# AGENDA

Kent and Medway Mental Health NHS Trust

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| **Title of Meeting** | Trust Board Meeting (Public) |
| **Date** | 26th March 2026 |
| **Time** | 09.30 to 12.00 |
| **Venue** | Meeting Rooms 2 & 3, Farm Villa, Hermitage Lane, Maidstone ME16 9PH |

| Agenda Item | DL | Description | FOR | Format | Lead | Time |
|---|---|---|---|---|---|---|
| TB/25-26/143 | 1. | Welcome, Introductions & Apologies | | Verbal | Chair | 09.30 |
| TB/25-26/144 | 2. | Declaration of Interests | | Verbal | Chair | |
| **BOARD REFLECTION ITEMS** | | | | | | |
| TB/25-26/145 | 3. | Personal Experience – The difference that accessing the right care can make. | FN | Verbal | JK | 09.35 |
| TB/25-26/146 | 4. | Continuous Improvement Story – Physical Health Monitoring – For Newly Prescribed Anti-Psychotics. | FN | Paper | AR | 09.45 |
| **STANDING ITEMS** | | | | | | |
| TB/25-26/147 | 5. | Minutes of the previous meeting | FA | Paper | Chair | 09.55 |
| TB/25-26/148 | 6. | Action Log & Matters Arising | FA | Paper | Chair | |
| TB/25-26/149 | 7. | Chair's Report | FN | Paper | JC | 10.00 |
| TB/25-26/150 | 8. | Chief Executive's Report | FN | Paper | SS | 10.05 |
| TB/25-26/151 | 9. | Board Assurance Framework | FA | Paper | JK | 10.10 |
| **STRATEGY, DEVELOPMENT AND PARTNERSHIP** | | | | | | |
| TB/25-26/152 | 10. | Strategic Delivery Priorities – Closing Report | FD | Paper | SS | 10.20 |
| TB/25-26/153 | 11. | Five-year trust strategy 2026-2031 | FD | Paper | SS | 10.30 |
| TB/25-26/154 | 12. | Sustainable Communities Provider Collaborative Progress Report | FD | Paper | SS | 10.40 |
| TB/25-26/155 | 13. | Trust Partnership Working | FD | Paper | AR | 10.50 |
| **OPERATIONAL ASSURANCE** | | | | | | |
| TB/25-26/156 | 14. | Integrated Quality and Performance Report | FD | Paper | SS | 11.00 |
| TB/25-26/157 | 15. | Independent Quality and Safety Governance Review – Board Consideration and Next Steps | FA | Paper | SS | 11.10 |
| TB/25-26/158 | 16. | Finance Report – Month 11 | FD | Paper | NB | 11.20 |
| TB/25-26/159 | 17. | Workforce Deep Dive – Staff Survey | FD | Paper | SG | 11.25 |
| TB/25-26/160 | 18. | Children and Young Persons Mental Health and All Age Eating Disorders | FD | Paper | DHS | 11.35 |
| TB/25-26/161 | 19. | Quality Priorities | FD | Paper | JK | 11.45 |
| **CONSENT ITEMS** | | | | | | |
| TB/25-26/162 | 20. | Report from Quality Committee | FN | Paper | SW | 11.50 |
| TB/25-26/163 | 21. | Report from People Committee | FN | Paper | KL | |
| TB/25-26/164 | 22. | Report from Audit and Risk Committee | FN | Paper | PC | |
| TB/25-26/165 | 23. | Report from Finance, Business and Investment Committee<br>• Estates Strategy | FN | Paper | MW | |
| TB/25-26/166 | 24. | Register of Interests | FN | Paper | TS | |

| CLOSING ITEMS | | | | | | |
|---|---|---|---|---|---|---|
| TB/25-26/167 | 25. | Any Other Business | | | Chair | 11.55 |
| TB/25-26/168 | 26. | Questions from the Public | | | Chair | |
| | **Date of Next Meeting:** Thursday, 29th May 2026 | | | | | |

