Director of Communications and Engagement	Outside of Tolerance	3	3	9	27/03/2027
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
29/03/2024 Risk Opened																			
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in refreshing its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FBI regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** To complete the Annual ERIC Return — Deputy Director for Estates — COMPLETED — G Tender for 6 Facet Survey — Deputy Director for Estates — 30/03/2026 — R CAMHs Estate due diligence to understand and identify risk level within current estate and inform future investment needs — Deputy Director for Estates — 31/03/2027 — A	Chief Finance and Resources Officer	In Tolerance	2	3	6	31/03/2027
01/04/2020 Risk Opened																			
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Services Business Continuity Plans	Reporting to FBI TIAA Audit Contract Monitoring Minutes	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of the present hybrid working arrangements — Director of Estates and Facilaities — 31/03/2026 — R	Chief Finance and Resources Officer	In Appetite	2	3	6	08/04/2027

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	28th May 2026
Title of paper:	Sustainable Communities Provider Collaborative Progress Report
Author:	Julia Hart, Acting Director Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This paper provides an update on work of the Sustainable Community Care Collaborative.

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

This report includes:

- An update on progress in Community Mental Health Framework (CMHF).
- Neighbourhood Health programme plan updates.
- An update on key performance metrics including UEC.

Areas to bring to the Board's attention

- Updates on the refinement for the CMHF Model of Care
- Progress made against the NHS England national Enhanced Therapeutic Observations and Care programme in Kent and Medway
- Agreement to have nine Multi Neighbourhood footprints working in partnership with the 45 Single Neighbourhoods
- UEC Mental Health saw a continued decrease in A&E presentation numbers in 25-26

Version control 02 - **Public**

- The Kent & Medway system architecture has evolved, the work of the Sustainable Community Provider Collaborative will now form part of the Neighbourhood Health Collaborative moving forward.

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

Kent and Medway Mental Health NHS Trust

1. Board reporting – programme update forward plan for 2026-27

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

2. Programme updates May 2026

2.1 Kent and Medway Community Mental Health Framework (CMHF)

This section provides an update on the Mental Health Together element of the community mental health transformation. The CMHF team have agreed refinements to the model of care, working through their multi-disciplinary and multi-agency workstream to ensure meaningful engagement across partnerships.

Further to the CMHF update in March 2026, the following has been undertaken:

- Defined the low to medium interventions and the medium to high pathways.
- Task-and-finish groups established to improve the duty function and medical support, and to develop clear guidance for the low-to-medium and medium-to-high pathways. A partner group has been set up, to operationalise low to medium interventions and ensure triage is swift and understandable to all agencies.
- Locality plans have been produced for the short/medium term to enable operationalisation of the refined Model of Care. This ensures a common approach to operationalisation, considering locality nuances.
- Completion of demand and capacity modelling to inform staffing requirements occurred in March 2026.
- Work has commenced both with partners and internally to understand impact and planning required for the refined model.
- A training needs analysis is underway, which is due in May 2026.
- Agreed RiO will be retained across all partnerships to support improved continuity of care and reduction of referrals between services.

The programme continues to address safety and risk priorities through alignment with feedback from the CQC to ensure relevant learning and recommendations are embedded as part of the refined model and to create a single, consistent message for staff.

In line with the communication plan, further actions have been undertaken or are planned including: interviews with key members of staff to explain the benefits of the refined model of care; ‘Natter with Neil’ sessions to give staff opportunity to feedback; an animation explaining the patient journey and regular staff briefings using a range of media.

Key performance indicators are being finalised, as part of the Integrated Quality and performance Report (IQPR). These will be monitored in the directorate strategy deployment quality review

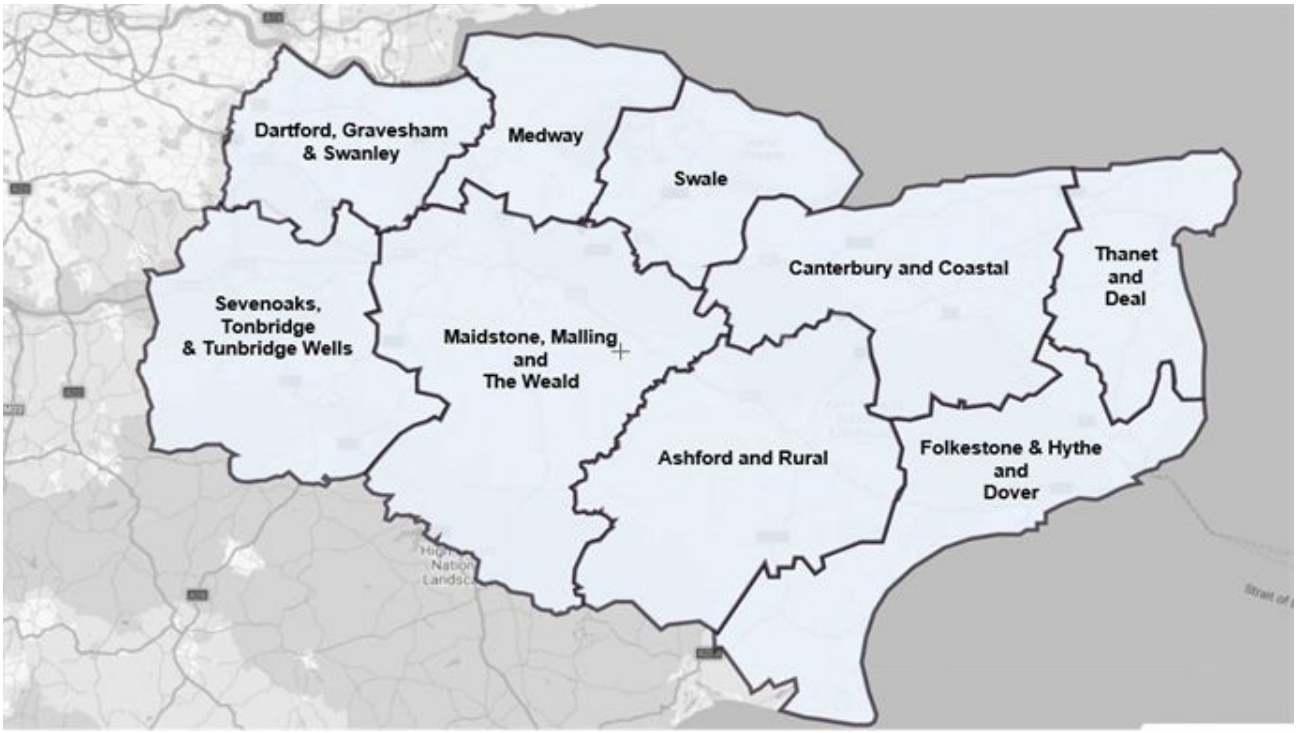
meetings (SDQR). There will be a move to a 4-week assessment target with patients expected to be in treatment within 18 weeks of referral.

The table below outlines progress against key CMHF milestones by workstream.

Workstream	Milestones	Timelines	Comments (as at 20/4/26)
Model of Care Delivery	Working with partners to further define the triage model (based on the Medway approach)	May 2026	Partner workshop on 27 April to agree the operationalisation of triage
	Consolidate explicit guidance for interventions and pathways: • Medium to high pathways • Low to medium interventions	May 2026	Two task and finish groups set up as part of Model of Care Delivery workstream in March to look at explicit guidance for low to medium interventions and medium to high pathways and interventions. High level information on medium to high pathways and interventions was produced in March, to inform this work
	Complete task and finish group for Duty and urgent referral process	May 2026	To define and agree Duty provision within the refined Model of Care with a standardised approach
	Locality planning	Mar 2026	Locality plans for April-July completed
Workforce	Review demand and capacity modelling and costing to inform workforce planning	Apr 2026	Completed with workforce workstream, with staff group updates and engagement planned from early July onwards
	Training needs analysis and plan to transition from existing to refined interventions/pathways	May 2026	Task and finish group in place. Some training has commenced
	Staff and partner engagement	Ongoing	Linked to the comms and engagement workstream
Comms and engagement	Ongoing engagement with staff and partners, using a range of media, as part of a wider campaign	Ongoing	Video completed Animation approved Further briefings planned
	Development of FAQs	Complete	1st set of FAQs circulated
	Patent engagement approach	May 2026	To follow staff engagement
	Feedback tools in place	Feb - May 2026	Staff feedback mechanisms in place Patient feedback tools to be developed in May
Data/digital	Options paper to define the impact of the refined model of care on data and digital usage/practices	Apr 2026	Completed
	Confirm core KPIs to measure success	Apr 2026	Progressing - Moving to a 4-week assessment target with patients expected to be in treatment within 18 weeks of referral
Finance & commissioning	Co-design specifications, timeframes and outcomes	May 2026	Partnership committee in place to take forward managing partnership contracts
	Evaluate impact of the refined model and plan for longer term procurement	Jan 2027	

2.2 Progressing Neighbourhood Health plans across the county

Since the last Trust Board meeting it has been agreed that there will be nine Multi Neighbourhood footprints that will work in partnership with the 45 Single Neighbourhoods, which are broadly aligned to the current Primary Care Network footprints. Multi-neighbourhood footprint population and geographical areas are highlighted below.



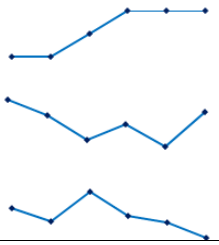
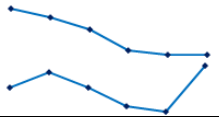
A series of in-person engagement events explored *What Matters Most* to members of the public; with these events identifying the following themes:

- **Access to services** | a simple system which gives a clear understanding of how to access care and where to go. A single, trusted point of access for everyone regardless of a person's circumstances e.g. homeless
- **Communication and clear narratives** | use of plain language which is consistent across the Kent and Medway system. Ongoing communication and feedback on progress and involving people in the development
- **Trust and continuous care** | people not expected to repeat their story and are treated as experts in their own lives. Care is continuous and well-coordinated between staff and support organisations.

Informed by learning from public engagement, the Folkestone & Hythe National Pilot site and the Chatham South East Accelerator Site, alongside the ICB are now actively working with stakeholders to commission to the agreed Kent & Medway Neighbourhood Model.

We are also reviewing the programme of work in alignment with the Neighbourhood National Framework which was published on the 17th of March Neighbourhood health framework - GOV.UK. During 2026-27 we will continue to work with Health and Wellbeing Boards to develop Neighbourhood plans. A system-wide Communications and Engagement Group is now established and will shortly be developing public facing communication to support Neighbourhood Health.

3. Current performance data

Measure	Agreed trajectory	Current data						AVG	Line Graph	RAG
		Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26			
Methodology: RAG is determined by two factors; • Agreed target, or • Averages. These are compiled based on performance data for the previous 6-month financial period covered and may therefore change for the report period being covered. The RAG rating reflects this same 6-month period. • A 10% tolerance is proposed for attributing an amber status within the respective data point cell.										
		Programme: Dementia Pathway Transformation								
Increase dementia diagnosis rate	66.7% by March 2026	62.3%	62.3%	62.1%	62.0%	62.0%	62.3%	N/A		
		Programme: Mental Health Urgent and Emergency Care								
Reduced MH A&E attendance and increase in attendance at safe havens	Reduce Reduce Increase	*% MH A&E presentations against total presentations* 1.7% / 1.7% / 1.8% / 1.9% / 1.9% / 1.9% *A&E attendances for adult patients with primary MH need* 866 / 805 / 713 / 771 / 688 / 820 *Safe Haven attendance* 1811 / 1753 / 1887 / 1778 / 1748 / 1681						1.82% 777 1776		
Crisis house bed occupancy	85%	*Medway bed occupancy* 85% / 83% / 80% / 75% / 74% / 74% *Ashford bed occupancy* 80% / 90% / 80% / 68% / 65% / 94%						N/A		
Reduced mental health in ambulance/ police conveyances to A&E	Reduce	*Primary MH A&E presentation - Ambulance conveyance* 410 / 381 / 346 / 399 / 375 / 424 *Primary MH A&E presentation - Police conveyance* 38 / 24 / 31 / 23 / 50 / 51						389 36		
Reduction in incidence of Section 136	Reduce	68	58	66	73	55	54	62		

Exception reporting on performance

- MH A&E attendances were 1.8% of total A&E presentations in 2025/26. In 2024/25 they were 1.9% and 2.65% in 2021/22.
- Over the last 2 years, there has been a reduction, moving from a total of 8727 MH presentation in 24/25 to 8700 in 25/26.
- Local variation remains with East Kent UEC services seeing on average 5% of their total A&E attendances being for MH during 2025/26. This is being addressed as previously reported on and is also part of wider flow and clinically ready for discharge system wide work.
- The decline in MH A&E attendances during 2025/26 has been accompanied by a positive increase in footfall to the Safe Have sites, comparing 2024/25 with 2025/26 overall attendance increased by 20%. The Ashford crisis house is at 94% occupancy, however Medway remains at 74%.

4. Programme Milestones for 2026-2027

Milestone Tracking Key

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

Community Mental Health Framework					
Milestone	**25-26**	**26-27**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**
Demand and capacity for MHT+ workforce productivity	X				
Development of refined operating model to support delivery of agreed clinical model (to incorporate demand/capacity, workforce, digital, estates and contracting)			X		
Transition and sustainability of refined clinical and operating model to BAU				X	
Implementation of new CHYPS AMS pathway into the CMHF			X		

Dementia Pathway Transformation				
Milestone	**26-27**			
	Q1	**Q2**	**Q3**	**Q4**
Level 1 – Continuation to roll out new care home diagnosis process and training across the county	X	X		
Level 1 – Additional funding for primary care supporting level 1 and 2 dementia diagnosis to be agreed	X	X		
Level 1 – Evaluate the care home pilots based on data and completed DiADeMs	X	X		
Level 2 – Go live with community dementia diagnosis pilot in Folkestone & Hythe	X			
Level 2 – Conduct a clinical audit on Folkestone & Hythe to assess efficacy of model	X	X		
Level 2 – Scale up pilot across 2 additional PCN areas within the Folkestone & Hythe footprint		X		

Mental Health Urgent & Emergency Care					
Milestone	**25-26**	**26-27**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**
Bespoke Conveyance (to include sit and wait) go-live	X				
Publishing of revised Crisis 136 Standards				X	
Centralised HBPOS Go Live				X	
William Harvey Safe Haven increase to 24-hour service				X	
Procurement of Thanet and Medway Crisis Houses					X

Joint Working Across Health & Social Care					
Milestone		**26-27**			
	Q4	**Q1**	**Q2**	**Q3**	**Q4**
Embedding joint working practices and culture of inter-organisational collaboration	X				
Evaluation of KMMH Social Worker secondment work takes place	X				
Finalisation of evaluation report on KMMH Social Worker secondment		X			
Complete mapping exercise of contracted services across the system covering health and social care			X		
Planning for a workshop surrounding commissioning gaps and needs, based on outputs from the mapping exercise			X		

Exception reporting on milestones

CMHF

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

Dementia

- Milestones have been refreshed to support the expansion of Level 1 and the go-live of Level 2 delivery. Progress has been delayed by challenges engaging primary care and difficulties releasing care home staff for training at scale. As a result, only a small number of DiADeMs have been completed, limiting the ability to evaluate the pathway. The evaluation, originally scheduled for Q4 2025/26, has slipped to Q2 2026/27.
- Mitigating actions to support delivery include targeted engagement events, system webinars, strengthened partner communications, and progression of a business case for funding to support primary care involvement. These measures aim to stabilise delivery and achieve the revised milestones during 2026/27.

UEC

- As per the previous report and no change to anticipated completion dates:
  - Centralised Health Based Place of Safety expected to open Q3 26/27 (delays due to construction issues); team will continue to use current health-based place of safety (HBPoS).
  - Revision of S136 standards will now be implemented in Q3 26/27 as above in line with the changed HBPOS go live date.
  - Ashford Safe Haven build delayed until July 2026 with a revised go live date of November 2026. This is part of the wider William Harvey Hospital capital build programme. A temporary location is in use during the day but the service is unable to move to 24/7 operations due to limited estate capacity.
  - Thanet and Medway Crisis Houses; due to delays with procurement support crisis house openings have been delayed from Q4 2025 to most likely Q4 26/27 as a suitable building is yet to be identified. The capital investment is from the Pears Foundation.

Joint Working

- Embedding joint working practices has been in part achieved through the Joint Mental Health Pathways Working Group which includes SROs from the ICB, Local Authorities and

KMMH, who meet monthly. A result of this work there has been a number of planned workshops to strengthen cross-organisational working, covering flow and CRfD.

- Obtaining patient feedback to support the evaluation of lead social workers has just been completed. Financial data showing potential savings is being validated by contract leads.

Upcoming changes to board reporting

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

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Clinical Strategic Plan – Phase 1 Findings and Transformation Themes
Author:	Vineeta Mann, Interim Strategy Advisor
Executive Director:	Dr Afifa Qazi, Chief Medical Officer

Purpose of paper

Purpose:	For discussion
Submission to Board:	Board requested

Overview of paper

The purpose of this paper is to provide the Board with an overview of the early thematic areas that have been identified to be the focus and scope of the new Clinical Strategic Plan.

Issues to bring to the Board's attention

The Clinical Strategic Plan will be developed to align with the organisational strategy and will be used as the delivery method for the clinical aspects of the trust strategy over the next five years.

Its purpose is not simply to describe the current services, but to define how the trust will need to evolve in response to increasing demand, rising complexity, workforce pressures, inequalities and changing population need.

The development of the trust's five-year Clinical Strategic Plan is being delivered over two phases.

- **Phase 1** brings together data and engagement to establish a shared understanding of the key pressures, risks, inequalities and opportunities across the organisation through triangulation of data, operational insight, benchmarking and engagement.
- **Phase 2** will move into prioritisation of these themes and set out the pathway and wider organisational changes required, as part of a final Clinical Strategic Plan that comes to Board for approval in September 2026.

This paper summarises the findings from Phase 1. This phase was intentionally broad and diagnostic in approach and is not intended to represent the final Clinical Strategic Plan or a fully prioritised transformation programme.

Through this phase, we have identified the clinical cohorts and cross-cutting themes where pressures and opportunities appear most consistently concentrated and where further prioritisation and pathway redesign work should now focus.
These include:

- Serious mental illness
- Children and young people
- Neurodevelopmental disorders (NDD) / Learning disability
- Older adults
- Complex / comorbid patients (including substance misuse)
- Complex Emotional Difficulties (CED) and self-harm

The next phase of work will focus on prioritisation, sequencing and development of clinically-led improvements, taking account of organisational capacity, deliverability and operational pressures.

The Board is asked to:

- NOTE the Phase 1 methodology, findings and emerging areas of focus
- SUPPORT the proposed next phase approach
- NOTE that further prioritisation and sequencing will be required during Phase 2 to ensure deliverability within existing organisational capacity and resources.

Governance

Implications /Impact:	The final Plan will inform future organisational priorities, pathway redesign and resource allocation across the trust. Delivery is likely to require changes to how we work, workforce configuration, operational processes and partnership-working over a period of time. There will be implications for our clinical workforce, as well as digital capability, estates utilisation, sustainability and organisational change. Decisions around prioritisation will be managed through our Doing Well Together improvement approach.
Assurance:	Assurance has been informed through triangulation of quantitative performance data, benchmarking, operational intelligence, clinical engagement and multidisciplinary workshops undertaken during Phase 1.
Oversight:	Oversight of the development of the plan will be provided through EMT and our Strategy Deployment Review Group.

1. Strategic Context and Alignment to Trust Strategy

The Trust has agreed a draft five-year organisational strategy (2026–2031), which sets out five "True Norths" focused on timely access, safe care, positive experiences, smarter working, and staying well.

The Clinical Strategic Plan is the primary mechanism for translating the clinical aspects of the strategy into clinically-led improvement, ensuring that strategic ambition is consistently reflected in future models of care, pathway design and operational delivery.

KMMH has identified the need for a Clinical Strategic Plan in order to:

- Proactively define the future clinical model rather than responding reactively to increasing operational pressure
- Deliver the Trust's strategic ambitions through clinically-led pathway and operating model redesign
- Create greater clarity on where investment, workforce and operational focus will deliver the greatest impact
- Align clinical, operational and enabling strategies behind a shared long-term direction

An enabling workforce plan will be developed in parallel to define how future pathways and models of care will be delivered in practice and require different ways of working clinically.

The Clinical Strategic Plan is not intended to create a separate transformation programme, but to provide a coherent clinical framework through which existing and emerging projects and improvement programmes, operational priorities and future investment decisions can be aligned.

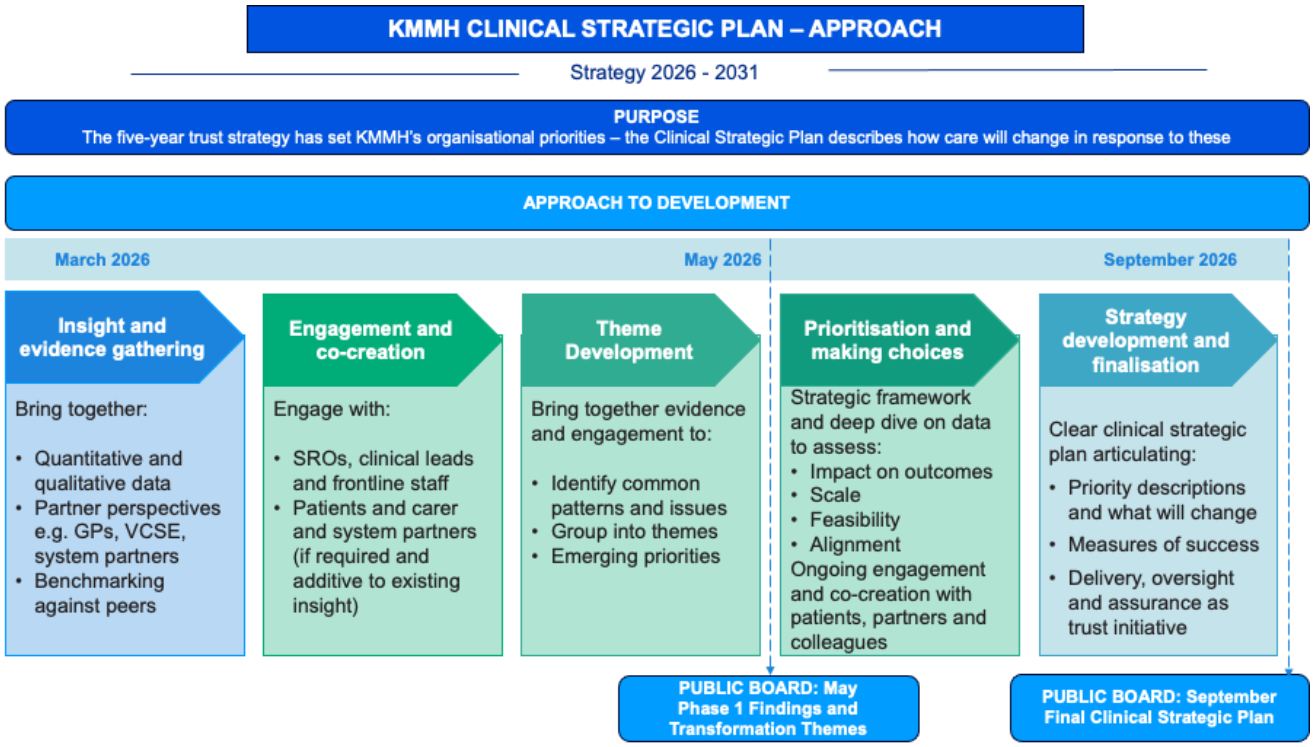
2. Phase 1 development of the Clinical Strategic Plan

System Pressures and Theme Development (March–May 2026)

Phase 1 has focused on a structured, evidence-led and clinically engaged process designed to ensure alignment between population need, our commissioned services, operational reality and clinical experience. The aim of this has been to develop a shared understanding of the key pressures, risks and improvement opportunities across the organisation through triangulation of:

- Quantitative performance and activity data
- Population health and demographic analysis
- National NHS priorities
- Evidence-based practice
- Technology advances
- Benchmarking against peer organisations
- Quality, safety and operational insight
- Clinical and operational engagement
- Two multidisciplinary clinical planning workshops

This phase has identified the recurring system themes and clinical areas where issues relating to access, continuity, complexity, flow, operational pressure and outcomes are most consistently concentrated.



3. System-wide findings

Across all sources of evidence, there is a consistent system narrative. There was strong alignment between the quantitative data, operational intelligence, benchmarking and clinical engagement regarding where pressures, risks and opportunities are most concentrated across the organisation. The detailed phase 1 evidence base, diagnostic findings and engagement and insight can be found in Appendix 1.

4. Strategic Transformation Framework

Across all engagement, analysis, patient and community insight and benchmarking activity, a number of consistent themes emerged repeatedly across services, pathways and population groups. They describe the shift required from the current reactive, fragmented system towards a more preventative, integrated and outcomes-focused model of care.

4.1 From Reactive Care to Prevention and Early Intervention

The current system is predominantly oriented towards crisis response and episodic intervention, with limited capacity for prevention or early identification.

Strategic intent:

- Shift the balance of care towards prevention, early identification and proactive management of need
- Reduce avoidable escalation into crisis and urgent care pathways
- Strengthen population health approaches and earlier intervention in community settings

Implications for future model of care:

- Strengthen integrated working with primary care, Talking Therapies and develop neighbourhood models
- Develop proactive risk identification and outreach models for high-risk cohorts
- Invest in early intervention pathways across children, young people and SMI populations

4.2 Continuity of Care and Relational Ownership

Fragmentation of care and repeated hand-offs between services is leading to loss of continuity, weaker therapeutic relationships and poorer outcomes for complex patients.

Strategic intent:

- Strengthen relational continuity and long-term clinical ownership of care
- Reduce unnecessary transitions and fragmentation across pathways
- Improve patient experience through more stable therapeutic relationships

Implications for future model of care:

- Define clearer “clinical ownership” models for complex and long-term conditions
- Reduce siloed episodic care models where clinically appropriate
- Embed named key worker / care coordinator models for high-need cohorts

4.3 Integrated and Joined-Up Care Across the System

Patients frequently experience disconnected pathways across community, inpatient, urgent care, primary care and partner agencies.

Strategic intent:

- Create more seamless, integrated pathways across organisational boundaries
- Reduce duplication, delays and gaps in care
- Improve coordination across health, social care and VCSE partners

Implications for future model of care:

- Develop integrated care pathways for complex and high-risk cohorts
- Strengthen interfaces between mental health, physical health and social care
- Improve transitions between services (e.g. CAMHS to adult, inpatient to community)

4.4 Multidisciplinary Team (MDT) Working and Care Coordination

Increasing complexity of need requires more coordinated, multidisciplinary approaches to care delivery.

Strategic intent:

- Strengthen MDT working as the default model for complex care
- Improve coordination of care planning and decision-making
- Reduce duplication and improve clinical efficiency

Implications for future model of care:

- Standardise MDT structures for high-complexity cohorts
- Strengthen care coordination roles and functions
- Enable shared digital care planning and decision support tools

4.5 Pathway Simplification and Operational Efficiency

Current pathways are often overly complex, variable and administratively burdensome, reducing productivity and diverting clinical capacity away from patient care.

Strategic intent:

- Simplify pathways and reduce unnecessary variation
- Improve flow, responsiveness and clinical productivity
- Reduce administrative burden on clinical teams

Implications for future model of care:

- Rationalise referral, assessment and triage processes
- Remove duplication across systems and documentation requirements
- Streamline processes (e.g. safeguarding, referrals, handovers)

4.6 Trauma-Informed and Compassionate Care

Many patients present with histories of trauma, adversity and social complexity which can contribute to mental and physical health problems. This is not consistently reflected in service design or delivery.

Strategic intent:

- Embed trauma-informed principles across all pathways and services
- Improve psychological safety, dignity and therapeutic relationships
- Reduce system-induced harm and trauma
- Increase co-production and working better with families and carers

Implications for future model of care:

- Train and support workforce in trauma-informed approaches
- Co-design services that recognise the impact of adversity and complexity
- Strengthen strengths-based, recovery-oriented practice
- Promote a consistent culture of compassion across the organisation

4.7 Digital Enablement, Data and Insight-Driven Care

Opportunities exist to improve care quality, flow management and decision-making through better use of digital tools and data.

Strategic intent:

- Use data and digital capability to support proactive, informed care delivery
- Improve visibility of demand, flow and outcomes across pathways
- Enable more consistent and evidence-based decision-making

Implications for future model of care:

- Improve interoperability across systems and services
- Develop real-time operational and clinical dashboards
- Strengthen population health analytics and risk stratification tools
- Support digital tools that reduce administrative burden

4.8 Consistency, Equity and Reduction of Unwarranted Variation

There is significant variation in access, thresholds and outcomes across populations and geographies.

Strategic intent:

- Reduce unwarranted variation in access, care and outcomes
- Improve equity across population groups and localities
- Ensure consistent application of clinical standards and thresholds

Implications for future model of care:

- Use data to identify and address variation in access and outcomes
- Strengthen equity-focused service design using EDI and lived experience insight
- Standardise core pathways while allowing appropriate local flexibility

4.9 Place-Based and System-Wide Partnership Working

Many drivers of mental health need sit outside traditional clinical boundaries and require coordinated system responses.

Strategic intent:

- Strengthen multi-agency approaches to mental health and wellbeing
- Address wider determinants of health through partnership working
- Shift towards place-based, system-led models of care

Implications for future model of care:

- Deepen integration with local authorities, VCSE and wider system partners
- Align mental health strategy with housing, education, justice and social care systems
- Develop joint prevention and early intervention initiatives

5. Priority cohorts where cross-cutting themes were most prominent

Across the phase 1 evidence, engagement and benchmarking activity, a number of clinical cohorts emerged consistently as areas where pressures, risks and opportunities for clinically-led improvement appear most consistently concentrated.

These cohorts are not intended to represent standalone programmed of the final set of organisational priorities, but instead provide the starting point for further prioritisation, pathway redesign and sequencing during phase 2.

1. Serious Mental Illness (SMI)

Identified due to:

- Significant physical health inequality and reduced life expectancy
- Rising prevalence and increasing complexity
- Fragmented long-term care and lack of continuity
- High system impact through admissions and crisis demand

2. Children and Young People (CYP)

Identified due to:

- Rapidly increasing demand and complexity
- High levels of distress and increasing crisis presentations
- Significant unmet need
- Significant opportunity for prevention and life-course improvement
- Challenges in transition to adult services
- Disproportionate levels of complexity, trauma and mental health need amongst looked after children and care-experienced young people

3. Neurodevelopmental Disorders (NDD) / Learning Disability

Identified due to:

- Sustained long waits and capacity mismatch
- Increasing recognition and diagnostic demand
- Lack of pathway clarity and ongoing support
- High operational pressure and increasing unmet need

4. Older Adults

Identified due to:

- Rapidly ageing population and dementia prevalence
- Increasing complexity of mental health presentations, frailty and comorbidity
- Interface with acute hospitals and social care
- End of life care
- Long lengths of stay and system flow pressures

5. Complex / Comorbid Patients (including substance misuse)

Identified due to:

- Fragmented care, multiple service hand-offs and poor coordination
- High risk and high service utilisation cohort
- Lack of integrated care pathways for complexity

6. CED and Self-Harm

Identified due to:

- Increasing demand on urgent and emergency pathways
- High repeat attendance and readmission rates
- Rising self-harm and suicide concerns
- Limited early intervention and continuity of care

7. Phase 2 development

Prioritisation and Strategic Plan (May–September 2026)

We will move from system diagnosis to prioritisation, pathway redesign and strategic planning. This will include further pathway analysis to define specific initiatives, alignment with existing programmes and operational priorities, assessment of deliverability and impact, and the development of future models of care and enabling plans through ongoing engagement and co-creation.

The final Clinical Strategic Plan will set out:

- Agreed strategic priorities and transformation focus areas
- Proposed model of care, pathway and operating model changes
- Delivery sequencing and roadmap
- Governance, measures of success and outcomes

This phase will focus on determining where the Trust can achieve the greatest impact through targeted activity over the next 3–5 years.

Appendix 1 – Detailed Phase 1 evidence base and diagnostic findings

Population need, demand and complexity are increasing significantly

The population served by Kent and Medway is experiencing sustained growth in demand for mental health services, alongside increasing complexity of need.

