AGENDA

Kent and Medway Mental Health NHS Trust

Title of Meeting Trust Board Meeting (Public)
Date 26th November 2026
Time 09.30 to 12.15
Venue Meeting Rooms 2 and 3, Farm Villa, Hermitage Ln, Maidstone ME16 9PH

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/26-27/89	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/26-27/90	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/26-27/91	3.	Personal Experience – Chiron in custody and the community	FD	Verbal	JK	09.35
STANDING ITEMS						
TB/26-27/92	4.	Minutes of the previous meeting	FA	Paper	Chair	09.45
TB/26-27/93	5.	Action Log & Matters Arising	FA	Paper	Chair	
TB/26-27/94	6.	Chair's Report	FN	Paper	CL	09.50
TB/26-27/95	7.	Chief Executive's Report	FN	Paper	SS	10.00
TB/26-27/96	8.	Board Assurance Framework	FA	Paper	JK	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/26-27/97	9.	Neighbourhood Health Collaborative Progress Report	FD	Paper	SS	10.40
TB/26-27/98	10.	Integrated Quality and Performance Review	FD	Paper	SS	10.50
Break – 10 mins						
SUB-BOARD COMMITTEE REPORTS						
TB/26-27/99	11.	Report from Quality Committee	FD	Paper	MD	11.10
TB/26-27/100	12.	Report from Mental Health Act Committee	FD	Paper	MD	
TB/26-27/101	13.	Report from People Committee	FD	Paper	PC	
TB/26-27/102	14.	Report from Charitable Funds Committee	FD	Paper	SB	
TB/26-27/103	15.	Report from CYP / AAED Committee	FD	Paper	SW	
TB/26-27/104	16.	Report from Partnership Committee	FD	Paper	KL	
TB/26-27/105	17.	Report from Finance, Business and Investment Committee	FD	Paper	KC	
OPERATIONAL ASSURANCE						
TB/26-27/106	18.	Finance Report – Month 7	FN	Paper	NB	11.40
TB/26-27/107	19.	Safer Staffing Report (aka Nursing Establishment Review)	FD	Paper	JK	11.50
TB/26-27/108	20.	Use of Trust Seal	FA	Paper	TS	12.00
CLOSING ITEMS						
TB/26-27/109	21.	Any Other Business • Reflection of values			Chair	12.05
TB/26-27/110	22.	Questions from the Public			Chair	
	Date of Next Meeting: Thursday, 28th January 2027					

Members:		
Colin Lynch	CL	Trust Chair
Stephen Waring	SW	Non-Executive Director and Trust Senior Independent Director
Kim Lowe	KL	Non-Executive Director
Susan Baker	SB	Non-Executive Director
Kevin Corrigan	KC	Non-Executive Director
Margaret Dalziel	MD	Non-Executive Director
Dr Julie Hammond	JH	Associate Non-Executive Director
Pam Creaven	PCr	Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Julie Kirby	JK	Acting Chief Nursing Officer
Nick Brown	NB	Chief Finance and Resources Officer
Ali Layne-Smith	ALS	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Kindra Hyttner	KH	Director of Strategy and Engagement
Tony Saroy	TS	Trust Secretary
Lucia Barnes	LB	Interim Deputy Trust Secretary
Allen R	AR	Personal Story
Noami Lengyel	NL	Clinical Specialist Occupational Therapist
Apologies:		
Julius Christmas	JC	Non-Executive Director and Trust Vice Chair

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

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Kent and Medway Mental Health NHS Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 13.00 on Thursday 24th September 2026
Meeting Rooms 2 and 3, Farm Villa, Hermitage Ln, Maidstone ME16 9PH

Members:			
	Colin Lynch	CL	Joint Chair KCHFT and KMMH
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Kim Lowe	KL	Non-Executive Director
	Kevin Corrigan	KC	Non-Executive Director
	Margaret Dalziel	MD	Non-Executive Director
	Susan Baker	SB	Non-Executive Director
	Pam Creaven	PC	Non-Executive Director
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Julie Kirby	JK	Acting Chief Nursing Officer
	Ali Layne-Smith	ALS	Interim Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Strategy and Engagement
	Daryl Judges	DJ	Deputy Trust Secretary
	Lucia Barnes	LB	Interim Deputy Trust Secretary (Minutes)
	Tony Saroy	TS	Trust Secretary
	James Read	JR	Lived Experience (Personal Story)
	The Board was joined by members of the public and members of staff.		
Apologies:			
	Julius Christmas	JC	Non-Executive Director (Deputy Chair)

Item	Subject	Action
TB/26-27/63	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and noted the apologies which had been received, welcome was extended to Sue Baker at her first Trust Board meeting. All written reports were taken as read.	
TB/26-27/64	**Declarations of Interest** No new interests were declared.	
TB/26-27/65	**Personal Experience – My experience within KMMH services, including inpatient rehabilitation** The Board welcomed James who discussed the experience of accessing community services at Highlands House, accompanied by their support worker and the service matron. The Board heard that coordinated community support, involvement in care decisions, regular support-worker contact and an individualised clinical approach	

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	had contributed to a substantial improvement in the person's experience and reduced reliance on acute and emergency services. The person described the adverse effect of unnecessary attendance at an emergency department, including long waits and an unsuitable sensory environment. They explained that listening support and access to known community staff could be more helpful when an acute medical intervention was not required. The Chief Operating Officer highlighted learning about pathways from NHS 111 and ambulance services into emergency departments. The Board heard that work was under way with system partners to reduce avoidable conveyance and emergency department attendance. A Board Member asked how the community matron role differed from an acute inpatient matron role. The response emphasised the coordination of multiple services, multidisciplinary clinical input, quality and safety oversight, and the development of a clear whole-system plan. The Board recognised the person's contribution to their own recovery and thanked them and the supporting staff for sharing the experience.	
TB/26-27/66	**Minutes of the previous meeting** The Board **approved** the minutes of the meeting held in July 2026 with no amendments.	
TB/26-27/67	**Action Log & Matters Arising** The Board reviewed the action log and confirmed that all actions should be closed, after requesting further information on the following actions: • **TB/26-27/14** – "Explore what support can be provided by the transformation team to improve workforce race and disability data, to enable clear linkage between workforce metrics, analysis and actions " - it was reported that work was focusing on progression through recruitment and development pathways. The Chair was satisfied that milestones had been incorporated into the People function's work plan and agreed that the action could close. • **TB/25-27/39** – "To consider the learning from the Personal Experience presentation within relevant service improvement programmes, including patient voice, therapeutic relationships, trauma-informed care and the inpatient environment. - the action arising from the previous person experience story had been incorporated into the rehabilitation service review, including work on model fidelity and national guidance, and was closed. • **TB/25-27/54** – "To ensure that learning from the Community Mental Health Survey is triangulated with feedback from clinicians and incorporated into the Trust's improvement plan" - it was confirmed that staff and patient survey findings were being triangulated to identify areas requiring additional attention. • **TB/25-27/57** – "to strengthen arrangements for closing the feedback loop for staff raising concerns through Freedom to Speak Up and demonstrate how concerns raised have informed learning and improvement." - it was explained that Freedom to Speak Up contacts and closed cases were subject to quality review and directorate analysis. Monthly directorate discussions had been	

Item	Subject	Action
	introduced to strengthen local ownership and organisational learning. The Board agreed that this action could close. The Board **noted** the action updates and approved the closures recorded at the meeting.	
TB/26-27/68	**Chair's Report** The Chair highlighted positive feedback following the provider oversight meeting with NHS England and the Integrated Care Board. External colleagues had recognised the cohesion, openness and transparency of the Trust's leadership team and its understanding of the improvement work required. The Chair also reported improved collaboration through the system Joint Committee and welcomed planned organisational development work. The Board discussed the revised Non-Executive Director visit arrangements. Members welcomed the structured approach and the improved ability to triangulate visit findings with performance, workforce and quality information. Non-Executive Directors asked the Executive team to demonstrate what would change as a consequence of identified themes, how improvement would be measured and how recurring themes would become business as usual. Members also requested a systematic programme of visits, while retaining flexibility for additional visits, and a concise briefing for each visit. The Trust Secretary advised that one programmed visit per quarter would be supplemented by flexibility for Non-Executive Directors to undertake additional visits. The Board noted the need to preserve established management and escalation routes and avoid visits becoming an alternative operational escalation mechanism. The Chair concluded that visit findings must lead to visible activities and outcomes, distinguish immediate environmental issues from longer-term cultural matters, and align with the governance improvement programme. **Action: By November, DHS shall respond to the recommendations arising from Non-Executive Director visits, including measurable outcomes, triangulation arrangements and evidence of improvement, and report to the Trust Board.** The Board **noted** the Chair's report and endorsed the revised approach to Non-Executive Director visits.	
TB/26-27/69	**Chief Executive's Report** The Chief Executive highlighted the positive provider oversight meeting and the external recognition of improvements alongside the Trust's continuing challenges. The Board noted three national priorities to March 2027: the reduction in inappropriate out-of-area placements, the reduction of 12-hour waits in emergency departments for people requiring mental health care, and improved access to	

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	children and young people's services within four weeks. These would be incorporated into future Integrated Quality and Performance Reports (IQPRs). The Chief Executive reported progress with the provider alliance, welcomed additional programme leadership capacity and noted the successful long-service awards. There was discussion about the reliability and visibility of data quality. The Chief Executive and Chief Finance Officer advised that a data quality group was in place and that work was under way to establish a clearer improvement plan. The Board supported including a visible data quality assessment within future performance reporting and the use of the IQPR. Members reflected on a well received Annual General Meeting that had been held and recognised the responses from some of the Executive leads. The Board also discussed the relationship with local government and the development of multi-neighbourhood arrangements. The Chief Operating Officer reported that work was progressing to align directorate leadership with nine multi-neighbourhoods and the constituent single neighbourhoods, while maintaining sufficient capacity to work with future local authority structures. **Action: By November 2026, NB to present a clear data quality improvement plan and proposals for displaying data quality confidence within the Integrated Quality and Performance Report and report to the Trust Board.** The Board **noted** the Chief Executive's Report.	
TB/26-27/70	**Board Assurance Framework (BAF)** The Board reviewed the transitional Board Assurance Framework (BAF) which comprised two parts, Part A where we currently are, and Part B the new proposed BAF, noting that limited assurance was reported across several strategic risks. Inpatient flow, safe high-quality care, organisational culture and achievement of strategic ambitions remained significant concerns. The Board was advised that detailed work with committee chairs had prepared the new framework for implementation through the October committee cycle, with a stronger version expected for November. The Board considered whether cyber security should remain within the digital strategic risk or become a separate eighth strategic risk. Members discussed the interdependencies between cyber security, digital development and artificial intelligence and recognised that cyber security had distinct causes, controls, impacts and risk appetite. Following discussion, the Board agreed that cyber security should be established as a separate strategic risk. The allocation of committee oversight would be resolved separately.	

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	The Board agreed that the financial risk appetite should change from open to cautious, reflecting the Trust and system financial position while avoiding undue restriction on appropriate decision-making. Members challenged the timeliness of risk reviews and emphasised that risk ownership must operate through directorates and not remain solely with executive directors. It was confirmed that Executive briefings, committee scrutiny, management training and a revised Risk Management Framework would support the required change. **Action: By November 2026, NB and JK must present the revised Board Assurance Framework, including the separate cyber security risk and confirmed committee oversight, report to the Trust Board.** The Board **approved** the Board Assurance Framework structure subject to cyber security being recorded as a separate strategic risk. The Board agreed that the financial risk appetite should move from open to cautious and that the committee responsible for oversight of the separate cyber security risk would be determined outside the meeting.	
TB/26-27/71	**Governance Improvement Plan** The Chief Executive reported that the programme remained critical to strengthening assurance, escalation and information flows. It was reported to be in an Anber-Green rating and some milestones required recovery, but weekly Executive oversight was in place. The Board noted that implementation would require cultural as well as procedural change, including clearer committee responsibilities, reduced duplication and stronger directorate ownership. Members supported reducing duplication so more time could be spent considering insight, outcomes and assurance. The Board **noted** the Governance Improvement Plan.	
TB/26-27/72	**Integrated Quality and Performance Report** The Chief Executive introduced the revised IQPR and advised that it provided limited assurance overall. The report had been revised to more clearly align performance, quality and strategic priorities, but did not yet demonstrate consistent improvement, comprehensive root-cause analysis or sufficiently developed mitigation. Patient flow remained the Trust's principal operational risk. A developing recovery plan would be considered by the Executive Management Team and subsequently incorporated into Board reporting. Non-Executive Directors welcomed the improved presentation and asked for clarity for the following elements: • variations between directorates in patient and staff experience;	

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	• the effect of staff absence and vaccination uptake on performance; • the need to prevent deterioration in access during winter; • how local ownership would be supported; • how areas of good practice would be identified and spread; and • how health inequalities and outcomes would be made more visible. The Chief Operating Officer explained that waiting-time performance was affected substantially by backlog and that the winter plan focused on known high-intensity users. Sickness absence was monitored at directorate level, with targeted support for areas of concern. The refined *Mental Health Together* model was expected to reduce pressure by involving voluntary-sector partners at the front door. The Chief Executive confirmed that monthly directorate reviews would strengthen local accountability and allow learning from stronger-performing services. The Board encouraged committees to make targeted use of deep dives where limited assurance persisted. The Board **noted** the Integrated Quality and Performance Report and accepted the overall limited assurance assessment.	
TB/26-27/73	**Neighbourhood Health Collaborative Board Progress Report** The Chief Executive advised that the report required redesign to reflect the current neighbourhood alliance rather than legacy arrangements. Future reporting would focus on agreed priorities, including reducing emergency department attendance, improving work with primary care and progressing pathway transformation. The Board discussed access for underserved communities and the importance of trusted community relationships, lived-experience leadership and coordinated outreach with partner organisations. Members discussed whether commissioned voluntary-sector organisations reflected local communities and provided demonstrable quality and value. The Board heard that an engagement team was building relationships with underserved communities and that the Integrated Care Board was reviewing legacy commissioning arrangements. The Board requested greater visibility of work with acute providers to reduce avoidable emergency department attendance. The Chief Medical Officer reported that daily system meetings, weekly reporting and clinical pathway work were in place across East Kent, Medway and Maidstone. The emergency department-to-inpatient conversion rate had reduced substantially, although delays for people awaiting mental health beds remained a significant concern. **Action: By January 2027, SS and AR to redesign the Neighbourhood Health Collaborative report to cover agreed priorities, inequalities, community engagement, outcomes and system delivery and report to the Trust Board**. The Board **noted** the progress report.	
TB/26-27/74	**Draft Commissioning Intentions**	

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	The Chief Finance Officer welcomed the Integrated Care Board's publication of commissioning intentions as a positive step towards a more strategic, outcomes-based commissioning environment. The Board endorsed active Trust engagement but noted that the proposed changes could involve significant alterations to contracts, productivity requirements, value-for-money assessment, provider relationships and organisational behaviours. Members discussed whether the Trust had brought together the necessary internal preparatory work. The Chief Executive acknowledged that the Trust and system were developing their maturity in this area and that greater clarity would be required about future contracting arrangements. The Chair requested Board development support to ensure that members understood the scale and implications of the change. **Action: By January 2027, SS and CL to arrange Board development on the commissioning intentions, including contractual, financial, quality and governance implications, and report to the Trust Board.** The Board **noted** and endorsed the direction of the draft commissioning intentions	
TB/26-27/75	**Report from Quality Committee** The Committee Chair reported that the Quality Committee had sought stronger evidence of impact, effectiveness, sustainability and resilience rather than descriptions of governance processes. The Committee had received assurance regarding infection prevention and control, clinical audit compliance and progress under the Quality Improvement Plan. Limited assurance remained regarding the impact and sustainability of the Quality Improvement Plan, risk formulation and safety planning, regional variation, data quality and transitions between services. The Chief Nurse confirmed that the Quality Improvement Plan reporting template was being revised to demonstrate impact more clearly. A new impact report and work with the corporate nursing team would strengthen written assurance and the use of trend data. The Board **discussed** the Quality Committee Chair's Assurance Report and noted the areas of limited assurance and planned improvements to reporting.	
TB/26-27/76	**Report from People Committee** The Committee Chair explained that limited assurance reflected a higher evidential threshold rather than deterioration. Plans were in place, but consistent evidence of outcomes and impact was not yet available. The Committee had endorsed the direction of the new People Portal but had not approved implementation. Further assurance was required regarding internal governance, programme risk and implementation readiness. The related risk had been added to the risk register.	

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	The Committee also highlighted agency expenditure, the nursing workforce pipeline and the need to disaggregate children and young people's workforce pressures. The Chief People Officer confirmed that monthly workforce information included analysis by protected and workforce characteristics and that action was being taken to prevent recruitment delays caused by insufficient availability of trained Cultural Inclusion Ambassadors. The Board requested a concise briefing describing the People Portal, the Trust's accountability, system governance and the route to any future approval. **Action: By November 2026, ALS to provide a briefing to the Trust Board on the People Portal covering scope, resources, risks, Trust accountability, system governance and the route to approval.** The Board **discussed** the People Committee Chair's Assurance Report and **noted** that the People Portal remained endorsed in principle but was not yet approved for implementation.	
TB/26-27/77	**Report from Audit and Risk Committee** The Committee Chair reported limited assurance regarding the Trust risk register. Although controls were recorded, they did not consistently result in movement in risk scores, indicating a need to strengthen organisational understanding of controls, assurance and risk treatment. The Committee had undertaken a cyber security deep dive and received reasonable assurance from the programme dashboard and planned improvements. Third-party supplier assurance remained an area requiring attention. The Chair asked that the Board receive a focused discussion on artificial intelligence and cyber security, including both opportunities and threats. The Chief Finance Officer advised that sensitive operational details might require consideration in private, while transparent high-level assurance could be provided publicly. **Action: By January 2027, NB must present an appropriately scoped report on artificial intelligence and cyber security to the Trust Board, with sensitive matters directed to the private Board where necessary.** The Board **discussed** the Audit and Risk Committee Chair's Assurance Report and **noted** the limited assurance regarding the Trust risk register.	
TB/26-27/78	**Report from Finance and Business Investment Committee** The Committee Chair reported limited assurance regarding the Digital Plan because of a material third-party supplier risk. The Committee had considered contract extensions, business continuity matters and an assertive outreach business case. The assertive outreach proposal was considered compelling and requires further refinement before final approval.	

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	The Board **discussed** the Finance and Business Investment Committee Chair's Assurance Report and **noted** the identified digital supplier risk.	
TB/26-27/79	**Report from Children and Young People Committee** The Committee Chair reminded the Board that the Committee was transitional and time limited. Staff continued to report positively on the transfer into the Trust. Workforce capacity, particularly medical recruitment, remained the most significant concern. Progress had been made in non-medical recruitment, but medical recruitment actions would take longer to deliver. The digital transition remained a material concern. Although joint working had improved, a detailed delivery plan was required to assess the risk to the March 2027 deadline. It was confirmed that a revised paper would be presented to the Committee in October. The quality and safety dashboard would transfer to the Quality Committee as part of the progressive transition of business to permanent committees. The Board **discussed** the Children and Young People Committee Chair's Assurance Report and **noted** the continuing workforce and digital transition risks	
TB/26-27/80	**Deep Dive: Triangulation of Culture, Performance and Quality** The Chief Executive introduced the Trust's first integrated analysis of culture, quality and performance data. The analysis provided signals rather than definitive conclusions and identified variation requiring local investigation, including a need for further work in West Kent. The Board welcomed the report and agreed that Trust-wide expectations should be accompanied by local diagnosis and intervention. Members emphasised that analysis should extend below directorate level to individual teams and services. The Board discussed the importance of: • using the analysis as a supportive improvement tool; • helping local leaders understand and use the information; • incorporating staff survey results and other proxy measures; • integrating workforce, employee relations, Freedom to Speak Up and quality information; • focusing equality, diversity and inclusion work on a small number of measurable gaps; • distinguishing cultural issues from process and systems failures; and • demonstrating the relationship between culture and quality of care. The Chief People Officer confirmed a target of at least 65% participation in the staff survey, while emphasising that both quantitative results and anonymised comments would be analysed. Weekly participation information would enable targeted support to teams.	

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	The Chair welcomed the analysis as a useful baseline for the further work required. **The Board requested an initial improvement plan setting out the priority interventions, local ownership and intended measures of impact. It also requested that the analysis return to the Board after sufficient time had elapsed to assess whether the interventions had resulted in tangible and sustained improvement.** **Action: By March 2027, ALS to present a focused culture improvement plan to the Trust Board, including team-level ownership, priority interventions, measures of impact and the relationship between culture and quality.** **Action: By March 2027 ALS to present to the Trust Board an updated integrated culture, performance and quality analysis against the September 2026 baseline to demonstrate the extent of tangible and sustained improvement.** The Board **noted** the deep dive and endorsed the proposed direction of travel, subject to a more focused action plan and measurable outcomes.	
TB/26-27/81	**Finance Report, Month 5** The Chief Finance Officer reported that the Month 5 position was consistent with expected pressures. Inpatient expenditure and inappropriate out-of-area placements remained the principal financial pressures, although early improvement was visible. Controls over inpatient nursing expenditure, bank use and enhanced observations were being strengthened. Discussions with NHS England concerning children and young people's capital expenditure were progressing. The cash position was expected to tighten and required careful management. Recovery of aged debt from the Integrated Care Board would improve the position. The Chair sought assurance that cost improvement plans were being developed from the bottom up and would provide recurrent benefits. The Chief Finance Officer described work with services to align demand, capacity, resources and funding and confirmed that sustained reductions in inpatient and out-of-area expenditure were essential to improving the recurrent position. The Board **noted** the month 5 Finance Report.	
TB/26-27/82	**Medical Revalidation Annual Report** The Chief Medical Officer presented the statutory annual report. The Board was advised that 192 doctors were connected to the Trust, appraisal compliance was 98%, actions were in place for the remaining cases, and all practising doctors held an appropriate licence to practise. The Board **approved** the Medical Revalidation Annual Report for submission to NHS England.	
TB/26-27/83	**Emergency Preparedness, Resilience and Response Annual Report**	

Item	Subject	Action
	The Board received the annual report, self-assessment and related assurance documentation. Substantial compliance had been assessed, with one of the 58 elements outstanding. Progress had since been made and completion was expected shortly. The Board noted the forthcoming work required to meet the requirements of Martyn's Law. The Board **approved** the Emergency Preparedness, Resilience and Response Annual Report and associated self-assessment.	
TB/26-27/84	**Winter Plan 2026/27** The Chief Operating Officer presented the winter plan and explained that it formed part of the wider Kent and Medway and regional planning process. The plan would remain dynamic throughout winter. The priorities included patient flow, vaccination, East Kent pressures, high-intensity users and adverse-weather resilience. The Trust aimed to reduce the number of people clinically ready for discharge to no more than 27 and limit inappropriate out-of-area placements to no more than five. A Non-Executive Director questioned whether vaccination ambitions were sufficient and sought greater assurance regarding vulnerable populations. The Board agreed that further discussion should refine aspects of the plan, but recognised the requirement to approve it before submission. The Board also discussed the need for equivalent planning for hot weather and the recognised spring peak in demand for mental health services. Members requested consideration of medication-related heat risks and alignment of workforce planning with seasonal demand. **Action: By January 2027, DHS and AQ to assess the need for a seasonal resilience plan covering spring and hot-weather pressures, including workforce capacity and medication-related risks, and report to the Trust Board.** The Board **approved** the Winter Plam.	
TB/26-27/85	**Register of Interests** The Board received the Register of Interests. Members were reminded to notify the Trust Secretary of changes. The Board **noted** the Register of Interests.	
TB/26-27/86	**Standing Orders Amendment** The Trust Secretary clarified that the proposed amendment related to the Standing Orders and would formally establish the Partnership Committee.	

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	The Board was advised that no amendment had yet been approved to remove the Mental Health Act Committee from the governance structure. It would therefore remain in operation pending further consideration, although substantive Mental Health Act assurance was also being considered by the Quality Committee. The Board **approved** the amendment to the Standing Orders establishing the Partnership Committee and noted that the Mental Health Act Committee would remain within the formal governance structure pending a further proposal.	
TB/26-27/87	**Reflection on delivery of the Trust values in reports and discussions** Members reflected that the discussions throughout the meeting aligned strongly with the Trust's values of Caring, Inclusive, Curious and Confident.	
TB/26-27/88	**Any Other Business** No additional business was raised.	
TB/26-27/89	**Questions from Public** A staff member raised the limited visibility of corporate and support staff within the culture analysis and Non-Executive Director visit programme. The Chair accepted the challenge and agreed that corporate services should receive equivalent attention. The staff member also cautioned against focusing on the staff survey response rate at the expense of feedback content and highlighted internal programme management expertise. The Chief Executive and Chief People Officer confirmed that detailed comments were reviewed and used alongside quantitative results and that corporate services offered examples of improvement from which the wider Trust could learn. A member of staff highlighted recently published evidence concerning Open Dialogue and emphasised the importance of continuity of care. A member of the public also challenged the Board to show more clearly how performance information affected the experience of people using services. The Chief Executive acknowledged that lived-experience involvement was not yet consistently embedded and reported that a new approach was being developed across strategic programmes and governance. Board members confirmed that continuity of care was being addressed through the clinical strategy and neighbourhood working. **Action: By November 2026, Trust Secretariat must incorporate corporate and support services into the Non-Executive Director visit programme.** The Chair thanked all contributors, staff and members of the public.	
	Date of Next Meeting The next meeting of the Board will be held on Thursday 26th November 2026.	

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 11/2026

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 NOVEMBER 2026								
30/07/2026	TB/26-27/44	Board Assurance Framework (BAF)	By October 2026, TS to support further development of the Board Assurance Framework and wider assurance model through Board Development Sessions, ensuring clear Board ownership of strategic risks and assurance.	JK	October 2026		The revised Board Assurance Framework has now been completed, with support provided to Executive colleagues to strengthen understanding, ownership and oversight of strategic risks and assurance. Further Board development sessions will be arranged should the Board feel these would be beneficial in embedding the new approach	**In progress**
24/09/2026	TB/26-27/68	Chairs Report	DHS shall respond to the recommendations arising from Non-Executive Director visits, including measurable outcomes, triangulation arrangements and evidence of improvement, and report to the Trust Board.	LB	November 2026		Trust Secretariat to provide DHS with a consolidated NED visit report, including recommendations, measurable outcomes, triangulation and evidence of improvement, to inform DHS's response and assurance to the Trust Board.	**In progress**
24/09/2026	TB/26-27/69	Chief Executive's Report	NB to present a clear data quality improvement plan and proposals for displaying data quality confidence within the Integrated Quality and Performance Report and report to the Trust Board.	NB	November 2026		Proposals for the data quality improvement plan are under review by EMT. An update to be provided at the meeting.	**In progress**
24/09/2026	TB/26-27/70	Board Assurance Framework (BAF)	NB and JK to present the revised Board Assurance Framework, including the separate cyber security risk and confirmed committee oversight, report to the Trust Board.	NB/JK	November 2026		On the agenda for discussion Propose to close	**In progress**
24/09/2026	TB/26-27/73	Neighbourhood Health Collaborative Board Progress Report	SS and AR to redesign the Neighbourhood Health Collaborative report to cover agreed priorities, inequalities, community engagement, outcomes and system delivery and report to the Trust Board.	SS/AR	November 2026		Paper has been refined and is on agenda for discussion.	**In progress**
24/09/2026	TB/26-27/74	Draft Commissioning Intentions	SS and CL to arrange Board development on the commissioning intentions, including contractual, financial, quality and governance implications, and report to the Trust Board.	SS/CL	November 2026		The commissioning intentions have been incorporated into the wider financial planning process. Further Board development will take place as part of the planned December Board away day,	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 11/2026

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Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							including consideration of the contractual, financial, quality and governance implications. An update will subsequently be reported to the January Trust Board.	
24/09/2026	TB/26-27/76	Report from People Committee	ALS to provide a briefing to the Trust Board on the People Portal covering scope, resources, risks, Trust accountability, system governance and the route to approval.	ALS	November 2026		Board paper included within pack Propose to close	**In progress**
24/09/2026	TB/26-27/76	Report from Audit and Risk Committee	NB to present an appropriately scoped report on artificial intelligence and cyber security to the Trust Board, with sensitive matters directed to the private Board where necessary.	NB	November 2026		Deferred to Board Seminar in December 2026	**In progress**
24/09/2026	TB/26-27/84	Winter Plan 2026/27	DHS and AQ to assess the need for a seasonal resilience plan covering spring and hot-weather pressures, including workforce capacity and medication-related risks, and report to the Trust Board.	DHS/AQ	November 2026		This will be in the Living Well programme along with winter Planning. Propose to close.	**In progress**
24/09/2026	TB/26-27/89	Questions from Public	Trust Secretariat to incorporate corporate and support services into the Non-Executive Director visit programme.	TS	November 2026		The Non-Executive Director visit programme has been updated to incorporate visits to corporate and support services Propose to close	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
24/09/2026	TB/26-27/80	Deep Dive: Triangulation of Culture, Performance and Quality	ALS to present a focused culture improvement plan to the Trust Board, including team-level ownership, priority interventions, measures of impact and the relationship between culture and quality.	ALS	March 2027			**Not Due**

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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
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
28/05/2026	TB/25-27/9	Board Assurance Framework (BAF)	TS to finalise and implement the revised Non-Executive Director Visit and Assurance Framework, including arrangements for consistent reporting to support triangulation of assurance information	TS	September 2026		Revised NED Visit and Assurance Framework drafted and aligned to the Trust Strategy and Board Assurance Framework, with updated visit, reporting and escalation arrangements developed to support consistent reporting and triangulation of NED observations with committee assurance, quality and performance information. To be closed	**CLOSED**
29/01/2026	TB/25-26/125	Sustainable Communities Provider Collaborative Progress Report	Present a 'broader health inequalities' update for the Board	AR	July 2026	September 2026	Addressed in the Alliance paper. To be closed.	**CLOSED**
28/05/2026	TB/26-27/14	Workforce Deep Dive - Workforce Race Equality Standard and Workforce Disability Equality Standard	Explore what support can be provided by the transformation team to improve workforce race and disability data, to enable clear linkage between workforce metrics, analysis and actions	AR	September 2026		Discussions are ongoing, including how this work aligns with PCREF progress, protected characteristic training and the breakthrough objective to recommend KMMH as a place to work. To be closed.	**CLOSED**
30/07/2026	TB/25-27/39	Personal Experience – My experience within KMMH services, including inpatient rehabilitation	DHS and JK to consider the learning from the Personal Experience presentation within relevant service improvement programmes, including patient voice, therapeutic relationships, trauma-informed care and the inpatient environment.	DHS/JK	September 2026		This has been addressed through the rehabilitation work. To be closed.	**CLOSED**
30/07/2026	TB/25-27/42	Chair's Report	NB to provide assurance regarding the monitoring and utilisation of clinical environments and estate capacity, including consideration of issues relating to ward environments, space utilisation and patient experience.	NB	September 2026		Estates work is ongoing, with existing arrangements providing assurance on specific aspects of condition and capacity. Further detail is needed to triangulate wider issues, with a proposal due to the Finance, Business and Investment Committee in November.	**CLOSED**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 11/2026

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
30/07/2026	TB/25-27/46	Improvement Collaborative - Impact Report 2025/26	AR to bring a deep dive will be brought to the Public Board meeting to consider how improvement activity, organisational culture programmes and leadership and management development work align, whether they are mutually reinforcing and what further organisational changes may be required.	AR	September 2026		Joint paper with KH and ALS on the agenda. To be closed.	CLOSED
30/07/2026	TB/25-27/53	Integrated Quality and Performance Report (IQPR)	SS and NB to bring forward proposals to strengthen the front-end narrative of the IQPR, including greater emphasis on strategic delivery, future trajectory and progress against strategic objectives.	SS/NB	September 2026		Work is underway it will be a report rather than a proposal. To be closed.	CLOSED
30/07/2026	TB/25-27/54	CQC Community Survey	AQ and JK to ensure that learning from the Community Mental Health Survey is triangulated with feedback from clinicians and incorporated into the Trust's improvement plan.	AQ/JK	September 2026		The Chief Medical Officer liaised with the AHP Lead, who agreed to triangulate feedback from the staff and patient surveys. To be closed.	CLOSED
30/07/2026	TB/25-27/57	Freedom to Speak Up Annual Report	SS, in conjunction with the Executive Team, to strengthen arrangements for closing the feedback loop for staff raising concerns through Freedom to Speak Up and demonstrate how concerns raised have informed learning and improvement.	SS	September 2026		FTSU concerns are reviewed and monitored through Executive and SDR oversight, with themes and learning used to improve practice and communicated to staff. Unresolved concerns are escalated through the appropriate leadership route. To be closed.	CLOSED

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Trust Board (Public)**
Meeting Date	**26 November 2026**
Title	**Chair's Report**
Author	**Colin Lynch, Trust Chair**
Presenter	**Colin Lynch, Trust Chair**
Purpose	**For noting and discussion**

1. Introduction

My report focuses on matters of significance to Kent and Medway Mental Health NHS Trust ("the Trust") and my activity since the September Board meeting. It remains aligned to the three themes used in my previous reports and to the five Doing Well Together ambitions: timely access, safe care, positive experiences, smarter working and staying well.

2. Key themes, activity and reflections

Trust colleagues, team engagement and service improvement

On 1st October I was delighted to attend a meeting of our Trust's EDI and Staff Network Chairs. It was really helpful for me to learn more about the important work of our Networks, including on how they constructively influence KMMH policy development and to listen to suggestions about how we can help the Networks be more effective.

On 1st October I also had the pleasure of visiting our Trevor Gibbens Unit (TGU). Colleagues were proud of their focus on service improvement work, the joined up, supportive approach of senior management and the positive difference that our care has on many patients. Known challenges in areas such as physical infrastructure and security and the inconsistent ability of our systems to 'talk effectively or efficiently' to each other were also highlighted.

The September Board discussion reinforced that Non-Executive Director (NED) visits should be a structured source of listening and assurance, not a parallel management or escalation process. The programme is being developed around a planned quarterly cycle, concise guidance for visiting directors, clearer actions and intended outcomes, and systematic links to committees and improvement plans. It will also retain flexibility for additional visits to priority areas and will extend attention to corporate and support colleagues as well as clinical services.

The latest visits again show committed colleagues, strong local leadership and significant innovation. They also repeat important messages about communication, feedback loops, management autonomy, workforce capacity and the practical support required to embed change. The Board's role is to ensure that these insights are triangulated, acted on and tracked to sustainable improvement.

System leadership for sustainable patient, public and partner benefit

The Kent and Medway system context continues to shift towards outcomes-based commissioning, integrated neighbourhood working and more integrated physical and mental healthcare. Our September Board welcomed the Integrated Care Board's (ICB) commissioning intentions and recognised that the Trust must prepare for changes in contracts, service design, productivity expectations and partnership accountability. This has implications for Board and committee agendas, organisational capability and the way in which we demonstrate value and outcomes. Work is ongoing in all of these areas.

On 22nd September, together with our CEO I attended the Joint Committee of Kent and Medway NHS providers and ICB. Our focus was on system finances, governance and accountability, our transformation priorities and trajectories, the ICB's Commissioning Intentions and how best to work together as senior leaders across several organisations. On that subject, the ICB is leading a procurement for an Organisational Development Facilitator, to help us set and embed the trust and confidence needed to make our transformation work as effective as it needs to be. I've taken on the system lead Chair role on that Organisational Development procurement.

On 24th September, I attended an evening event for Mental Health Chairs across the country focussed on the latest digital services developments and opportunities, including in relation to Artificial Intelligence. The need for all NHS providers to embed ways of working that maximise productivity, the amount of patient – facing time for our clinicians and public value for money, while improving outcomes and experience for our patients and service users, is patently here to stay. And is a theme running through the ICB's commissioning intentions. This is an area of significant exciting opportunity for KMMH.

On 30th September, I attended an NHS Alliance conference for Chairs and Non-Executive Directors. This primarily was aimed at understanding and discussing evolving Government priorities for health, social care and local government.

I would also like to welcome both Professor Hilary Thomas who has started as Chair of East Kent University NHS Foundation Trust and Stephanie Elsy as Chair of NHS Kent and Medway. I've already had the opportunity to meet both Hilary and Steph and I am looking forward to continuing the constructive working and partnering relationships that we have with each organisation.

On 12th November, together with our CEO I attended the Kent and Medway Provider Alliance meeting that is comprised of all our NHS provider organisations Chairs and CEOs and senior primary care leadership. We signed off the revised governance arrangements and discussed the increasing progress with the main transformation work taking place via the Neighbourhood and Acute Collaboratives. Chairs attend the Provider Alliance on a bi-monthly basis and we are increasingly focussed on seeking substantive assurance from the Collaboratives and our CEO colleagues on delivery on key transformation programmes of work.

Board effectiveness, resilience and being fit for the future

The Board seminar day on 29 October included a strategic review six months into Doing Well Together. The session considered the Trust's strategic risks, delivery trajectory and the conditions required to convert ambition into measurable outcomes. At the heart of setting those conditions for success is a relentless focus on embedding the empowering, caring and curious inclusive culture everywhere in our organisation. It also provided an opportunity to reflect on Board assurance, governance development and the need for clearer links between strategy, risk, performance and improvement.

The Governance Improvement Programme has remained a priority. Work since September has focused on embedding revised committee arrangements, terms of reference and workplans; strengthening escalation and information flow; developing the Board Assurance Framework (BAF) and risk-management approach; and improving the quality of Board and committee reporting. The next phase must distinguish between outputs being delivered and new arrangements being implemented, embedded and shown to be effective. There is much more to do with our BAF and risk-management and it will be a major focus of Board and management colleague development over the next several months.

I am pleased to report that we have successfully concluded the recruitment process for our substantive Chief Nurse. Following a rigorous process on 30 October, involving a strong field of candidates and engagement with colleagues and patients, a successful appointment has been made.

This is an important appointment for the Trust, providing continuity and stability within our Executive Team and further strengthening our clinical leadership as we continue to deliver *Doing Well Together* and maintain our focus on safe, compassionate and continuously improving care for our patients and service users.

Thematic review of Trust Chair and NED visits

Following feedback from NEDs and the September Board discussion, the process has been refined to place greater emphasis on the questions that matter most to teams, the outcomes expected from each visit and the identification of good practice that can be shared, adopted, scaled or evaluated. Visit feedback is first considered with relevant Executive and service leads before thematic reporting through the appropriate committee and Board route.

Purpose and summary

This report brings together findings from five completed visits since the last Board, the Psychiatric Liaison Service at Medway Maritime Hospital; Children and Young People and All Age Eating Disorder services at George Turle House; Allied Health Professional, Psychiatric Intensive Care and Mother and Baby Unit services at Littlebrook Hospital; three North Kent community teams; and Mental Health Together and Mental Health Together Plus at Laurel House.

The visits provide Reasonable Assurance overall. Strong local practice was evident in compassionate care, triage and admission avoidance, clinical leadership, multidisciplinary working, workforce development, physical-health and medicines practice, partnership working and innovation. Recurring concerns relate to workforce capacity, organisational communication, local autonomy, support from corporate functions, digital and estates constraints, and the need for visible feedback when colleagues raise ideas or concerns. No visit identified an issue requiring immediate escalation.

Assurance at a glance

Theme	Positive assurance	Area requiring further assurance	Assessment
Access, pathways and recovery	Effective MHT triage and care navigation; EIP achievement of the two-week standard; Recovery Houses, Safe Havens and Rapid Response supporting alternatives to admission.	Increasing complexity, variable access and capacity; timely implementation of MHT Plus and consistent use of community alternatives.	Reasonable
Quality and safety	Strong risk assessment in liaison; collaborative PICU care planning; embedded reflective practice; good physical-health and recovery focus.	Enhanced-observation oversight, clinical supervision consistency, estates limitations and sustained implementation of care models.	Reasonable

Workforce, culture and leadership	Visible local leadership, strong multidisciplinary teams, reflective practice, recruitment successes and future workforce development.	Career progression, medical and hard-to-fill roles, workload, HR support, change fatigue and professional recognition.	Limited to Reasonable
Communication and colleague voice	Positive local team communication, Staff Voice developments and examples of feedback shaping local decisions.	Repeated concern that organisational change feels top-down and that colleagues do not consistently see what happens after speaking up.	Limited
Digital, estates and smarter working	Innovation in enhanced observations, therapeutic environments and local service redesign.	RiO functionality, Trust-wide observation data, community and liaison estates, and operational information required for planning.	Limited
Partnership and integrated care	Strong acute, primary care, VCSE, social-care and cross-service relationships.	System capacity and availability of prevention and social-care support remain dependencies.	Reasonable

Good practice and learning

- Mental Health Together triage and the Care Navigator "Better Understanding" conversation, with approximately 60% of referrals directed to support other than secondary mental health services.
- Early Intervention in Psychosis delivery against the two-week referral-to-treatment standard, supported by vocational work, family intervention, psychological therapy and medication management.
- Alternatives to admission through Recovery Houses, Safe Havens, Home Treatment and 24/7 Rapid Response services, supported by flexible multidisciplinary working.
- Children and Young People and All Age Eating Disorder services' bottom-up capacity and demand review, strong school-based outcomes and consistent use of reflective practice, daily risk huddles and visible leadership.
- Allied Health Professional-led innovation, including the Substance Misuse Course, workforce-pipeline work and visible advocacy for AHP professions.
- PICU innovation through the Harmony Garden, therapeutic animal activity and the award-winning zonal-observation model, alongside strong preceptorship and multidisciplinary preparation for the female PICU.
- Mother and Baby Unit multidisciplinary and partnership working, family connection and community engagement, including follow-up activity with former service users.

Areas for improvement

Communication, engagement and feedback loops

Several visits described positive communication within local teams but less confidence that organisational feedback leads to visible action. Organisational change can feel top-down, middle managers can feel disconnected from decisions, and colleagues asked for earlier

involvement, clearer explanation of why changes are required and a consistent "you said, we did" feedback loop. This strengthens the recurring theme reported in September.

Workforce capacity, development and corporate support

Workforce remains the principal operational concern across the visits. Teams described increasing complexity, pressure on supervision and reflective time, shortages in medical and hard-to-fill community roles, and concern that career pathways do not always recognise the contribution of all professional groups. Managers also reported slow or inconsistent HR support. Positive recruitment and development examples should be used to inform a more enabling and responsive workforce approach.

Transformation and local autonomy

Teams broadly supported the direction of Mental Health Together Plus, CRAM and person-centred models, noting that the number and pace of concurrent initiatives risk implementation fatigue. Mature, well-functioning teams asked for greater autonomy over recruitment and local decisions. The Trust should be clear which decisions must be standardised and controlled centrally and which can safely be taken closer to the point of care.

Digital, estates and operational information

The visits identified opportunities to use digital systems more effectively, including Trust-wide monitoring of enhanced observations and improved RiO functionality. Estates continue to affect care in community and liaison settings. These insights should be considered alongside the Board's decision to separate cyber security and digital transformation within the strategic risk framework, ensuring that innovation, clinical safety, productivity and information quality are considered together.

Flow, prevention and system dependency

Community and specialist teams demonstrated strong commitment to admission avoidance and least-restrictive care. However, increasing complexity, capacity pressures and limited preventative and social-care support create risk across pathways. Committee assurance should therefore distinguish what the Trust can improve directly from issues requiring action with commissioners and system partners.

Recommendations

The Board is asked to:

- **Note** the Chair's activity and reflections since the September meeting.
- **Note** the strong examples of local leadership, multidisciplinary working, admission avoidance, workforce development and innovation.
- **Consider** how recurring workforce, communication, autonomy, digital, estates and system-capacity themes are triangulated and reported through the relevant Board committees.
- **Consider** how future reporting shows the management response, intended outcome and evidence that improvement has been sustained.

Kent and Medway Mental Health NHS Trust

Chief Executive's Board Report

Date of Meeting: 26th November 2026

Introduction

The past couple of months have been an important period for the trust, where we have continued our focus on the improvements we know we need to make with some significant milestones that demonstrate the progress being made for patients.

The publication of the CQC Well-Led report in October provided further clarity about the areas where we need to improve, particularly governance, leadership, culture and organisational assurance. Importantly, many of these issues were already understood by the trust and action was underway. The CQC also recognised progress in patient safety, partnership working and other areas, while being clear that we now need to demonstrate that improvement is sustained and embedded consistently across the organisation.

Our focus must therefore remain firmly on delivery and evidence of impact. Through our Quality and Governance Improvement Plans, we are strengthening accountability, oversight and clinical grip, with the ultimate test being whether patients, families and colleagues experience a safer, more consistent and better service.

At the same time, there is much to be positive about. In October we opened our new Centralised Place of Safety, creating a modern, purpose-designed environment for people experiencing mental health crisis, and in November our Female Psychiatric Intensive Care Unit (FPICU), completing our women's inpatient pathway and enabling more women to receive appropriate specialist care within Kent and Medway.

Taken together, these developments reflect a trust that understands where it needs to improve and is increasingly turning that understanding into tangible change. We should be proud of that progress, while remaining clear-eyed about the work still ahead. Our priority remains delivering Doing Well Together and ensuring that the changes we make translate into better, safer and more consistent care for the communities we serve.

National Update

National Mental Health Strategy

The publication of this critical document will be published later this year or early next year. At the recent national mental health Chief Executive meeting, we discussed the current working draft and shared our thoughts based on our local population needs. The strategy will be based around, protecting the populations mental health, finding help earlier, staying supported and ensuring there are high-quality inpatient services when required. The current themes align to our new five-year strategy, Doing Well Together, that we published in June, and our draft clinical strategic plan which we have been developing with clinicians and our

local communities. I will keep the Board updated on publication timeframes and bring back to Board once published, alongside our clinical strategic plan.

National Independent review into mental health conditions, ADHD and autism

Last month the national independent review was published. The review provides a significant challenge to the way mental health and neurodevelopmental services are currently organised. It concludes that rising mental distress, particularly among children and young people, is real, while demand for ADHD and autism assessment has increased at a rate that existing services cannot sustainably meet. Its central proposition is a move away from a predominantly "diagnosis-dependent" model towards a "needs-led plus diagnosis" approach, where people receive timely support according to need, functional impairment and risk rather than having to wait for a diagnosis before help is available. The review also calls for integrated mental health and neurodevelopmental pathways, earlier intervention and prevention, stronger specialist provision for people with severe and complex needs, greater multidisciplinary and neighbourhood working, improved quality assurance and commissioning, and safe use of digital and AI-enabled approaches. Importantly, success should increasingly be measured through improvements in functioning, participation, education, employment and quality of life, rather than activity, diagnosis and waiting times alone.

For KMMH, the review provides a timely framework against which the Board should consider our future clinical model and our role across the wider Kent and Medway system. In particular, we should consider whether our pathways sufficiently provide support before and while people wait for diagnosis; integrate mental health, autism and ADHD needs rather than reinforcing condition-specific silos; protect capacity for people with severe, complex and enduring mental illness; and connect effectively with primary care, neighbourhood teams, education, social care and the voluntary sector. The Board will also need assurance about the quality and consistency of assessment, including commissioned independent provision; whether our workforce and digital strategy can support a more integrated needs-led model; and whether our outcomes framework adequately captures functioning, inequality, participation and quality of life alongside access and waiting-time measures. Given the review anticipates reforms beginning within 12–24 months alongside a longer-term 10-year programme, I believe we should use its recommendations proactively to test our existing transformation priorities and identify where we should work with system partners to accelerate change rather than wait for further national direction. Some of this will have already started from the work being undertaken in the neighbourhood health alliance. A stock take will be undertaken in the next month to align with us publishing our clinical strategic plan.

NHS: Provision of Single-Sex services and facilities

We remain committed to delivering single-sex accommodation that protects the privacy, dignity and sexual safety of all our patients. As we respond to the revised national guidance, our patients' needs and wishes will continue to be fully considered and discussed with them, with clinical need and safety central to accommodation decisions.

NHS England's revised guidance, Privacy, dignity and safety in hospital accommodation, was published on 15 October 2026 and replaces Delivering same-sex accommodation (2019), with updated reporting requirements. It reaffirms the NHS Constitution's same-sex

accommodation pledge and sets out that trans patients should be accommodated in line with their biological sex, while protecting the clinical needs, privacy, dignity and safety of all patients. Where such a placement is not clinically appropriate, alternative arrangements should be considered. If no suitable alternative is available, clinical need takes priority, and any resulting breach must be documented and reported. Our approach will remain person-centred, involving patients in decisions wherever possible.

Kent & Medway System Update

Provider Alliance

The Kent and Medway Provider Alliance Board met on Friday 13th November. The meeting focussed on developing the Alliance arrangements to establishing clearer governance, accountability and delivery. The proposed framework formalises delegation and reserved matters while retaining the statutory accountability of individual Provider Boards, with the Alliance increasingly focused on assurance, delivery and collective action. Three priorities are proposed for 2026/27 and 2027/28: resetting the acute model of care, delivering neighbourhood health, and consolidating corporate services where feasible. The alliance is focussed on Home First, urgent community response, dementia and mental health urgent care, alongside referral management, endoscopy, orthopaedics and imaging, with a substantial programme to develop shared corporate services across People, Digital, Procurement, Estates, Corporate Governance and Nursing.

System Leadership Group (SLG)

System planning for 2027/28 is closely linked to current-year recovery, with a focus on demand and capacity, shifting care into community and neighbourhood settings where appropriate, and ensuring that financial, workforce and activity assumptions are aligned. Winter resilience remains an immediate priority, particularly reducing discharge delays and improving P2/P3 capacity, alongside the development of a single 18-month Alliance plan aligned to commissioning intentions, the Joint Plan and the medium-term financial plan.

Neighbourhood Health Board

The Kent and Medway Neighbourhood Health programme continues to move from design into implementation, with progress across both single and multi-neighbourhood models, although delivery remains mixed and several workforce, contractual, digital and data dependencies require continued system focus. The programme is now proposing to expand learning from the Folkestone, Hythe and Rural pilot through six further "fast follower" neighbourhoods, with mobilisation planned from January and live testing from March 2027. Encouraging early evidence from the pilot includes reductions in A&E attendances and emergency admissions, particularly for people living in care homes, but the programme is appropriately treating these findings as emerging evidence which needs to be validated across different neighbourhoods before wider adoption. Progress with the single-neighbourhood contract is also behind trajectory, with 5,930 people having received all three core interventions against an October target of 10,000, reinforcing the need to address workforce capacity, GP leadership, interoperability and consistent measurement of outcomes.