| **Members:** | | |
|---|---|---|
| Dr Jackie Craissati | JC | Trust Chair |
| Peter Conway | PC | Non-Executive Director (Deputy Chair) |
| Stephen Waring | SW | Non-Executive Director (Senior Independent Director) |
| Mickola Wilson | MW | Non-Executive Director |
| Kim Lowe | KL | Non-Executive Director |
| Julius Christmas | JCh | Non-Executive Director |
| Sean Bone-Knell | SBK | Non-Executive Director |
| Dr MaryAnn Ferreux | MAF | Non-Executive Director |
| Julie Hammond | JH | Associate Non-Executive Director |
| Pam Craven | PCr | Associate Non-Executive Director |
| Sheila Stenson | SS | Chief Executive |
| Donna Hayward-Sussex | DHS | Chief Operating Officer and Deputy Chief Executive |
| Dr Afifa Qazi | AQ | Chief Medical Officer |
| Julie Kirby | JK | Chief Nursing Officer (Interim) |
| Nick Brown | NB | Chief Finance and Resources Officer |
| Sandra Goatley | SG | Chief People Officer |
| Dr Adrian Richardson | AR | Director of Partnerships and Transformation |
| **In attendance:** | | |
| Kindra Hyttner | KH | Director of Strategy and Engagement |
| Tony Saroy | TS | Trust Secretary |
| Kevin Corrigan | KC | Incoming Non-Executive Director (Observing) |
| Adam Doyle | AD | ICB Chief Operating Officer |
| Hazel Garnham | HG | Lived Experience (Personal Story) |
| Shannon Paine | SP | Corporate Head of Nursing & Quality (Continuous Improvement Story) |
| **Apologies:** | | |
| | | |

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

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

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|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Improvement Story: Physical Health Monitoring – For Newly Prescribed Anti-Psychotics |
| **Author:** | Shannon Paine: Corporate Head of Nursing & Quality<br>Ben Francis: Head of Improvement – Capability and IMS |
| **Executive Director:** | Adrian Richardson, Director of Transformation & Partnerships |

## Purpose of paper

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| **Purpose:** | Noting |
| **Submission to Board:** | Board requested |

## Overview of paper

This improvement story outlines the Trust's response to the CQC Section 29A Warning Notice issued in early 2025 for insufficient physical health monitoring of patients newly prescribed antipsychotic medication. It summarises the improvement approach taken, the progress achieved to date, and the next steps required to support full Trust-wide implementation.

## Issues to bring to the Board's attention

While early adoption is strong, and the improvements recorded significant, challenges around workload, physical space and pathway ownership remain, and addressing these will be key to sustainable Trust-wide implementation.

## Governance

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|---|---|
| **Implications/Impact:** | Patient safety |
| **Assurance:** | Reasonable |
| **Oversight:** | Quality Committee |

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# Improvement Story:

## Physical Health Monitoring – For Newly Prescribed Anti-Psychotics

Shannon Paine

Caring | Inclusive | Curious | Confident

# 1. Problem:

On the 8th April 2025 the Trust received a section 29A Warning Notice from CQC.

At the time of the finding, there was no reliable evidence that patients newly prescribed antipsychotic medication were receiving physical health monitoring in line with NICE guidance. CQC identified this gap, prompting an immediate review.