This is reflected in:

- **Growing and ageing population**
  - Kent and Medway serves a population of approximately 1.9 million, with annual growth of around 1.3–1.6%, driving sustained increases in overall service demand
  - Around 20% of the population is already aged over 65, with a projected 25% increase in over-65s by 2040, significantly expanding the older adult cohort requiring mental health support
  - Dementia prevalence alone is expected to increase by over 40% by 2030, as well as increasing frailty and multimorbidity, contributing to rising complexity of need within older adult services
  - There is a strong bidirectional relationship between frailty and depression: older adults with frailty are 2.5–4 times more likely to experience depression, and around 40% of frail older adults also have depression
  - This contributes to higher levels of long-term complexity, service utilisation and care coordination needs
- **Increased prevalence of mental health conditions in children and young people**
  - While the number of people under the age of 18 remains steady, an estimated 60,000 children and young people are likely to have a mental health disorder with self-harm rates in Medway in this group exceeding the national average.
  - There has been approximately 28% growth in referrals to CAMHS between 2020 and 2022
- **Sustained increase and higher than average referrals, especially in the community**
  - Mental Health Together (MHT/MHT+) transformation has seen a 4.6% increase of community referrals above plan, equivalent to 2000 extra patients
  - Referral rates are around 5,000 per 100,000 people compared to a sample median of 1,800
- **Rising severity and complexity of need**

  - Severe Mental Illness (SMI), as recorded in the Quality and Outcomes Framework (QOF) in primary care, has one of the highest increases in prevalence, increasing from approximately 17,800 to 21,000 patients between 2023 and 2025
  - Rising prevalence of neurodevelopmental conditions and therefore demand, as well as improvements in awareness and screening leading to earlier and more frequent detection
  - Increasing emotional complexity and self-harm presentations
  - Growing physical and mental health comorbidity and increasing complexity associated with an ageing population

The current model of care is increasingly unable to keep pace with demand

The growth in demand and complexity is increasingly exceeding the capacity and resilience of the current model of care, resulting in sustained pressure on access, productivity and service responsiveness.

This is reflected in:

- **Sustained delays in access to care**
  - Average waits from MHT community referral to intervention of approximately 11 weeks
  - Median waits of approximately 77 weeks for ASD assessments and 61 weeks for ADHD pathways
- **Reduced effective capacity and clinical productivity**
  - High DNA rates across generic CMHTs of 16%, significantly above the benchmark median of 10%
  - Contacts per clinical WTE per day of approximately 1.7 compared to a median benchmark of 2.0
  - Staff described fragmentation, multiple processes, duplication and increased administrative burden reducing time for direct patient care

Delayed access and fragmented pathways are contributing to increasing acuity and crisis presentation

The evidence suggests that many patients are entering services later, often after deterioration in their mental health, increasing both complexity and clinical risk.

This is reflected in:

- **Rising urgent care demand across the system**
  - Safe Haven attendances increasing from approximately 500 per month (2023) to 1,500 per month (2024)
  - Rates of mental health emergency department presentations for depression are higher in men, ethnic minority populations and in more deprived areas
  - Individuals with EUPD account for approximately 30% of mental health readmissions, representing the largest readmission cohort
  - Many individuals presenting in crisis are not previously known to services
- **Fragmentation and loss of continuity across pathways**

    - Repeated transitions between services (e.g. CAMHS to adult, community to inpatient, mental health to physical health services) leading to loss of therapeutic relationships
    - Patients “falling through gaps”, particularly where complexity or comorbidity is present
- **Reactive model of care:**
    - Workshop participants agreed that the current system ecosystem remains heavily organised around thresholds, pathways and episodes of care rather than continuity, prevention and long-term management of need

The system has become congested, with poor flow reducing resilience across pathways

The increasing focus on crisis management is contributing to wider flow challenges across inpatient and community pathways.

This is reflected in:

- **Pressures on inpatient capacity**
    - Bed occupancy consistently operating at approximately 95–97%, significantly above the recognised benchmark of 85%
    - Lower bed provision per 100,000 population compared with benchmark organisations (16 vs 22 median)
- **Delayed discharges and inefficient flow**
    - High lengths of stay and increasing delayed discharges
    - Approximately 30% of bed days occupied by patients clinically ready for discharge, compared with a sample median of 15%, resulting in an estimated impact of £7m
- **Widespread system impact and reduced resilience**
    - Continued use of out of area placements linked to flow and capacity pressures
    - Clinical leaders describe limited “headroom” or buffer capacity, where pressure in one part of the system rapidly affecting others

This is contributing to poorer outcomes, inequality and unmet need

Taken together, the data and engagement demonstrate that the current model is not consistently delivering the outcomes required for the population served.

This is reflected in:

- **Significant inequalities in outcomes**
    - A life expectancy gap especially in people with SMI; people with SMI die 15–20 years earlier than the general population
    - Approximately two-thirds of deaths in people with SMI are linked to largely preventable physical health conditions
    - Dover and Thanet experience suicide rates above the England and SE average
    - Suicide remains the leading cause of death in children and young people
    - Higher levels of deprivation, self-harm and unmet need concentrated in East Kent and coastal communities
    - Increase in alcohol related deaths and drug misuse mortality in East Kent
- **Evidence of unmet and hidden need**

- Significant unmet need within the system particularly where patients do not engage until crisis
- Engagement patterns suggest late identification and delayed intervention in some cohorts
- Complexity within vulnerable groups, including looked after children and care-experienced young people

What patients, partners and communities told us

The Phase 1 findings were further reinforced through wider engagement undertaken via the Trust's organisational strategy work, identity development programme, insights gained by the involvement and engagement team, and ongoing conversations with patients, carers, communities and system partners.

Across these engagement activities, there were consistent themes regarding how people experience mental health care and where change is most needed.

Patients, carers and communities frequently described services as difficult to navigate, fragmented and overly organised around organisational or pathway boundaries rather than individual need. Many people spoke about repeatedly telling their story, experiencing multiple hand-offs between teams and services, and not knowing who was responsible for coordinating their care.

There was a strong desire for:

- greater continuity of care and clearer relationship ownership
- more joined-up support across pathways, organisations and professional groups
- earlier help and intervention before people reached crisis point
- services that feel more connected to communities and everyday life

Engagement also highlighted expectations that the Trust should play a broader role as an anchor organisation within local communities. It should play a leading role in supporting prevention, signposting and community resilience, even where the Trust is not the direct provider of care.

System partners, including primary care, VCSE organisations and wider stakeholders, similarly described challenges navigating pathways and accessing timely advice and support, particularly for individuals with complexity, comorbidity or escalating risk.

VCSE partners highlighted both the significant role they already play in supporting prevention and community wellbeing, and their willingness to do more to help prevent escalation into crisis where stronger partnership arrangements and sustainable funding models can be developed.

These insights closely aligned with the quantitative findings and clinical engagement from Phase 1, particularly in relation to:

- fragmentation and lack of continuity
- increasing crisis demand and the need for earlier intervention and prevention
- the importance of integrated neighbourhood and partnership models
- reducing organisational barriers and improving coordination of care

Appendix 2 – Glossary of Terms

Acronym or Term	Plain English Definition
ASD / ADHD	Autism Spectrum Disorder (ASD) – a developmental condition affecting how a person communicates and experiences the world. Attention Deficit Hyperactivity Disorder (ADHD) – a neurodevelopmental condition affecting concentration, impulsivity, and activity levels. Both conditions lead to specialist service needs and longer wait times noted in the report.
CED (Complex Emotional Difficulties)	A term KMMH uses to refer to severe and long-standing emotional and interpersonal difficulties often linked to personality disorder diagnoses. The Trust adopted “Complex Emotional Difficulties” to avoid stigma, focusing on the person’s needs rather than the label of ‘personality disorder’.
CYPS / CYP	Short for Children and Young People’s Services and “Children and Young People” respectively. In KMMH, this refers to specialist mental health services for under-18s, often known as child & adolescent mental health services (CAMHS).
Did Not Attend (DNA)	NHS shorthand meaning a patient missed a scheduled appointment without giving notice (i.e., they did not attend). For example, “DNA rate 16%” means 16% of appointments were no-shows.
Mental Health Together (MHT) Mental Health Together+ (MHT+)	A new name for KMMH’s integrated community mental health service for adults of all ages. It brings together previously separate services into one joined-up team, so people with mental health needs get faster, more personalised care from a single service.
Multidisciplinary Team (MDT)	A team of professionals from different specialties who work together to plan and provide care. For example, a mental health MDT may include doctors, nurses, psychologists, social workers and others collaborating on a patient’s treatment.
Neurodevelopmental Disorders (NDD)	A category of conditions involving differences in brain development that can affect learning, behaviour, or social skills. This includes autism, ADHD, learning disabilities, etc. Such conditions often require specialist pathways and have featured in the Clinical Plan due to issues like long waiting times for assessment.
Quality and Outcomes Framework (QOF)	A national NHS programme for GP practices. It rewards GPs for meeting quality targets (e.g., on managing chronic illness or preventive care). The aim is to encourage high-quality care by measuring and incentivising good performance in general practice.
Safe Haven	A drop-in mental health crisis support centre. Safe Havens in Kent & Medway are open to anyone 18+ who is experiencing mental distress or crisis, offering supportive, non-clinical help out-of-hours in a welcoming, safe space (no referral needed)
Serious Mental Illness (SMI)	A term for severe and long-term mental health conditions that seriously affect daily life. Examples include schizophrenia, bipolar disorder, and other chronic psychiatric illnesses that require ongoing care. This is a category used in NHS services to identify those with the highest needs.
True North	A guiding goal or long-term outcome the Trust aims to achieve in its strategy. KMMH’s draft 5-year plan sets out five “True North” objectives (e.g.

	timely access to services, safe care, positive experiences, smarter working, and staying well).
VCSE (Voluntary, Community & Social Enterprise)	Collective term for charities, voluntary groups, and community organisations. In the context of health care, VCSE organisations support wellbeing and prevention in the community (outside the NHS or government).

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	28th May 2026
Title of paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of paper

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

The report focuses on the True North and Breakthrough Objectives in order to deliver the key strategic aims. This month there is an additional focus on System Improvement in East Kent.

Issues to bring to the Board's attention

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

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

Version control 02 - **Public**

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

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

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

NHS
Kent and Medway
Mental Health
NHS Trust

Integrated Quality & Performance Report

(IQPR)

May 2026

Contents

1. Chief Executive Overview

This report highlights the trust performance for April, focussing on where performance is improving, areas of concern and what actions we are taking to address these. In presenting this report, the Board are asked to note that the Trust continues to operate under sustained operational pressure, primarily driven by patient flow constraints and high demand for services. I have included some additional updates this month in relation to the quality and safety of our services. This will be further developed for the July report.

Patient flow / Bed state

Management of our beds remains a key priority for us. Bed occupancy across our acute beds has remained high throughout quarter 4 and into April (97.9%). Our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 58.5 days in April against a target of 64.7 days, however CRFD continues to be a significant pressure accounting for over 20% of bed days. We have frequently operated in Operational Pressures Escalation Level (OPEL) 4 for the last 3 months.

Our CRFD cohort of patients in acute beds has increased in the last two months to 70 as of 12th May (53 in KMMH beds and 17 in Step down beds, Ticehurst). It is positive to note that the use of external placements (excluding female PICU) has decreased to 95 bed days in April compared to over 600 in May 2025. I do want to acknowledge the hard work of our clinical and operational teams in managing our on-going bed flow. Average Length of Stay (ALoS) on younger adult (YA) and older adult (OA) acute wards remain above target and annual average for the third successive month, representing challenges faced following the winter period. Our ALoS for YA wards remain within the average national benchmark, but OA wards are increasing, linked to delays in securing suitable residential and nursing care provision in the community. Some variation in Length of Stay (LoS) on YA wards is linked to individual clinical practice and is being addressed by the Acute Directorate. Levels are comparable to that experienced in the same period of 2025 with reduced LoS expected through the summer if similar trends continue.

A short- and medium-term plan was discussed and agreed at the February Board seminar. The emphasis of this plan is to improve flow through the system; we will keep Board sighted via this report and our key performance indicators (KPIs) monitored. As briefed last month there is a system focus on East Kent Hospitals Corridor care, and we are an important partner in supporting to eliminate this. Monthly progress meetings are taking place with NHS England and Integrated Care Board (ICB) colleagues. We are reporting on our six-point plan at these meetings. An update is provided in the report after this introduction.

Access: Community Mental Health, Mental Health Together (MHT)

The waiting time measures across all relevant Community services have been reviewed and updated in this report for the first time to ensure they effectively reflect the experiences of patients accessing local services. Two measures have been implemented, a measure of time to assessment within 4 weeks and a one of time to commencement of intervention (including outcomes measures and care planning) within 18 weeks. These measures will reflect the entire patient journey across MHT and MHT+, whereas the previous measure was limited to MHT only.

The waiting list for commencement of intervention stands at 6,536 as at May 12th. Of the 6,536 waiting 78.9% are waiting under 18 weeks and 31% are within 4 weeks. However, 344 patients are currently waiting over 38 weeks, this is the focus of the Access Breakthrough objective ensuring these patients are waiting safely but a relentless focus to reduce this to zero by April 2027.

We have been focussed on eliminating those patients who have sadly waited over 52 weeks, this is currently 121 patients (1.9% of total list) as of 12th May. All these patients have been seen in MHT and are awaiting the recording of an intervention and/or commencement of an intervention. All patients reported as waiting over 52 weeks are reviewed weekly to ensure safety plans are in place.

Safety:

There are no immediate indicators of systemic deterioration in safety of care associated with the wider system and internal operational pressures; however, the position continues to require close oversight, particularly in relation to patients waiting for care and those experiencing delayed discharge. Processes are in place to ensure regular clinical review and safety planning for these patients.

The use of prone restraint remains under review, with ongoing scrutiny to ensure alignment with policy, minimisation of use, and patient safety. Every episode of prone restraint is reviewed on a daily basis and oversight is in place both through the Heads of Nursing & Quality and Deputy Chief Nurse.

Incidents of self-harm for acute services have reduced from 110 in March to 88 in April. Ligature remains the most frequently reported type of self-harm. Several actions are in place to support a further reduction in the number of self-harm incidents:

- The self-harm formulation support tool for staff and patients that was developed by the self-harm steering group is being finalised
- Psychoeducation leaflets for patients and their families, friends and carers are in the process of being developed.

- A task and finish group is being established to develop a bitesize training offer for ward staff, and another group will be developing a plan to pilot the use of “safety cards” on the ward.

New measures for Risk and Care Plan compliance have been introduced. These can be seen on page 13 of this report. Data completeness and compliance are improving month on month as the implementation of the new supporting policies continues to be embedded. This is part of the trust quality improvement plan.

Our new, trust-wide experience measure, titled “Your Experience Matters”, launched on the 1st April 2026. Developed in close partnership with clinical teams, communications and engagement colleagues, and service users. The new approach introduces a more concise and meaningful way of capturing feedback and is explicitly aligned to our core trust values. It simplifies our current arrangements by bringing together the existing patient reported experience measure (PREM), carer reported experience measure (CREM) and mandatory Friends and Family Test (FFT) into a single central experience questionnaire. Importantly, it will enable respondents to identify whether they are a service user or the loved one of someone using our services which, for the first time, will allow us to directly compare patient and carer experience using the same metrics. This combined approach will streamline how feedback is gathered, reduce duplication or confusion, and will provide a more holistic and consistent view of experience across our services

Inequalities and data improvement

Ethnicity recording has improved to 88.2% of community (MHT/MAS) referrals through clear, practical changes. Since January 2026, 176 staff have completed protected characteristics training, reporting increased confidence to ask for information, explain Trust data and use data to inform practice. Patients can now see why we collect this information on the Trust website, with additional information sheets in development.

New processes have also been introduced to make ethnicity easier to record. Targeted work in West Kent using the Doing Well Together methodology increased recording from 76.1% to 86.2% in 2025/26. With these foundations in place, the Ethnicity, Diversity and Inclusion Power BI report is now being used to support improvement, and focused work on Restrictive Practices, Mental Health Act detentions and Memory Assessment Services (MAS) access shows how data is being used to improve care.

2. System Improvement – East Kent

The KMMH six-point improvement plan is a core component of the East Kent system-wide programme to eliminate Corridor care, developed in response to the CQC visit to East Kent University Foundation Trust (EKUFT) hospitals (QEQM in Thanet and WHH in Ashford) in February 2026. We have Liaison teams assessing people who present to Emergency Departments (ED) in a crisis, that are working jointly with the Trust and wider system to support eliminating corridor care.

The KMMH plan is led by the Chief Medical Officer and was implemented from 30 March 2026, with April representing the first full month of data. It focuses on six priority areas: (1) escalation processes, (2) Safe Haven provision, (3) admission conversion rates, (4) repeat ED presentations by known patients, (5) self-harm presentations and (6) ambulance conveyance. Actions in place:

- A revised escalation protocol between KMMH and EKHUFT is now embedded, underpinned by a daily communication rhythm that both organisations report is working well.
- Review of the Safe Haven model has confirmed it predominantly supports lower-level presentations below the threshold for admission; as a result, a bid for a fully resourced clinical and VCSE-delivered mental health urgent and emergency care service was submitted to the South East Region of NHSE on 8 May 2026.

Metrics have been agreed to monitor progress against the six-point plan with delivery by the end of Q2. Some initial impact has been observed as set out below:

- Admission conversion rates showed early improvement in April, with Thanet reducing from a historical baseline of 8.3% to 6.5%, approaching the Q1 target of 6.3%. Ashford experienced a temporary increase linked to higher acuity, though the strengthened interface with Home Treatment is supporting safer, more consistent decision-making. We do not yet have a reliable data trend to evidence sustained progress.

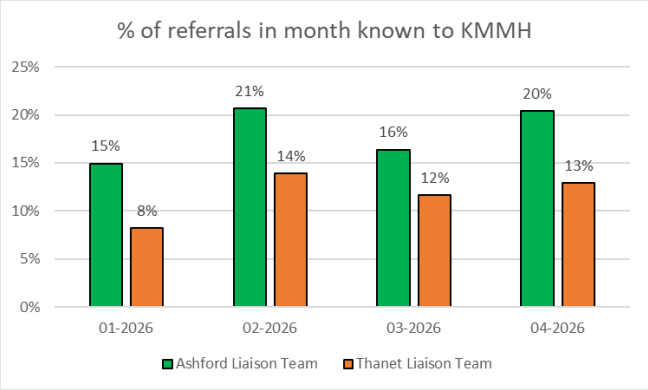
Ashford Liaison Team
% of total referrals rcvd that were admitted in month

Month	Refs Rcvd in month	% admitted
01-2026	239	5.4%
02-2026	184	7.6%
03-2026	223	4.9%
04-2026	228	9.6%

Thanet Liaison Team
% of total referrals rcvd that were admitted in month

Month	Refs Rcvd in month	% admitted
01-2026	231	7.8%
02-2026	193	6.2%
03-2026	245	3.7%
04-2026	231	6.5%

- Over the past 12 months, 53.1% of patients presenting to Thanet Liaison were known (open or previously open)to KMMH services; this proportion has now reduced significantly, most recently measuring 20% and 13% against a Q1 target of 15%.



- Self-harm presentations remain high at WHH (35.1%) but have reduced in Thanet from 18.2% to 14.7%, in line with the Q2 target of 15%.
- Ambulance conveyance to ED remains high at both QEQM and WHH, with system partners progressing pathway improvements through a multi-agency workshop scheduled for 27 May 2026.
- ED waits for a mental health bed over 12 hours have not changed significantly; however, ED waits over 12 hours not awaiting a bed have reduced in Thanet from 11.3% to 6%. Between late March and early May, 18 patients waited over 12 hours for a mental health bed across QEQM and WHH, and a further 63 patients experienced waits over 12 hours not related to mental health bed availability, primarily due to physical health delays, Approved Mental Health Professional (AMHP) availability and access to crisis house beds.

Overall, early progress is evident, with continued trajectory monitoring and system actions required to embed and sustain improvement.

3. Trust Wide Integrated Quality and Performance Dashboard

Access

Executive Sponsor: Donna Hayward-Sussex, Chief Operating Officer & Deputy CEO

True North

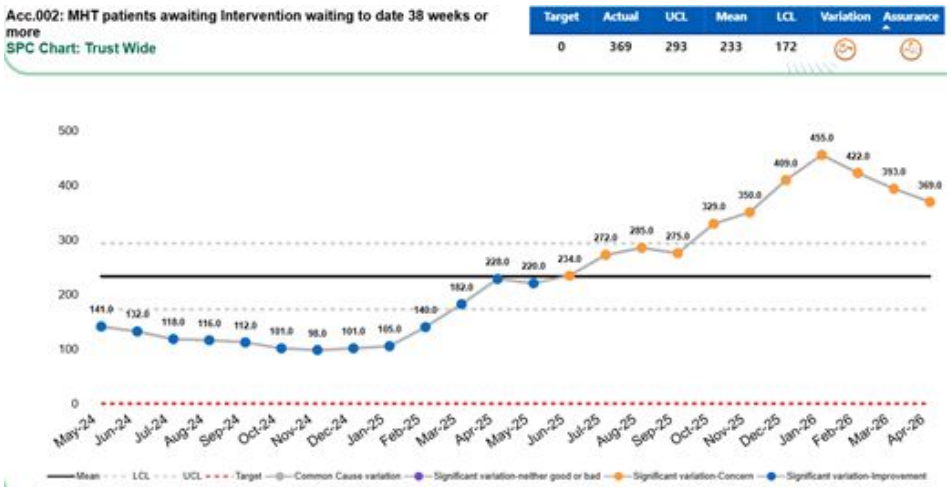
Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acc.001: % Mental Health Together patients receiving treatment in 18 weeks	85.0%	74.6%	77.8%	78.2%	79.2%	78.6%	83.1%	80.4%	83.8%	77.0%	71.7%	70.6%	63.9%

Breakthrough Objectives

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acc.002: MHT patients waiting for treatment for 38 weeks or more	0	220	234	272	285	275	329	350	409	455	422	393	369

Focus on Breakthrough Objectives

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



Data Source	RiO	Data Quality Confidence	

What is being measured?

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

What is the data telling us and key actions in place

Increases were observed in 2025 in East and West Kent as result of workforce pressures and availability of groups to match patient need, resultant action following these pressures has seen a reduction of four consecutive months supported by weekly huddles and increased training on waiting list management reports following the launch of redefine measures to more accurately reflect clinical practice.

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

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

Watch Metrics

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acc.003: % Mental Health Together patients receiving an assessment in 4 weeks		60.5%	69.7%	70.3%	69.2%	62.4%	67.4%	66.1%	70.6%	58.8%	65.9%	60.3%	50.4%
Acc.004: Open Access Crisis Line: Calls received	3,274	3,110	3,266	3,383	3,047	2,976	3,227	2,794	2,968	3,174	3,070	3,159	2,848
Acc.005: Open Access Crisis Line: Abandonment Rate (%)	12.0%	34.3%	36.9%	37.1%	38.9%	40.2%	28.3%	21.2%	25.0%	22.4%	25.7%	24.3%	20.2%
Acc.006: Assess people in crisis within 4 hours		94.7%	86.9%	93.7%	91.4%	93.6%	91.0%	90.9%	84.9%	91.4%	85.1%	73.0%	88.1%
Acc.007: People presenting to Liaison Services: triaged within 1 hour		90.7%	92.3%	92.1%	89.4%	90.8%	90.9%	89.2%	93.9%	92.3%	89.6%	90.0%	92.3%
Acc.008: Liaison Psychiatry referrals closed within 12 hours	95.0%	80.0%	81.6%	84.6%	82.1%	81.8%	82.8%	81.5%	82.6%	82.8%	81.6%	85.8%	84.6%
Acc.009: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	24.4%	26.4%	29.6%	12.3%	10.4%	6.5%	16.2%	15.7%	8.3%	8.5%	16.3%	18.3%
Acc.010: Place of Safety Length of Detention: % under 24 hours	75.1%	75.0%	79.0%	80.0%	78.7%	86.9%	86.4%	89.8%	90.5%	85.2%	89.8%	93.3%	100.0%
Acc.011: Dementia diagnosis within 6 weeks	95.0%	26.5%	26.5%	31.1%	25.3%	21.3%	22.5%	27.2%	23.2%	20.0%	17.7%	31.5%	29.4%
Acc.012: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%	69.6%	72.2%	70.0%	85.7%	92.3%	87.0%	76.5%	76.9%	50.0%	80.0%	68.2%	90.0%
Acc.013: % MHLD referrals commencing treatment in 18 weeks	86.1%	100.0%	81.3%	92.9%	84.8%	83.8%	83.7%	70.7%	95.8%	87.7%	87.5%	87.5%	83.0%
Acc.014: Perinatal assessments (against annual target)	2,000	216	182	183	163	177	180	161	144	174	150	175	600
Acc.015: DNA Rate – All Appointments		10.7%	11.0%	10.7%	10.1%	10.5%	10.4%	9.8%	10.0%	10.6%	10.5%	10.2%	10.0%
Acc.016: Number of Active Referrals waiting less than 18 weeks to first contact (MHS CYP)		1,517	1,489	1,339	979	1,072	946	1,176	1,042	1,101	1,076	1,179	1,098
Acc.017: CYP Crisis Assessments within 4 hours (Referral to Contact)		78.2%	84.4%	81.2%	88.4%	77.6%	77.1%	76.0%	76.1%	79.3%	76.7%	67.8%	71.3%
Acc.018: % Routine Eating Disorders Activity-Based Clock Stop Achieved Within 4 Weeks Aged 0–18		84.2%	85.7%	87.9%	91.1%	92.0%	100.0%	97.1%	93.0%	98.2%	96.8%	93.1%	78.0%

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

Acc.009. Methodology refined in April 2026 and applied historically

Safety

Executive Sponsor: Julie Kirby, Chief Nurse

True North

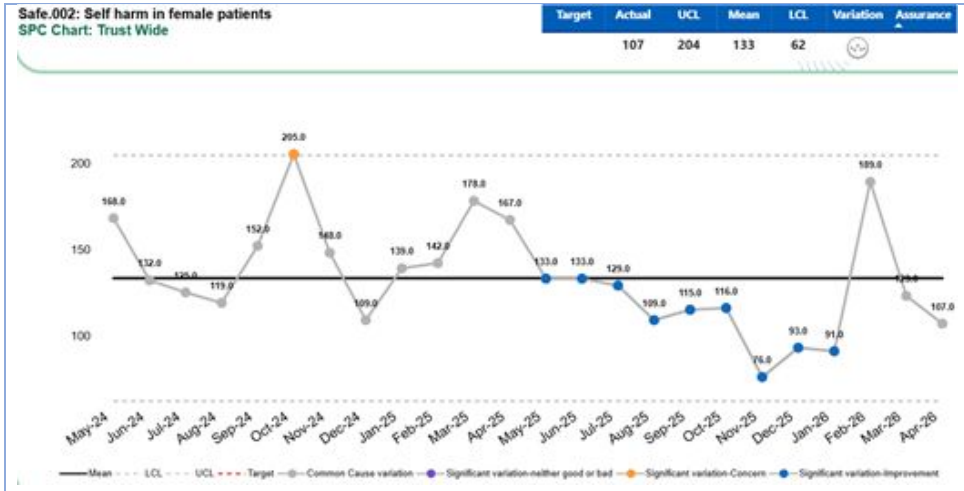
Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Safe.001: Number of patient harms		165	175	178	149	146	152	105	127	116	232	153	139

Breakthrough Objectives

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Safe.002: Self harm in female patients		133	133	129	109	115	116	76	93	91	189	123	107

An additional Breakthrough Objective to reflect **improving the management of self-harm in the community** is to be developed in Quarter 1 of 2026/27.

Focus on Breakthrough Objectives



Data Source	InPhase	Data Quality Confidence	

Some potential data completeness issues being investigated within community services

What is being measured?

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

What is the data telling us and key actions in place

SPC is showing normal cause variation, the mean since May 2024 is 133.

Incident numbers for acute services have reduced from 110 in March to 88 in April. Foxglove ward had the highest reported level of self-harm in April with 53 incidents; however, this had decreased from 77 incidents in March. Ligature remains the most frequently reported type of self-harm, followed by cutting and then head banging.

The self-harm formulation support tool for staff and patients that was developed by the self-harm steering group is being finalised. Psychoeducation leaflets for patients and their families, friends and carers are in the process of being developed. A task and finish group is being established to develop a bitesize training offer for ward staff, and another group will be developing a plan to pilot the use of “safety cards” on the ward.

Watch Metrics

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Safe.004: Risk Compliance		1.1%	5.6%	9.5%	12.3%	15.0%	17.3%	19.2%	19.4%	20.9%	25.5%	29.2%	31.3%
Safe.005: Care Plan Compliance		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.8%	0.9%	2.1%	15.4%	25.6%	33.0%
Safe.006: Patients receiving follow-up within 72 hours of discharge		83.9%	89.9%	91.3%	85.8%	88.5%	87.0%	88.7%	85.9%	90.8%	86.7%	88.2%	84.7%
Safe.007: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
Safe.008: All Deaths Reported And Suspected Suicide		149	152	135	113	137	146	104	164	177	145	132	90
Safe.009: Restrictive Practice - All Restraints		95	57	100	87	111	163	170	141	99	140	131	105
Safe.010: Restrictive Practice - No. Of Prone Incidents	0	2	12	8	4	7	16	12	4	10	3	10	7
Safe.011: Care Plan in date for patients in treatment (CYP & AAED)		78.6%	78.7%	76.1%	75.4%	75.9%	77.3%	78.1%	77.7%	77.7%	77.8%	79.0%	79.6%
Safe.012: Risk assessment in date for patients in treatment (CYP & AAED)		86.8%	86.9%	86.5%	85.1%	84.4%	84.3%	84.6%	84.7%	83.6%	83.9%	84.7%	85.2%

Safe.004 & 005: Care Plan and Risk indicators have been introduced following recent policy developments. Further discussions are underway to refine policy to better align to clinical practice and therefore subsequent changes to the measure definitions are expected in future months to aligned with amended policy upon finalisation. Data is therefore subject to change in future reports.

Experience

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

True North

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Exp.001: % of patients feel that the overall experience of our services was good/ very good (FFT % Positive)	90.0%	88.7%	91.2%	90.8%	88.4%	88.8%	87.4%	83.6%	86.9%	87.4%	88.3%	87.4%	80.1%
Exp.002: Trust Staff Engagement Score	6.8											6.7	

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

Breakthrough Objectives

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

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

Focus on Breakthrough Objectives

Exp.003: % of patients feel that we are good/ very good at including them in decisions about their care. *Insufficient data points to analyse by SPC*	**Data Source**	Your Experience Matter	**Data Quality Confidence**	

What is being measured?

Measure moving forward

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

- Being included in decisions about the care provided

Measure baseline (prior)

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

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

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

What is the data telling us and key actions in place

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

Next steps

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

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

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

What is being measured?

What is the data telling us and key actions in place

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

	Target 26/27	Mar-25	Jul-25	Jan-26	Mar-26
Acute	66%	60.90%	50%	no data	60%
Children/AAED	60%	no data	no data	no data	65%
Forensics & Specialist	66%	61.70%	36.60%	27%	60%
East	45%	41.30%	26.70%	7%	37%
North	60%	56.80%	53.30%	30%	50%
West	52%	50.20%	41.70%	35%	44%
Support Services	65%	63%	59.50%	51%	62%
Trust	60%	56.70%	44.80%	33%	54%
Data Source		Staff Survey 24	Pulse	Pulse	Staff Survey 25

March 2026 data reflects the National Staff Survey 2025 for which the sample size was 2001. The most recent Pulse survey was conducted in April 2026 by 487 staff – results will be available 2nd Week in May. Children/AAED will be added to surveys from July 2026.
Key Actions:

- **Day-to-day Experience** - The approach to improving Staff Experience and Engagement has evolved for 2026. All directorates are be producing an action plan which is tied into the True North and Breakthrough objectives of the 2026-2031 Trust strategy. Directorates will be sharing their results, holding staff focus groups and developing these plans in May/June 2026. Actions will be regularly reviewed during SDR or as per directorate review process as applicable.
  Alongside this a short trial of creating Staffroom Community (East directorate) will take place and be subsequently rolled out across all directorates. This will enable stronger narrative control and leaders feeling more empowered to drive local conversations and build trust with their people.
- **Staff Voice** – Following the successful trial in Forensics, Staff Voice forums are currently being established for each directorate. The aim is to reach a wider range of staff feedback and contribution across the directorate in addition to other listening/response mechanisms. All forums are expected to be established with their elected representatives and first meetings taking place by late June 2026. Meetings will then take place quarterly.
- **Leadership behaviours** – improvement leadership behaviours are incorporated in the trust leadership programme – Leading Well Together. Behaviours were assessed to gain a personal benchmark through the creation of a new 360 tool, this is currently being repeated in line with 2026 appraisal timelines.

	Leadership behaviours are being incorporated as a focus in the Culture (strategic initiative) – behaviours, expectations, how we work, how decisions are made, how teams are led and managed. This group has been set up and actions will follow once agreed. • **Talent Toolkit** – Trial talent toolkit with EMT and Deputies to see how process works and what is working well/ not before rolling out into Trust. • **Positive Experience** – a focus in how it feels to work here; engagement, involvement, belonging is an additional focus and currently being explored in terms of key action areas. This also sits alongside the True North objective to increase engagement to 7.3 by 2030. **Health and Wellbeing** – The new 3 year plan is drafted and will be finalised by July 2026.