Mental health remains an important component of the developing neighbourhood model, with the Mental Health Neighbourhood Leadership Working Group bringing together work on urgent and emergency care, neighbourhood mental health workforce and dementia. Current priorities include strengthening alternatives to Emergency Department attendance, including Safe Havens; developing an ARRS workforce model that connects effectively with wider mental health services; and progressing dementia diagnosis and support closer to home. Delivery is currently behind plan in several areas and milestones are being refreshed, with dependencies around contracting, operational capacity and data. For the trust, this is an important opportunity to ensure mental health is embedded from the outset in the emerging integrated neighbourhood teams, rather than developed as a parallel pathway, with clear measures of impact on patient experience, inequalities, crisis demand and avoidable hospital attendance.

Black History System Event and Trust Event

I had the pleasure of being invited to join the system Black History event in October with my fellow Chief Executives for Kent & Medway and the Black History event that took place at Britton House, our Medway and Swale Community services. The key points I made as part of these events were:

- Our biggest learning is that we need to listen differently and demonstrate what changes as a result. More than 700 hours of colleague listening has already helped shape the EDI plan and five-year strategy.
- Our workforce is also part of the communities we serve. With colleagues from 77 countries, the Trust must take advantage of the opportunity to make much greater use of their cultural insight, lived experience, relationships and community connections, giving those voices greater influence within the organisation.
- Access to mental health care is fundamentally about trust, not simply service availability. Engagement with Black African and Black Caribbean communities has highlighted stigma, shame, family reputation and expectations around resilience as potential barriers to seeking help. Our services need to understand intersectionality and respond to the different experiences of communities and individuals.
- The Trust's ambition is to become actively anti-racist. I was honest that this is a journey and that the organisation has not got everything right, yet. This commitment extends beyond individual EDI initiatives to the culture of the organisation and the care provided to communities.
- Listening is increasingly being converted into action. I described the move from engagement as an activity towards an "insight-to-action" approach, including establishing the community insight and co-creation team and placing greater emphasis on underserved and seldom-asked communities.
- Community insight needs to be combined with robust equality data. This is informing our work on the Patient and Carer Race Equality Framework (PCREF) and racial inequalities, including understanding differences in restrictive practice, Mental Health Act detention and access to Memory Assessment Services.

- There are also tangible actions we have taken that colleagues can see, these include strengthening mechanisms for reporting and challenging racism, restorative approaches, investment in allyship, Board and Executive sponsorship of staff networks, co-creation of an anti-racism plan and better equality data.

I strongly believe that success should ultimately be visible through greater trust, earlier access to care, culturally relevant services, stronger voice and more equitable outcomes for Black and Global Majority colleagues and communities. Diversity is a source of organisational strength, but we must move beyond listening and good intentions to demonstrate tangible, measurable change in people's experience and outcomes.

Trust Update

Chief Nurse

I am delighted to report that we have successfully concluded the recruitment process for our substantive Chief Nurse position, a pivotal appointment for the Trust with our continued focus on delivering high-quality, safe and compassionate care.

Following a rigorous selection process, four strong candidates were interviewed on 30th October and took part in several staff and patient focus stakeholder groups. The final panel comprised myself, Colin Lynch, Chair; Andrea Lewis, NHS England Regional Chief Nurse; Margaret Dalziel, Non-Executive Director; and Alice Sigfrid, Clinical Manager. The calibre of candidates was extremely high, reflecting both the importance of the role and the strength of the opportunity within our organisation.

The Trust has moved to the onboarding stage of recruitment. The Trust is awaiting responses from third parties and so I am unable to announce the name of the successful candidate at this stage. A public announcement will occur once final recruitment checks have taken place.

Six-month strategy update

October marked six months since the launch of our five-year strategy, Doing Well Together. Alongside the performance reported through our Integrated Quality and Performance Report (IQPR), I have attached to my report an update that gives the Board and the public a fuller picture of our journey: what is changing, where challenges remain and what we need to strengthen to deliver our ambitions. **Appendix 1.**

We are beginning to see encouraging progress across our five True North ambitions. More people referred to Mental Health Together, our community service, are starting treatment within 18 weeks, and the number waiting more than 38 weeks has roughly halved. There is much more to do to reduce delays, ease pressure across inpatient pathways and improve the experiences of patients and staff.

We have also needed to be honest about our starting point. Some of the foundations needed to deliver our strategy were not sufficiently established. Strengthening our data, improvement skills and governance is an essential part of delivering better care. We are bringing together performance and quality data with the experiences of patients, carers, staff and communities, and helping teams build the skills to act on that evidence and assess whether changes are working.

Our Governance Improvement Plan and the new Board Assurance Framework (BAF) presented today support this work, giving the Board a clearer view of the risks to our ambitions, the strength of our controls and where further action is needed.

As we move into the second half of the year, we must balance ambition with our capacity to deliver. This means prioritising improvements to care today while building the foundations for longer-term change, including our contribution to integrated neighbourhood services alongside system partners and the ambitions of the national 10 Year Health Plan. We will deliver in phases, being clear about what we can achieve, by when, and where we need to focus our collective effort.

Governance Improvement Plan Update

Good progress continues to be made in delivering our Governance Improvement Programme, with all six areas on track and the programme remaining rated Green-Amber overall. We have now reached an important transition point, moving from the design and implementation of strengthened governance arrangements to ensuring these are consistently embedded and demonstrably improving assurance, accountability, escalation and decision-making across the Trust. The next phase will therefore place greater emphasis on evidencing impact and sustained improvement, including in response to the findings from the recent CQC Well-led assessment. A fuller update on progress, key areas of focus and the next phase of the programme is attached at **Appendix 2.**

Centralised Health Based Place of Safety

People experiencing a mental health crisis across Kent and Medway and needing urgent help and support, will now be cared for in our centralised Health-Based Place of Safety at Priority House in Maidstone. On 23rd October I was joined by Superintendent Rob Marsh, Head of Kent Police's Force Strategic Prevention Command to officially open our new unit which brings together care previously provided in three sites across the county, to provide a much improved, calm and therapeutic environment. We were also joined by Sojan Joseph, MP for Ashford, who reflected on his 22 years working in mental health services in Kent and Medway, and why this purpose-built suite is an important step forward for urgent mental health care and our continued close working with the police. I would like to thank everyone involved in ensuring that we delivered this very important environment so that local people can get the care the specialist urgent care they need.

Kent and Medway opened its first psychiatric intensive care unit for women

This month we opened Kent and Medway's first NHS psychiatric intensive care unit for women. I was joined by Jim Dickson, MP for Dartford, in formally opening the 10-bed facility, which will serve the whole county and bring much needed short-term, intensive care for women experiencing serious mental health difficulties. Women needing this level of care deserve to have it close to the people and places they know, and by dedicated, caring staff who know them best. Offering this for the first time is something I'm incredibly proud of and I'd like to thank everyone who has been part of it. I'd also like to thank partners and staff who joined us on the opening day to mark this important milestone and to our wonderful staff who are already caring for 6 women who have been safely transferred out of private and out of area beds and welcomed into the unit. There's always more to do in mental health, but these moments matter.

Leadership, culture and strategy delivery

Our recent Board seminar focused on the culture we need to provide consistently high-quality care for our patients, and to deliver the ambitions in our strategy. The Board agreed what good culture should look like across the trust and explored the gaps between that ambition and people's experience's today. This gives us a clearer basis for shaping our culture programme and assessing whether it makes a difference for patients and staff.

Across the seminar, and our October executive and deputies away day, we also focused on how we lead delivery of the strategy while responding to immediate pressures on services and across our system. We identified the need for clearer accountability and faster decision-making, supported by our governance improvement work. We have identified where we need to focus our effort and are taking this forward through identifying the capacity required and the choices needed to make delivery realistic.

Mental Health Together (MHT) Plus Caseload Management Report

When I had the privilege of visiting Merseycare with Claire Hursell our Director of Digital, we saw the impact a caseload management tool had in supporting staff to manage risk. I am delighted to say after months of development we have developed our in-house Mental Health Together Plus Caseload Management Report - Complexity Factors Business Intelligence (BI) tool to give clinical teams clearer oversight of their caseloads and help identify emerging patient safety risks earlier. Co-designed by Digital and BI colleagues with frontline clinicians, the tool brings together key complexity factors to highlight patients who may need greater attention including those with limited engagement, no recent contact or no future planned contact, supporting better prioritisation and clinical decision-making. East Kent recently presented at the Clinical Summit how they are using the tool to strengthen risk-assessment compliance and identify patients who might otherwise be at risk of not having their needs met. A massive well done to all colleagues who have been involved in this initiative, this will make a difference for staff in managing their patients but importantly for the patients ensuring we can meet their needs.

Britton House visits by Medway Councillors

Since our last Board meeting, we have been delighted to host two visits to Britton House by Medway councillors, providing valuable opportunities to strengthen our relationships with local elected representatives and showcase the work of our services. This included a visit from Councillor Dan McDonald, Chair of the Health and Adult Social Care Board (HASC). I was joined on both occasions by Dr Adrian Richardson and Wendy Dewhirst. North Kent Service Director and her team.

These visits are an important part of maintaining strong relationships with our local partners and enabling councillors to hear directly about our services, the communities we support and the excellent work of our colleagues. I would like to extend my sincere thanks to colleagues at Britton House for the warm welcome they provided and for taking the time to support and accommodate both visits alongside their day-to-day responsibilities. Their professionalism, openness and enthusiasm in showcasing the work of the service were greatly appreciated.

MP meetings

This month I met separately with Sojan Joseph MP and Lauren Sullivan MP, and welcomed both, alongside Jim Dickson MP to the opening of our female PICU. These conversations

provide valuable opportunities to hear what matters to their communities, strengthen their understanding of our services and explore how we can work together to improve local care. Sojan's mental health nursing experience brings particular insight and a strong commitment to what we do across all of Kent and Medway. I look forward to continuing to build these relationships and supporting our MPs in championing the needs of our communities.

Awards and recognition

There has been much to celebrate since my last report to Board, not least the recognition our colleagues continue to receive for their expertise, innovation and commitment to improving care.

- Kate Merlini-Moorcroft, Occupational Therapy Apprentice, won two awards at the 2026 HSJ Patient Safety Awards for her Minimal Risk Activity Pack (MRAP): Early-stage Patient Safety Innovation of the Year and the Mental Health Safety Improvement Award. The initiative was introduced across the organisation as part of our Innovation Den initiative, where staff are supported by our Improvement Team to roll-out winning ideas.
- Dr Ishak Pala, Consultant Liaison Psychiatrist, was named International Medical Graduate Lead Champion of the Year at the Royal College of Psychiatrists Awards 2026.
- Dr Mudasir Firdosi, Director of Undergraduate Medical Education, has achieved Senior Fellowship of the Higher Education Academy (SFHEA).

We have also been shortlisted for two awards:

- Amy Cunninhham has been shortlisted for the Start Afresh programme in the Nursing Times Awards
- Shannon Paine has been shortlisted for the Nurse Leader Rising Star Awards for the Nursing Times Workforce Awards
- HSJ Awards 2026: Medicines, Pharmacy and Prescribing Initiative of the Year

I am incredibly proud to see colleagues recognised in this way. Their achievements are testament not only to their individual talent and dedication, but to the innovation, learning and commitment to better care that we see every day across our trust.

Partnership Working

In October, we co-hosted a pre and post diagnostic support service workshop, where, alongside the Provider Alliance, we bought together over 30 different organisations and people with lived experience to map out what the future of pre and post dementia diagnosis support should look like across Kent and Medway. This will form an integral part of the future commissioning landscape for those affected by dementia in the county.

On 15 October, the Trust held an evening community launch for the Mental Health Act and Restrictive Practice (MHARP) project as part of the Patient and Carer Race Equality Framework (PCREF), bringing together people with lived experience, carers, community and faith organisations, colleagues and system partners. The launch was an important step in moving beyond the data to understand people's experiences, build trust and strengthen our

commitment to working collaboratively with communities to develop and co-produce future countermeasures.

Charity and Volunteers

The trust Charity continues to strengthen its position as a strategic partner to the trust. In partnership with the Global Majority Network, Cultural Attire Fridays took place during October as part of Black History Month. Staff were invited to wear cultural attire to raise money to support the charity's work. Patients at Bridge House will shortly be able to benefit from an outside gym secured by the charity from a Sport England bid worth over £8,000.

Volunteers continue to play a significant role in improving our patient and staff experiences within the trust. In the first quarter of this financial year, we again saw an impressive number of volunteers and hours provided. Between April and June 2026, we were the second-best mental health trust in England for both number of volunteers and the number of volunteer hours.

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. Please keep nominating, I know the difference this makes for our staff to be recognised for their hard work and dedication to the trust, our patients and their families.

The trust in the news

Over the past month, positive regional and national media coverage has highlighted investment in local care, including the opening of our first female psychiatric intensive care unit and our new centralised Health-Based Place of Safety, alongside our improvement work. Coverage of the CQC well-led findings has also brough scrutiny of the challenges we are addressing. The publication of a version of the report containing factual inaccuracies added complexity to this coverage. We continue to communicate openly about the findings and the action we are taking.

Conclusion

The CQC Well Led report reinforces the importance of our governance and quality improvement plans. Our focus remains on delivering these changes and demonstrating the difference they make for patients and staff. Alongside this work, we are focusing our capacity on fewer priorities within our Doing Well Together strategy, recognising the need to balance longer-term improvement with immediate pressures on patient flow, our Staying Well strategic ambition, as we head into winter.

Opening two new facilities has been a particular privilege. Meetings with MPs, both at the openings and separately, and visits with Medway councillors have also highlighted their strong advocacy for us and mental health. We will continue to build these relationships to champion the needs of our communities.

Finally, as winter pressures increase, clear priorities, strong partnerships and support for our staff will remain essential in the months ahead. Thank you to colleagues across the trust for their continued commitment to safe, compassionate care.

Sheila Stenson
Chief Executive
26th November 2026

Executive Team Visits

Sheila Stenson
New Female PICU
New Centralised Placed Based of Safety
Britton House
Priority House

Donna Hayward-Sussex
Cherry Tree House - CYP
George Turtle House – CYP
Mental Health Services at the Beacon - Thanet
Kent & Medway Adolescent Hospital
Mental Health Services Adults Swale
CYPMHS & AAEDS Community Services Swale

Julie Kirby
New Female PICU, Littlestone Lodge
Centralised Place of Safety
KMAH and Littlebrook wards (Acute and PICU)

Nick Brown
The Beacon, Thanet
Ashford Liaison Psychiatry
Mental Health Plus and CYP, Highlands House

Dr Afifa Qazi
Britton House
Medway LPS
Beech House

Dr Adrian Richardson
Britton House, Gillingham

Kindra Hyttner
111 Tonbridge Road Rebab Unit
FPIC Opening, Dartford
Eureka Medical Centre, Ashford

Value in Practice Awards

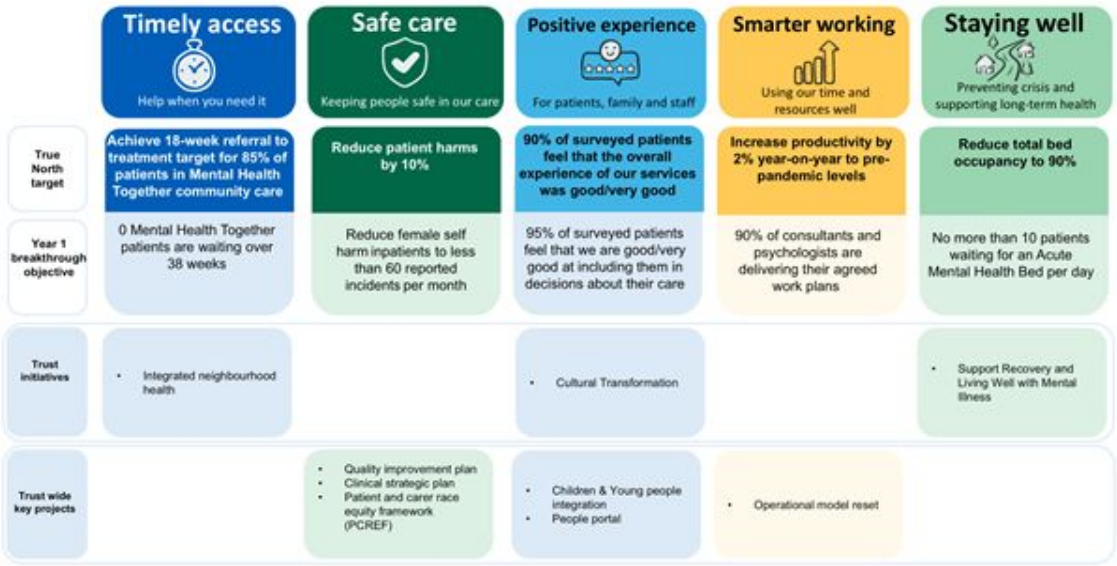
Directorate	August	September
North	Rebecca Bush, Support Time and recovery Worker Team: Dartford Liaison	Dr Catherine McGoldrick, Clinical Psychologist,
East	Lee Bates, Liaison Nurse Team: SKC MHT+	Geralyn Nicholls, Community Psychiatric Nurse, Thanet MHT
West	Karen Underdown, Admin Assistant Team: Review & Resettlement	Debra Martin, Governance Lead, Highlands House
Forensic	Ayomide Ayodele, Health Care Assistant Team: Liaison Diversion and Reconnect Admin	Beth McKay, Admin Co-ordinator, TGU
Support services	Cheryl York, Senior HR Advisor Team: Trust Capital	Ian Marks, PALS and Complaints Officer
Acute	Sharon James, Senior Administrator Team: Sevenscore	Jumy Onih Oladele, Matron
Children & Young Persons and All Age Eating Disorders	Miah Harper-John, Multi-disciplinary pathway worker Team: All Age Eating Disorder Service	Beth Ridd, Senior Triage Clinician

Appendix 1- Six Month Strategy Update

Over the first six months of delivery, we have focused on getting the basic foundations right to support implementation of our five-year strategy. This has included strengthening governance, establishing programme foundations, defining the scope of key initiatives, understanding interdependencies and identifying opportunities to improve quality and reduce unwarranted variation. Together, this work has created the foundations for sustained improvement and better outcomes for people, families and communities.

Our five True Norths set out the long-term ambitions we are working towards over the life of the strategy. To translate these ambitions into action, we have established a set of Year 1 breakthrough objectives, focused on those improvements expected to have the greatest impact on access, quality, experience, resources and outcomes.

Trust-wide initiatives (3-5 year transformational programmes) and projects (12-18 month trust-wide improvement) have been aligned to our ambitions, providing a clear line of sight between our long-term ambitions and delivery priorities.



As we prepare for the next phase of delivery in 2026/27, we are assessing the capability, capacity and resources required to deliver our strategic priorities effectively and to determine priorities for the next six months. This will enable us to focus investment and effort on areas where we expect the greatest impact and of greatest strategic risk, while ensuring improvement can be sustained over time. As a result, some programmes will accelerate during the rest of 2026/27, while others will be phased over subsequent years of the strategy.

As a five-year strategy, not all programmes will progress at the same pace. The following update highlights progress against our Year 1 breakthrough objectives and some of the key initiatives and projects that sit underneath them, and demonstrates how we are moving from establishing foundations to delivering measurable improvements and sustainable outcomes.

Appendix 1- Six Month Strategy Update

Timely access: help when you need it Timely access: help when you need it			
True North outcome	**Year 1 Breakthrough Objective**	**Why this?**	**Current year 1 position**
85% of MHT referrals treated within 18 weeks	0 Mental Health Together patients are waiting over 38 weeks	Waiting times too long; variation between localities and communities, individuals	**18-week access:** improved from 59.9% to 69.9% (Apr-Sep 2026) **38+ week waits:** halved (323 to 154 patients, Apr-Sep 2026)

Integrated neighbourhood health forms part of the wider Kent and Medway Neighbourhood Health Provider Collaborative, which is moving from mobilisation into delivery and testing neighbourhood-based models of care across the system. The ambition is to embed mental health within wider neighbourhood health and care models, bringing together primary care, community services, local authorities, VCSE organisations and specialist mental health services to provide more coordinated, proactive and person-centred support closer to home. The programme is being developed through a structured test-and-learn approach, informed by population need, service utilisation, outcomes and learning from early neighbourhood implementation. A phased programme of stakeholder engagement, population analysis, service mapping and pathway design is underway, aligned to the Mental Health, Learning Disability and Autism (MHLDA) Review.

Delivery is currently focused on three priority areas:

1. **Crisis prevention and flow improvement** - developing a coordinated approach to crisis prevention, alternatives to hospital care and recovery following crisis, with a focus on earlier intervention, improving patient flow and reducing avoidable admissions, emergency department attendances and out-of-area placements.

2. **Primary care mental health** - strengthening mental health support within neighbourhoods through the development of Mental Health Practitioners and wider primary care mental health initiatives. Current work is focused on understanding population need, workforce capacity and service demand to develop a sustainable neighbourhood-based model that supports earlier intervention, improves access to support closer to home and reduces reliance on secondary care services where needs can be safely met in the community

3. **Dementia transformation** - strengthening support closer to home through improved diagnosis pathways and enhanced pre- and post-diagnostic support. Progress includes an increase in the Kent and Medway dementia diagnosis rate to 63.2%, implementation of a community-based assessment and diagnosis pilot, and the co-production of a future support model with people with lived experience, carers and system partners to address gaps in post-diagnostic support.

These priorities are being developed across all levels of the system's Four Layers of Care, recognising that improving outcomes requires intervention across primary care, neighbourhood, community, specialist and acute mental health services. A phased programme of stakeholder engagement, population analysis, service mapping and pathway design is underway, aligned to the Mental Health, Learning Disability and Autism (MHLDA) Review. Learning from the three priority areas, alongside findings from the commissioning review, and Fokestone & Hythe neighbourhood pilot, will be used to

Appendix 1- Six Month Strategy Update

inform and refine the future neighbourhood mental health model for Kent and Medway, ensuring it is shaped by evidence, population need and emerging system priorities.

Safe care: keeping people safe in our care			
True North outcome	**Year 1 Breakthrough Objective**	**Why this?**	**Current year 1 position**
Reduce patient harms by 10%	Reduce female self harm inpatients to less than 60 reported incidents per month	Women disproportionately represented in self-harm incidents and self harm was the highest reported type of patient harm	**Total harm:** 108 incidents, below the target of 143 (Sept, 26) **Female acute self-harm incidents:** 62 in January, 154 in February, 100 in March, 80 in April, 46 in May, 53 in June, 130 in July, 76 in August and 41 in September 2026. N.B This measure focuses on female self-harm incidents within acute inpatient wards, where the majority of incidents occur and where the primary improvement work is being delivered. Other female inpatient wards have consistently reported low incident numbers and remain below the target threshold, meaning their inclusion would have minimal impact on the overall picture.
	Improve the management of self-harm in community services (focusing on liaison psychiatry)	Self-harm is the most frequent reason for referral to liaison psychiatry services, with identified variation across populations and localities.	**Self-harm in the community:** Analysis of liaison psychiatry referral data has identified the services, localities and population groups with the highest levels of self-harm presentations, with targeted audits, root cause analysis and clinical interventions underway to strengthen support and improve outcomes.

The Quality Improvement Plan (QIP) remains a key project supporting delivery of the Safe Care ambition, as well enabling both Timely Access and Positive Experiences for patients. The QIP provides a structured approach to improving quality, reducing unwarranted variation and delivering better outcomes for people who use our services. During 2026-27, work has focused on strengthening the use of data, evidence and improvement methods to identify priorities, target improvement activity and support learning across services. Priority areas have included improving support for people at highest risk of self-harm, strengthening clinical decision-making, risk assessment and formulation, and improving oversight of quality concerns. Together, this work is helping embed a culture of continuous improvement and creating the conditions for sustained improvements in quality, safety and outcomes.

The Patient and Carer Race Equality Framework (PCREF) is a key project supporting the Trust's commitment to reducing inequalities in access, experience and outcomes for people from racialised communities. Building on the focused work we delivered in 2024-25 to improve health inequalities data and recording, progress this year has included: the development of the Mental Health Anti-Racism Programme (MHARP): expansion of the Global Majority Hub: further improvements in ethnicity data quality and recording; and more meaningful community engagement and co-design. Together, this work is strengthening the evidence, insight and community voice needed to better understand inequalities and inform future improvement activity. Improved data quality is enhancing the Trust's ability to monitor

Appendix 1- Six Month Strategy Update

access, experience and outcomes across different ethnic groups, providing greater visibility of variation and helping to target improvement activity where it is needed most. The next phase of PCREF delivery will be taken forward through four connected workstreams focused on clinical pathways, data and digital, culture and workforce, and community partnerships and communications. Action will be co-designed with communities to ensure we fully understand and addressing inequalities in access, experience and outcomes, as well as disparities in Mental Health Act detentions and restrictive practice.

Development of the Clinical Strategic Plan has been a key focus over the last six months. This plan will deliver a different job from our organisational strategy and our quality improvement plan. The strategy sets out the whole organisation's ambitions over five years across access, safety, experience, resources and outcomes. The quality improvement plan sets out how we will keep improving safety, effectiveness and experience of the services we run today. The clinical strategic plan sits between the two. It describes the care we will provide in the coming years – our clinical models, pathways and priorities – and how that care will turn our strategic ambitions into better outcomes for patients. It also gives clinicians a shared direction for how services should develop.

Over the past six months, we have built the plan with clinicians, people who use our services, carers and community partners. That engagement has shown us where the priorities lie, which very much align with the NHS 10 Year Health Plan: supporting people to stay well, earlier intervention and prevention, and more integrated care, closer to home. In May, the government announced a new cross-government mental health strategy for England. It is expected to be published at the end of this year or early next year, and to focus on these same areas. Therefore, we are keeping our plan in draft until then, so we can test it against the national strategy and make sure the two line up. This is a deliberate choice and means the final plan will reflect both what our communities and clinicians have told us, and what is expected nationally. We expect to bring the final plan to the Board in early 2027, depending on when the national strategy is published.

Positive experience: for staff, patients and families			
True North outcome	**Year 1** **Breakthrough Objective**	**Why this?**	**Current year 1 position**
90% of surveyed patients feel that the overall experience of our services was good/very good	95% of surveyed patients feel that we are good/very good at including them in decisions about their care	Patients want care that feels more relational	**Patient Involvement in Care Decisions:** 75.9% of patients who responded to the survey, feel included in decisions about their care, against a target of 95% (Sept 2026). **Patient Experience:** 72% of patients who responded to the survey reported their overall experience as good or very good (Sept 2026). **N.B** introduced Your Experience Matters (YEM) and changed the methodology used to measure patient involvement and experience. Increased response rates, more representative feedback and changes to how responses are calculated mean current results are not directly comparable with earlier periods.

Appendix 1- Six Month Strategy Update

Improve staff engagement score to 7.3	Increase the percentage of staff that would recommend KMMH as a place to work from 54% to 60%	Staff advocacy and experience not yet consistent across teams and individuals	**Staff engagement score:** at 6.7 (Mar 2026) **Recommendation as a Place to Work:** 45.6% of staff would recommend KMMH as a place to work (471 people)(Pulse Survey, July 2026).

The Cultural Transformation Programme is focused on improving the experience of care for patients, families and carers, as well as the experience and wellbeing of our staff. Culture remains one of the Trust's significant strategic risks and is reflected in SR6 the Board Assurance Framework. Over the last six months, our focus has been on building a clearer understanding of what is driving staff experience before committing to action. An in-depth triangulated analysis of workforce, quality and performance data was developed and shared in September, and the analysis from that and further staff engagement sessions has informed the development of six cultural characteristics, endorsed by the Board. Development work has continued in the background since then.

We have deliberately chosen not to finalise the plan until the 2026 NHS Staff Survey results are available and we have reviewed the positive experience for staff improvement work led by directorates over the last six months. This will let us test our understanding against latest evidence and reassess our priorities. This insight will shape targeted improvement plans, co-produced with leaders, directorates, staff voice councils and staff networks, and help us agree the action we take going forward. A Cultural Transformation Plan will be ready in March 2027.

As a system early adopter of the NHS People Portal programme, the Trust has committed to working with partners across Kent and Medway and NHS England to support the design and implementation of a new national workforce platform that will replace ESR and support the full employee journey from recruitment through to retirement. The programme aims to modernise workforce systems and people processes, improve the employee experience through more accessible self-service and a more consistent workforce journey, strengthen workforce planning and management capability, and reduce reliance on multiple systems and interfaces. It is also expected to support greater administrative efficiency and provide a scalable platform for future delivery of people services across the system.

The national programme will be delivered through a phased implementation approach through to 2030, with Early Adopter organisations progressing through a series of national readiness and assurance gateways. During the reporting period, initial engagement and readiness activity has commenced across the Trust. As national requirements and timelines continue to develop, the Trust is prioritising ensuring resource, capacity and capability requirements are fully understood and aligned with wider organisational priorities before progressing to the next phase of delivery.

Appendix 1- Six Month Strategy Update

Smarter working: using our time and resource well			
True North outcome	**Year 1 Breakthrough Objective**	**Why this?**	**Current year 1 position**
Increase productivity by 2% year-on-year to pre-pandemic levels	90% of consultants and psychologists are delivering their agreed work plans	Variation across teams and reported activity and sustainable models of care	**Productivity:** improved by 10% exceeding the year 1 target of 2% target (June 2026). **N.B** further analysis is required to understand the factors contributing to this increase. **Consultant and psychologist** productivity measures are being refined to better reflect clinically meaningful activity, with final standards due in November 2026.

The Operational Model Reset has undertaken initial discovery work, workforce engagement and option development to better understand how services can be organised and delivered more effectively. Following consideration of wider organisational priorities and programme interdependencies, further development has been paused while the Trust undertakes a fundamental review of the programme. The next phase will build on the workforce engagement completed to date, using the feedback and insight gathered from staff to inform future proposals and ensure any changes are aligned to strategic priorities, informed by operational need, and supported by a clear understanding of resource, capacity and implementation requirements.

Staying well: preventing crisis and supporting long term health			
True North outcome	**Year 1 Breakthrough Objective**	**Why this?**	**Current year 1 position**
Reduce total bed occupancy to 90%	No more than 10 patients waiting for an Acute Mental Health Bed per day	c.14 patients waiting daily on average (7-22); worsening trend increases clinical risk and impacts wider health care system and outcomes	**Bed occupancy:** remains above the 90% target, currently at 95.4% (Sept, 26) **Patients waiting for an acute MH bed:** remain above the Year 1 target of 10 per day, with an average of 12.6 patients (Sept, 26) N.B This measure includes patients waiting in a variety of settings, including ED and Places of Safety. Performance is influenced by both inpatient bed availability and wider patient flow factors, including delays in accessing community, social care and alternative step-down pathways.

Appendix 2

Governance Improvement Programme

The Trust continues to make good progress in delivering its Governance Improvement Programme (GIP), established to strengthen the effectiveness, clarity and consistency of governance and assurance across the organisation. It provides a structured approach to improving decision-making, strategic risk management, escalation and assurance to the Board. The programme remains rated Green-Amber overall, reflecting strong delivery of the required governance infrastructure while recognising that the next phase must show consistent implementation and impact.

The programme is structured around six interconnected areas:

- Governance Structure;
- Terms of Reference and Delegation;
- Assurance, Escalation and Information Flow;
- Governance Discipline and Capability;
- Board Oversight and Continuous Improvement; and
- the Board Assurance Framework (BAF).

All six areas are reported as on track, providing a strong platform to move from redesigning governance arrangements to demonstrating that they operate consistently and effectively in practice.

Strengthening the governance architecture

Good progress has been made in simplifying the Trust's governance architecture, with Board and sub-Board arrangements reviewed and a clearer end-to-end governance map established. Committee Terms of Reference, workplans and the Scheme of Delegation are also being refreshed to strengthen accountability, assurance and alignment of responsibilities. These changes provide clearer lines of sight from operational governance to the Board, reduce duplication and sharpen the focus on effective assurance.

Improving assurance, escalation and information flows

Progress has been made in strengthening information flows, escalation and assurance, supported by a revised Integrated Quality and Performance Report, improved reporting arrangements and clearer links between committee workplans, strategic risks and the BAF. The next phase will focus on strengthening data quality and triangulation, embedding consistent reporting standards and demonstrating that these arrangements are delivering stronger, more effective assurance in practice.

Strengthening strategic risk and the Board Assurance Framework

Significant progress has been made in strengthening the BAF and its relationship with the Trust's strategy and committee assurance arrangements. The Board has agreed a revised structure and strategic risk set aligned to the Trust's 2026-31 Strategy. Risk articulations have been refreshed, with responsibility for scrutinising each strategic risk allocated across the Board's assurance committees.

Work with Committee Chairs and Executive Leads continues to improve the articulation of controls, actions, assurances and assurance gaps. This will help the BAF operate as a dynamic framework through which the Board can assess whether principal strategic risks are being effectively controlled and assured.

BAF review is being incorporated into standard committee workplans, reinforcing committee responsibility for assurance over allocated strategic risks. The next phase will further align operational risk registers with the BAF and continue development of the wider Risk Management Framework.

Moving from delivery to embedding

The programme has reached an important transition point. Much of the governance architecture is delivered or well advanced. The priority is shifting from introducing arrangements to demonstrating that they are consistently understood, used and effective. Measurement therefore distinguishes completed outputs from evidence of impact and embedded change.

Areas requiring further maturity include delegation, data quality and triangulation, reporting standards, escalation, alignment of operational risk management with the BAF and consistent understanding of governance expectations. These form a significant part of the next phase.

The Trust does not regard a revised structure, template or process as the end point. Success will increasingly be judged by evidence that the changes improve assurance, accountability, escalation and the quality of Board and committee decision-making.

Board oversight and demonstrating sustainable improvement

Governance improvement is being incorporated into ongoing Board oversight rather than treated solely as a time-limited project. A quarterly GIP reporting cycle is included in the Board forward plan, with work progressing on a Well-led self-assessment and annual reviews of governance structures and Terms of Reference.

This provides an important foundation for responding to the governance issues highlighted by the recent CQC Well-led assessment, particularly those concerning risk management, committee oversight, escalation, data quality and demonstrable closed-loop assurance.

The next phase will place greater emphasis on evidence and impact. The Board and its committees will oversee completion of the remaining actions, while increasingly testing whether the changes produce stronger and more consistent assurance in practice.

Overall, substantial progress has been made in establishing the foundations for stronger governance. The focus is now to consolidate those improvements, address the remaining areas requiring attention and demonstrate that the arrangements are consistently embedded and delivering sustained improvement.

Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

Meeting details

Date of meeting:	26th November 2026
Title of paper:	Board Assurance Framework
Author:	Julie Kirby, Acting Chief Nurse Louisa Mace, Risk Manager
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of paper

This is the first full BAF report in the new format requested by the Board for November following approval in September. It summarises implementation progress, explains the framework and sets out the principal risk movements, their implications, decisions and next steps. The framework links eight strategic risks to their causes, underlying register risks, controls, assurance evidence and gaps. The BAF in its entirety is included at Appendix 1.

The elevated risk profile means patients remain exposed to delayed treatment, deterioration, avoidable harm and out-of-area care, particularly where inpatient flow is constrained (highest cause score 20). Workforce pressures and partner dependencies can prolong delays, reduce continuity and slow community transformation; gaps in data and digital capability can weaken decision-making and limit productivity. Temporary staffing financial exposure has increased from 9 to 12, adding cost pressures that may constrain investment in services. Cyber risk has reduced from 15 to 12 but remains outside appetite, with potential disruption to care and access to records.

Issues to bring to the Board's attention

- The overall risk profile remains elevated, with the highest exposure relating to safe, timely and high-quality care, particularly inpatient flow.
- Cyber risk has reduced, but remains outside cautious appetite. Temporary staffing exposure has increased.
- The Board is asked to confirm the proposed SR6 risk appetite and approve the revised statement and seven new or reworded causes.
- The Board is asked to accept the time-limited SR7 assurance gap while the Partnership Committee completes its first cycles of review.
- Further assurance must demonstrate measurable impact, reliable data, cross-committee dependencies and stronger second- and third-line assurance.

Governance

Implications/Impact:	Strategic risks affect patient safety and experience, workforce capacity, financial sustainability, delivery of Doing Well Together 2026–2031, operational resilience and public confidence.
Assurance:	Limited - New framework makes cause exposure, controls and assurance gaps more visible. Scores and action completion do not, alone, demonstrate risk reduction. Committee assurance statements, outcome trajectories and independent testing are needed to evidence control effectiveness and residual exposure.
Oversight:	The Board receives the framework. Owning committees review their strategic risks and provide assurance summaries. The Audit and Risk Committee will review operation of the framework across committees in December; maturity will be reassessed in March 2027.

First report in the new format

Public Board | November 2026

1. Purpose of this paper

In September the Board approved the move to a new Board Assurance Framework (BAF) from the October committee cycle and asked to receive the first full framework in the new format in November. This paper delivers that step. The framework in its entirely is at Appendix 1.

This paper explains what has happened since September, how the report is built and how to read it, what it shows this month, the decisions it asks of the Board and what comes next.

The framework adopts a risk, cause, effect approach distinguishing the eight strategic risks that could prevent delivery of Doing Well Together 2026–2031, the causes driving those risks and their potential consequences for patients, staff and service delivery. It links these to the controls intended to reduce exposure and the assurance evidence needed to demonstrate that those controls are making a difference.

All causes are now scored. The revised framework therefore provides a complete cause level risk profile and a stronger basis for tracking movement, testing whether controls are effective and focusing Board attention on impact rather than activity alone.



Figure 1. How the new framework moves from risk identification to evidence of impact.

Why this matters: The new format makes visible where controls exist but their effect has not yet been demonstrated, where assurance depends mainly on management reporting, and where delivery relies on partners or other factors outside the Trust's direct control.

2. Progress since the September Board

In September the Board approved the revised strategic risk statements, created an eighth strategic risk for operational resilience owned by the Audit and Risk Committee and approved the move to the new framework from the October committee cycle. The table sets the go-live plan agreed in September against the position now.

Step	Planned in September	Position at November
October and November committee meetings	Each committee confirms and scores its causes, records gaps, and agrees its first assurance statement.	The SR1 draft received by the Quality Committee was insufficiently developed to support assurance to the Board. Further work has since been completed, and the updated SR1 is included in Appendix 1. Other committees had either not met or not received their risks for review when this report was finalised.
November Board	First full framework in the new format, with committee assurance statements.	Framework produced and completed. Committee assurance statements not received as per point above.
December Audit and Risk Committee	First review of how the framework is working across committees.	On track.
March 2027	Maturity reassessed against a single evidence test.	On track.

For SR6, Leadership and Culture, an Open appetite is proposed for Board agreement, enabling new approaches to leadership and cultural development on a comply or explain basis. This does not permit closed cultures, concerns left unaddressed or discrimination: any decision increasing these risks must be explained to the People Committee. The seven causes are scored at 16 (three) and 12 (four); their position against tolerance cannot be assessed until the Board confirms the appetite.

3. How the report is built and how to read it

The full framework links strategic risks to their causes, the underlying register risks, controls, assurance evidence and gaps. Read the scores alongside the evidence of control effectiveness and the owning committee's assurance statement: a scored cause identifies exposure, but does not by itself demonstrate that risk is reducing.

The highest current cause score indicates the greatest exposure within each strategic risk; it is not an average of its causes. These views should be read alongside risk appetite, assurance gaps and the priority questions for the next cycle.

4. What the framework shows this month

Risk	Highest score	What the Board needs to know	Impact
SR1 **Safe, high-quality care**	**20**	Highest exposure. Inpatient flow is scored 20; community access, self-harm and assurance gaps remain material.	Delayed treatment, avoidable harm, deterioration, use of out-of-area care and pressure across the pathway.
SR2 **Financial sustainability**	**12**	No causes are recorded outside appetite, but medium-term sustainability and temporary staffing remain material.	Reduced capacity to invest in services, people, estate and digital infrastructure.
SR3 **Digital, data and technology**	9	Data quality, digital planning, adoption and transferred-service dependencies limit assurance.	Clinical and operational decisions may rely on incomplete information; productivity benefits may not be realised.
SR4 **Safe and therapeutic estate**	**9**	Current scored exposure is moderate; Board assurance must show risk reduction from investment and maintenance.	Unsafe or unsuitable environments, lost capacity and higher maintenance costs.
SR5 **Sustainable workforce**	**16**	Temporary staffing, absence of a strategic workforce plan and shortage roles are key drivers.	Reduced continuity, workforce pressure, delayed care and constrained improvement capacity.
SR6 **Leadership and culture**	**16**	Follow-through on concerns, involvement, inclusion and leadership variation are prominent.	Closed-culture conditions, unresolved concerns, inconsistent care and staff experience.
SR7 **Partnership and health inequalities**	**16**	Partner capacity, shared data and governance remain immature; committee assurance is developing.	Delayed discharge, slower community transformation and persistent inequalities.
SR8 **Operational resilience**	**12**	Cyber risk has improved but remains outside cautious appetite; recovery capability requires testing.	Service disruption, loss of records access, clinical risk, confidentiality breaches and recovery cost.

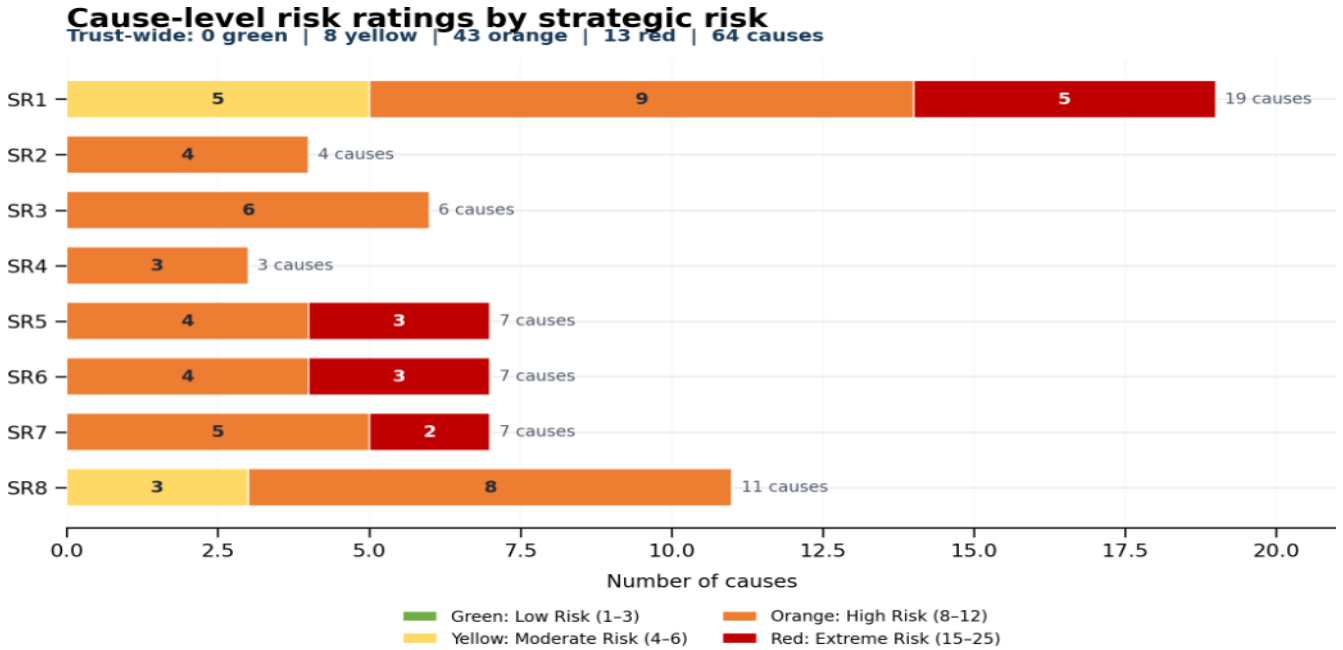


Figure 1. Distribution of active cause ratings within each strategic risk using the agreed Risk Level guide. SR5.8 is scored 8 and SR5.9 is scored 12.

Trust-wide cause profile: 0 green, 8 yellow, 43 orange and 13 red causes. The visual shows both the volume and concentration of exposure beneath each strategic risk.

4.2 Principal movements and changes

Area	Movement	Why the Board needs to know	What is happening
Cyber attack	**15 → 12; moved from SR3.1 to SR8.1**	Controls have strengthened, but exposure remains outside the cautious appetite.	Further work will test recovery, privileged access, supplier assurance and unsupported technology.
Temporary staffing	**Financial cause widened to bank and agency: 9 → 12. Workforce cause reframed: current 16, proposed 8.**	Cost controls do not by themselves assure continuity, staff competence or quality of care.	Finance, workforce and quality reporting will be triangulated.
Leadership and culture	**SR6 consolidated and reframed into seven causes; organisational culture scored 12. Fairness and inclusion transferred from SR5.6.**	Makes involvement, follow-through on concerns, empowerment, inclusion, recognition and capacity for change explicit, strengthening scrutiny of whether culture supports safe care and improvement.	Cultural measures will be refined
Sickness absence	**New cause: 12**	Recognises the impact on capacity, staff and patient experience, and temporary staffing.	Locality hotspots and high-absence cohorts are being monitored.
Strategic workforce plan	**SR5.10 expanded to absorb workforce models from removed SR5.4: current 16, proposed 8.**	The Trust cannot yet show that future workforce supply and skills match service demand.	The 2026–2031 Strategic Workforce Plan is due in quarter 4 of 2026/27, incorporating skills-mix and gap analysis, workforce supply and new roles. The proposed reduction is not evidence of improvement already achieved.
Operational resilience	**New strategic risk**	Cyber, critical systems, business continuity and information governance can disrupt every service.	Audit and Risk Committee oversight and independent testing will be strengthened.
Care pathways and transferred services	**SR1.11 scope clarified; SR1.16 widened to children and adults. SR1.20, SR1.21 and SR5.7 removed from the BAF.**	Changes clarify strategic oversight; removal of a separate cause does not demonstrate reduced access or staffing risk.	Relevant neuro and transferred-service staffing risks move to CYP operational/directorate registers. A separate all-age eating disorder access cause is no longer considered necessary.
Financial and estate causes	**Financial sustainability remains driven by the in-year position, the underlying recurrent gap, temporary staffing and lead-provider responsibilities. Estate causes cover capital investment, maintenance and compliance, and environmental sustainability.**	Makes the financial and estate exposures, including affordability, backlog and delivery dependencies, more explicit.	Committee assurance must demonstrate that capital prioritisation, maintenance controls and Green Plan delivery are reducing the recorded exposure.

Area	Movement	Why the Board needs to know	What is happening
Recruitment and career development	**SR5.1 and SR5.5 substantially developed. Career development: current 15, proposed 6. Removal of staff competition (SR5.2) recommended**	Recruitment and development controls address workforce supply, continuity and succession. Proposed scores must not be presented as achieved reductions.	Targeted recruitment, workforce planning, university/professional partnerships, career pathways and succession controls added. SR5.2 remains low-scored pending evidence; voluntary turnover is 7.3%.
Digital and partnership dependencies	**Digital adoption and benefits realisation are recorded under SR3.8. Transferred-service and partner-data dependencies remain visible across the digital and partnership risks and require further committee assurance.**	Clarifies the dependencies affecting transferred-service delivery and confirms that changes in classification are not evidence of reduced exposure.	Evidence is still required on sustained digital adoption, realised benefits, partner information and residual transferred-service dependencies.

Important interpretation: Reclassification, consolidation or removal of a separate BAF cause does not itself demonstrate reduced exposure. Relevant risks transferred to operational registers remain subject to local oversight. Proposed scores are not achieved reductions, and proposed changes remain subject to review. Retired cause numbers are not reused.

5. What the first cycle has shown

The first cycle has established a scored cause level profile and made the links between strategic risks and the open register more visible. It has also highlighted that control activity and management reporting do not, on their own, demonstrate reduced exposure. Assurance needs to show measurable impact, reliable data and the effect of dependencies across committees and partners. The first full cycle to be reporting to board with each committee assurance summaries will be January 2027.

5.1 Priority assurance questions for the next cycle

Board question	Evidence required	Expected route
Are high-scoring controls reducing risk?	Outcome trajectories, sustained improvement and explanation of residual exposure.	Owning committee assurance summaries.
Are people waiting longest safe?	Triangulation of waiting time, deterioration, incidents, experience and clinical review.	Quality Committee.
Is staffing sufficient and safe where pressure is highest?	Establishment, actual staffing, temporary use, acuity, incidents and patient experience.	People and Quality Committees.
Can the Board rely on reported data?	Validation standards, data limitations and confidence statements for key measures.	Finance, Business & Investment and Quality Committees.
Are partner commitments being delivered?	Named commitments, milestones, exceptions, contingency and partner-owned assurance.	Partnership Committee.
Can essential services recover from major disruption?	End-to-end restore tests, prolonged outage exercises and closure of identified gaps.	Audit and Risk Committee.

6. Next steps

- Each owning committee will complete a concise assurance statement covering movement, the quantitative position, new evidence, impact and overall assurance level following each committee.
- Reporting will distinguish action completion from control effectiveness and measurable outcome change.
- The revised risk management framework, updated risk training and restructuring of InPhase into strategic, corporate and service or operational levels will continue.
- The Audit and Risk Committee will test consistency of assurance and progress towards the agreed maturity expectations.

In December, the Audit and Risk Committee will undertake the first review of how the framework is working across committees. The revised Risk Management Framework, policy, procedure and risk appetite statement will go to the same meeting. In March 2027, maturity will be reassessed against a single evidence test. Both milestones remain on track.

7. The Board is requested to:

- Receive the first Board Assurance Framework report in the new format and note that all causes are scored.
- Note that the overall risk profile remains elevated, with the highest exposure relating to safe, timely and high-quality care, particularly inpatient flow.

- Note the movements in individual risks, including the reduction in cyber risk, increasing temporary staffing exposure and the reframing of leadership and culture risk.
- Confirm the proposed risk appetite for SR6, Leadership and Culture. (Open)
- Accept the time limited assurance gap for SR7 while the Partnership Committee completes its first cycles of review.

Source: BAF V0.9, 17 November 2026.

KENT AND MEDWAY MENTAL HEALTH NHS TRUST

BOARD ASSURANCE FRAMEWORK

Eight strategic risks, aligned to Doing Well Together 2026 to 2031

Version: Final 1.0, 18th November 2026, updated for the November 2026 Board Cycle

VISION

Helping communities stay well and live well with their mental health

MISSION

A proactive, united mental health service for our communities across Kent and Medway.

VALUES

Caring. Inclusive. Curious. Confident.

REPUTATIONAL RISK APPETITE STATEMENT

As a Board we accept that improvement at the pace this Trust needs will attract scrutiny. We will take decisions that are open to challenge where they are evidenced, lawful and in the interests of the people we serve, and we will explain them publicly. We have no appetite for decisions that conceal poor performance, delay the disclosure of harm, or leave the Board unable to demonstrate how it reached a view.