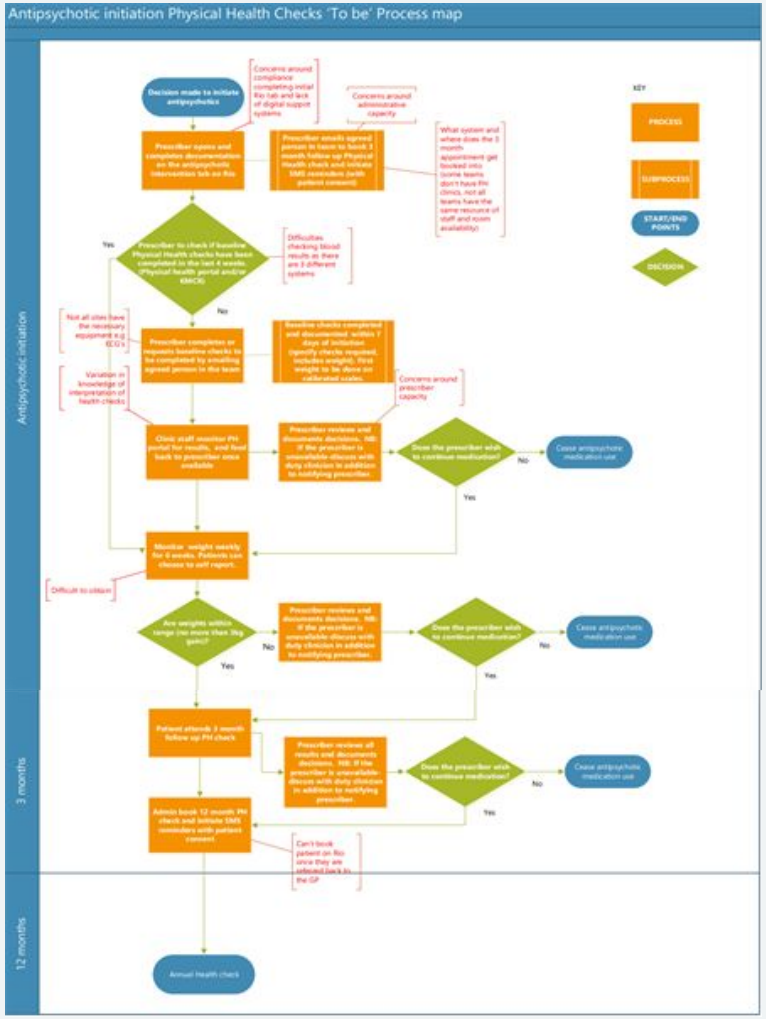
Internal audits showed that physical health monitoring was being carried out inconsistently across community mental health services, with 0% completion (in one area) of the required 12-week physical health checks for those starting antipsychotics. The situation could have led to significant physical health risks going undetected, placing patients at potential risk of harm.

# 2. Approach:

Our initial step was to build a shared understanding of the issue by engaging with task-and-finish groups, including all key individuals. These discussions identified that no consistent process existed for physical health monitoring when initiating antipsychotic medications.

Process Mapping was used to understand the future state requirement , and then a PDSA (Plan–Do–Study–Act) approach was utilised to begin developing and testing some changes.

A sample audit was also completed to inform this work.



# 3. Goal / Aim:

## Goal:

For all patients newly prescribed oral antipsychotics to receive physical health monitoring in line with NICE guidance (baseline, 12 weeks and 12 months)

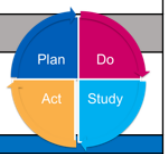
## Aim:

1. Increase in number of patients with antipsychotic initiation tab opened
2. Improve compliance with baseline and 3 month checks
3. Define process from point of prescribing antipsychotic, to 12-month check