Watch Metrics

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Exp.005: Complaints - actuals		61	58	49	52	66	43	46	38	71	49	72	76
Exp.006: Compliments - actuals		122	159	174	118	139	153	150	178	124	135	117	141
Exp.007: Compliments - per 10,000 contacts		32.8	41.0	40.8	31.8	34.5	35.8	37.0	46.7	29.4	35.1	28.3	35.4
Exp.008: Your experience matters: Response Count		626	605	577	424	456	507	353	434	405	501	478	427
Exp.009: Your experience matters: Response Volume		3.7	3.5	3.2	2.6	3.1	2.8	2.0	2.5	2.2	2.8	2.7	2.4
Exp.010: Your experience matters: Achieving Regularly, % good/very good													81.0%
Exp.011: Complaints acknowledged within 3 days (or agreed timeframe)	100%	94%	93%	92%	95%	89%	84%	95%	98%	97%	94%	96%	97%
Exp.012: Complaints responded to within 30 days (or agreed timeframe)	100%	76%	81%	86%	80%	83%	88%	75%	81%	79%	72%	86%	77%
Exp.013: Decrease violence and aggression		374	396	462	392	462	456	469	371	386	363	384	349
Exp.014: Medication errors		62	50	54	45	55	54	36	40	31	52	45	39
Exp.015: Increase percentage of BAME staff in roles at band 7 and above	20.0%	27.0%	27.5%	29.8%	30.6%	30.9%	30.9%	30.7%	30.5%	31.1%	31.0%	31.0%	31.1%
Exp.016: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%	0.17%	0.32%	0.44%	0.39%	0.23%	0.12%	0.11%	0.27%	0.35%	0.23%	0.23%	0.36%

Resources

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

Methodology for reporting of intended True North, Increase Overall Productivity, to be defines for reporting in future reports.

Breakthrough Objectives

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Res.002: Psychology & Medic contact time per FTE		0.40	0.40	0.38	0.36	0.38	0.40	0.39	0.34	0.39	0.36	0.35	0.37

Focus on Breakthrough Objectives

Res.002: 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 un-outcomed 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	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Res.002: Psychology & Medic contact time per FTE		0.40	0.40	0.38	0.36	0.38	0.40	0.39	0.34	0.39	0.36	0.35	0.37
Res.003: Staff Sickness - Overall	4.5%	4.3%	4.1%	5.0%	5.2%	4.9%	4.9%	5.5%	5.9%	5.1%	5.2%	5.1%	5.1%
Res.004: Vacancy Gap - Overall	11.5%	10.1%	10.3%	10.2%	10.3%	10.2%	10.2%	10.3%	10.2%	10.4%	10.4%	10.3%	10.4%
Res.005: Mandatory Training For Role	90.0%	95.4%	94.8%	95.4%	95.6%	94.8%	95.4%	95.3%	95.6%	95.7%	95.5%	94.9%	94.6%
Res.006: Leaver Rate	12.3%	12.6%	12.6%	11.9%	11.9%	11.4%	11.2%	11.7%	12.1%	12.3%	12.6%	12.3%	11.8%
Res.007: Leaver Rate (Voluntary)	13.0%	8.9%	9.0%	8.2%	8.1%	7.8%	7.7%	7.4%	7.4%	7.5%	7.6%	7.3%	7.2%
Res.008: Safer staffing fill rates	80.0%	112.1%	109.6%	110.2%	109.2%	110.3%	109.0%	108.6%	109.6%	109.4%	110.8%	109.0%	111.0%
Res.009: In Month Budget (£000)	0	(15,315)	(15,413)	(15,303)	(17,957)	(15,725)	(15,710)	(15,553)	(15,537)	(15,537)	(15,514)	(15,536)	(15,911)
Res.010: In Month Actual (£000)		(16,064)	(15,684)	(15,469)	(17,979)	(16,362)	(16,355)	(16,094)	(16,332)	(15,992)	(16,128)	(16,100)	(15,883)
Res.011: In Month Variance (£000)		(749)	(271)	(166)	(23)	(637)	(645)	(541)	(795)	(455)	(614)	(564)	28
Res.012: Agency spend as a % of the trust total pay bill	3.2%	2.5%	2.6%	1.9%	2.0%	1.8%	2.2%	1.7%	2.2%	1.3%	1.8%	0.4%	1.3%

Prevention

Executive Sponsor: Afifa Qazi, Chief Medical Officer

True North

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Prev.001: Bed Occupancy (Net)	92.0%	94.0%	95.8%	95.3%	96.8%	97.7%	96.4%	97.9%	97.0%	97.7%	97.7%	95.0%	97.9%

Breakthrough Objectives

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Prev.002: Number awaiting bed (at period end)													19

Data reflects manually collected data by the Patient Flow Team, the new bed management form within RiO is in its final stages of testing which will result in increased visibility of this data and greater data quality.

Focus on Breakthrough Objectives

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

	Baseline being formulated and analysis will occur once this is in place

Watch Metrics

Measure Name	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Prev.003: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	608	875	775	625	608	574	590	561	482	407	453	316	218
Prev.004: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	21	28	28	19	17	22	18	17	14	13	17	5	9
Prev.005: CRFD Bed Days Lost (Acute beds)		1,439	1,370	1,551	1,827	1,690	1,565	1,723	1,717	1,647	1,712	1,657	1,424
Prev.006: Clinically Ready for Discharge (CRfD) length of stay (LoS)	64.7	86.9	69.6	46.3	82.2	81.9	92.9	45.8	69.9	116.1	53.7	74.9	58.5
Prev.007: Clinically Ready for Discharge (CRfD) over 100 days at period end	0	17	14	14	17	16	15	17	19	20	22	14	14
Prev.008: Clinically Ready for Discharge (CRfD): YA Acute	7.0%	18.9%	15.2%	14.4%	17.5%	17.9%	15.2%	20.3%	22.0%	19.9%	22.0%	17.1%	14.3%
Prev.009: Clinically Ready for Discharge (CRfD): OA Acute	12.0%	21.3%	25.4%	31.9%	36.2%	31.8%	30.6%	28.7%	23.6%	24.6%	29.6%	31.3%	27.9%
Prev.010: Average Length Of Stay (Younger Adults Acute)	34.0	38.9	35.1	36.2	32.8	42.6	50.9	27.5	31.5	61.3	44.1	46.0	51.8
Prev.011: Average Length Of Stay (Older Adults - Acute)	77.0	102.4	88.8	71.4	69.1	104.3	79.7	76.0	81.6	71.1	120.4	115.3	92.1
Prev.012: Adult acute LoS over 60 days % of all discharges	16.0%	17.0%	14.9%	14.5%	12.2%	14.4%	22.9%	12.9%	13.3%	20.4%	15.6%	19.7%	23.7%
Prev.013: Older adult acute LoS over 90 days % of all discharges	37.7%	40.0%	33.3%	30.3%	30.0%	43.3%	31.3%	24.0%	42.9%	25.9%	29.6%	50.0%	44.0%
Prev.014: Readmissions within 30 days (YA & OP Acute)	8.8%	6.3%	11.4%	10.4%	16.7%	12.6%	12.0%	10.3%	12.2%	12.3%	11.8%	9.9%	7.8%
Prev.015: Average Length of Stay in C&YP Mental Health wards (Days)		27.2	61.6	2.8	91.3	15.3	25.2	29.0	79.5	69.9	1.5	10.2	36.2

Prev.003& 004 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. 218 bed days were used in April 2026, 123 were female PICU patients within contracted beds resulting in 95 out of area placement days as an accurate reflection of trust performance.

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 Q3 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			Q3 2025/26 1	NOF Score	Provider value	
Average metric score			Q3 2025/26 2.02	NOF Score	Provider value	
Unadjusted segment			Q3 2025/26 1	NOF Score	Provider value	
Financial override	Q3 2025/26	No	Yes	Yes	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	Q3 2025/26	1	NOF Score	
Effectiveness and experience of care domain segment	Q3 2025/26	1	NOF Score	
Patient safety domain segment	Q3 2025/26	3	NOF Score	
People and workforce domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain segment	Q3 2025/26	1	NOF Score	

Extract as at 01/04/2026

Directorate Reports: True North and Breakthrough Objectives

Acc.001: % Mental Health Together patients commencing intervention in 18 weeks

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
East Kent	85.0%	74.7%	77.0%	81.4%	79.2%	79.4%	82.2%	80.3%	83.0%	75.8%	66.7%	69.0%	62.6%
North Kent	85.0%	81.2%	81.8%	76.8%	83.2%	79.2%	87.3%	82.5%	87.4%	79.8%	85.0%	79.4%	71.7%
West Kent	85.0%	67.4%	74.2%	73.1%	73.0%	75.8%	79.1%	77.7%	79.1%	75.0%	65.5%	61.5%	59.3%

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

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
East Kent	0	124	133	158	175	172	212	222	261	289	276	250	235
North Kent	0	20	25	25	25	22	23	28	32	37	36	24	14
West Kent	0	76	76	89	85	81	94	100	116	129	110	119	120

Exp.001: % of patients feel that the overall experience of our services was good/ very good (FFT % Positive)

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute	90.0%	77.2%	86.9%	90.0%	80.3%	76.6%	79.2%	67.8%	78.8%	70.4%	70.0%	68.6%	67.8%
East Kent	90.0%	89.7%	96.7%	90.2%	91.8%	92.0%	91.1%	82.4%	81.5%	84.6%	83.9%	93.8%	74.2%
Forensic and Specialist	90.0%	89.7%	81.8%	87.3%	85.3%	85.7%	81.4%	84.0%	88.2%	93.8%	91.7%	90.7%	94.0%
North Kent	90.0%	89.7%	89.5%	94.3%	100.0%	100.0%	91.4%	100.0%	85.7%	100.0%	88.0%	94.2%	85.7%
West Kent	90.0%	88.6%	97.0%	89.9%	90.0%	89.1%	87.7%	87.5%	90.8%	93.8%	95.3%	82.5%	91.1%

Exp.002: Trust Staff Engagement Score

Directorate	Target	Mar-26
Acute	6.8	7.0
East Kent	6.8	5.7
Forensic and Specialist	6.8	6.9
North Kent	6.8	6.7
West Kent	6.8	6.3

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

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute	95.0%												73.0%
East Kent	95.0%												82.0%
Forensic and Specialist	95.0%												89.0%
North Kent	95.0%												78.0%
West Kent	95.0%												79.0%

Exp.004: % of staff would recommend KMMH as a place to work

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute	66.0%			50.0%								60.0%	
East Kent	45.0%			26.7%						7.0%		37.0%	
Forensic and Specialist	66.0%			36.6%						27.0%		60.0%	
North Kent	60.0%			53.3%						30.0%		50.0%	
West Kent	52.0%			41.7%						35.0%		44.0%	

Safe.001: Number of patient harms

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute		105	95	101	89	83	92	53	76	70	173	117	91
CYP & AAED		165	175	178	149	146	152	105	127	116	232	153	157
East Kent		21	24	25	26	23	21	15	16	20	25	9	17
Forensic and Specialist		11	20	23	11	11	9	7	5	4	4	5	10
North Kent		10	12	9	14	15	10	10	12	11	10	5	13
West Kent		17	23	20	9	14	20	18	17	11	20	16	8

Safe.002: Self harm in female patients

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute		93	84	81	70	73	82	42	66	62	154	100	79
CYP & AAED		133	133	129	109	115	116	76	93	91	189	123	122
East Kent		11	14	13	6	19	11	13	10	16	16	7	9
Forensic and Specialist		9	12	19	19	2	2	2	1	1	1	1	6
North Kent		9	9	5	6	13	8	7	7	4	6	4	8
West Kent		11	14	11	8	8	13	12	9	8	12	11	5

Prev.001: Bed Occupancy (Net)

Directorate	Target	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Acute	92.0%	94.0%	95.8%	95.3%	96.8%	97.7%	96.4%	97.9%	97.0%	97.7%	97.7%	95.0%	97.9%

Prev.002: Number awaiting bed (at period end)

Trust wide position, directorate breakdown n/a

Res.013: Clinician Contact time per FTE

Directorate breakdown not currently reported

Report Guide

True North

The guiding direction of the organisation

Timeframe: 3-5 years

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

Breakthrough Objectives

The improvement focus of the organisation

Timeframe: 0-12 months

- **Measurable outcome**

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

Watch Metrics 

Important metrics to understand department performance

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

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	28th May 2026
Title of paper:	Finance report for Month 1 (April 2026)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of paper

The attached report provides an overview of the financial position for month 1 (April 2026).

Issues to bring to the Board's attention

For the period ending 30th April 2026, the Trust has reported a breakeven position (post technical adjustments) this is in line with the financial plan.

The key items to highlight are:

- External bed expenditure remains a pressure, although run rates have reduced significantly year-on-year (£0.66m reduction compared to April 2025).
- Agency spend was £0.60m, consistent with March after adjusting for transferred services.
- Acute inpatient pay pressures persist, with additional nursing (registered and unregistered) utilised above establishment, resulting in a £0.34m in-month pressure.
- Cash balance closed at £6.54m, in line with plan.
- Capital expenditure is above plan, driven by the transfer of assets as part of the Children and Young People and All Age Eating Disorders service transfer; discussions are ongoing with NHS England regarding how this should be reflected in the capital programme.

Governance

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

NHS
Kent and Medway
Mental Health
NHS Trust

Finance Reporting Pack

Trust Board
April 2026

Contents

1. Executive Summary

Key Messages

For the period ending 30th April 2026, the Trust has reported breakeven position (post technical adjustments) this is in line with the financial plan.

April marked the transfer of Children and Young People (CYP) and All Age Eating Disorders (AAED) services to the Trust, and the financial position reported for the month reflects the inclusion of these services.

Key pressures for the Trust are:

External beds

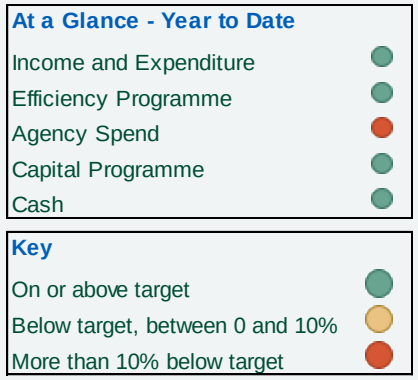
- External bed expenditure continues to represent a financial pressure; however, current run rates show a significant reduction compared to the same period in 2025/26 (£0.66m reduction). In-month, usage of external Acute beds reduced to 2 beds (from 5 in the previous month), while external PICU usage remained stable at 6 beds.
- In April, 807 stepdown bed days were purchased, at a cost of £0.25m, with utilisation of 665 days (82% occupancy). At this level, the trust has seen cost avoidance of £0.32m.
- Taken together the in-month budgetary pressure for external bed usage totals £0.10m.

Acute Inpatient staffing

- The Trust continues to utilise nursing staff above establishment across acute inpatient wards in response to sustained operational pressures and patient acuity.
- In April, the trust employed 59.5 WTE above establishment (March: 67.7 WTE), indicating an improving trajectory but remaining materially above planned levels. This has resulted in an in-month pressure of £0.34m

Agency spend

- Agency spend in April totalled £0.60m, of which £0.31m relates to agency staff used in Child and Young People (CYP) and All Age Eating Disorder services. Excluding these, agency spend has reduced by 43.2% (£0.22m) from the same period in 2025/26.
- In month spend levels were highest in CYP and AAED, with 51.4% of overall agency spend, due to medical vacancies, and also East Kent (28.9%) due to continuing medical vacancies.



Capital Programme

As of 30th April, the overall capital position is £8.30m over the planned position submitted to NHS England (NHSE) driven primarily by the recognition of assets associated with the CYP and AAED service transfer.

Discussions are on-going with NHSE regarding this impact and the impact on the trust's capital allocation.

Excluding these assets the position is £0.18m behind plan; this is primarily due to an IFRS16 remeasurement linked to the pending rent review for the Eureka Medical Centre. This is partially offset by several projects being ahead of schedule compared to plan.

Cash

The closing cash position for April was £6.54m which is a decrease in month of £2.08m and is £0.09m higher than the plan of £6.46m. The decrease in cash related to payments relating to the 2025/26 capital programme and is in line with plan.

2. Finance KPIs

I&E position

2026/27 YTD	**£0.0m**	**breakeven**
2026/27 Plan	**£0.0m**	**breakeven**

The Trust has in line with a breakeven plan. Key pressures include Acute Inpatient staffing and External beds and these are mitigated with non-recurrent benefits and pay slippage.

Cash position

Cash Balance	**£6.54m**
Expenditure Days	6.9

The Trust's plan assumes a cash position of £5.0m at the end of 2026/27. This reflects the use of financial freedoms within the capital programme.
The closing cash position for March was £8.63m reflecting an in-month decrease of £4.09m and is £0.49m which was in line with the forecast.

Capital spend

Actual YTD	**£9.51m**
Plan YTD	£1.21m

The Trust has £10.0m plan of capital spend this year, with a planned spend of £18.56m the increase is attributable to the CYP and All Age Eating Disorder transfer. Discussions are on-going regarding the capital allocations which need to transfer and technical treatment of the transfer.

WTEs utilised

M1 actual	**4,477**
Prior Month	**3,987**
Planned Staffing	**4,890**

WTEs utilised are monitored by NHS England against the Trust's workforce plan. Actual staffing figures include contracted substantive staff as well as any bank and agency usage within the reporting month. Staff increases in month are due to service transition of CYP and AAED staff and as planned.

WTEs Inpatient (WTE)

M1 actual	**738**
Prior Month	**746**
Planned Staffing	678

In April, the trust employed 59.5 wte above establishment (March: 67.7 wte), indicating an improving trajectory but remaining materially above planned levels. This has resulted in an in-month pressure of £0.34m

WTEs Community (WTE)

M1 actual	**931**
Prior Month	**939**
Planned Staffing	984

Community teams saw a small decrease in month. The demand and capacity modelling is close to being finalised at which point there will be an increase in staffing as included within the Trust plan. This increase will be closely monitored and controlled so that it remains within an acceptable increase in run rate.

Agency spend

M1 actual	**£0.60m**
Prior Month	**£0.29m**
Planned Run Rate	£0.74m

Agency spend increased as new agency costs were incurred with CYP/AAED services. Excluding these, agency costs remained in line with March costs. Month 1 actuals were lower than plan mostly due to CYP & AAED spend being lower than planned. A review will be undertaken in month to ensure all CYP & AAED costs have been captured.

Bank spend

M1 actual	**£1.81m**
Prior Month	**£1.79m**
Planned Run Rate	£1.53m

In month, bank spend marginally by £0.16m (40.2WTE), due to decreases in staff to cover sickness, annual leave and additional observations across a number of teams and wards, affecting all Directorates.

CYP Run Rate

M1 actual	**£0.60m**
Prior Month	**N/A**
Planned Run Rate	£0.74m

Agency spend increased as new agency costs were incurred with CYP/AAED services. Excluding these, agency costs remained in line with March costs. A review will be undertaken in month to ensure all CYP & AAED costs have been captured.

External beds spend

Average Beds in Month	**8**
Prior Month	**11**

In April, usage of external Acute beds decreased, from average 5 beds to 2. PICU usage remained at 6 beds.
The Trust is funded for the equivalent of 7 PICU beds, which is predominantly used to fund a block contract for 5 Female beds.

Corporate Spend

M1 actual	**£6.47m**
Prior Month	**£5.95m**
Planned Run Rate	£5.50m

In month, spend increased by £0.97m some of which will be due to pay award pain in month 1 but also increases in costs relating to the CYP and AAED service services and increases in support staff and support contracts such as maintenance and catering for the new services. Budgets are being aligned to ensure all CYP & AAED budgets are correct.

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		
	Budget £000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	358,746	30,201	29,747	(454)	30,201	29,747	(454)
Employee Expenses	(289,309)	(24,068)	(23,052)	1,017	(24,068)	(23,052)	1,017
Operating Expenses	(63,416)	(5,310)	(6,256)	(946)	(5,310)	(6,256)	(946)
Operating (Surplus) / Deficit	**6,022**	**823**	**440**	**(384)**	**823**	**440**	**(384)**
Finance Costs	(5,768)	(919)	(898)	21	(919)	(898)	21
Surplus / (deficit) for the period	**253**	**(96)**	**(458)**	**(362)**	**(96)**	**(458)**	**(362)**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	**(253)**	**96**	**458**	**363**	**96**	**458**	**363**
System control Surplus / (Deficit)	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Statement of Financial Position

	31st March 2026	30th April 2026
	Actual £000	*Actual* £000
Non-current assets	183,623	192,114
Current assets	21,129	22,306
Current liabilities	(31,756)	(39,386)
Non current liabilities	(37,757)	(38,143)
Net Assets Employed	**135,240**	**136,890**
Total Taxpayers Equity	**135,240**	**136,890**

The Trust is reporting a breakeven position at the end of April. This is in line with plan.

Income

The year-to-date adverse variance against plan is largely attributable to the timing of income recognition associated with the donated R&D Hyperfine scanner. This income is anticipated to be recognised in subsequent months, which will mitigate the current variance.

Employee expenses

The Trust is reporting an in-month underspend on employee expenses of £1.02m.

This consists of underspends on substantive pay and agency of £0.15m and is offset by overspends on bank (where bank is planned to support rotas).

Substantive pay increased by £3.94m over March spend. Of this, £3.30m relates to the transfer of CYP and AAED services. The remaining movement reflects the estimated impact of the pay awards, including £0.33m relating to the Agenda for Change award paid in-month. Excluding the impact of the transferred services, bank staff reduced in month, and agency spend remained broadly in line with March.

Operating expenses

Other non pay pressures relate to external bed usage (£0.10m) and the includes assumptions around the costs relating to CYP which are under review and this position is anticipated to be refined in the coming months.

Total assets

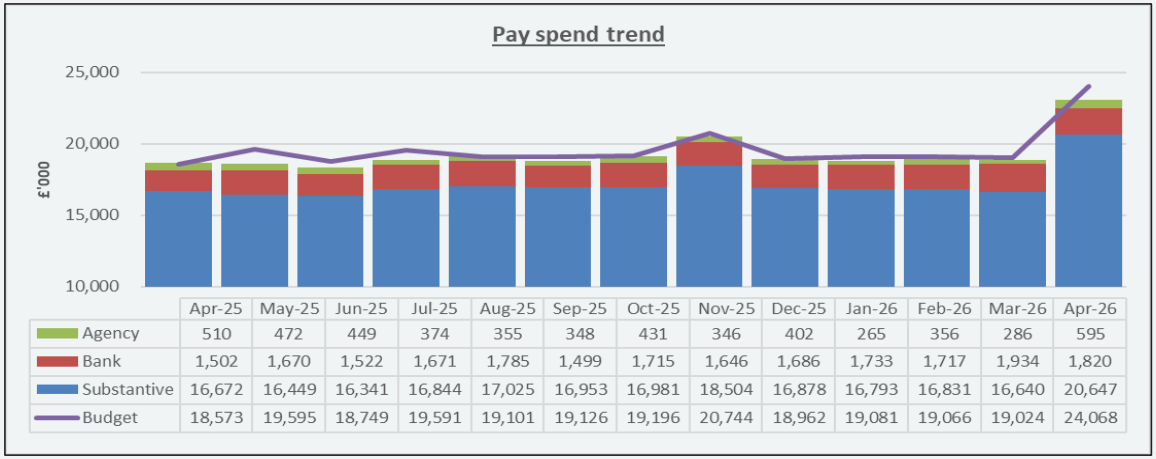
Total assets increased by £7.57m during the month, primarily reflecting the transfer of assets associated with the CYP and AAED services from North East London NHS Foundation Trust. This increase is largely driven by the recognition of lease liabilities for properties from which these services are delivered across Kent.

Total liabilities

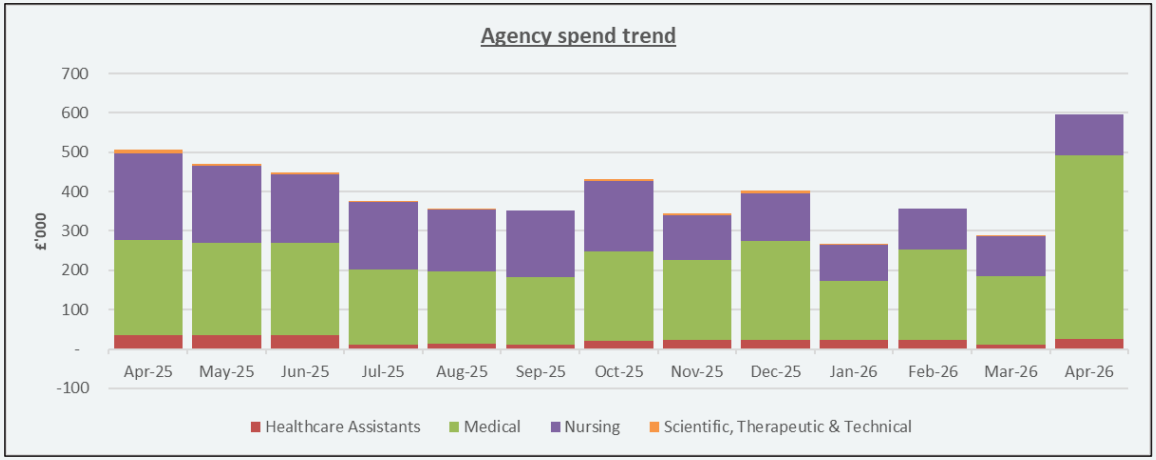
Total liabilities have increased by £8.02m in the month. This mainly relates to the transfer of leases for the CYP and AAED services from North East London NHS Foundation Trust.

Appendices

Exception report – Pay trend



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26
Agency	510	472	449	374	355	348	431	346	402	265	356	286	595
Bank	1,502	1,670	1,522	1,671	1,785	1,499	1,715	1,646	1,686	1,733	1,717	1,934	1,820
Substantive	16,672	16,449	16,341	16,844	17,025	16,953	16,981	18,504	16,878	16,793	16,831	16,640	20,647
Budget	18,573	19,595	18,749	19,591	19,101	19,126	19,196	20,744	18,962	19,081	19,066	19,024	24,068



As at the end of April the Trust reported a year-to-date underspend on pay of £1.02m.

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 64.6 WTE below plan.

Substantive pay

- Substantive pay increased by £3.94m over March spend. Of this, £3.30m relates to CYP/AAED staff.
- The remaining movement reflects the estimated impact of the pay awards, including £0.33m relating to the Agenda for Change award paid in-month. Medical pay awards will be transacted in June and bank rates are being finalised and are anticipated to be paid in Quarter 1. Band 2 staff have had pay rates increased in line with minimum wage.

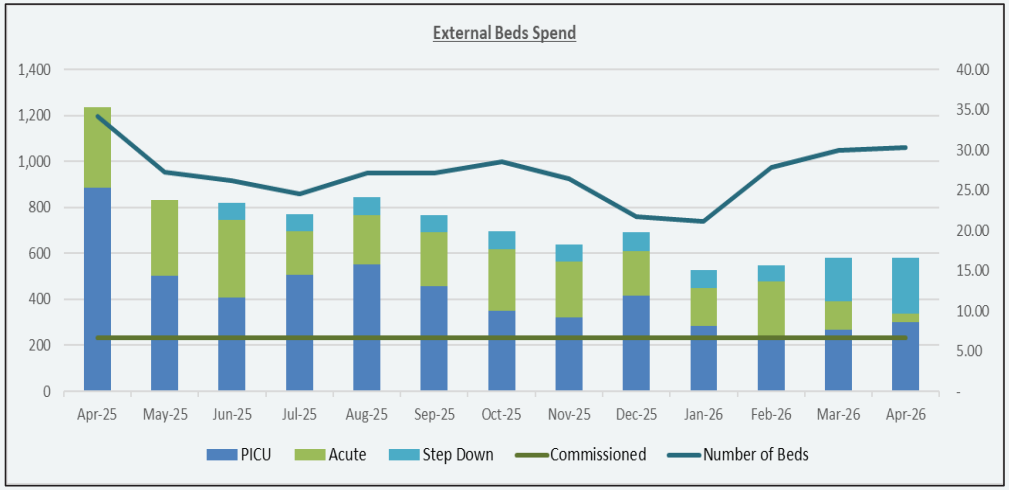
Temporary staffing

After an increase in bank spend in March, this reduced in month to £1.71m, the same spend as recorded in February, plus an additional £0.10m for CYP/AAED services, totalling £1.81m spend in month. Cover for annual leave and sickness is noted to have reduced in month.

- Agency spend in April totalled £0.60m, of which £0.31m relates to agency staff used in CYP/AAED services. Excluding these, agency spend has reduced by 43.2% from the same period in 2025/26 and is broadly in line with the March 2026 position (1.2% higher).
- Within this, nursing agency remains limited, with £0.05m (43.5%) supporting CYP/AAED services and £0.06m supporting community services across East, North and West Kent, including Crisis & Home Treatment, MHT/MHT+/MAS and Liaison.
- Medical agency usage outside CYP reduced to 8.0 WTE in April (6.5 WTE in East Kent), with agency now ceased in North Kent following the departure of a Consultant.
- CYP/AAED services continue to rely on higher agency usage, with 13.6 WTE at a cost of £0.26m in-month, reflecting underlying workforce gaps, including 17.7 WTE medical vacancies across Consultant and Specialty Doctor roles. This position is being actively reviewed as part of the post-transfer stabilisation and workforce planning approach.

Caring Inclusive Curious Confident

Exception report – External beds



Commentary

In April, usage of external Acute beds decreased, from average 5 beds to 2. PICU usage remained at 6 beds.

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.

Over the past year, escalated levels of Clinically Ready for Discharge (CRFD) patients held on Acute Inpatient wards has led to both external Acute and PICU beds being utilised above funded levels.
To help alleviate this pressure, the Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to Trust beds.

The external beds graph shows that the number of beds used during the same period in 2025/26 has remained broadly unchanged, while the associated costs have reduced significantly. Spend has decreased by £0.66m compared to the same period, despite only a small reduction of three beds in use.

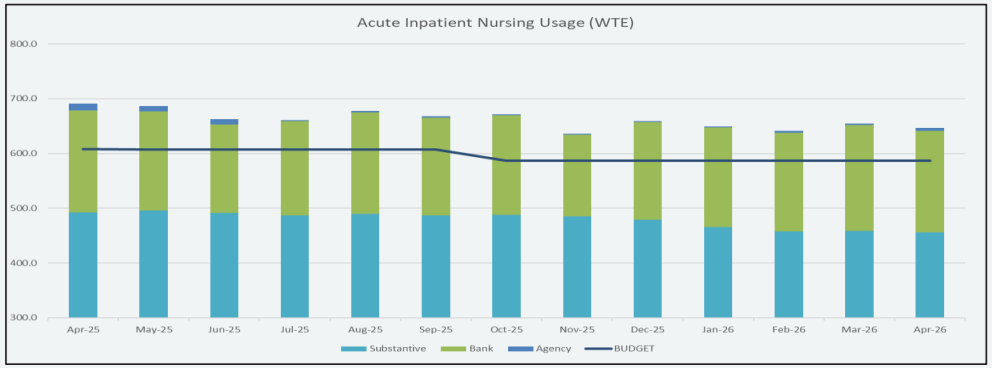
Exception report – Inpatient staffing

Commentary

In April, 59.5 additional WTE above establishment were utilised, decreasing from 67.7 WTE in March. The year-to-date pressure totals £0.34m.

In month changes

- Levels of additional observations increased in month, costing approximately £0.15m in additional staffing to support, the same as last month.
- Annual leave cover decreased from £0.31m to £0.20m
- Sickness cover increased from £0.13m to £0.14m
- Study leave cover decreased from £0.11m to £0.10m
- Other cover cost £0.08m in month, including £0.02m cover for staff who are supernumerary or working off ward, £0.02m cover for staff management days and £0.03m described as “other leave”.



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Capital position

	Annual			Year to Date		
	Plan	Forecast	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
System Capital expenditure						
Capital Maintenance and Minor Schemes	3,247	3,247	0	15	180	165
Information Management and Technology	350	350	0	0	197	197
Section 136 development	2,250	2,250	0	45	227	182
Public Decarbonisation	0	0	0	0	0	0
IFRS 16 Leases	585	585	0	535	30	(505)
IFRS 16 Leases - CAMHS	104	1,743	1,639	34	1,673	1,639
Total system expenditure	**6,536**	**8,175**	**1,639**	**629**	**2,307**	**1,678**
External expenditure						
Out of Area Placement (Female PICU)	2,539	2,539	0	300	163	(137)
PFI 2025/26	236	236	0	20	20	0
R&D - Hyperfine Swoop Imaging System	578	578	0	123	190	67
Solar Installation	138	138	0	138	(9)	(147)
Thanet Crisis Assessment Service	50	50	0	0	0	0
Total external expenditure	**3,541**	**3,541**	**0**	**581**	**364**	**(217)**
Intra DH expenditure						
Adol Hosp	0	6,522	6,522	0	6,522	6,522
Castleside	0	318	318	0	318	318
Total Intra DH expenditure	**0**	**6,840**	**6,840**	**0**	**6,840**	**6,840**
Total Capital Expenditure	**10,077**	**18,556**	**8,479**	**1,210**	**9,511**	**8,301**

Commentary:

As of 30th April, the overall capital position is £8.30m over the planned position submitted to NHS England (NHSE) driven primarily by the recognition of assets associated with the CYP and AAED service transfer.

Discussions are on-going with NHSE regarding this impact and the impact on the trust's capital allocation.

Excluding these assets the position is £0.18m behind plan; this is primarily due to an IFRS16 remeasurement linked to the pending rent review for the Eureka Medical Centre. This is partially offset by several projects being ahead of schedule compared to plan.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28 May 2026
Title of paper:	Workforce Deep Dive – WDES and WRES
Author:	Yasmin Damree-Ralph, Diversity and Inclusion Manager
Executive Director:	Ali Layne-Smith, interim Chief People Officer

Purpose of paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of paper

The Board requested a deep dive paper concerning grievances and employee relations related to race and disability. The Trust does not consistently categorise these areas by demographics and as an alternative, the annual Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), 2026 report has been provided for information as it features a section on employee relations.