RISK APPETITE

The Board set its risk appetite at the Board Seminar on 6 August 2026 and asked each committee to say whether its risks depart from that position. The committees did so in September. The scale is set out here because the words carry different meanings to different readers.

The scale

- Averse. Avoidance of risk and uncertainty is the overriding objective.
- Minimal. Preference for very safe options. Risk taken only where there is limited possibility of adverse outcome.
- Cautious. Preference for safe options that carry a low degree of residual risk, with limited potential for benefit.
- Open. Willing to consider all options and choose the one most likely to deliver benefit, while providing acceptable assurance.
- Seek. Eager to be innovative and to choose options offering higher benefit, accepting greater inherent risk.
- Mature. Confident in setting high levels of risk appetite because controls, forward scanning and response are robust.

RISK MATURITY

The Board set a maturity target for each risk on 6 August 2026 and the committees tested the targets in September. At Developing, risk, cause and effect are separated and controls are described but not yet assessed. Established requires control effectiveness to be assessed, which this framework first does in the October committee cycle. No strategic risk could therefore evidence Established in September.

- September 2026. Every risk is recorded at 2 Developing, with two exceptions. SR7 is to be confirmed, because the working group discussed 1 Emerging on the ground that the Partnership Committee has not yet met. SR8 has no target, and the Finance and Business Committee is asked to set one (as of today the committee has not met).
- March 2027. 3 Established is the target for SR1, SR2 and SR3. The Audit and Risk Committee will apply a single evidence test to every risk at that point.

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THE STRATEGY THIS FRAMEWORK PROTECTS

Doing Well Together, the five-year strategy approved by the Board on 26 March 2026, sets five True North priorities and seven capabilities that must be strengthened to deliver them. Every strategic risk on this framework exists because it threatens one or both.

The five True North priorities

- Access. Help when you need it. People can get the right mental health support at the right time, close to home wherever they live. Measured by 85% of patients referred to Mental Health Together treated within 18 weeks.
- Safety. Keeping people safe in our care. Measured by improved management of patient harm, outcomes consistent across protected characteristics, and more services accredited to high-quality standards.
- Experience. Positive experiences for staff, patients and families. Measured by staff experience moving towards the best-performing mental health trusts, progress against the EDI plan, and 90% of patients likely to recommend the Trust.
- Resources. Using our time, money and resources wisely. Measured by continued financial sustainability, more time and resource spent on patient care, and progress towards net zero by 2040.
- Prevention. Supporting people with mental illness to live well and stay well. Measured by bed availability, more people helped earlier with fewer crises and avoidable admissions, and fewer known patients needing emergency department care.

The seven capabilities to be strengthened

1. Improving safety and quality measures. 2. Accelerating digital, data and technology-enabled care. 3. Strengthening our workforce. 4. Strengthening leadership, improvement and innovation. 5. Making our estates and infrastructure fit for purpose. 6. Embedding a strong organisational culture. 7. Accessible patient communication and co-creation.

The strategy states that oversight will be strengthened through integration with the Board Assurance Framework, so that strategic priorities and organisational risks are consistently tracked, managed and reported. This document is the mechanism by which that commitment is met.

HOW THIS FRAMEWORK WORKS

The Board holds eight strategic risks. Each statement is fixed for the life of the framework, and the causes beneath it change as pressures change. Anything new is a cause of one of the eight, or an entry on the Corporate or Directorate risk register.

Risk, cause and effect

- Risk. The strategic uncertainty. What could prevent the Trust from achieving a strategic objective. Each begins "There is a risk that the Trust will not...".
- Cause. The underlying driver that makes the risk more or less likely. This is the level at which the Board scores, challenges and assures.
- Effect. The strategic consequence if the risk materialises, across patients, quality, finance, reputation and regulatory standing.
- Rules for causes. Causes move on and off the framework as pressures change. A cause number is never reused once a cause is removed, so the audit trail is preserved (Annex D). Causes are listed separately so that a committee can see which specific issue needs attention, even where several relate to the same theme. Each cause has a named lead who is responsible for delivery and for the evidence that controls are working.

The four assurance columns, and control effectiveness

Controls and assurances answer different questions, and the two gap columns are where the Committee does its work.

- Controls. What is in place to address the cause.
- Control effectiveness. A judgement on whether the control works, rated Effective, Partially effective, Not effective, or None in place. Recording that a control exists is not the same as recording that it works, and the difference is the substance of both 2026 external reviews. Ratings in this draft are the author's and are for confirmation by the risk owner.
- Gaps in control. Where a control does not exist, or exists and is not working. A control that has been in place while the score rose is a gap.
- Assurances. Evidence that the controls are in place, are being followed, and are making a difference. Sources are marked 1st line (management), 2nd line (internal independent) and 3rd line (external).
- Gaps in assurance. Where the evidence is absent, is only 1st line, reports activity rather than effect, or is not seen by the Board.

The committee assurance summary

Earlier drafts closed each risk with an analysis box. It has been removed. Each committee now receives an assurance summary for the risks it owns, prepared on a separate template. The summary records what has changed since the last meeting, the position in numbers, new assurance received, and a level of assurance on the Trust's four-point scale (substantial, reasonable, limited or none). The Risk Manager drafts it before each meeting. The committee agrees it, and it becomes the committee's assurance statement to the Board.

Scoring

Scores for the risks included in the 12 November 2026 InPhase export have been refreshed and are held at cause level. Risk-level inherent and current scores are shown as the highest scoring cause. Executive leads propose scores, the owning committee tests them and the Board signs them off. Scoring is completed using the matrix in the SOP which is based on the NPSA matrix and allows for assessments of consequence across a number of domains.

Roles, and where each risk is seen

Executive leads shape each risk, its causes and its scores. The owning committee tests them and makes a recommendation. The Board takes the decision. Each committee receives only the strategic risks it owns. The Audit and Risk Committee and the Board receive the whole framework. Beyond SR8, which it owns, the Audit and Risk Committee reviews how the framework is working across all committees. It looks for inconsistency, for causes that span committees and may fall between them, and for emerging issues to refer to the right committee. InPhase remains the single record, and each InPhase risk is being linked to the cause it sits under.

THE EIGHT STRATEGIC RISKS

Ref	There is a risk that the Trust will not...	True North priority	Owning committee	Appetite	Highest cause	Causes
SR1	consistently provide timely access to safe, high-quality and compassionate care	Safety, and Access	Quality Committee	Open	20	19
SR2	maintain financial sustainability	Resources	Finance, Business & Investment	Cautious	12	6
SR3	develop and use digital systems, data and technology to improve care and productivity	Resources, Experience	Finance, Business & Investment	Open	16	6
SR4	maintain a safe, therapeutic and fit-for-purpose estate	Experience, Resources	Finance, Business & Investment	Open	9	8
SR5	attract, recruit, retain and develop the right people to sustain its workforce	Experience	People Committee	Open	16	7
SR6	develop the leadership and organisational culture needed to deliver its strategy (interim wording)	Experience, cross-cutting	People Committee	Open	16	7
SR7	work effectively as a partner to deliver integrated care and reduce health inequalities	Prevention	Partnership Committee (shadow, Oct 2026)	Open	16	7
SR8	maintain operational resilience against disruption, including cyber-attack, loss of critical systems and failures of information governance	Resources, cross-cutting	Audit and Risk Committee	Cautious	12	3

SR1. SAFE, HIGH-QUALITY CARE

There is a risk that the Trust will not consistently provide timely access to safe, high-quality and compassionate care.

Strategy alignment: True North: Safety (keeping people safe in our care), and Access (help when you need it). Capability: improving safety and quality measures.
Owning committee: Quality Committee.
Risk appetite: Open
Current position against appetite: The latest InPhase export records 19 SR1 causes, all scored. The highest current score is 20 for inpatient flow.
CQC well-led quality statements: Well-led: governance, management and sustainability; learning, improvement and innovation; shared direction and culture. The risk also engages the safe, effective and responsive key questions.
Independent maturity rating (Quality Governance Review, 23 January 2026): Patient Safety: Lagging. The review cites inconsistent reliability of core safety controls in risk formulation, care planning and Mental Health Act processes, reinforced by the Rapid Review and by the warning notices.
Scores: Inherent (highest contributing cause): 25 (5 x 5). Current (highest contributing cause): 20 (5 x 4), inpatient flow. Target scores vary by cause in the 12 November 2026 InPhase export.
Risk maturity: 2 Developing at September 2026. Target of 3 Established by March 2027.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
SR1		**There is a risk that the Trust will not consistently provide timely access to safe, high-quality and compassionate care.**					
		Caused by:					
SR1.1	**Unwarranted variation in clinical practice, with no quality improvement method consistently embedded across services** *InPhase ID 02290; stage Being Reviewed; current score 16; target 6 by 2027-11-10; review date 2025-12-10; manager Lianne Joyce.* **Risk description:** There is a risk that unwarranted variation in clinical practice, caused by quality improvement methods not being consistently embedded across services, results in inconsistent care and outcomes, leading to avoidable harm, regulatory non-compliance and reputational damage. **Mitigation indicator:** CQC inspection reports rating as Good or Outstanding CQC Mental Health Act Reviews report with minimal actions Quality Improvement Plan evidence of improvement and outcomes	**Primary control** Quality checking **Controls in place** • Trust Quality Improvement Plan, providing structured oversight of improvement activity and progress across directorates. • Patient Safety and Quality Assurance Group, with escalation to Quality Committee. • Learning Review Group, embedding learning from incidents, complaints and reviews. • CQC engagement arrangements, including routine engagement meetings and tracking of regulatory requirements. • Mental Health Act review processes, with	**Gaps in control / further controls** • No single improvement method has been adopted and applied consistently across directorates. • None of the controls is rated for effectiveness, so the Board cannot tell which are working. • Frontline understanding of the CQC quality statements is inconsistent, so "good" is defined differently in different services.	**Assurances** • 1st Line: • Quality Improvement Plan progress reporting to the Patient Safety and Quality Assurance Group • Monthly CQC huddles • 3rd Line: • CQC Well-Led inspection findings, March 2026	**Gaps in assurance** • The current BAF entry records no assurance for this risk. The assurance field is populated with four improvement actions in place of evidence. • No 2nd line assurance on quality governance. • The only 3rd line source is the inspection that identified the weakness.	**Deputy Chief Nurse**	**16**

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
		oversight through MHLOG and MHAC. • Effectiveness: Partially effective. Controls exist across improvement, learning and regulatory engagement, but none are tested for effect.					
SR1.2	**Sustained pressure on inpatient flow, with waits in excess of 12 hours in emergency departments, the community and the place of safety.** *InPhase ID 08065, current score 20, static since July.* There is a risk that sustained pressure on inpatient flow, causing waits in excess of 12 hours for admission to an acute psychiatric ward from emergency departments, the community and the place of safety, results in delayed treatment, avoidable harm and poorer patient outcomes, alongside longer lengths of stay, increased use of out-of-area placements, financial pressure and reputational impact.	**In place** • Support Recovery and Living Well programme, including the accelerated 60-day flow recovery plan. • Daily bed-flow arrangements covering demand, capacity, escalation, discharge trajectories and complex cases. • Acute Discharge Standard Operating Procedure, discharge training and Bed Management Terms of Reference. • Purposeful admission, gatekeeping, Red to Green and length-of-stay review processes. • CRFD review, patient-level escalation and dedicated discharge coordination. • Crisis, home-treatment and liaison	• Controls are extensive, but sustained improvement in flow outcomes has not yet been demonstrated. • Ward practice remains variable across admission, discharge planning, length of stay and escalation. • Delivery depends on housing, social care, community and step-down capacity outside the Trust's direct control. • The CRFD tracker and some recovery interventions are not yet fully implemented or embedded. • There is no confirmed contingency if partner capacity and planned pathways are delayed. • Clinical, operational, analytical and improvement capacity may constrain delivery. • Changes are not yet fully embedded	**First line** • Weekly corridor-care and CRFD reporting. • Daily bed-state, admission-wait and place-of-safety reporting. • Programme dashboard covering delivery, benefits, quality, risks and dependencies. • Monthly IQPR and Strategy Deployment Review reporting. • 60-day plan assurance reporting to EMT. • Patient-level CRFD tracking and escalation. **Second line** • Quality Committee scrutiny of access, safety and patient-flow outcomes. • EMT and programme-board review of delivery, risks and recovery actions. • Trust Strategy Deployment Review oversight	• Action completion is reported more clearly than measurable impact on flow and patient outcomes. • Assurance does not consistently triangulate admission waits, length of stay, CRFD, readmission, out-of-area placements and patient experience. • Measurable benefits have not yet been sustained sufficiently to show that controls are effective. • Limited independent assurance is available on whether admission, ward and discharge controls operate consistently. • Partner-owned assurance on housing, social care and step-down capacity remains limited. .	Chief Medical Officer	20

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
		arrangements supporting admission avoidance. • Local and system escalation with the ICB, local authorities and other partners. **In development** • CRFD tracker recording barriers, actions, owners and escalation. • Discharge marathons, length-of-stay huddles and GIRFT implementation. • Step-down and discharge-to-assess capacity with system partners. • Demand and capacity modelling to determine the sustainable future bed requirement.	into routine operating processes and governance.	of the breakthrough objective. • ICB review of system dependencies and shared actions. **Third line** • GIRFT review and comparison against national standards. • External benchmarking of CRFD, length of stay and bed use.			
SR1.3	**Demand for Memory Assessment Services exceeding Trust and system capacity.** *InPhase ID 00580; stage Approved; current score 12; target 12 by 2027-03-31; review date 2027-01-11; manager Neil Robertson.* **Risk description:** There is a risk that the current Memory Assessment Service model is unable to meet current and increasing demand, causing delays in diagnosis and access to treatment and support, resulting in poorer outcomes for patients and families, continued failure to achieve the Dementia Diagnosis Rate, and increased system, financial and reputational risk.	**Primary control** System wide response to achieve improved Memory Assessment services across Kent and Medway through the Neighbourhood Alliance. **Controls in place** • System-wide response through the Neighbourhood Alliance • Standardised operational oversight within directorates with	Gaps in control / further controls • Phase 2 of original plan is parked for 6 months and the score is at its target of 12, so no further mitigation is planned. • Two actions are red and past their dates; optimisation of the phase 1 model (May 2026) and scoping the effect of the improved diagnosed rate (April 2026).	Assurances **1st line** • Weekly performance review as part of directorate sustainability huddles, with challenge and identification of patients who need closer navigation as well as monitoring of performance by individuals within teams.	**Gaps in assurance** • Dementia diagnosis rate performance across Kent and Medway is not reported to the board.	Deputy Chief Operating Officer	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
	Mitigation indicator: Dementia Diagnosis Rate: target 67%; improved from 60.3% (Sept 2024) to 62.3% (Mar 2026), 63.2% (Sep 2026) but remains below target (SPC showing 11 points above mean). Timely diagnosis: target 95% diagnosed within six weeks; 24.2% achieved (Jun 2026), with performance remaining significantly below target and no sustained improvement demonstrated. Waiting times have reduced from 27 weeks on average to 12.2 weeks (Nov 2026). Further improvement will be linked with community model implementation and demand and capacity modelling for revised MAS teams within CMHF revised model.	named accountability reviewed through the SDR process • Waiting list management policy and standard operating procedure • Community Model Task Force comprising KMMH, wider NHS and VCSE partners • Phase 1 optimisation embedded in weekly sustainability huddles, community model roll-out in Folkestone and Hythe • Effectiveness: partially effective. The score has fallen for reasons outside of the trust's control, in addition to change in workflows, including policies and SOPs, standardisation of the model across MAS services and having been built into operational performance review.	• Demand and capacity modelling is not complete.	• Directorate level SDR reviews performance monthly with countermeasure summaries to address performance **2nd line** • Dementia diagnosis and pre and post diagnosis reporting to community collaborative via neighbourhood working group, DDR reported there			
SR1.4	**Community capacity not matched to demand under the Mental Health Together model and CYP Neuro, with delayed access to assessment and treatment** *InPhase ID 08157; stage Approved; current score 16; target 8 by 2027-03-31;*	**Primary control** Community Mental Health Programme milestone plan and daily/weekly/2 weekly waiting list review at	**Gaps in control / further controls** • The approach to people waiting over 18 weeks is still in development, so the longest waiters	**Assurances** • Team level management • Dashboards • Caseload management tool	**Gaps in assurance** *None recorded.*	Deputy Chief Operating Officer	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
	review date 2026-11-10; manager Neil Robertson. **Risk description:** There is a risk that patients experience delays in accessing timely assessment, treatment and therapeutic intervention, caused by community service capacity and workforce availability not keeping pace with current and projected demand under the Mental Health Together model, resulting in potential deterioration in mental health, increased use of urgent and crisis services, avoidable hospital admission, poorer patient experience and additional pressure across the wider care pathway. **Mitigation indicator:** - 85% of people to start treatment within 18 weeks. - Local understanding of the waiting well needs of people waiting over 18 weeks without regular contact. - 100% of those accepted for assessment of needs has a DIALOG plus completed. - 95% of people have a completed risk assessment in MHT+	service, operational and programme level with mitigations shared with partners **Controls in place** • Daily review of adult community 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. • Caseload reduction actions for MHT and MHT+ • COO operational report meeting agenda referrals, waiting times and caseload; monthly Quality Improvement Plan huddles • DIALOG+ as initial assessment, care plan and baseline outcomes at the point of triage • Weekly Trust-wide safety huddle chaired by the Chief Nurse • Demand and capacity modelling for MHT completed • Demand and capacity modelling for CYP neuro	are the least controlled group. • No control addresses clinical risk held on a waiting list. • Care navigation at the point of access is due 31/12/26 and risk assessment compliance has moved to 31/3/27. Part delivery - Medway and SW Kent. Full delivery subject to community mental health programme dependency. Transformation exposed around 2000 additional referrals a year above the demand model, approx. 4.6%, and MHT activity rose 26% in 12 months. The controls manage the waiting list that is a result of this, but not the demand assumptions that failed.	• Partnership Forums • IPQR • SDR - Trust wide and individual directorates			

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
		completed - system work also underway • Trust strategic objective focusing on reducing the number of patients with long waiting times in MHT / MHT+					
SR1.5	**Inconsistent risk assessment, care planning and therapeutic observation.** *CQC Well-Led finding, March 2026* *Manager– Lianne Joyce* There is a risk that patients do not receive safe, personalised and consistently coordinated care, caused by variation in the quality, completion and review of risk assessments and care plans, resulting in risks not being appropriately identified or managed, inconsistent clinical decision-making, gaps in continuity of care and potential avoidable patient harm.	**Controls:** • Directorate led CRAM training (1a, 1c, 1f) • Weekly CRAM engagement meetings (1h, 1b) • DIALOG+ at the point of triage ETOC programme - led by HON Reporting to Performance & Quality Assurance Group (3a) • BI business partner supporting with CRAM data, supporting performance and quality (1b, 1c) • Staff being advised of upcoming appointments where CRAM is required (1d, 1f) • Weekly monitoring of data quality around recording of review dates (1c) • Quality of completed CRAM being assessed via monthly CRAM audit and quarterly Gather audits (1c) • Trust wide work around risk pathway (2a, 3a)	• Data Quality issues around incorrect review dates being recorded. Although it has been agreed MAS do not have to complete CRAM it is still included in reporting figures. This will be fixed when we move to the new pathways in the new financial year. • Trust level training currently paused, however training plans agreed and being delivered locally in all Directorates. • ETOC programme started but no evaluated outcomes yet	**1st line** • Monthly CRAM audits on Matron's teams channel. (https://nhs.sharepoint.com/:f:/r/sites/msteams_6fcfe7-Matrons/Shared%20Documents/Weekly%20CRAM%20audit%20spreadsheet?csf=1&web=1&e=ZbYT0n) • Quarterly gather audits • Mandatory training report (compliance with CRAM training Dec 25 at 97%) • BI reports • QIP reporting **3rd line** • Independent Rapid Review of a Focused Group of Incidents, November 2025 • External quality governance review January 2026 - gaps in risk and care planning	No gaps in assurance listed	Deputy Chief Nurse	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
		• Outcomes of CQC Well-Led Inspection included in QIP					
SR1.6	**Frequency and severity of self-harm on acute wards, in particular among female patients.** *InPhase ID 07960; stage Approved; current score 16; target 6 by 2027-06-14; review date 2026-12-11; manager Rachael Sanderson.* **Risk description:** There is a risk that an evidence-based and consistent approach to the prevention and management of self-harm is not embedded across admission, inpatient care and discharge, resulting in increased frequency or severity of self-harm, serious injury or death, increased use of observations and restrictive practice, poorer patient experience, and increased regulatory, financial and reputational impact. **Mitigation indicator:** Target: fewer than 60 reported self-harm incidents per month, sustained for 12 consecutive months. The target has not yet been achieved. Monthly female acute inpatient self-harm incidents remain variable, ranging from 41 to 154 during January to September 2026. However, the most recent position shows improvement, with 41 incidents reported in September, the lowest level during this period. A sustained reduction below 60 incidents per month is required before the mitigation target can be considered achieved.	**Primary control** Evidence-based approach to self-harm across three pillars: decisions to admit, inpatient care, and timely discharge. **Controls in place** • Senior clinical shared decision-making on admission requests, informed by NICE guidance, acute versus chronic risk, purposeful admission principles and gatekeeping processes. • Co-produced model of care designed and disseminated across the organisation. • Patient-specific care planning using co-produced formulation, Positive Behaviour Support and personalised risk management, reinforced through MDT review, handover and senior clinical oversight.	**Gaps in control / further controls** • CED/EUPD admission guidance remains at test-and-learn stage in one locality and has not yet been implemented consistently Trust-wide. • The agreed self-harm model of care, including formulation-based care planning and trauma-informed approaches, is not yet consistently embedded across inpatient services. ASH and MRAP have been evaluated and rolled out but are not yet fully embedded. • Pathways supporting people with recurrent self-harm and high levels of distress outside inpatient care, alongside clear ownership of multi-agency discharge planning, require further development.	**Assurances** • Performance and quality • Acute and Trust SDR metrics, including self-harm driver measures and trend/thematic analysis of incidents. • BI dashboard and InPhase reporting to monitor self-harm activity and emerging patterns. • Operational and clinical oversight • Matrons' daily huddles and governance huddles. • Clinical Risk Forum records demonstrating review of high-risk patients and risk/discharge planning. • Governance • Self-Harm Steering Group records providing oversight of improvement activity, trends, learning and actions. • Quality and Patient Safety Assurance Meeting and	**Gaps in assurance** • Need to develop a clearer escalation route for changes in self-harm data patterns (e.g. increasing numbers of male self-harm incidents). • There are discrepancies between data that has been reported in relation to self-harm in different forums. This highlights potential data quality and reporting issues which need to be resolved.	Director of Allied Health Professions and Patient Experience	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
		• Acute Clinical Risk Forum, Executive High-Risk Forum and High Intensity User Pathway provide multidisciplinary review, escalation and support for positive risk-taking and discharge planning. • Senior clinical oversight of discharge barriers and long-stay patients, with multidisciplinary planning to support timely discharge and alternatives to admission where clinically appropriate. • Trust-wide Self-Harm Steering Group, and reporting via the Quality and Patient Safety Assurance Group, SDR, Quality Committee and Board provide oversight of self-harm trends, learning, improvement activity and strategic risk. Effectiveness: Partially effective.	• Identified variation in alarm system effectiveness remains while the Trust-wide replacement programme is completed.	Quality Committee reporting. • Trust SDR oversight of performance and delivery and Board. • Safety assurance • Safety Culture Bundle audits. • Second-line annual environmental ligature audit. • CQC inspections.			
SR1.7	**Violence and aggression, and continued reliance on restrictive interventions** *InPhase ID 07891; stage Approved; current score 12; target 6 by 2027-06-30;*	**Primary control** Restrictive Practice policy and guidance **Controls in place**	**Gaps in control / further controls** • Clinical leadership and programme infrastructure for	**Assurances** • Incident reporting via InPhase • Reporting into Quality and Patient	**Gaps in assurance** • Gap in capturing staff experience through current data collection	Corporate Head of Nursing & Quality	12

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	review date 2027-01-11; manager Shannon Paine. **Risk description:** There is a risk that ineffective prevention and management of violence and aggression results in physical injury and psychological harm to patients and staff, leading to increased restrictive practice, poorer patient outcomes and experience, staff sickness and reduced workforce capacity, with subsequent regulatory and reputational impact. **Mitigation indicator:** Reducing trend in violent and aggressive behaviours within the organisation as evidenced through quarterly reporting.	• Restrictive Practice Framework covering policy, guidance and oversight • Violence Reduction Strategy with aligned workstreams, including inpatient and racial incident reduction • Continuous Improvement approach supporting QI methodology and local intervention • Personal Safety and Security Strategy, including CCTV where available • Compliance with the Use of Force Act and Operation Cavell • Incident reporting and monitoring via inphase. • Safety huddles in place on all inpatient wards. • 90%+ sustained compliance with physical interventions training • Reporting of restrictive interventions rates by ethnicity feeding in to MHAC • Annual Use of Force Act report completed.	restrictive practice reduction require strengthening, including clearer arrangements to support engagement from community mental health services. • Absence of trust PBS framework.	Safety Assurance Group and then to Quality Committee and trust board • CQC inspections also review violence and aggression	methods (improved, but not consistently so to allow us to track improvement)		

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		• Patient and Carer Race Equality Framework workstreams is focused on reducing restrictive practices and detentions for overrepresented ethnicities.					
SR1.8	**Failure to learn systematically from incidents, complaints and concerns, and to hold changes in practice.** *InPhase ID 08643; stage Approved; current score 8; target 4 by; review date 2026-12-10; manager Lianne Joyce.* **Risk description:** Failure to systematically learn from incidents, complaints and concerns and sustain improvements in practice. Cause: Inconsistent identification, triangulation and sharing of learning, with insufficient oversight to ensure agreed actions are embedded and sustained. Effects: Recurrence of avoidable incidents and patient harm. Repeated complaints, concerns and themes. Variation in practice and quality of care. Failure to demonstrate sustained improvement and organisational learning. Reduced Board, regulatory and stakeholder assurance. **Mitigation indicator:** Evidence that learning from patient safety incidents, complaints and concerns is consistently identified, translated into action, implemented and sustained, with a reduction in recurrent themes and harm.	**Primary control** Trust Patient safety plan (PSIRP) with an identified learning review group as part of the PSIRF governance structure. **Controls in place** • Established PSIRF governance including daily incident review, weekly PSIDP, proportionate learning responses, Patient Safety Learning Review Group oversight, Learning from Deaths processes, action tracking, thematic analysis and triangulation of learning with wider quality and patient/carer experience intelligence.	**Gaps in control / further controls** • PSIRP requires review to be updated following further review of systemic learning across all sources including PSIRF/ Patient experience/ Regulatory and other insight data including IQPR and QIP	**Assurances** • PSIRP • Quality improvement plan (QIP) reporting • PSIRF governance including learning review group	**Gaps in assurance** • Out of date PSIRP-plans in place to update and review current plan and review previous priorities, understand if actions have supported sustained improvement and review if priorities need amending.	Deputy Chief Nurse	8
SR1.9	**Variability in clinical leadership and oversight across services and geographies** *InPhase ID 08648; stage Approved; current score 6; target 4 by 2028-05-10; review date 2026-05-10; manager Lianne Joyce.*	**Primary control** Medical and Nursing Professional Structures **Controls in place** • SDR process at directorate and trust level	**Gaps in control / further controls** • No control addresses variation in clinical leadership capability, which	**Assurances** • Staffing establishments • Training compliance	**Gaps in assurance** • Reliability of ESR data vs financial data regarding staffing establishments- new ESR system	Deputy Chief Nurse	6

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Manager *Risk owner is exec lead for associated committee – risk manager is for individual cause*	Current Scoring
	Risk description: There is a risk that clinical leadership and oversight are inconsistent across services and geographical areas, due to variability in leadership capacity, structures and arrangements, resulting in inconsistent clinical practice, reduced assurance and potential impacts on the quality and safety of patient care. **Mitigation indicator:** Clinical leadership vacancies Appraisal ratings at exceeding expectations Training compliance for clinical leadership IQPR and SDR reviews	• Monthly CQC huddles • Establishment reporting • Appraisals and supervision	the inspection specifically identified however strengthened governance processes supports identification of variation in care delivery. • The SDR process is a performance review mechanism and is not designed to assure clinical leadership quality		due over next 18 months		
SR1.10	**Failure to meet mental health act legal requirements, including detention in health-based places of safety beyond the expiry of S136 detention.** *InPhase ID 08647; stage Approved; current score 8; target 3 by 2027-01-29; review date 2026-12-10; manager Gemma McSweeney.* **Risk description:** Failure to meet Mental Health Act legal requirements, resulting in unlawful detention or restriction of patients' rights. Causes Delays in Mental Health Act assessment, decision-making or onward placement. Inadequate monitoring and escalation of Section 136 expiry times. Capacity, pathway or operational pressures affecting timely assessment and disposition. Inconsistent understanding or application of statutory requirements. Effects Patients remaining in a health-based place of safety beyond the lawful Section 136 period. Unlawful deprivation of liberty and infringement of patients' rights. Potential harm, distress or deterioration in patient experience. Legal, regulatory, financial and reputational consequences for the Trust. Reduced assurance regarding	**Primary control** Section 136 HBPoS Standard Operating Procedure and escalation process, providing a standardised system for monitoring the statutory detention period, with defined escalation at four-hour intervals, bed identification/allocation processes, management of breaches and governance oversight. **Controls in place** • Section 136 SOP and escalation pathway, four-hourly monitoring and escalation, daily oversight of prolonged stays, breach incident reporting, Mental Health Act training and requirements for clear documentation of	**Gaps in control / further controls** • Strengthen automated monitoring and escalation of Section 136 expiry/breaches, legal-status and consent/capacity documentation, and the pathway for individuals remaining in HBPoS after expiry, alongside system action to address delays in onward placement.	**Assurances** • Assurance through HBPoS performance and breach monitoring, incident review, Mental Health Act compliance reporting, governance oversight of prolonged stays, training compliance and monitoring of actions arising from CQC findings.	**Gaps in assurance** None recorded.	Head of Nursing & Quality – Acute Directorate	8

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	Mental Health Act compliance and quality of care. **Mitigation indicator:** Reduction and sustained elimination of avoidable Section 136 breaches, with 100% of cases approaching expiry appropriately escalated and all post-expiry stays supported by clearly documented legal status, capacity/consent and rationale. % of Section 136 episodes completed within the statutory timeframe. 100% compliance with required escalation processes. 100% documentation of legal status where the Section 136 period expires. Reduction in the number and duration of HBPoS breaches. Evidence of routine governance review and action on recurrent causes.	legal status following expiry of detention.					
SR1.11	**Under-identification of autistic people and people with learning disability among those accessing or referred to Trust services, so that reasonable adjustments cannot reliably be made** *InPhase ID 08654; stage Approved; current score 12; target 6 by 2027-06-01; review date 2027-02-01; manager George Matuska.* **Risk description:** Due to inconsistent processes for identifying, recording and communicating autism and learning disability needs, alongside gaps in staff awareness and knowledge, there is a risk that autistic people and people with a learning disability are not consistently identified when accessing Trust services, resulting in reasonable adjustments not being implemented, inequitable access to care, poorer patient experience, potential harm and failure to meet statutory equality obligations. **Mitigation indicator:** Recorded flags of autism to be at least 6.5%, and at least 9.6% for learning disability	**Primary control** Digital flags for autism and learning disability implemented across all inpatient services **Controls in place** • LD&A programme structured in 3 workstreams - immediate need, health inequalities and reasonable adjustments - targeted and focussed conversations, with identified leads, to address this risk • Oliver McGowan Tier 2 training completed by over 1/3 of all staff • Reasonable adjustments now show in RiO: A red “RA” near Actions and Overview means	**Gaps in control / further controls** • Recorded flags stand at 1.4% autism and 1.65% learning disability against expected prevalence of 6.5% and 9.6% • Digital flagging covers inpatient services only and most of the contacts are in the community	**Assurances** • 1st line - baseline prevalence analysis • LD&A delivery reporting	**Gaps in assurance** • Identification gap and trajectory are not reported to the Quality Committee or Board. • Training completion is recorded but the effect on reasonable adjustments is not. • No outcome or harm data disaggregated for autistic people or people with a learning disability.	Learning Disability and Autism Lead	12

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		adjustments are recorded on the national flag.					
SR1.12	**Failure to meet the access standard, with people waiting beyond 18 weeks from referral to treatment in Mental Health Together.** *InPhase ID 08653; stage Approved; current score 16; target 6 by 2027-01-21; review date 2027-01-14; manager Neil Robertson.* **Risk description:** Cause: Insufficient capacity and variation in access and flow processes to consistently meet demand and achieve the 18-week referral-to-treatment standard. Effect: People may wait longer for appropriate care and treatment, increasing the risk of deterioration, crisis and poorer outcomes, alongside failure to achieve the 85% access standard. **Mitigation indicator:** At least 85% of people referred to Mental Health Together commence treatment within 18 weeks of referral, with performance achieved and sustained.	**Primary control** Robust waiting-list and access management, supported by standardised triage, weekly access and flow oversight, and demand and capacity monitoring to manage waiting times and prioritise people according to need. **Controls in place** • Redesigned waiting-list management process, supported by a Waiting List Policy and standard operating procedure. • Weekly access and flow huddles to monitor waiting lists, demand, capacity and flow. • Standardised triage and prioritisation to ensure people are managed according to clinical need. • Increased use of digital and telephone assessments to support timely access. • Access and Flow Board oversight of access performance and improvement.	**Gaps in control / further controls** • No consistent Trust-wide control specifically manages performance against the 85% within 18 weeks standard. • Variation in waiting times between localities is not sufficiently controlled. • The approach to people approaching 18 weeks is not yet consistently applied, particularly those waiting over 15 weeks. • No consistent control monitors the clinical risk or potential deterioration of people experiencing the longest waits. • Current improvement activity does not provide a clear trajectory towards achieving and sustaining the 85% standard.	**Assurances** 1st line • Monthly IQPR; Access and Flow Board reports • Weekly access and flow huddles • Daily DNA review and action • Weekly data cleansing and ensuring all appointments have an outcome 2nd line • Reporting to the Quality Committee through Strategy Deployment Reviews • Performance against 38 week wait eradication breakthrough objective • MHT referral volumes: c. 3800 per month received since April 2025 against a full-year forecast of 44,922	**Gaps in assurance** • Performance against the 85 per cent standard reached the Board for the first time in September 2026, at 77 per cent. • No reporting of harm or outcome for the people waiting longest, which repeats the gap at SR1.4. • Improvement is published as a percentage change with no baseline and no trajectory to the standard. • Waiting times reduced by about 10 per cent while activity rose 26 per cent. Neither figure is expressed against the 85 per cent standard, so the Board cannot see distance from target.	Deputy Chief Operating Officer	16

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		• Caseload reduction actions across Mental Health Together and Mental Health Together Plus. • Demand and capacity modelling for community services. • Monthly IQPR monitoring of access and performance.					
SR1.13	**Failure to manage medicines safely, including prescribing, administration, reconciliation and monitoring.** *CQC inspection finding, 2025-2026, and Quality Plan 2026-2027 Priority 2. InPhase ID 8681; Stage Approved; Current score 6; target 4 by 2027-01-12; review date 2027-01-12; manager Jagdip Bahia* If medicines are not safely prescribed, administered, reconciled and monitored due to gaps in systems, practice, competency or oversight, there is a risk of medication error or failure to identify medicine-related harm, resulting in avoidable patient harm, deterioration, serious incidents and regulatory non-compliance.	**Primary control** Medicines management governance, pharmacy oversight, staff competency, audit and quality assurance processes to monitor compliance with safe prescribing, administration, reconciliation and medicines monitoring requirements. **Controls in place** • Trust medicines policies and procedures, pharmacy oversight, electronic prescribing and administration controls, staff training and competency assessment, medicines reconciliation, high-risk medicines protocols, physical health and therapeutic monitoring, audit, incident reporting and medicines governance	• Gaps remain in consistent compliance with medicines management processes, including medicines reconciliation, physical health and therapeutic monitoring, staff competency and timely completion of required checks. Further strengthening of Trust-wide assurance, data triangulation and oversight of recurrent incidents, high-risk medicines and service-level variation is required.	**1st line** • Prescribing incident reporting • Medication safety indicators on the Clinical Outcomes Dashboard **2nd line** • Reporting to CEOG and the Quality Committee **3rd line** • POMH-UK national audit	• Prescribing incident reports fell from 38 to 28 across the year and are published as a 26.3 per cent reduction in medication errors. A fall in reports is not evidence of a fall in errors, and no measure distinguishes the two. • No omitted dose or administration audit is reported to the Quality Committee. • No assurance covers the services named in the warning notices.	Chief Pharmacist	6

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		processes are in place to support safe prescribing, administration and monitoring of medicines.					
SR1.14	**Insufficient staffing capacity in community and crisis services to deliver safe care.** *CQC inspection finding, 2025-2026. BAF InPhase ID 8687; Stage Being Reviewed; Current Score 12; target 6; no review or target dates; manager Louise Saxton* Due to sustained workforce pressures and increasing demand and acuity, there is a risk that community and crisis services have insufficient capacity to deliver safe, timely and effective care, resulting in delayed intervention, reduced responsiveness to deterioration, avoidable harm, increased use of urgent/inpatient services and poorer patient and staff experience.	**In place** • Safer staffing policy • Caseload reduction actions for MHT and MHT Plus, with daily, weekly and fortnightly review at service, operational and programme level • Weekly vacancy control panel for all non-medical vacant posts • Improved Crisis Line staffing and call handling processes **In development** • Demand and capacity modelling for community services **Effectiveness (draft):** *Not effective. The finding concerned capacity. The recorded controls manage caseload allocation and recruitment expenditure.*	• No control establishes a safe caseload threshold for community teams. • Establishment and actual staffing for the services named in the warning notices are not held on this framework. • Workforce supply sits under SR5, which carries no score and no workforce plan, so this cause depends on a risk the Trust cannot currently measure.	**1st line** • Caseload management tool and team-level dashboards • Monthly IQPR workforce metrics	• No safe staffing report for community and crisis services reaches the Quality Committee or the Board. • No assurance links staffing levels to incidents, delayed follow-up or harm. • No 2nd or 3rd line assurance.	Head of Nursing and Quality - East Kent Directorate	12
SR1.15	**Temporary staff deployed in inpatient settings without assurance that they hold the training required to care for patients safely.** *InPhase ID 08644; stage Approved; current score 6; target 3 by 2027-01-11 00:00:00; review date 2026-12-10 00:00:00; manager Shannon Paine.* **Risk description:** Cause: Temporary staff may be allocated to shifts without evidence that they have completed the required training to safely restrain patients, as there is currently no control in place to prevent this. Effect: This	**Primary control** • Oversight of agency deployment is in place. Rostering arrangements in inpatient services. **Controls in place** • Oversight of agency deployment • Rostering arrangements in inpatient services	**Gaps in control / further controls** • No reporting of training compliance for temporary staff to the Quality Committee or the Board. • The only independent source is the inspection that raised the issue.	**Assurances** **1st line** • Agency usage reporting through the monthly IQPR and finance report **3rd line** • CQC well-led feedback, March 2026	**Gaps in assurance** • No reporting of training compliance for temporary staff to the Quality Committee or the Board. • The only independent source is the inspection that raised the issue.	Corporate Head of Nursing & Quality	6

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	could result in patients being restrained by staff who are not appropriately trained or competent, increasing the risk of harm to patients and staff. While agency staffing is controlled in relation to cost under SR2.3 and supply under SR5.3, there is currently no equivalent safety control relating to restraint training. **Mitigation indicator:** There are currently no reported patient safety incidents where a lack of appropriate training among temporary staff has been identified as a contributing factor. This is further supported by positive staff feedback, which indicates confidence that appropriately trained staff are available on each shift.	**In development** • Review of training compliance requirements for temporary staff • Strengthened scrutiny of agency staff rostering					
SR1.16	**Use of out of area placements for children and adults, with people treated away from their local area and support networks.** *InPhase ID 08646; stage Approved; current score 9; target 3 by 2027-01-15 00:00:00; review date 2026-12-10 00:00:00; manager Neil Robertson.* **Risk description:** Cause: Continued demand, flow pressures and delayed discharge are impacting acute inpatient bed capacity. Effect: This may result in continued placements outside the usual pathway and delays in accessing appropriate inpatient care, despite improvements in bed availability and length of stay. **Mitigation indicator:** Children and adults receive care locally, maintaining continuity with their existing support networks and local care teams.	**Primary control** • Purposeful admission methodology and gatekeeping; Red to Green on all wards **Controls in place** • Daily bed flow call covering demand, capacity, escalation and complex cases • Purposeful admission methodology and gatekeeping; Red to Green on all wards • Increased use of alternatives to admission, including crisis houses and home treatment • Expanded step-down capacity and discharge to assess models • Local and system escalation of delayed discharge with the	**Gaps in control / further controls** • Out of area placements are managed as a consequence of inpatient flow. No control holds them in their own right. • No stated tolerance, target or elimination date. • The controls depend on partner capacity, which is held at SR7.2 and is not assured. • The recorded controls were written for adult inpatient flow. None covers placements of children and young people.	**Assurances** 1st line • Out of area placement reporting • Daily bed state; monthly IQPR to public Board 2nd line • NHSE reporting arrangements are in place; however, the data is not currently considered sufficiently reliable to provide robust assurance.	**Gaps in assurance** • Placement numbers, duration and distance are not reported to the Quality Committee as assurance for this framework. • No reporting of outcome or experience for people placed out of area. • No reliable 2nd or 3rd line assurance.	Deputy Chief Operating Officer	9

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		ICB and local authority					
SR1.17	**Failure to review deaths, learn from them and hold changes in practice, including responses to coroners' Prevention of Future Deaths reports.** *InPhase ID 08650; stage Approved; current score 12; target 4 by 2027-01-15 00:00:00; review date 2027-01-15 00:00:00; manager Lianne Joyce.* **Risk description:** Cause: There is a risk that deaths are not consistently subject to sufficiently detailed or timely review, limiting the identification of opportunities for learning and improvement. Effect: This could result in recurring themes, care quality concerns or opportunities to improve patient safety not being identified or acted upon promptly, reducing organisational learning from deaths. **Mitigation indicator:** Learning from every death is identified in a timely manner, effectively communicated across the organisation, and embedded into practice to support sustained improvements in patient safety and quality of care.	**Primary control** • Mortality review processes aligned to national guidance, with all deaths reviewed and 4.1 per cent through structured judgement review **Controls in place** In place • Mortality review processes aligned to national guidance, with all deaths reviewed and 4.1 per cent through structured judgement review • Learning from Deaths (Mortality Review) Group, with reporting to the Quality Committee • Collaboration with the Medical Examiner; alignment with PSIRF and complaints • Participation in LeDeR and NCISH	**Gaps in control / further controls** • 4.1 per cent of deaths receive a structured judgement review and no control states what proportion should. • No control tests whether actions arising from mortality review, or from Prevention of Future Deaths reports, are completed and sustained. • Themes in physical health, communication and risk assessment recur across years, and no control addresses recurrence.	**Assurances** 1st line • Mortality Review Group reporting • Learning from deaths reporting to the Quality Committee 3rd line • Coroners' Prevention of Future Deaths reports • LeDeR and NCISH national programmes	**Gaps in assurance** • The status of actions arising from Prevention of Future Deaths reports is not reported to the Board. • Coroner and PFD themes are recorded as learning, and no assurance demonstrates that the learning has held. • No 2nd line assurance on the mortality review process.	Deputy Chief Nurse	12
SR1.18	**Failure to maintain sexual safety for patients in inpatient and community settings.** *InPhase ID 08651; stage Approved; current score 6; target 3 by 2027-02-19 00:00:00; review date; manager Alison Deakin.* **Risk description:** Cause: There is a risk that appropriate controls and safeguards are not consistently in place to identify, prevent and respond to sexual safety concerns across inpatient and community settings. Effect: This	**Primary control** • Trust-wide Sexual Safety Charter, supported by clear reporting and escalation processes, staff training, risk assessment, safe observation practices and environmental standards.	**Gaps in control / further controls** • Sexual safety is named in the Trust's published account as an area of increased national focus alongside ligature reduction and restrictive practice. Both of those are held on this framework.	**Assurances** 1st line: • Sexual Safety Charter; quality assurance checks; sexual safety information and staff training. 2nd line • Trust-wide Safeguarding Group oversight and	**Gaps in assurance** • Sexual safety incidents are not reported to the Quality Committee.	Head of Safeguarding	6

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	could result in patients experiencing sexual harassment, abuse, exploitation or other sexual safety incidents, leading to physical or psychological harm and a failure to provide safe, effective care. **Mitigation indicator:** Sustained compliance with sexual safety standards demonstrated through quality assurance monitoring, staff training compliance and review of sexual safety incidents and themes.	**Controls in place** In place • Sexual Safety Charter. • Sexual safety posters and information across relevant clinical areas. • Quality assurance visits incorporating sexual safety compliance checks. • Preventing Sexual Harassment training for leaders and managers. • Trust-wide Safeguarding Group oversight and monitoring. • Safeguarding Team support and sexual safety resources.	• Preventing Sexual Harassment training for leaders and managers is not mandatory.	benchmarking against Sexual Safety Charter standards. 3rd line: • National NHS England Sexual Safety in Healthcare Organisational Charter framework.			
SR1.19	**Failure to discharge the statutory duty of candour.** *InPhase ID 08652; stage Being Reviewed; current score 6; target 3 by 2027-02-26 00:00:00; review date; manager Lianne Joyce.* **Risk description:** Cause: There is a risk that the statutory Duty of Candour is not consistently identified, completed and evidenced for all qualifying patient safety incidents, including timely notification and written follow-up. Effect: This could result in patients and families not receiving timely, open and transparent communication following a patient safety incident, leading to loss of trust, poor patient or family experience, and potential non-compliance with statutory requirements. **Mitigation indicator:** 100% compliance with Duty of Candour requirements for qualifying incidents, with timely notification and written	**Primary control** • Duty of Candour process embedded within patient safety incident governance, with identification, notification, written follow-up and completion recorded for all qualifying incidents. **Controls in place** • Established governance for incidents, complaints and duty of candour • Staff training in compassionate communication • Processes strengthened	**Gaps in control / further controls** • No control records the point at which the duty is triggered, discharged and evidenced for each qualifying incident. • No control addresses timeliness of the initial notification or of the written follow-up. • Candour sits inside incident governance and has no owner named on this framework.	**Assurances** 1st line • Incident governance reporting	**Gaps in assurance** • No duty of candour compliance rate is reported to the Quality Committee or the Board. • Audit and feedback are described as strengthening the process, and no audit finding is recorded. • Non-compliance is a breach of a statutory regulation and carries no 2nd or 3rd line assurance.	Deputy Chief Nurse	6

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	follow-up evidenced. Reported via PSIRF through Trust Governance process.	through audit and feedback • PSIRP					
		Resulting in:					
		• People waiting longer than the access standard for assessment and treatment. • Avoidable harm to people using our services. • Inconsistent quality and safety of care across services and geographies. • Failure to meet the CQC fundamental standards, resulting in adverse findings or enforcement action. • Reduced confidence among patients, carers, staff, partners and regulators. • Increased likelihood of legal challenge, with financial and reputational consequences.					

SR2. FINANCIAL SUSTAINABILITY

There is a risk that the Trust will not maintain financial sustainability.