KMPT IMPROVEMENT
Doing Well Together

## PDSA Planner

| | | | | |
|---|---|---|---|---|
| **Aim (overall goal for this project):** | | | | |
| For patients newly prescribed oral antipsychotics to receive physical health monitoring in line with NICE guidance. | | | | |
| **Change idea:** | | | | |
| Define process from point of prescribing antipsychotic, to 12 month check (with baseline checks and 3 month check required in between) | | | | |
| **PDSA objective (describe the objective for this PDSA cycle):** | **Cycle No: 1** | **What questions do you want answered for this test of change?:** | | |
| To test the newly defined process for patients newly prescribed antipsychotics, and the associated physical health checks | | Are people following the agreed process?<br>Are there any barriers to implementing the agreed process?<br>What is the impact on the workforce? | | |
| **Plan** | | | | |
| **Predict what will happen when the test is carried out:** | | **Measures to determine if prediction succeeds:** | | |
| 1. Increase in number of patients with antipsychotic initiation tab opened<br>2. Improved compliance with baseline and 3 month checks | | 1. An increase in number of patients with antipsychotic initiation tab opened (this will be pulled from BI)<br>2. An increase in number of patients with antipsychotic initiation tab opened who had baseline and 3 month checks completed (this will be a manual audit) | | |
| **List the tasks needed to set up this test of change:** | | **Person responsible:** | **When to be done:** | **Where to be done:** |
| 1. Identify the test sites – SWK and Thanet MHT<br>2. Baseline data collection<br>3. Establish project membership group and frequency of meetings | | Shannon Paine | 1st September | |
| **Do** | **Describe what happened when you ran the test:** | | | |
| Both pilots ran as planned, with each site identifying a lead nurse to coordinate the pilot (band 7 nurse in each team) . The lead nurses then undertook some engagement sessions with their teams, including prescribers, to explain the process and to ensure all had a clear understanding of what was being asked. | | | | |
| **Study** | **Describe the measured results and how they compared to the predictions:** | | | |
| The results show very positive results in the area of 3 month checks, with 100% compliance in this area post pilot for both teams. SWK also had 100% compliance for baseline checks, whereas Thanet saw a slight reduction in this. In terms of narrative, it appears as though this relates to patients who were 'discovered' to have been prescribed an oral antipsychotic without any notification and so the team acted to ensure a 3 month check was offered. Both teams also had an increase in the number of antipsychotic initiation tabs opened. | | | | |
| **Act** | **Describe what modifications in the plan will be made for the next cycle from what you learned:** | | | |
| 15 survey responses were received from staff across both teams. | | | | |



# 4. Current State:

In late 2024, an antipsychotic initiation intervention tab was added to RIO to support the identification of patients prescribed oral antipsychotic medication.

Utilisation of this intervention tab remained extremely low, indicating that the tab was not being consistently or effectively used. In the area highlighted by the CQC, they found no evidence that patients were being offered a physical health check at 12 weeks, there was also a mixed and inconsistent understanding among staff regarding the relevant NICE guidance, contributing to variation in practice.

# 5. Implementation / Change:

To design an effective and workable solution, a series of conversations and interactions were had with key individuals involved in delivering and managing the process. These assisted the development of the “to be” process for antipsychotic initiation and associated physical health monitoring.

As part of the implementation, a one-page guidance document was developed to support prescribers, providing clear, concise instructions on when and how to use the intervention tab within RIO. Following testing in selected areas, the new process has been validated and shown to work reliably in practice. With the model now defined and proven, the next step was to scale the approach across all relevant teams.

We also worked with BI colleagues to introduce a ‘antipsychotic initiation’ filter on the physical health dashboard, meaning managers had better oversight.

One Page Guidance – Antipsychotic Initiation

- Decision made to initiate antipsychotic → Prescriber to open intervention tab and notify relevant person in the team via email:

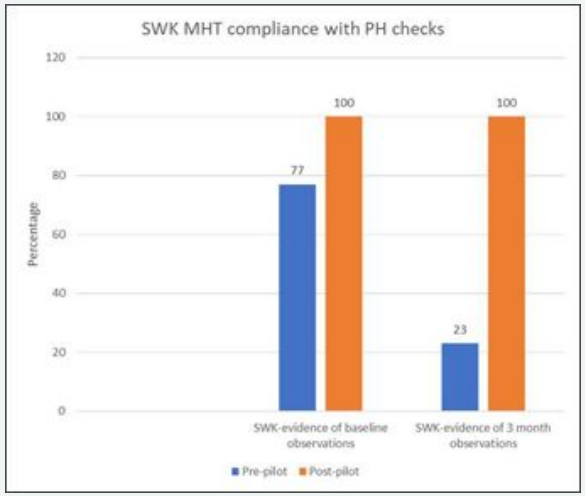
Summary | River View | Client image | Interventions