Issues to bring to the Board's attention

The Trust is required to publish our WDES and WRES reports annually.

Governance

Implications/Impact:	Findings from the WRES and WDES reports provide an indicator of the impact of our policies and procedures on our Global Majority, and disabled colleagues. We combine the results with information from the staff survey, our networks, and listening events to drive improvements in the experience of colleagues with these protected characteristics.
Assurance:	Reasonable
Oversight:	Oversight by People Committee

Version 2 - **Private**

Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) 2026 Report

Kent and Medway Mental Health NHS Trust

1. Executive Summary

The 2026 WDES and WRES data presents a mixed picture of workforce equality. On disability, Board disability representation is above the overall workforce disability declaration rate, which is a positive indication at senior level. However, recruitment outcomes remain uneven, with non-disabled applicants 2.32 times more likely to be appointed from shortlisting than disabled applicants.

On race, the data indicates more significant inequality. Black, Asian, Minority Ethnic (BAME) staff represent 31.76% of the workforce but only 20.83% of Board voting membership, indicating under-representation at Board level. White applicants are 1.76 times more likely than BAME applicants to be appointed from shortlisting, and BME staff are 2.78 times more likely than White staff to enter the formal disciplinary process.

There are also important data quality issues. Disability status is unknown or not recorded for 19.33% of the workforce, rising to 65.06% of medical and dental staff.

In the recruitment data, applicants whose disability status is unknown have an unusually high appointment rate, which suggests declaration or recording issues that may obscure the true position.

The staff survey findings strengthen this picture by showing that BAME staff report worse day-to-day experiences than White staff. In the staff survey, 43.8% of staff from Mixed/Multiple, Asian, Black and Other ethnic groups reported harassment, bullying or abuse from patients, relatives or the public in the last 12 months, compared with 25.7% of White staff. BAME staff were also more likely to report discrimination from staff (12.4% compared with 7.8%) and were less likely to believe that the Trust provides equal opportunities for career progression or promotion (47.4% compared with 54.6%).

The staff survey also shows important disparities for disabled staff. Disabled staff were more likely than non-disabled staff to report harassment, bullying or abuse from patients, managers or colleagues (46.2% compared with 37.5%), almost twice as likely to report feeling pressure from managers to come to work when not well enough to perform their duties (21.5% compared

Prepared from the NHS WDES/WRES 2025/2026 data collection

with 11.2%), and less likely to feel that their work is valued by the organisation (38.2% compared with 49.5%). Disabled staff also reported a lower staff engagement score (6.2 compared with 6.9).

2. Introduction

This report provides an analysis of the organisation's 2026 Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) data for Kent and Medway Mental Health NHS Trust. It brings together workforce, recruitment, Board representation and staff experience data to assess the extent to which equality is being realised for disabled staff and for staff from Black and minority ethnic backgrounds across the organisation.

The purpose of the report is to identify areas of progress, highlight persistent inequalities, and support informed decision-making on the Trust's equality priorities and action planning. The analysis shows some positive indicators, including stronger Board disability representation and good access to non-mandatory training and development for BME staff. However, it also identifies significant areas of concern, particularly in relation to recruitment outcomes, disciplinary disproportionality, representation at senior levels, and the lived experience of staff captured through the staff survey.

The report is intended to support People Committee and senior leadership oversight by providing a clear picture of both formal workforce outcomes and day-to-day staff experience. In particular, the inclusion of staff survey findings strengthens the analysis by showing how inequalities are experienced in practice, including higher levels of harassment, discrimination, reduced confidence in fair progression, lower feelings of being valued, and lower engagement among some staff groups.

Taken together, the findings in this report provide an evidence base for targeted action to improve fairness, inclusion and accountability across the Trust. They also highlight the importance of continued attention to data quality, especially where incomplete declaration or recording may limit assurance and obscure the full extent of inequality.

WDES and WRES data submission is on or before the 30th May, and it is expected that the WDES and WRES report is published on the trust's website by October.

3. . Headline Metrics

Area	Metric	Result	Interpretation
WDES	Disabled staff in workforce	9.48%	Disability declaration remains incomplete due to 19.33% unknown status.
WDES	Board disability representation	13.04%	Above workforce disability declaration rate (+3.58 percentage points).
WDES	Relative likelihood of appointment (non-disabled vs disabled)	2.32	Non-disabled applicants are more likely to be appointed from shortlisting.
WRES	BAME staff in workforce	31.76%	BAME staff form nearly one third of the workforce.
WRES	Board BAME representation	20.83	Below workforce BAME representation (-10.93 percentage points).
WRES	Relative likelihood of appointment (White vs BAME)	1.76	White applicants are more likely to be appointed from shortlisting.
WRES	Relative likelihood of formal disciplinary entry (BME vs White)	2.78	BAME staff are significantly more likely to enter the formal disciplinary process.

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WRES	Relative likelihood of accessing non-mandatory training (White vs BME)	0.88	BAME staff are slightly more likely than White staff to access non-mandatory training and CPD.
WRES Staff Survey	Harassment, bullying or abuse from patients/public	43.8% vs 25.7%	BAME staff report substantially worse experience than White staff.
WRES Staff Survey	Discrimination from staff	12.4% vs 7.8%	BAME staff report higher discrimination from colleagues.
WRES Staff Survey	Belief in equal opportunities for career progression	47.4% vs 54.6%	BAME staff report lower confidence in fair progression.

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3. Workforce Disability Equality Standard (WDES)

3.1 Metric 1 - Workforce Profile and Representation

As of 31 March 2026, the workforce total recorded was 3,936 staff. Of these, 373 staff (9.48%) are recorded as disabled, 2,802 staff (71.19%) as non-disabled, and 761 staff (19.33%) as disability unknown/null.

Disability representation is broadly similar across non-clinical and clinical staff groups: 9.7% in non-clinical roles and 10.2% in clinical roles. However, medical and dental staff show a major data quality issue, with only 0.79% recorded as disabled and 65.08% recorded as unknown/null.

At senior levels, the picture is mixed. Disabled representation is 15.7% in senior non-clinical roles (Bands 8c–VSM), but only 5.6% in senior clinical roles.

3.2 Metric 2 – Recruitment

Recruitment is the most significant WDES concern. Non-disabled applicants are 2.32 times more likely than disabled applicants to be appointed from shortlisting.
In total, 266 disabled applicants were shortlisted and 3 were appointed, equating to an appointment rate of 1.13%. By comparison, 2,066 non-disabled applicants were shortlisted and 54 were appointed, an appointment rate of 2.61%.

A further 97 shortlisted applicants had disability status recorded as unknown/null, and 33 of those were appointed, equating to an appointment rate of 34.02%. This pattern suggests inconsistent declaration or recording of disability status during recruitment.

3.3 Metric 3 - Formal Capability Process

Employee Relations (ER) does not currently collect or maintain data on the disability status of employees entering formal capability processes. Furthermore, there are no central records held on the number of cases initiated on the grounds of ill health, representing a limitation on the management of information available.

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3.4 Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

The staff survey findings add an important lived-experience dimension to the WDES workforce metrics. They show that disabled staff report a less positive working experience than non-disabled staff across several indicators.

3.4.1 Metric 4a – patients (reported in the last 12 months)

33.6% of staff with disabilities report experiencing harassment, bullying or abuse from patients. This increased from 32.7% last year. KMMH are above the national average of 27.2%.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total number of staff	%	2025/2026 Total number of staff	%
Disabled	613	31.6%	581	30.6%	636	32.7%	622	33.6%
Non-Disabled	1582	28.8%	1296	26.2%	1410	30.2%	1335	28.8%
Total	2195		1877		2046		1957	

3.4.2 Metric 4b - managers (reported in the last 12 months)

12.5% of staff with disabilities reported harassment, bullying or abuse from managers. This increased from 11.04% last year. KMMH are above the national average of 11.5%.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total Number of staff	%	2025/2026 Total Number of staff	%
Disabled	613	11.3%	577	13.3%	634	11.04%	615	12.52%
Non-Disabled	1561	6.0%	1277	6.5%	1380	6.96%	1317	6.61%

Prepared from the NHS WDES/WRES 2025/2026 data collection

3.4.3 Metric 4c: other colleagues

21.4% of staff with disabilities report experiencing harassment, bullying or abuse from colleagues. This has increased from 18.8% last year. KMMH are above the national average of 18.8%

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total Number of staff	%	2025/2026 Total Number of staff	%
Disabled	609	17.7%	562	19.5%	630	18.8%	605	21.4%
Non-Disabled	1561	11.5%	1263	12.8%	1365	12.2%	1313	13.2%
Total	2170		1825		1995		1918	

Disabled staff were more likely than non-disabled staff to experience harassment, bullying or abuse from patients, managers or colleagues (46.2% compared with 37.5%). Reporting levels following the last incident were broadly similar (64.0% for disabled staff and 65.7% for non-disabled staff), which suggests that the main issue is prevalence of poor treatment rather than lower reporting alone.

Disabled staff were less likely to believe that the Trust provides equal opportunities for career progression or promotion (50.0% compared with 53.3%). While this gap is smaller than some other indicators, it is consistent with wider concerns about recruitment conversion and senior representation in clinical leadership roles.

A particularly important issue is health and wellbeing at work. Disabled staff were nearly twice as likely to say they had felt pressure from their manager to come to work despite not feeling well enough to perform their duties (21.5% compared with 11.2%). This indicates a material concern regarding management practice, support, and psychological safety.

Disabled staff were also less likely to say that they were satisfied with the extent to which the organisation values their work (38.2% compared with 49.5%), and their staff engagement score was lower overall (6.2 compared with 6.9). Together, these findings suggest that disabled staff are experiencing a less inclusive workplace culture than non-disabled colleagues.

The survey shows that 73.2% of disabled staff said that their employer had made reasonable adjustments to enable them to carry out their work. While this is positive for those who disclosed and requested adjustments, it still means that more than one in four disabled staff did not report this positive experience, and the survey findings should therefore be considered alongside the reported need to validate local policy and passport arrangements.

21.4% of staff with disabilities reported harassment, bullying or abuse from colleagues. This increased from 18.8% last year. KMMH are above the national average of 18.8%

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total Number of staff	%	2025/2026 Total Number of staff	%
Disabled	609	17.7%	562	19.5%	630	18.8%	605	21.4%
Non-Disabled	1561	11.5%	1263	12.8%	1365	12.2%	1313	13.2%
Total	2170		1825		1995		1918	

Disabled staff were more likely than non-disabled staff to experience harassment, bullying or abuse from patients, managers or colleagues. Reporting levels following the last incident were broadly similar, which suggests that the main issue is prevalence of poor treatment rather than lower reporting alone.

3.4.4 Metric 4d: Percentage of staff saying that, the last time they experienced bullying or harassment at work, they or a colleague reported it

64.0% of staff with disabilities say that the last time they experienced bullying or harassment at work, they or a colleague reported this. This is a decrease from last year which was 66.2%, however KMMH are above the national average which is 61.6%.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total number of staff	%	2025/2026 Total number of staff	%
Disabled	238	64.7%	242	60.7%	252	66.2%	264	64.0%
Non-Disabled	491	68.0%	409	65.5%	469	67.5%	437	65.6%
Total	729		651		721		701	

3.5 Metric 5: Percentage believing that Trust provides equal opportunities for career progression or promotion.

Disabled staff were less likely to believe that the Trust provides equal opportunities for career progression or promotion (50.0% compared with 53.3%). While this gap is smaller than some other indicators, it is consistent with wider concerns about recruitment conversion and senior representation in clinical leadership roles.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total Number of staff	%	2025/2026 Total Number of staff	%
Disabled	608	59.5%	584	53.6%	633	53.2%	622	50.0%
Non-Disabled	1571	60.3%	1290	59.3%	1405	58.0%	1333	53.3%
Total	2179		1874		2038		1955	

3.6 Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Disabled staff were nearly twice as likely to say they had felt pressure from their manager to come to work despite not feeling well enough to perform their duties (21.5% compared with 11.2%). This indicates a concern regarding management practice, support, and psychological safety, a particularly important issue on the trust's health and well-being of staff at work.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024	%	2024/2025	%	2025/2026	%

Prepared from the NHS WDES/WRES 2025/2026 data collection

			Total Number of staff		Total Number of staff		Total Number of staff	
Disabled	408	17.9%	366	19.6%	400	19.2%	418	21.5%
Non-Disabled	726	14.9%	560	11.4%	606	10.7%	588	11.2%
Total	1134		2060		1006		1006	

3.7 Indicator 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Disabled staff were less likely to say that they were satisfied with the extent to which the organisation values their work (38.2% compared with 49.5%), and the staff engagement score was lower overall (6.2 compared with 6.9). Together, these findings suggest that disabled staff are experiencing a less inclusive workplace culture than non-disabled colleagues.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total Number of Staff	%	2024/2025 Total Number of Staff	%
Disabled	615	45.2%	582	41.2%	635	36.6%	621	38.1%
Non-Disabled	1584	49.9%	1298	51.5%	1410	52.8%	1337	49.5%
Total	2199		1880		2045		1958	

3.8 Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

The survey shows that 73.2% of disabled staff said that their employer had made reasonable adjustments to enable them to carry out their work. While this is positive for those who disclosed and requested adjustments, it still means that more than one in four disabled staff did not report this positive experience, and the survey findings should therefore be considered alongside the reported need to validate local policy and passport arrangements.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	%	2023/2024 Total Number of staff	%	2024/2025 Total number of staff	%	2025/2026 Total number of staff	%
Disabled	376	77.9%	365	78.3%	400	78.2%	407	73.2

3.9 Metric 9: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation (out of 10)

The staff engagement score for disabled staff is 6.1, compared with 6.8 for staff without disabilities. The national average for disabled staff is 6.6 and 7.1 for staff without disabilities. Staff engagement in KMMH is below the national average for both disabled and non-disabled.

Workforce Group (Clinical & non-clinical)	2022/2023 Total Number of staff	Score	2023/2024 Total Number of staff	Score	2024/2025 Total number of staff	Score	2025/2026 Total number of staff	Score
Disabled	616	6.7	584	6.8	637	6.3	624	6.1
Non-Disabled	1589	7	1300	7.2	1417	6.9	1342	6.8
Total	2205		1884		2054			

Board Representation

Board disability representation is stronger than the workforce profile. Three of the 23 Board members (13.04%) are recorded as disabled, compared with 9.46% in the overall workforce. However, 21.74% of Board members are recorded as disability unknown/null, which is slightly higher than the workforce unknown rate.

Prepared from the NHS WDES/WRES 2025/2026 data collection

4. Workforce Race Equality Standard (WRES)

4.1 Indicator 1 - Workforce Profile and Representation

As of 31st March 2026, the workforce total was 3,936 staff. Of these, 1,250 staff (31.76%) are recorded as BME, 2,410 staff (61.23%) as White, and 276 staff (7.01%) as ethnicity unknown/null. BAME representation varies significantly by staff group: 13.8% in non-clinical roles, 35.6% in clinical roles, and 67.58% in medical and dental staff. At senior levels, BAME representation remains below the overall workforce profile: 11.76% in senior non-clinical roles and 17.32% in senior clinical roles, compared with 31.76% across the workforce overall.

4.2 Indictor 2 - Recruitment

The WRES recruitment indicator shows a disadvantage for BAME applicants. White applicants are 1.76 times more likely than BAME applicants to be appointed from shortlisting. The data shows an increase of 0.58 from the 2024/2025 data (likelihood 1.18).

Analysis of recruitment outcomes indicates a disparity in appointment rates following shortlisting. While a higher number of BAME applicants were shortlisted (1,412 compared to 884 White applicants), their likelihood of appointments was significantly lower (2.05% vs 3.62%). This suggests that inequalities may be occurring at later stages of the recruitment process, such as interview, assessment, or final selection.

4.3 Indicator 3 – Entering Formal Disciplinary Process

The most concerning WRES metric is formal disciplinary entry. BAME staff are 2.78 times more likely than White staff to enter the formal disciplinary process. The data shows an increase of 0.16, from the 2024/2025 data (likelihood 2.62).

The likelihood of entering the formal disciplinary process is 4.18% for BAME staff compared with 1.51% for White staff.

While the data indicates that BAME staff are 2.78 times more likely to enter the formal disciplinary process compared to White staff, this finding should be interpreted with caution due to the relatively small number of cases involved. The total number of staff entering the process is low (52 BAME staff and 36 White staff), meaning that even small changes in numbers can

significantly affect the calculated likelihood. As such, the figures may be sensitive to fluctuation and should be considered alongside the overall context and workforce size.

4.4 Indicator 4 - Access to Non-Mandatory Training and CPD

The relative likelihood ratio is 0.8, indicates that BAME staff are slightly more likely than White staff to access non-mandatory training and CPD.

Access rates are 88.4% for BAME staff compared with 78.6% for White staff. This suggests some positive practice in access to development opportunities, although it has not yet translated into parity in senior representation or disciplinary outcomes.

4.5 Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

The staff survey findings reinforce the structural inequalities shown in the WRES indicators and provide evidence of day-to-day differences in staff experience by ethnicity.

512 (43.7%) of BAME staff who completed the staff survey stated that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This is an increase from last year of 1%. (21 more responses from BAME staff). The percentage remains high and above the national average for BAME staff at 33.8%. White staff experience has increased by 1.%.

Staff from Mixed/Multiple ethnic groups, Asian/Asian British, Black/African/Caribbean/Black British, and Other ethnic groups were much more likely than White staff to report harassment, bullying or abuse from patients, relatives or the public in the last 12 months This is the largest gap identified in the WRES indicators and suggests that BAME staff face disproportionate exposure to poor treatment from service users and the public.

2021 Staff Survey		2022 Staff Survey		2023 Staff Survey		2024 Staff Survey		2025 Staff Survey	
White	BAME	White	BAME	White	BAME	White	BAME	White	BAME
26.8%	35.4%	28.0%	35.7%	25.3%	35.2%	27.1%	42.7%	25.6%	43.7%

Prepared from the NHS WDES/WRES 2025/2026 data collection

1650 responses	463 responses	1735 responses	446 responses	1477 responses	400 responses	1561 responses	491 responses	1452 responses	512 responses

4.6 Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.

21.8% of BAME staff who completed the staff survey stated that they have experienced harassment, bullying or abuse from staff in the last 12 months, this is an increase from last year of 2.4%. (20 more responses from BAME staff). The percentage is above the national average for BAME staff at 20.2%. White staff experience has increased to 19.2 from 17.5% in 2024.

Although the percentage point difference is more modest, it remains important because it indicates that inequity is not confined to external interactions and may also be reflected in internal workplace culture.

2021 Staff Survey		2022 Staff Survey		2023 Staff Survey		2024 Staff Survey		2025 Staff Survey	
White	BAME	White	BAME	White	BAME	White	BAME	White	BAME
18.0%	18.0%	16.2%	19.8%	19.0%	20.6%	17.5%	19.4%	19.2%	21.8%
1655 responses	461 responses	1731 responses	445 responses	1479 responses	393 responses	1555 responses	483 responses	1449 responses	503 responses

4.7 Indicator 7: Percentage believing that Trust provides equal opportunities for career progression or promotion.

47.3% of BAME staff stated believing the Trust provides equal opportunities for career progression or promotion (31 more responses from BAME staff). This is a decrease of 3.3% of BAME staff believing that KMMH provides equal opportunities compared to the previous year.

Confidence in fairness of progression is lower among BAME staff, this finding closely aligns with the WRES recruitment and senior representation indicators and strengthens the case for a focused progression and talent management response.

2021 Staff Survey		2022 Staff Survey		2023 Staff Survey		2024 Staff Survey		2025 Staff Survey	
White	BAME	White	BAME	White	BAME	White	BAME	White	BAME
62.8%	51.5%	62.8%	50.8%	60.7%	47.3%	58.4%	50.6%	54.5%	47.3%
1690 responses	474 responses	1723 responses	443 responses	1477 responses	397 responses	1561 responses	482 responses	1448 responses	513 responses

Prepared from the NHS WDES/WRES 2025/2026 data collection

4.8 Indicator 8: In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leaders or other colleagues?

12.3% of BAME staff stated that they had personally experienced discrimination. The staff survey indicates that this has increased for our BAME staff from 10.2% to 12.3%. This is still slightly lower than the average of 12.6% across the NHS. However, it is significantly higher than our white staff where 7.8% of staff stated that they experience discrimination from managers/team leader/colleagues, also an increase of 0.9% compared to the previous year.

BAME staff were also more likely to report discrimination from staff in the last 12 months. This is a notable difference and is consistent with the wider pattern of disproportionality seen in disciplinary entry. Taken together, the survey and workforce data suggest that both formal outcomes and everyday staff experience require attention.

2021 Staff Survey		2022 Staff Survey		2023 Staff Survey		2024 Staff Survey		2025 Staff Survey	
White	BAME	White	BAME	White	BAME	White	BAME	White	BAME
6.7%	12.6%	5.7%	10.8%	7.4%	13.7%	6.9%	10.2%	7.8%	12.3%
1693 responses	475 responses	1736 responses	444 responses	1462 responses	394 responses	1535 responses	477 responses	1436 responses	510 responses

Indicator 9 - Board Representation

Board ethnicity is less representative than the workforce. BME staff make up 31.76% of the workforce but only 20.83% of Board voting membership, a gap of -10.93 percentage points. The Board ethnicity unknown/null rate is 12.50%, compared with 7.01% in the workforce overall.

Prepared from the NHS WDES/WRES 2025/2026 data collection

5. Key Organisational Themes

5.1 Strengths

- Board disability representation is above the overall workforce disability declaration rate.
- BAME staff access non-mandatory training and CPD at slightly higher rates than White staff.
- The staff survey responses indicate ongoing work to improve ESR declaration rates and encourage disabled applicants to apply for jobs.
- The staff survey data indicates that the organisation provides targeted career development opportunities for disabled staff.
- The staff survey indicates that 73.2% of disabled staff said reasonable adjustments had been made to enable them to carry out their work.

5.2 Risks and Concerns

- Disability declaration remains incomplete for robust assurance, particularly in medical and dental staff.
- There are recruitment inequalities affecting both disabled applicants and BAME applicants.
- BAME staff are significantly overrepresented in formal disciplinary entry.
- Board ethnic diversity is below workforce representation, and Board declaration completeness needs improvement.
- Employee relations and capability systems do not currently appear to record disability status.
- BAME staff report substantially higher harassment, bullying or abuse from patients, relatives or the public, alongside higher discrimination from staff and lower confidence in equal opportunities for progression.
- Disabled staff report poorer experiences of workplace culture and wellbeing, including greater exposure to harassment, lower feelings of being valued, and significantly higher pressure to attend work when unwell.

6. Priorities - Action Plan

WDES & WRES Action Plan (12 Months)

Phase	Months	Action	Lead	Support	Key activities	Output
Phase 1: Foundation & Diagnostics	1–3	Disability Declaration Improvement	Workforce Information Manager	EDI Practitioner; HR Business Partners; Medical Staffing Lead	Audit declaration rates including medical & dental staff; Review onboarding and recruitment forms; Launch awareness campaign	Baseline declaration report
Phase 1: Foundation & Diagnostics	1–3	Recruitment Pathway Review (WDES & WRES)	Head of Resources	EDI Practitioner; Workforce Information Team; Directorate HRBPs	Map recruitment pathways; Analyse conversion rates; Review panel decision-making	Recruitment inequalities diagnostic
Phase 1: Foundation & Diagnostics	1–3	Disciplinary Disproportionality Deep Dive	Employee Relations Lead	Workforce Analytics; EDI Practitioner; FTSU Guardian	Review disciplinary cases; Triangulate with grievance and FTSU data; Identify systemic drivers	Root cause analysis report
Phase 2: Design & Intervention	4–6	Disability Data Capture & Monitoring	Workforce Information Manager	ESR Manager; EDI Practitioner	Update systems to capture disability status; Align datasets for WDES	Integrated dataset
Phase 2: Design & Intervention	4–6	Recruitment Effectiveness Review & Optimisation	Head of Resourcing	EDI Practitioner; Workforce Information Team	Evaluate existing interventions; Analyse outcomes by protected characteristics; Identify variation across divisions; Conduct quality audits of panels; Gather candidate and panel feedback; Strengthen accountability	Recruitment effectiveness report
Phase 2: Design & Intervention	4–6	Progression & Leadership Pathways (BAME Staff)	EDI Manager	EDI Practitioner, OD/L&M Facilitator,	Develop mentoring and leadership programmes	BAME progression strategy
Phase 2: Design & Intervention	4–6	Board Representation & Data Completeness	EDI Manager	Trust Secretary; EDI Practitioner	Improve Board diversity data	Board diversity plan
Phase 3: Implementation	7–9	Targeted Recruitment Improvements Rollout	EDI Manager	Recruitment Manager; EDI Practitioner; HRBPs	Implement targeted actions based on findings; Embed equality reviews into governance	Targeted improvements embedded
Phase 3: Implementation	7–9	Monitoring & Reporting Systems	EDI Manager	EDI practitioner, BI Manager	Build WDES/WRES into EDI Dashboard	Live reporting dashboard
Phase 4: Evaluation & Embedding	10–12	Impact Evaluation	Workforce Information Manager	EDI Lead Practitioner	Reanalyse key metrics	Evaluation report
Phase 4: Evaluation & Embedding	10–12	Staff Experience Validation	EDI Manager	FTSU Guardian; HRBPs, ER Manager	Reassess survey and FTSU data	Staff experience report
Phase 4: Evaluation & Embedding	10–12	Board Assurance & Sustainability	Chief People Officer	EDI Manager	Present to Board and agree KPIs	Sustainability plan

Prepared from the NHS WDES/WRES 2025/2026 data collection

7. Recommendations

1. notes the current WDES/WRES data position.
2. Approves the data to be submitted to NHS England via the DCF portal
3. approves this combined action plan.
4. supports delivery through the EDI Steering Group, update progress report bi-annually to People Committee.

Prepared from the NHS WDES/WRES 2025/2026 data collection

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Restrictive practice deep dive, January- December 2025
Author:	Jackie Dee'ath, Service Manager - Promoting Safe Services
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Discussion
Submission to Board:	Committee requested

Overview of paper

This report accounts for Restrictive Practices between January – December 2025. As a result of a deep dive into the data, it identifies the top three trends of our current state and details actions and potential countermeasures to reduce any unwanted variations or trends. The data detailed within uses demographic characteristics to support analysis. Therefore, the following information provides a county-wide baseline.

Issues to bring to the Board's attention

The following data covers the calendar year of 2025 with a total of:

- 1276 restraints; an increase from 1,015 in 2024 (↑20%)
- 88 prone restraints; an increase from 79 in 2024 (↑10%)
- 191 seclusions; a decrease from 291 in 2024 (↓34%)

Governance

Implications/Impact:	National policy and the Mental Health Act Code of Practice require mental health providers to deliver least restrictive, proportionate and patient-centred care, with a clear ambition to reduce and, where possible, eliminate restrictive interventions.

Version 2 - **Public**

	The Trust's 2025 data demonstrates mixed performance against this direction: • Overall restraint and prone restraint have increased (20% and 10% respectively) • Seclusion has reduced significantly (34%), indicating progress in some areas These patterns reflect national system pressures, including rising acuity, delays in access to inpatient care, and increasing violence and aggression.
Assurance:	Trust Wide Security and Safety Learning Group
Oversight:	Quality Committee

Introduction

The Mental Health Act (MHA) Code of Practice provides the statutory framework underpinning restrictive practice, National policy and the Mental Health Act Code of Practice require mental health providers to deliver least restrictive, proportionate and patient-centred care, with a clear ambition to reduce and, where possible, eliminate restrictive interventions.

This report accounts for Restrictive Practices between January – December 2025. As a result of a deep dive into the data, it identifies the top three trends of our current state and details actions and potential countermeasures to reduce any unwanted variations or trends. The data detailed within uses demographic characteristics to support analysis. Therefore, the following information provides a county-wide baseline.

In Kent the ethnic minorities population has increased from 3.1% in 2001 to 10.6% in 2021. Kent & Medway Population data used for this report is sourced from: 2021 Census Table: Cultural Diversity in Kent, and Mid-year population estimates: age and sex profile, both by Kent Analytics, Kent County Council.

There are more female than male residents in Kent, 51.2% (826,200) female and 48.8% (784,100) male. This pattern is seen in England and in all of Kent's local authority districts.

In some of our Trust's datasets, a proportion of ethnicity data is either unstated, unknown, or under 'Other Ethnicity', which impacts the quality of our analyses.

Restrictive Practices Data

The following data covers the calendar year of 2025 with a total of:

- 1276 restraints; an increase from 1,015 in 2024 (↑20%)
- 88 prone restraints; an increase from 79 in 2024 (↑10%)
- 191 seclusions; a decrease from 291 in 2024 (↓34%)

1. Restraints incl. Prone

Graph 1: Restraints, Prone restraints & Seclusions – by month

Data reports increase in both restraints and the use of the prone position across 2025, but a significant reduction in the use of seclusion. Changes in patient acuity, longer waiting times for an inpatient bed, socio and economic pressures along with societal changes and desensitisation to aggression are all contributing factors. Reports of violence and aggression are nationally increasing within the NHS and the use of certain restrictions correlate.

In KMMH, staff receive nationally accredited training to prevent, reduce and safely manage restrictive practices. The safety culture is embedded and assurances are provided through a tiered directorate structure. The lack of a Positive Behaviour Support (PBS) / Patient Safety Plans (PSP) framework in the Acute directorate could be a contributing factor, as generally, a few complex patients can be involved in high levels of aggression, restraints and self-harm.

Indices of Multiple Deprivation – What decile do those that receive a restraint sit in?

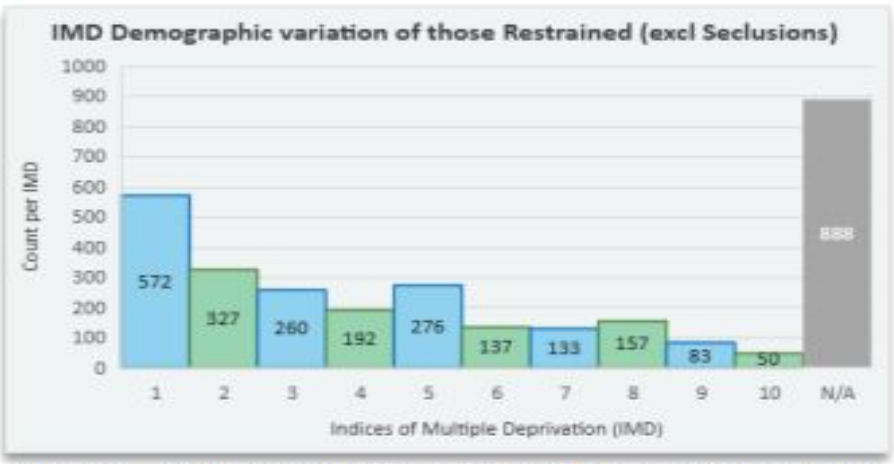
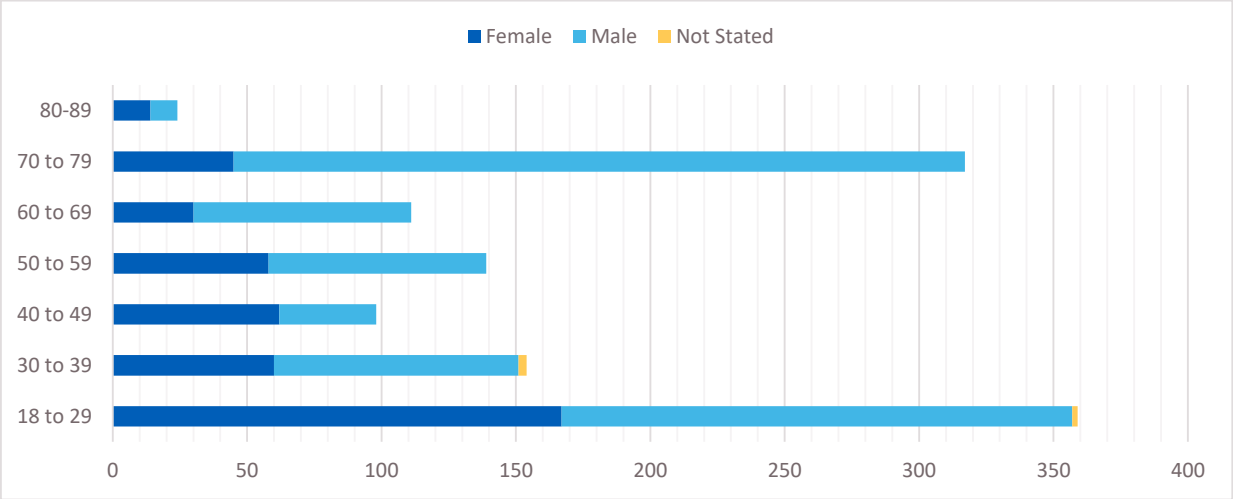


Figure 8 - Bar Chart demonstrating the IMD decile of Patients who receive a Restrictive Practice

The Figure above (figure 8), illustrates where our service users (who receive restraints) sit against the Indices of Multiple Deprivation between May 2022 and April 2026. The Indices are calculated along Lower Super Output Areas (postcodes) on the social demographics of an area, such as Educational Attainment, Housing, Employment type, Infrastructure, Health Service access etc. Decile 1 represents the most deprived areas based on socio-economic data, whereas Decile 10 is the least deprived. This chart highlights that the majority of our service users who receive restraints are from the most deprived deciles (1-5). Specifically, for those where we could gain IMD data, Quintile 1 is the most represented in regards to Restrictive Practices. Therefore, highlighting that Restraints are disproportionately applied to those in the most socio-economically deprived groups.