Strategy alignment: True North: Resources (using our time, money and resources wisely). No matching capability is named in the strategy.
Owning committee: Finance, Business and Investment Committee
Risk appetite (Cautious, a departure from Open): Limited financial impact is accepted where there is a benefit for patient care. Material unplanned overspends are not accepted. Small investments to test an opportunity remain possible within this position. The Committee noted that a Cautious financial appetite acts as a check on the Open appetite for estate and digital.
Current position against appetite: No causes outside tolerance
CQC well-led quality statements: Well-led: governance, management and sustainability. Use of resources.
Independent maturity rating (Quality Governance Review, 23 January 2026): No category of the Quality Governance Review covers financial sustainability. This risk carries no independent maturity assessment.
Scores: Inherent (highest contributing cause): 20 (4 x 5). Current (highest contributing cause): 12 (3 x 4), two causes. Target: to be set when the Committee tests causes in October 2026.
Risk maturity: 2 Developing at September 2026. The Committee proposed 3 Established, which is recorded as the target for March 2027.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR2	**There is a risk that the Trust will not maintain financial sustainability.**						
	Caused by:						
SR2.1	There is a risk that the Trust will not deliver its agreed in-year financial position. Expenditure above planned levels, income below planned levels, or savings shortfalls and implementation delays, with insufficient in-year mitigation to offset their financial impact. An adverse variance against the agreed year-end financial position, increasing pressure on Trust and system resources and reducing financial flexibility.	**In place** • Approved annual financial plan and delegated budgets • Monthly statements to budget holders • Monthly budget monitoring and forecast review with recovery actions to address identified shortfalls • Standing Financial Instructions • Cost Improvement Programme process • Trust Capital Group oversight; Business Case Review Group • Executive review of financial performance and delivery risks • A monthly forecast and mitigation tracker in place showing approved actions and benefits against the plan.	• Financial pressures and dependencies outside the Trust's direct control are identified • Identify any impact on plan delivery is sensitivity-tested, and deliverable are agreed, with residual risks escalated where they cannot be fully mitigated. • Arrangements for identifying implementation dependencies, assessing the financial impact of delays and agreeing mitigations to protect in-year savings delivery are not recorded.	**1st line** • Documented Executive-led budget and forecast reviews, evidencing validation of key assumptions, explanations for material movements, agreed corrective actions and follow-up. • Monthly finance and CIP reporting showing actual and forecast performance against the agreed annual plan, finance-validated savings and mitigation benefits delivered, and the remaining forecast gap. • Sensitivity analysis showing the impact of material pressures and dependencies, the deliverability of proposed mitigations and residual exposure. **2nd line** • Recorded Finance, Business and Investment Committee conclusions on forecast credibility, savings and mitigation	• Arrangements for identifying external financial pressures, sensitivity-testing their impact and agreeing deliverable mitigations are not fully recorded.	Deputy Director of Finance	8

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
				delivery, with follow-up of challenges, actions and escalations. • Relevant internal audit findings on financial management, forecasting and CIP controls, including the review date, assurance opinion and progress against recommendations. **3rd line** Documented regional NHS England assessment of financial performance, forecast credibility and recovery arrangements, including outstanding concerns and required actions.			
SR2.2	A structural mismatch between recurrent income and expenditure, with insufficient recurrent savings, leaving an underlying gap, alongside separate cash and capital funding constraints. Recurrent expenditure exceeding recurrent income and insufficient recurrent savings to close the underlying gap. Cash availability and inadequate capital funding may constrain delivery independently of the deficit and require separate assessment. A persistent underlying deficit and reduced financial resilience, potentially limiting cash available to meet commitments and capacity to fund capital investment and service priorities. Cash and capital funding constraints may also limit delivery where the in-year plan is achieved.	• **Approved medium-term financial planning,** integrating service, workforce and investment plans and setting out the underlying deficit, recurrent savings requirement and trajectory towards recurrent balance, with regular review and corrective action. • **Executive-led sustainability programme, with named owners**, delivery milestones and management of implementation dependencies, reviewing progress towards closing the recurrent gap and escalating shortfalls requiring further decisions. • Recurrent CIP approval and delivery controls, including finance validation of net recurrent benefits, quality-impact assessment, delivery tracking and corrective action, distinguishing recurrent savings from non-recurrent measures and avoiding double-counting.	• Capital availability: Assurance that sufficient capital funding is available to deliver the Trust's investment priorities, including the impact of funding shortfalls and proposed mitigations, is not recorded. • External pressures and dependencies: Evidence that mitigations address changes in funding, external pressures and implementation delays affecting medium-term sustainability is not recorded • Scenario and sensitivity testing of the medium-term position, assessing demand and cost pressures, funding assumptions and recurrent savings	1st line • Medium-term financial plan updates showing the underlying recurrent position, progress against the agreed trajectory towards recurrent balance, and the remaining gap. • Finance-validated recurrent savings and sustainability programme reporting, showing benefits delivered against plan, implementation milestones, dependencies and corrective actions, separately identifying non-recurrent measures. • Documented scenario and sensitivity analysis showing the resilience of the medium-term plan to funding changes, cost pressures and savings shortfalls, including agreed responses and residual exposure. • Cash-flow reports showing forecast balances, funding requirements, material movements and actions to address emerging shortfalls. • Capital reports showing expenditure and commitments against	Capital availability: Future capital funding remains subject to confirmation, limiting assurance that the Trust's medium-term investment priorities can be delivered. External pressures and dependencies: Assurance on the effectiveness of mitigations for changes in funding, external pressures and implementation delays remains to be demonstrated.	Deputy Director of Finance	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		• **Cafsh-flow forecasting,** identifying funding requirements and emerging shortfalls, reviewing receipts and commitments, and escalating action needed to meet financial obligations. • **Capital programme prioritisation and approval**, aligning commitments with confirmed funding, forecast cash availability and whole-life revenue costs, with review of funding dependencies and escalation of unfunded priorities. • **Sustainability Review**: Use of SLR and national costing returns to understand VFM of the services.	shortfalls, with agreed responses and escalation of residual risks.	confirmed funding and forecast cash availability, whole-life revenue implications, and unfunded priorities requiring decisions. 2nd line • Recorded Finance, Business and Investment Committee conclusions on the credibility and deliverability of the sustainability trajectory, recurrent benefits, cash and capital affordability, with follow-up of actions and escalations. • Relevant internal audit findings on financial planning, recurrent savings validation, cash management and capital controls, including the review date, assurance opinion and outstanding recommendations. 3rd line • Documented NHS England assessment of the medium-term financial plan and recovery arrangements, including funding assumptions, outstanding concerns and required actions, where available.			
SR2.3	Temporary staffing expenditure above funded assumptions. Vacancies, sickness absence and recruitment difficulties creating gaps in substantive staffing and reliance on bank and agency expenditure above funded assumptions. Workforce supply drivers are held under SR5, including SR5.3; SR2.3 addresses the associated financial exposure. Staffing expenditure above plan, placing pressure on financial sustainability and reducing resources available for service priorities. Temporary staffing use within funded assumptions is not,	**In place** • Prior authorisation of medical agency expenditure through Executive sign-off, with CEO approval required for above-cap rates. • Prior approval of agency shifts; retrospective approval is not permitted. • Weekly agency expenditure reporting and monthly workforce control panel for all non-medical vacant posts, providing management challenge of expenditure and recruitment decisions. Assessment of temporary-cover costs, corrective action and escalation requires confirmation.	• Bank usage: Arrangements for approving, challenging and escalating bank usage are not recorded.	**1st line** • Documented approval and exception records, demonstrating compliance with agency authorisation requirements. • Finance-validated staffing reports, showing bank, agency and total staffing expenditure against funded assumptions, explaining changes in usage, rates and substantive costs, and identifying the remaining forecast exposure. • Recorded management reviews and workforce control panel decisions.	• Improved FBI reporting required • Potential NHSE sanctions are noted in the risk as unconfirmed, and no assurance tracks that exposure. • The CQC identified that temporary staff may not hold the training required to restrain patients safely. That is a	Chief Medical Officer	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	by itself, evidence of financial failure.	• Monthly Executive-led directorate management reviews of agency usage, supported by QPR meetings. *Arrangements for agreeing corrective actions, following up delivery and reviewing combined bank, agency and substantive staffing costs require confirmation.* • Appointed medical recruitment lead for hard-to-recruit areas, addressing workforce supply drivers linked to SR5. • Recruitment and retention premium for consultant posts in the East and testing of a virtual consultant post, linked to SR5. Net financial benefits should be assessed against the additional substantive costs and any reduction in temporary-cover expenditure. **In development** • CYP Recruitment Strategy, owned by the Deputy Chief Medical Officer, due 31 March 2027		**2nd line** • Recorded Finance, Business and investment committee on present position and forecast exposure. • Relevant internal audit findings on temporary-staffing authorisation, expenditure controls and reporting, including the review date, assurance opinion and outstanding recommendations. **3rd line** Documented NHS England assessment, of temporary-staffing expenditure, including outstanding concerns and required actions (linked to planning submission).	named quality consequence of agency use and it is assured nowhere. • Linked workforce and quality committee conclusions, providing assurance that financial measures remain consistent with safe staffing and temporary-staff training requirements.		
SR2.4	Commissioning and lead-provider responsibilities, delegated authority, funding and financial risk-sharing not fully agreed or documented. Commissioning responsibilities, delegated authority, funding and financial risk-sharing arrangements not fully agreed or documented. Exposure to unfunded commitments, disputed costs and unclear accountability, placing pressure on financial plan delivery and service priorities.	**Oversight in place; further work required** • CFRO oversight, supported by the Contracts team, of commissioning and lead-provider contractual and financial arrangements. Further work will confirm the coverage and operation of existing controls and identify any strengthening required.	• Review existing arrangements to confirm responsibilities, delegated authority, funding and financial risk-sharing are appropriately documented. • Confirm approval and escalation arrangements for unresolved funding or contractual matters. • Capture any improvements identified through the review, with agreed actions and timescales.	1st line • CFRO and Contracts team review of agreements, financial exposure and outstanding actions. 2nd line • Finance, Business and Investment Committee scrutiny of review findings and material exceptions. 3rd line • Relevant written commissioner confirmations or external assessments, where available.	Under review: Bring together the supporting evidence and review findings to confirm that existing controls are operating as intended, with any residual issues reported through the agreed assurance route.	Deputy Director of Finance	9

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	Resulting in:						
	• Inability to deliver core services and health outcomes within available resources. • Financial deficit, and insufficient cash to fund future capital programmes. • Intervention and sanction by NHS England. • Adverse impact on the wider ICS financial position. • Reduced capacity to invest in workforce, estate and digital infrastructure.						

SR3. DIGITAL, DATA AND TECHNOLOGY

There is a risk that the Trust will not develop and use digital systems, data and technology to improve care and productivity.

Strategy alignment: True North: Resources, and Experience. Capability: accelerating digital, data and technology-enabled care.
Owning committee: Finance, Business and Investment Committee
Risk appetite (Open): The Trust is willing to consider all options for digital development and choose the one most likely to improve care and productivity. Information Security remains Cautious and sits under SR8.
Current position against appetite: Not currently measurable. None of the six causes carries a score now that cyber-attack has moved to SR8, and four carry no control.
CQC well-led quality statements: Well-led: governance, management and sustainability; learning, improvement and innovation.
Independent maturity rating (Quality Governance Review, 23 January 2026): Digital, Data and Insight: Lagging. Assurance is materially constrained by data quality, fragmented reporting architecture and manual workflows.
Scores: Inherent: not recorded in this section. Current (highest contributing cause): 9, recorded for SR3.2, SR3.4, SR3.5 and SR3.6. Target: not recorded in this section. The inherent and target scores will be completed after the Committee has met and tested the scores.
Risk maturity: 2 Developing at September 2026. The Board set 1 Emerging on 6 August, which was not agreed. The Committee proposed 3 Established, which is recorded as the target for March 2027. Members described known gaps in third-party management and interoperability.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR3	**There is a risk that the Trust will not develop and use digital systems, data and technology to improve care and productivity.**						
	Caused by:						
SR3.2	**Delay in integrating CYP/AAED services into KMMH.** Continued reliance on NELFT for CYP/AAED digital services following transfer on 1 April 2026 may hinder integration with adult services and delay KMMH taking responsibility for reporting and performance data.	**In place** CYP/AAEDS Migration Programme Plan covering Technology, Clinical Systems and Business Intelligence. *Control effectiveness to be confirmed from milestone delivery and acceptance evidence.*	**Under review:** Confirm ownership, milestones and acceptance criteria across the three migration workstreams, together with interim NELFT service, data-sharing and exit arrangements. These are confirmation questions, not findings that controls are absent.	**1st line:** • Monthly progress updates against the migration plan. **2nd line:** Digital reporting to the Finance, Business and Investment Committee and separate reporting to the CYP/AAEDS Committee	The update identifies no assurance gap. Confirm evidence of milestone acceptance, reporting-data validation and management of residual NELFT dependencies; progress reporting alone does not demonstrate successful integration.	Director of Digital and Performance	9
SR3.4	**Insufficient digital literacy, capability and skills.** Without improved digital literacy across the Trust, staff may struggle to use clinical and productivity systems effectively, contributing to poor data quality and continued overuse of progress notes.	**In place** Digital Literacy Toolkit supporting self-assessment against role-specific minimum skills and signposting to online learning; basic training by the Digital training team; ad hoc Rio training. Rio access for new starters is conditional on completing training.	No requirement for Rio refresher training is recorded; mandatory training applies on joining. **Under review:** Confirm the response to low-confidence areas identified by the digital skills audit, including role-specific support, ownership and review dates.	**1st line:** • Records demonstrating that new starters receive Rio access only after completing Rio training; digital skills audit identifying reported confidence and support needs. **2nd line — to confirm:**	The update identifies no assurance gap. Initial training evidence does not establish sustained proficiency: confirm evidence of improved skills, appropriate use of clinical systems and reduced data-quality issues, linked to SR3.3.	Director of Digital and Performance	9

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
				The route for scrutiny of skills improvement and associated data-quality outcomes.			
SR3.5	**Digital funding and specialist capacity not aligned with the requirements of the digital plan.** Constraints in available funding, specialist skills or recruitment could limit the Trust's ability to deliver its digital priorities while maintaining core digital services, delaying improvements in care and productivity.	**In place** • Business-case and vacancy-panel approval processes for additional digital investment and staffing. • Additional CYP/AAEDS resource requirements identified through a business case following transfer to KMMH. • Additional cyber, network and field-engineering posts approved, with recruitment underway and recruitment difficulties remaining.	**Under review:** Confirm the funding and specialist capacity required to deliver the digital plan alongside business-as-usual commitments, including recruitment dependencies, prioritisation and any interim arrangements needed while approved posts remain vacant.	**1st line** • Documented business-case and vacancy-panel decisions, supported by recruitment and resource reporting showing capacity against delivery requirements and implications for milestones. • Digital programme reporting identifying resource dependencies, agreed responses and remaining delivery exposure. **2nd line** • Finance, Business and Investment Committee conclusions on the affordability and deliverability of the digital plan, including material resource constraints and action follow-up.	**Under review:** Bring together evidence that approved resources are available and sufficient for agreed priorities, with unresolved constraints and their delivery implications reported through the digital assurance route.	Director of Digital and Performance	9
SR3.6	**Data quality insufficient to support clinical care, operational management and Board assurance.** Poor data quality can limit the Trust's understanding of its performance and create patient safety risks when staff cannot easily locate important patient information. It can also affect staff across the system who cannot access important patient information through KMCR.	**In place** • Trust-wide Data Quality Improvement Plan • Directorate-level data quality leads • Data Quality Group, with monthly data quality reporting through SDRs • Enhanced validation processes within clinical systems • Near real-time operational BI dashboards, with Business Intelligence Partners supporting service directors to improve data quality.	• Under review: Confirm validation standards and exception handling for data relied on for clinical decisions and Board assurance. • Under review: Confirm the Data Quality Group reporting line and whether the separately named Digital and Data Quality Group is the same forum, with clear escalation and accountability. • Under review: Confirm validation	**1st line** • Data quality dashboards and Data Quality Group review of key concerns; evidence of validation, issue resolution and residual limitations to be brought together. • Monthly reporting through SDRs **2nd line** • Reporting to the Quality Committee **3rd line** • MHSDS Data Quality Maturity Index, improved to 91.5%	• A single national index is the only external measure, and it covers dataset completeness rather than the quality of the clinical record. • No assurance addresses the reliability of the specific data used elsewhere on this framework. Every other risk is assured using figures the Trust has said are limiting.	Director of Digital and Performance	9

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		.	and accountability for data drawn from NELFT platforms during migration of CYPMH and AAED services. • The Executive Management Team describes multiple versions of the truth. RiO scanning and uploading is inconsistent and statutory processes remain partly paper based.	Quality Governance Review, 23 January 2026: Digital, Data and Insight rated Lagging	• Confirm the Data Quality Group reporting route and linked conclusions on clinical-record quality and the reliability of Board-reporting data. The updated source identifies the reporting line as unclear; a forum name alone is not evidence of effectiveness.		
SR3.8	**Failure to sustain digital adoption and realise the intended benefits.** Technology alone does not transform organisations; transformation depends on its adoption. The Trust needs capacity to identify, test and adopt digital innovation, including artificial intelligence, and to sustain the use of key improvements well beyond initial implementation so that they deliver benefits for care and productivity.	**In place** Digital project management includes early-life support and handover to business-as-usual support, with a suitable SRO for each project, often outside Digital. Digital clinicians work with Digital teams on design and implementation. Where appropriate, Business Analysts translate clinical requirements and redesign business processes.	Alignment of Trust transformation and digital transformation projects is being strengthened through new governance arrangements under design. **Under review:** Confirm benefits ownership, post-implementation review and the approval route for innovation. Supplier cyber assurance is addressed separately at SR8.10.	**1st line:** • Project Board and • Digital and Data Strategy Group reviews of implementation, handover and adoption. **2nd line:** • Finance, Business and Investment Committee scrutiny. Dated conclusions on sustained use and benefits, rather than implementation activity alone, require confirmation.	**Under review:** Confirm evidence of sustained adoption and realised care and productivity benefits, and completion of the revised transformation governance arrangements. Project and committee names identify routes, not assurance conclusions.	Director of Digital and Performance	9
SR3.9	**An insufficiently developed or aligned digital delivery plan.** A strategic digital plan aligned with the Trust's ambitions is needed to embed digital into delivery, particularly to improve access, deliver virtual care and enable a more proactive approach through automation and integration.	**Under review:** Digital and Data Strategy Group oversight is identified. The existing Digital and Data Strategic Plan has expired; arrangements and milestones for refreshing it against the new Trust strategy require confirmation. Approval routes are not a substitute for a current delivery plan.	The Digital and Data Strategic Plan has expired and has not been updated since the new Trust strategy was published. Confirm the refresh lead, approval timetable, prioritised roadmap, resource dependencies and delivery milestones.	**1st line:** • Digital and Data Strategy Group review of the plan. **2nd line:** • Finance, Business and Investment Committee scrutiny and Trust Board consideration. Dated findings, decisions and follow-up require confirmation.	**Under review:** Bring together evidence of strategic alignment, an agreed delivery timetable and subsequent delivery against milestones. The updated attachment supplies reporting routes but no dated assurance conclusion for the refreshed plan.	Director of Digital and Performance	8
	Resulting in:						
	• Inability to deliver the productivity ambitions in the strategy.						

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	• Clinical and operational decisions made on data that is not dependable. • Staff time lost to manual workflows and to systems that do not connect. • Digital investment that does not deliver its intended benefit. • Continued dependence on platforms the Trust does not own or control.						

SR4. A SAFE AND THERAPEUTIC ESTATE

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

Strategy alignment: True North: Experience, and Resources. Capability: making our estates and infrastructure fit for purpose.
Owning committee: Finance, Business and Investment Committee
Risk appetite (Open): The Trust is willing to consider all options for its estate and choose the one most likely to deliver benefit. The Committee noted that large investment in estate the Trust owns calls for a more careful approach than leased estate.
Current position against appetite: In tolerance on both scored causes, as recorded on InPhase. The entry for 08146, previously recorded as in appetite, has been corrected. Six of the eight causes carry no score.
CQC well-led quality statements: Well-led: governance, management and sustainability; environmental sustainability. The risk also engages the safe key question in respect of premises and equipment.
Independent maturity rating (Quality Governance Review, 23 January 2026): No category covers the estate directly. Buildings and premises is one of the four regulation breaches cited in the April 2025 warning notice for community services.
Scores: Inherent (highest contributing cause): 16 (4 x 4). Current (highest contributing cause): 9 (3 x 3), two causes. Target: to be set when the Committee scores causes in October 2026.
Risk maturity: 2 Developing at September 2026.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Scoring
SR4	**There is a risk that the Trust will not maintain a safe, therapeutic and fit-for-purpose estate.**						
	Caused by:						
SR4.1	**Inability to invest in refreshing the estate.** Risk: The Trust may be unable to achieve the improvements required to create functionally suitable accommodation that supports safe, therapeutic care of sufficient capacity in the right locality. Cause: (1) Capital funding availability and programme-delivery constraints may delay or prevent priority schemes. (2) Access to system and partner neighbourhood health accommodation of suitable quality and capacity in the right locality. Effect: Unsuitable clinical and workplace accommodation may remain in use, constraining service capacity and increasing maintenance costs and exposure to adverse premises findings. This entry addresses renewal, replacement and improvement; SR4.2 addresses maintenance and compliance.	**Operating controls and proposed improvements** • **Capital prioritisation and oversight:** The multidisciplinary Capital Working Group prioritises schemes; Trust Capital Group oversees cost, risk and programme delivery within approved funding envelopes. • **Capital programme planning:** A five-year rolling capital programme that uses condition surveys and services priorities to inform investment. • **Proposed accommodation improvements:** Clinical and Estates co-design, design methodologies and annual estate priorities informed by both clinical activity priorities and estate condition surveys form strategic investment plan for the estate. • **Funding:** Annual bid submission to NHSE	• funded milestones, • prioritisation decisions record, • interim mitigations for deferred or unfunded schemes,	**1st line** • Capital-delivery reports showing progress against approved priorities, funding and programme exceptions. • Condition-survey findings, PLACE results and ERIC benchmarking informing investment priorities and care-environment review. **2nd line** • Identified route: Finance, Business and Investment Committee reporting on capital prioritisation, delivery and residual exposure.	• Under review: Confirm evidence of risk reduction from investment and residual exposure in deferred schemes. • Confirm current survey and PLACE evidence, aligned scheme acceptance dates and relevant committee conclusions.	Director of Estates and Facilities	9

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Scoring
		Estates Safety Fund to target backlog.					
SR4.2	**Inability to maintain the estate to a safe and compliant standard.** Risk: Premises, engineering systems or facilities may fail and become unsafe, non-compliant and unavailable for use. Cause: Asset deterioration, outstanding maintenance, incomplete remediation of identified defects, insufficient resourcing or funding of maintenance activities including cleaning. Effect: Environmental hazards, loss of service capacity, increased costs and adverse regulatory findings may arise.	**Operating controls** • **Maintenance delivery and contract management:** Hard and Soft FM specifications, regular contract reviews and KPI monitoring govern maintenance delivery. Computer Aided Facilities Management (CAFM) system manages asset-based planned preventative and statutory maintenance. • **Workload and service-availability management:** Daily operational management and response though Helpdesk monitoring together with monthly service quality performance service management reporting and review, bi-monthly Wider Senior Management Team reviews, quarterly support-services QPR reviews, backlog prioritisation and service continuity plans support management of service disruption.	. • Confirmation of high-risk backlog tolerances, • Clinical escalation and the impact of temporary expenditure controls on safety, workload and backlog.	**1st line** • Management monthly maintenance and compliance reports showing delivery against KPIs, overdue work and material exceptions; contract-review records and corrective-action tracking. • Cleaning-audit and fire-safety review findings, with action follow-up. **2nd line** • Identified route: Finance, Business and Investment Committee reporting on maintenance and compliance exceptions; relevant internal audit findings where available and within scope.	• Under review: Confirm statutory-reporting scope and data definitions, and closure evidence for material maintenance, cleaning-audit and KMMAH engineering exceptions. • Confirm the safety impact of expenditure controls, relevant committee conclusions and maintenance-specific audit evidence; the ligature-data opinion at SR4.3 does not cover maintenance.	Director of Estates and Facilities	9
SR4.8	**Failure to deliver the Green Plan and the Trust's environmental sustainability commitments.** Risk: The Trust may not deliver its Green Plan and environmental sustainability commitments. Cause: Gas-demand pressures and funding or delivery dependencies may limit progress against the emissions trajectory and planned decarbonisation work. Effect: Progress towards the Trust's net-zero	**Operating arrangements and proposed improvements** • **Monitoring and reuse:** Waste and utilities monitoring tracks performance; WARPit supports reuse. Solar and EV strategy is underway. • **Proposed investment approach:** The draft estate plan includes sustainability-led investment, fabric-first design and further	• Green Plan ownership, • review arrangements, • emissions trajectory. • Reconciliation of solar coverage and EV installation totals/status • Confirm cause lead and scoring, delivery dependencies and climate-adaptation priorities.	**1st line:** • Waste, utilities, reuse and project reports showing performance, delivery and exceptions relevant to Green Plan commitments. **2nd line:** • Finance, Business and Investment Committee biannual Green Plan reporting	• Under review: Validate utility and emissions baselines, reconcile solar/EV figures, and confirm evidence of sustained progress against the trajectory with relevant committee conclusions.	Director of Estates and Facilities	8

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Scoring
	ambition may be delayed and the intended environmental and resource benefits may not be realised. Waste and reuse benefits do not, by themselves, close the emissions gap.	decarbonisation projects. Implementation status remains unconfirmed. • **Green-space arrangements:** The draft plan includes Green Space Group involvement and proposed maintenance and ownership plans. Their operating status and contribution to Green Plan delivery remain unconfirmed.		on sustainability progress.			
	Resulting in:						
	• Clinical and workplace environments that are not fit for purpose. • Loss of services and of operational capacity. • Avoidable harm arising from the physical environment, including ligature incidents. • Adverse regulatory findings in respect of premises and equipment. • Increased revenue cost of maintaining an ageing estate, displacing investment elsewhere.						

SR5. A SUSTAINABLE WORKFORCE

There is a risk that the Trust will not attract, recruit, retain and develop the right people to sustain its workforce.

Strategy alignment: True North: Experience (positive experiences for staff, patients and families). Capability: strengthening our workforce.
Owning committee: People Committee
Risk appetite (Open): The Trust is willing to consider all options for its workforce and choose the one most likely to deliver benefit. The position moves from Seek. The Committee noted that decisions in practice are often more cautious than Open, and that work is needed for the Trust to operate at this level.
CQC well-led quality statements: Well-led: workforce equality, diversity and inclusion; capable, compassionate and inclusive leaders; freedom to speak up; shared direction and culture.
Independent maturity rating (Quality Governance Review, 23 January 2026): Workforce, Learning and Development: Developing. Enablers are strengthening while service pressure, supervision quality and change fatigue limit capacity to embed improvement.
Scores: Inherent (highest contributing cause): 20 (4 x 5). Current (highest contributing cause): 12 (3 x 4), temporary staffing, shared with SR2.3 until InPhase 07557 is split.
Risk maturity: 2 Developing at September 2026.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR5	**There is a risk that the Trust will not attract, recruit, retain and develop the right people to sustain its workforce.**						
	Caused by:						
SR5.1	**National shortage of key clinical roles, in particular medical and registered nursing staff.** *Identified June 2026. InPhase ID 8689.* There is a risk that the Trust may be unable to attract staff with the right mix of skills, both now and in the future, due to national shortages of the required skills. Jobseekers may be unwilling to relocate or commute to work in the region, or there may be too few students training in the relevant areas to meet the community's future needs. The Trust requires a broad range of skills, including those of healthcare support workers, clinical digital experts, AHPs, social workers, nurses and OTs. Some or all of these skills may be in short supply at any given time **Current Score:** C4xL3= 12 Moderate **Target Score:** C4xL2 = 4 Moderate	**In place** • Medical lead for recruitment appointed to support hard-to-recruit areas • Recruitment and retention premium for consultant posts in the East **In development** • Targeted recruitment campaigns for hard to fill roles commissioned through Workforce Control Panels • Reinvigorate work experience / open days opportunities to showcase the range of roles available in the Trust • Partner with professional bodies, colleges, jobcentres, and universities to offer work placements for roles with scarce skills (e.g. dietetics) • Strategic Workforce plan for 2026 – 31 in development	• The controls sit within a financial risk owned by the Chief Medical Officer, and are framed as expenditure control rather than workforce supply. • No workforce plan is recorded on the BAF. • The vacancy control panel restricts recruitment; it does not increase supply. No target is set for skillsets needed per FY. Recruitment based on vacancies rather than skills gas or opportunities	**1st line** • Monthly IQPR workforce metrics • Published workforce position: vacancy rate 10.3% against a 14% target, turnover 12.3% against a 16.5% target, both improving in year • Create and maintain a list of "hard to fill" roles for FY – monitor progress in filling those roles on quarterly basis • VCP has been repurposed as the Workforce Control Panel (WCP) with a broader remit than approving vacancies. **2nd line** • CPO Provider Alliance workstream **3rd line** • Quality Governance Review, 23 January 2026: Workforce, Learning and Development rated Developing • Monthly PWR reporting to NHSE	• Both published measures sit inside target and are improving, and neither measures this risk. Vacancy and turnover describe headcount stability. They do not describe supply of shortage roles, capability, or the establishment gap inherited on the CYPMH and AAED transfer. The Committee should expect the published figures to be used to argue that SR5 is not strategic. • No TORs exist for WCP • Gaps in assurance can be assessed versus strategic workforce plan once completed.	Recruitment and Temporary Staffing Manager	12

		Effectiveness (draft): *Not effective. The controls restrict recruitment expenditure; they do not increase supply.*					
SR5.2	**Competition for staff from other providers, including pay differences across the county boundary.** *Clarified at the People Committee session, 15 September 2026. To be held at a low score while evidence is gathered.* InPhase ID 8688 **Proposed for closure – voluntary turnover is green (7.3%) and run rate has been below 8% for 18 months**	**Not in place** • No control is recorded on the current framework. **Effectiveness (draft):** *None in place.*	• No recorded control, owner or timescale. • No system-level workforce agreement is recorded, despite the Trust operating in a market with defined competitors.	*None recorded.*	• No assurance route exists for this cause. • No evidence has yet been gathered on where leavers go or on pay differences with neighbouring providers.	Recruitment and Temporary Staffing Manager	*Clarified at the People Committee session, 15 September 2026. To be held at a low score while evidence is gathered*
SR5.3	**Reliance on agency and temporary staffing to fill establishment, with consequences for continuity and quality of care, and financial stability.** *InPhase ID 8691, Also held as a financial risk under InPhase ID 07557.* There isa risk that sustained reliance on agency and temporary staff above the agreed staffing establishment, creates an unsustainable staffing model and compromising continuity and quality of patient care. Frequent changes in personnel may disrupt therapeutic relationships, reduce familiarity with patients' needs and care plans, and may contribute inconsistent care delivery and poorer patient experience. Expenditure on temporary or agency workforce may constrain investment in the substantive workforce, reinforcing reliance on temporary staffing and affecting longer-term service sustainability. **Current Score** – C4xL4 = 16 **Target Score** – C4xL2 = 8	**In place** • Executive and CEO sign-off of agency spend and above-cap rates • Agency recruitment restriction; no retrospective approval of shifts • Weekly monitoring of agency spends • Monthly executive-led directorate management meetings reviewing agency usage **For development** • Confirm safe staffing requirements for high spend services, factoring in sickness absence, vacancy factor, patient acuity, and enhanced observational requirements • Prioritise recruitment plans to staff high spend areas to establishment • Review "headroom" arrangements monthly and adjust as necessary	• The risk is owned by the Chief Medical Officer and framed financially. There is no equivalent control set owned by the Chief People Officer addressing the workforce consequence. • No control addresses continuity of care for people supported by a temporary workforce. • The score has risen from 9 to 12 because of recruitment needed for the children and young people's services transferred from NELFT. In addition to financial exposure, the focus on delivering safe and consistent patient care and experience needs to be built into the controls to reduce risk of harm to patients.	**1st line** • Monthly IQPR; monthly finance report Delivery of recruitment plans Patient complaints, InPhase reports, etc triangulated with temporary / agency staff usage **2nd line** • Finance, Business and Investment Committee monitoring Escalations to ICB (SBARs) to factor in temporary / agency staffing levels **3rd line** • Internal audit	• All assurance addresses cost. • The stated consequence of the risk is an impact on quality and safety of services, and nothing evidences whether that is occurring.	Recruitment and Temporary Staffing Manager	16

		• Require additional supervisory approval for any temporary staffing requests to cover vacancies • Triangulate patient complaints, gaps in care, missed observations, InPhase reports etc with temporary / agency staff overlay **Effectiveness (draft):** *Partially effective for cost. The score has risen from 9 to 12 with these controls in place. Not rated for continuity and quality of care, which the risk names as its consequence.*					
SR5.5	**Limited career pathways, development and talent management.** *Identified June 2026. InPhase ID 8692.* There is a risk that without clear talent, career and development pathways aligned to current and future needs, the Trust will experience lower staff engagement, higher turnover, skills gaps and weaker succession planning. This may increase recruitment and temporary staffing costs, compromising continuity of care and the ability to meet changing service needs and strategic ambitions. **Current Score** – C3xL5 = 15 **Target Score** - C3xL2 = 6 (over 5 years)	**In place** • Leadership and management development programmes • Delivery of the leadership development programme • Improvement capability building through Doing Well Together **For Development:** • Create and publish at least one career pathway, aligned to future skills gaps • Identify niche roles (SROs, Clinical Digital Specialists, Loggists) and create development pathways to build organisational knowledge • Provide transparent eligibility criteria and protected learning time for rotations, secondments, development moves, work shadowing, and mentoring. • Succession planning for one role / function in the Trust where there is lack of progression and attrition linked to lack of	• Development activity is recorded under the culture risk rather than the workforce risk, so neither committee sees the whole. • No control addresses career pathways, talent management or succession.	**1st line** • Staff survey results; pulse survey results • Exit interview feedback Proposed 1st line • Pathway uptake • Number of planned developments moves and rotations • Talent pools exist 2nd line: • Talent Pipeline strength for key roles	• Appraisal completion, personal development plan completion and mandatory training compliance are not recorded as BAF assurance. • No assurance on the effect of the leadership programmes.	Deputy Chief People Officer	15

		progression opportunities from exit interview **Effectiveness (draft):** *Partially effective. Development activity is delivered; career pathways and succession are not addressed.*					
SR5.8	**Mandatory and statutory training compliance insufficient to evidence a competent workforce.** *CQC well-led feedback and Quality Account 2025-2026. InPhase ID 8695* L – 2 C - 4	**In place** • Mandatory training programme with compliance monitoring and directorate-level oversight • Mental Health Act training, recorded at 95 per cent to 100 per cent against a 90 per cent target • Oliver McGowan Tier 2 training; physical intervention and simulation de-escalation training • Information governance training, recorded at 97.4 per cent • Competency framework for risk formulation and care planning **In development** • Review of training compliance requirements for temporary and agency staff **Proposed development:** MLOG outcome – agreed schedule of mandatory training by role	• No single mandatory and statutory training compliance position is held for the Trust, by subject and by staff group. • Training for temporary and agency staff is under review rather than controlled, which is the subject of a CQC finding and of SR1.15. • Recorded training is completion of a module. No control tests competence in practice.	**1st line** • Training compliance reporting through the monthly IQPR and directorate reporting	• No consolidated training compliance report is recorded as assurance for this framework. • 2,156 staff are recorded as having received some form of training in risk formulation and care planning. That is an activity count and not a compliance position. • No 2nd or 3rd line assurance on training or on competence.	Head of Learning & Development	8
SR5.9	**Clinical and management supervision not consistently delivered, recorded, or used to assure practice.** *Quality Governance Review, 23 January 2026. InPhase ID 8696* L - 3 C - 4	**In place** • Supervision policy and supervision structures introduced alongside new risk formulation templates • Improved access to supervision within the staff wellbeing offer	• Supervision quality and consistency are recorded by the review as a material gap, and no control sets a standard, a frequency or a minimum content. • Sampling found unrecorded supervision,	**1st line** • Supervision compliance reporting where it is held at directorate level • Internal Audit **3rd line**	• No supervision compliance position is reported to the People Committee or the Board. • The review's finding rests on a sample, and the Trust has not since established the true position.	Learning & Development Team Leader	12

		• Clinical supervision linked to audit findings and appraisal **In development** • Supervision workstream within the Leadership, Culture and Governance theme of the Quality Plan	so the Trust cannot evidence what it delivered. • No control links supervision to the safety-critical practice it exists to assure, in particular risk formulation and care planning.	• Quality Governance Review, 23 January 2026: Workforce, Learning and Development rated Developing	• No assurance connects supervision to the quality of practice.		
SR5.10	**Absence of a strategic workforce plan.** *Agreed at the People Committee session, 15 September 2026. InPhase ID 8697* Without a five-year strategic workforce plan linked to population health needs, staffing capacity and skills may not meet changing demand. This may also limit preventive and community-based service development and delivery of the clinical strategy. Current Score – C4xL4=16 Target Score – C4xL2=8 (over 5 years)	**In development** • Strategic Workforce Plan for 2026 – 2031 to be published Q426/27 • Skills mix review and gap analysis of workforce needs to inform planning for FY27/28. Recruit to plan • Identification of transformative workforce models, including new and extended roles (from SR5.4) • Headcount and funding for "build" roles (apprenticeships, trainees, graduates, work placements) identified and funded **For future development** • Model 3-year workforce recruitment and development plan based on population demand and needs vs vacancy .	• No workforce plan exists, so the causes on supply, new roles and career pathways (SR5.1, SR5.4 and SR5.5) have nothing to be measured against.	**1st Line** • Strategic Workforce plan for 2026 -2031 published • Progress against deliverables monitored and reported • Reduced voluntary turnover as a result of poor career progression **2nd line**	• Progress against SWP in 1, 3 and 5 years	Workforce Planning Manager	16
SR5.11 NEW	**Sickness absence rate consistently above Trust target (% from SDR)** *InPhase ID 8698* *NHSE requirement (NOF??) to reduce sickness absence rate by 1%. Oncost of temporary or agency staffing to cover sickness absence. Indicator of low / morale, prevalence*	• Sickness absence monitored and reported monthly • Sickness absence target set at Trust and directorate level • Sickness absence "hotspots" identified at locality level 4 for targeted	• Outcome of existing policies and processes • Reporting at Directorate and Trust level can obscure high areas with very high sickness absence rates	**1st line:** • Reported in IQPR, Directorate and Trust SDR	Not previously on risk register but significant impact for Trust, staff and patient experience	Deputy Chief People Office	12

	of mental ill health as main reason for sickness absence **Owner:** Directorate HRBP Current Score – C4xL3 = 12 Target Score – C4xL2 = 8 (time period TBC)	• focus – improvement tracked and monitored • Register of top 100 people with highest sickness absence maintained and monitored					

SR6. LEADERSHIP AND CULTURE

There is a risk that variation in leadership, organisational culture and ways of working undermines the quality, safety and experience of care for patients, families and carers, as well as the experience and wellbeing of our staff.

Strategy alignment: True North: Experience, and cross-cutting across all five True Norths. Capabilities: embedding a strong organisational culture, and strengthening leadership, improvement and innovation.

Owning committee: People Committee. The causes were reset following the October 2026 Board culture workshop. The governance and assurance causes formerly held here have been folded in or moved out, as recorded at Annex D.
Risk appetite (proposed: Open, comply or explain): Propose this is OPEN for wider agreement with the Board. The Trust is willing to try new approaches to developing its leadership and culture. It has no tolerance for closed cultures, for concerns that are not acted on, or for discrimination, and any decision that would increase these risks must be explained to People Committee.
Current position against appetite: All seven causes carry a proposed score: three at 16, three at 12 and one at 9. Whether these are within tolerance depends on the appetite the Board sets. .Cannot be judged until appetite is confirmed. The Board received the first triangulated view of culture, performance and quality on 24 September 2026. It showed significant variation between teams and staff groups, with East Kent the directorate where culture, performance and workforce pressures converge. The paper proposed three cultural outcomes as the basis for Board-level measures: issues lead to action and learning; people are clear and empowered to act; experience is equitable and consistent, which the Board endorsed. Proposed measures were shared with the Board in October 2026 and will be further developed and shared with the Board in January 2027. The development of the cultural transformation plan has been phased, to ensure it uses the latest 2026 NHS Staff Survey data.
CQC well-led quality statements: Well-led: shared direction and culture; capable, compassionate and inclusive leaders; freedom to speak up; governance, management and sustainability; learning, improvement and innovation.
Independent maturity rating (Quality Governance Review, 23 January 2026): Governance, Assurance and Risk Management: Lagging. Regulatory Readiness: Lagging. Leadership and Culture: Developing. Vision and Strategy: Developing. Continuous Improvement: Developing.
Scores: Inherent (highest contributing cause): 16 (4 x 4). Current (highest contributing cause): , SR6.2 SR6.3 and SR6.5. Target: 9 (3 x 3) by March 2028. This replaces the InPhase target of 6 by March 2027, which is not achievable because the cultural transformation plan launches in March 2027.
Risk maturity: 2 Developing. Target of 3 Established by March 2028, once controls are tested against agreed cultural measures being shared with the Board in January 2027.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR6	**There is a risk that variation in leadership, organisational culture and ways of working undermines the quality, safety and experience of care for patients, families and carers, as well as the experience and wellbeing of our staff.**						
	Caused by:						
SR6.1	**Variation in leadership capability, behaviours and accountability.** There is a risk that leaders across the Trust do not consistently model the behaviours, decision-making and accountability the Trust expects, which may result in inconsistent staff experience between teams, directorates and geographies, closed cultures going undetected, and poorer and less safe care for patients. *InPhase ID 08337, to be retitled SR6.1. Current score 16 (4 x 4), increased from 9 in September 2026. Target 9 (3 x 3) by March 2028. CQC Well-Led finding, March 2026. Takes in the former leadership capability and Board visibility causes.*	**In place** • Leading Well Together leadership programme covering self, team and Trust leadership. First cohort trained. • Leadership and team development for the executive team and deputies • Annual appraisal for the executive team and deputies, with 360 feedback and objectives aligned to the strategy, values and the NHS leadership competencies (2024) • Trust values and behaviours	• No leadership and behavioural framework is yet in place for leaders, so the behaviours expected of leaders are not defined or therefore held to. • Middle management capability, identified at inspection, is not addressed by any current control outside East Kent. Managers' report uncertainty about what is expected of them, competing priorities, and	**1st line** • Triangulated Culture, Performance and Quality Deep Dive, Board, 24 September 2026. Leadership Behaviour Index 76.2%, close to the Picker benchmark of 76.6%, but with wide variation between teams (for example, neuropsychology: culture 33.3%, leadership behaviour 82.7%). The paper itself offered limited assurance. • Staff survey results by service • Pulse survey results • Appraisal and one-to-one compliance	• No leadership behaviour indicators are defined or reported beyond the staff survey index • Variation between teams is now visible on the culture dashboards, but team-level triangulation with performance, quality and workforce data has not been done. • Culture measures rely mainly on the annual staff	Head of Organisational Development	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	(Consider 12 (3 x 4): the deep dive shows leadership behaviour close to benchmark, with the weakness in clarity, accountability and manager capability) **Owner: Xanthe Whittaker**	• Staff experience as a True North priority, with directorate ownership of team experience and focused interventions in hotspot areas • Targeted development plans for leaders who are underperforming • Leadership cultural competence (EDI action plan, focus area 2) • Strategy Deployment Review (SDR) at directorate and Trust level • Executive and non-executive visits to services. • Cultural Change and Culture vs Performance dashboard, identifying hotspot teams by culture score • Targeted programme in East Kent: focus groups with 208 colleagues, leadership expectations reset for the senior team and managers, and performance management training **In development:** • Cultural transformation plan, a three-to-five-year Trust-wide programme, to launch in March 2027 • Leadership and behavioural framework aligned to the new NHS Staff Standards • Structured learning from teams with consistently strong culture (Places of Safety, Acute PICU, North Kent inpatient rehabilitation, estates, low secure) • Revised Leading Well Together programme, to include targeted development with top 50 leaders • Cultural compact • Coverage plan for EMT visits and mechanism to feed back (CEO and Trust secretariat developing)	accountability for delivery without the authority or support to act. • Expectations are applied inconsistently in practice. For example, zonal observations are used differently across the Trust because local understanding varies (safer staffing review, May 2026). • The SDR process reviews performance. It is not designed to assure leadership capability. • Executive visits have no coverage plan across services and geographies, and nothing feeds what is seen back into the BAF. • Leadership programmes are evaluated on attendance and participation feedback only. There is no baseline or follow up to show whether participants lead differently afterwards (Action – agree impact measures before the next Leading Well Together programme starts) • Clinical leadership development plan • Directorate A3 problem-solving on culture through the Doing Well Together	**3rd line** • Quality Governance Review, 23 January 2026: Leadership and Culture rated Developing • CQC Well-Led inspection, March 2026 and subsequent report.	survey, and the dashboards show a static position rather than trends. • The planned assurance (internal audit of culture, leadership and speaking up; organisational development deep dives; external review) has not yet been received.		

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		Effectiveness: *Not effective. Leadership development is being delivered, but no framework yet sets out the behaviours expected of leaders, and the Trust cannot yet show whether development changes how leaders behave or how their teams experience work and perform. and nothing holds leaders to them.*	Improvement Management System				
SR6.2	**Variable patient, family and carer involvement and influence.** There is a risk that patients, families and carers are not involved in a way that genuinely influences decisions about their care and about how services are designed and improved, because involvement is inconsistent across services and is often treated as a process rather than a partnership, which may result in care that does not meet people's needs, missed early warning of poor care, and loss of trust in the Trust. *New InPhase record.* ***Proposed score 16 (4 x 4). Target 9 (3 x 3) by March 2028. Quality Governance Review, January 2026, and Rapid Review, November 2025.*** **Owner: Michelle Summers**	**In place** • Co-creation strategic plan and delivery-to-outcomes framework • Lived experience and VCSE involvement within key strategic priorities, initiatives and projects (Mental Health Together, PCREF and selected improvement programmes) • New Involvement & Engagement team recruited and growing co-creation community and co-creation partners • Positive patient experience true north ambition. • Carer Information form on Rio, and the Trust's first Family, Friends and Carers standard operating procedure • Trust-wide Patient Experience and Carer Experience meetings. • Patient, carer, complaints, survey and Healthwatch intelligence used to identify themes. • First patient and public insight to action report, and an insight to action plan with phased timelines **In development** • Patient Experience Dashboard providing ward-level insight	• The co-creation plan and framework are not fully operational, due to capability and capacity issues in the team. A plan is in place to address this and we expect to be fully functioning by May 2027. • The insight to action approach is developed but not yet embedded. • The patient and public involvement payment policy is out of date. • The Rapid Review described family and carer involvement as a tick-box exercise rather than a partnership. • Patient and family voice is not visible in governance forums or senior decision-making. • No routine infrastructure for gathering insight, reporting case studies and action. • No triangulated or systematic view of patient experience,	**1st line** • Monthly patient experience reports, including complaints and compliments dashboards • Patient and public involvement case studies • Your Experience Matters patient, family and carer survey **2nd line** • Trust wide patient experience group reporting into Quality Committee • Co-creation plan delivery and insights reporting into Quality Committee, and Board. **3rd line** • CQC community Mental Health survey • Healthwatch Kent and Medway reports Quality Governance Review, 23 January 2026: Patients, Families and Carers rated Lagging	• No measure of whether involvement changed a decision or influenced a positive change	Deputy Director of Communications, Strategy and Engagement	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		• Revised patient and public involvement and engagement payment policy • Digitisation of the Triangle of Care self-assessment • Capability development of Involvement and Engagement team • Insight to action report mechanism • System Insight Network to engage formally and report back to communities and partners, and ensure all voices are heard equitably **Effectiveness (draft):** *Partially effective. Involvement takes place, but there is no evidence that it changes decisions consistently across services.*	insight and involvement				
SR6.3	**Variable trust and follow-through on concerns.** There is a risk that staff, patients and families do not trust that concerns they raise will be heard, acted on and fed back, because responses to concerns are slow and inconsistent and the outcome is not always closed off with the person who raised it, which may result in fewer concerns being raised, risks to patient safety going unaddressed, and the conditions for closed cultures. *New InPhase record. Proposed score 16 (4 x 4). Target 9 (3 x 3) by March 2028. The September 2026 deep dive identifies this as the Trust's principal cultural weakness.* **Owner: Sarah Atkinson**	**In place** • Freedom to Speak Up Guardian and policy, with annual reporting • Freedom to Speak Up escalation pathways and guidance for managers • Staff Voice forums in all directorates **In development** • Cultural transformation plan, a three-to-five-year Trust-wide programme, to launch in March 2027 • Insight to action approach for staff voice, developed • 'You said, we did, we are doing' approach, being tested in East Kent • Improving our learning culture workstream within the cultural transformation plan • Scoping a 'process improvement project' to sit as one of the culture transformation priority projects. **Effectiveness (draft):** *Partially effective. The routes to speak up work: 87.8% of staff feel confident to speak up. But only 46.5% believe*	• No standard or timescale for responding to a concern, giving feedback and closing the loop, and no assurance that managers understand what good feedback looks like. (Action: scope a process improvement project to sit within the culture transformation plan) • No clear timescales for clinical investigations, or for keeping people updated during them. • The Freedom to Speak Up Guardian reports having to chase feedback for extended periods. 44% of staff who approached the Guardian had already raised their concern internally	**1st line** • Freedom to Speak Up annual report, Public Board, July 2026: 128 concerns raised in 2025-2026, up from 111. Only 3.6% were anonymous, against a 10% national average. Top themes: management issues (46), systems and processes (35), behaviours and relationships (20). West Kent had the highest rate of concerns raised (5.17% of staff). • Triangulated Culture, Performance and Quality Deep Dive, Board, 24 September 2026: 'concerns would be addressed' is the lowest-scoring cultural measure (46.5%). Wards such as Woodchurch (78.3%) and Jasmine (76.2%) show it can be done. • Questions added to the end of mandatory training, July 2026: around 10% of over 100 staff felt their views and ideas were listened to and taken	• No measure of time to respond, or of whether feedback was given. • Freedom to Speak Up themes are not triangulated with grievance and employee relations cases. • No 'you said, we did' measure on speaking up is reported to People Committee.	Deputy Director of Transformation and Partnerships	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		their concern would be addressed, so follow-through is not controlled.	without feeling heard. • The proportion of staff citing fear of reprisal rose from 5% to 15% during 2025-2026. • No monitoring of whether recommendations from Freedom to Speak Up and other speaking-up routes are implemented and lead to change. ACTION: track if FTSU reports are followed up and acted on (Ali Layne-Smith) • No agreed route to act where formal processes repeatedly show that an individual is having a negative impact on culture, staff wellbeing or quality of care. • The Rapid Review found instances where escalation did not happen despite risk indicators being present.	seriously (early, small sample) 2nd Line: • FTSU Guardian reports directly to CEO, and provides annual report to People Committee and Board **3rd line** • Quality Governance Review, 23 January 2026 • CQC Well-Led inspection, March 2026 (freedom to speak up quality statement)			
SR6.4	**Limited staff empowerment, delegated authority and ownership of improvement.** There is a risk that staff do not feel able to make decisions and lead improvement in their own areas, because authority is not clearly delegated and improvement skills and support are unevenly spread, which may result in slower improvement, reliance on senior escalation, and lower staff engagement. *New InPhase record. Proposed score 12 (3 x 4). Target 8 (2 x 4) by March 2028. Quality Governance Review, January 2026: Continuous Improvement rated Developing.*	**In place** • Improvement capability building through the Doing Well Together improvement programme • Governance Improvement Plan **In development** • Cultural transformation plan, a three-to-five-year Trust-wide programme, to launch in March 2027 • Revised governance structure, KMMH leadership and delivery structure, and a scheme of delegated	• No scheme of delegated authority for frontline decisions is clearly understood. • Managers report feeling accountable for delivery without always having the authority, skills or organisational support to act, and that systems and policies do not make their jobs easier.	**1st line** • Staff survey questions on ability to make improvements • Improvement training reports 17.7% of staff have had improvement awareness training. 12 in-patient units trained in improvement management system and using improvement huddles to drive local ownership & empowerment • Triangulated Culture, Performance and Quality	• No 2nd line assurance. • No measure of variation between teams. • No evaluation of whether improvement training is understood and being actively followed by staff and leaders.	Deputy Director of Transformation and Partnerships	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	Owner: Sarah Atkinson	authority for frontline decisions (Governance Improvement Plan actions) • Leadership, management and organisational capability workstream within the cultural transformation plan, including removing barriers in systems and processes • Embedding improvement, learning and psychological safety **Effectiveness (draft):** *Partially effective. Improvement capability is being built, with no measure of how far it reaches.*	• No measure of staff ownership of improvement at team level or that improvement training is changing frontline and leadership behaviours. • The reach of improvement capability across teams is not known.	Deep Dive, Board, 24 September 2026: qualitative evidence from leaders and managers on authority and support to act **3rd line** • Quality Governance Review, 23 January 2026: Continuous Improvement rated Developing			
SR6.5	**Inequitable experience of fairness, inclusion and belonging across professions, teams, services and protected characteristics.** There is a risk that staff do not experience fairness, inclusion and belonging equally, because experience varies by profession, team, service and protected characteristic and inclusion actions are not held to a stated standard, which may result in discrimination, poorer retention of under-represented groups, and services that are less able to meet the needs of diverse communities. *New InPhase record. Proposed score 12 (3 x 4). Target 8 (2 x 4) by March 2028. Takes in values and inclusion from SR5.6, which keeps the employment standards.* ***[Consider 16 (4 x 4): the WRES and WDES disparities in the September 2026 deep dive are material]*** **Owner: Yasmin Damree-Ralph**	**In place** • Doing Well Together, Positive Experience ambition and breakthrough objective • EDI action plan 2026-31 reported to People Committee. Focus areas: (1) Safe, fair and accountable environments; (2) Data, transparency and reporting systems; (3) Fair recruitment and inclusive leadership; (4) Workforce capabilities and training; (5) Staff support and inclusion • Allyship training • Work to embed organisational values **In development** • Cultural transformation plan, a three-to-five-year Trust-wide programme, to launch in March 2027 to include alignment of Equity, diversity and inclusion and consistency of experience for all staff **Effectiveness (draft):** *Partially effective. Activity is delivered against no stated standard. A trust-level inclusion score of 74% masks material gaps between staff groups.*	• The EDI action plan and the cultural transformation programme's equity and inclusion workstream are not yet mapped to each other, and do not share measures. • Action: align the two around shared measures of narrowing experience gaps between groups, before the plan launches in March 2027. • No plan yet to address equity of experience for all staff. • No established route for staff networks to influence decisions and working conditions trust-wide. • No evaluation of whether training is changing views, values and behaviours.	**1st line** • EDI action plan progress reports to People Committee • Staff survey and pulse survey results • Triangulated Culture, Performance and Quality Deep Dive, Board, 24 September 2026. By ethnicity, gaps of 40.1 percentage points in the culture composite, 35.8 in psychological safety and 31.7 in staff voice. Disabled colleagues: 66% on respect for individual differences (72.6% non-disabled), 45.3% would recommend the Trust (58.2%), and 21.5% feel pressure to work when unwell (11.2%). • Staff survey **2nd line** • WRES, WDES and gender pay gap reports, reported to People Committee and Board. • EDI Steering Group, which reports into People Committee **3rd line** • Independent cultural competency assessment (2024)	• No 3rd line assurance on inclusion. • No thematic analysis of grievance and employee relations cases. • No baseline or trajectory is yet set for narrowing the experience gaps.	Diversity and Inclusion Manager	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR6.6	**Limited recognition, organisational pride and advocacy.** There is a risk that staff do not feel recognised or proud to work for the Trust and would not recommend it, because recognition is inconsistent and positive work is not well known inside or outside the Trust, which may result in lower engagement and retention, weaker recruitment, and reduced public confidence. *New InPhase record. Proposed score 9 (3 x 3). Target 6 (2 x 3) by March 2028. Links to the staff recommend breakthrough objective, which the September 2026 deep dive names as the overarching test of cultural improvement.* ***[Consider 12 (4 x 3): July 2026 pulse advocacy is below target in three of the four areas that have one]*** **Owner: Asim Janjua**	**In place** • Positive Staff Experiences ambition work • Internal and external communications on Trust achievements **In development** • Cultural transformation plan, a three-to-five-year Trust-wide programme, • enabling strategy due December 2026 **Effectiveness:** *Not yet assessed. The impact of this year's Positive Experiences work is being reviewed.*	• No agreed recognition approach across the Trust. Where teams have focused on recognition, such as estates, results are strong. • Some corporate teams report feeling disconnected from the wider organisation and less valued than clinical colleagues. • Action: complete the review of the impact of Positive Experiences work. Owner to confirm, by March 2027	**1st line** • Staff survey 'recommend as a place to work' score • Staff survey 'recommend as a place to be cared for' score • Quarterly pulse survey, July 2026, % recommending the Trust as a place to work: East Kent 37.7% (61 respondents); West Kent 43.8% (64; target 52%); Forensics and Specialist 18.2% (33; target 66%); Support Services 48.4% (93; target 65%); children and young people's services 60.3% (58; target 60%)	• Pulse samples are small, and the culture dashboards do not yet include pulse results. • No measure of advocacy as a place to receive care. • No established 2nd line defence, but Comms strategy and delivery will report into new Partnership Committee	Head of Communications and Marketing	12
SR6.7	**Variation in organisational capability, capacity and ways of working to deliver change, innovation and system transformation.** There is a risk that the Trust does not have the capability, capacity and ways of working to deliver change at the pace its strategy requires, because change capability is uneven, staff report change fatigue and too many priorities compete for the same people, which may result in strategic priorities stalling, staff burnout, and the Trust being a weaker partner in system transformation. *New InPhase record. Proposed score 12 (4 x 3). Target 9 (3 x 3) by March 2028. Change fatigue is named in the Trust's published staff survey position.* **Owner: Sarah Atkinson**	**In place** • Trust Doing Well Together strategy (2026-31) and agreed priorities to March 2027 • Directorate Improvement Business partners in place to support local improvement, provide coaching and ensure change happens in line with the agreed methodology • Strategy Deployment Review (SDR) at directorate and Trust level • Governance Improvement Plan being implemented, including a new governance structure and leadership and delivery architecture • Organisational change policy for formal change and consultation In development • Cultural transformation plan, a three-to-five-year Trust-wide programme	• No agreed trust-wide blueprint for what good change looks like and no single view of all the change affecting the same staff. Impact judged narrowly on whether a role is formally affected, rather than on how change affects the wider environment, teams people work with and the way they work. • Action: develop and agree Trust-wide change blueprint, building on the organisational change policy and DWT method with comms blueprint as one part of it by April 2027.	**1st line** • Staff survey and pulse survey results	• No 2nd or 3rd line assurance.	Deputy Director of Transformation and Partnerships	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		• Approach to resource and capacity planning for strategic delivery and to prioritise strategic delivery • Resource plans for strategic priorities 26/27 including requirements for People Portal • Change communications and engagement blueprint **Effectiveness (draft):** *Partially effective. Prioritisation was agreed recently, so its effect is not yet evident.*	• Culture and operational pressure interact differently by directorate. For example, Acute has the strongest clinical culture score (63.7%) alongside the weakest quality composite (49), and the Patient Flow Team scores 22.6% on culture. The link between pressure and culture is not yet understood. • West Kent shows an emerging sustainability risk (vacancies 12.9%, temporary staff 8.8%) that is not yet fully visible in quality measures. • The SDR process reviews performance. It is not designed to assure capability and capacity (to be addressed through new transformation group) • Resource requirements for all priority strategic work not yet fully defined, creating uncertainty around Trust's ability to plan and secure necessary capacity. Action: to complete by early December for 26/27 agreed priority breakthrough objectives, initiatives and projects.				