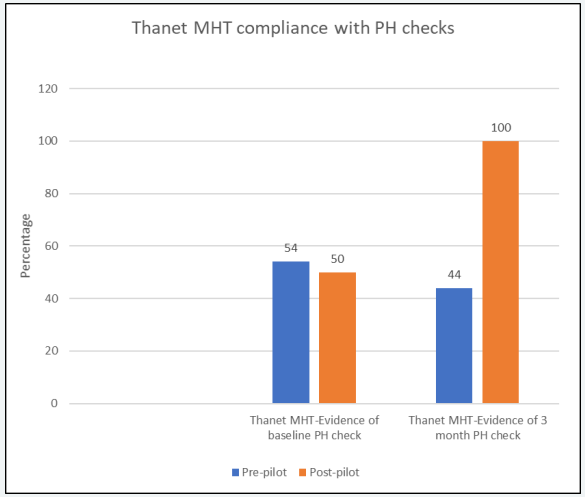
Interventions
- Interventions - KMPT
- Interventions - Out-of-area
- Riverview Timeline
- Colleague Granted LR

1. Interventions – KMPT
2. Create New
3. Add date/time and referral source
4. Intervention component – Initiation of Antipsychotic Medication

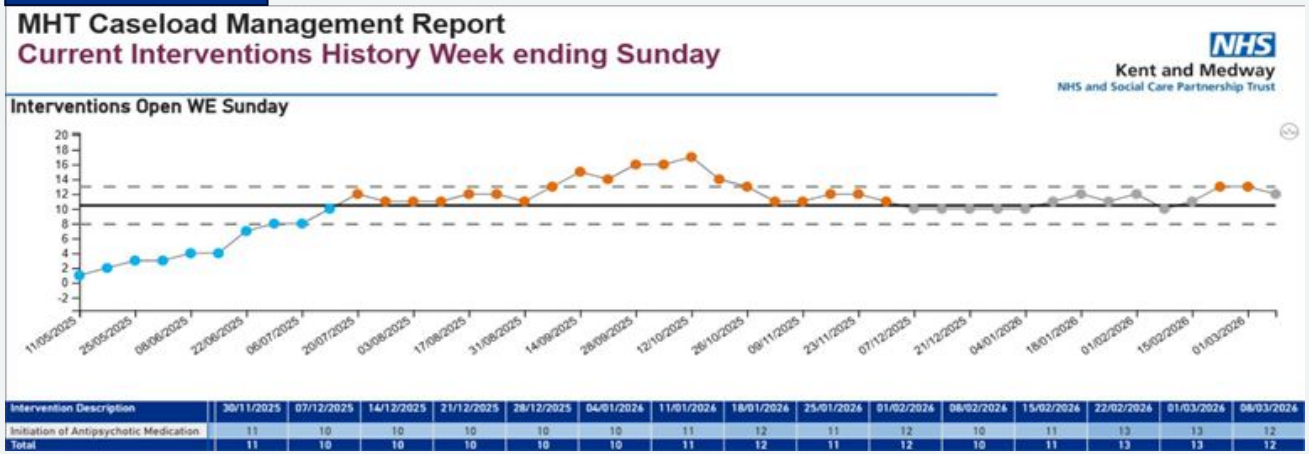
- Prescriber to check if baseline checks have been completed within last 4 weeks (check Physical Health Portal and/or KMCR)
- If not, prescriber to request checks to be completed by emailing agreed person in team. Checks to include:
  - HbA1c
  - Lipids (fasting if possible)
  - U & E's including eGFR
  - LFT's
  - Prolactin
  - BP and pulse
  - Weight and waist circumference
  - GASS
  - Smoking
  - ECG
- Weights to be monitored weekly for the first 6 weeks - patients can self-report this (if not able to, a local plan to be agreed)
- 3 month physical health check to be booked in (BP, pulse, HBA1C and lipids, weight, smoking, GASS)
- If patients refuse physical health checks and the clinical decision is to continue with antipsychotic treatment, to document plan on Rio