Although, data was unobtainable for 888 service users. Please note, due to when Lower Super Output Area data is refreshed (nationally), there is a known lag in being able to map to newer postcodes (which is required for analysis). Decile data is only for those where an obtainable postcode is within Kent and Medway, a number of N/A points will have out of area postcodes.

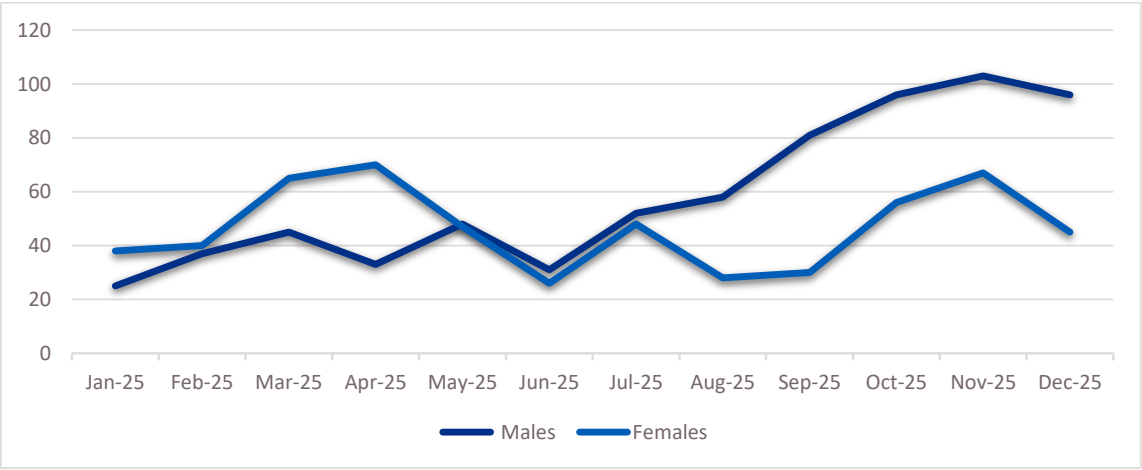
Graph 2: No. of Restraints – by age group and sex



The restraint data has been categorised into both age brackets and by sex. As expected, the 29 and under age group account for 30% of all restraints (359) with a general reductive correlation seen in the increasing age groups. Although some older adults may have to endure restraint for personal care due to confusion, dementia etc, the above data is outside the expected range. An outlier in the 70-79 age group reveals that one patient on an Older Adult ward was ascribable to 193 of the total 317 restraints (39%) for this age bracket.

In 2024 more females were restrained than males (x= 56%, y=43%). However, there has been a shift in the data with males now accounting for 56% of all restraints and females being involved in 44% of all restraints. This is particularly evident in the (18-29 and (70-79) age brackets. Although the total number of reported restraints has increased slightly in 2025 compared to the previous year, the below Graph 3 shows a confident positive shift from mid-year. One factor that can be attributed to the decrease is the alternative to self-harm box, a peer-led project offering safer alternatives to actual self-harm practices, and consequently, reducing restraints. This was piloted in May 2025 on two female wards in Canterbury. Anecdotally, data shows a 19% reduction in restraints. An outlier was identified on one ward whereby one patient was restrained 17 times within two weeks, predominantly for assaulting others, not self-harm. Removing this patient from the data would then show a 30% reduction in restraint within the 6-month pilot.

Graph 3: No. of Restraints – by sex



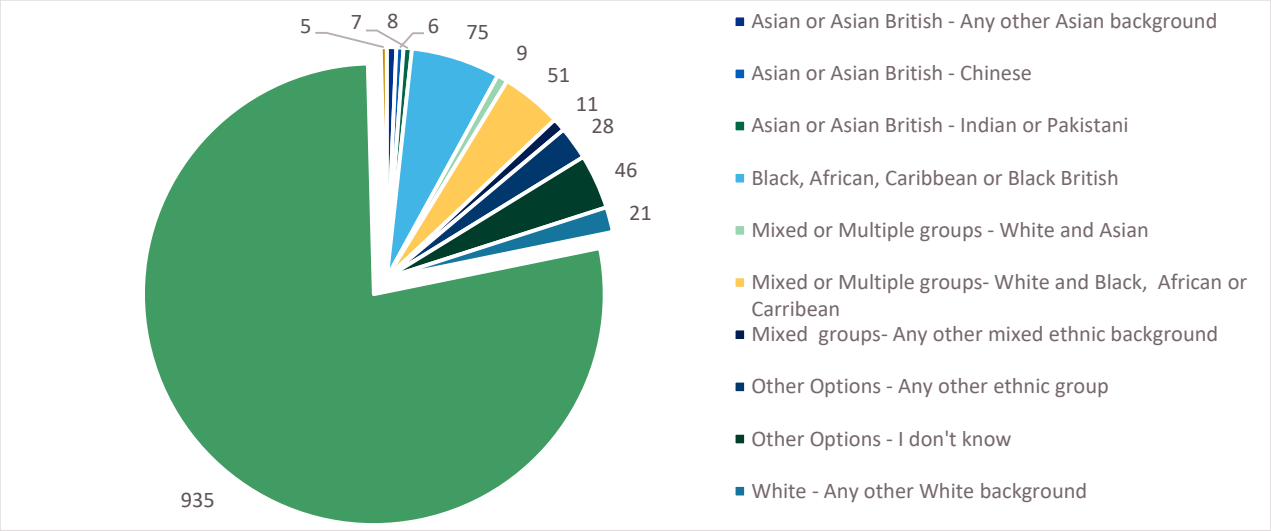
What is the recorded Sex of those being restrained?

1361 Restrictive events attributed to **females**

2106 Restrictive events attributed to **males**

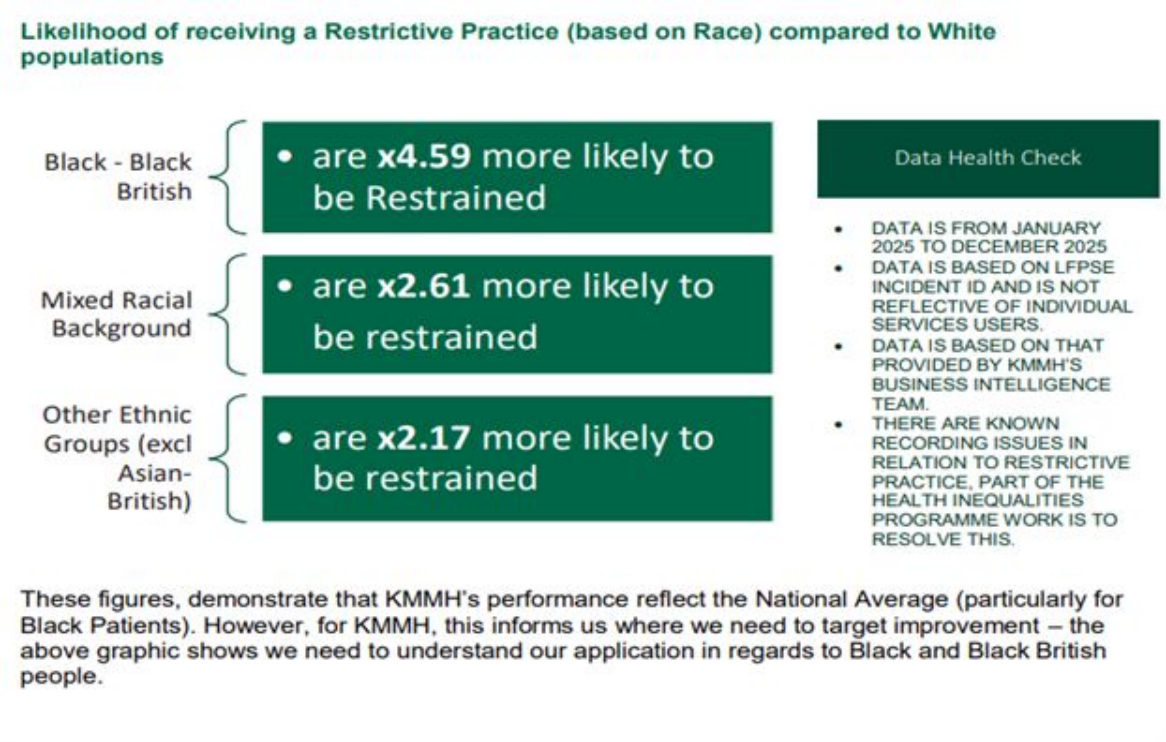
The above highlights that restraints between January 2024 and December 2025 were applied to incidents involving 'Males' more than incidents involving 'Females' within our care.

Graph 4: Restraints by Ethnicity

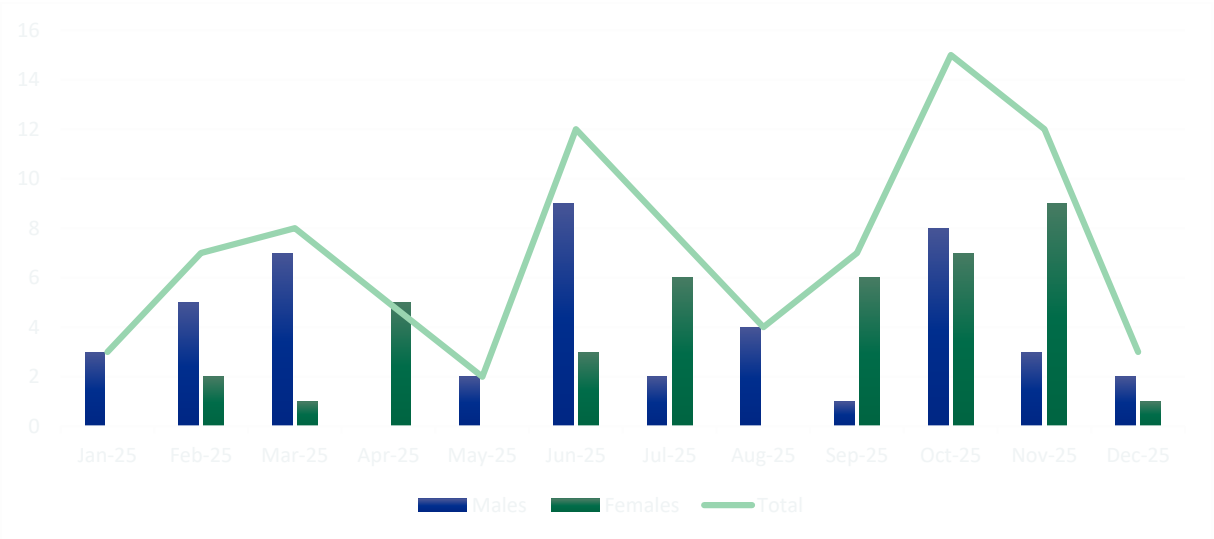


Of the total incidents of restrictive practices, White patients were involved in most restraints at 935 (78%), compared to 72% the previous year. They are still under-represented compared to the general population in Kent (88.6%). Again, Black patients were over-represented in this category, accounting for 75 (6%) of all restraints. Black, Asian and Minority Ethnic groups were also disproportionately over-represented at 19.2% compared to population percentage of 11.4%.

Whilst the data indicates the number of restraints, it does not provide us with the number of patients involved and therefore we cannot detail the impact this has on individuals. It is unfortunate that one patient may experience restraint several times during their inpatient stay. Further and deeper analysis is required to understand the impact, understand patients lived experience and an area of further quality improvement to be explored.



Graph 5: Prone Restraints by Sex



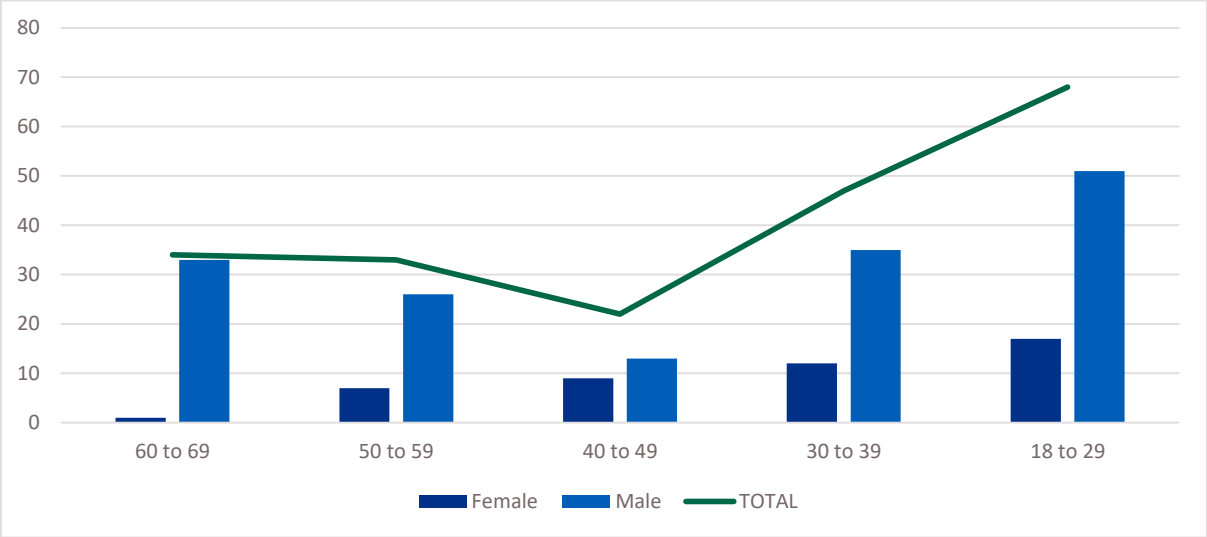
Our data shows a slight increase of seven in prone restraints from the previous year. It also indicates a shift. In the previous year, men (53) were twice as likely to be subjected to prone restraint than females (25). In 2025, the gap between males and females significantly closed with 46 and 40 respectively. The administration of intra-muscular medication is the most reported reason for using prone, followed by staff being forced forward into that position.

It is now mandatory for a Swarm Huddle to be conducted every time prone restraint is used. This will continue to help identify themes, identify systemic gaps and enable learning to be shared and inform ongoing quality improvement work.

Improvement work to date includes the development and delivery of long-acting treatment (LAT) training, this supports developing a working knowledge of land-marking and location of deltoid, dorsogluteal, ventrogluteal and vastus lateralis injection sites. This is attended by Qualified and student nurses. We promote this training at the Practice Assessor updates we provide for registered nurses who are PA

trained and ask them to ensure all student nurses having KMMH placements have completed it and also the Olanzapine injection training, prior to being supervised to learn to administer practical application of intramuscular injection (IMI) of LAT. This way registered nurses are regularly upskilled and also competent to share knowledge with student nurses. Last update provided we had 91 trained trainers across the trust to support the LAT training roll out alongside I learn training module.

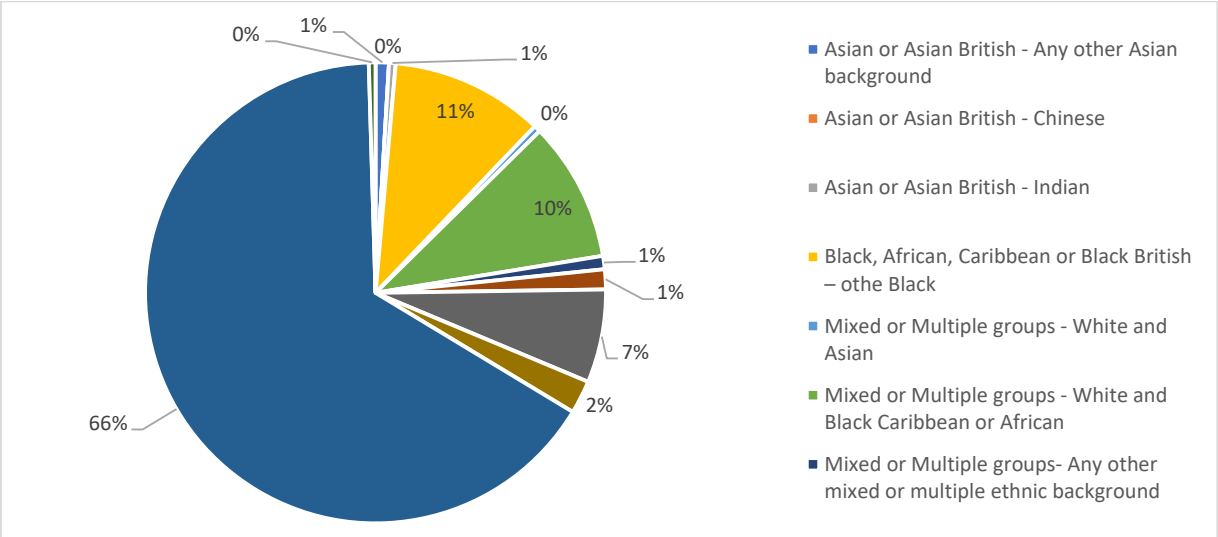
2. Seclusions



Males are secluded far more than females accounting for 77% of the total seclusions. As stated above, females are more likely to be restrained to prevent self-harm and are therefore less likely to be secluded due to risk; males generally exhibit aggression and violence to others, and this could be a factor in understanding the data.

The majority of seclusions involved adults aged between 18-30 years (115). Of the 33 older adults secluded in 2024, only two patients were being cared for on older adult wards (Sevenscore and Heather Wards) and these were in a quiet room with staff constantly de-escalating. The majority of the other over 60 years were secluded in our PICU and male adult wards.

Graph 9: Seclusions – by Ethnicity



Similar to restraint data, Black, Asian and Minority Ethnic groups are more likely to be subjected to seclusion than their white counterparts; 25% compared to 68% respectively, with 6% of records stating ethnicity as ‘not known’. Again, Black and global majority patients are four times more likely to be secluded, a disproportionate number of 44 seclusions of the total 191.

Identified Trends

This section summarises the identified trends and current countermeasure progress to reduce incidents of restrictive practices. Recommendations for further work are given below.

Trend 1: Males are more likely to be restrained than females.

- Although restraints on females occur to control aggression, the rationale for the majority is to prevent further harm from self-harm episodes. There has been an increase in male patient-patient assaults which is a likely factor in the increase in restraints.
- Relational Security (See, Think, Act) training and practices should be implemented throughout the Acute directorate. It has had a positive impact within the Forensic and Specialist directorate and aligns to early warning signs, power dynamics between patients as well as staff and promotes preventative interactions.
- Continued work in ‘women’s health’ and ‘reducing self-harm’ will further reduce the use of restrictive practices and this forms part of the trust ongoing strategy.
- The development of a PBS/PSP structured framework will target complex patients that often display self-harm, distressed behaviours and aggression. This work has started and is making progress but still at the early current state scoping aspect.

Trend 2: Black & Global majority patient experience disproportionate use of force

- Black and Global majority patients are more likely to endure all forms of restrictive practices for reasons not identified.
- A transformational improvement project is well underway and is currently starting to engage with various communities of faiths, ethnicities and ages to understand perspectives and co-create countermeasures. This will feed into the Patient carer race equality framework working group as a trust priority.
- Physical Interventions training incorporates theoretical and discussional aspects to the disproportionate use of force for these groups.

Trend 3: The use of Prone position is used predominantly for Intra-muscular Injections

- Injection site champions need to be reinstated, and clear guidance and training given to staff to further the great work that has already been described regarding LAT training.
- Physical Intervention training needs to explore the safe use of the deltoid injection site
- Every use of prone restraint is required to have a swarm huddle for learning, however, work is required to share learning amongst directorates and to ensure that PSS team leads are involved in huddles to promote alternatives to prone position. SWARM huddles to inform thematic learning going forward in this area and to support trust quality governance reporting.

These patterns reflect national system pressures, including rising acuity, delays in access to inpatient care, and increasing violence and aggression.

The Restrictive Practice A3 Improvement Project

KMMH has not previously used Improvement Methodology to improve how we apply Restrictive Practices, however with the commencement of Yellow-Belt Certifications and A3 Improvement Methodology within the Trust, the Clinical Lead for Promoting Safe Services has utilised the opportunity to explore our 'current state' and implement improvements. This was driven by our regular review of data highlighting negative variations (particularly along race and ethnicity) in our application of Restrictive Practices.

A3 Approach -

A3 Methodology follows defined steps, designed to ensure that an area is fully explore prior to improvements being implemented; ensuring that we are doing the 'right thing', the 'right way' at the 'right time'. To date we have completed initial background analysis and scoping, the problem statement and are currently undertaking 'Current condition analysis'. It is the first four stages of an A3 which will allow the Trust to develop actionable, and sustainable outputs to deliver improved and sustainable outcomes.

The A3 Timeline

Where Restrictive Practice Sits within the Health Inequalities Programme

To ensure that opportunities within the application of Restrictive Practices are fully explored, an A3 Improvement Project has been commenced.

The A3 Restrictive Practice project sits within the Health Inequalities Programme, specifically the **Clinical Pathways and Improvement Workstream**.

This allows the project to have access to a large group of internal and external stakeholders, whilst ensuring robust oversight and accountability is in place.

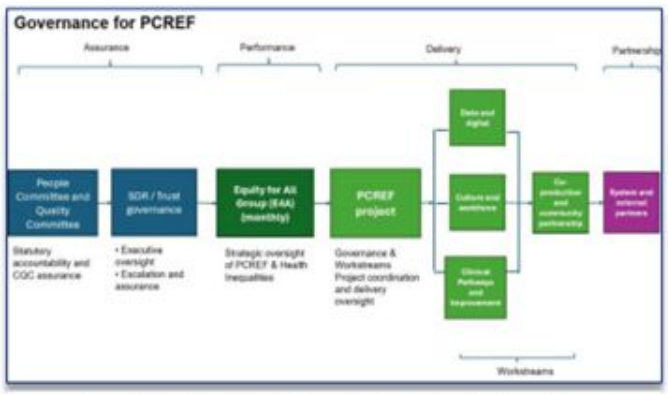


Figure 7- Health Inequalities Programme Governance Structure

Next Steps for Restrictive Practices and Health Inequalities:

In the coming months we will (in conjunction with other Health Inequalities Programme Workstreams and the Equity for All group):

1. Build a co-production network
2. Improve the quality of our Restrictive Practice data, and analyse it in more detail (supported by community and service user voice)
3. Work with co-producers to understand root causes.
4. Develop and Implement countermeasures to drive improvements and reduce inequalities.

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Annual Establishment Review 2026
Author:	Lianne Joyce, Interim Deputy Chief Nurse & Shannon Paine, Corporate Head of Nursing & Quality
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of paper

The paper seeks to provide the Quality Committee assurance that nursing and healthcare support worker (HCSW) establishments across inpatient services are safe, sustainable and responsive to patient need, in line with statutory duties and national safe staffing guidance, and to identify any areas where further development, mitigation or review is required.

This annual safer staffing establishment review provides reasonable assurance that current inpatient ward establishments are safe and appropriate when professional judgement is applied alongside workforce tools, and that risks associated with staffing are understood, monitored and escalated through established governance processes. There are some recommendations that would further strengthen our assurance regarding some ward areas across the trust and are set out in the paper.

Across all services reviewed (acute working-age, older adult, rehabilitation, forensic and specialist wards) Ward establishments are largely filled, with minimal vacancy-related risk.

Children and Young people and All Age Eating Disorder services were transferred to the Trust on the 1st April 2026 therefore were not included in this review but will be included in future mid-year and full review processes going forward.

Staffing pressure is primarily driven by patient acuity, dependency and complexity, rather than by vacant posts.

Issues to bring to the Board's attention

The annual safer staffing review provides reasonable assurance that staffing across inpatient services is safe overall, with risks well understood, monitored and actively mitigated. The Board is asked to note that safety is currently reliant on escalation, bank use and professional judgement in higher-acuity areas, and that targeted establishment and skill-mix reviews are required to ensure sustainability.

Governance

Implications/Impact:	Regulatory implications/ impact on legal/patient safety
Assurance:	Directorate Risk Registers
Oversight:	Corporate Nursing Directorate/Quality Committee

This annual safer staffing establishment review provides reasonable assurance that current inpatient ward establishments are safe and appropriate when professional judgement is applied alongside workforce tools, and that risks associated with staffing are understood, monitored and escalated through established governance processes. There are some recommendations that would further strengthen our assurance regarding some ward areas across the trust and are set out in the paper.

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Staffing pressure is primarily driven by patient acuity, dependency and complexity, rather than by vacant posts.

Typical Acuity Levels (High to Low)

The tool typically categorises patient care needs along a spectrum, ranging from:

Highest Dependency (Level 5): Patients who are highly unstable and at risk, often requiring 2:1 or continuous, 1:1 supervision.

Moderate/High Dependency (Level 4): High level of intervention needed for severe, acute symptoms.

Intermediate Dependency (Level 3): Moderate needs, requiring regular supervision but allowing for some independence.

Lower Dependency (Level 2): Stable patients requiring routine monitoring and low-intensity support.

Independent (Level 1): Patients who are stable and able to manage their own needs.

The Mental Health Optimal Staffing Tool (MHOST) provides a helpful baseline however, staff consistently reported that the acuity indicators do not fully capture the breadth of activities undertaken. For example, a patient may be assessed as Level 1 (independent) within the ward environment, yet still require multiple staff escorts throughout the day for off-ward activities, appointments, or observation, resulting in a significantly higher staffing demand than the acuity level alone suggests.

Professional judgement, triangulated with quality and workforce data, is therefore essential to maintaining safe care delivery.

The review identifies some areas requiring further review, particularly times during the day with higher reported levels of acuity, the ratio of registered staff to unregistered staff based on detail of acuity needs reported such as self-harm, fill rates in rehabilitation units, female specific wards areas and our psychiatric intensive care unit. The review also demonstrates active oversight, mitigation and escalation, consistent with expectations of a well-led organisation.

Regulatory and National Framework Alignment

This review has been conducted in accordance with:

National Quality Board (2016) – *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*

NHS Improvement (2018) – *Developing Workforce Safeguards*

Health and Social Care Act 2008 (Regulation 18)

CQC Safe and Well-Led domains, specifically:

- How the service ensures sufficient numbers of suitably qualified, competent, skilled and experienced staff
- How learning, risk and quality information informs staffing decisions
- How leaders understand, manage and mitigate staffing risk

Methodology

The Trust undertook its annual safer staffing review using the Mental Health Optimal Staffing Tool (MHOST), supplemented by structured professional judgement discussions.

Data Sets Used:

- 30 day MHOST acuity and dependency collection (ward-level; completed by band 6 and 7 clinicians who attended the training)
- Funded establishment versus tool output (FTE and CHPPD)
- Vacancy data
- Sickness absence data (previous 6 months)
- Incident data (previous 6 months)
- Complaints and compliments
- Clinically Ready for Discharge (CRFD) data
- Fill rates and roster data
- Professional Judgement Process- Professional judgement meetings were held at service and ward level, involving:

  - Ward managers and matrons
  - Senior nursing leadership
  - AHP and therapy leads
  - Service directors
  - Medical staffing

These meetings tested whether staffing tool outputs:

- Reflected lived clinical reality
- Aligned with known quality and safety risk
- Were supported or contradicted by workforce, incident and experience data

Where discrepancies were identified, professional judgement was explicitly documented, in line with NQB expectations.

As part of our response to the recommendation identified in last year's report, training was provided by the national CNO team in January, strengthening staff understanding and application of the tool.

Actual staffing CHPPD/ FTE and MHOST tool CHPPD/ FTE

Ward	Actual CHPPD	MHOST CHPPD Recommended	Actual FTE Nursing, HCSW, apprentices (exc WM)	MHOST FTE Recommended
Acute Mental Health Wards – Male				
BLUEBELL - male	134.19	141.66	29.25	27.50
BOUGHTON - male	120.88	147.77	29.25	25.90
CHARTWELL - male	145.75	168.50	29.25	33.50
PINEWOOD - male	147.63	113.88	29.25	29.70
Acute Mental Health Wards – Female				
AMBERWOOD – female (although male during reported period)	138.43	93.94	31.25	18.20
CHERRYWOOOD - female	145.11	107.83	29.25	20.90
FERN - female	122.55	147.55	31.25	27.51
FOXGLOVE – female	142.05	173.37	29.25	33.10
UPNOR - female	131.10	183.30	31.20	35.00
Acute Mental Health Wards – Older Adults				
HEATHER - male	148.57	97.01	33.00	21.06
SEVENSCORE - male	142.54	97.89	32.00	19.50
THE ORCHARDS - male	116.87	99.20	33.00	19.09
JASMINE - female	144.92	68.31	33.00	15.00
RUBY - female	135.37	100.44	33.00	20.00
WOODCHURCH - female	136.41	85.85	33.00	17.50
Acute Mental Health Wards – Psychiatric Intensive Care Units (PICU)				
WILLOW SUITE - male	141.57	170.85	34.70	41.40
Forensic Learning Disabilities Low Secure Units				
ALLINGTON CENTRE - male	140.80	109.20	45.35	30.00
BROOKFIELD CENTRE – male	145.85	47.91	40.87	12.70
TARENTFORT CENTRE - male	135.03	97.49	43.61	26.80
Forensic Psychiatry Medium Secure Units				
EMMETTS - male	133.53	123.70	36.30	26.00
GROOMBRIDGE – male	135.49	150.33	36.62	31.40

PENSHURST - male	140.86	164.23	43.41	33.00
WALMER - female	131.53	140.88	40.11	29.00
Specialist Services				
BRIDGE HOUSE - mixed	135.67	53.26	16.34	9.84
ROSEWOOD MBU - female	119.30	83.34	23.46	16.30
Inpatient Rehabilitation Units				
ETHELBERT ROAD - mixed	131.21	61.59	16.98	11.50
RIVENDELL - male	134.31	61.14	16.98	11.41
THE GROVE - female	133.89	52.63	16.98	9.80
NEWHAVEN LODGE - male	137.57	39.99	17.73	7.47
ROSEBUD - mixed	140.41	53.43	17.60	9.98
TONBRIDGE ROAD - female	135.73	34.96	18.35	6.53

Red – Understaffed. Green – Matched or within 5 FTE. Blue – Over 5 FTE difference.

Generic and Service-Specific Findings

Many wards areas felt the MHOST tool did not accurately reflect the acuity of the wards with the suggested FTE numbers alone. Patients typically score at acuity levels 2–4, with frequent escalation to higher need, however during professional judgement conversations, Matrons and Heads of Nursing & Quality did feel wards score more patients on acuity level 1 than was actually indicated (they identified further training opportunities on the use of the tool would be helpful in addition to the training already received)

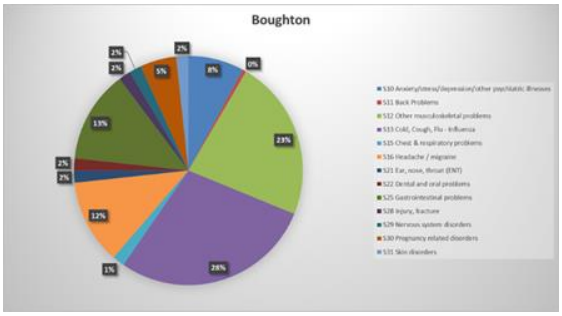
Acuity, Dependency and Complexity discussions described high levels of:

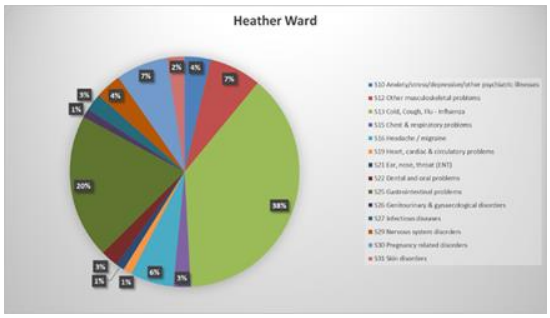
- Self-harm (particularly on female wards) which was supported by trust data collection
- Violence and aggression, patient to staff and patient to patient which was supported by trust data collection
- Variable use of Zonal observations with some areas describing this not being used due to staffing numbers required, this indicated an inconsistent understanding of application and use with further work required to define a trust wide standard
- Emotional dysregulation resulting in significant volumes of enhanced care and observation (1:1, 2:1 and occasionally higher), not always fully reflected in acuity scoring, particularly on wards in West Kent where ECT patients are often required to be nursed on 1:1 to ensure they adhere to ECT protocols

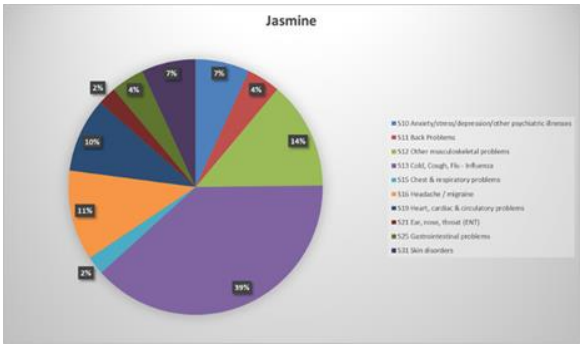
Acute younger adult, PICU and older adult wards:

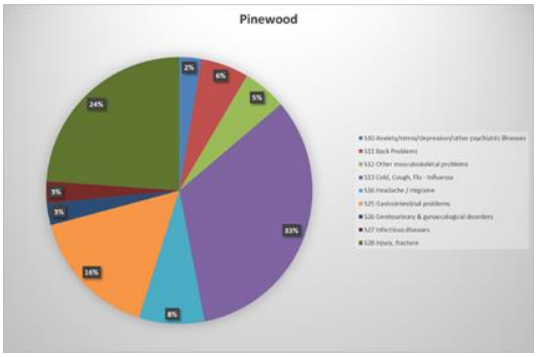
Staffing and Workforce data supports nursing establishments are mostly fully recruited to.