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	Closed or moved out of SR6: The former organisational culture, leadership capability and Board visibility causes are now held within SR6.1.						
	Resulting in: • **Poorer and less safe care for patients, families and carers, and reduced positive experience, including the conditions in which closed cultures can develop** • **Reduced staff experience, engagement, wellbeing and willingness to speak up** • **Inconsistent practice, with increased incidents and complaints** • **Continued regulatory scrutiny** • **Loss of confidence among patients, carers, staff, partners, regulators and commissioners** • **Failure to deliver the ambitions set out in Doing Well Together.**						

SR7. PARTNERSHIP AND HEALTH INEQUALITIES

There is a risk that the Trust will not work effectively as a partner to deliver integrated care and reduce health inequalities.

Owning committee: Partnership Committee.

Risk appetite and maturity have not yet been scored, as the Partnership Committee has only recently commenced and is operating in shadow form. The Board is asked to accept the resulting assurance gap while this work progresses, rather than regard the assessments as provisional. Appetite and maturity will be assessed and reviewed through successive committee cycles as the Committee tests the risk, controls and supporting evidence. The assurance statement to the Board will evolve accordingly.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR7	**There is a risk that the Trust will not work effectively as a partner to deliver integrated care and reduce health inequalities.**						
	Caused by:						
SR7.1	Unclear roles, accountabilities and decision rights across commissioning and partnership arrangements	**In place** • Standing Orders, Standing Financial Instructions and Scheme of Delegation define the Trust's internal authority. • Partnership Committee terms of reference and workplan provide oversight of SR7 and material partnership arrangements. • Programme governance is established for Mental Health Together and other significant programmes. • Contracts, letters of intent and continuation arrangements support current partner delivery. • Commissioning oversight considers Trust and partner performance across whole pathways. **In development** • A single commissioning and partnership operating framework. • Formal agreements defining roles, decision rights, reserved matters,	• No single approved framework defines the Trust's roles as commissioner, provider, host, lead provider and delivery partner. • Decision rights, delegated authority and reserved matters are not consistently documented. • Some arrangements continue to rely on interim rather than long-term agreements. • Committee and collaborative governance boundaries are not consistently defined. • Commissioning, contractual, programme and partnership risks are not fully aligned. • The Partnership Framework and Register are not yet embedded.	**First line** • Approved governance documents and signed partnership agreements. • Partnership and programme reports, decisions and action logs. • Partnership Register recording roles, risks, delegations and escalation routes. **Second line** • Partnership Committee scrutiny of partnership governance and accountability. • Finance, Business and Investment Committee oversight of material contractual and hosting arrangements. • Periodic review of compliance with the Partnership Framework. **Third line** • Internal audit review of partnership governance, commissioning controls and delegated arrangements.	• No consolidated assurance confirms that all material partnerships have clear roles, delegations and escalation routes. • No complete report identifies partnerships operating under current, interim, incomplete or expired agreements. • Reporting demonstrates governance activity more clearly than whether accountabilities are understood and effective. • Partner-owned assurance on shared responsibilities remains limited. • Lead-provider and hosting arrangements are not yet fully assured. • No internal audit opinion has been	Head of Improvement	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		liabilities and escalation routes. • Partnership Framework and Register applying governance proportionate to strategic importance and risk.			received on the overall partnership governance environment.		
SR7.2	Misaligned priorities, incentives and operating models across partner organisations Proposed owner: Deputy Chief Operating Officer Current LxC: 4 x 3 Target L x C: 2 x 3	**In place** • Joint governance and delivery arrangements across major system programmes. • System escalation arrangements for delayed discharge, capacity and other cross-organisational issues. • Mental Health Together programme governance, including partner mobilisation and locality planning. • Whole-pathway commissioning oversight across performance, quality, outcomes and finance. • Partnership principles covering shared purpose, mutual benefit and reciprocal accountability. **In development** • Shared outcomes and performance measures for material partnerships. • Partnership Framework and Register recording partner commitments, dependencies and escalation routes. • Formal recovery and dispute-resolution arrangements where agreed commitments are not delivered.	• No single framework aligns priorities, incentives and operating models across material partnerships. • The Trust has limited authority over capacity, funding and decisions controlled by partners. • Partner commitments are not consistently recorded with owners, milestones and measurable outcomes. • Escalation arrangements rely heavily on relationships rather than agreed triggers and consequences. • There is no consistent contingency where planned partner capacity or investment is delayed. • Financial and operational benefits may be realised by one partner while risks and costs fall to another.	**First line** • Programme reports covering partner commitments, milestones, dependencies and delivery risks. • Whole-pathway reporting across access, activity, quality, outcomes and finance. • Exception reports on overdue actions, underperformance and unresolved escalations. **Second line** • Partnership Committee scrutiny of partner dependencies, delivery and unresolved issues. • Finance, Business and Investment Committee oversight of material financial consequences. • Quality Committee oversight of patient-safety and pathway impacts. • Contract-management assurance against agreed specifications and outcomes. **Third line** • Partner or ICB confirmation of agreed commitments and capacity plans. • Internal audit or independent review of	• No consolidated assurance confirms that all partners are delivering their commitments. • Reporting primarily reflects the Trust's position rather than a jointly agreed system view. • Limited partner-owned assurance is received on shared risks and controls. • No routine measures show overdue commitments, unresolved escalations or repeated non-delivery. • Planned partner capacity and investment are not supported by consistent contingency assurance. • Current evidence demonstrates system activity more clearly than aligned priorities, changed behaviour or improved outcomes.	Deputy Chief Operating Officer	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
				significant system arrangements.			
SR7.3	Fragmented governance, assurance and escalation across organisational boundaries Proposed owner: Company Secretary Current LxC: 3 x 3 Target L x C: 2 x 2	**In place** • Shadow Partnership Committee established with interim terms of reference and workplan. • Commissioning Group and Partnership Group provide supporting operational oversight. • Programme governance is established for significant partnership programmes. • EMT provides escalation for material delivery, financial and quality issues. • Standing Orders and the Scheme of Delegation define internal decision-making authority. **In development** • Partnership Framework and Register defining proportionate governance requirements. • Governance map connecting Trust, partnership and system forums. • Standard reporting, decision logs and escalation criteria. .	• No single approved governance framework covers all material partnerships. • Decision rights, reserved matters and delegated authority are not consistently documented. • Trust, programme and partner risk registers are not routinely reconciled. • Escalation routes do not consistently define triggers, owners and resolution timescales. • Referral arrangements between Board committees are not fully embedded. • No consistent process ensures decisions made in partner forums are implemented and reported through Trust governance.	**First line** • Partnership, commissioning and programme reports, decisions and action logs. • Partnership Register recording governance, risks and escalation routes. • Exception reporting on overdue decisions, partner underperformance and unresolved escalation. **Second line** • Partnership Committee scrutiny of material partnerships, risks and dependencies. • Audit and Risk Committee oversight of BAF and risk-management arrangements. • Corporate governance review of responsibilities, delegations and reporting routes. • Periodic review of compliance with the Partnership Framework. **Third line** • Internal audit review of partnership governance and escalation. • Partner or ICB confirmation of agreed governance arrangements.	• No consolidated assurance confirms that all material partnerships have effective governance and escalation arrangements. • The Partnership Committee has not yet demonstrated effectiveness through a full cycle of operation. • No complete reconciliation exists between Trust, programme and partner risk registers. • Partner-owned assurance on shared risks remains limited. • No routine measures show unresolved escalations, overdue decisions or repeated partner non-delivery. • Current reporting demonstrates governance activity more clearly than timely decisions, resolved accountability and improved outcomes.	Company Secretary	9

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR7.4	Insufficiently mature relationships, trust and reciprocal accountability with partners Proposed owner: Deputy Director of Transformation and Partnerships Current LxC: 3 x 4 Target L x C: 2 x 3	**In place** • Partnership Committee provides oversight of strategic partnerships, partner dependencies and SR7. • Executive and senior leadership engagement with the ICB, local authorities, NHS providers and VCSE partners. • Joint programme governance for Mental Health Together and other significant partnership programmes. • Commissioning and contract-management arrangements provide routes for reviewing partner delivery. • Local and system escalation arrangements support resolution of operational **issues.** **In development** • Partnership Framework and Register, with proportionate governance and review arrangements. • Partnership principles set expectations for shared purpose and outcomes. • Regular assessment of partnership maturity, effectiveness and benefits. • Clear partner commitments, accountable owners and escalation routes. • Agreed arrangements for addressing underperformance, unresolved disputes and repeated non-delivery.	• No consistent Trust-wide method for assessing the maturity and effectiveness of partnerships. • Partner commitments are not always recorded with named owners, milestones and measures. • Relationships may depend on individuals rather than enduring organisational arrangements. • No common process defines how repeated partner under-delivery will be addressed. • Partnership agreements do not consistently cover expected behaviours, reciprocal accountability, performance improvement and exit arrangements. • Limited ability to hold partners to account where the Trust has no contractual authority. • Potential conflicts arising from the Trust's provider, commissioner, host or lead-provider roles are not consistently documented.	**First line** • Partnership Register and maturity assessments. • Partnership Committee, Commissioning Group and Partnership Group reports. • Records of partner commitments, actions, decisions and escalations. • Contract and programme performance reports. • Evidence of jointly agreed outcomes, delivery milestones and benefits. • Partner feedback on the quality and effectiveness of the relationship. **Second line** • Partnership Committee scrutiny of partnership maturity, delivery and unresolved issues. • Periodic review of compliance with the Partnership Framework. • Thematic review of selected partnerships to test reciprocal accountability and delivery. **Third line** • Partner confirmation of jointly owned risks, controls and commitments. • Internal audit review of partnership governance and management of partner dependencies.	• No consolidated assessment of the maturity and effectiveness of all material partnerships. • Limited partner-owned assurance is received by the Trust. • No routine measure in terms of confidence, disputes or benefits of partnership • Current reporting demonstrates activity and engagement more clearly than the quality of relationships or their effect on outcomes.	Deputy Director of Transformation and Partnerships	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		• Reciprocal assurance, with partners providing evidence on risks and controls they own.					
SR7.5	Inconsistent data, intelligence and information sharing across partners Proposed owner: Deputy Chief Operating Officer Current LxC: 4 x 4 Target L x C: 2 x 2	**In place** • Data-sharing agreements and contractual information requirements for relevant partnerships. • Existing programme and commissioning dashboards covering activity, performance, quality and outcomes. • Information governance processes for reviewing data-sharing arrangements. • Mental Health Together and other programme reporting using data from Trust and partner organisations. • Established escalation routes for material data-quality and information-governance issues. **In development** • Minimum dataset and common definitions for material partnerships. • Triangulated partnership dashboard covering access, outcomes, quality, finance, workforce, experience and inequalities. • Data-quality standards and statements of confidence accompanying partnership reports. • Improved reporting by locality, pathway and population group.	• Partners do not consistently use common definitions, reporting periods or data standards. • Data-sharing agreements are not confirmed for every material partnership. • Information is not always sufficiently timely or detailed to identify variation and inequality. • Trust and partner information is not consistently triangulated into a whole-pathway view. • Ownership and correction of data-quality issues are not always clear. • Patient experience, financial, workforce and outcome data are not routinely considered together.	**First line** • Signed data-sharing agreements. • Validated partnership and programme dashboards. • Data-quality reports, exception logs and corrective actions. • Statements of confidence accompanying key reports. **Second line** • Partnership Committee scrutiny of whole-pathway information and data quality. • Information Governance and Data Quality assurance through the appropriate Trust groups. • Periodic review of compliance with information-sharing requirements. **Third line** • Internal audit or independent data-quality review. • Commissioner or partner validation of shared performance and outcome information.	• No consolidated dashboard provides a reliable whole-pathway view across the Trust and its partners. • Reports do not consistently state data limitations or levels of confidence. • Limited assurance is available on the completeness and comparability of partner-supplied information. • Inequalities analysis is not routinely embedded in partnership reporting. • No independent review has tested the reliability of the combined partnership dataset.	Deputy Chief Operating Officer	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR7.6	Insufficient patient, carer, community and VCSE involvement in partnership design and assurance Proposed owner: Deputy Director Strategy and Engagement/ Deputy Director of Transformation and Improvement Current LxC: 4 x 3 Target L x C: 3 x 2	**In place** • Co-production Strategic Plan and associated governance arrangements. • Trust-wide Patient Experience and Carer Experience meetings. • Patient, carer, complaints, survey and Healthwatch intelligence used to identify themes. • Lived-experience and VCSE involvement within Mental Health Together, PCREF and selected improvement programmes. • Partnership principles include collaboration, co-production and shared ownership. • Partnership Committee oversight includes patient and community benefit and the effectiveness of strategic partnerships. **In development** • Partnership Framework requiring proportionate patient, carer, community and VCSE involvement. • Patient and carer experience dashboard and improved service-level analysis. • Partnership Register recording involvement arrangements for each material partnership. • Two-way feedback from partners and people using services. • Lived-experience involvement in	• No consistent minimum standard for involvement across all material partnerships. • Patients, carers, communities and VCSE organisations are not always involved from initial design through to evaluation. • Involvement can occur after priorities, models or funding decisions have been substantially developed. • Underserved communities and people experiencing health inequalities are not consistently represented. • Partnership governance does not routinely include lived-experience leadership. • No consistent process records how feedback has changed decisions or services. • Financial pressure and short-term contracting may limit meaningful VCSE involvement. .	**First line** • Records of involvement, co-production activity, feedback and resulting actions. • Evidence showing how patient, carer, community and VCSE input changed partnership design. • Representation data, including participation from underserved communities. • Patient and carer experience dashboard and partnership-level outcome measures. **Second line** • Partnership Committee scrutiny of involvement and patient or community benefit. • Quality Committee assurance through patient and carer experience reporting. • Periodic review of compliance with the Partnership Framework. • Thematic review of involvement within selected partnerships. **Third line** • Healthwatch or external review of involvement arrangements. • Internal audit review of partnership design and assurance.	• No consolidated assurance shows the quality and impact of involvement across all material partnerships. • Reporting focuses more on who was engaged than what changed as a result. • No consistent “you said, we did” reporting for partnership decisions. • Limited assurance that involvement reflects the diversity of Kent and Medway. • VCSE and community feedback is not routinely presented directly to the Partnership Committee. • No independent assessment confirms that involvement is embedded consistently. • route exists for this cause.	Deputy Director Strategy and Engagement/ Deputy Director of Transformation and Improvement	12

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		• Partnership Committee assurance. • Joint involvement and engagement approach with KCHFT to support neighbourhood alliance					
SR7.7	Collective capacity and capability constraints Proposed owner: Deputy Director of Transformation and Partnerships Current LxC: 4 x 4 Target L x C: 3 x 2	**In place** • Joint programme and delivery arrangements across major partnerships. • Trust workforce, finance, digital and transformation plans. • Programme governance identifies capacity, capability and dependency risks. • Formal prioritisation and change control are used for significant programmes. • Commissioning and contract-management arrangements monitor partner delivery. • Partnership Committee oversight of material dependencies and delivery risks. **In development** • Joint workforce, finance, digital and transformation plans for material partnerships. • Partnership Register identifying critical capacity and capability dependencies. • Demand and capacity modelling across whole pathways. • Benefits-realisation arrangements showing whether shared	• No consolidated assessment of collective capacity and capability across material partnerships. • Joint plans do not consistently show required and available capacity highlighting any shortfalls and mitigations • Limited contingency where a partner cannot provide the required workforce, funding, digital support or specialist capability. • Competing organisational priorities can divert resources from agreed partnership commitments. • Benefits and productivity requirements are not consistently matched to the capacity	**First line** • Programme reports covering capacity, milestones, dependencies and delivery confidence. • Joint workforce, financial, digital and transformation plans. • Demand and capacity analysis for material pathways. • Benefits and KPI reporting against agreed partnership outcomes. • Exception reports for capacity shortfalls and delayed partner commitments. **Second line** • Partnership Committee review of material capacity constraints and recovery plans. • Finance, workforce and digital assurance through the relevant Board committees. • Programme assurance and benefits-realisation reviews. • Risk-register alignment across Trust and partnership programmes. **Third line** • Internal audit or independent programme assurance.	• No consolidated assurance shows whether partnerships have sufficient collective capacity to deliver agreed commitments. • Workforce, finance, digital and transformation assurances are reported separately rather than triangulated. • Limited partner-owned assurance confirms the availability and sustainability of committed resources. • No consistent measure shows whether capacity constraints are delaying benefits or increasing costs. • Contingency arrangements have not been independently tested. • Current assurance is stronger on programme activity than on sustainable delivery capability.	Deputy Director of Transformation and Partnerships	16

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
		resources deliver the intended outcomes. • Contingency and recovery plans for material partner-capacity constraints.	needed to deliver them. • The Trust cannot always direct resources controlled by partner organisations.	• Partner confirmation of resources committed and available.			
	Resulting in:						
	• Continued inequality in access and in outcomes across Kent and Medway. • Failure to deliver the community mental health model at the pace intended. • Continued delayed discharge and use of out of area beds. • Loss of the Trust's credibility and influence as a system partner. • Failure to deliver the partnership ambitions in Doing Well Together.						

SR8. OPERATIONAL RESILIENCE

There is a risk that the Trust will not maintain operational resilience against disruption, including cyber attack, loss of critical systems and failures of information governance.

Strategy alignment: True North: Resources, and cross-cutting across all five True Norths. No matching capability is named in the strategy.
Owning committee: Audit and Risk Committee. Because the Committee also oversees the whole framework, it reports its assurance on SR8 directly to the Board and internal audit tests SR8 independently.
Risk appetite (Cautious): The Trust prefers safe options that carry a low degree of residual risk. This reflects the Information Security position set by the Board on 6 August 2026.
Current position against appetite: Outside tolerance for cyber-attack (SR8.1), as recorded on InPhase. The two other causes carry no score.
CQC well-led quality statements: Well-led: governance, management and sustainability. The risk also engages the safe key question in respect of records and systems.
Independent maturity rating (Quality Governance Review, 23 January 2026): Digital, Data and Insight: Lagging. That rating concerns data quality and reporting. No category of the review covers cyber security, business continuity or information governance directly.

Scores: Inherent (highest contributing cause): 20 (4 x 5). Current (highest contributing cause): 8 causes 12 (3 x 4), cyber-attack, reduced from 15. Target: 9 (3 x 3) by March 2027, as recorded on InPhase.

Risk maturity: No target was set on 6 August 2026 because the risk did not then exist. The Audit and Risk Committee and Finance and Business Committee is asked to set one.

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
SR8	**There is a risk that the Trust will not maintain operational resilience against disruption, including cyber-attack, loss of critical systems and failures of information governance.**						
	Caused by:						
SR8.1	**Technology vulnerability and technical debt.** Risk: Trust infrastructure, applications or devices may be successfully compromised. Cause: Unsupported, unpatched, insecure or technically vulnerable technology, including the recorded unsupported devices and SMART-device exposure requiring assessment. Effect: Loss of system or information availability, disruption to services and clinical risk from loss of access to records, with associated recovery costs.		•	•			
SR8.4	**Compromise of identities or privileged access.** Risk: Compromised or misused user, service or privileged identities may allow unauthorised access to Trust systems and information. Cause: Incomplete third-party privileged-access rollout and potential gaps in account ownership, access reviews, authentication coverage or control of standing privilege, requiring confirmation. Effect: Information-governance breaches or system compromise, potentially disrupting	•					

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	services, restricting access to records and increasing recovery costs.						
SR8.5	**Insufficient ability to detect and respond to cyber-attack.** Risk: Malicious activity may remain undetected or effective intervention may be delayed. Cause: Recorded gaps in alert generation, log security and proactive discovery, outstanding monitoring integration and response coverage requiring confirmation, including out-of-hours responsibilities. Effect: Cyber compromise may persist or cause greater disruption, increasing loss of access to systems and records, clinical risk and recovery costs.	•		•			
SR8.6	**Inability to recover critical services following cyber compromise.** Risk: The Trust may be unable to restore critical systems, data and services within agreed recovery requirements after a cyber incident. Cause: Compromise of identity services or recovery infrastructure, with identity-independent recovery arrangements still under examination and restoration capability requiring confirmation through testing. Effect: Prolonged service disruption and loss of access to clinical records, increasing clinical risk, paper-based operating requirements and recovery costs.	•		•			
SR8.7	**Human behaviour and cyber security culture.** Risk: An attacker may gain access to Trust systems or information through phishing, credential compromise or unsafe user behaviour. Cause: Insufficient cyber awareness or security culture, reflected in the recorded culture assessment gap; formal training completion does not, by itself, establish safe behaviour. Effect: Information or systems may be compromised, potentially causing confidentiality breaches, service disruption, loss	•		•			

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	of access to records and recovery costs.						
SR8.8	**Insufficient cyber resilience capability and specialist capacity.** Risk: The Trust may be unable to sustain cyber controls or respond effectively to an incident. Cause: Constraints in specialist capacity and skills, recruitment still underway, and key-role, on-call and additional incident-support resilience requiring confirmation. Effect: Controls may not be maintained, monitored or improved consistently and incident response may be delayed, increasing service disruption, clinical risk and recovery costs. National services support, but do not replace, local capacity.	•		•			6
SR8.9	**Inadequate cyber governance, assurance or control implementation.** Risk: Material cyber exposure may persist without effective management intervention. Cause: Potential weaknesses in risk and control ownership, implementation of required controls, evidence validation or action follow-up, with register mappings, scoring, appetite and deadlines requiring reconciliation. Effect: Unresolved exposure may leave the Trust vulnerable to service disruption, information-governance breaches and recovery costs, while limiting the Board's ability to judge whether cyber controls are effective.	•		•			6
SR8.10	**Insufficient capital investment to maintain infrastructure, devices and products.** Risk: Core digital infrastructure and security capability may not be maintained or renewed adequately. Cause: Potential shortfalls in lifecycle investment against technical-debt and security requirements, including the unresolved Pentera renewal or alternative-capability decision. Effect: Greater likelihood or impact of cyber compromise, potentially	•		•			

Ref	Risk, cause and effect	Controls *What is in place to address the cause*	Gaps in control *Where the control does not exist, or does not work*	Assurances *Evidence the controls are in place, are followed, and make a difference*	Gaps in assurance *Where the evidence is absent or insufficient*	Risk Owner	Current Scoring
	disrupting services and access to records and increasing clinical risk and recovery costs. Investment sufficiency and resulting risk reduction require evidence; funding pressure alone does not establish control failure.						
SR8.11	**Third-party or supply-chain compromise.** Risk: Compromise, failure or loss of a critical supplier or externally provided service may affect Trust information, systems, services or recovery. Cause: Dependence on external and fourth-party services, with recorded supply-chain assurance gaps and critical-provider coverage, local responsibilities and recovery arrangements requiring confirmation. Effect: Service disruption, loss of access to information, confidentiality breaches or delayed recovery, with associated clinical risk, financial cost and reputational damage.	•		•			
SR8.2	**Loss of critical systems or services, with business continuity and emergency preparedness arrangements that have not been tested for a prolonged outage.**		•				
SR8.3	**Failures of information governance and data protection, including breaches of confidentiality and of statutory data protection duties.**		•	•	•		
	Resulting in:						
	• Loss of availability or accessibility of key business systems, including patient records and pharmacy information. • Clinical risk arising from loss of access to records. • Breaches of information governance, with penalty or fine from the Information Commissioner. • Financial cost of recovery, and damage to the Trust's reputation. • Disruption to services across every other strategic risk on this framework.						

ANNEX A. WHERE THE CURRENT FOURTEEN RISKS GO

Reclassification changes where a risk is held and by whom it is scrutinised. It does not reduce its seriousness. Every one of the fourteen risks below remains live, scored and owned. The Board asked for assurance that escalation routes keep these risks visible; this table is the basis for that assurance.

InPhase ID	Current BAF risk	Executive lead	Becomes	Treatment
08065	Inpatient flow. Score 20, static.	Chief Medical Officer	SR1.2, with SR7.2 and SR2.7	Cause of SR1 on patient flow. The system-dependent element is a cause of SR7, and the financial effect appears under SR2.7.
08157	Delivering the Community Mental Health Framework. Score 16, static.	Chief Operating Officer	SR1.4	Cause of SR1 on timely access to community services.
02290	Delivery of safe, high-quality care (formerly CQC compliance). Score 16, static.	Chief Nurse	SR1.1	Absorbed into the strategic risk itself. Its components become causes.
07960	Reduce self harm in female patients on acute wards. Score 16, static.	Chief Nurse	SR1.6, with SR4.3	Cause of SR1, with environmental ligature risk under SR4.3.
08337	Organisational culture impact on delivery of strategic ambitions. Score 16, up from 9.	Director of Strategy and Engagement	SR6.1	Cause of SR6
00580	Organisational inability to meet Memory Assessment Service demand. Score 12, at target.	Director of Partnerships and Transformation	SR1.3	Cause of SR1 on access, subject to the review of what follows diagnosis.
07891	Organisational management of violence and aggression. Score 12, static.	Chief Nurse	SR1.7	Cause of SR1, with its effect on staff noted under SR5
04673	Organisational risk, cyber attack. Score 12, down from 15.	Chief Finance and Resources Officer	SR8.1	Cause of SR8. Moved from SR3.1
07557	Trust agency usage. Score 12, up from 9.	Chief Medical Officer	SR2.3 and SR5.3	Temporary staffing cause under SR2 for cost, owned by the Chief Finance and Resources Officer, and under SR5 for supply, owned by the Chief People Officer.
08174	Delivery of financial targets. Score 12, static.	Chief Finance and Resources Officer	SR2.1	Cause of SR2 on the in-year financial position. Target date expired.
08175	Delivery of underlying financial sustainability. Score 12, static.	Chief Finance and Resources Officer	SR2.2	Cause of SR2 on the underlying and medium-term position. Target date expired.
08480	Risk to stakeholder confidence. Score 12, static.	Director of Communications and Engagement	SR7.8	Cause of SR7 on external scrutiny. Moved from SR6.2. Reputational effects are recorded across each strategic risk. No update this period.
08173	Delivery of a fit-for-purpose estate. Score 9, static.	Chief Finance and Resources Officer	SR4.1	Cause of SR4 on investment in the estate. No update this period.
08146	Maintenance of a sustainable estate. Score 9, static.	Chief Finance and Resources Officer	SR4.2	Cause of SR4 on a safe and compliant estate. Appetite verdict corrected to in tolerance.

ANNEX B. WHAT THIS DRAFT STILL NEEDS

This is a working draft. The following are known omissions.

Work remaining:

- Risk management framework has been re drafted and is a work in progress, to be approved
- Risk training to be updated, in progress by Risk Manager
- Operational and Service risk register on inphase to be merged into one to create three distinct areas – Strategic, corporate and then service/operational (naming tbc)

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ANNEX C. WHERE THE MOORHOUSE REVIEW'S SEVEN RECOMMENDATIONS LAND

The Quality Governance Review made seven priority recommendations. Each is mapped below to the causes that answer it

1. Strengthen safety-critical controls and escalation

- Risk formulation, care planning and Mental Health Act statutory compliance sit at SR1.5 and SR1.10. Escalation criteria sit at SR6.5. Variation in clinical leadership sits at SR1.9.

2. Improve governance discipline and assurance standards

- Standardised reporting, action tracking and consequence for slippage sit at SR6.3 and SR6.5. Committee workplans and Terms of Reference sit at SR6.11.

3. Build leadership accountability, capability and psychological safety

- Culture and hotspots sit at SR6.1. Leadership capability and accountability sit at SR6.4. Inclusive working environment and speaking up sit at SR5.6. Supervision sits at SR5.9.

4. Develop data quality and the insight used for assurance

- Data quality sits at SR3.6. Interoperability sits at SR3.3. Access data sits at SR1.12.

5. Embed patient, family and carer involvement and equity in assurance

- Voice as a source of assurance sits at SR6.7. Co-production sits at SR7.5. Equity sits at SR7.7.

6. Strengthen regulatory readiness

- The inspection tracker and evidence library sit at SR6.9. Testing whether completed actions changed practice sits at SR1.8 and SR6.10.

7. Translate quality priorities into operational action

- Improvement method and variation sit at SR1.1. The golden thread sits at SR6.3.

ANNEX D. CAUSE CHANGE LOG, DRAFT 0.6 TO DRAFT 0.8

A cause number is never reused once a cause is removed. This log is the audit trail of how the causes have changed since Draft 0.5, and it is the starting point for the first committee assurance summaries in October. Sixty-three causes become seventy-two: nine are added, two move to another risk under a new number, and one is replaced.

Ref	Cause	Change	Agreed at	Detail
SR1.11	Under-identification of autistic people and people with a learning disability	Amended	Quality Committee session, 15 September 2026	Narrowed to people accessing or referred to Trust services.
SR1.16	Out of area placements	Amended	Quality Committee session, 15 September 2026	Widened to cover children and adults.
SR1.20	Delayed access to children and young people's mental health services	Removed	November BAF review	Held by the Children and Young People's Committee until it stands down. Following review, relevant neuro risk to be managed through the CYP operational/service risk register.
SR1.21	Delayed access to all-age eating disorder services	Removed	November BAF review	Held by the Children and Young People's Committee until it stands down. Following review, a separate BAF cause is no longer considered necessary.
SR2.3	Temporary staffing, bank and agency	Amended	FBI Committee session, 7 September 2026	Widened from agency. Score increased from 9 to 12.
SR2.5	Unplanned variation in demand	Retired	FBI Committee session, 7 September 2026	Replaced by SR2.7. Number not reused.
SR2.7	Cost of out of area placements	Added	FBI Committee session, 7 September 2026	Replaces SR2.5.
SR3.1	Cyber attack	Retired	Board paper, 24 September 2026	Moved to SR8.1. Number not reused.
SR3.3	Poor interoperability across clinical and corporate systems	Removed	November BAF review	Removed to avoid duplication; interoperability issues remain managed through wider digital risks and programme oversight.
SR3.7	Digital innovation and adoption	Added (proposed)	Not yet seen by the Committee	Proposed drafting following the FBI Committee session of 7 September 2026.
SR4.3	Environmental safety in inpatient areas	Amended	FBI Committee session, 7 September 2026	Reworded to cover fixed and non-fixed ligature risks, with ligature named explicitly.
SR4.6	Location of services for neighbourhood working	Added	FBI Committee session, 7 September 2026	New cause.
SR4.7	Tenure, owned or leased	Added	FBI Committee session, 7 September 2026	New cause.
SR4.8	Green Plan and environmental sustainability	Added	FBI Committee session, 7 September 2026	New cause.
SR5.1	National shortage of key clinical roles	Amended	November BAF review	Significantly developed. New risk narrative, current/proposed scoring, targeted recruitment, workforce planning, work experience and professional-body/university partnerships have been added.

Ref	Cause	Change	Agreed at	Detail
SR5.2	Competition for staff from other providers	Amended/ Recommended to remove	People Committee session, 15 September 2026	Clarified to include pay differences across the county boundary. Held at a low score while evidence is gathered. Voluntary turnover has remained below 8% for 18 months and is currently 7.3%.
SR5.3	Reliance on agency and temporary staffing	Amended	November BAF review	**Expanded/reframed.** Now explicitly covers continuity and quality of care **and financial stability**, supported by a rewritten risk description and additional controls. Current score is shown as **16**, proposed 8.
SR5.4	Absence of transformative workforce models, including new and extended roles	Removed	November BAF review	Incorporated within SR5.10 and delivery of the Strategic Workforce Plan.
SR5.5	Limited career pathways, development and talent management	Amended	November BAF review	Substantially expanded with a new risk description, current score **15**, proposed score **6**, and new controls around career pathways, niche roles, development moves and succession planning.
SR5.6	Trust not being a good employer, including EDI/workforce equality standards	Removed	People Committee session, 15 September 2026	Proposed to close under SR5 and move into SR6. Relevant cultural, fairness and inclusion elements now incorporated within SR6.
SR5.7	Medical and clinical staffing in transferred CYPMHS and AAED services	Removed	November BAF Review	To be removed from the BAF and managed through the CYP Directorate risk register.
SR5.10	Absence of a strategic workforce plan	Added	People Committee session, 15 September 2026	New cause. Expanded significantly. It now incorporates **transformative workforce models from SR5.4**, skills-mix/gap analysis and workforce supply/build roles. Current score **16**, proposed **8**.
SR5.11	Sickness absence rate consistently above Trust target	Added	November BAF review	Reflecting the impact of sustained sickness absence on workforce capacity, staff and patient experience and temporary staffing requirements.
SR6.1	Organisational culture	Amended	November BAF review.	Ownership moved to the Director of Strategy and Engagement. This now absorbs the former organisational culture, leadership capability and Board visibility causes. Score has been amended to **12** in the table following comments.
SR6.2	Variable patient, family and carer involvement and influence	Added	November BAF Review following Board Seminar	**New InPhase cause.** Proposed score 16. Driven by inconsistent involvement and the risk that involvement becomes process rather than genuine partnership.

Ref	Cause	Change	Agreed at	Detail
SR6.3	Variable trust and follow-through on concerns	Added	November BAF Review following Board Seminar	**New InPhase cause.** Proposed score 16. The September 2026 deep dive identifies this as the Trust's principal cultural weakness.
SR6.4	Limited staff empowerment, delegated authority and ownership of improvement	Added	November BAF Review following Board Seminar	**New InPhase cause.** Proposed score 12.
SR6.5	Inequitable experience of fairness, inclusion and belonging across professions, teams, services and protected characteristics	Added	November BAF Review following Board Seminar	**New InPhase cause.** It takes in values/inclusion previously sitting under SR5.6. Current table score is 16.
SR6.6	Limited recognition, organisational pride and advocacy	Added	November BAF Review following Board Seminar	**New InPhase cause.** Linked to the staff-recommend breakthrough objective. Current table score 12.
SR6.7	Variation in organisational capability, capacity and ways of working to deliver change, innovation and system transformation	Added	November BAF Review following Board Seminar	**New InPhase cause.** Proposed/current score 12. Change fatigue and competing priorities are specifically identified.
SR7.6	Dependencies on NELFT for transferred services	Amended	Partnership Committee session, 14 September 2026	Kept as a time-limited cause. Now covers digital systems and inquests.
SR7.8	External scrutiny and stakeholder confidence	Added (moved)	Board paper, 24 September 2026	Moved from SR6.2. Score 12.
SR8.1	Cyber attack	Added (moved)	Board paper, 24 September 2026	Moved from SR3.1. Score reduced from 15 to 12.
SR8.2	Loss of critical systems, business continuity	Added	Board paper, 24 September 2026	New cause under the new SR8.
SR8.3	Information governance and data protection	Added	Board paper, 24 September 2026	New cause under the new SR8.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details	
Date of meeting:	26 November 2026
Title of paper:	Neighbourhood Health Collaborative Board Progress Report
Author:	Julia Hart, Deputy Director, Neighbourhood Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of paper

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

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

This report includes:

- An update on the work of the Neighbourhood Collaborative and the mental health case for change
- An update on the dementia transformation programme
- An update on Enhanced Therapeutic Observations and Care
- An update on key performance metrics including Urgent and Emergency Care (UEC).

Areas to bring to the Board's attention

- Mapping of MHLDA services across Kent and Medway in alignment with the Integrated Care Board (ICB) to identify services and gaps
- Dementia -Level 1 training has been delivered across care homes and primary care but some funding and contract mechanisms remain unresolved limiting primary care participation and evaluation
- The Enhanced Therapeutic Observation and Care (ETOC) programme continues to make progress in strengthening system-wide governance, clinical oversight and reduction of avoidable enhanced care use. The agreed 10% system spend reduction target remains starting point for system recovery phase.

Version control 02 - **Public**

Governance

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

1. Neighbourhood Health Collaborative

Across Kent and Medway, neighbourhood health has moved from initial mobilisation into a structured test-and-learn phase. Forty-five single-neighbourhood footprints and nine multi-neighbourhood areas have been established, with the latter grouped into four clusters to support integrated clinical, operational and system leadership. The Single Neighbourhood contract was mobilised in July 2026 with full GP practice participation, and the proactive and reactive care model developed in Folkestone, Hythe and Rural is now being extended to six further neighbourhoods to test its effectiveness and scalability. In parallel, work is progressing to define a consistent multi-neighbourhood model for intermediate care, admission avoidance and discharge, linking neighbourhood teams with urgent community response, virtual wards, Home First and hospital services. The programme is therefore moving in a positive direction, although further work is required to strengthen workforce capacity, information sharing, outcome measurement and the consistency of delivery before a final model is agreed for wider implementation

The Kent and Medway Neighbourhood Health Collaborative programme is increasingly moving from design and mobilisation into delivery and the continued development of the multi-neighbourhood model and integrated proactive and reactive approaches to care. The focus is now on embedding delivery, evaluating what is working and building on learning to further develop and scale neighbourhood-based models across Kent and Medway. Mental health is an integral part of this work. The aim is to develop an integrated, neighbourhood-based approach to mental health support across Kent and Medway, informed by population need, service utilisation and outcomes. The ambition is to make sure mental health is fully embedded in wider neighbourhood health and care models, connecting primary care, community services, local authorities, VCSE partners and specialist mental health services around people rather than organisations.

Programme Priorities

The delivery of the case for change is being progressed through the system wide Mental Health Neighbourhood Leadership Working Group with the neighbourhood collaborative contributing to each of the different elements. These are-:

Priority	Focus
1. Crisis prevention and flow improvement	A coordinated crisis-prevention and flow-improvement model combining step-down capacity, Assist & Embrace and alternative crisis pathways, including with South East Coast Ambulance Service, to reduce ED attendances, avoidable admissions and out-of-area placements
2. Dementia support closer to home	Closing the post-diagnostic support gap and rebalancing delivery between KMMH and VCSE partners, with specialist clinical interventions retained by KMMH and more personalised support provided in neighbourhoods
3. Primary care mental health	A sustainable, well-supervised Mental Health Practitioner workforce embedded in neighbourhood teams and aligned with Mental Health Together

The wider review of mental health commissioning will test how pathways work across the system's Four Layers of Care. The table below gives an initial view of where each priority sits across those layers, and shows that intervention is needed at every layer, not just in acute care.

Layer of care	Where the three priorities sit
Primary care	• Mental Health Practitioners working in general practice (priority 3) • Streamlined dementia diagnosis for non-complex cases, supported by GPs with extended roles (priority 2)
Single neighbourhood	• Mental Health Practitioners linked to neighbourhood teams through a named link person (priority 3) • Dementia Care Coordinators and VCSE post-diagnostic support (priority 2) • Identifying rising-risk and high-intensity cohorts earlier, including people not known to services (priority 1) • Early crisis prevention, including Assist & Embrace and Safe Havens (priority 1)
Multi-neighbourhood	• Community mental health services aligned to multi-neighbourhood footprints through Mental Health Together (priority 3) • Specialist dementia assessment, diagnosis and Cognitive Stimulation Therapy (priority 2) • Crisis Recovery Houses and step-down capacity (priority 1)
Acute	• Fewer mental health ED attendances, avoidable admissions and out-of-area placements – achieved mainly by identifying and supporting people earlier in primary care and neighbourhoods, alongside more timely discharge (priority 1)

Leadership and governance

The Mental Health Neighbourhood Leadership Working Group was established in October 2026 and meets fortnightly. Donna Hayward-Sussex chairs the group as Executive SRO, as agreed through system chief executives. Its agreed terms of reference set out its scope across multi-neighbourhood development, the three strategic priorities and the cross-cutting enablers – population health, workforce, finance, benefits realisation, data and digital, VCSE capacity, estates and engagement.

The dementia workstream SROs are Adrian Richardson and Rakesh Koria, Clinical Director for Neighbourhood Health at Kent and Medway ICB. There are proposed leads for the other two workstreams.

Stakeholder engagement and early mapping

A system stakeholder session was held on 2 November 2026, with partners from the ICB, both councils, primary care, acute and community providers and the VCSE sector invited to test an initial view of current provision, with a focus on crisis prevention and primary care mental health. Draft service maps and a short survey were shared to gather further input. This will be aligned with the mapping work being undertaken as part of the mental health commissioning review.

How our phased approach aligns with the commissioning review

Our four-phase approach has been established. Phase One will be undertaken by the ICB as part of the commissioning review. The remaining phases are led by the Working Group and are not dependent on the review's later stages. Where the review's pathway findings and recommendations add to or challenge our plans, we will use them to test and refine what we are doing rather than waiting for them.



Figure 1. Neighbourhood mental health phased approach

The table below sets out how and when each phase will be taken forward.

Our phase	How and when it will be taken forward
1. Understand need and current provision	Baseline drawn from the review's Stage 1 diagnostic (December 2026), with our mapping, survey and business case evidence as input
2. Design future neighbourhood models	Led by the Working Group from December 2026, using the Stage 1 baseline and learning from delivery in the three priority areas, with the full plan to the Alliance in January 2027

Our phase	How and when it will be taken forward
3. Identify gaps and opportunities	Led by the Working Group, comparing the Stage 1 baseline with the agreed neighbourhood model; refined as the review's pathway findings emerge
4. Embed, scale and sustain	Already under way through delivery in the three priority areas, and continuing throughout

2. Programme updates November 2026

2.1 Crisis prevention and flow improvement

This covers people whose mental health needs are escalating, who are at risk of crisis or in crisis, or who need support to recover and step down after a crisis episode. It includes activity aimed at:

- preventing escalation where there is an identifiable risk of crisis
- supporting people experiencing a mental health crisis
- providing alternatives to hospital attendance or admission where appropriate
- improving flow through mental health crisis pathways
- supporting recovery and transition back into community-based support following crisis.

It is the largest and most complex of the three areas, so the first phase will be deliberately incremental to avoid the scope expanding faster than the system can deliver.

Between now and January 2027 we will:

- Build a forward-looking understanding of our bed base – current and future demand, length of stay and length of treatment, and patients who are clinically ready for discharge – to set out the step-down and community capacity we will need.
- Scope the trust-wide extension of Assist & Embrace, and confirm where the Safe Haven model and data sit within this workstream.
- Agree an initial set of outcome measures against 2025/26 baselines.

Key interdependencies include corridor care, the Staying Well programme, mental health emergency departments, Safe Havens, community mental health transformation (Mental Health Together) and primary care neighbourhood developments.

2.2 Dementia Transformation Programme

Dementia Transformation Programme

Since the previous Board update, Kent and Medway's Dementia Diagnosis Rate has increased to 63.2% for Q2 2026/27, 0.5 percentage points above the previous quarter and the highest recorded for the county. Although below the national ambition of 66.7%, this demonstrates continued progress in earlier identification and diagnosis.

The improvement is a reflection of the internal dementia programmes within KMMH as well as the continued progress within the community model.

Level 1: care-home diagnosis

Training has been delivered across care homes and primary care, with further interest generated through the Kent County Council Registered Managers Forum.

Funding and contract mechanisms remain unresolved, which is limiting primary care participation and the activity available for evaluation. The key sticking point is agreement of the contractual mechanism and payment for the additional primary care activity required within the model. Discussions between the ICB and LMC are continuing, with a further formal discussion to progress agreements 25 November. Training materials, care-home engagement and mobilisation activity are continuing in parallel so implementation can progress once agreement is reached.

Level 2: community assessment and diagnosis

The first Level 2 pilot is live in Folkestone, Hythe and Rural. The operating procedure, prescribing pathway, competency framework, clinical governance, administrative responsibilities and evaluation requirements have been established.

The pilot was due to mobilise in August 2026, and formally launched on 28 September, with effective referral flow beginning in the week commencing 12 October and assessments starting in the week commencing 19 October. This was later than planned due to the time required to establish safe workforce, governance, administrative and digital arrangements.

At the latest complete reporting point (19 October), the pilot had received 15 referrals, booked 10 assessments and completed four assessments. Diagnostic outcomes were not available at the reporting cut-off. Five referrals were declined during the first two weeks of active data flow. Referral appropriateness and the reasons for declined referrals will inform pathway guidance and primary care education.

Impact will be assessed through a defined evaluation framework covering referral activity and appropriateness, time from referral to assessment and diagnosis, diagnostic outcomes, patient and carer experience, workforce feedback, clinical safety and resource impact. This will provide the evidence required to determine whether the model is safe, effective and suitable for wider rollout.

It is too early to draw conclusions about diagnostic outcomes, time to diagnosis or impact on the wider Memory Assessment Service. However, the pathway is operational, and people are progressing to assessment. Early implementation has identified the need for dedicated administrative support, a standardised EMIS referral template, clear consent arrangements, improved referral quality and consistent clinical, operational and experience data.

Clinical assurance includes an agreed competency framework, advanced practitioner supervision, consultant oversight, diagnostic formulation meetings, specialist input into initial cases, direct clinical review where required and escalation of complex presentations to Level 3.

The planned Q1–Q2 clinical audit will now follow implementation and assess activity, referral appropriateness, clinical outcomes, timeliness, experience and operational impact. Expansion to Total Health Excellence and The Marsh has also moved from Q2 into November because of

workforce pressures, stakeholder availability and local readiness. Applying learning from Folkestone, Hythe and Rural before wider rollout provides a safer and more sustainable basis for expansion.

Digital cognitive assessment opportunity

There is an opportunity to use the Level 2 community pathway as a proof of concept for Cognitron digital cognitive assessment, alongside related discussions and testing within KMMH. The proposed approach would enable digital cognitive assessment to be explored across both existing KMMH pathways and the developing community model, initially involving Folkestone, Hythe and Rural, Total Health Excellence and The Marsh, with a further Medway site to be identified.

Next steps are to confirm scope and timing, secure clinical and information governance oversight, and agree how usability, pathway impact and outcomes will be evaluated. Testing will be integrated within the wider diagnostic pathway and would involve a further pilot period from January to March 2027, with learning informing any future decision on adoption or scale.

Pre- and post-diagnostic support review

The previous Board report brought pre- and post-diagnostic support within the programme's scope. The principal system engagement phase has now been completed.

A multi-agency workshop on 6 October brought together primary care, health and social care providers, local authorities, voluntary and community sector organisations, specialist practitioners and lived-experience representatives. It built on service mapping, patient and carer feedback, professional surveys and comparator learning.

The central finding was that support should begin at first concern, continue through assessment and diagnosis, and adapt as needs change. Key themes included a named point of contact, accessible information, proactive follow-up, carer support, local community support, clear routes back into services and crisis prevention.

Outputs have been consolidated into proposed design principles covering a minimum neighbourhood offer, the future operating model, equality considerations, workforce requirements, outcomes and commissioning responsibilities.

Senior responsible officers have reviewed and supported the initial outputs. The original timetable anticipated workshop output validation by wider system stakeholders by the end of October, this will now take place in November ahead of recommendations being further refined. A wider socialisation and co-production phase will now test the emerging recommendations directly with citizens through lived experience and dementia support groups across Kent and Medway. This will provide further opportunity for people living with dementia and carers to confirm whether the proposed priorities reflect their experience, identify anything missing and help refine the recommendations before they are finalised and discussed with commissioners.

This work will strengthen proposals for care-home support, community crisis prevention, young-onset and rare dementias, support following Level 3 diagnosis, and alignment across health, local authority and voluntary and community sector services. The modest timetable movement provides greater assurance that recommendations are co-produced and suitable to inform future commissioning.

Overall position and immediate priorities

The programme has made substantive progress since the July 2026 Board report. Level 2 is operational, the principal pre- and post-diagnostic workshop has been completed, and Kent and Medway has achieved its highest recorded Dementia Diagnosis Rate.

Not all original milestones have been achieved. Level 1 remains dependent on funding agreement; Level 2 mobilisation and evaluation started later than planned; and expansion has moved into November. These variances are monitored through weekly highlight reporting and programme governance.

A related risk is the loss of routine Primary Care Network-level Dementia Diagnosis Rate reporting following changes to the national dataset. Practice dementia-register counts will provide interim trend information while longer-term analytical options are explored. This limits attribution of diagnosis-rate changes to individual pilots but does not prevent monitoring of activity, outcomes and experience.

The three immediate priorities are:

1. **Level 1 funding and contracting:** Secure primary care funding and contracting mechanism to enable wider implementation and evaluation.
2. **Level 2 scale-up and evaluation:** Sustain and evaluate Folkestone, Hythe and Rural pathway and safely mobilise further pilots, applying early learning and assessing clinical outcomes, timeliness, experience and operational impact.
3. **Future pre- and post-diagnostic support model:** Validate the October workshop outputs through further lived-experience engagement and share findings with commissioners in December to inform future support-model design.

2.3 Primary Care Mental Health

Primary care mental health – This builds on the Folkestone, Hythe and Romney Marsh pioneer, which Andy Cruickshank is leading. The central question is how Additional Roles Reimbursement Scheme (ARRS) funding can best support both adult and children and young people's mental health needs in primary care, most likely through a multidisciplinary team approach.

Between now and January 2027 we will:

- Confirm the current number, employment and supervision arrangements of Mental Health Practitioners by PCN, and how these map to the 45 single neighbourhoods.
- Agree with GP partners a standard model with room for local tailoring, including formal clinical supervision from KMMH through Mental Health Together and a single identified link person in each neighbourhood.
- Scope how the model can extend to children and young people's mental health.
- Agree with the ICB and GP partners the framework we want to work within for primary care mental health.
- Agree how primary care mental health will be commissioned.

Key interdependencies include the implementation of Mental Health Together, which will align community mental health services to multi-neighbourhood footprints with referral based on GP registration, the PCN DES local variation and the Single Neighbourhood Health Offer, and the development of integrated neighbourhood teams.

3. Provider Alliance Improvement Programmes November 2026

3.1 Enhanced Therapeutic Observation and Care (ETOC)

The **NHS England Enhanced Therapeutic Observations and Care (ETOC) Programme** is a multi-year improvement programme designed to support NHS organisations to strengthen the way enhanced care is assessed, delivered and overseen. ETOC is intended to provide safe, effective and therapeutic care for patients requiring additional observation and support, while promoting recovery, dignity and a person-centred approach. The national programme is structured around four key pillars: effective leadership and oversight; person-centred and safe therapeutic care; education and training; and effective workforce planning and deployment.

The programme aims to improve **patient outcomes and experience**, ensure ETOC is used appropriately and proportionately, strengthen staff skills and organisational governance, and support more effective workforce deployment. It also seeks to reduce length of stay where appropriate, improve workforce efficiency and reduce reliance on temporary staffing through locally led, clinically informed models of care. This provides a national framework within which systems can reduce unwarranted variation and develop safer, more sustainable approaches to enhanced care.

Kent and Medway in 2025 re-established a Steering Committee to drive this work forward. The Committee meets monthly to review progress against agreed national and local targets.

Overall progress and assurance: The ETOC programme continues to make progress in strengthening system-wide governance, clinical oversight and reduction of avoidable enhanced care use. The agreed 10% system spend reduction target remains starting point for system recovery, with a continued focus on appropriate onward care, early identification of complex cases and reducing prolonged ETOC episodes. Providers are developing and refining assurance arrangements, including daily clinical reviews and regular check-and-challenge processes. However, variation in practice, gaps in provider quality data and inconsistent recording of ETOC-related incidents continue to limit system-wide comparison and assurance. The programme is therefore maintaining a quality-led approach, with expenditure considered alongside patient safety and clinical outcomes, recognising the impact of delayed discharge, bed capacity and wider system constraints. Two work streams have been created as task and finish groups to deliver distinct pieces of work.

1. ***Standardisation of clinical processes:*** The clinical process workstream is nearing completion, with a one-page guide developed to establish consistent expectations for assessment, review and escalation while retaining appropriate local flexibility. Key expectations include a minimum 24-hourly review and escalation where ETOC continues beyond 72 hours. Work is also progressing to strengthen organisational accountability and evidence that agreed

processes are operating in practice, including more consistent out-of-hours decision-making. The workstream has recognised that a single enhanced-care assessment is not an immediate priority given differences in patient groups, clinical requirements and digital systems. The next priority is to embed and evidence consistent practice; improve incident reporting and ensure financial reductions do not compromise patient safety.

2. ***ETOC training framework:*** A system-wide training framework is being finalised around bronze, silver and gold levels, differentiated by staff roles and responsibilities, from general workforce awareness through to enhanced-care delivery and senior clinical decision-making. Existing provider materials are being reviewed to reduce duplication and develop a consistent core offer, supported by practical case studies, competency requirements and learning from incidents. The framework will address clinical judgement, therapeutic engagement, restrictive practice, escalation and decision-making out of hours, with appropriate coverage of mental health, dementia, delirium, learning disability, autism and other relevant needs. Expected go-live of Q4 for system framework.

Key dependencies remain the finalisation and governance sign-off of the framework, confirmation of ownership and hosting for shared e-learning, and agreement on delivery arrangements across organisations. These are important next steps in addressing variation in staff capability and supporting safer, more consistent and cost-effective ETOC practice across the system while maintaining quality of care for patients facing mental health, dementia or delirium issues.

4. Near-term milestones

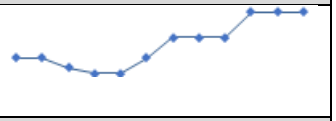
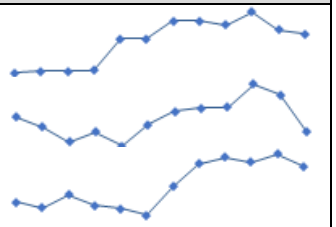
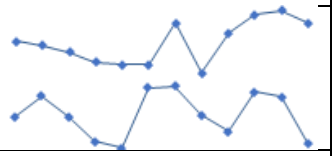
The milestones below take the programme from the Stage 1 baseline to the full plan in January 2027. Each workstream will have its own detailed delivery plan, and the full plan will bring these together into a single critical milestone roadmap.

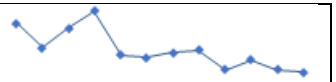
When	Milestone	Lead
November 2026	Working Group confirms workstream leads	Executive SRO
November 2026	Mapping, survey and OBC4 evidence shared with the review team; single data request route agreed with the ICB	KMMH Strategy and Delivery teams with ICB
November 2026	Lived experience, family and carer representation agreed for the Working Group	Executive SRO
Late November / early December 2026	MHLDA review Stage 1 diagnostic report	ICB

When	Milestone	Lead
December 2026	Working Group reviews the diagnostic and Stage 2 priorities, and confirms implications for the three priority areas	Working Group
December 2026	Clinically ready for discharge and length of stay baseline complete	KMMH Finance
To be agreed	Paper to the Provider Alliance on current impact and plans to support urgent and emergency care this winter	Executive SRO
January 2027	Full neighbourhood mental health plan and milestone roadmap to the Provider Alliance	Executive SRO
February 2027	MHLDA review final report and implementation roadmaps	ICB
May 2027	Mental Health Together implementation, aligning community mental health services to multi-neighbourhood footprints	KMMH

5. Current performance data

Overall performance remains mixed: dementia diagnosis has continued to improve but remains below ambition; Safe Haven use has increased compared with earlier in the year, while urgent care demand and crisis-house utilisation remain variable.

Measure	Agreed trajectory	Current data												AVG	Line Graph
		Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sep 26		
Methodology: Red, Amber, Green (RAG) is determined by two factors; • Agreed target, or • Averages. These are compiled based on performance data for the previous 12-month financial period covered and may therefore change for the report period being covered.															
		Programme: Dementia Pathway Transformation													
Increase dementia diagnosis rate	66.7% by March 2026	62.3%	62.3%	62.1%	62.0%	62.4%	62.4%	62.7% (now quarterly)			63.2%			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*												1.82%	
		1.14%	1.17%	1.18%	1.19%	1.9%	1.9%	2.3%	2.3%	2.2%	2.5%	2.1%	2.0%		
		A&E attendances for adult patients with primary MH need												855	
		866	805	713	771	688	820	898	920	927	1069	1001	779		
		Safe Haven attendance												1989	
		1811	1753	1887	1778	1748	1681	1976	2210	2284	2232	2320	2190		
Crisis house bed occupancy	85%	*Medway bed occupancy*												N/A	
		85%	83%	80%	75%	74%	74%	94%	70%	89%	98%	100%	94%		
		Ashford bed occupancy													
		80%	90%	80%	68%	80%	68%	95%	81%	73%	92%	90%	67%		
Reduced mental health in ambulance/ police conveyances to A&E	Reduce	*Primary MH A&E presentation - Ambulance conveyance*												432	
		410	381	346	110	375	424	527	533	500	621	535	422		
		Primary MH A&E presentation - Police conveyance												42	
		38	24	31	23	50	51	57	42	48	55	41	36		

Reduction in incidence of Section 136	Reduce	68	58	66	73	55	56	56	57	49	53	49	48	57	

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	26th November 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 and endorsement (proposed changes to quality targets and reporting)
Submission to Board:	Standing Order

Overview of paper

The IQPR gives an integrated assessment of performance against our Doing Well Together strategy and the wider quality and performance measures that need the Board's greatest attention. Overall assurance remains partial and limited for inpatient flow. Some access and safety measures are improving, but improvement is not yet consistent across services or shown to be sustained.

Issues to bring to the Board's attention

The Board is asked to NOTE:

- **Assurance is partial overall and limited for flow.** Improvement is real in places, but not yet consistent or shown to be sustained.
- **We are ahead of national comparators in some areas.** Crisis response is in the best national scoring band, 69.9% started treatment within 18 weeks (61.7% nationally), and finance is in the top quartile nationally.
- **Improving:** long waits in community are falling, September staying well (flow) measures improved, and risk assessment, medication safety and clozapine monitoring are all better.
- **Patient flow is our most significant risk.** Occupancy is 95.4% against a 90% target in our Staying Well true north ambition (89% nationally). However, initial October data, outside of this report, shows delayed discharges increasing again. The October 60-day sprint is the main immediate improvement response.
- **Priority areas for improvement:** patient experience scores have fallen, outcomes are not yet measurable, and there are access gaps and inconsistency in community Mental Health Together, memory assessment and CYP services.

The Board is asked to ENDORSE proposed changes to six quality measures and targets (see Quality & Safety section).

Governance

Implications/Impact:	Patient safety, access and flow, finance. Regulatory oversight by CQC and NHSE/I.
Assurance:	The Board can take partial assurance overall and limited assurance on inpatient flow. Sustained, measurable impact is not yet demonstrated.
Oversight:	Oversight by Trust Board and all Committees

Chief Executive Summary

The November 2026 Integrated Quality and Performance Report (IQPR) provides partial assurance overall and limited for patient flow. There is clear evidence of progress in adult community access, including reductions in the number of people waiting more than 38 weeks, alongside improvements in risk-assessment compliance, medication safety and clozapine monitoring. However, the impact of these improvements remains variable between services and directorates. Our central assurance test is therefore whether improvements are being consistently embedded and sustained, and whether they are delivering demonstrably better outcomes and experiences for patients rather than improvements in activity or recording alone. At this stage we are unable to take assurance this is the case.

Why these five areas. Doing Well Together, our five-year strategy, focuses on five True North priorities (timely access, safe care, positive experiences, smarter working and staying well), and the IQPR measures them, because they are where we most need to improve and where the difference for people will be greatest. The Quarter 1 National Oversight Framework supports this: we rank 53 of 58 providers (segment 3), in the top quartile for finance, productivity and innovation, but the bottom quartile for access, people, experience and effectiveness. Seven of ten comparable mental health trusts are also in the bottom quartile for access. This report is therefore deliberately weighted towards our hardest challenges, as well as those areas of national and regional priority, not a balanced scorecard of everything we do.

Where we are doing well. Our crisis response is in the best national scoring band (83% seen face-to-face within 24 hours in September). Inpatient length of stay reduced by 4.86 days between August and September, providing an encouraging early sign of improved flow, although sustained improvement is not yet demonstrated. 14-day readmissions fell from 8.9% to 7.4%, and out-of-area placement days fell by 9.5% in September. 69.9% of people in the community started treatment within 18 weeks against 61.7% nationally, and adult waits over 38 weeks have roughly halved since January, to 154. We are top quartile nationally for finance, productivity and innovation, and productivity above the 2% national target. Risk-assessment compliance, medication errors and clozapine monitoring have all improved as part of our Quality Improvement Plan, and NHS England and Kent and Medway Integrated Care Board (ICB) colleagues have provided highly positive feedback on this focused work.

Where we must improve. The area requiring the most sustained executive focus remains inpatient flow and capacity. This remains our most significant organisational risk and a multifaceted one. Bed occupancy remains at 95.4% against a 90% standard and above the reported national level of 89%, while clinically ready for discharge delays and reliance on external placements continue to constrain capacity. Although there were encouraging improvements in September, these predated the 60-day flow sprint and subsequent reporting must demonstrate that reductions in length of stay, delayed discharge and out-of-area placements can be sustained without adverse consequences for safety, patient experience or readmissions. The Supporting Recovery and Living Well programme now must establish clear trajectories, milestones, benefits and accountable ownership, supported by validated bed modelling.

We must retain a strong focus on patient experience, consistent safety controls and outcomes. Reported patient-experience scores have declined, particularly in relation to communication, involvement and continuity of care, and we need clearer evidence that feedback and complaints are changing practice. Variation remains in depot physical-health monitoring, 72-hour follow-up, care planning and risk assessment within CYP services. DIALOG+ must increasingly demonstrate whether care is improving the outcomes that matter to patients, supported by stronger paired-assessment completion and evidence that findings are influencing individual care plans and service improvement.

How this connects with our Board Assurance Framework (BAF). This report is first-line evidence for five of the eight strategic risks: SR1 (safe, high-quality care and timely access), SR2 (financial sustainability), SR5 (workforce), SR6 (leadership and culture) and Inpatient flow (SR1.2). Inpatient flow is the highest-scoring cause on the BAF, at 20, which matches our limited assurance on flow in this IQPR. The access, safety and patient-experience measures in this report map to SR1 and SR6 causes, and the "next assurance points" in each section are the evidence the BAF and Board needs to see before scores can reduce.

Decision for the Board. We ask the Board to endorse proposed changes to six quality measures (Refs 25, 29, 30, 31, 39 and 45), including extending the complaint response time from 30 to 40 days with a 95% compliance target, in line with benchmarking. The Quality Committee will consider the impact.

Next steps. Over the coming months, executive attention will remain focused on converting early improvement into sustainable delivery. By January 2027, we expect to see further reductions in long waits across all three community directorates and a clinically validated productivity baseline with clear improvement priorities. Alongside this, we must have improved flow performance on a sustained basis. I strongly believe a large part of this is within the organisations ability to improve and we must proactively. demonstrate evidence of control.

Board focus.

The Board should therefore seek assurance over the coming months that:

- adult access improvement is sustained and replicated across all three community directorates;
- the 60-day flow programme delivers demonstrable reductions in Clinically Ready For Discharge (CRFD), occupancy and out-of-area use;
- safety improvements are sustained and unwarranted service-level variation reduces;
- patient and staff experience actions produce measurable improvement;
- DIALOG+ develops into a meaningful measure of clinical outcomes, rather than primarily a completion measure; and
- productivity and financial improvement become increasingly recurrent and demonstrably release clinical capacity.

NHS
Kent and Medway
Mental Health
NHS Trust

Integrated Quality & Performance Report

(IQPR)

November 2026
(September Data)

1

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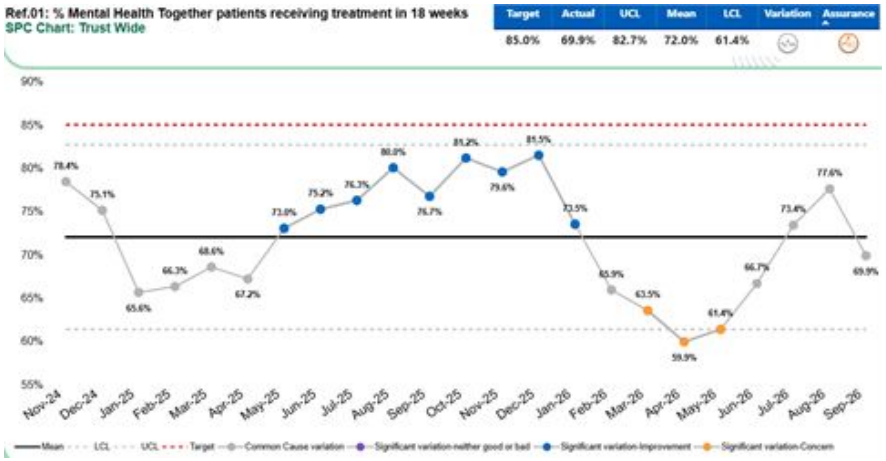
1.Doing Well Together



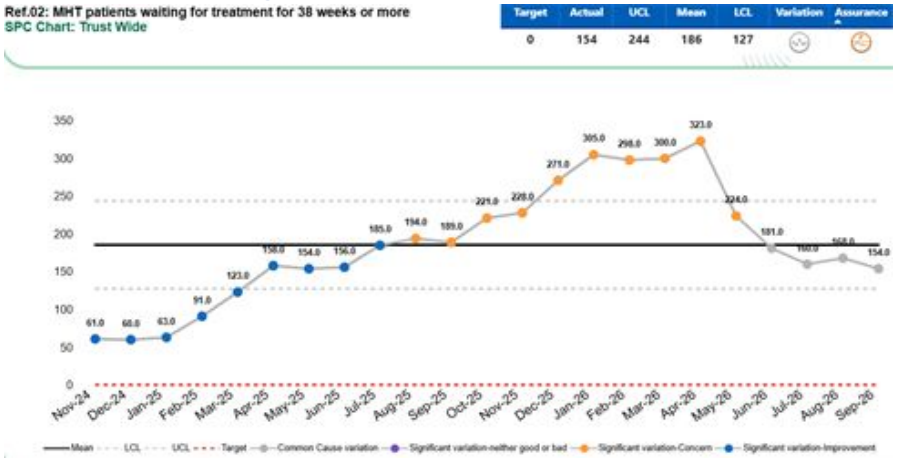
People can get the right mental health support at the right time, close to home wherever they live.

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

True North



Breakthrough



Assurance level: Partial Assurance

Direction of travel: Improving, but there is variation across the directorates.

Key Assurance Challenge: The key challenge is demonstrating that current improvement is sustained and replicated across all directorates, reducing variation and releasing measurable capacity. Assurance is dependent on evidence that improvements are embedded rather than concentrated within individual services or areas.

Current: Performance continues to demonstrate progress towards the 85% 18-week True North goal. In September, 69.9% of patients started treatment within 18 weeks, while the number waiting over 38 weeks reduced further to 154, following a reduction of close to 50% in quarter one and further improvement in quarter two. CQC's 2025/26 State of Care report recorded national performance at 61.7%. The average wait from referral to treatment commencement also reduced to 99 days in September, compared with an average of 113 days over the preceding four months.

The overall direction of travel is improving, particularly for the longest waits, but improvement is not yet consistent across all directorates. East Kent accounts for 86% of the reduction in long waits, reflecting both significant improvement and its larger share of activity and long waits. North Kent experienced an increase in waits over 38 weeks during September, primarily driven by challenges within one team in maintaining effective oversight and management of the waiting list. Separately, planned interventions to support recovery have been delayed pending completion of partner recruitment. The position is therefore improving with continued variation, rather than stabilisation.

Main change: With staff consultation concluded, the programme is moving from redesign into implementation, with rollout of the full revised model planned to be complete by May 2027. The immediate priority is completing partner recruitment and preparing for consistent implementation across all areas. Success will be assessed after implementation and embedding through sustained improvement across North, West and East Kent, reduced directorate variation and continued progress towards the 85% 18-week True North goal.

Looking ahead: We remain on track to deliver the year-one breakthrough objective by March 2027, notwithstanding the recent dip in North Directorate performance. Delivery remains challenging, however, with demand and capacity modelling identifying additional workforce requirements, which are currently being addressed through phased recruitment across KMMH and partner organisations.

Partner mobilisation is unlikely to begin before March 2027, with rollout planned to be complete by May 2027. Learning from the Medway pilot indicates an approximately 12-week implementation and embedding period, during which training and induction can temporarily constrain treatment capacity and increase waits. Successful recruitment and embedding will therefore be critical to expanding capacity and sustaining reductions in waiting times.

Reducing the backlog of people experiencing the longest waits remains an important component of improving 18-week performance, but it will not, in isolation, deliver the ambition of 85% commencing treatment within 18 weeks. The underlying challenge is also one of demand and treatment capacity. Community mental health activity increased by approximately 26% between 2023 and 2025, and this higher level of demand has subsequently been sustained. Between November 2025 and October 2026, 43,306 referrals were received, averaging 3,609 per month, broadly consistent with the previous 12-month baseline of 3,637 per month. This indicates that services are operating with sustained demand at an elevated level rather than managing a short-term increase. Achieving and sustaining the 85% ambition will therefore require both continued reduction of the existing backlog and sufficient recurrent treatment capacity to meet ongoing demand and prevent a new long-wait cohort developing. This is reflected in the demand and capacity modelling, which has identified the requirement for additional staffing, alongside implementation of the revised clinical model and, over the longer term, development of neighbourhood and primary care mental health capacity.

The Neighbourhood Mental Health programme is expected to support this by strengthening demand management, earlier intervention and community capacity, including more sustainable primary care mental health provision. Over time, this should reduce reliance on Mental Health Together, help prevent avoidable escalation into secondary care and enable specialist services to focus capacity on people with more complex needs. Agreement of the primary care model is targeted for March 2027; this is a model-agreement milestone, not delivery of additional capacity. The timing and scale of the benefit, and its impact on the 18-week trajectory, cannot yet be quantified with confidence.

Next assurance point: January 2027 will assess whether improvement is sustained and spreading across all three community directorates. This will be evidenced by month-on-month reductions in waits over 38 weeks across all three community directorates and improvement in the proportion of patients commencing treatment within 18 weeks.

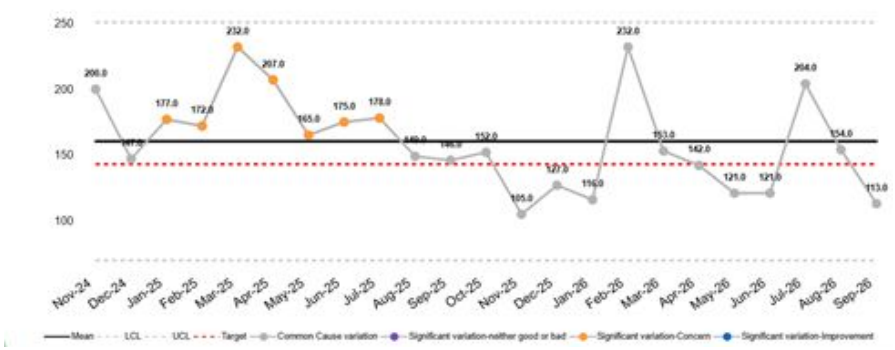
People are safe when they receive care from us, whether in our wards or communities.

Executive Sponsor: Julie Kirby, Interim Chief Nurse

True North

Ref.36: Number of patient harms
SPC Chart: Trust Wide

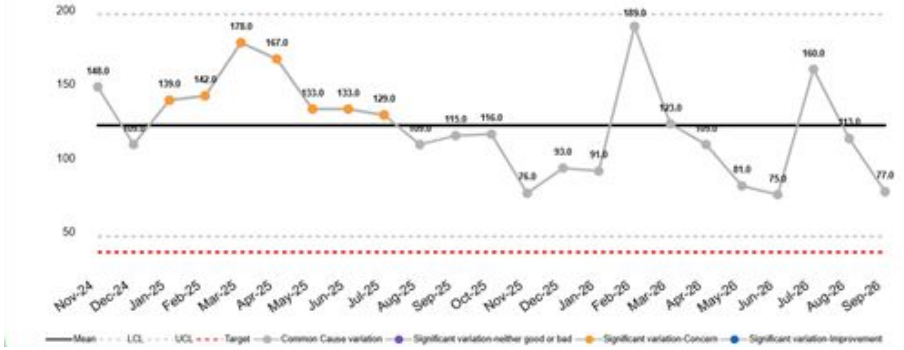
Target	Actual	UCL	Mean	LCL	Variation	Assurance
143	113	251	160	70		



Breakthrough

Ref.37: Self harm in female patients
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
36	77	197	122	47		



Assurance level: Partial

Direction of travel: Improving overall, with material variation, normally driven by a small number of complex high need cases.

Key Assurance Challenge: The recent reduction in reported self-harm incidents is encouraging, but the level of month-to-month variation means there is not yet sufficient evidence of sustained improvement or that current interventions are driving the change. Further assurance is required through trends in incident severity, repeat incidents, variation between wards and patient outcomes, alongside evidence that interventions and clinical guidance are consistently embedded.

Breakthrough objective inpatient - Female acute inpatient self-harm incidents show positive signs of improvement, with six of the past seven monthly data points below the mean. July was the exception, with a patient-specific increase involving one person with complex needs contributing to the 130 incidents reported. Incidents subsequently reduced to 76 in August and 41 in September. Ward-level figures should be interpreted alongside individual circumstances and repeated incidents, which are frequently concentrated among a small number of people with complex needs. Since January, 11 incidents have been reported on Walmer Ward and 9 on the Mother and Baby Unit. Both remain below the identified target and have therefore not been prioritised for specific improvement activity. Routine analysis identifies outlier wards for targeted work. Outlier status can change with the patient population or internal and external patient moves,

particularly where incidents involve a small number of people, typically those with Complex Emotional Difficulties. A ward may therefore cease to be an outlier following a patient move, rather than solely through changes in ward practice.

Work continues to strengthen care and support for people who self-harm, including embedding the co-produced model of care for people who self-harm; developing admission and clinical guidance for people with Complex Emotional Difficulties; and developing tools and resources for patients, families and staff to support consistent, individualised approaches to understanding and managing self-harm.

Breakthrough objective community - Initial work has focused on establishing a reliable baseline for demand on psychiatric liaison services relating to self-harm. Available referral data indicates that self-harm is frequently recorded as a leading reason for referral (22.8% of all Liaison referrals in September); however, data quality and extraction issues mean that the current figures require validation before they can provide a robust baseline. Resident doctors are undertaking a 12-month clinical audit of the last 12 months is therefore underway within the liaison service reporting the highest number of self-harm referrals. This will provide a more detailed understanding of who is accessing the service, routes into liaison, whether individuals are already known to mental health services and outcomes following assessment.

A Root Cause Analysis workshop with psychiatric liaison colleagues has also been completed, providing insight into the factors contributing to the level of self-harm presentations seen by liaison services. Start Afresh and Assist & Embrace are now in place across the county, although the degree of implementation and maturity varies between localities. Current work is consequently focused on strengthening the baseline and understanding variation in implementation, to inform the next phase of improvement activity. Data will be provided once we have the reliability and baseline established.

Next assurance point: Assess sustained reductions in inpatient self-harm incidents and severity, alongside evidence that learning informs practice and agreed clinical approaches are applied consistently. A 12-month assessment period is proposed because a small number of individuals can account for a high proportion of incidents, making a longer timeframe necessary to demonstrate genuine, consistent improvement.

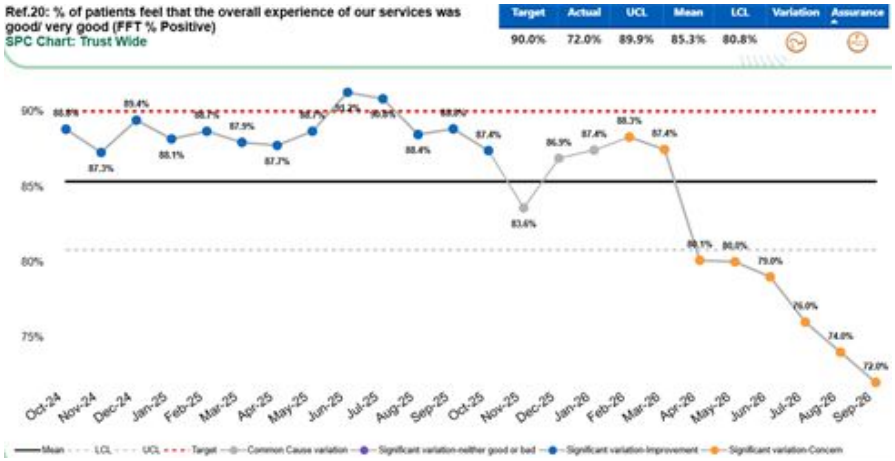
Reporting and target assurance: Assurance against the target of 36 remains qualified. The wider IQPR measure covers inpatient and community self-harm and suicide-attempt incidents for patients recorded as female, excluding CYP & AAED and rejected incidents; it therefore differs from the acute inpatient series discussed above. Although the methodology is unchanged from previous IQPRs, the target's derivation and whether it was calculated using the same service coverage and methodology remain unconfirmed. A review is underway to agree coverage, validate the baseline and establish consistent Trust and directorate targets. This will ensure that changes in reporting are clearly distinguished from changes in clinical outcomes.
.



People feel listened to, involved in decisions and supported by a culture that reflects our values.

Julie Kirby, Interim Chief Nurse & Ali Layne-Smith, Chief People Officer

True North



Exp.002: Trust Staff Engagement Score
(annual figure from NHS staff survey)

Target: 6.8

March 2026: 6.7

Breakthrough

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.22: % of patients feel that we are good/ very good at including them in decisions about their care	95.0%									80.0%	79.6%	79.4%	78.7%	75.8%	75.9%
Ref.23: 60% of surveyed staff recommend us as a place to work	60.0%						33.0%		54.0%	50.7%			45.6%		

(Insufficient data points to produce SPC analysis)

Assurance level: Partial

Direction of travel: Deteriorating for reported patient experience; uncertain for staff experience.

Key Assurance Challenge: Interim staff feedback is positive but is not directly comparable with the annual NHS Staff Survey and does not yet establish an improving trend. Assurance will increase when directorate-level evidence from the cultural dashboard and annual survey demonstrates sustained improvement.

Patient Experience: Overall patient experience reported through Your Experience Matters; however, the proportion of respondents reporting a good or very good overall experience or experience of involvement in decisions about care has reduced, and this downward trend requires continued attention. In September, 72% rated their overall experience as good or very good and 75.9% reported positive involvement in decisions about their care. National benchmarks are not yet available; the CQC annual community survey is the only available comparison. The reduction should be considered alongside a substantial increase in feedback following the launch of Your Experience Matters, with responses rising from 427 in April to 940 in August 2026 and digital completion increasing from 24% to 62%. This provides a broader evidence base for understanding experience but does not in itself account for the reduction in positive scores.

Patient feedback highlights recurring concerns about communication, involvement in decisions and continuity of care. Directorate actions include improving communication with carers, clarifying ward-review arrangements and ensuring care and discharge plans are shared consistently. These actions address the reported concerns, but their impact on the declining experience scores is not yet demonstrated. The next update should show which services are improving and whether patients report better communication and involvement.

Staff experience: Interim staff feedback is positive, but an improving trend is not yet established. Feedback captured through mandatory training suggests 85% of respondents would recommend the Trust as a place to work. These early findings reflect a limited dataset from newly introduced reporting. Engagement activity has increased and our first cultural dashboard will provide richer insight at directorate level.

Looking ahead: Our priority now is to strengthen local leadership ownership of both patient and staff experience. Leaders will be expected to actively encourage feedback; understand what people are telling us and demonstrate how this is being used to improve services and staff experience. Over the next six months, we will strengthen directorate-level ownership, use available directorate-level feedback to target support while the cultural dashboard is developed and continue to improve the quality and reach of patient and staff feedback. The culture dashboard will be developed in year two of the strategy (2027). Development will be informed by the 2026 NHS Staff Survey results and directorate-led staff experience work undertaken in 2026/27. Together, these will inform the culture transformation plan, due for completion in March 2027, and the dashboard's development. A dashboard delivery date has not yet been specified.

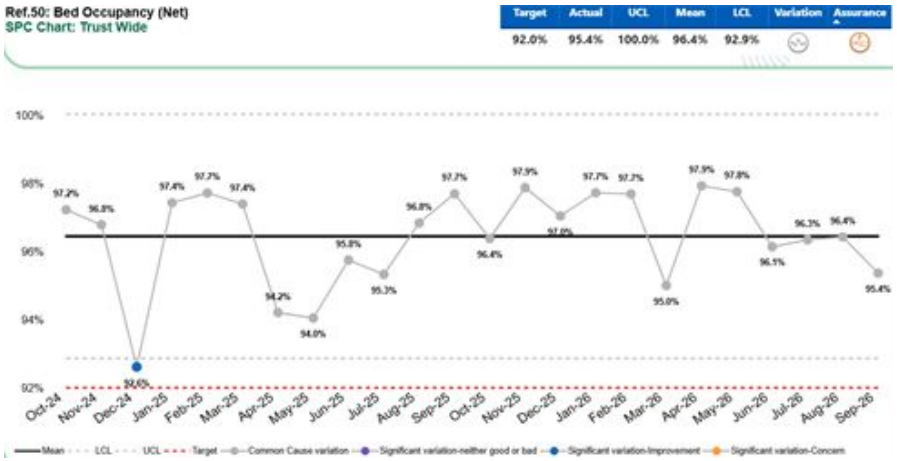
Next assurance point: evidence that directorate actions improve involvement scores, reduce variation and show how feedback has changed services. The review date and delivery milestones remain to be confirmed



People with mental illness are supported to recover, stay well and live well in their communities.

Executive Sponsor: Afifa Qazi, Chief Medical Officer

True North



Breakthrough

Measure Name	Target	V	A	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.51: Number awaiting bed (monthly average)				19.0	20.4	17.0	17.2	12.1	12.6

(Insufficient data points to produce SPC analysis)

Assurance level: Limited

Direction of travel: Deteriorating overall, improving position on Clinically ready for discharge.

Key Assurance Challenge: September shows encouraging improvement in out-of-area use and length of stay, alongside reported improvements in quality measures. Sustained impact is not yet established, and occupancy and delayed discharge remain significant constraints. Assurance will increase when flow improves against agreed trajectories, alongside stable or improving readmissions, patient experience and safety outcomes.

Current: Bed occupancy remains above the 90% target at 95.4% (CQC state of care report recorded national performance at 89%). Out-of-area placement days increased sharply in quarter two compared with quarter one but reduced by 9.5% from 758 in August to 686 in September. The September total includes 194 contracted female PICU bed days, leaving 492 other out-of-area placement days. Discharge delays continue to consume substantial inpatient capacity. The number of people clinically ready for discharge reduced from a peak of 79 to 53 at the end of September, but CRFD delays still accounted for 1,401 bed days, compared with 1,462 in August. The average number of people awaiting a bed has reduced in recent months from 17 to 12.

Main change and emerging evidence: The Trust launched a 60-day sprint in October to strengthen clinical scrutiny of admissions, discharge coordination and barriers to flow. Improved demand-and-capacity analysis is also clarifying bed use, system pressures and the pathway changes needed for a sustainable model. September's improvements predate the sprint and cannot be attributed to it. Programme updates report reductions of 4.86 days in length of stay and 1.1 days in length of treatment between August and September, alongside lower 30-day readmissions, improved patient experience, increased Your Experience Matters participation and a 41% reduction in reported Acute Directorate harms. These are encouraging early signals, but do not yet demonstrate sustained recovery or programme impact. Continued scrutiny is needed to confirm that improved flow is maintained without deterioration in safety, experience or readmissions.

Looking ahead: The 60-day sprint will establish whether tighter clinical oversight of admissions, discharge planning and barriers to flow can deliver measurable reductions in clinically ready for discharge patients, length of stay and out-of-area placements, with a sustained improvement in bed occupancy. It will also identify which changes should become standard practice and provide the baseline and trajectories for the longer-term programme.

In practical terms, the Supporting Recovery & Living Well Trust Initiative brings the current flow work into one coordinated programme. It will align the command centre, ward-level discharge processes and CRFD standards, while strengthening admission gatekeeping, Crisis Resolution and Home Treatment Team involvement, and community alternatives to admission. Recovery plans must also address the stated national priorities of reducing inappropriate out-of-area placements by 95% by March 2027 and reducing 12-hour ED breaches.

CRFD performance improved significantly by the end of September but deteriorated during October, with 62 people on the CRFD list in early November, creating significant pressure on inpatient capacity. The contributing system factors have been identified and escalated with partners, with focused work underway to restore improvement.

Next assurance point: a delivery plan with agreed trajectories, milestones and consistent measure definitions, supported by bed modelling. This should set out the anticipated impact of the work being undertaken and allow delivery to be monitored.



People benefit when we use our time, skills and resources well so more goes into care.

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

Domain	Type	Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Smarter Working	TN	Ref.65: Productivity Increase Year on Year	2.0%			4.6%	4.3%	4.4%	5.8%	7.2%	6.1%	10.4%	9.0%	10.0%

(Insufficient data points to produce SPC analysis)

Breakthrough

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

Finalisation of measure and testing with clinical leads ongoing prior to publication

Assurance level: Partial

Direction of travel: Not yet established.

Key Assurance Challenge: Reported productivity does not yet demonstrate sustainable release of clinical capacity or financial benefit. The breakthrough data is being revised, with a clear, clinically validated baseline expected by January 2027. This is a measurement milestone, not evidence of improvement; assurance will depend on identifying and addressing the causes of reduced clinical time and demonstrating the impact of subsequent changes.

Current: Reported productivity remains materially above the 2% year-on-year national NHSE target and our True North goal. Work with clinical leads is refining the breakthrough measure to capture patient-facing activity, preparation and indirect clinical work consistently. Data validation and root-cause analysis will provide a clearer understanding of how clinical time is used and where operational changes can release capacity. The findings will inform targeted smarter-working actions and flow through into the 2027/28 operational reset and job-planning cycle.

Looking ahead: The immediate priority is to establish the breakthrough baseline by January 2027 and use the root-cause findings to shape the 2027/28 focus. This work will inform targeted smarter-working actions, workforce planning and the April 2027 job-planning cycle for consultants and psychologists. The focus is on removing avoidable barriers to clinical time, with clearer standards and recording that properly recognise preparation and indirect clinical work. Delivery milestones and measures of capacity released will be developed from the validated baseline.

Next assurance point: January 2027: review the clinically validated breakthrough measure and baseline, root-cause findings and proposed priorities for the operational reset. This review should establish the basis for an improvement plan with accountable actions and delivery milestones; sustainable clinical capacity and financial benefits will require subsequent assessment.

2. Board Assurance Statement

Overall assurance: PARTIAL

Adult access and selected safety measures are improving, but sustained effectiveness across services is not yet demonstrated. Inpatient flow provides limited assurance; gaps in outcomes and productivity evidence constrain confidence in sustainable recovery.

Improving • **Adult access:** fewer long waits; treatment commencement improving, with directorate variation. • **Selected safety measures:** medication safety and clozapine monitoring. • **September flow:** lower CRFD, length of stay and out-of-area use. Predates the October sprint; not evidence of its impact.	**Principal concerns** • **Capacity:** 95.4% occupancy (target 90%); CRFD and external-bed reliance persist. Initial October data indicates increased CRFD. • **Patient experience:** declining scores; communication, involvement and continuity concerns. Interpret alongside participation changes. • **Access and CYP:** pathway gaps, inconsistent recovery and data-quality limitations. • **Sustainability:** workforce pressures and reliance on non-recurrent financial benefits.
Early evidence of control effectiveness • Targeted medication-safety interventions. • Clozapine monitoring. • Adult long-wait management. *Effectiveness remains inconsistent ~~uneven~~ between services.*	**Sustained effectiveness not yet demonstrated** • Inpatient flow programme and CYP recovery. • Experience and complaints interventions. • 72-hour follow-up. • Productivity programme and measurable capacity release.

Three Board assurance questions

1. Flow: Are changes releasing sustainable capacity without deterioration in safety, experience or readmissions?

2. Outcomes: Are improvements producing demonstrably better patient outcomes, rather than improved activity or recording alone?

3. Sustainability: Are operational improvements reducing underlying workforce and financial pressure, rather than relying on temporary benefits?

Next evidence required

- **January 2027 — adult access:** sustained long-wait reductions and improved 18-week treatment commencement across all three community directorates.
- **January 2027 — productivity:** clinically validated baseline, root causes and improvement priorities; not proof of benefits delivered.
- **Dates to be agreed:** flow plan with validated baselines, trajectories and milestones supported by bed modelling; stronger safety-control reliability; feedback and paired DIALOG+ evidence showing changes in care. Interpret experience alongside participation changes and use comparable staff-experience evidence.

3. Quality & Safety

Overview:
The quality and safety position remains mixed, supporting partial assurance overall. There are some areas of improvement evident but other areas of concern. The table below sets out the key areas of focus and action being undertaken.

Area	Current assessment	Control effectiveness and next assurance test
Risk Assessments	Substantial improvement in reported compliance, although variation remains and sustained clinical effectiveness is not yet demonstrated. Fortnightly QIP reporting shows directorate risk-formulation compliance of 70–90% on the refined measures, compared with a reported starting point below 40% in June 2026. The comparison should be interpreted alongside changes in reporting methodology and recording accuracy. Fortnightly reporting provides direct Chief Nurse oversight, team-level accountability and targeted support. East Kent has shown particularly positive progress, with learning on recording accuracy and clinical documentation shared across directorates. The refined measure excludes pathways such as Memory Assessment Services where a full risk formulation may not be clinically indicated. This does not change the expectation that risk is considered, assessed and appropriately documented within every clinical assessment. Risk assessment and formulation remain a QIP priority.	**Early evidence of improved compliance;** clinical effectiveness not yet established: strengthened oversight and team-level reporting support targeted improvement. Ongoing quality audits assess the standard and clinical effectiveness of formulations, alongside review of patient-safety incidents and emerging learning themes. **Proposed reporting refinement:** align future IQPR reporting with the clinically informed QIP methodology, making eligibility criteria and the implications for comparison with previous results clear. **Next assurance test:** sustained improvement in completion and audited quality, reduced directorate variation, and evidence from incident review and learning that improved formulation is translating into safer care.
Medication Errors	Early evidence of effectiveness. Acute medication errors have improved significantly since April following targeted local work, including medication skills workshops, staff support and competency development. West Kent also reduced incidents from 5 to 3 in July. However, the localised rise at Priority House means effectiveness is not yet consistently demonstrated across all services. Priority house have supported a localised improvement plan which is being monitored to understand impact moving forward.	**Early evidence of control effectiveness:** targeted Acute interventions have coincided with sustained improvement since April, with improvement also evident in West Kent. Effectiveness is not yet demonstrated consistently, given the localised increase at Priority House. **Next assurance test:** sustained reduction in recurrence and evidence that targeted interventions are narrowing service-level variation.
Clozapine and depot physical health checks.	Controls appear effective for clozapine, less effective for depot monitoring. Clozapine compliance reaches 93% East, 88% West and 84% North against the 85% internal KPI, whereas overall depot compliance remains constrained by lipid monitoring, including 69.5% East and 65.3% North. Reporting should distinguish between monitoring offered and completed. At Thanet depot clinic, lipid-monitoring compliance was 71.5%, rising to 87.6% when documented patient declines were taken into account. This will be considered in future reporting	**Mixed control effectiveness:** controls appear effective in maintaining strong clozapine monitoring, but have not yet produced consistent depot compliance, particularly for lipid monitoring. **Next assurance test:** sustained improvement against trajectory and reduced variation between directorates, distinguishing monitoring offered from monitoring completed.
CYP care planning and risk assessment compliance.	Performance indicates that the expected care-planning and risk-assessment controls are not yet being applied consistently. Data-quality issues reduce confidence in the precise level of compliance, but do not remove the underlying assurance concern. The next test is whether validated data demonstrates sustained improvement in compliance and reduced variation across CYP services. CYP/AAED services are currently being transitioned into the Quality Improvement Plan and the same approach will apply consistently.	**Controls are not consistently demonstrated**. The directorate review has identified variation in care plan and risk assessment compliance alongside recording and data quality issues. The review has identified areas of further validation whilst maintaining focus on improving care planning and risk assessment compliance. **Next Assurance test:** Validated data demonstrating improved care-plan and risk-assessment compliance, with reduced variation between CYP services

	This also forms part of our qualitative data oversight with positive indication being seen of improving involvement of patients and their loved ones through the gather audit process across care planning and risk documentation. This data set is being aligned through the QIP and will support ongoing linkage between IQPR and QIP reporting to strengthen the narrative of impact.	and evidence that the issues identified through directorate review have been addressed.
Complaints volume and response timeliness	Patient participation has increased substantially, providing a stronger evidence base, but the rise in complaints, 80% response timeliness and material variation in involvement indicate that listening and response mechanisms are not yet delivering consistently reliable experience. Directorate analysis is identifying recurring themes around communication, discharge planning and timeliness, providing a clearer basis for targeted improvement. The next step is to demonstrate how learning from complaints and patient feedback informs changes in practice, improves patient experience and reduces recurring concerns.	Analyse themes and service-level variation, strengthen oversight of overdue responses and demonstrate how learning is translated into measurable improvement. Directorate actions include standardising feedback collection, seeking direct patient narrative, improving communication with carers, making ward-review arrangements clearer and ensuring care and discharge plans are shared consistently. **Next Assurance Test:** should show whether these actions improve both experience scores and the timeliness of complaint responses.
72 hour follow up	Controls are not yet reliably effective. Performance is 85.7% against 90% and four West Kent breaches occurred at different stages of the pathway, including administrative allocation delay, incomplete ward discharge planning, and transfer-of-care arrangements. This suggests that improvement requires reliable controls across the discharge-to-community handover rather than action on a single cause.	**Control effectiveness not yet demonstrated:** performance remains below target and breach analysis identifies failures at multiple points in the discharge-to-community pathway. Further work to understand breach themes and to improve reliability of the follow up. **Next assurance test:** sustained achievement of the 90% standard alongside a reduction in recurring breach causes

Looking at the wider measures, there is evidence of progress: violence and aggression reduced to 333 incidents in July, meeting the monthly threshold for the first time this year after four consecutive monthly reductions. Risk quality and compliance continue to improve, alongside a substantial increase in patient feedback participation. Prone restraint incidents remain low, and each is reviewed. Reporting the duration of prone restraint is under consideration, recognising that patients may move into a prone position; the focus remains on an immediate return to supine.

Despite this progress, several measures remain materially below standard or are deteriorating. Medication errors, physical health checks for people prescribed depots and care plan compliance remain concerns.

Within acute services, however, medication errors have improved significantly since April, as shown in the chart below. This improvement is attributed to targeted work with local teams, including medication skills workshops, staff support and skills development to meet competency standards.



Physical health checks within clozapine clinics have also improved significantly, although concerns remain in depot clinics. The focus here is on improving lipid monitoring.

Assurance remains constrained by significant service-level variation. Directorate reviews identify concerns concentrated in specific teams, enabling targeted action, but improving Trust-wide results do not yet demonstrate that controls are consistently embedded. East Kent is a positive outlier for risk-assessment quality and compliance, with learning shared across community directorates.