Short-term sickness predominately details (cold/flu, headaches, musculoskeletal issues), with some wards experiencing peaks linked to stress and sustained workload.

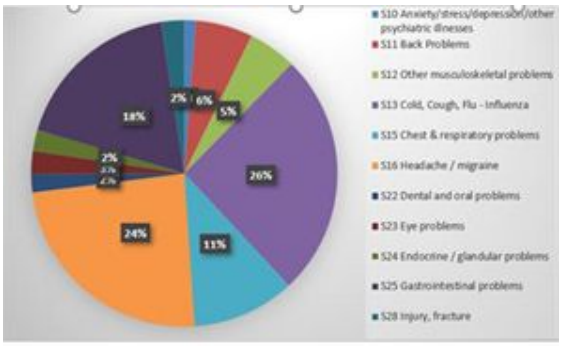








Willow:



Staffing pressure is persistent despite low vacancy rates, indicating demand-led rather than workforce-led risk.

- Acuity, Dependency and Complexity details high levels of:
- Self-harm (particularly on female wards)
- Violence and aggression
- Emotional dysregulation

Significant volumes of enhanced observation (1:1, 2:1 and occasionally higher), not always fully reflected in acuity scoring, particularly on wards in West Kent where ECT patients are often required to be nursed on 1:1 to ensure they adhere to ECT protocols. This was also reflected with fill rates for the ward areas (specifically females and PICU ward areas) indicating regular use of bank staffing to cover the ward acuity needs specifically relating to enhanced care needs (observations) (See below)

Staff consistently reported a perception that risks and incidents increased during the latter part of the afternoon. However, as part of this review, analysis focused solely on the volume of incidents rather than the time at which they occurred. As a result, despite this theme being raised across multiple wards, there was no specific data available to substantiate the concern. It is however recognised that at this time of day there is

- Reduced AHP and therapy presence due to working times
- Reduced senior clinical visibility
- Increased incidents and need for containment, this was particularly reflected in the professional judgement conversations relating to wards where there were high levels of self-harm and violence and aggression risk activity that required more frequent risk assessment, formulation and planning reviews, this supported further consideration of registered staffing ratios in these areas based on the registered requirements of review in relation to this activity.
- There was also discussion around the need for increased activity during these hours of the day and consideration of the type of workforce that may be required to support this, recognising the importance of Allied health professionals, Psychology and wider MDT team members particularly in relation to activity, therapeutic activity, medical assessment and treatment and wider aspects of a patients care plan.

A recommendation is therefore made to undertake further analysis of incident timing to explore this issue in more detail. Currently wards book additional staff via bank to support increased activity which increases numbers of staff but this does not always mean this reflects the right staff groups based on needs.

Willow ward described a high usage of enhanced observations and a discontinuation of zonal observation usage, below shows a high level of patient acuity as you would expect within a PICU environment but also a high usage of staffing above baseline funded establishment when reviewing fill rates, especially in relation to HCA roles:

March Fill Rates

Ward	Day RN	Day HCA	Night RN	Night HCA	Overall
Willow	99.8%	204.9%	149.9%	240.3%	176.3%

Skill Mix

Ward leaders consistently reported that registered nurse presence is critical to safe risk assessment, de-escalation and care planning. Over-reliance on HCSWs in high-risk environments to manage observations can increase risk, even where overall headcount appears sufficient. Upnor ward is notable for this (shown below). This would further support consideration of the skill mix ratio in these ward environments.

On eRoster, fill rate refers to how much of the planned or required staffing has actually been filled.

On Upnor Ward in March, an HCA fill rate of 193% indicates that almost twice the planned Healthcare Assistant hours were worked compared to the original roster.

	Mar-26			
	Day		Night	
Ward	RN	HCA	RN	HCA
Upnor Ward	120.4%	125.1%	99.3%	193.3%

Staff feedback identified this as a response to an increase in incidents and a need for additional HCA support to manage enhanced observation requirements. In March there were 45 recorded incidents on Upnor Ward, compared to 18 in January. However, it was also noted that increasing HCA numbers alone does not always effectively mitigate risk in the most effective way. In situations involving higher clinical complexity and escalating incidents, an increased presence of registered nurses should be considered to provide the clinical leadership, assessment, and decision-making required to safely manage care.

Female Younger Adult Acute Wards

Female acute wards consistently demonstrate a distinct and higher-risk clinical profile compared to mixed or male wards, characterised by sustained levels of self-harm, emotional dysregulation, trauma presentation and relational risk. Establishment reviews identified persistently high incident volumes, particularly self-harm (including repetitive and severe presentations), alongside violence and aggression, safeguarding concerns and frequent escalation to enhanced observations. These risks are not episodic but represent a stable pattern of acuity, placing sustained demand on nursing staff and significantly increasing cognitive, emotional and relational workload.

The below tables demonstrate the volume of incidents on 2 of the female wards over a 6 month period – 338 in total for Foxglove, and 397 in total for Fern.

For comparison, in the same reporting period, Boughton Ward had a total of 142 incidents and Amberwood Ward had a total of 117.

Foxglove Ward – incidents over 6 months

	2025				2025 Total		2026		2026 Total	Grand Total
Row Labels	Sep	Oct	Nov	Dec			Jan	Feb		
Self-Harming Behaviour	16	19	16	33	84		20	91	111	195
Violent and Aggressive Behaviour (Patient to Staff)	12	5	3	3	23		3	4	7	30
Disruptive, Violent and Aggressive Behaviour (Patient, Anti-Social Behaviour)	7	3	7	2	19		2	5	7	26
Disruptive, Violent and Aggressive Behaviour (Patient to Patient)	3	5	8	1	17		6	3	9	26
Missing Patient	1	3	2	2	8		1	2	3	11
Medication	3	2	1	1	7		1		1	8
Patient Accidents and Falls		1		2	3		1	3	4	7
Patient Personal Property / Data / Information				1	1		1	2	3	4
Fire		3			3			1	1	4
Disruptive, Violent and Aggressive Behaviour (Staff to Patient)	1		2		3					3
Physical Health			2		2			1	1	3
Access, Admission, Transfer and Discharge	1	1		1	3					3
Documentation		1		1	2					2
Property	1				1			1	1	2
Estates / Facilities		1		1	2					2
Infection Control							1	1	2	2
Patient Confidentiality / Information Governance		1	1		2					2
Violent and Aggressive Behaviour (Visitor / Other to Staff)		1			1					1
Security			1		1					1
Treatment / Procedure							1		1	1
Service Disruptions							1		1	1
Violent and Aggressive Behaviour (Patient to Visitor / Other)								1	1	1
Staff Accidents and Falls								1	1	1
Disruptive, Violent and Aggressive Behaviour (Visitor / Other to Patient)							1		1	1
Staff Confidentiality / Information Governance				1	1					1
Grand Total	45	46	43	49	183		39	116	155	338

Amberwood Ward – incidents over 6 months

	2025				2025 Total	2026		2026 Total	Grand Total
Row Labels	Sep	Oct	Nov	Dec		Jan	Feb		
Disruptive, Violent and Aggressive Behaviour (Patient, Anti-Social Behaviour)	4	9	7	7	27	5	14	19	46
Violent and Aggressive Behaviour (Patient to Staff)	2	3	5	3	13	3	1	4	17
Missing Patient	1	3	4		8	2	6	8	16
Disruptive, Violent and Aggressive Behaviour (Patient to Patient)	2	3	1	2	8	3	2	5	13
Property	1	3	1		5	2	3	5	10
Self-Harming Behaviour			1	1	2				2
Medication		1		1	2				2
Access, Admission, Transfer and Discharge			1	1	2				2
Documentation			1		1				1
Security		1			1				1
Restraint Processes						1		1	1
Staff Accidents and Falls							1	1	1
Estates / Facilities				1	1				1
Patient Personal Property / Data / Information							1	1	1
Clinical / Assessments (Including Diagnosis, Scans and Tests)		1			1				1
Death (Unexpected Death)		1			1				1
Patient Accidents and Falls				1	1				1
Grand Total	10	25	21	17	73	16	28	44	117

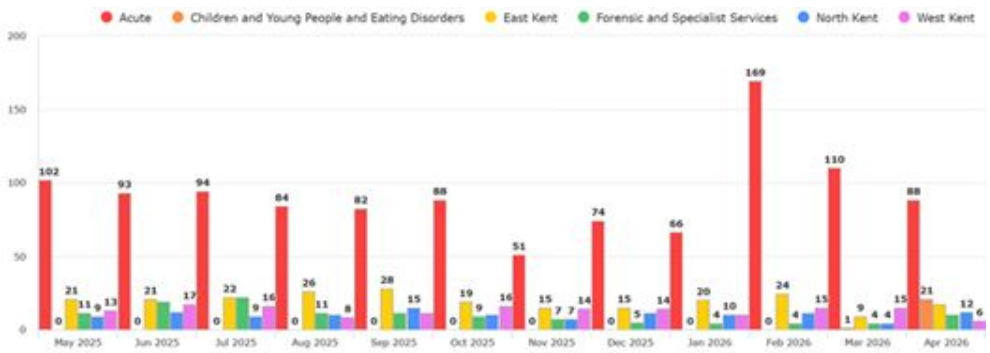
Fern Ward – incidents over 6 months

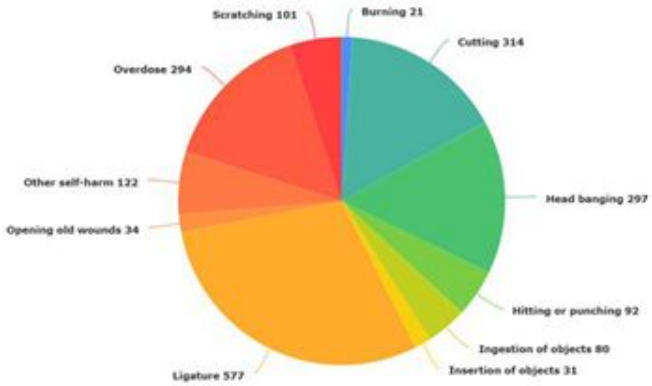
	2025				2025 Total	2026		2026 Total	Grand Total
Row Labels	Sep	Oct	Nov	Dec		Jan	Feb		
Disruptive, Violent and Aggressive Behaviour (Patient, Anti-Social Behaviour)	13	24	26	8	71	17	24	41	112
Self-Harming Behaviour	23	20	9	15	67	10	16	26	93
Violent and Aggressive Behaviour (Patient to Staff)	4	13	13	6	36	5	4	9	45
Disruptive, Violent and Aggressive Behaviour (Patient to Patient)	11	14	7	4	36	2		2	38
Missing Patient	6	12	2	4	24	2	2	4	28
Medication	6	4	3	1	14	4	5	9	23
Patient Accidents and Falls	3		2	2	7	2	4	6	13
Security	1	2	1	2	6				6
Care / Ongoing Monitoring and Review	1		1	1	3		2	2	5
Patient Confidentiality / Information Governance	2		1	1	4		1	1	5
Access, Admission, Transfer and Discharge	2		1	1	4		1	1	5
Documentation		2	1		3				3
Staff Accidents and Falls			1		1	2		2	3
Patient Personal Property / Data / Information	1	1	1		3				3
Estates / Facilities	1		1		2				2
Death (Unexpected Death)						1		1	1
Infection Control				1	1				1
Property		1			1				1
Fire			1		1				1
Violent and Aggressive Behaviour (Visitor / Other to Staff)			1		1				1
Service Disruptions			1		1				1
Staff Conduct						1		1	1
Medical Devices, Equipment and Supplies						1		1	1
Staff Confidentiality / Information Governance		1			1				1
Patient Transport		1			1				1
Communication and Consent							1	1	1
Physical Health						1		1	1
Nutrition Food / Meals From Kitchen						1		1	1
Grand Total	74	95	73	46	288	49	60	109	397

Boughton – incidents over 6 months

From a trust overall perspective for self-harm data for last 12 months:

- Reduction of self-harm in inpatient settings remains a trust breakthrough objective for 2026 – 2027 and a new breakthrough objective focusing on the management of self-harm in the community has also been introduced.
- The majority of self-harm incidents within the organisation occur within the inpatient female acute wards with non-fixed ligature remaining the most prevalent form of self-harm in those settings.





Outputs from the Mental Health Optimal Staffing Tool (MHOST) indicate a requirement for higher nursing establishments on female wards specifically Foxglove and Upnor, reflecting elevated acuity scores, observation needs and patient dependency. (See self-harm data above).

In some ward areas, the tool recommends an increase in staffing capacity (See table on page 3), however clinical teams consistently report that even where establishments align with or exceed tool recommendations, staffing continues to feel constrained due to the nature of the work rather than patient numbers alone and have indicated the registered staffing numbers do not feel sufficient, an example given was the (younger adult) ward have two registered staff on a shift and one of those staff is required for ward reviews, this depletes registered staff to one for the majority of the shift. Another example given by Allington centre is the two separate ward environment areas creates a challenge to safely staff all areas with registered staff at night.

In particular, the tool does not fully capture the intensity of trauma-informed engagement required to manage chronic self-harm, prevent escalation, and deliver safe, compassionate care.

Clinical narrative highlights that female wards frequently operate with multiple concurrent enhanced observations (including 1:1, 2:1 and higher levels) Acuity level 3-4, often driven by trauma responses rather than acute psychosis. Where zonal observation models are implemented effectively, these are used deliberately to reduce reliance on prolonged 1:1 observation; however, this approach requires higher baseline staffing, experienced registered

nurses, and strong clinical leadership. Without this, wards are more likely to revert to restrictive observation models, increasing both staff need and patient distress.

Fill rates for Foxglove Ward (female) vs Bluebell Ward (male)

	Mar-26			
	Day		Night	
Ward	RN	HCA	RN	HCA
Foxglove	89.3%	120.7%	99.8%	165.0%

	Mar-26			
	Day		Night	
Ward	RN	HCA	RN	HCA
Bluebell	112.9%	93.6%	99.9%	109.2%

These figures indicate a marked difference in actual HCA staffing demand between Foxglove Ward and Bluebell Ward, particularly overnight, when compared with what was originally planned on eRoster. Through March Foxglove was experiencing significantly higher day and night staffing demand, especially at night. Bluebell was operating close to its planned establishment, with only modest additional staffing required.

The consistently high fill rates on Foxglove—particularly 165% at night—suggest that:

- Planned HCA numbers do not fully reflect actual acuity, observation levels, or risk profile
- Staffing is being increased reactively to maintain safety, often with temporary bank staffing that include existing staff working extra hours (approx. 50% of all bank work) or NHSP workers.

This is also reflected in the MHOST acuity charts. Foxlgove Ward demonstrates sustained high acuity throughout the period, with limited representation of lower-acuity patients.

Based on review of the Bluebell Ward acuity chart, the profile demonstrates a more mixed and comparatively stable acuity pattern than Foxglove, with clearer movement between acuity levels and less sustained highest-dependency need.

Staff wellbeing and sustainability are a particular concern on female wards due to the cumulative impact of managing high-harm behaviours, repeated incident reporting, night-time A&E transfers, and the emotional labour of relational containment. The reviews consistently recommend that staffing models on female wards explicitly recognise this complexity and support a more therapeutic, trauma-informed offer, including:

- Increased registered nurse presence to support de-escalation and risk assessment, formulation and planning
- Staffing levels that enable protected therapeutic time, not just task completion
- Consideration of enhanced or twilight staffing to address predictable late-day escalation and roles that support increased activity and therapeutic engagement

Overall, both MHOST outputs and professional judgement strongly support the conclusion that female wards require an increase and more skilled staffing establishments to remain safe as a baseline establishment without additional temporary staffing, reduce restrictive practices, and deliver effective trauma-informed care. This represents an evidence-based adjustment to staffing in response to clinical need, rather than an over-establishment, and aligns with national guidance on safe, compassionate and least-restrictive mental health care.

From reviewing the recurrent periods of multiple enhanced observations (two 2:1 and one 1:1 simultaneously) this equates to the deployment of five additional staff. This could also support further review of the registered establishment compared to unregistered. This would need to be further defined from reviewing all the acuity metrics over a longer period of time to accurately reflect exact uplifts required and the breakdown of registered and non-registered staffing. This would also need to include review of how we apply headroom requirements as part of recommendations from this review.

Night-time fill rates regularly exceed 130%, reflecting safety-driven escalation, not over-establishment. This also aligns with the clinical narrative that acuity increases

Summary of Key Themes Emerging from Female Ward Incident Data:

1. Sustained High Self-Harm and High-Risk Behaviour

Female acute wards (particularly Foxglove and Fern) demonstrate a very high and sustained level of self-harm and high-risk incidents, rather than short-term spikes. The pattern is consistent across the reporting period and aligns with clinical narratives of chronic trauma presentation, emotional dysregulation and repetitive harm behaviours. This reinforces that elevated risk is endemic to the clinical population rather than reflective of transient staffing or environmental issues.

2. Cumulative Violence, Aggression and Relational Risk

Levels of violence and aggression, including patient-to-staff and patient-to-patient incidents, remain high across female wards, particularly where:

Self-harm escalation co-exists with peer-to-peer distress

Relational containment is required for multiple patients simultaneously
This increases cognitive and emotional workload for staff and significantly contributes to burnout and sickness risk if not mitigated through appropriate staffing models.

3. Overall Incident levels disproportionately being concentrated on Female Wards

When self-harm, aggression and safeguarding-related incidents are considered together, female wards carry a disproportionately high overall incident volume, compared with mixed or male wards. This validates both:

MHOST outputs, which indicate higher staffing need, and

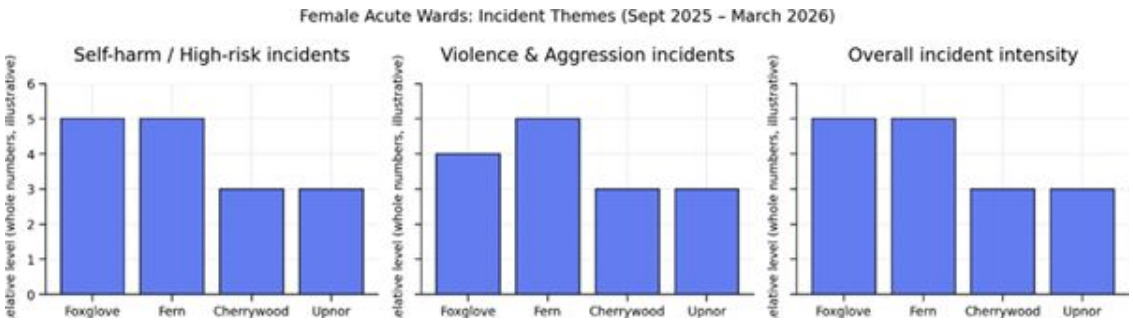
Professional judgement, which highlights that standard establishments do not fully reflect the intensity of therapeutic and relational work required.

4. Implications for Safer Staffing and Therapeutic Offer

The incident profile supports the need for:

- Higher baseline staffing establishments on female wards
- Increased registered nurse presence
- Staffing models that explicitly enable a trauma-informed, therapeutic approach, rather than reliance on prolonged enhanced 1:1 observation
- Sufficient staffing to safely implement zonal observation models, reducing restrictive practices while maintaining safety

The data and narrative together demonstrate that workforce pressure on female wards is risk-driven, not vacancy-driven, and that staffing levels above traditional tool outputs represent evidence-based risk mitigation, not over-establishment.



The thematic incident graph illustrates a consistently higher intensity of self-harm across all four female wards, violence and overall incident activity on female acute wards, particularly Foxglove and Fern, when compared across services. Please see above self-harm charts on pages 8-9.

Acute Older Adult Wards

Current staffing tools were described as failing to capture the true complexity of care required on older adult wards during professional judgement discussions. They were felt to significantly underrepresent levels of personal care dependency, the impact of frailty, and the management of dementia-related aggression. MHOST can identify some aspects of dementia-related aggression, but it does not reliably or fully capture its intensity, fluctuation, or risk impact on staffing. This is because dementia-related aggression is often episodic and fluctuating (e.g.

sundowning), context-dependent (environment, noise, staffing, routine changes) and behaviourally driven rather than diagnostically acute.
The tools were also described as not adequately accounting for situations requiring multiple staff for moving and handling, or the time and resource demands associated with escorting patients to acute hospitals and outpatient appointments. This challenge is further compounded by the fact that four out of six older adult wards operate as stand-alone units, limiting flexibility and shared staffing support. Incident and experience data highlight these gaps, demonstrating that current workforce planning methods do not fully reflect the realities of delivering safe and compassionate care in these settings.

However, high incident volumes are often attributable to single high-need patients, requiring disproportionate staffing input. For example, on Heather Ward in January, of the recorded 46 incidents of violence and aggression, 38 were related to one patient who had advanced dementia.

Older adult wards consistently record higher compliments and lower complaints, supporting the effectiveness of current staffing ratios.

NQB Principle: Staffing decisions must reflect dependency and complexity, not just patient numbers – this is clearly evidenced.

Community Inpatient Rehabilitation Wards

There was a described under-representation by teams of workload across rehabilitation wards, where patients typically score at acuity levels 1–2, masking the true intensity of care required. These scores fail to reflect the significant 1:1 rehabilitation and skill-building work, the staffing demands associated with escorting patients and supporting community integration, and the substantial cognitive, relational, and behavioural workload inherent in recovery-focused care.

Discharge and flow pressures were described to further exacerbate this mismatch, with prolonged clinically ready for discharge (CRFD) delays common, including cases exceeding 900 lost bed days (see below table). Despite being CRFD, these patients continue to require substantive staffing input, often with increasing frustration, complexity, and risk over time. This is compounded by environmental risk, as several rehabilitation settings are not designed to accommodate escalating acuity, thereby increasing both staffing pressures and safety concerns for patients and staff alike.

Unit	Number of CRFD patients during data collection	Lost bed days
Rosebud	2	Not detailed in update
Newhaven	1	109
Tonbridge road	4	275
The Grove	3	161
Rivendell	6	919
Ethelbert Rd	1	42

Staff teams raised the excessive fill rates in some of the areas (North) were due to increasing levels of acuity being managed which was described being due to having patients admitted that did not always meet the rehabilitation model criteria and was more due to bed pressures, this

was part of the units mitigation to manage higher acuity levels. This required additional staffing (bank) to be booked to manage observation levels, levels of risk and environmental risks. Some fill rates exceeded 180% in the North (see below). This forms part of escalation conversations between services and patient FLO teams regarding most appropriate pathways for patients and how to best support higher acuity.
Several rehabilitation environments are not designed for escalating acuity, creating additional staffing requirements to mitigate risks in relation to the physical environment.

Rosebud Fill rates:

March Fill Rates

	Mar-26			
	Day		Night	
Ward	RN	HCA	RN	HCA
Rosewood Lodge	126.9%	186.0%	99.5%	109.5%

Forensic and Specialist Inpatient Services

The MHOST Staffing tool outputs consistently recommend reductions of between 5 and 14 whole-time (See table on page 4) equivalent staff compared with current establishments across the specialist directorate. As part of the professional judgement reviews, all ward leaders unanimously agreed that implementing such reductions would be unsafe and unworkable in practice and did not accurately reflect patient acuity and need. This disparity reflects key drivers of workload under-estimation within the tools, including the demands of working in secure environments, split or multi-building ward layouts, and the need for enhanced supervision such as 2:1 care. It also identified that due to the complexity of the MHOST tool, and variable levels of understanding, and the level of clinical judgement required, annual refresher training is recommended to support accurate and consistent use

Additional pressures were described to arise from court attendance, escorted leave requirements, and discharge-focused workload, all of which place significant and sustained demands on staff time but are insufficiently reflected in current capturing of staffing models through the MHOST tool. This clinical discussion related to the lower MHOST recommended FTE compared to actual FTE in post, no additional staffing was indicated in addition to current establishments apart from Allington.

The discussion focussed on the environment at Allington and how the separate areas was creating challenge with current registered establishment particularly on nights to safely manage the requirements. This is a suggested area of review for the forensic & specialist directorate leadership team and the required establishment on night shifts.

Trust-Wide Themes

Across all wards reviewed, it is acknowledged staffing tools alone do not provide sufficient assurance of safe and sustainable workforce levels. The demands of enhanced care observations and patient escorts significantly dilute therapeutic time and staffing resource on the wards in addition to training, sickness and maternity leave. Further review is therefore suggested to consider approaches to 'headroom' that is built into current ward establishments as this does not feel to be adequately meeting the needs. This will be identified within the recommendations to consider the removal of headroom and for a more detailed analysis and recommendation around suggested FTE to cover these needs.

Clinically Ready for Discharge (CRFD) patients continue to have a material impact on workload calculations, as they often require significant ongoing staff input whilst not being reflected in acuity scoring. It was also noted that clinical deterioration can occur while a patient is designated as CRFD, which may result in increased acuity and associated risk. It was also recognised that when patients are required to be cared for in settings that do not fully align with their identified needs, this can significantly increase both acuity and risk. For example, caring for CRFD and CED patients within environments not designed to meet their specific clinical or therapeutic requirements can contribute to increased complexity, behavioural escalation, and staffing pressures.

Environmental layout also has a direct and often underestimated impact on staffing need, influencing visibility, supervision, efficiency and ability to utilise zonal observation to their maximum capability, this was particularly highlighted at the Willow Suite where zonal observations are not currently used due to staff levels but this is having a negative impact on levels of restrictive practices.

In this context, skill mix and substantive staffing is as critical as overall headcount, as the complexity of care cannot be met by numbers alone. Consequently, good or excessive fill rates can mask underlying staffing strain, over usage of temporary bank staffing, potentially obscuring risk and pressure within ward teams. We also need to consider the impact of higher fill rates with excessive bank usage versus a higher ratio of registered staffing not just more numbers (temporarily) in baseline establishments as sometimes substantive staff who know a patient group can negate the need for more excessive numbers of temporary staffing, addressing some of the areas that report increasing acuity levels described by teams. This is supporting consideration of a skill mix review across our younger adult females ward specifically.

Zonal Observations:

Zonal observations are a key component of the Trust's commitment to least-restrictive, person-centred care and are used proactively to reduce reliance on enhanced 1:1 observation wherever it is clinically safe to do so, however during the clinical narrative discussions use of zonal observations are not consistently used across the trust.

When implemented effectively, zonal observation models allow staff to maintain visibility across groups of patients, promote therapeutic engagement, encourage independence, and support a more normalized ward environment. This approach aligns with national guidance to minimise restrictive practices and avoid unnecessary enhanced observations, which can be intrusive for patients and resource-intensive for services and can be detrimental in reducing length of stay. The establishment review identified that wards actively using zonal observations are often doing

so as a deliberate safety strategy, balancing risk management with dignity, recovery and relational care. While zonal observation models require skilled staff presence, clear role allocation and effective clinical leadership, they support safer and more sustainable staffing by preventing escalation to prolonged 1:1 or 2:1 observation. The review therefore supports the continued use of zonal observations across all wards when clinically indicated as a positive practice, with professional judgement applied to ensure staffing levels remain sufficient to maintain safety, therapeutic quality and responsiveness during periods of increased demand. This will feature as a recommendation to feature within the ETOC national programme of work that is supported by the Heads of Nursing and Quality across Acute and Forensic & Specialist directorates.

Recommendations

1. Strengthen Use of the MHOST Tool Alongside Professional Judgement

Strengthen the use of the MHOST tool alongside professional judgement discussions within safer staffing reporting. This will include a review of the current process to identify opportunities to improve data collection, tool application, and staff knowledge and confidence in using MHOST. Targeted ongoing training for all registered clinicians undertaking establishment reviews should be implemented to improve the consistency and accuracy of acuity and dependency scoring, and to support ward and matron teams to fully understand how complexity can be captured within the tool and when it is appropriate to challenge tool outputs using professional judgement.

2. Strengthen BI reporting for safer staffing

Other Trusts routinely utilise BI systems to collate and analyse staffing and workforce data. As part of this work, a review should be undertaken to strengthen how staffing data is captured and reported locally. The development of a Safer Staffing dashboard could enable real-time visibility of staffing levels against planned establishment, and could also help identify staffing shortfalls, escalation risks, and pressure points early. It is therefore recommended that this is a key priority.

3. Enhance Safer Staffing Review Frequency and Governance Oversight

Enhance governance oversight by continuing to complete biannual establishment reviews in 2027, comprising an annual full review and a six-month refresh. Clear and consistent reporting structures to the Quality Committee should be maintained, including escalation routes for emerging risks between review cycles. A twelve-month reporting framework will be defined, with clear timelines, agreed data requirements, and named owners responsible for submission to support an improved structure for collation of data with clear responsibilities. This will be completed by Deputy Chief Nurse and Head of corporate nursing and should be completed within two months.

4. Review Staffing Establishments Where Clinically Indicated

Undertake a trust-wide review of skill mix across inpatient and specialist ward establishments, considering the balance of registered and non-registered staff alongside FTE. Where clinically indicated by the staffing review, focused reviews in the following areas should be undertaken:

Acute to review:

Female younger adult acute wards and PICU (Willow) to review a longer period of time, focussed on acuity as described in the report, to understand the requirement of staffing WTE, the breakdown of registered and non-registered staffing establishment. To be completed by the acute and Forensic and specialist directorates triumvirates leadership teams in relation the wards described. To be completed within a three month timeframe. This will then be supported through the QIA process in the event of any material changes, with oversight by Quality Committee through the Patient Safety and Quality Assurance group meeting.

Forensic and specialist directorate to review:

Allington centre; with particular attention to registered and unregistered staffing ratios and staffing levels across the 24-hour period (given the environmental challenges they face)

Specific consideration should be given to the afternoon and twilight periods and environments. Staffing establishments and roles should be aligned to patient group need, including the delivery of trauma-informed care, management of self-harm, violence and aggression, associated risk assessment, formulation and care planning, and sustained enhanced observations. Suggested Staffing models should be aligned to predictable escalation patterns rather than treating these as exceptional. This should be reported back to Quality committee with defined recommended changes following this review, suggested timescales should be discussed and agreed by directorate leadership teams.

The review should prioritise sufficient registered nurse presence in high-risk environments, reduce reliance on temporary staffing where possible, and explicitly recognise that apparently “good” or high fill rates may mask unsustainable staffing pressure when skill mix is misaligned with clinical need. Staffing models should again align to predictable escalation patterns rather than exceptions.

5. Review of ‘headroom’ requirements

This review should explicitly define ‘headroom’ requirements’ with a suggestion to remove headroom as applied currently to describing the FTE needed to complete and cover training, average sickness, average maternity leave, and average of enhanced care needs considering use of bank temporary workforce over current establishments. This should be led by Triumvirate leadership teams for acute, forensic & specialist and East, west and north kent directorates to define the needs for each ward/ unit areas. Suggested timeframe completion of three months with reported recommendation back to the Patient Safety and Quality Assurance Group.

Establish a Trust-Wide Position on Zonal Observations

Establish and endorse a trust-wide position on zonal observation as a core component of least-restrictive, recovery-focused care. Ensure ward establishments are sufficient to implement zonal observation models safely and consistently, informing the quality and requirement of prolonged 1:1 or 2:1 enhanced observation. This position should be clearly reflected in Trust policy and linked to the ETOC national programme of work being led by Heads of Nursing and Quality for Inpatient and Specialist Directorates and should be completed within 6 months which aligns to current ETOC programme.

6. Review of admissions into rehabilitation units and the alignment to the rehabilitation admission criteria

Specific review focussed and completed by community triumvirate leadership teams on fill rates across our rehabilitation units and the rationale for excessive staffing usage and what this indicates regarding patient acuity and need and what impact working at baseline staffing would mean for the quality and safety of the service. For completion within three months and to be reported back to the Patient Safety and Quality Assurance Group meeting.

Understand the impact of increasing acuity of admissions into these settings and the impact of staffing and management of environments. Understand readmission rates back into acute beds following transfers to rehabilitation unit settings and define learning to support improvement in use of settings and patients experience. This should also define how this can improve excessive fill rates with bank staffing safely ensuring services maintain quality and safety of care for patients.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Governance Improvement Plan
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Approval
Submission to Board:	Board requested

Overview of paper

A paper setting out the Trust's response to external reviews of its governance.

Issues to bring to the Board's attention

The Governance Improvement plan has been developed in response to external review findings by Moorhouse and wider organisational feedback regarding complexity, duplication and clarity within the Trust's current governance arrangements. The review identified that governance effectiveness is influenced not only by structures and processes, but also by behaviours, clarity of accountability, escalation culture and the quality of organisational data and insight.