NHS England and ICB colleagues were invited to the Trust as part of a Rapid Quality Review. They met teams from East Kent and the Corporate Nursing Directorate to discuss the Quality Improvement Plan and how the new approach is driving improvements across the Trust. Feedback from all involved was highly positive, recognising the Plan's visible impact.

Complaint response timeliness against the 30-day target appears unchanged. Last month, 17 cases involving 14 individuals breached the target: 3 in North Kent, 6 in West Kent and 8 in East Kent, including 3 complaints from one individual. Delays arose from senior leadership sign-off, case-handler sickness, delayed investigator responses and the need for professional or multi-agency meetings before responses could be issued. Quality assurance of letters and investigations also required further enquiries or administrative work. However, the target requires review: benchmarking by the complaints lead indicates that most organisations use 25–40 days. NHSE and PSO state that there is no national response timeframe and that timescales should be agreed according to the nature of the complaint. They emphasise keeping the complainant informed and providing a response that sets out the findings, offers apologies where appropriate and explains what is being done as a result of the complaint.

Measure Name	Target	V	A	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Ref.19: Clozapine and depot clinic physical health check screening in last 12 months (MHT+)	85.0%			80.0%	80.2%	76.7%	75.7%	77.2%	77.1%	78.2%	77.0%	75.5%	76.7%	78.6%	81.5%
Ref.24: Complaints - actuals	43			46	38	71	49	72	70	54	52	78	65	69	78
Ref.25: Compliments - actuals	177			150	178	124	135	117	147	141	138	172	139	163	139
Ref.27: Your experience matters: Response Count				353	434	405	501	478	427	621	744	938	940	915	927
Ref.28: Your experience matters: Response Volume				2.0%	2.5%	2.2%	2.8%	2.7%	2.4%	3.6%	4.0%	5.1%	5.6%	5.1%	5.2%
Ref.29: Your experience matters: Achieving Regularly, % good/very good	90.0%								81.0%	81.0%	80.1%	79.0%	77.3%	77.2%	
Ref.30: Complaints acknowledged within 3 days (or agreed timeframe)	100%			95%	98%	97%	94%	96%	97%	98%	90%	92%	93%	98%	99%
Ref.31: Complaints responded to within 30 days (or agreed timeframe)	100%			75%	81%	79%	72%	86%	78%	80%	93%	80%	84%	83%	81%
Ref.32: Decrease violence and aggression	334			469	371	386	363	384	352	344	346	333	324	280	352
Ref.33: Medication errors	21			36	40	31	52	45	38	37	51	48	38	38	60
Ref.40: Care Plan Compliance	90.0%			0.9%	1.1%	2.3%	15.6%	25.7%	33.1%	40.0%	46.6%	51.7%	50.2%	49.6%	49.7%
Ref.41: Patients receiving follow-up within 72 hours of discharge	90.0%			87.9%	85.9%	89.5%	86.7%	88.3%	84.0%	85.2%	79.8%	82.8%	83.5%	86.6%	83.0%
Ref.43: All Deaths Reported And Suspected Suicide				104	161	177	145	133	91	80	66	120	330	145	140
Ref.44: Restrictive Practice - All Restraints	85			170	141	99	140	131	104	88	89	101	88	56	68
Ref.45: Restrictive Practice - No. Of Prone Incidents	0			12	4	10	3	10	7	7	2	3	4	3	1
Ref.46: Care Plan in date for patients in treatment (CYP & AAED)	90.0%			78.1%	77.7%	77.7%	77.8%	79.0%	79.6%	79.1%	73.0%	73.3%	81.4%	78.8%	77.9%
Ref.47: Risk assessment in date for patients in treatment (CYP & AAED)	85.0%			84.6%	84.7%	83.6%	83.9%	84.7%	85.2%	84.7%	79.2%	79.0%	86.2%	84.4%	83.7%

The evidence of control effectiveness is mixed. Targeted interventions are associated with improvement in medication safety and clozapine monitoring, but controls are not yet demonstrating consistent effectiveness across depot monitoring, 72-hour follow-up and complaints. CYP assurance is further constrained by data-quality issues that prevent a reliable assessment of control effectiveness.

The next area of focus will therefore be on narrowing service-level variation, ensuring recovery milestones are achieved and audits demonstrate better quality of practice rather than completion alone. Executive attention will remain focused on the pace and impact of recovery actions, with escalation where trajectories are not achieved.

Deaths: reporting and interpretation. The August total of 330 reflects clearance of a recording backlog and should not be read as 330 deaths occurring that month. Reporting by recording date can distort the monthly trend; the spike alone does not demonstrate a deterioration in mortality or suicide outcomes. The graph below presents deaths by date of death. Recent figures remain provisional and may increase as delayed notifications are received, so an apparent reduction should not be interpreted as improvement until the data matures.



Proposed refinements to quality targets and reporting
Following review against national and local benchmarking, subject matter experts in the corporate nursing team have proposed refinements to quality targets and reporting. The changes below are being considered to make measures more meaningful, improve visibility of performance and set achievable thresholds while maintaining high expectations of care.

- Ref 25 – Compliments: Remove the target in line with national benchmarking.
- Ref 29 – Your Experience Matters (YEM): Replace the overall average across quantitative scores with individual domain scores. As the domains cover distinct aspects of experience, separate reporting would provide clearer insight into performance.
- Ref 30 – Complaints within three days: Reduce the compliance target from 100% to 95%, recognising that a small number of exceptions may be unavoidable while retaining a high expectation of timely delivery.
- Ref 31 – Complaint response times: Extend the response timeframe from 30 to 40 days in line with local and national benchmarking and reduce the compliance target from 100% to 95% to allow for a small number of unavoidable exceptions. The emphasis remains on involving the complainant and providing a thorough, patient-focused response.
- Ref 39 – Risk compliance: Align reporting with the Quality Improvement Plan by excluding ineligible services.
- Ref 45 – Prone restraint: Refine the measure to focus on incidents lasting more than one minute, rather than incident counts alone. Reported incidents have reduced, but patients may unavoidably move into a prone position; the proposed measure would emphasise the immediacy of return to supine.

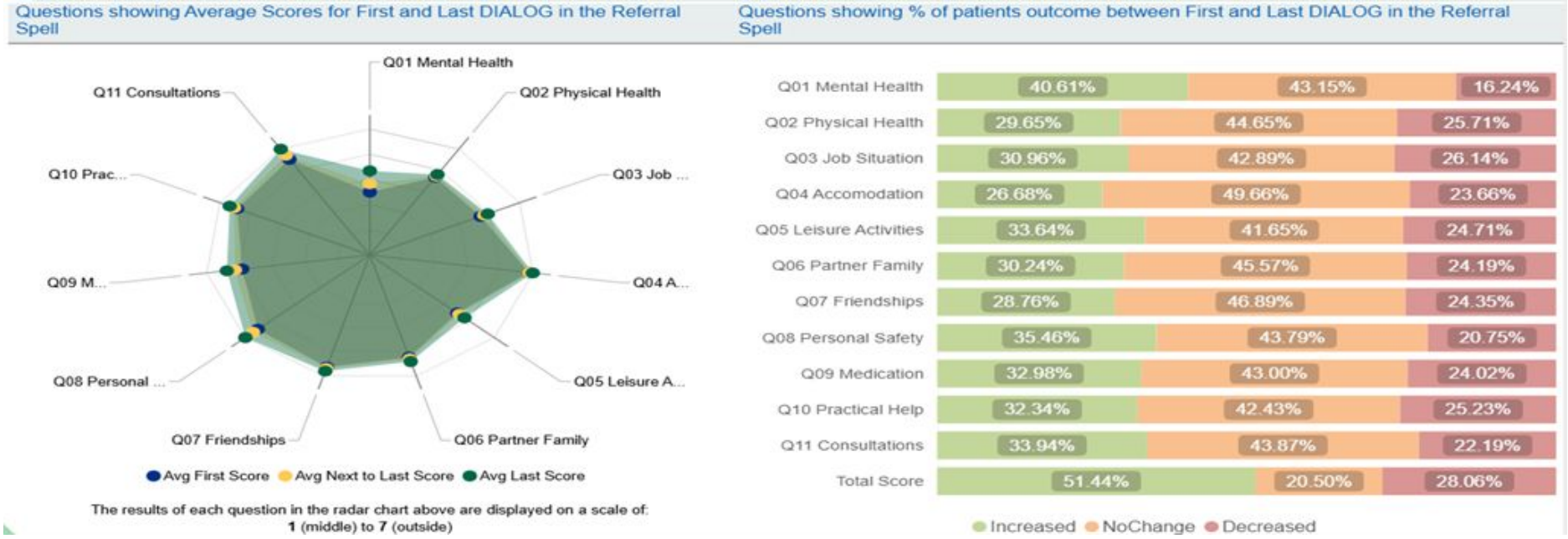
Board are asked to endorse this work, with the impact to be discussed through the quality committee and necessary changes made to reporting.

4. Patient Outcomes

DIALOG+ must show whether care improves outcomes that matter to patients, not simply whether assessments are completed. Data points remain limited and subject to change, so monthly comparisons require caution. This month's findings show encouraging improvement signals alongside less favourable mental-health results, which require attention but do not yet establish a sustained deterioration. The findings help focus improvements in care, but do not yet demonstrate sustained improvement or establish the impact of care.

Within Mental Health Together, DIALOG+ spans initial assessment, regular reviews and transitions. The “Plus” element should connect patient priorities to a co-produced care plan, agreed goals and interventions. Worsening scores should prompt understanding of the person's experience and review of their care and support.

The priority is to strengthen paired assessments, understand service and domain variation, and show how findings change care. Aggregated data also offers potential to identify neighbourhood needs and gaps in provision, as recognised in discussions with partners. Future reporting should show what has been learned, what has changed and whether patients benefit.



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Data extracted 19/10/2026

Next steps: Improve completion of paired DIALOG+ measures for patients receiving ongoing treatment, recognising that some patients may complete only one DIALOG+ intervention before their care is provided outside Trust-managed services. For patients continuing treatment within the Trust, completion of DIALOG+ at three-monthly intervals is essential to demonstrate change over time and provide meaningful evidence that care is delivering the outcomes that matter to patients.

5. Operational Performance

Access

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.03: Face to Face v's virtual (MHT+ & EIP)	85.0%			72.1%	72.1%	68.2%	71.1%	73.6%	73.4%	74.3%	76.1%	76.2%	76.5%	77.4%	78.1%
Ref.04: Open Access Crisis Line: Calls received	3,274			3,227	2,794	2,968	3,174	3,070	3,159	2,848	3,068	3,112	3,366	3,338	3,037
Ref.05: Open Access Crisis Line: Abandonment Rate (%)	12.0%			28.3%	21.2%	25.0%	22.4%	25.7%	24.3%	20.2%	20.7%	25.1%	25.6%	25.1%	21.0%
Ref.06: Assess people in crisis within 4 hours	90.0%			91.0%	90.9%	84.9%	91.4%	85.1%	73.0%	88.1%	84.9%	83.8%	82.4%	85.7%	84.3%
Ref.07: People presenting to Liaison Services: triaged within 1 hour	90.0%			90.9%	89.2%	93.9%	92.3%	89.6%	90.0%	92.6%	93.4%	91.5%	90.0%	90.9%	87.6%
Ref.08: Liaison Psychiatry referrals closed within 12 hours	95.0%			82.8%	81.5%	82.6%	82.8%	81.6%	85.8%	84.7%	85.3%	84.9%	86.3%	87.3%	86.2%
Ref.09: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%			6.5%	16.2%	15.7%	8.3%	8.5%	16.3%	18.0%	13.9%	12.0%	18.9%	17.9%	10.4%
Ref.11: MAS diagnosis within 6 weeks	95.0%			22.5%	27.2%	23.2%	20.0%	17.7%	31.5%	29.1%	21.6%	22.0%	18.6%	17.0%	17.0%
Ref.12: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%			87.0%	76.5%	76.9%	50.0%	80.0%	68.2%	83.3%	52.9%	50.0%	59.3%	68.4%	63.2%
Ref.13: % MHLD referrals commencing treatment in 18 weeks	86.1%			83.7%	70.7%	95.8%	87.7%	87.5%	87.5%	75.5%	72.2%	85.1%	88.6%	91.3%	86.7%
Ref.14: Perinatal assessments (against annual target)	2,000			180	161	144	174	150	175	603	193	192	151	137	190
Ref.16: % of Active Referrals waiting less than 18 weeks to first contact (MHS CYP inc Neuro)				13.5%	16.3%	14.9%	15.7%	15.6%	16.9%	16.9%	15.3%	16.9%	16.2%	13.6%	14.4%
Ref.17: CYP Crisis Assessments within 4 hours (Referral to Contact)	95.0%			77.1%	76.0%	76.1%	79.3%	76.7%	67.8%	81.6%	90.7%	61.1%	81.6%	83.9%	83.1%
Ref.18: % Routine Eating Disorders Activity-Based Clock Stop Achieved Within 4 Weeks Aged 0–18				100.0%	97.1%	93.0%	98.2%	96.8%	93.1%	78.0%	89.3%	92.5%	88.1%	84.1%	63.2%
Ref.49: % of Referrals waiting greater than 104 weeks for ND assessment (ADHD & ASC)				40.2%	41.6%	43.8%	46.2%	48.7%	52.2%	54.8%	57.7%	60.0%	62.5%	61.6%	61.9%

Overview:

Overall access performance remains variable across pathways, providing partial assurance. There is evidence of improvement in several areas, but the scale and persistence of some gaps remain significant. Face-to-face activity continues to improve, increasing from 72.1% in October 2025 to 78.1% in September 2026, although this remains below the 85% target. MHLDS 18-week performance is comparatively strong and reached 86.7% in September against an 86.1% target, following 91.3% in August. This indicates that the 18-week target is currently being achieved within MHLDS, despite wider access pressures.

The most material gaps are concentrated in MAS, Liaison Psychiatry, crisis response and CYP pathways.

Material Gap	Evidence and Judgement	Trajectory and evidence of impact	Next Assurance Test
MAS	Diagnostic timeliness remains materially below standard, with 17.0% diagnosed within six weeks against 95%. Performance has declined from 31.5% in March and remained at or below 22% since May, indicating a sustained capacity challenge rather than short-term variation.	Required capacity has now been agreed, with implementation aligned to the refined MHT model. The impact of this is not yet demonstrated, as the capacity changes have not yet translated into improved performance.	Evidence that agreed capacity is operational and producing sustained improvement in six-week diagnostic performance, with performance moving in line with the recovery trajectory.
Crisis	The position shows some signs of improvement but not sustained recovery. Crisis Line abandonment improved from 25.1% to 21.0%, against a 12% target, but four-hour assessments were 84.3% against 90% and have remained below target since May.	Early evidence of improvement, but the reliability of improvement is not yet established. Improvement has not yet been sustained sufficiently to establish recovery against the standards.	Sustained improvement over successive reporting periods in both Crisis Line abandonment and four-hour assessment performance, consistent with the agreed trajectory.
Liaison Psychiatry	Performance remains below standard: one-hour triage is 87.6% against 90% (CQC state of care puts the national average at 56% nationally), 12-hour closure is 86.2% against 95%, and only 10.4% of referrals requiring a mental health bed are closed within 12 hours, against 95%. The evidence links the most significant gap to wider inpatient capacity and delayed-discharge pressures.	Recovery is constrained by inpatient capacity and delayed discharge. The evidence suggests that Liaison recovery cannot be achieved through pathway action alone while delayed discharge continues to restrict inpatient capacity.	Improvement against the one-hour and 12-hour standards, particularly for patients requiring a mental health bed, alongside evidence that improved inpatient flow is reducing transfer delays.
CYP Services	The position is mixed. Four-hour crisis assessment has improved substantially, from 61.1% in June to 83.1% in September, although still below 95%. In contrast, routine Eating Disorder performance deteriorated from 92.5% to 63.2%, while the proportion of neurodevelopmental waits exceeding 104 weeks increased to 61.9%. CYP and all-age eating disorder data have both transfer-related and underlying data-quality issues, which are being addressed.	Progress varies across CYP pathways. Crisis access has improved, but deterioration in Eating Disorder performance and increasing neurodevelopmental waits mean improvement is not yet evident across CYP pathways as a whole.	Evidence that improvement in CYP crisis access is sustained, alongside recovery in Eating Disorder performance and improvement in neurodevelopmental waits.

Flow

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.10: Place of Safety Length of Detention: % under 24 hours	75.1%			86.4%	89.8%	90.5%	85.2%	89.8%	93.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ref.52: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	608			590	561	482	407	453	316	218	355	437	716	758	686
Ref.53: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	21			18	17	14	13	17	5	9	16	14	24	23	19
Ref.54: CRFD Bed Days Lost (Acute beds)				1,565	1,723	1,717	1,647	1,712	1,657	1,441	1,758	1,650	1,738	1,462	1,401
Ref.55: Clinically Ready for Discharge (CRfD) length of stay (LoS)	64.7			92.9	45.8	69.9	116.1	53.7	74.9	58.5	85.6	83.2	64.5	63.0	49.3
Ref.56: Clinically Ready for Discharge (CRfD) over 100 days at period end	0			15	17	19	20	22	14	14	15	16	15	14	14
Ref.57: Clinically Ready for Discharge (CRfD): YA Acute	7.0%			15.2%	20.3%	22.0%	19.9%	22.0%	17.1%	14.7%	18.4%	17.7%	18.7%	19.9%	19.1%
Ref.58: Clinically Ready for Discharge (CRfD): OA Acute	12.0%			30.6%	28.7%	23.6%	24.6%	29.6%	31.3%	27.9%	31.5%	31.7%	30.9%	18.7%	20.1%
Ref.59: Average Length Of Stay (Younger Adults Acute)	34.0			50.9	27.5	31.5	61.3	44.1	46.0	51.8	54.6	46.0	48.2	31.8	35.2
Ref.60: Average Length Of Stay (Older Adults - Acute)	77.0			79.7	76.0	81.6	71.1	120.4	115.3	92.1	104.6	117.0	100.2	124.0	72.9
Ref.61: Adult acute LoS over 60 days % of all discharges	16.0%			22.9%	12.9%	13.3%	20.4%	15.6%	19.7%	23.7%	20.2%	19.4%	23.6%	14.8%	14.3%
Ref.62: Older adult acute LoS over 90 days % of all discharges	37.7%			31.3%	24.0%	42.9%	25.9%	29.6%	50.0%	44.0%	32.1%	38.5%	41.2%	46.2%	26.3%
Ref.63: Readmissions within 30 days (YA & OP Acute)	8.8%			12.0%	10.3%	12.2%	12.3%	11.8%	9.9%	7.8%	11.8%	10.4%	12.8%	12.7%	10.7%
Ref.64: Average Length of Stay in C&YP Mental Health wards (Days)	60.0			63.0	41.0	80.0	98.0	0.0	111.3	59.7	79.0	61.2	37.0	41.0	61.0

Ref52: 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. 686 bed days were used in September 2026, 194 were female PICU patients within contracted beds resulting in 492 out of area placement days as an accurate reflection of trust performance.

Overview:

Overall flow performance remains mixed, providing limited assurance. There is emerging evidence of improvement in some flow measures, but this is not yet sufficiently sustained or reflected in the overall capacity position to demonstrate recovery. Occupancy remains at 95.4% against the 90% standard, while CRFD continues to consume significant inpatient capacity. The next assurance test is whether the coordinated flow programme delivers sustained capacity release against agreed trajectories, supported by bed modelling, without deterioration in safety, experience or readmissions. The most material challenges remain occupancy, CRFD and the reliability of improvement in length of stay and wider patient flow.

Material Gap	Evidence and Judgement	Trajectory and evidence of impact	Next Assurance Test
Occupancy	Occupancy remains 95.4% against the 90% target (and a national occupancy level of 89%), demonstrating that inpatient capacity remains under significant pressure. While there are emerging signs of improved flow, these have not yet translated into a sustained reduction in occupancy.	The October sprint targets the principal drivers of inpatient flow. September provides the pre-sprint baseline; subsequent reporting must demonstrate sustained reductions in occupancy.	Sustained reduction in occupancy towards 90%, providing evidence that improvements in flow are translating into released inpatient capacity.
CRFD / discharge	CRFD continues to consume significant inpatient capacity. The report identifies early improvement, but the level remains sufficient to materially affect occupancy and available beds.	CRFD is a central focus of the flow programme. September's improvement predates the October sprint and does not establish its impact. Subsequent reporting must demonstrate sustained reductions in bed days lost to delayed discharge and more reliable discharge coordination and escalation.	Sustained improvement in CRFD, reflected in fewer occupied bed days and corresponding improvement in available capacity.
Length of stay / wider flow	Length of stay reduced by 4.86 days and length of treatment by 1.1 days between August and September, alongside a reduction in the average number awaiting a bed from 17 to 12. These provide early evidence of improved flow but have not yet translated into sufficient reduction in occupancy to demonstrate sustained recovery.	September establishes a starting point for assessing the October sprint; subsequent reporting must demonstrate sustained improvement in CRFD, occupancy and wider flow.	Agree a validated length-of-stay baseline, supported by bed modelling. Subsequent reporting should demonstrate sustained reductions in length of stay, releasing capacity and reducing waits for admission, without deterioration in safety, patient experience or 30-day readmissions.

Productivity

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.15: DNA Rate – All Appointments	8.0%			10.4%	9.8%	10.0%	10.6%	10.5%	10.2%	10.1%	10.1%	10.1%	10.6%	10.3%	9.8%
Ref.66: Psychology & Medic contact time per FTE				0.40	0.39	0.34	0.39	0.36	0.35	0.37	0.40	0.24	0.23	0.24	0.24
Ref.77: Clinician Contact time per FTE				0.33	0.34	0.32	0.34	0.34	0.32	0.36	0.37	0.24	0.23	0.23	0.23

Overview:

Partial assurance. Reported productivity is above the 2% national target and DNA performance is improving, but declining clinical contact time and limitations in the current productivity measure mean there is not yet sufficient evidence that reported productivity is translating into sustainable patient-facing capacity.

Workforce

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.34: Increase percentage of BAME staff in roles at band 7 and above	20.0%			30.9%	30.7%	30.5%	31.1%	31.0%	31.0%	31.1%	31.1%	32.6%	32.4%	32.3%	32.3%
Ref.35: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%			0.12%	0.11%	0.27%	0.35%	0.23%	0.23%	0.36%	0.35%	0.35%	0.26%	0.68%	0.61%
Ref.67: Staff Sickness - Overall	4.5%			4.9%	5.5%	5.9%	5.1%	5.2%	5.1%	5.1%	5.1%	5.5%	5.4%	5.2%	5.6%
Ref.68: Vacancy Gap - Overall	11.5%			10.2%	10.3%	10.2%	10.4%	10.4%	10.3%	10.4%	10.6%	10.5%	10.8%	10.7%	11.0%
Ref.69: Mandatory Training For Role	90.0%			95.4%	95.3%	95.6%	95.7%	95.5%	94.9%	94.6%	94.4%	94.3%	94.6%	94.6%	94.1%
Ref.70: Leaver Rate	12.3%			11.2%	11.7%	12.1%	12.3%	12.6%	12.3%	11.8%	11.9%	12.4%	11.8%	11.8%	11.8%
Ref.71: Leaver Rate (Voluntary)	13.0%			7.7%	7.4%	7.4%	7.5%	7.6%	7.3%	7.2%	7.5%	8.4%	7.4%	7.2%	7.3%
Ref.72: Safer staffing fill rates	80.0%			109.0%	108.6%	109.6%	109.4%	110.8%	109.0%	111.0%	110.3%	108.0%	109.3%	110.5%	106.2%

Overview:
The workforce position provides partial assurance. Mandatory training compliance remains strong, with continued focus on assuring that training is appropriately targeted and delivering the intended impact on practice.

Supervision compliance remains inconsistent: the Acute Directorate has been below target since December 2025, with marked ward-level variation. Vacancy and sickness pressures in specific crisis, liaison and community services are affecting access, cancellations and service resilience. Recovery actions include weekly exception reporting, additional training dates, targeted compliance plans, recruitment and cross-directorate support.

Sickness absence remains above target, with Trust and directorate averages masking areas of higher absence. Operational leaders have visibility of the 50 individuals with the highest sickness-absence rates in directorates. Bespoke plans are in place to support individuals to return to work with Occupational Health advice and support, and managers are being supported to utilise our sickness absence management policies and procedures in a fair and consistent way.

Recovery actions address the identified risks, but sustained effectiveness is not yet demonstrated in the highest-risk services. The next assurance test is whether improved workforce measures translate into fewer cancellations, reduced access pressures and stronger service resilience, alongside sustained training and supervision compliance.

Finance

Measure Name	Target	V	A	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Ref.79: In Month Turnover				25,321	26,587	25,769	25,158	26,885	41,498	29,749	30,029	29,996	29,786	30,249	30,099
Ref.80: In Month Expenditure				(25,137)	(26,405)	(25,584)	(24,974)	(26,700)	(41,268)	(29,749)	(30,029)	(29,996)	(29,785)	(30,249)	(30,099)
Ref.81: In Month Variance				184	182	185	183	185	230	0	0	0	1	0	0
Ref.82: Agency spend as a % of the trust total pay bill	696			418	350	432	258	338	133	596	679	801	872	535	366
Ref.83: Bank spend as a % of the trust total pay bill	1,356			1,728	1,525	1,692	1,743	1,727	1,794	1,810	1,863	1,631	1,924	2,009	1,728

Overview:
The financial position provides partial assurance on in-year delivery, but further work required around recurrent sustainability. Month 6 break-even relies on vacancy slippage, phased community investment and £2.92m of non-recurrent non-pay benefits, rather than sustainable underlying improvement. CIP delivery is £4.65m to date, with £10.37m forecast against the £10.35m target. Only £7.29m is recurrent; shortfalls in external beds, acute inpatient and corporate review schemes limit assurance from headline delivery.

Despite September improvement, external placements generated £2.65m of year-to-date pressure and acute inpatient staffing £1.00m, with staffing 26.4 WTE above establishment. High clinically ready for discharge levels constrain internal capacity and contribute to external bed requirements.

September agency expenditure fell to £0.37m, largely through assumed VAT recovery rather than reduced utilisation. Forecast expenditure of £7.43m exceeds the £6.46m cap by £0.97m, requiring stronger workforce controls.

Next assurance to link financial balance and recurrent CIP to agency and bank use, vacancies, external bed expenditure, CRfD bed days and capacity released through redesign. It should quantify the recurrent gap, with accountable actions and milestones, distinguishing in-year delivery from sustainable cost reduction.

6. Appendices

National oversight Framework (NOF) Rating Quarter 1

KMMH Position: Overall

Average score

2.69

Below Average and/or Financial Deficit

Likely range: 2.20 to 3.13

Financial deficit

No

Overall segment

3

Below Average and/or Financial Deficit

Based on average metric score

Capability rating

Amber/Green

Provider rank

53 out of 58 providers

Likely range: 25 to 58

Breakdown by domain:

Domain	Ave score	Quartile
Access	3	4
Patinet Safety	2.37	3
Finance, productivity and innovation	1.33	1
People	3.1	4
Experience of care	3.45	4
Effectiveness of care and population health	2.67	4

Data source: Kent and Medway NHS and Social Care Partnership Trust – Mental health and community provider – NHS Oversight Framework - NHS England public data gateway

Full national dashboards used in 25/26 not updated as at 11/09/26

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Title of Meeting	**Quality Committee**
Meeting Date	**26th November 2026**
Title	**Quality Committee Chair's Report**
Author	**Margaret Dalziel, Non-Executive Director**
Presenter	**Margaret Dalziel, Non-Executive Director**
Executive Director Sponsor	**Julie Kirby, Acting Chief Nursing Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Chief Nurse's Quality Report	• BAF/ SR1 • IQPR • Quality Improvement Plan • Violence and Aggression/Restrictive Practice Report • Co-creation Strategy and Plan • Suicide Thematic Report • National Quality Strategy & Thirlwall Enquiry • Research and Innovation Strategy Update • Patient Safety Incident Response Report • CQC Report • Mortality Report • Flu vaccination plan	• Committee Effectiveness Review

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
BAF / SR1 Board Assurance Framework (the Board's record of the biggest risks to quality and how well they are controlled)	The Committee received an early incomplete draft of the revised Board Assurance Framework (BAF). It failed to translate into a workable BAF that sets out accountability, timescales or the impact of controls. The Committee considered that it provided limited to no assurance in its current form and sought immediate attention to correct the position.	**Limited**	The Executive lead and senior team will hold an intensive development session, with input from the Audit and Risk Committee Chair. A fully developed BAF has been requested for the January 2027 Committee, with clear ownership, timescales and evidence of impact.
IQPR Integrated Quality and Performance Report (the Trust's main regular performance report)	The Committee considered that the Integrated Quality and Performance Report (IQPR) did not provide a sufficiently clear account of cohesiveness in presentation and therefore relevance, nor of performance, recovery action or impact. Important improvement activity was not visible, and ownership and timescales were unclear. Important improvement work was described verbally but was not visible in the report, for example early intervention access, crisis line call abandonment, mental health support in emergency departments, bed flow and out-of-area placements. Some measures and targets need review. The report therefore provided limited assurance.	**Limited**	Following discussion with the Executive team the Acting Chief Nursing Officer will confirm who is accountable and set a timetable for significantly improving the report and report both to the Committee in January 2027. Future reports should use readable charts, short exception commentary, named owners and timescales, and a review of measures and targets.

Quality Improvement Plan QIP	The report was clearer and much improved. 90% of actions have been delivered or are on track. Directorates are taking more ownership, long waits have reduced, waiting list oversight is stronger, and physical health monitoring and training compliance have improved. External reviewers from NHS England and the Integrated Care Board who visited in early November reported clear evidence that the plan is embedded in practice. Areas still needing focus: assessing and planning for patient risk, crisis care, dementia pathways, basic life support training for child and adolescent services, and consistent use of patient and carer experience.	**Reasonable (controls) Limited (impact)**	The Committee received reasonable assurance on controls and processes, but limited assurance on demonstrated and sustained impact. Future reports should separate physical health monitoring offered, completed and declined, and align more closely with the BAF and IQPR. Reports should use the Trust's assurance terms: no, limited, reasonable or substantial.
Patient Safety Incident Response PSIRF (how the Trust investigates and learns from incidents)	The Trust's patient safety incident response plan has expired. Its priorities are under review following evaluation and the transfer of children and young people's and all-age eating disorder services. The previous priorities have not yet been formally closed and revised priorities have not yet been submitted to the Board.	**Reasonable (process) Limited (impact)**	Interim Head of Patient Safety and Interim Deputy Chief Nurse to submit and evaluation of the previous PSIRP outputs, and the plan for establishing new priorities with clear timescales for Board approval.

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Impact and pace of improvement	Across the reports received, the Committee noted assurance on established processes and improvement activity, that all surfaced consistent themes and issues, but limited evidence of effectiveness of learning therefore sustained impact, this being mostly gleaned from verbal updates. Greater pace and clearer demonstration of measurable change are required.	**Limited**	Future reporting should show what has changed, the impact achieved and whether improvements are being sustained.

The Committee asked the Board to note:

• The BAF provided limited to no assurance in its current form. A fully developed version is expected at the January 2027 Committee.

• The IQPR provided limited assurance and needs to give a clearer, joined-up picture of performance, recovery action, ownership and impact.

• Reports gave stronger assurance on processes and controls than on effectiveness of actions, sustained impact and pace of improvement.

• The Committee supported moving mortality oversight to the Medical Directorate.

• Positive progress: the Place of Safety has opened and the female PICU is progressing; 90% of Quality Improvement Plan actions are delivered or on track; the number of restraint and violence and aggression are reducing; staff flu vaccination uptake is ahead of last year.

• Areas to watch: safety after discharge from services; refreshing the Trust's patient safety incident priorities; higher rates of restraint among Black patients.

• No items were referred to other committees. Barriers to research and innovation will be taken to the Executive Team.

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2026**
Title	**Mental Health Act Committee Chair's Report**
Author	**Margaret Dalziel, Committee Chair**
Presenter	**Margaret Dalziel, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
	• Chief Medical Officer's Report • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • CQC MHA Monitoring Visits Report • 136 breaches/ Section 132 benchmarking report/ Section 62 compliance • Health Inequalities • Legislation Update	

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Medical Officer's Report *Digital and business intelligence support*	Digitalisation of Section 17 leave and stronger Mental Health Act data analysis remain delayed by Digital and Business Intelligence capacity constraints. Current systems can be bypassed and do not reliably prevent progression when statutory steps are incomplete, reducing the effectiveness of training and retrospective checks.	**Limited**	The Committee Chair will escalate this to Digital and Business Intelligence, seeking a revised delivery timetable and clarity on prioritisation, particularly for the Section 17 solution and data on persistent blockers and trends.
CQC Mental Health Act Monitoring Visits Report	The Committee received assurance on robust monitoring: 13 Mental Health Act visits and one patient-focused visit, with positive feedback on compassion, dignity and family engagement. Recurring concerns remain about consent-to-treatment documentation, Mental Capacity Act and Deprivation of Liberty Safeguards compliance, Section 132 rights and advocacy access. Capacity assessments and best-interest documentation were incomplete in 11 of 13 visits. Assurance was therefore received on process, but not yet on sustained improvement.	**Reasonable (process)** **Limited (impact)**	Identify Mental Health Act representation within the Trust-wide Quality Improvement Plan governance. Cross-reference recurring themes and provide named owners, timescales and evidence that improvement has been tested and sustained.
Mental Health Act Activity Data Quarterly Report *Mental Health Act activity and ward scrutiny*	Scrutiny activity was below the minimum standard of 12 visits because of long-term sickness and a vacancy. Section 132 rights on admission remained a recurring issue, although rereading improved. Five patients awaiting a Second Opinion Appointed Doctor had missed required weekly Section 62 reviews; this was corrected after feedback. The Committee requested clearer trend comparison and resulting actions.	**Limited**	Refocus ward-based in-reach on admission processes and strengthen ward ownership with operational leaders. Future reports should show trends, actions, impact and whether the minimum scrutiny standard has been restored.

Health Inequalities	Inequalities persist: Black people were reported as 2.5 times more likely to be detained than White people, rising to 5.3 times for forensic detention, and 2.2 times more likely to be restrained. The Patient and Carer Race Equality Framework improvement project uses co-creation but was four weeks behind plan because of survey information governance issues. The Committee supported the approach but sought clearer countermeasures, milestones and measurable impact.	**Reasonable (approach) Limited (impact)**	Future reports should set out delivery timescales, progress against countermeasures and measurable impact, supported by comparison with similar mental health trusts. Consider a Board seminar once actions and early impact are demonstrable.
Associate Hospital Managers Report / Legislation Update	Five additional Associate Hospital Managers are due to join, improving capacity and diversity ahead of legislative change. The Committee received assurance that six-monthly audits are routinely discussed and that support and escalation routes were available regarding an informal complaint. Planning is considering opt-out advocacy and increased review volumes, pending the revised Code of Practice.	**Reasonable**	Future reports should summarise audit findings and trends, evidence the diversity statement and continue workforce and advocacy capacity planning for the revised legislation and Code of Practice.

The Committee asked the Board to note:

- Digital and Business Intelligence capacity is delaying the Section 17 solution and stronger compliance analysis.
- Monitoring is robust, but recurring statutory compliance themes do not yet demonstrate sustained improvement.
- Health inequalities remain significant; clearer milestones, countermeasures and evidence of impact are required.
- The Mental Health Act Committee will continue for two further meetings while the Quality Committee develops.

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26 November 2026**
Title	**People Committee Chair's Report**
Author	**Pam Creaven, Non-Executive Director and Committee Chair**
Presenter	**Pam Creaven, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**Ali Layne-Smith, Chief People Officer**
Purpose	**For assurance and noting**

Agenda Items

People items	Patient items	Finance items
• Workforce sustainability and culture • Sickness absence and local hotspots • Nursing and medical workforce pipelines • Staff voice and HR support	• Workforce capacity and safe staffing • Mandatory training and patient safety • Resident doctor wellbeing and safe working	• Agency and temporary staffing pressure • Costed nursing workforce plan • Mandatory training time and cost efficiencies • People Portal implementation resource

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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.
People Committee main report and workforce hotspots	The Committee welcomed the improved breadth of workforce data and information. Sickness absence remained above target with team-level hotspots above 10% obscured by directorate averages. West Kent also showed a concentration of workforce pressures.	**Reasonable**	A triangulated West Kent deep dive will return to the next Committee, drawing together workforce, culture, patient experience, change and service information. The fuller directorate cultural project plan will follow once staff survey results are available, with the final plan expected for Board in March 2027. Future reporting will include corporate services and show the impact of completed People Plan actions.
Nursing workforce strategy and newly qualified nurses	The Committee recognised the breadth of work across newly qualified nurse recruitment, preceptorship, Band 5 role review, apprenticeships and advanced practice. However, it took limited rather than reasonable assurance because there is not yet a validated, costed and monitorable delivery plan. Fourteen employment outcomes were reported from 76 locally qualifying nurses, while 69 preceptees are already supported. The proposed hybrid recruitment model remains dependent on funded posts, workforce experience mix, preceptorship capacity and financial approval.	**Limited**	A coordinated and costed nursing workforce plan will return, aligned to the Strategic Workforce Plan and planning cycle. It should set out route-specific recruitment numbers, vacancies, funding, preceptorship capacity, experience mix, delivery milestones, outcome measures, BAF linkage and the interfaces with Finance, Business and Investment, and Quality Committees.

Children and young people's medical workforce	The Committee remained concerned that 57% of consultant posts within children and young people's services were covered through bank or agency arrangements. Clinical activity was maintained, but the current position presents a continuing workforce sustainability and financial risk. Recruitment initiatives were described, including resident doctor pipeline development, remuneration and role attractiveness, and international recruitment expected to develop from 2027, but the Committee did not yet have a concise plan against which progress and agency reduction could be monitored.	**Limited**	A clear recruitment and retention plan with milestones, vacancy trajectory, agency expenditure impact and measurable outcomes will be incorporated into future Committee reporting and the Strategic Workforce Plan.
Statutory and mandatory training streamlining	The Committee received reasonable assurance on progress in aligning training to national requirements and reducing unnecessary repetition. Approved changes were estimated to release 68,977 staff hours and £2.159m over ten years, although these are modelled rather than realised cash savings. Assurance was constrained by the delayed NHS England framework, very low directorate representation at the Mandatory Learning Oversight Group and the need to evidence whether training changes improve outcomes. The Committee also emphasised that any change to Freedom to Speak Up training must support, rather than weaken, the wider cultural response to speaking-up concerns.	**Reasonable**	Directorate representation and decision-making attendance at the Mandatory Learning Oversight Group will be strengthened. An annual training plan will quantify staff time, cost and outcome measures. Freedom to Speak Up requirements will be reviewed with the cultural transformation programme and subject matter experts.

	Further exploration is required for mandatory training requirements to ensure they are proportionate to the risks being managed and that proposed changes are supported by appropriate evidence, clear outcome measures and an agreed organisational risk appetite.		
Resident doctor assurance	The Committee received reasonable assurance on the NHS England Resident Doctor 10-Point Plan, with 19 of 21 lines compliant and two partially compliant. The unresolved issue concerned sustainable on-call rest accommodation at Littlebrook Hospital. Quarterly Guardian reports showed 11 upheld exception reports in April to June and 33 in July to September; payment arrangements for additional Tier 2 hours had been clarified. The Committee also received positive GMC National Training Survey results: overall satisfaction improved to 83.26, the Trust ranked 26th nationally and fourth in Kent, Surrey and Sussex, although the 58% response rate limits representativeness.	**Reasonable**	The Board is asked to note the 10-Point Plan and GMC survey as required. Estates and medical leadership will continue to secure a sustainable on-call rest facility and monitor Tier 2 workload and exception reporting. Medical Education will implement the response plan and seek to improve future GMC survey participation.

HR Helpdesk and staff voice	The Committee received positive assurance from the staff story and Helpdesk update. Since launch, the service had handled 3,752 queries and supported 252 manager drop-in attendances; 72.4% of survey respondents rated the experience good or excellent. The Committee welcomed the responsiveness and improved use of demand data, while noting an opportunity to distinguish queries suitable for self-service or manager capability development from complex matters requiring specialist advice.	**Reasonable**	Helpdesk demand themes will be used to target communications, self-service resources and manager spotlight sessions, including sickness absence. Future reporting should demonstrate service impact, efficiency, recurrent demand reduction and learning relevant to People Portal implementation.

Matters for Board attention:

The Board is also asked to note the positive assurance from the Resident Doctor 10-Point Plan, Guardian of Safe Working Hours reports, GMC National Training Survey, HR Helpdesk and mandatory training streamlining programme. No additional expenditure or workforce establishment was approved by the Committee.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26 November 2026**
Title	**Charitable Funds Committee Chair's Report**
Author	**Susan Baker, Committee Chair**
Presenter	**Susane Baker, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Transformation and Partnerships**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quarterly impact report • Charity strategy development• Annual Report and Accounts 2025/26	• Charity risk register • Q3 operational plan • Finance report • Committee effectiveness review • Terms of Reference

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another Committee.
Quarterly Impact Report	The Committee received reasonable assurance on Q2 delivery and welcomed the positive impact of charitable activity, including therapeutic projects, grant success and significant growth in corporate volunteering. Members asked that future reports place greater emphasis on measurable beneficiary outcomes, patient and staff experience, corporate partner impact and the criteria used to select projects, alongside financial and activity measures.	**Reasonable**	The impact framework will be strengthened through the developing charity strategy. Future reports will include clearer outcome measures, a structured grants pipeline, project-selection criteria and relevant feedback from beneficiaries and corporate volunteers.
Charity Risk register	The Committee approved the refreshed risk register but received limited assurance because the charity continues to face significant financial sustainability, income concentration and operational resilience risks. Current uncertainty includes the future level of Trust support, reliance on restricted income, historical recharges, a vacancy and reduced capacity within a small team.	**Limited**	Longer-term financial forecasts, clarity on Trust support, an appropriate operating reserve, income diversification and business-continuity arrangements will be developed. Restricted and unrestricted income will be reported separately, with the new financial-control and capacity risks kept under review
Q3 Operational Plan and NHS Health Lottery	The Committee approved the Q3 operational plan and received reasonable assurance on prioritisation during a period of reduced team capacity. The winter campaign was confirmed as the immediate delivery priority, supported by progress on the charity rebrand and the proposed NHS Charities Together Health Lottery. Members sought explicit assurance on the regulatory, information-governance and reputational	**Reasonable**	Lottery launch will proceed only once all governance and control requirements are complete. A short assurance note will be circulated confirming where regulatory responsibility and liability sit.

	arrangements applying to community promotion of the lottery.		
Finance Report	The Committee noted a small year-to-date surplus and approved repayment to the Trust outstanding salary recharges. Members requested clearer forward reporting of secured, forecast and unsuccessful income opportunities, including confidence levels and separate presentation of restricted and unrestricted funding. The absence of a confirmed reserves policy was identified as an important governance gap.	**Reasonable**	A draft reserves policy will be brought to the next Committee meeting. Future finance reports will categorise income sources more clearly and provide an end-of-year projection supported by confidence assessments.
Annual Report and Accounts 2025/26	The Committee approved the substantive content of the Annual Report and Accounts, subject to final design, editorial checks and confirmation by the independent examiner. The final document will be presented to the Corporate Trustee for approval.	**Reasonable**	The final designed report will be checked by Finance and the independent examiner before submission to the Corporate Trustee.
Development of Charity Strategy	The Committee supported development of a medium-term strategy that establishes a clear charitable purpose, demonstrates additionality beyond statutory NHS provision and aligns appropriately with the Trust strategy while preserving the charity's independence. The strategy will need to address financial sustainability, the balance of restricted and unrestricted income, priority setting, return on investment, impact measurement, lived-experience involvement, partnerships, advocacy and the charity's distinctive strengths, including corporate volunteering. As this work is at an early stage, limited assurance was received.	**Limited**	A facilitated development session will be arranged, with trustee, lived-experience, staff and partner input. Learning from other NHS charities will inform the work. A developed draft and first-year delivery plan are expected to return during spring 2027, with approval targeted for the April Committee meeting
Committee Effectiveness and Terms of Reference	The Committee noted positive effectiveness findings, while recognising the low response rate and limitations of the current assessment tool. It agreed	**Reasonable**	The effectiveness tool will be reviewed before the next annual cycle. Trust Secretariat will

	to introduce a short effectiveness reflection at the end of each meeting. Amendments to the Terms of Reference were identified, including removal of the obsolete Engagement Council reference, clearer quorum wording and consideration of greater separation between the Trust and charity finance roles.		update the Terms of Reference before submission to the Corporate Trustee.

The Committee asks the Board to note the assurance received, the limited assurance in relation to the charity risk profile and early-stage strategy development, and the approval of the Annual Report and Accounts 2025/26 subject to final independent examination and presentation.

The Committee also highlights the need for a reserves policy and clearer long-term arrangements for financial sustainability and Trust support.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2026**
Title	**Children and Young People's and All Age Eating Disorders (CYPMHS & All AED) Committee Chair's Report (October and November)**
Author	**Stephen Waring, Committee Chair**
Presenter	**Stephen Waring, Committee Chair**
Executive Director Sponsor	**Donna Hayward-Sussex, Chief Operating Officer and Deputy Chief Executive**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
• Workforce & Capacity Report • Deep Dive: Outcomes and Experience Measures (child/family-focused metrics)	• CYP and AAED Risk Register • CQC / Regulatory Compliance Update	• Digital Migration Report • Estates Assurance Report

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Workforce & Capacity Report	One-to-one compliance, mandatory training and recruitment improved. Further trend information, targets and trajectories are required to demonstrate sustained progress. Workforce oversight will transfer to the People Committee.	**Reasonable**	Further workforce reporting will be considered through the People Committee, including trends, targets and trajectories.
CYP and All Age Eating Disorders Risk Register	Mitigations were clearly described, but risk scores remain unchanged while actions are embedded and evidenced. Digital data access and accuracy, out-of-area eating disorder placements and administrative vacancies remain key concerns.	**Limited**	Escalation with the ICB is being progressed regarding responsibility for out-of-area eating disorder placements.
Digital Migration Report	The programme remains rated amber. Progress has been made on the Rio migration contract and recruitment, but data mapping remains complex and digital migration continues to be a significant transitional risk.	**Limited**	An earlier Assurance Board meeting will be arranged, with appropriate non-executive representation.
Estates Assurance Report	Strong progress was reported on estates integration, cleaning, planned maintenance and fire risk actions. Residual risks remain around lease transfers, dilapidations, roof access and fire compartmentation, with interim controls in place.	**Reasonable**	Ongoing oversight will transfer to the Finance, Business and Investment Committee, with outstanding transitional property matters kept under review.
CQC / Regulatory	Regulatory contact remains consistent with previous experience. Future reporting will take a broader view of patient safety, care and experience, triangulating regulatory	**Reasonable**	Future reporting will be considered through the Quality Committee, with a

Compliance Update	intelligence with incidents, complaints, safeguarding, access and patient experience.		broader focus on patient safety, outcomes and experience.
Deep Dive: Outcomes and Experience Measures	Outcome measure capture is incomplete and inconsistent across services and localities, with reporting still reliant on manual processes. The All Age Eating Disorder Service provides a stronger model that could support wider improvement.	**Limited**	A further update will return in March, setting out progress, milestones and evidence of impact on patient outcomes and experience.

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Title of Meeting	**Public Trust Board**
Meeting Date	**20 November 2026**
Title	**Shadow Partnership Committee Chair's Report**
Author	**Kim Lowe, Non-Executive Director (Committee Chair)**
Presenter	**Kim Lowe, Non-Executive Director (Committee Chair)**
Executive Director Sponsor	**Dr Adrian Richardson, Director of Transformation and Partnerships**
Purpose	**Discussion**

Agenda Items

People items	Patient and community items	Finance and governance items
• Partnership behaviours and reciprocal feedback • Lived experience and community accountability • Sustainable relationships with VCSE partners	• Mental Health Together whole-pathway assurance • Partnership register and benefits realisation • Neighbourhood and collaborative working	• Commissioning scope and contractual oversight • Provider Alliance hosting and accountability • Delegated authority and constitutional requirements

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.
Purpose and development of the Shadow Partnership Committee	The inaugural meeting confirmed the Committee's intended focus on two central questions: whether the Trust is commissioning effectively and whether it is acting as an effective partner. Members agreed that	**Limited**	The Chair, Executive Lead and Trust Secretariat will refine the Committee agenda, workplan and Terms of Reference during the shadow period. A short Board development session was proposed

	the Committee should remain in shadow form while its scope, reporting routes and supporting arrangements are tested. The shadow period should continue for approximately six months, with progress reviewed before formal commencement.		to be used to clarify the Committee's developing remit and boundaries.
Board Assurance Framework and strategic risk	The Committee reviewed the emerging strategic risk relating to partnership working and concluded that the risk description and causes require further development. Some proposed causes appeared to relate to business-as-usual operational or contractual matters rather than risks owned by this Committee. The terms "co-production", system governance and health inequalities also require greater precision so that causes, consequences and controls are clearly distinguished.	**Limited**	The Director of Transformation and Partnerships and Trust Secretariat will revise the risk wording, causes and ownership, and return an updated proposal to the next shadow meeting.
Commissioning scope, finance and contracting	The Committee supported development of whole-pathway oversight for Community Mental Health Together and the perinatal provider collaborative, bringing together Trust and partner delivery rather than focusing only on individual partner contracts. However, the Committee has no delegated financial or contractual authority while operating in shadow form. Approval of expenditure, contracts and variations must continue through the existing Standing Financial Instructions, Scheme of Delegation and authorised committee routes.	**Limited**	A recommendation will be developed on the interface with the Finance, Business and Investment Committee and the approval route during shadow operation. Future reporting should provide a single pathway view of activity, access, quality, outcomes, finance, risks and recovery.
Mental Health Together commissioning and	The Committee received reasonable assurance that the model of care, partner mobilisation, due diligence and locality planning provide a stronger foundation for delivery. Members supported oversight of the whole	**Reasonable**	The developing assurance framework should include reciprocal partner feedback, clear escalation routes, routine quality and financial review, and evidence of patient and community

partnership assurance	pathway, including the Trust's own delivery, partner delivery and interdependencies. Further assurance is required on the final service specification, outcomes and KPI framework, data quality, partner reporting, conflicts of interest, and the effectiveness and sustainability of partnership arrangements.		benefit. Consideration should also be given to future independent assurance through internal audit.
Partnership principles, register and assurance model	The Committee endorsed the development of a single Trust partnership register, proportionate risk assessment and clear ownership. Members also identified the need for a concise partnership compact setting out mutual expectations, behaviours and ways of working, developed with partners rather than by the Trust alone. Current reporting remains more descriptive than evidential and does not yet demonstrate consistently whether partnerships are effective or delivering measurable additional value.	**Limited**	The Partnership Group will progress the register, map existing arrangements and develop proposals for partnership principles, maturity assessment, benefits realisation and reciprocal partner feedback. An initial update should return to the next shadow meeting.
Provider, commissioner and collaborative governance roles	The meeting identified a material gap in the emerging model: the need to distinguish clearly between the Trust's roles as commissioner, lead provider, delivery partner, host and participant in provider collaboratives. Existing workstreams covering commissioning oversight, the Provider Alliance and neighbourhood health do not fully capture assurance on the Trust's performance as a delivery partner. Reporting routes for participation in provider collaboratives also require clarification.	**Limited**	The governance model will be remapped to include the Trust's delivery-partner role and to clarify which matters are overseen by the Partnership Committee, supporting groups, the Finance, Business and Investment Committee or the Board.