It aims to simplify governance arrangements, clarify roles and accountability, strengthen the flow of risk, quality and performance intelligence from ward to Board, and strengthen assurance and decision-making.

The proposed changes include revised governance structures and committee arrangements, updated Terms of Reference, clearer escalation routes, strengthening the Board Assurance Framework, improving consistency and quality of reporting, and embedding stronger governance discipline and behaviours across leadership forums.

Delivery will be led by the Trust Secretary under Chief Executive oversight, with progress reported and monitored through Board committees, and quarterly reporting to the Board.

Board members should note that the measures within the plan are primarily implementation and governance maturity outputs designed to establish stronger foundations and clearer governance arrangements. Sustainable improvement will also depend on cultural and behavioural change being embedded over time, alongside strengthening the quality, integration and use of organisational intelligence.

The Board is asked to approve the attached Governance Improvement Plan and support the phased implementation approach set out in the paper.

Governance	
Implications/Impact:	Legal, regulatory and organisational effectiveness impact
Assurance:	Limited assurance for current governace arrangements; Reasonable assurance for Governance Improvement Plan
Oversight:	Trust Board

Introduction

The Board is asked to approve the attached Governance Improvement Plan, which sets out a structured programme of actions to strengthen the Trust's governance arrangements following the external review by Moorhouse.

The plan responds to learning from recent internal and external reviews and reflects the Board's ambition to maintain strong grip, clear accountability and effective assurance across quality, safety, risk and performance.

The focus of the plan is to:

- Clarify governance roles, delegation and escalation
- Reduce duplication and unnecessary complexity
- Strengthen line-of-sight from frontline intelligence to Board oversight
- Embed consistent governance discipline across the organisation

The plan will be overseen by the Chief Executive, with delivery led by the Trust Secretary and team, and progress will be monitored through Board.

Board is asked to:

- Approve the Governance Improvement Plan at Appendix A

1. Purpose

This Governance Improvement Plan sets out the actions required to ensure the Trust's governance arrangements are clear, proportionate, effective and focused on impact, supporting safe, high-quality care and effective Board oversight. The Trust's governance structure must be aligned to:

- Statutory and regulatory requirements (including Well-Led and Quality governance expectations)
- Recent service changes and system developments (including CYP and All Age ED arrangements)
- The Trust's strategic priorities and 5-year strategy
- The Board's role in providing clear grip, assurance and line of sight from risk to impact as per the trust's standing orders, standing financial instructions, and scheme of delegation

The plan focusses on structure, clarity, effectiveness and assurance**.**

2. Objectives

The following objectives have been set to ensure the governance improvement plan delivers what is required following external reviews.

- Strengthen clarity of governance structures and accountabilities

- Ensure Terms of Reference reflect the purpose of the meetings, with the objective of assurance from every meeting within the governance structure
- Improve escalation and assurance from services to Board
- Flow of risk, quality intelligence and performance escalation from the floor to Board
- Reduce duplication and inactive governance forums
- Provide clarity for Directorate, service and place-based governance forums and how they are part of the Trust governance
- Support consistent governance discipline and behaviours
- Interfaces between executive decision-making and Board assurance made clearer
- Support sustained compliance with Well-Led expectations

3. Key Review Questions

As the improvement plan is undertaken the following critical questions will be asked at each step of the plan.

- Does each governance forum have a clear purpose, authority and value?
- Is there a clear line of sight from frontline risk and intelligence to Board action?
- Are roles, escalation routes and decision rights consistently understood?
- Is assurance streamlined, triangulated and focused on impact, rather than volume?
- Are there any duplicate, inactive or time-limited forums that should be closed or redesigned?

4. Key Outputs from the improvement plan

The improvement plan will produce:

1. **Confirmed Governance Structure**
    - Clear, up-to-date governance map showing Board → executive → operational flows
2. **Refined Terms of Reference**
    - Updated ToRs where required, reflecting best practice and decision-making
3. **Governance Improvement Actions**
    - Clear, prioritised actions with named owners and agreed timelines
4. **Board Assurance Summary**
    - Concise narrative describing how the revised structure strengthens grip, oversight and accountability

5. Measures of Success

The improvement plan will be measured by the following:

Key Outputs

- Consistent application of revised governance arrangements
- Improved clarity for leaders and managers on roles and escalation
- Reduced duplication and clearer decision-making

6. Governance and Oversight of the Review

- The review will be overseen by the Trust Secretary, working with the Chief Executive and Chair
- Progress and outputs will be reviewed by the appropriate Board Committee for endorsement, prior to full Board consideration
- Any structural changes will be subject to Board approval whether through amendment of the Standing Orders, or sub-board committee's terms of references.

Governance Improvement Plan				
Action	**Action Detail**	**Lead**	**By when**	**Output**
Governance Structure				
Review Trust governance structure and make changes – set out clearly the board-sub committees that are part of this structure	Governance structure overhaul	Trust Secretary	July Board	Agree end to end governance map. Ensure all executive leads part of review.
Review each Board sub-committee and its function, including reviewing the Terms of Reference (TOR)		Trust Secretary	July Board	List of forums to be closed, merged or redesigned, agreed with Executive.
Review the Equality Impact Assessment (EQIA) function, including reviewing TORs, processes and forms	Align EQIA into new governance structure	Trust Secretary/ CMO/ CNO	July Board	EQIA embedded into agreed structure and assurance routes.
Review every meeting that is below every board sub-committee: 1. Look at its purpose 2. Review its TOR 3. Decide if needed going forward 4. Agree which meetings are required and will provide assurance to the relevant board sub-committee	Board sub-committee and meeting structure overhaul	Trust secretary will lead executive for Board sub-committee	July Board	
Terms of Reference and Delegation				

Review all Board and Board Committee Terms of Reference against actual practice		Trust Secretary	End of June	TOR changes where needed Trust Secretariat to lead on drafting these.
Review Executive leads and Executive attendees for each Board sub-committee	Important as we recruit new NEDs to the Trust Board	CEO/Chair	July Board	
Clarify where decision-making, assurance and advisory functions sit		CEO	End of June	Clear delegation and escalation model
Confirm governance arrangements for transitional services and programmes		Executive leads	End of June	Time-bound governance arrangements with exit criteria - for example CYP board sub-committee
Close or amend ToRs for forums that no longer operate as intended	Led by sub-board committees with endorsement by ARC	Trust Secretary	End of July	Rationalised governance documentation
Publish a clear schedule of delegation	Scheme of delegation reviewed and updated where required	CFO	July Board	Single, accessible delegation framework. Trust secretariat to support.
Assurance, Escalation and Information Flow				
Map risk, quality and performance escalation routes from services to Board		CNO	End of June	Clear escalation pathways, via the trust governance framework
Test escalation using real risk and quality examples		CNO	End of July	Test assurance works in practice
Improve the quality, use and integration (triangulation) of data and business intelligence		CFO	September	Realign the focus of the business intelligence team and how it supports decision-making, assurance and data quality

Improve triangulation of performance data, patient and staff experience, and wider feedback and insight	Agreed triangulated dashboards and reports	CFO/CNO/CPO/DofS	November	Triangulated reports on staff and patients, for Quality Committee and People Committee. Test assurance via SDRs.
New IQPR designed and implemented		CFO/CNO	July Board	New look IQPR to be shared by mid-June for review by CEO
SDR packs to be updated as part of review of IQPR for Board		DofTP	September	New look SDR packs
Quality Digest redesigned in alignment with IQPR redesign for Trust Board		CFO/CNO	July Quality Committee	New look Quality Digest to be shared by mid-June. Data to be triangulated from multiple sources
Strengthen consistency and quality of reporting into Board sub-Committees		All Executives	July	Clearer, impact-focused committee reports that provide assurance not reassurance
Governance discipline and capability				
Re-confirm expectations of chairs, members and attendees of governance forums		Trust Secretary	End of June	Shared understanding of governance roles
Revise board sub committee template for Board updates		Trust Secretary/Ned Committee Chairs	July Board	Consistent reporting across forums
Revise Board and Board sub-committee front sheets		Trust Secretary	July meetings	Clear and concise front sheets linked to trust strategy
Train authors in insight-driven report writing		Trust Secretary	On-going	Standard format for report writing
Refresh Committee workplans		Trust Secretary/Executive lead	September meetings and ongoing	Standard workplan, driven by strategy, BAF and regional/national agenda

Reduce agenda overload and focus on decision-making and assurance		Committee chairs/ Executive leads		Focussed agendas. Support from Trust Secretariat
Support leaders to embed good governance behaviours	Present to TLT and cascade to all leaders via leaders' event	Trust Secretary	On-going	Improved governance maturity – leaders can describe the governance floor to board
Board oversight and Continuous improvement				
Provide the Board with a concise assurance update on governance improvements		Trust Secretary	September Board	Report to Board quarterly with an update for one year
Review governance effectiveness through external Well-Led self-assessment		Trust Secretary/Chair/CEO		Plan for early 2027
Agree approach signed off by Trust Board for annual cycle of routine review of governance structures and ToRs		Trust Secretary/Chair	July Board	Sustainable governance improvement. Continuous improvement cycle.
Board Assurance Framework (BAF)				
Review BAF format and agree new format. Embed understanding of BAF role		CNO	September Board	New BAF format signed off by Board
Review the current strategic risks included on the BAF and update to reflect the new five-year trust strategy		CNO	July TBC forum	The risks on the BAF represent the Trust's true principal strategic risks. Operational risks are appropriately managed outside the BAF as part of the Trust Risk Register
Strengthen risk articulation. The risk–cause–impact/effect logic is clear and coherent		CNO	September Board	

Review controls and mitigating actions		CNO	September Board	Clearly distinguish between controls that are embedded and actions that are still in progress
Strengthen assurance narrative. The narrative clearly explains why the Board can be assured. Gaps in assurance are explicitly identified		All executives	September Board	Assurance is triangulated (e.g. data, audit, independent review, executive testing)
Align Committee assurance to the BAF		Trust Secretary	September Board and Sub-Committees ahead of Board	Which Board Committee provides primary assurance for each BAF risk How committee discussions, reports and escalations explicitly reference the BAF How assurance flows from committees into Audit & Risk Committee and Board. Annual surveys to be presented to ARC with NED lead for each board sub-committee
Regular committee and Board review	Must be on every Board and sub-committee agenda at the start of the agenda to frame the meeting context	Trust Secretary/Chief Nurse	On-going	BAF reviewed by Audit & Risk Committee. Brought back to the Board for discussion, challenge and confirmation. Each Board sub-committee to own their relevant risks
Align trust risk registers to the new BAF format		Trust Secretary / CNO	October	New trust register risk format.

Trust Board meeting

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Co-creation strategic plan: implementation update
Author:	Michelle Summers, Deputy director of communications, involvement and engagement
Executive Director:	Kindra Hyttner, Director of strategy and engagement

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

This paper outlines progress made in establishing the foundations of a more embedded organisational approach to co-creation, alongside early learning and the next phase of development focused on stronger governance, triangulated insight, capability-building and evidencing impact.

Issues to bring to the Board's attention

In July 2025, the Board approved the new co-creation strategic plan and framework reflecting a strategic shift from activity-led engagement towards a more structured, outcome-focused approach.

This work aligns with the expectations of the CQC Well-Led framework and NHS England guidance, which emphasises the importance of meaningful involvement, co-creation, reducing inequalities, and the use of insight to inform improvement, governance and decision-making.

Since approval of the framework, work has focused primarily on building the foundations required to support this approach, including:

- Establishing a new involvement and engagement function
- Implementing a co-creation framework, and training approach
- Building and strengthening relationships with communities and partners
- Beginning to develop a more integrated organisational insight model.
- Developing an emerging theory of change and delivery-to-outcomes framework

There are early examples of co-creation influencing strategic priorities and improvement activity, including the development of the trust's strategy and emerging clinical strategic plan, Mental Health Together clinical model refinement and community engagement work linked to inequalities.

However, the approach remains at an early stage of maturity and is not yet consistently embedded across the trust. The next phase will focus on strengthening governance, triangulation of insight, clearer measurement of impact and increasing visibility through Board and committee reporting arrangements.

The Board is asked to:

- Take limited assurance from the progress made in establishing the foundations of the co-creation approach, while recognising that arrangements for measurement, triangulation, governance and evidencing impact are still developing
- Endorse the next phase of delivery and priority areas of focus
- Continue to provide scrutiny and oversight as the approach matures

Governance

Implications/Impact:	If the trust does not effectively involve patients, carers, staff and communities in shaping services and improvement there is a risk that organisational decisions and strategic priorities will not fully reflect the needs and experiences of the populations we serve. This may impact confidence, quality of care, reduction of inequalities and successful delivery of the trust's strategy and well-led ambitions.
Assurance:	Limited assurance can be provided. The foundations of a more structured and outcome-focused co-creation approach are being established. Governance arrangements, triangulation of insight, capability building and reporting mechanisms are developing, with further work required to embed consistent organisational approaches and strengthen evidencing of impact over time.
Oversight:	Executive oversight through strategy deployment, with increasing integration into Quality Committee and wider Board governance arrangements as the co-creation approach matures and aligns with trust governance improvements.

Co-creation strategic plan: implementation update

What has changed?

The new team was recruited to by mid-September 2025. Since then, the trust has begun to see a shift in how involvement and engagement is understood by staff and applied across the organisation.

Our vision is to place patient and carer insight and experience at the heart of service design, delivery and improvement. We will achieve this by systematically listening, intelligently analysing, and meaningfully acting on feedback, and by closing the feedback loop so that people can see how their voices shape our services.

Patient experience and engagement are complementary and mutually reinforcing:

- Experience tells us what is happening and where improvement is needed.
- Engagement helps us understand why and how to improve through co-creation.

Since establishing the new team, we have moved from:

- **Engagement as activity to influencing strategic decisions –** patient and community voices are beginning to inform priority programmes (Mental Health Together); and the development of the trust's strategic priorities (it's new, five-year Doing Well Together strategy and emerging clinical strategic plan). Lived experiences, community insight and stakeholders have shaped priorities and delivery focus; and co-creation has been applied to the development of patient centred information including for female patients who are admitted into the Psychiatric Intensive Care Unit (PICU), and for those being prescribed anti-psychotic medication for the first time.
- **Informal engagement to intentional relationship-building –** We have begun to establish more trusted and sustained relationships. We now have 34 Voluntary Community Social Enterprise sector (VCSE) partners, community groups and champions. We have also worked to strengthen relationships with Healthwatch Kent and Medway, and local authorities.
- **Building relationships with communities who experience inequalities** - A particular focus has been placed on building relationships with communities who experience poorer access, outcomes or representation within mental health services. Priority areas have been informed by working with partners to understand local population health data from the Joint Skills Needs Assessment (JSNA) and the National Race Observatory, to identify which communities experience the greatest health inequalities and barriers to access - helping to target our engagement activity where it is most needed. These include Gypsey, Roma and Traveller communities, in partnership with Kent Community Health Foundation trust (KCHFT), people who have lived experience of Serious Mental Illness (SMI), Global Majority communities in East Kent and rural farming communities.

This represents an early but important transition from listening in isolation to using insight to shape and improve the care we provide - and better connect to our system priorities for meaningful change.

Early learning

The first phase of implementation has helped the trust better understand the infrastructure required to embed meaningful co-creation at scale. Learning includes:

- Meaningful co-creation with people who have lived experience requires consistent support, preparation and relationship-building to ensure participation is inclusive, trauma-informed, psychologically safe and suitable for all involved
- Co-creation has greatest impact when explicitly aligned to strategic priorities and programmes
- There is variation across the organisation in understanding and application, with stronger adoption in priority programmes and less consistency elsewhere
- Insight is increasingly stronger, but not yet triangulated with patient experience and organisational performance data to inform decision-making
- Building trusted relationships, particularly with underserved communities, requires sustained focus over time
- Governance, capability and accountability need to continue to mature to support consistent implementation
- The importance of clearer organisational understanding of the different but connected roles of patient experience, and involvement, engagement and co-creation.

These lessons highlight the importance of investing sufficient time, capability and infrastructure to support high-quality co-creation effectively and are directly shaping the next phase of delivery.

Strengthening data and insight to inform improvement and assurance

Work is underway within the trust to improve governance through the governance improvement plan, which will include triangulating data and insight more routinely to drive strategic decisions, manage risks and support executive and Board-level assurance. From a co-creation perspective, this would mean unifying involvement, engagement and co-creation insights and feedback with patient experience (e.g. patient, family and carer surveys, complaints and compliments, serious incidents) and organisational performance.

In advance of this, the involvement and engagement team will improve how it measures the impact of co-creation and involvement activity over time. This includes:

1. Establishing a dedicated insight tool that allows the team, and wider staff, to gather and analyse insight and feedback in a more structured, and less manual way
2. Developing clearer baselines
3. Rolling out a delivery-to-outcomes framework

This will enable a more robust assessment of whether involvement, engagement and co-creation is influencing decision-making, service improvement and outcomes for the communities we serve.

Developing a Theory of Change and Delivery-to-Outcome Framework

Previous Board discussions highlighted the importance of strengthening how the trust measures the impact of co-creation beyond participation, activity and engagement metrics alone. In response, work is underway to develop a more consistent organisational approach to understanding, evidencing and assuring the contribution co-creation makes to improvement, experience, equity and outcomes over time.

Historically, involvement and engagement activity within healthcare organisations has often been measured through levels of activity, participation and feedback. While these remain important measures – and we have made progress against them - the trust is seeking to strengthen how it demonstrates whether lived experience, community insight and co-creation are influencing decision making, service improvement, organisational learning and outcomes.

An emerging theory of change (appendix 1a) and delivery-to-outcomes framework (appendix 1b) has therefore been developed to support this next phase of maturity. The framework sets out how co-creation activity contributes to change through stages including participation, learning, application, embedding and strategic contribution. This approach recognises that the impact of co-creation is often contributory rather than directly attributable and therefore focuses on evidencing the pathway between involvement activity and improvements in services, experience, access, inequalities, and trust outcomes over time.

The framework is underpinned by trauma-informed principles, recognising the importance of psychological safety, inclusion, trust, shared power and avoiding harm when working alongside people with lived experience, carers and underserved communities.

Initial work will focus on developing clearer baselines and outcome measures, improving triangulation between experience, engagement, operational and inequalities data, and strengthening governance and reporting arrangements. Over time this will support greater organisational visibility and assurance regarding how co-creation is influencing improvement activity, decision-making and outcomes.

Next phase: priorities and pace

In 2026/27, the trust will take a phased approach to delivering co-creation, prioritising impact over scale.

The next phase will focus on:

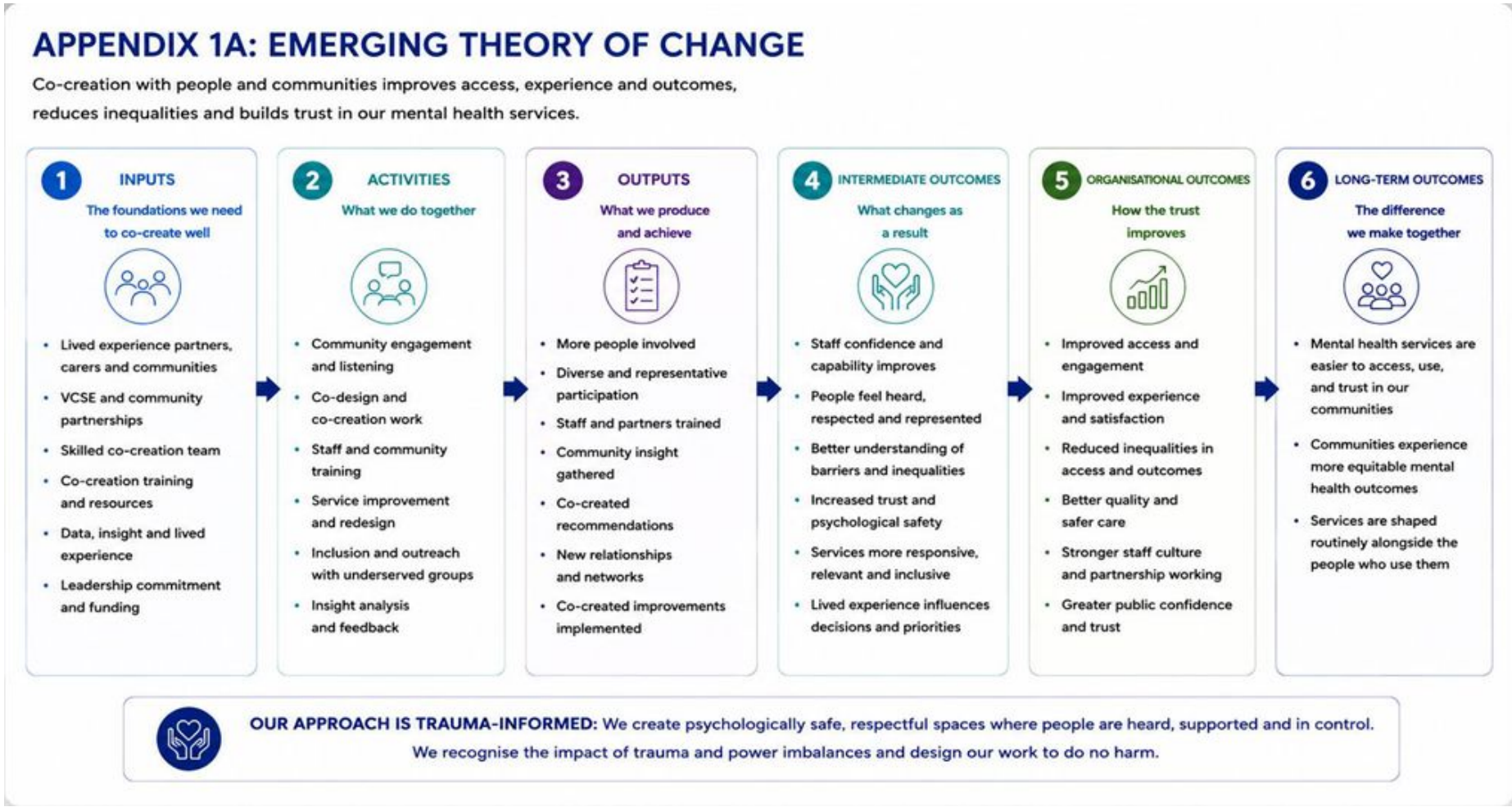
1. **Embedding co-creation in strategic priority programmes –** ensuring lived experience and community insight are built into our strategic programmes and improvement work across the trust.
2. **Introducing the delivery-to-outcomes framework** – implementing a clearer organisational framework to strengthen how co-creation activity, learning, influence and outcomes are understood, measured and evidenced over time.
3. **Building organisational capability and consistency** - supporting staff to embed co-creation as standard practice through training, development, practical support and clearer organisational expectations.
4. **Broadening reach and deepening community relationships -** continuing to build trusted relationships with communities, carers, VCSE partners and underserved groups to improve inclusion, representation and equity.

5. **Strengthening triangulation of insight and intelligence** – bringing together involvement, engagement, patient experience, inequalities, operational and performance data to support more informed decision making, improvement and assurance.
6. **Strengthening governance, assurance and reporting –** improving visibility, accountability and oversight through clearer governance arrangement, committee reporting and organisational assurance processes.

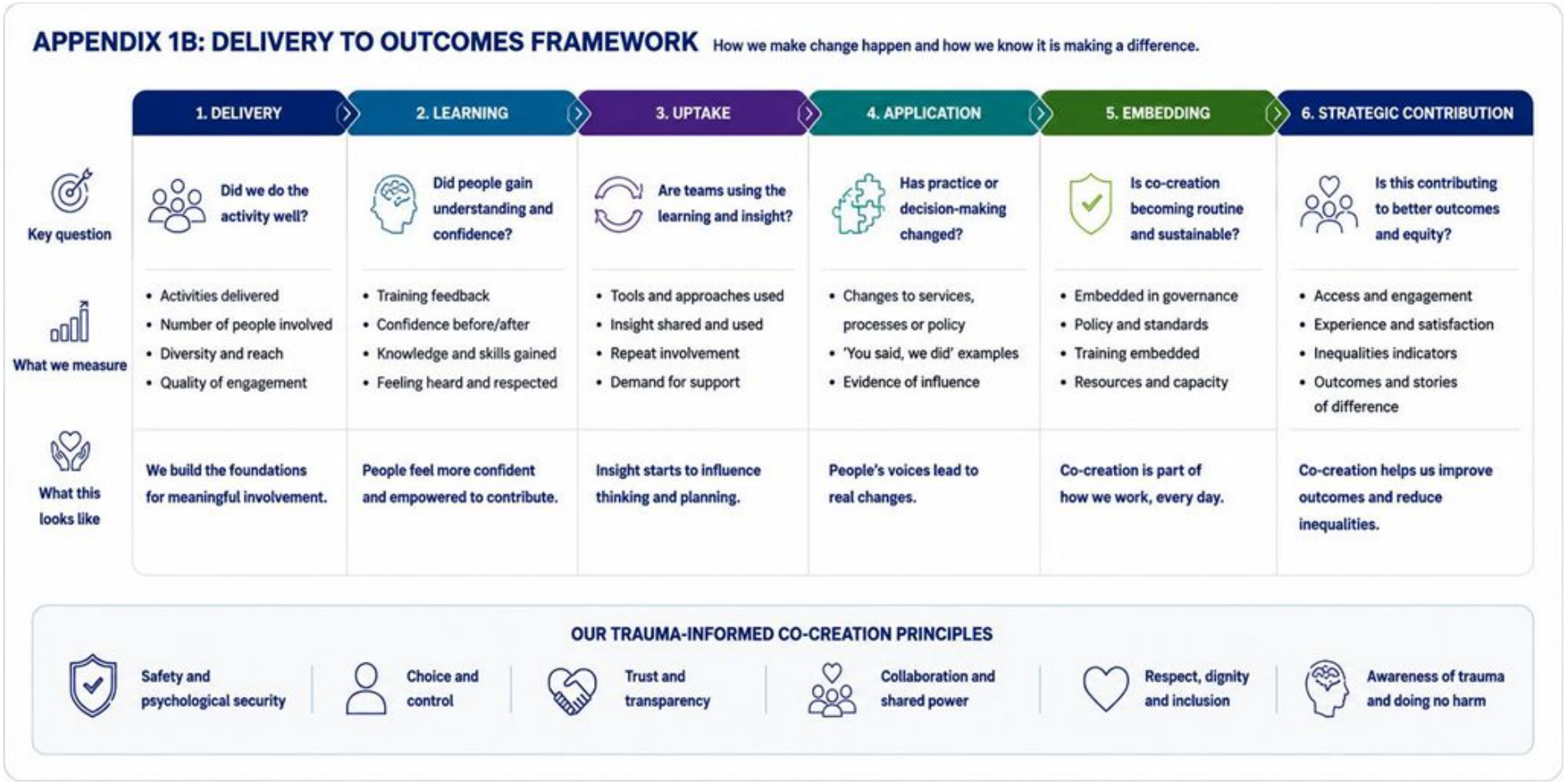
The next phase will place greater emphasis on visibility and assurance, ensuring the Board and Quality Committee are increasingly able to see how co-creation and organisational insight are influencing decisions, improvement activity and outcomes over time.

Trust Board meeting

NHS
Kent and Medway Mental Health NHS Trust



Version 1 - **Public**


APPENDIX 1B: DELIVERY TO OUTCOMES FRAMEWORK
How we make change happen and how we know it is making a difference.
1. DELIVERY
2. LEARNING
3. UPTAKE
4. APPLICATION
5. EMBEDDING
6. STRATEGIC CONTRIBUTION
Key question
Did we do the activity well?
Did people gain understanding and confidence?
Are teams using the learning and insight?
Has practice or decision-making changed?
Is co-creation becoming routine and sustainable?
Is this contributing to better outcomes and equity?
What we measure
• Activities delivered
• Number of people involved
• Diversity and reach
• Quality of engagement
• Training feedback
• Confidence before/after
• Knowledge and skills gained
• Feeling heard and respected
• Tools and approaches used
• Insight shared and used
• Repeat involvement
• Demand for support
• Changes to services, processes or policy
• 'You said, we did' examples
• Evidence of influence
• Embedded in governance
• Policy and standards
• Training embedded
• Resources and capacity
• Access and engagement
• Experience and satisfaction
• Inequalities indicators
• Outcomes and stories of difference
What this looks like
We build the foundations for meaningful involvement.
People feel more confident and empowered to contribute.
Insight starts to influence thinking and planning.
People's voices lead to real changes.
Co-creation is part of how we work, every day.
Co-creation helps us improve outcomes and reduce inequalities.
OUR TRAUMA-INFORMED CO-CREATION PRINCIPLES
Safety and psychological security
Choice and control
Trust and transparency
Collaboration and shared power
Respect, dignity and inclusion
Awareness of trauma and doing no harm

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	28th May 2026
Title of paper:	Standing Orders Amendment (CYP & All AED)
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of paper

A paper setting out the proposed change to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation to create the Children and Young Persons and All Age Eating Disorders ('CYPMHS & All AED') Committee.

Issues to bring to the Board's attention

The paper sets out the changes to the Trust's Standing Orders, which operationalises the Board's approval in March 2026 for the creation of a sub-board committee to deal with all transitional risks arising from the transfer of CYPMHS and All AED services.

The new committee will be time limited as the committee supports the Trust, and provides oversight on behalf of the board, for the smooth transition of CYPMHS and All AED services from North East London Foundation Trust (NEFLT) to the Trust.

To assist the Board in approving the amendment to the Standing Orders, the Terms of Reference is attached (amended on a de minimis basis regarding quoracy), and a draft Committee workplan is also attached.

Governance

Implications/Impact:	Well-Led: Governance
Assurance:	Significant
Oversight:	Oversight by Audit and Risk Committee

Version 2 - **Public**

Key Changes Requested for Approval

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

SO/SFI number	Current wording	New wording	Reason
8.12.8	N/A	Primary Role: To provide the Board with assurance concerning all aspects of post-transfer transitional risks relating to the quality, safety, performance, workforce stability and operational resilience of Children and Young People's Mental Health (CYPMH) and All Age Eating Disorders (AAED) services. To assure the Board that the structures, systems and processes are in place and functioning effectively to support the safe, high-quality delivery of services and the successful transition to business-as-usual arrangements within the defined post-transfer period. To assure the Board that where there are risks, deterioration in performance, or emerging issues that may jeopardise the Trust's ability to deliver safe, effective and timely care, these are identified, escalated and managed in a controlled and timely manner, with appropriate action taken or escalation to the Board where required.	To formally create the sub-board committee within the Trust's governance structure

Draft - Terms of Reference

Name of Committee	**CYPMH & AAED Services Committee**	
Date	**13th March 2026**	
Version	**V.1**	
Approval	**Trust Board**	**Date: 26th March 2026**
Next review due	**March 2027**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1	Draft	13.03.26	Service transfer PMO	1st Draft

1. Constitution

The Board hereby resolves to establish a Committee, to be known as the Children and Young Persons Mental Health (CYPMH) and All Age Eating Disorders (AAED) Services Committee for a period up to 12 months. The Committee holds no executive powers. The Board may resolve to remove this Committee at a point it feels that transitional risks have become standard business risks.

Any amendments to the Terms of Reference must receive formal approval from the Trust Board.

The Committee is authorised by the Board to examine any matter within its remit and may request any information it considers necessary from any member of staff.

All staff are required to cooperate fully with any such requests.

2. Purpose

The Committee provides assurance to the Trust Board on the post-transfer transitional risks related to quality, safety, performance, workforce stability, and operational resilience of CYPMH and AAED services during its 12-month post transfer period. The transfer date is 01.04.26.

The Committee will ensure that any deterioration, risks, or emerging concerns are identified, and managed in a timely manner so far as possible. Where it is not possible to manage those matters, the Committee may either escalate to the Board or cross-refer to another sub-Board Committee.

3. Aims

To assure the Board that the structures, systems and processes are in place and functioning to support post-transfer matters and allow for transitional risks to be effectively managed.

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

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

4. Objectives

Specific to All CYPMH community services and AAED services:

To seek assurance through formal reporting that during the 12 months post service transfer that:

1. Robust quality and governance systems support safe, high-quality CYPMH and AAED care

Structures, policies, systems, and processes for quality assurance, continuous quality improvement, and all aspects of clinical, information, and quality governance are effective, consistently applied, and aligned with the needs of Children and Young People's Mental Health and All Age Eating Disorder services.

2. Regulatory and statutory compliance is actively achieved and maintained

Effective mechanisms are in place to ensure full compliance with relevant regulatory requirements—including CQC standards—and that recommendations or actions arising from CQC inspections or other regulatory bodies are implemented and monitored appropriately.

3. Risks to quality, safety, and service continuity are identified and managed proactively (including the Phase 2 digital full transfer programme)

Current and emerging risks to patient safety and service delivery, related to the transition from NELFT to KMMH, are clearly recorded, understood, mitigated, and escalated in a timely and proportionate manner.

4. Performance and quality metrics drive continual improvement

The Trust uses meaningful, child- and family-focused quality indicators, performance metrics, and outcome measures that support continual improvement in service quality, accessibility, experience, and effectiveness across CYPMHS. These indicators also extend to all-age eating disorder services, ensuring consistent monitoring and improvement across the full care pathway.

5. Complaints, incidents, and patient safety events inform learning and improvement

Trends, themes, and learning arising from complaints, incidents, safeguarding concerns, and patient safety events, impacted by the transfer of services are recognised, shared, acted upon, and used to strengthen a positive safety and learning culture.

6. Workforce capability and culture support safe and effective CYPMH and AAED delivery

Workforce capacity, training, development, and wellbeing are monitored and supported to ensure staff are equipped to deliver safe, compassionate, and high-quality care, particularly during and after the service transition.

5. Methodology

To discharge its remit, the CYPMH & AAED Services Committee will adopt a structured assurance-based methodology, focused on the systematic oversight of quality, safety, performance, workforce and risk during the post-transfer period.

The Committee will seek assurance through the receipt, scrutiny and triangulation of formal reports, exception reporting and escalation from established programme and operational governance arrangements supporting the CYPMH and AAED service transfer.

Specifically, the Committee will:

- Receive and review regular assurance reports on the safety, quality and effectiveness of CYPMH and AAED services, including performance against agreed quality indicators, access standards, waiting times, caseloads, outcomes and experience measures.
- Receive assurance on workforce capacity, stability, capability and wellbeing, including recruitment, retention, training, agency usage and vacancy management, and the impact of workforce risks on service continuity and quality.
- Receive and scrutinise reports on incidents, safeguarding concerns, complaints, serious incidents and patient safety events relating to CYPMH and AAED services, and seek assurance that learning is identified, disseminated and acted upon.

- Receive and review risk reports relating to the service transfer, including risks recorded on programme and corporate risk registers, and seek assurance that risks are appropriately mitigated, escalated and reviewed.
- Receive assurance on compliance with statutory, regulatory and commissioning requirements, including progress against any actions arising from CQC reviews, internal audits or external scrutiny relevant to CYPMH and AAED services.
- Receive reports from established programme governance forums, including the Service Transfer Programme Steering Group and any associated delivery or oversight groups, which will provide structured assurance on transfer milestones, integration progress, digital readiness and benefits realisation.
- Direct the provision of exception reports where performance, quality or safety thresholds are not met, and escalate matters of concern to the Trust Board where appropriate.
- Approve and oversee an annual workplan aligned to the defined post-transfer assurance period, setting out the Committee's planned areas of focus, including deep dives, thematic reviews, reporting cycles and key assurance checkpoints.
- Where required, request additional information, presentations or assurance from Executive Directors, programme leads, clinical leaders or operational managers to support the Committee in fulfilling its assurance role.

6. Membership

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

- Two Non-Executive Board members (one of whom will Chair the Committee);
- Chief Operating Officer
- Chief Nurse
- Chief Finance and Resources Officer
- Head of Quality
- CYPMHS / AAED Service Director
- CYPMHS / AAED Head of Nursing
- Workforce/HR Business partner
- Finance Business Partner

In Attendance and on request:

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

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

7. Quorum

A quorum shall be three members, which must include one non-executive member and one executive Board member.

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

To discharge its remit, the Committee will adopt the following methodology:

1. **Seek Assurance Through Established Programme Governance Structures**
   The Committee will obtain regular assurance on operational performance and service stability through the existing Service Transfer Programme governance arrangements, specifically:

   - **Service Transfer Programme Steering Group** – to provide strategic oversight, risks, emerging issues, and programme-level assurance relating to the successful transfer and mobilisation of CYPMH & AAEDs functions.
   - **Delivery Oversight Group** – to provide operational assurance, including progress against transition milestones, workforce and capacity planning, quality and safety indicators, and any mitigations in place where performance deviates from plan.

2. **Review Assurance Reports and Escalations**
   The Committee will receive and review:

   - Formal assurance reports submitted from the Steering Group
   - Escalations relating to operational risks, safeguarding concerns, workforce pressures, quality indicators, or delivery constraints.
   - Exception reports where delivery, safety, or performance thresholds are not met.

3. **Triangulate Information with Core Operational Data**
   The Committee will triangulate information from the governance groups with:

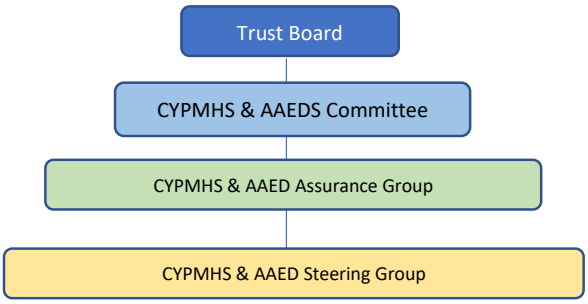
   - Routine CYPMHS & AAEDS performance dashboards.
   - Quality and safety reports, including incidents, complaints, and feedback.
   - Workforce metrics and capacity modelling.
   - Any independent review or audit outputs commissioned during the transition period.

4. **Maintain a Forward-Looking Oversight Perspective**
   The Committee will focus on both immediate post transfer operational performance and the medium-term embedding of the new service model, ensuring that:

   - Risks are actively managed and mitigated.
   - Children, young people and families continue to receive safe, timely, high-quality services.
   - Transition to "business as usual" governance is achieved within the 12-month window.

5. **Engage with Relevant Stakeholders When Required**
   The Committee may request additional information, presentations, or clarification from programme leads, operational managers, clinical leaders, or partner agencies to support assurance activity.

9. Accountability and Reporting – Group Structure



10. Committee rules and administration arrangements

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

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

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

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

11. Accountability and Reporting Arrangements (Annual Effectiveness Report)

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

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

12. Review and Monitoring

The Committee will automatically dissolve at the end of its 12-month lifecycle, unless the Board determines otherwise.

CYPMH & AAED Services Committee Workplan (June 2026 – June 2027; meetings monthly excluding August)

Agenda Items	For	Frequency	Responsible Person	Jun-2026	Jul-2026	Sep-2026	Oct-2026	Nov-2026	Dec-2026	Jan-2027	Feb-2027	Mar-2027	Apr-2027	May-2027	Jun-2027
Meeting Administration															
Meeting Dates															
Agenda to be agreed by (Chair/Secretary)	FI	Every Meeting	Committee Secretary / Chair	x	x	x	x	x	x	x	x	x	x	x	x
Papers to be requested by	FI	Every Meeting	Committee Secretary	x	x	x	x	x	x	x	x	x	x	x	x
Papers to be submitted by	FI	Every Meeting	All report owners	x	x	x	x	x	x	x	x	x	x	x	x
Papers to be circulated by	FI	Every Meeting	Committee Secretary	x	x	x	x	x	x	x	x	x	x	x	x
Opening Matters															
Welcome, Introductions & Apologies	FI	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Declarations of Interest	FI	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Minutes of the Previous Meeting	FA	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Action Log & Matters Arising	FA	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Core Assurance Reports (Quality, Safety, Performance, Workforce, Resilience)															
Integrated Quality & Performance Report (CYPMH/AAED extract)	FD	Monthly	Chief Operating Officer / Service Director	x	x	x	x	x	x	x	x	x	x	x	x
Quality & Safety Dashboard	FD	Monthly	Chief Nurse / Head of Quality	x	x	x	x	x	x	x	x	x	x	x	x
Workforce & Capacity Report	FD	Monthly	Workforce/HR Business Partner / Service Director	x	x	x	x	x	x	x	x	x	x	x	x
Operational Resilience / Service Continuity Update	FD	Monthly	Chief Operating Officer / Service Director	x	x	x	x	x	x	x	x	x	x	x	x
Transitional Risk Oversight & Programme Governance															
Service Transfer Programme Update & Milestones / Benefits Realisation	FD	Monthly	Programme Lead / Steering Group Chair	x	x	x	x	x	x	x	x	x	x	x	x
Programme Risk Register Review (including mitigations and escalation)	FD	Monthly	Programme Lead	x	x	x	x	x	x	x	x	x	x	x	x
Phase 2 Digital Full Transfer Programme Assurance	FD	Bi-Monthly	Digital Lead / Programme Lead	x		x		x		x		x		x	
Patient Safety, Learning, Safeguarding & Complaints															
Patient Safety Incidents & Learning Report (service-specific)	FD	Bi-Monthly	Head of Quality / Chief Nurse	x		x		x		x		x		x	
Safeguarding Assurance Report (service-specific)	FD	Quarterly	Safeguarding Lead / Head of Nursing	x			x			x			x		
Complaints, Concerns & Themes (CYPMH/AAED)	FD	Quarterly	Patient Experience Lead / Service Director	x			x			x			x		
Regulatory, Statutory Compliance & External Scrutiny															
CQC / Regulatory Compliance Update	FD	Quarterly	Chief Nurse / Head of Quality	x			x			x			x		
Audit / Independent Review Findings (transition-related)	FD	Bi-Annual	Relevant Executive / Programme Lead			x						x			
Deep Dives & Thematic Reviews (Assurance Checkpoints)															
Deep Dive: Access, Waiting Times & Demand/Capacity Modelling (including mitigation plan)	FD	Bi-Annual	Chief Operating Officer / Service Director		x						x				
Deep Dive: Outcomes and Experience Measures (child/family-focused metrics and pathway outcomes)	FD	Bi-Annual	Service Director / Patient Experience Lead			x						x			
Deep Dive: Workforce Culture (retention and wellbeing)	FD	Bi-Annual	Workforce/HR Business Partner / Head of Nursing	x					x						
Deep Dive: Workforce Capability (training, supervision, agency reliance)	FD	Bi-Annual	Workforce/HR Business Partner / Head of Nursing				x						x		
Deep Dive: Digital Transfer (Phase 2) – clinical safety case, cutover readiness, resilience	FD	Bi-Annual	Digital Lead / Programme Lead					x						x	
Deep Dive: Safeguarding & High-Risk Pathways (learning and multi-agency interface)	FD	Annual	Safeguarding Lead / Head of Nursing							x					
Checkpoint: Transition to Business-as-Usual (BAU) Governance & Committee Dissolution Readiness	FD	End-of-period	Committee Chair / Programme Lead												x
Closing Items															
New Risks to Report	FD	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Items Referred to or from Other Committees	FD	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Items to Report to the Trust Board	FD	Every Meeting	Committee Chair	x	x	x	x	x	x	x	x	x	x	x	x
Committee Workplan (review / amendments)	FN	Every Meeting	Committee Chair / Committee Secretary	x	x	x	x	x	x	x	x	x	x	x	x
Review of Terms of Reference	FA	Annual	Committee Chair									x			
Committee Effectiveness Review / Annual Effectiveness Report input	FD	Annual	Committee Chair												x

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Public Board Meeting**
Meeting Date	**28th May 2026**
Title	**Quality Committee Chair's Report (April and May 2026)**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Julie Kirby, Acting Chief Nursing Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Violence and Aggression/Restrictive Practice Report	• Chief Nurse's Report • Risk Register • Quality Impart Assessments • CQC Report • Quality Plan • Quality Improvement Plan Update • IQPR • Research and Innovation Strategy Update • Quality Digest • Section 29 Warning Notice Report • Bi-Annual Suicide Thematic Review • Quarterly Mortality Report • Safer Staffing Report – 6-month update	• Quality Accounts 2025/26 • Annual Policy Report

NHS
Kent and Medway
Mental Health
NHS Trust

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Violence and Aggression/Restrictive Practice Report	The Committee reviewed the report on violence and aggression, recognising this as a key priority area. While noting the significant level of activity and action planning in place, the Chair emphasised the need for a stronger focus on measurable outcomes and demonstrable impact, rather than process alone. Some areas of improvement were acknowledged, though trends remain variable, and further work is required to better understand the drivers behind changes in data. Concern was raised regarding the potential underreporting of racially motivated incidents and the risk of normalisation, with a clear expectation that this is addressed and that staff feel confident in reporting. The introduction of consequence frameworks, including formal warning letters, was welcomed as a positive step towards reinforcing a zero-tolerance approach to violence and aggression. The Committee also requested benchmarking against peer organisations and supported further work to define clear outcome measures	**Limited**	

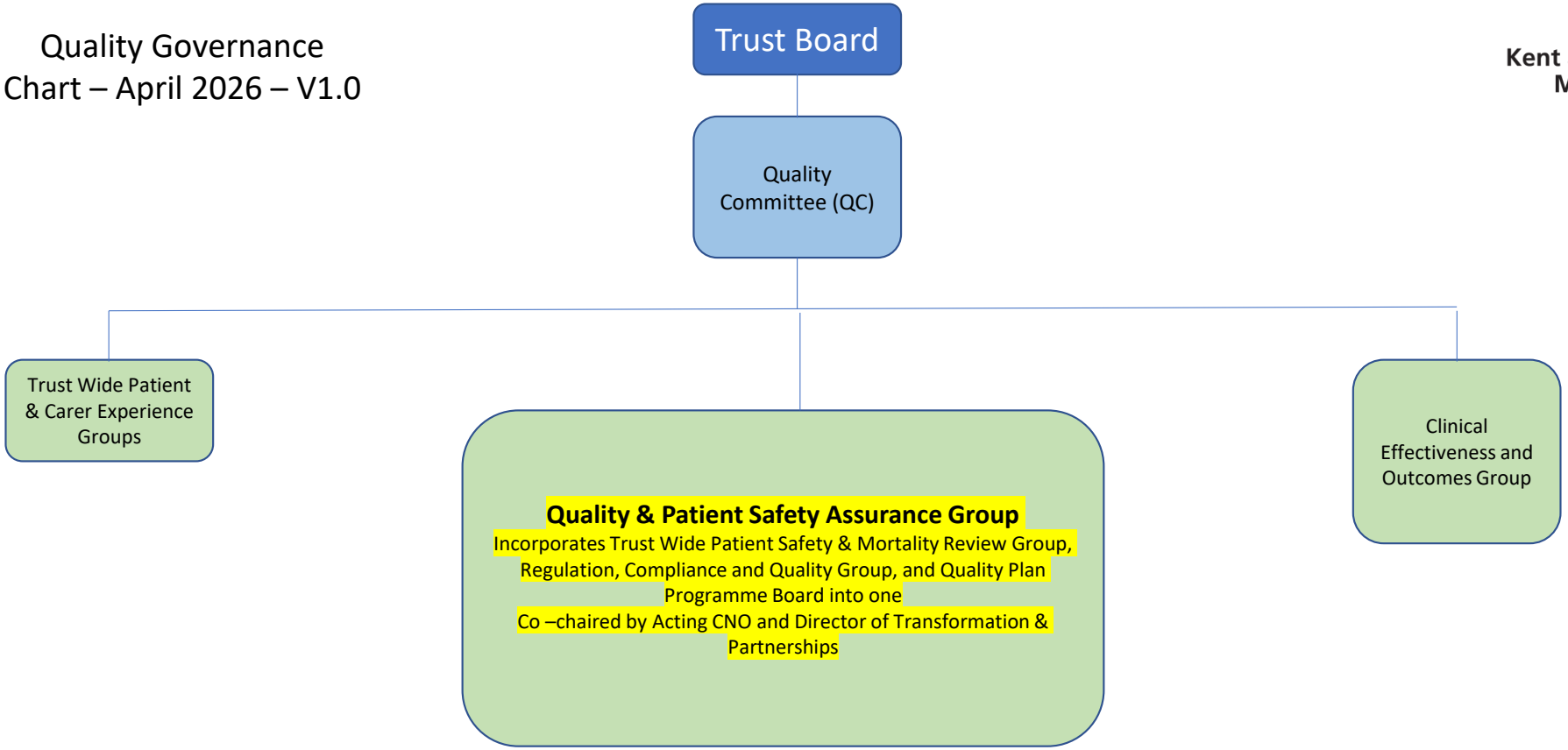
	of “what good looks like,” alongside strengthening data analysis to provide greater assurance of impact.		
CQC Report and Quality Plan	The Committee considered the CQC report as a discussion item and noted the comprehensive overview of regulatory activity and Trust response. Positive progress was recognised, particularly in the health-Based Place of Safety, where compliance and governance have significantly improved. Key areas identified for focus include strengthening oversight of governance structures (notably Regulation, Compliance and Quality Group), sustaining improvements in environmental risk management, and continuing to evidence embedded compliance and impact.	**Reasonable**	Next steps: These priorities will be taken forward as key areas of focus, with enhanced assurance and updates to be provided to the Committee at future meetings.
CQC Report (Section 29A)	Acting Chief Nurse advised they will be submitting a formal escalation letter to the CQC regarding prolonged waits for inspection reports and update of Section 29a warning notice for the HBPOS.	**Reasonable**	.At the subsequent meeting of the Committee, it was confirmed that the formal escalation had happened, and that a new inspector had been assigned to cover sickness absence at CQC.
Quality Improvement Plan Update	The Committee received assurance that the improvement programme continues to progress in the right direction, with work underway to strengthen reporting arrangements and improve oversight of delivery and impact. Members acknowledged feedback regarding the complexity of the current reporting format and	**Reasonable**	The Committee further noted that governance arrangements had now been agreed to ensure emerging patient safety themes and organisational learning are incorporated into the improvement programme. Future reports will place greater emphasis on demonstrating measurable

	noted plans to introduce a single streamlined reporting template focused on the four key themes and eleven priorities, with clearer alignment between actions, objectives and outcomes. The Committee also noted improvements in medicines competency recording through the implementation of automated uploads to I-learn, alongside confirmation that Consultant Connect remains available to all Community Mental Health Team prescribers through transformation funding.		impact, patient outcomes and patient experience alongside delivery progress. Key next steps include embedding the revised reporting template, strengthening impact measures and continuing to align safety improvement work across the organisation.
Quality Digest	The Committee received assurance from the Quality Digest report and noted ongoing oversight of patient safety, compliance, and safety culture across the Trust. Members welcomed the inclusion of a glossary of abbreviations and discussed staff confidence, risk aversion, and the need to strengthen safety culture and restorative approaches across teams. Updates were received on suicide prevention compliance, with assurance provided that work is underway to improve data accuracy and reporting processes. The Committee also received assurance regarding the implementation of automated fridge and room	**Reasonable**	Next Steps • Continue data cleansing and reporting improvements relating to suicide prevention compliance. • Progress safety culture and staff engagement work. • Continue monitoring improvement actions through future Quality Digest reports.

	temperature monitoring systems to strengthen compliance and patient safety.		
Acting Chief Nurse requested approval for a change in meeting structure under Quality Committee, amalgamating three quality meetings into one Quality and Assurance meeting. Proposed structure attached and board approval requested. Note: It is recognised the trust is due to undergo a review of its governance structure which this proposed change is in line with and it is not anticipated that this will require further significant change.			

Quality Governance Chart – April 2026 – V1.0

Kent and Medway Mental Health NHS Trust



Title of Meeting	**Public Board Meeting**
Meeting Date	**28th May 2026**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Ali Layne-Smith, Interim Chief People Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• People Committee Main Report • People Risk Register • Deep Dive- Culture • NHS England – 10 Point Plan to improve Resident Doctors Working Lives – Update • Clinical psychology support trial evaluation • WRES & WDES combined report		• Employment Tribunal Annual Report • HR Policies and Procedures • Annual Policy 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.
People Committee Main Report	The Committee received the first draft of the People Committee report and agreed this format would be used for future reporting. The dashboard and presentation were positively received, particularly the overview of workforce metrics, recruitment, sickness absence, turnover, staff survey feedback and People Plan priorities. The Committee highlighted the importance of ensuring future reporting aligns clearly to the Trust strategy and requested the future inclusion of an EDI dashboard. Concerns were noted regarding potential inaccuracies in sickness absence data, with a request for future reports to include clearer information on sickness reasons and assurance on data accuracy.	**Reasonable**	**Next steps:** • Future People Committee reports to follow the agreed format. • EDI dashboard to be incorporated into future reporting. • Reporting to demonstrate clearer alignment to Trust strategy and priorities. • Sickness absence data to be reviewed for accuracy, with future reports including breakdowns of reasons for absence.
Deep Dive-Culture	The Committee received a deep dive discussion on organisational culture, leadership behaviours and staff experience, linked to the Trust's new strategy, vision and values. Members acknowledged significant progress in developing organisational identity and leadership capability but recognised that staff and patient experience remain inconsistent across teams and services. Discussion focused on the importance of leadership behaviours, strengthening staff voice, improving accountability and reducing variation in experience across the organisation. Positive examples of team culture and feedback from newly transferred CYP staff were noted, alongside the need to better understand and spread good practice.	**Reasonable**	The Committee agreed that the next phase of work should focus on consolidation, embedding consistent behaviours and targeted improvement rather than introducing additional initiatives. A further detailed discussion and organisational culture improvement framework will return to People Committee in July 2026, supported by findings from the Well-Led Review, CQC feedback and Morehouse review.

NHS England – 10 Point Plan to improve Resident Doctors	The Committee received an update on the NHS England 10-Point Plan to Improve Resident Doctors' Working Lives and noted continued positive progress against the assurance framework, with the Trust performing above the Southeast average in both baseline and follow-up assessments. Members were assured that there were no significant unresolved concerns and that remaining partially compliant areas were already progressing towards full compliance.	**Reasonable**	The Committee also noted improvements delivered to support resident doctors' wellbeing and working experience, including enhanced rest facilities, rota transparency, payroll accuracy and timely reimbursement processes. Discussion highlighted the opportunity to apply wider learning from the programme to improve staff wellbeing and experience across the wider workforce
WRES & WDES combined report	The Committee received the WRES/WDES combined report and approved submission of the statutory data return to NHS England. Members noted a decline in performance across several indicators, reflecting themes identified within the staff survey, whilst also recognising positive progress in areas including Board disability representation, access to CPD for global majority staff, and improved reasonable adjustment processes. The Committee discussed concerns relating to recruitment disparities, disability awareness, and experiences of bullying and harassment, and agreed that further detailed consideration is required to better understand the underlying causes and identify additional actions. A deeper dive session will therefore be scheduled within the forward plan later in the year to review trends, outcomes and organisational response in more detail.	**Reasonable**	The Committee also noted that the current action plan will be reviewed and consideration given to renaming and aligning it more clearly within the wider EDI programme to ensure a more integrated and cohesive approach going forward.
It was agreed by the committee that concerns raised by the Chair regarding some papers coming to People Committee without prior review by Executive should be escalated, and that the role of the Trust Leadership Team (TLT) as the Trust's decision-making group requires further review and clarification. The Committee also agreed that the new Trust Committee paper template should be adopted for future reports to ensure consistency and alignment across Committees.			

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28th May 2026**
Title	**Mental Health Act Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
	• Chief Medical Officer's Report • Report from MHLOG • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • CQC Mental Health Act Reviews • The CTO paper • MHA/MCA Training Report • HBPoS / Section 136 Quarterly Update • Report from Associate Hospital Managers	

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Kent and Medway
Mental Health
NHS Trust

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Medical Officer's Report	The Committee received the Chief Medical Officer's report and was provided with reasonable assurance regarding the Trust's compliance with the Mental Health Act and associated governance arrangements. The Committee noted several areas of good practice, including fully compliant Mental Health Tribunal facilities across all sites, the successful implementation of the Mental Health Act Hearings Coordinator role (recognised positively during inspection), no backlog in Managers' Hearings, and the extension of the Service Level Agreement supporting ongoing partnership working. Areas of concern were highlighted in relation to inconsistent compliance with Section 62 requirements, which continue to be actively monitored, and temporary operational impacts from the recent meningitis outbreak, which required a short-term move to remote hearings. Concerns regarding the conduct of some Associate Hospital Managers were also noted, with action being taken to address professional standards. The Committee was assured that appropriate oversight, monitoring, and actions are in place to address identified risks, and will receive further updates where required.	Reasonable	
Mental Health Act Activity	The Committee received assurance that appropriate governance arrangements are in place and that data quality issues are being actively addressed. While scrutiny visit targets were slightly below plan due to workforce pressures,	Reasonable	Next Steps: • Improve data reporting to distinguish legacy and current issues.

Data Quarterly Report	actions are in place to address this. Compliance with Section 132 rights remains an area of focus, with some issues linked to legacy cases and ongoing work to strengthen processes and documentation. Limitations in current data systems were noted, particularly in distinguishing historic from current issues and capturing external referral data. Work is underway with the Business Intelligence team to improve reporting and data accuracy.		• Strengthen action tracking to ensure clear, outcome-focused improvements. • Continue work to improve Section 132 compliance. • Enhance data capture, including external referrals.
HBPoS / Section 136 Quarterly Update	The Committee considered the report on the Health-Based Place of Safety, noting the positive progress made following the implementation of revised practices in response to previous regulatory concerns. In particular, the absence of breaches during the reporting period and the strengthened clinical leadership arrangements were recognised as significant improvements. The inclusion of clearer quality metrics also provided increased visibility and assurance regarding service delivery. However, the Committee agreed that, overall, only limited assurance could be taken at this time. This was due to the emerging risk associated with prolonged lengths of stay within the Place of Safety. While services remain legally compliant, it was acknowledged that some individuals are experiencing extended stays of several days, with more recent cases exceeding a week. This is primarily driven by ongoing system pressures, including reduced acute inpatient bed availability and wider challenges in patient flow across urgent and emergency care pathways. The Committee noted that, although risk escalation processes are functioning effectively and the issue has	Limited	Next Steps: • A further report will be developed to provide a detailed review of prolonged lengths of stay within the Health-Based Place of Safety. • This will include analysis of contributing factors, particularly system flow and bed capacity constraints, alongside proposed mitigating actions. • Risk will be reported to Board for consideration. • Consideration will be given to whether this risk requires formal escalation to Board level. • Progress and any emerging risks will be brought back to the Committee for continued oversight.

	been identified promptly, the current trajectory presents a potential regulatory risk should it persist. Members emphasised the importance of maintaining oversight and ensuring that the organisation remains sighted on the balance between legal compliance and quality of patient experience.		

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**12th May 2026**
Title	**Audit and Risk Committee Chair's Report**
Author	**Kevin Corrigan, Audit and Risk Committee Chair**
Presenter	**Kevin Corrigan, Audit and Risk Committee Chair**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Board to endorse/amend the actions proposed**

Agenda Items

Finance and Regulatory items	
• Board Assurance Framework • Trust Risk Register • Risk Management Deep Dive • External Audit Progress Report • Internal Audit Progress Report • Anti-Crime Report • Draft Internal Audit Plan • Director of Finance Items	• Annual Governance Statement • Draft Accounts 2025/26

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.
Board Assurance Framework (BAF)	Committee scrutinised the clarity and quality of assurances, particularly around overdue actions, and sought clearer narrative explaining the transitional position pending a full BAF refresh. <u>Risk Management Deep Dive</u> Committee received a detailed update on the proposed redesign of the BAF, including a move to a cause-and-effect model and reduction in the number of strategic risks.	Limited Assurance	Exec, risk owners and risk team to update the BAF before submission to the Board.
Trust Risk Register (TRR)	Committee noted that risks remain largely static and recognised ongoing work to strengthen action quality and assurance, particularly in relation to inpatient flow, CRFD patients and CYP services.	Limited Assurance	
Digital Risks Report	The Trust is in a good place regarding the prominent digital risks, which are adequately controlled.	Reasonable Assurance	Recommendation that the Trust considers if delay in digital solutions rollout creates a risk of the Trust not being able to deliver its Strategic objectives.
External Audit Report	External Audit confirmed good progress against plan, no issues arising to date, and that no significant weakness in financial sustainability is currently anticipated.	Reasonable Assurance	
Internal Audit Report	One final report has been issued, which received reasonable assurance (Assurance Review of Internal Patient Transfers)	Reasonable Assurance	

Internal Audit Plan	Committee approved the revised plan, noting additional audit days to reflect Children and Young People's services transfer and inclusion of digital transformation and AI governance	Reasonable Assurance	
Anti-Crime Report	Committee noted positive overall counter-fraud position, with anticipated overall "green" rating against Counter Fraud Functional Standards, and discussed low completion rates for e-learning modules on conflicts of interest and the Bribery Act.	Reasonable Assurance	
Year End Documents	<u>Annual Accounts 2025/26</u> Committee noted delivery of financial duties, no material changes in accounting policies, and ongoing audit work. <u>Annual Governance Statement</u> Deferred to following meeting for more detailed discussion.		
Additional Comments:			

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28th May 2026**
Title	**Finance, Business and Investment Committee Chair's Report**
Author	**Mickola Wilson, Non-Executive Director**
Presenter	**Mickola Wilson, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
•	• Strategic Transformation Programmes-Dementia Update	• Chief Finance and Resources Officer Report including BAF • Finance Report for Month 12 • Service Line Reporting and Costing Update • Digital Update • Estates Update • Service Line Reporting and Costing Update

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Finance and Resources Officer Report including BAF	The Committee received assurance on the Trust's position across finance, estates and digital, with risks aligned to the Board Assurance Framework. The Trust delivered its in-year financial plan, with a minor agency overspend not expected to result in regulatory action.	**Reasonable**	Estates risks are currently within tolerance, with further strategic development underway, including plans for the medium secure estate. An exercise to triangulate the Risks in the BAF with the financial plan was in progress. Emerging risks relate to digital transformation and the impact of service transfers, with further work in progress to validate financial assumptions.
Future Finance plans and Children and Young People (CYP)	The Trust was working to a 3-year plan on a rolling budgets basis.	**Limited**	It was noted that the merger of CYP is likely to result in a financial shortfall of £1.1m, although mitigations are in place. It was also noted that the requirement to reduce agency spend for CYP was going to be extremely challenging, due to the availability of clinicians.
Finance Report for Month 12	The Committee noted that the organisation has delivered its planned surplus and capital targets for the year, with a recommendation to reduce the financial risk rating in the Board Assurance Framework based on current performance. Members discussed the use of step-down provision to support patient flow and reduce out-of-area	**Reasonable**	The Committee acknowledged delays in the rollout of community-based programmes, noting that these have resulted in in-year underspend but are expected to reverse as implementation progresses. Overall, the Committee recognised the strong financial delivery in-year, while

	placements. While this has delivered cost avoidance, it was recognised that there are practical and clinical limits to further expansion, and it does not represent a long-term solution without wider system support. A key area of focus is the cash position, which ended the year below plan due to the non-delivery of system-level savings. Whilst manageable, this requires close monitoring in the coming year		highlighting emerging risks and the importance of maintaining robust oversight into the next financial period.
Digital Update	The Committee noted the Digital Update and submission of the Frontline Productivity grant bid to support an Ambient Voice system.	**Reasonable**	Confirmation from NHS England is not expected until later in the year.
Estates Update	It was noted that this was the first report for the committee	**Limited**	The results from PLACE (patient feedback) were good and the delivery of projects had been very successful, the team were asked to also have regard to the comments from staff, and NED visits which frequently highlighted short coming in the maintenance response. The team were also asked to develop a plan for communications with staff regarding the work of the Estates Department.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28th May 2026**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quarter 4 Impact Report	• Charity Risk Register • Q1 Operational Plan (incl. CYP Charity arrangements) • Charity Strategy & Branding • Finance Report • Approval for Requests over £5000

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another Committee.
Quarter 4 Impact Report	The Committee reviewed the Quarter 4 Impact Report and received assurance regarding the positive progress across fundraising, volunteering, and charity-led initiatives. Members noted successful fundraising activity during the quarter, including the Christmas Appeal and early income generation linked to the Dementia Showcase Conference. The Committee also welcomed donations made to Children and Young People's services and recognised the continued growth and impact of volunteering across the organisation. Assurance was provided that appropriate systems and governance arrangements are in place to support the increasing number of volunteers, including improved digital tracking and a move towards more skills-based volunteering opportunities. The Committee discussed staffing capacity within the charity and volunteer team and received assurance that vacancies and team structures are being reviewed to ensure the service remains sustainable and appropriately supported. Members also reviewed the forensic patient skills project and highlighted the importance of having	**Reasonable Assurance**	Agreed Next Steps • Continue strengthening volunteer and staffing capacity arrangements. • Formalise evaluation measures for charity-funded projects. • Explore external funding opportunities where applicable. • Provide future updates on workforce changes and project outcomes.

	clear evaluation measures and exploring external funding opportunities where appropriate. The Committee welcomed the continued development of staff-led fundraising and community engagement opportunities, including involvement with the Duke of Edinburgh scheme.		
Q1 Operational Plan (incl. CYP Charity arrangements)	The Committee received assurance regarding delivery of the Quarter One Operational Plan and the breadth of charitable activity underway, including the dementia campaign, fundraising initiatives, corporate partnerships and CYP-related projects. Assurance was provided that the charity's primary fundraising focus remains aligned to wider Trust priorities.	**Reasonable Assurance**	The Committee discussed the proposed NHS Charities Together lottery scheme and agreed that further work is required to fully understand the associated risks, governance arrangements and financial benefits before consideration by Trustees. Overall, the Committee was assured by the progress and direction of travel.
Charity Strategy & Branding	The Committee received an update on the ongoing charity strategy and branding work, including feedback gathered to date from stakeholders and initial engagement activity. Members discussed the importance of ensuring the charity name and brand clearly reflect the charity's purpose, support fundraising activity, and maintain a strong connection to the Trust and mental health services. The Committee recognised the value of undertaking further engagement before reaching a final decision and agreed that additional testing of a shortlist of potential names should take place to support an evidence-based recommendation.	**Reasonable Assurance**	The Committee was assured that appropriate stakeholder engagement and governance arrangements are in place to support the development of the charity's future brand and identity. A shortlist of proposed charity names will be further developed and tested with stakeholders ahead of the July Committee meeting, with the preferred option subsequently presented to the Trustees for consideration and endorsement.