Future collaborative governance and delegated authority	The Committee agreed that no new delegated authority or collaborative structure should be approved at this stage. Existing arrangements should be mapped before any joint committee or committee-in-common option is developed. Any future proposal must have a defined purpose, scope, participating organisations, decision rights and approval route, and must identify the necessary amendments to the Scheme of Delegation, Standing Orders and Standing Financial Instructions before authority is exercised.	**Limited**	Separate governance assessments will be developed for commissioning oversight, Provider Alliance hosting and neighbourhood health. Any preferred model will return through the appropriate governance and Board approval routes with legal, financial and constitutional advice.

The Committee asks the Board to note:

- The inaugural meeting successfully identified the principal design and assurance issues requiring resolution during shadow operation.
- The Board is asked to note that the Committee currently has no delegated financial or contractual authority; the BAF risk and committee scope require refinement; whole-pathway commissioning assurance must include both Trust and partner delivery; and further work is required to establish a partnership register, reciprocal partner feedback, clear provider/commissioner boundaries and proportionate collaborative governance.
- The Committee will remain in shadow form while these arrangements are developed and tested.

Kent and Medway Mental Health NHS Trust

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2026**
Title	**Finance, Business and Investment Committee Chair's Report**
Author	**Colin Lynch, Trust Chair (Acting Committee Chair)**
Presenter	**Colin Lynch, Trust Chair (Acting Committee Chair)**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
• Temporary staffing paper Business Case	• Assertive Outreach Business Case • Mental Health Together (MHT) Contract update	• Financial Plan - Guidance Update • BAF Report • Finance Report and Forecast • Service Line Reporting and Costing Update • Digital and IT • Estates Update

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Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Committee.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Board Assurance Framework (BAF)	The revised BAF was welcomed as a significant step forward, but the Committee could not yet take sufficient assurance from it. Risk causes, ownership, risk appetite and evidence of control effectiveness need to be clearer. The main supporting papers also need to show explicitly how they provide assurance against strategic objectives and BAF risks.	**Limited**	Executive leads to refine the BAF following Board discussion, including clearer causes, executive ownership, assurance mapping and movement in risk. The Committee work plan and future papers will be aligned to the BAF. SR8 ownership was agreed to FBI Committee.
Financial Plan 2027/28	The Committee endorsed the planning approach and noted prudent assumptions. Assurance is moderated by a £2.5m adverse exit run-rate, uncertainty over national inflation assumptions, and the need to demonstrate triangulation with workforce and service plans. Closer alignment with KCHFT is also required.	**Reasonable**	An updated plan will be considered at the December Board development session. A further update on alignment with KCHFT will return in January.
Finance Report and Forecast	The in-year position remains broadly controlled and external bed expenditure has reduced. However, the position is not recurrently balanced, around 30% of cost improvement delivery is non-recurrent, and inpatient staffing and flow pressures remain material.	**Reasonable**	Future reports will enhance the reporting around impact of non-recurrent CIP, inpatient staffing pressures and delayed step-down provision.
Service Line Reporting and Costing	The report provided useful benchmarking, but limited assurance on outcomes or corrective action. Productivity growth in 2024/25 was below peers, leading to an adverse movement in the reference cost score from 87 to 90 (100 being national average, so 10% below this), KMMH identified as running at a	**Limited**	Consideration on how future reporting can be developed to consider triangulation of cost and outcomes; with clear actions where services are outside expected ranges.

	loss with further work to do with the commissioners on this.		
Digital and IT	The operational update did not yet provide sufficient strategic assurance on delivery, benefits or the impact of delay. The Committee particularly noted the need for pace on clinical AI scribing (With a pilot on-going within the trust) and clearer evidence of patient, workforce and productivity benefits.	**Limited**	Future reports will be structured around strategic objectives, measurable benefits, risks and the impact of delays on patients and staff.
Estates	Positive assurance was received from the opening of the female PICU and centralised Place of Safety. This was offset by the second power-related incident at KMMH, current closure and patient displacement, and capacity pressure within the Estates team. KPI reporting also needs to provide clearer assurance.	**Limited**	KMMH recovery and wider resilience learning will be progressed. The Estates strategy returns in January. Further work to do regarding with clearer KPIs reporting, and consideration of the resources required to support the capital position.
Business cases/ Contracts	The Committee approved the Assertive Outreach business case and supported award of the temporary staffing contract, subject to the controls described. The Mental Health Together contract was not approved pending resolution of partner costs, delivery model and stronger contractual assurance.	**Reasonable**	A strengthened Mental Health Together paper will return through an appropriate approval route, setting out partnership feedback, contractual levers and quality implications.
The Committee asked the Board to note: • Limited assurance was taken from the BAF in its current form. Further work to do to align the committee's workplan and assurance reporting to it. Clearer evidence of control effectiveness, ownership and risk movement.			

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• The financial position is controlled in-year but is not recurrently balanced; the £2.5m adverse exit run-rate, non-recurrent savings and inpatient pressures require continued focus.

• Positive progress included lower external bed expenditure, opening of the female PICU and centralised Place of Safety, and approval of Assertive Outreach and the temporary staffing contract.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	24 November 2026
Title of paper:	Finance report for Month 7 (October 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 7 (October 2026).

Issues to bring to the Board's attention

External beds

External bed expenditure continues to represent a financial pressure. In month usage showed increased from 12.7 to 13.4 beds in Acute with Psychiatric Intensive Care Unit (PICU) decreasing (10 beds to 8) and Step Down beds remaining at 1 as expected in month.

The year-to-date budgetary pressure for external bed usage totals £2.86m including Step Down beds.

With Step Down capacity closing and overall bed usage relatively flat in month but still over plan, Acute usage provides a risk to the financial position with a forecast £3.63m pressure to the financial position this year which takes into account current and forecast pressures, closure of Step Down beds and current Integrated Care Board (ICB) plans to purchase beds.

Acute Inpatient staffing

The Trust's Acute Inpatient wards continue to utilise Nursing staff (both registered and unregistered) over and above established levels due to operational pressures and complexity of patients and required care.

In October, 4.6 Whole Time Equivalent (WTE) more than September were utilised; 18.3 WTE above establishment. The year-to-date pressure totals £0.98m.

Agency spend

October agency spend totalled £0.52m after VAT rebates relating to prior periods. Before these rebates, spend was £0.72m. Medical agency was the main driver, with spend of £0.32m in

Children and Young People (CYP) / All Age Eating Disorders (AAED) and £0.14m in East Kent. Nursing agency spend in these localities was £0.08m and £0.04m respectively. Agency use in other staff groups was minimal.

Forecast agency spend is £6.94m against a cap of £6.46m. The increase reflects additional requests for medical agency cover due to sickness and vacancies. There have also been delays in CYP and AAED agency invoices. Further reductions are required to address the forecast £0.48m excess over the cap.

Mitigations

The Trust is presently seeing slippage in its Community and CYP & AAED budgets which are offsetting the pressures seen elsewhere. The Trust's plan is based on investing in community services. Additional non-recurrent and technical mitigations have been identified. Both represent a risk to the financial position as they cannot continue to support financial pressures caused by beds and Acute staffing.

Capital Programme

As at 31 October, forecast capital expenditure is £14.46m above the plan submitted to NHS England (NHSE), primarily due to assets recognised through the CYP and AAED service transfers.

Of this, £12.96m relates to intra-DoH leases which are excluded for statutory Capital Departmental Expenditure Limit (CDEL) purposes and therefore do not count against the Trust's CDEL limit.

The remaining £1.50m variance to plan principally reflects additional lease expenditure, partly offset by delays to the R&D Hyperfine project.

The current year-end forecast is c.£1.74m above available CDEL, primarily relating to leases associated with the CYP transfer from North East London NHS Foundation Trust (NELFT).

This position is being worked through with NHSE and will be updated next month once the CYP leases are fully confirmed and the basis of recognition and CDEL treatment for other Trust leases has been finalised.

Cash

October's closing cash balance was £7.37m, up £2.70m in month and £3.49m above the planned £3.88m.

Kent and Medway ICB debt of £2.18m remains more than 120 days overdue.

Governance

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

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Finance Reporting Pack
October 2026

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1. Executive Summary
2. KPIs
3. Primary Statements (I&E and Balance Sheet)

Appendices:

Forecast Position
Cost Improvement
Pay Trend
Inpatient Exception Report
External Beds Exception Report
Capital

Glossaries

1. Executive Summary

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

YTD financial position
£0.00m breakeven
Plan: breakeven

External beds
£2.86m pressure
Acute Remains at average 13

Inpatient staffing
£0.98m pressure
18.3 WTE above establishment

Agency Forecast
£0.48m over cap
Forecast £6.94m vs £6.46m

What the Board needs to know

Forecast: AMBER

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

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

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

Forecast assumes delivery; confidence dependant on Quarter 3 traction on the main risk areas.

Priority risks and controls

External beds: PICU above funded levels and continued significant use of Acute beds. Reduction trajectory in place.

Acute staffing: Staffing WTE usage reduced but still 18.3 WTE over establishment. Controls need sustained benefit.

Agency: October £0.52m, mainly CYP/ AAED and medical vacancies. Forecast £0.48m above agency cap.

Area of focus for October

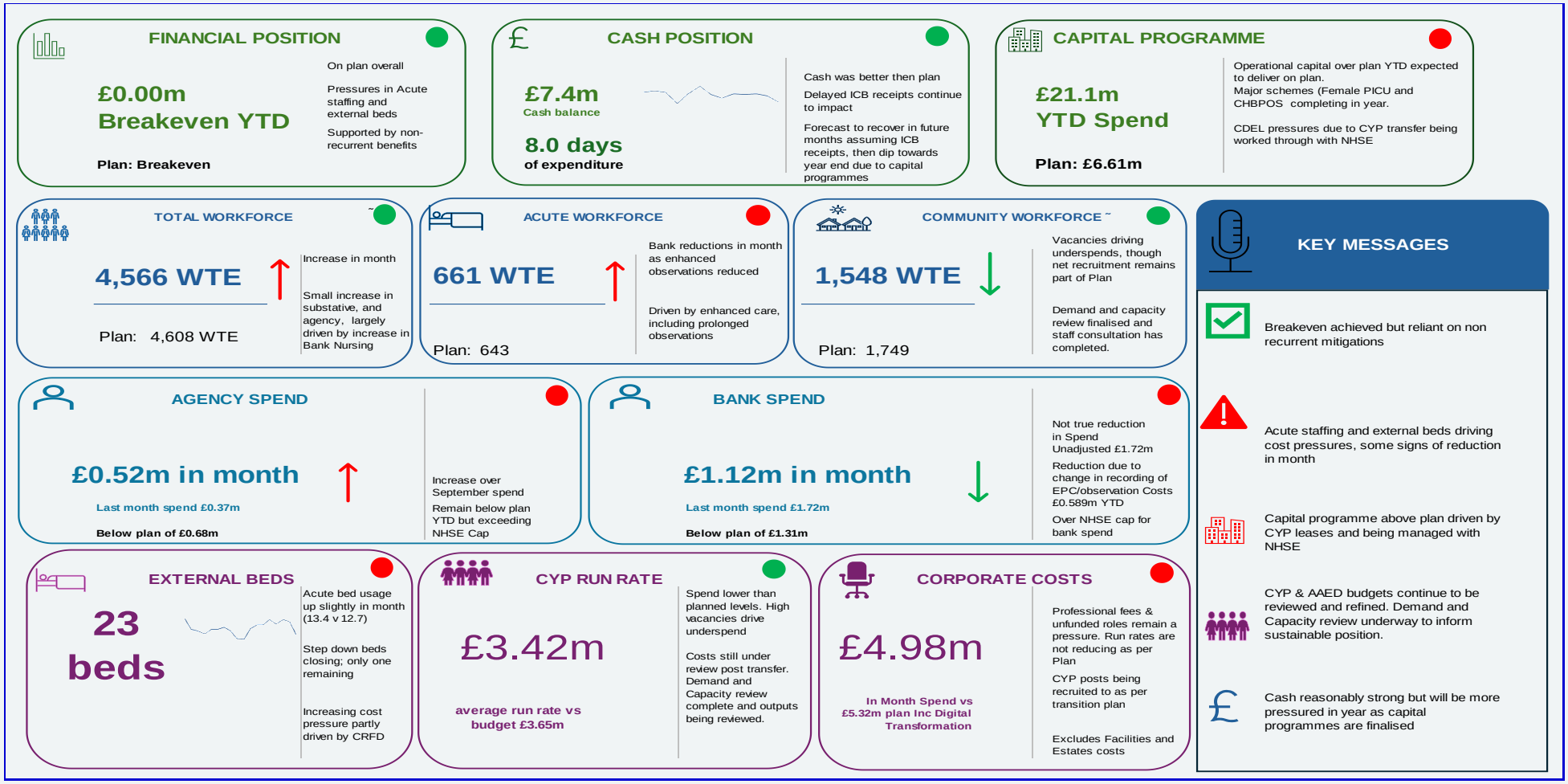
Assure
Confirm the external bed reduction trajectory and route to replacing temporary step-down with commissioned capacity.

Control
Track staffing controls, observation reductions and agency reductions.

Note
Capital is £14.46m above plan, due to non-CDEL leases; cash is £7.37m an improvement over September.

Caring | Inclusive | Curious | Confident

2. Finance KPIs



Caring | Inclusive | Curious | Confident

3. Primary statements

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
		£'000	£'000	£'000	£'000	£'000	£'000
Income	355,344	29,875	30,085	211	209,584	209,992	409
Employee Expenses	(282,838)	(23,818)	(23,002)	815	(167,484)	(164,100)	3,384
Operating Expenses	(65,799)	(5,546)	(6,565)	(1,019)	(38,045)	(41,944)	(3,899)
Operating (Surplus) / Deficit	**6,707**	**511**	**518**	**7**	**4,054**	**3,948**	**(106)**
Finance Costs	(6,264)	(479)	(481)	(2)	(3,874)	(3,946)	(72)
Surplus / (deficit) for the period	**444**	**32**	**36**	**4**	**180**	**2**	**(178)**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	**(443)**	**(32)**	**(36)**	**(4)**	**(180)**	**(1)**	**179**
System control Surplus / (Deficit)	**0**	**(0)**	**1**	**1**	**0**	**1**	**1**

Statement of Financial Position

	31st March 2026	30th September 2026	31st October 2026
	£000	£000	£000
Non-current assets	183,623	197,983	197,773
Current assets	21,129	19,501	20,814
Current liabilities	(31,756)	(29,873)	(31,599)
Non current liabilities	(37,757)	(49,787)	(49,127)
Net Assets Employed	**135,240**	**137,824**	**137,860**
Total Taxpayers Equity	**135,240**	**137,824**	**137,860**

The Trust is reporting a breakeven position at the end of October, in line with Plan.

Income
In month, income has exceeded plan. The full inflationary uplift for the final agreed pay awards is now reflected in the position, along with assumed funding to support patients with prolonged observations.

Employee expenses
The Trust is reporting a year-to-date underspend on employee expenses of £3.38m.

Pay underspends due to vacancy slippage across East, North and West Kent Community Directorates total £1.97m, including funds reserved for extending services under the Community Mental Health Framework (CMHF). An additional £2.32m is due to slippages in CYP recruitment (£2.06m of which is offset by a corresponding shortfall in recoverable income). This slippage is forecast to reduce through the year as recruitment continues, in line with plans to increase the Community pay run rate through the filling of vacancies.
Recruitment plans will also reflect the outcomes of the Mental Health Team (MHT) consultation, ensuring workforce investment aligns with the agreed future service model. Current pay slippages are partially offset by pressures arising from additional temporary staffing on Acute wards.

Operating expenses
Non pay includes spend on external placements compared to budget, with additional Acute beds utilised resulting in an overall year to date pressure of £2.86m, including spend on step-down beds.

In October, usage of external Acute beds increased slightly, from average 12.7 beds to 13.4. PICU usage decreased from 10 beds to 8 external beds were used in month against a commissioned base of 7 external female PICU beds.

Total assets
Total assets increased by £1.10m in the month, primarily related to increases in cash which are offset by increases in Trade Payables. The K&M ICB paid 50% of the debt that the Trust was expecting to receive in October, because of this some payable invoice payments have been delayed. Capital expenditure in month was £0.83m and was largely offset by depreciation and impairments of £1.06m.

Total liabilities
Total liabilities have increased by £1.07m in the month. This is due to delays in the payment of invoices as the Trust is managing its cash position.

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Appendicies

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Income and Expenditure Forecast

Commentary

The organisation has developed its forecast scenarios to reflect the principal risks and opportunities within the financial position. This work is on-going and a standing item of discussion within the Executive Team.

This assessment considers best, worst and likely positions, reflecting pressures such as external bed usage, patient acuity, complex care requirements and delivery of the Cost Improvement Programme. This work is supported by a developing set of actions and mitigations to strengthen the Trust's financial position and support delivery of the plan.

At Month 7 the Trust is forecasting:

- **A breakeven mid-range position** - Delivery of the core forecast assumptions. External acute bed usage follows the forecast trajectory, including an allowance for winter pressures. The forecast assumes support from Kent and Medway ICB to mitigate the impact of the delayed step down position. Acute inpatient pressures reduce in line with operational plans, including a reduction in temporary staffing usage associated with enhanced observations and patient acuity.

- **A best case of £0.5m surplus** - Delivery of the core forecast assumptions together with a reduction in external bed usage and full delivery of planned mitigations and control actions.

- **A worst case of £3.53m deficit** - External acute bed expenditure continues at levels experienced during the first half of 2026/27, with no additional capacity commissioned by Kent and Medway ICB. Acute inpatient pressures persist or increase, resulting in continued reliance on enhanced observations and temporary staffing. Seasonal pressures, including higher levels of sickness absence, further increase workforce costs in order to maintain safe staffing levels.

The forecast position is based on the following principal assumptions:

Area of spend	Rationale
External Acute bed	The forecast allows for an average of two beds through reflecting seasonal demand. ICB-commissioned capacity was expected to reduce CRFD and external bed demand, but procurement remains delayed. The Trust is working with system partners to determine how to deploy agreed support, seeking to mitigate expenditure pending capacity provision.
External PICU bed pressures	Male PICU usage increased materially in June but within the last month pressure has eased. This is currently assessed as a non-recurrent pressure and is expected to remain at 4 beds until the end of the year.
External step-down bed provision	The Trust used step-down beds to manage winter pressures pending ICB-commissioned provision. Provision has ended apart from one remaining patient, with discharge expected by 31 October.
Community expansion	Mobilisation in Care navigation services (front door), remaining community investment aligned to operational plans. The trust has just completed its consultation and is finalising contracts with partners. It is expected these will be in place in Quarter 3, with staffing levels increasing towards the end of Quarter 4.
Other run rate changes	Seasonal impacts
Other controls & mitigations	Acute inpatient pressures for prolonged observations and EPCs
Community framework roll out	Planned community expansion may be paused where necessary while bed-related pressures remain.
Delivery of the Cost Improvement Programme (CIP).	Focus on reducing inpatient staffing costs, supported by automated processes for temporary staffing, delivery of the bed trajectory and finalisation of the non-pay review.

Cost Improvement 2026/27

Total CIP target	Total CIP identified	CIP delivered YTD	Recurrent CIP FOT
£10,352k	£10,367k	£5.718k	£7,113k

Performance to date:

At month 7, £5.72m of CIP has been delivered to date.

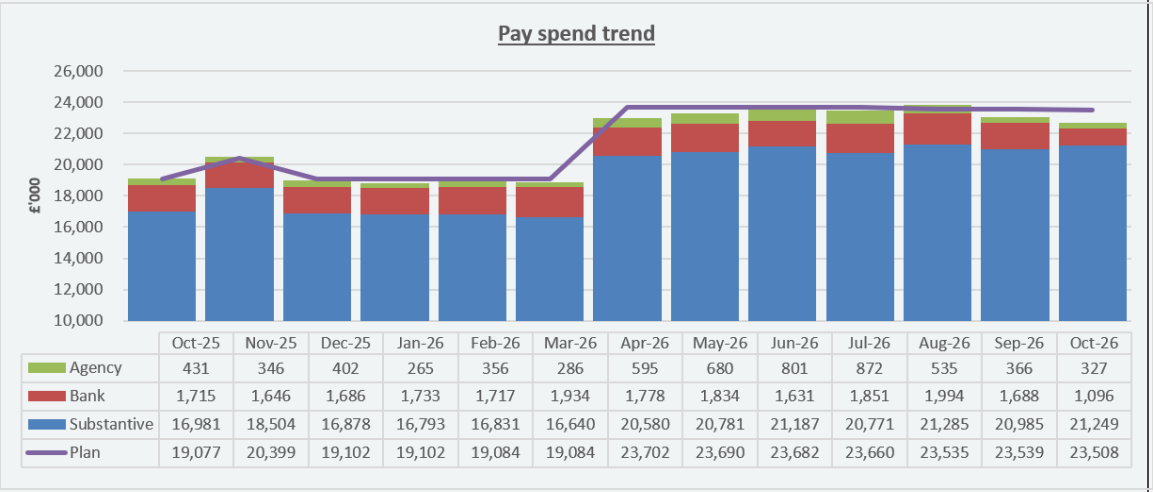
There are some schemes for which delivery is delayed namely Acute inpatient schemes which relates to utilisation of rotas and temporary staffing provision and the external beds utilisation which the Trust has experienced pressures on due to the increased demand on the Trust's bed base.
There are work programmes in place within the Trust and wider system which should enable these schemes to progress.

Corporate post reviews are underway, and the Trust has implemented a recruitment freeze on all corporate posts, covering both new appointments and the replacement of vacant roles.
Any exception will be limited to posts that are required to meet statutory obligations or are demonstrably safety-critical and will be subject to executive review and approval.

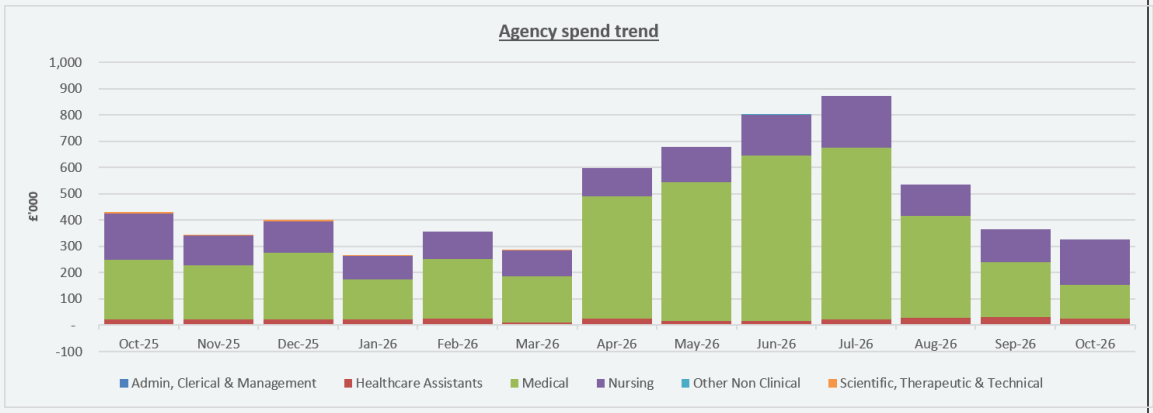
Pipeline schemes are being developed to address any slippage and provide the required mitigation, and these align to the 3-year CIP and Service Review programme that is already in place.

Area of spend	Recurrent?	Planned CIP Target	Forecast delivery	Variance
Acute inpatients	✓	1,600	1,050	(550)
Corporate review	✓	1,000	540	(460)
External beds	✓	2,620	1,383	(1,237)
Agency VAT	✓	1,000	1,000	0
CYP budgetary review	✓	1,100	958	(142)
Non pay review	✓	1,000	600	(400)
Agency Premium	✓	600	600	0
Community mitigations	✗	-	3,082	3,082
Forensic controls	✓	-	393	393
Community Service reviews	✓	-	589	589
Other	✗	1,432	172	(1,260)
Total		**10,352**	**10,367**	**15**

Exception report – Pay trend



	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26
Agency	431	346	402	265	356	286	595	680	801	872	535	366	327
Bank	1,715	1,646	1,686	1,733	1,717	1,934	1,778	1,834	1,631	1,851	1,994	1,688	1,096
Substantive	16,981	18,504	16,878	16,793	16,831	16,640	20,580	20,781	21,187	20,771	21,285	20,985	21,249
Plan	19,077	20,399	19,102	19,102	19,084	19,084	23,702	23,690	23,682	23,660	23,535	23,539	23,508

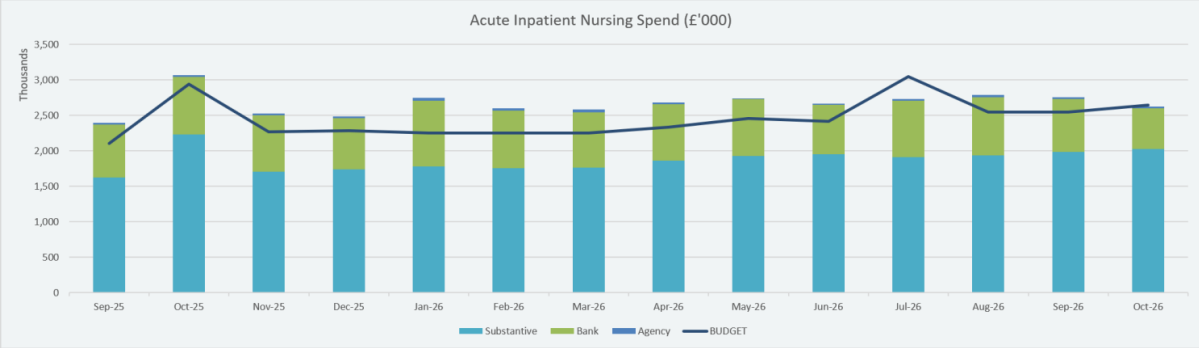


- The Trust continues to report a favourable pay position, with a year-to-date pay underspend of £3.38m at the end of October, reflecting the impact of vacancy management, recruitment controls and expenditure oversight across services.
- Workforce levels remain below plan, with the Trust operating at 42.9 worked WTE below NHSE workforce plan*. This remains an area of focus given increased scrutiny from NHS England and system partners regarding workforce growth, pay run rates and affordability.
- Pay expenditure continues to be influenced by service transfers and national pay awards. Following the transfer of CYP and AAED services in April 2026, substantive pay costs increased by £0.26m in October. All pay awards have now been enacted for all staff groups except Senior Managers which will be enacted in November pay.
- Bank staffing usage increased during the month. A reduction in enhanced observations in Acute was offset by increases in Forensics to support increases in enhanced observations, training and annual leave cover across a number of wards. Bank costs are presented in month as lower than previous months; this is due to a backdated adjustment for costs recharged to commissioners.
- Agency usage remains concentrated within CYP and AAED services, where significant medical vacancies continue to require temporary cover. Agency spend decreased by £0.04m in month. Work continues to identify VAT paid to agencies which can now be recovered following HMRC rulings. This is reducing agency spend shown this year.
- Delivery of the agency reduction plan remains a key financial risk. Current forecasts indicate agency spend of £6.94m against a cap of £6.46m, an adverse variance of £0.48m, driven primarily by ongoing and new medical staffing requirements. Further actions are required to reduce reliance on temporary staffing and improve compliance with the agency ceiling as well as to recover all VAT possible.

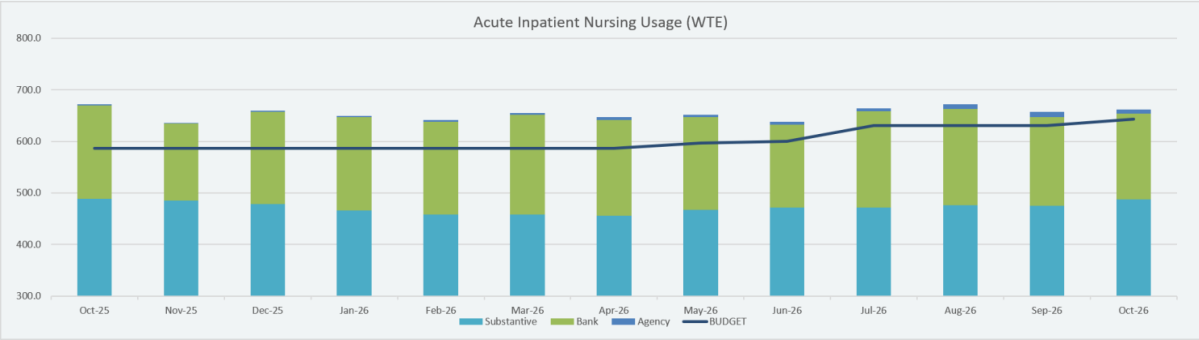
**WTEs reported within the finance report are based on Worked WTE from the ledger, providing the closest alignment to actual pay expenditure. This differs from NHSE workforce returns, which report contracted WTE and may include staff not currently working, for example due to long-term sickness or suspension. Worked WTE is therefore considered the most appropriate measure for financial reporting.*

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Exception report – Acute Inpatient staffing



Note - August '25 increase in spend and budget increased due to pay award being transacted. April '26 increase in budget and spend for 3.3% pay award . July '26 increase in budget to reflect revised headroom



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

Financial impact:

On average, usage over and above establishment over the last 12 months equates to 48.2 additional WTEs and £0.22m per month.

In October, 4.6 WTE greater than September were utilised; 18.3 WTE above establishment. The year-to-date pressure totals £0.98m.

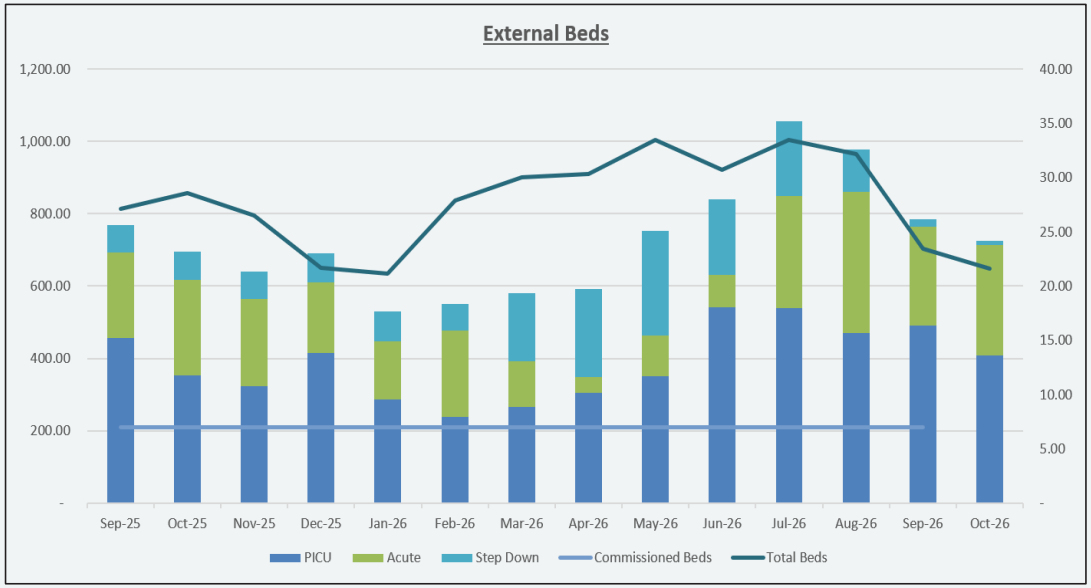
There are various drivers for the pressures including the following:

- Patients with highly complex care needs, costing approximately £0.42m in the year to date. Commissioning conversations continue to look at funding and resolution for these patients,
- Additional staff have been utilised to support patients and staff during estate works (such as door replacement) or staff training.
- Substantive staff that are currently unable to undertake their full role for Health and Safety Reasons are backfilled at additional cost.
- Delays in opening the Female PICU unit have led to the deployment of new staff onto current wards, sometimes in addition to the rota, at a cost of £0.46m for the year to date.

In month changes:

- Levels of additional observations decreased by £0.01m in month, costing approximately £0.01m in additional staffing
- Study leave cover remained at £0.04m

Exception report – External beds



Commentary

In October, usage of external Acute beds increased, from average 12.7 beds to 13.4. PICU usage decreased from 10 beds to 8.

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. 2 Male PICU beds were utilised in month at a cost of £0.07m, these are not funded.

Levels of Clinically Ready for Discharge (CRFD) patients held on Acute Inpatient wards remain exceptionally high leading to both Acute & PICU beds being required to increase bed base. The Trust is working through this and sustained improvement should support the reduction of OOA bed expenditure as we move into quarter 3.

The Trust used step-down capacity to repatriate patients from external Acute beds. Provision has ended apart from one remaining patient.

The external beds graph shows the continuing high use of external beds. PICU usage continues to exceed commissioned levels with Male PICU usage a risk to the financial position. Acute usage increased in month, additional to the use of step-down beds. Both are unfunded. Acute usage presents a risk to the financial position.

Capital position

	Annual			In month			Year to Date		
	Plan	*Forecast*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
System Capital expenditure									
Capital Maintenance and Minor Schemes	3,247	950	2,297	168	423	(255)	343	503	(160)
Information Management and Technology	350	2,179	(1,829)	0	70	(70)	0	462	(462)
Section 136 development	2,250	2,536	(286)	2	27	(25)	2,250	2,501	(251)
Out of Area Placement (Female PICU)	2,539	3,083	(544)	0	20	(20)	2,539	2,169	370
Solar Installation	138	141	(3)	0	0	0	138	141	(3)
IFRS 16 Leases	585	608	(23)	0	0	0	575	88	487
IFRS 16 Leases - CAMHS	70	1,894	(1,824)	0	0	0	7	1,667	(1,660)
Contingency	0	(487)	487	0	0	0	0	0	0
Total system expenditure	**9,179**	**10,904**	**(1,725)**	**170**	**540**	**(370)**	**5,852**	**7,531**	**(1,679)**
External expenditure									
PFI 2025/26	236	236	0	20	20	0	140	138	2
R&D - Hyperfine Swoop Imaging System	578	578	0	0	0	0	578	4	574
Thanet Crisis Assessment Service	50	50	0	0	0	0	0	5	(5)
Estates Safety Fund	0	4,451	(4,451)	0	271	(271)	0	395	(395)
EV Charge Points	0	12	(12)	0	0	0	0	0	0
Martyn's Law	0	49	(49)	0	0	0	0	0	0
Total external expenditure	**864**	**5,376**	**(4,512)**	**20**	**291**	**(271)**	**718**	**542**	**176**
Total Capital Expenditure against CDEL	**10,043**	**16,280**	**(6,237)**	**190**	**831**	**(641)**	**6,570**	**8,073**	**(1,503)**
Intra DH expenditure									
Winthrop Hall	0	8,958	(8,958)	0	0	0	0	8,958	(8,958)
Dover Health Centre	0	246	(246)	0	0	0	0	246	(246)
Cherry Tree House	33	1,019	(986)	0	0	0	33	1,019	(986)
Georges Turles Clinic	0	1,876	(1,876)	0	0	0	0	1,876	(1,876)
Unit 1, Gillingham Business Park	0	324	(324)	0	0	0	0	324	(324)
Maidstone Studios M2	2	229	(227)	0	0	0	2	229	(227)
Courtyard, Pudding Lane	0	340	(340)	0	0	0	0	340	(340)
Total Intra DH expenditure	**35**	**12,992**	**(12,957)**	**0**	**0**	**0**	**35**	**12,992**	**(12,957)**
Total Capital Expenditure	**10,078**	**29,272**	**(19,194)**	**190**	**831**	**(641)**	**6,605**	**21,065**	**(14,460)**

Commentary:
As at 31 October, forecast capital expenditure is £14.46m above the plan submitted to NHSE, primarily due to assets recognised through the CYP and AAED service transfers. Of this, £12.96m relates to intra-DoH leases which are excluded for statutory CDEL purposes and therefore do not count against the Trust's CDEL limit.

The remaining £1.50m variance to plan principally reflects additional lease expenditure, partly offset by delays to the R&D Hyperfine project.

The current year-end forecast is c.£1.74m above available CDEL, primarily relating to leases associated with the CYP transfer from NELFT.

This position is being worked through with NHSE and will be updated next month once the CYP leases are fully confirmed and the basis of recognition and CDEL treatment for other Trust leases has been finalised.

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Glossary

Acronyms and abbreviations:

AAED — All Age Eating Disorders

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

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

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

CYP — Children and Young People services.

DoH – Department of Health

HCA — Healthcare Assistant.

I&E — Income and Expenditure statement or position.

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

MAS — Memory Assessment Service.

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

NHS / NHSE — National Health Service / NHS England.

PICU — Psychiatric Intensive Care Unit.

PO — Purchase Order.

RAG — Red, Amber, Green status rating.

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

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

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

Finance terms:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Operational and capital terms:

Acute beds — Inpatient beds supporting patients requiring acute mental health care.

Block contract — A fixed arrangement for a specified capacity or service, rather than spot purchase.

Commissioned levels — The level of activity or capacity funded by commissioners.

Establishment — The planned staffing level for a ward or service.

External beds — Beds purchased from providers outside the Trust to meet patient need.

Funded levels — The activity or capacity assumed within the Trust's agreed funding.

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

Lease remeasurement — Accounting reassessment of lease value, for example after a rent review.

PO hold — A purchase order or invoice issue that delays payment processing.

Repatriation — Returning patients from external placements into Trust-provided beds.

Step Down beds — Lower-acuity capacity used to support discharge flow and reduce acute external bed use.

Treasury management — Managing cash, payments and financial obligations.

Year-end position — The forecast or actual financial position at the end of the financial year.

YTD pressure — Cumulative overspend or adverse variance against plan to date.

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	November 2026
Title of paper:	Bi-Annual 2026 Safer Staffing Review
Author:	Shannon Paine, Corporate Head of Nursing Lianne Joyce, Interim Deputy Chief Nurse
Executive Director:	Julie Kirby, Acting Chief Nurse

Purpose of paper

Purpose:	Discussion
Submission to Board:	NHSE Guidance

Overview of paper

This paper provides an update on progress since the November 2025 Mid-Year Establishment Review, presents the findings from the March 2026 full Trust-wide establishment review and provides an update on actions taken since this review.

Overall, it concludes that inpatient services remain safely staffed and that previous recommendations have largely been delivered. The review does highlight that current staffing challenges are increasingly driven by patient acuity, complexity and enhanced observation requirements rather than vacancies.

Issues to bring to the Board's attention

- Female acute wards continue to experience the highest levels of violence, aggression, self-harm and enhanced observations, requiring ongoing review of staffing establishments and skill mix, particularly during evenings and nights.
- Following the March 2026 review, staffing resources have been redistributed in some areas to better align workforce capacity with patient need, with ongoing monitoring required to evaluate the impact of these changes.
- Children's and Young People (CYP) & All Age Eating Disorders (AAED) inpatient services transferred into the Trust after the 2026 review was completed and should therefore be included within the next full staffing review.
- Female Psychiatric Intensive Care Unit (PICU) and centralised Health Based Place Of Safety (HBPOS) to be included in the next full staffing review.

Governance

Implications/Impact:	Patient safety
Assurance:	Reasonable Assurance
Oversight:	Oversight by People Committee

1. Background

Establishment reviews are a key component of the Trust's safer staffing arrangements and provide assurance that workforce establishments remain aligned to the needs of patients, service demands and organisational priorities. They are undertaken to determine whether the number, skill mix and deployment of staff are sufficient to deliver safe, effective and therapeutic care. NHS England and the National Quality Board (NQB) recommend periodic establishment reviews to ensure staffing remains aligned to patient acuity, dependency and service demand, rather than relying on historical staffing models.

The Trust utilises the Mental Health and Learning Disability Optimal Staffing Tool (MHOST) as part of its safer staffing methodology. MHOST provides an evidence-based assessment of patient acuity and dependency to support workforce planning. Consistent with national guidance, MHOST outputs are triangulated with professional judgement, quality indicators, workforce metrics and service-specific factors to determine the most appropriate staffing establishment and skill mix

2. Current Position: Mid-Year Establishment Review 2026 Update Against November 2025 Mid-Year Review

The 2026 Mid-Year Annual Establishment Review demonstrates that the Trust remains in a position of reasonable assurance regarding safe staffing across inpatient services, with establishments largely recruited to and staffing risks primarily driven by patient acuity, dependency and complexity rather than vacancy levels. This position is consistent with the conclusions reached in the November 2025 Mid-Year Review.

However, the 2026 review provides a significantly more mature understanding of staffing demand, highlighting that whilst establishments are generally safe, there are specific areas where baseline establishments and skill mix may no longer adequately reflect the complexity of patient need, particularly within female acute services, PICU and rehabilitation services.

3. Progress Against November 2025 Recommendations

i. MHOST Training and Staff Understanding

Recommendation 2025: Deliver safer staffing training through the NHS England CNO team and strengthen understanding of acuity scoring.

Progress: National CNO training was delivered in January 2026.The annual review confirms this recommendation was implemented. Staff understanding of the tool improved, although the March 2026 review identifies ongoing variation in application due to staffing changes and levels of confidence and recommends continued training and professional judgement oversight.

Further contact with NHSE Safer Staffing Lead to discuss further training – meeting scheduled for the end of November. Exploration is also happening with KCHFT regarding join up around the next MHOST staffing review, in view of their recent purchase of the MHOST license for their care home provision. This would further strengthen professional judgement conversations.

Status: Partially achieved and ongoing.

ii. Move Away from Daily MHOST Completion

Recommendation 2025: Discontinue daily acuity scoring and move to structured review periods undertaken by trained Band 6+ clinicians.

Progress: The 2026 review was undertaken using a structured 30-day collection period completed by trained ward leaders.

Professional judgement processes were embedded alongside tool outputs.

Status: Achieved.

iii. Comprehensive Establishment Review Following Training

Recommendation 2025: Undertake full establishment review in 2026.

Progress: Full trust-wide review completed. Included triangulation of acuity, incidents, complaints, workforce metrics, fill rates and professional judgement and identified several areas requiring focused establishment review.

Status: Achieved.

3. New Findings Since November 2025

The 2026 full review moved beyond whether establishments are filled and focused on whether staffing models truly reflect patient need.

i. Female Acute Wards

The review identified the following on female acute inpatient wards:

- High self-harm activity, including fixed and non-fixed ligature incidents.
- High violence and aggression.
- Multiple enhanced observations.
- Significant emotional and relational workload.

Analysis of mid-year violence, aggression and self-harm data indicates that female acute wards remain the areas with the greatest incidence of these events within the Trust

Evidence strongly supported reviewing staffing establishments and increasing registered nurse presence on female wards, particularly Foxglove and Upnor.

The review highlighted that the highest levels of need occur during the evening and early night-time periods, when incidents and patient distress increase. Clinical teams confirmed that additional support is required during these periods to maintain safe and therapeutic care.

A subsequent review of staffing across inpatient services identified opportunities to better align resources with patient need. Following analysis of acuity, incidents and workforce deployment, some resources have been safely redistributed from older adult wards where staffing levels were disproportionate to current demand. This includes a trial reduction in night-time Healthcare Support Worker provision on selected wards, with ongoing monitoring to ensure patient safety is maintained, This was also supported by the completion of a Quality impact assessment to ensure any quality impact of changes was fully understand and monitored. In addition, Clinical Environmental Assistant roles on older adult wards have been reviewed and reduced where these functions were assessed as supportive rather than essential to the delivery of safe care.

The released resource is being reinvested into female younger adult services to develop an enhanced evening and night-time support role. Work is underway to define the function of this role, including increasing therapeutic engagement, supporting risk reduction, and better meeting patient needs during periods of highest demand. The impact of these changes will be monitored

through ongoing safer staffing reviews, quality indicators, incident data and patient and staff feedback to ensure resources remain aligned to patient need.

ii. Rehabilitation Units

The review demonstrates that current staffing tools underestimate rehabilitation workload due to:

- Community integration requirements.
- Escort activity.
- Rehabilitation interventions.
- Long lengths of stay and delayed discharges.

The review identified that existing safer staffing tools may underestimate the workload within rehabilitation services, particularly where staff are required to support community access, provide escorts, deliver rehabilitation interventions and manage patients with extended lengths of stay. It is therefore recommended that a focused rehabilitation staffing review is undertaken, in the next full review, to determine whether current establishments and skill mix appropriately reflect the full range of activities required to support recovery-oriented care. There was no indication from the professional judgement conversations that there was more urgency required for this ask and this was deemed appropriate to wait for the next full staffing review planned for March 2027.

iii. Inpatient Safe Staffing Monitoring and Escalation Policy

The Trust's Safe Staffing Monitoring and Escalation Policy was identified as requiring review to ensure alignment with current national guidance and local safer staffing arrangements. A comprehensive revision was subsequently undertaken in August 2026 in collaboration with corporate, acute and forensic colleagues, resulting in an updated policy that has now been approved and communicated across relevant services.

4. New Services Requiring Inclusion

The annual review specifically noted that services transferred on 1 April 2026, including Children and Young People and All Age Eating Disorder services, were not included and should be incorporated into the next full review in March 2027.

In addition, since the publication of both papers there are now two further operational developments that should be included in the next safer staffing review cycle:

i. New Centralised Health-Based Place of Safety (HBPoS)

The 2025 review noted that HBPoS services were excluded because MHOST is not suitable for these environments. At that time there were three HBPoS sites, however there is now one centralised HBPoS which is operated with one multi-disciplinary staffing team.

MHOST can be used within a centralised HBPOS but its application is constrained by the nature of the setting. Because an HBPoS is designed for short-term emergency detentions (typically up to 24 hours under Section 136 of the Mental Health Act), any assessment must be adapted to function under rapid, high-pressure crisis timelines. Staffing levels will therefore be further reviewed in the full staffing review in March 2027.

ii. Female PICU

The annual review identified that female acute services and the existing male PICU already represent some of the highest-acuity environments in the Trust.

The opening of a female PICU provides an opportunity to establish staffing arrangements from the outset based upon:

- Acuity and dependency profiles.
- Enhanced observation demand.
- Seclusion and restrictive intervention activity.
- Incident rates.
- Registered nurse leadership requirements.
- Trauma-informed care models.
- Requirement for zonal observations.
- Therapeutic activity provision.

To establish safe staffing levels for the new service, national PICU staffing guidance was applied as well as benchmarking against comparable services in other organisations, and utilisation the MHOST tool. The findings were reviewed jointly by the Head of Nursing and Chief Nurse, and a staffing establishment was agreed based on the acuity, dependency and operational requirements of the service. Staffing levels will be further reviewed in the full staffing review in March 2027.

iii. CYP inpatient unit

CYP & AAED services transferred to KMMH on 1st April when the full staffing establishment review had already been undertaken. No changes have been made to staffing establishments or skill mix since the transfer. However, to ensure consistency of approach and provide assurance that staffing levels remain aligned to patient need, it is recommended that these inpatient services are included within the next full establishment review scheduled for March 2027, alongside all other inpatient areas.

5. Summary

The November 2025 mid-year review recommendations have largely been implemented, including MHOST training, improved data collection and completion of a full establishment review. The March 2026 review provides assurance that inpatient services remain safely staffed, while highlighting that current workforce pressures are primarily driven by patient acuity, complexity and enhanced observation requirements rather than vacancies. Targeted reviews of female acute wards have resulted in responsive staffing and skill mix adjustments, with ongoing monitoring required to evaluate the impact of these changes on patient outcomes and staff wellbeing.

In addition, the opening of the centralised HBPoS and Female PICU creates a requirement to review and validate evidence-based staffing models within these new services as well as the transfer of the CYP inpatient unit. All areas will be incorporated into the Trust's safer staffing governance framework, with formal establishment reviews undertaken once sufficient operational data is available to confirm sustainable staffing and skill-mix requirements. The next full Trust-wide establishment review is planned for March 2027.

The Committee is therefore asked to:

- Note that the November 2025 recommendations have largely been delivered.
- Take assurance that inpatient services remain safely staffed overall.
- Recognise the emerging risks associated with increasing patient acuity, complexity and enhanced observations.

- Endorse ongoing monitoring and evaluation of staffing changes within female acute services.
- Support further review of rehabilitation staffing models.
- Note that the centralised HBPoS, female PICU, and CYP & AAED services will be incorporated into the next full establishment review.
- Receive a further comprehensive establishment review report after completion of next scheduled staffing review (planned for March 2027)

Trust Board meeting

Kent and Medway Mental Health NHS Trust

Meeting details

Date of meeting:	26 November 2026
Title of paper:	Use of Trust Seal
Author:	Nicola Legg, Head of Legal Services
Executive Director:	Shelia Stenson, Chief Executive Officer

Purpose of paper

Purpose:	Approval
Submission to Board:	Standing Order

Overview of paper

The report is to give reassurance to the Board that all documents endorsed with the Trust Seal have been done in accordance with the Trust Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation.

Issues to bring to the Board's attention

Two documents have been signed and sealed as a deed during from Q4 25/26, Q1 26/27 and Q2 26/27 This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact:	None.
Assurance:	Substantial
Oversight:	Trust Board

Version 2 - **Public**

Number	Date of Sealing	Description	Signatures	Comments
168	25.03.26	Transfer of registered title of Rivendell unit	Sheila Stenson Jackie Craissati	
169	25.03.26	Lease of Maidstone Studios	Sheila Stenson Jackie Craissati	
170	30.04.26	Lease of Orchard House	Sheila Stenson Jackie Craissati	
171	06.08.26	Lease of Lenworth Clinic (CYP service transfer)	Sheila Stenson Jackie Craissati	
172	24.09.26	Licence to assign Maidstone Studios (CYP service transfer)	Sheila Stenson Colin Lynch	
173	24.09.26	Deed of assignment Maidstone Studios (CYP service transfer)	Sheila Stenson Colin Lynch	