# 6. Results / Benefits:

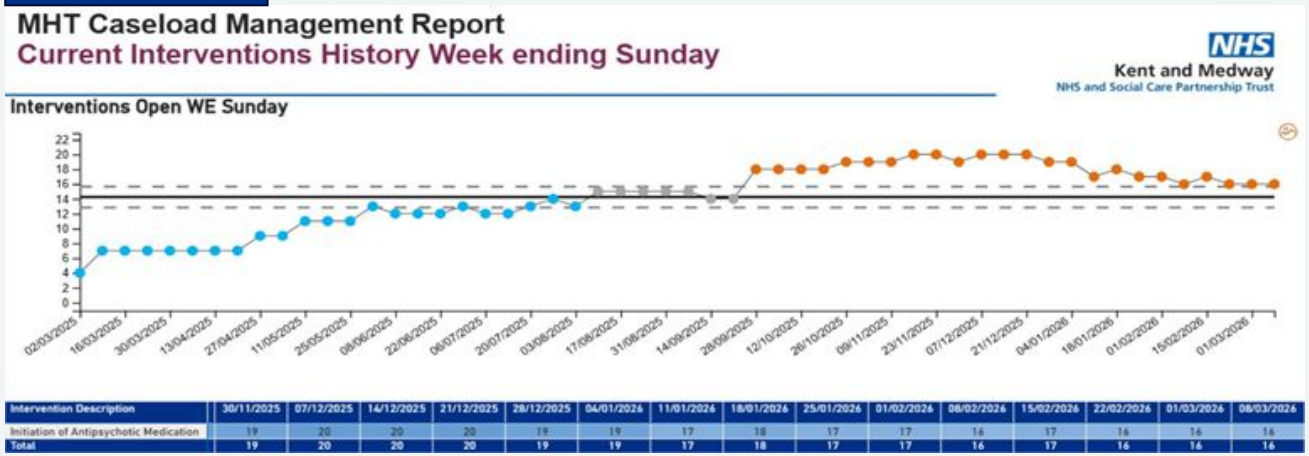



South West Kent




Thanet



# 6. Results / Benefits:

## Trust position

### MHT Caseload Management Report
### Current Interventions History Week ending Sunday

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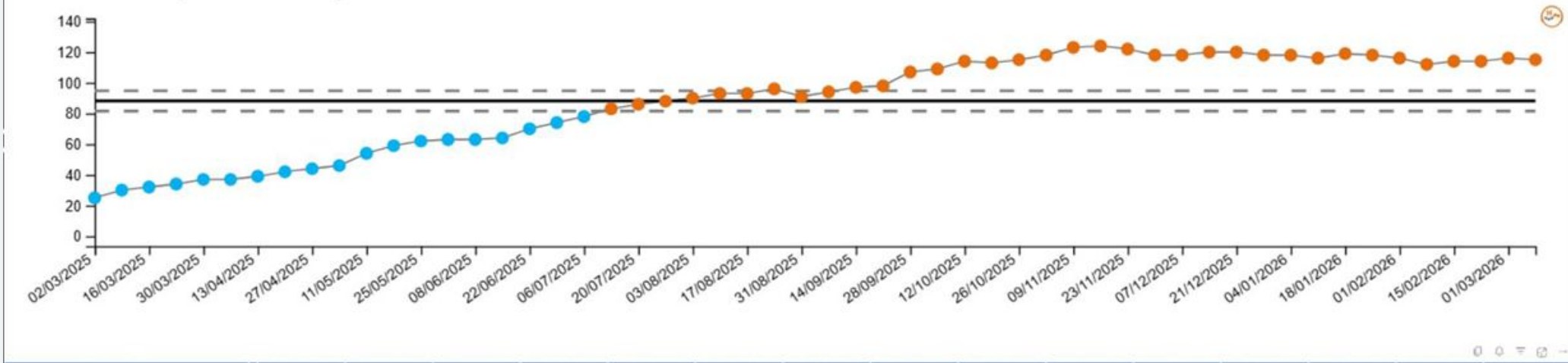
NHS and Social Care Partnership Trust

**Interventions Open WE Sunday**




| Intervention Description | 30/11/2025 | 07/12/2025 | 14/12/2025 | 21/12/2025 | 28/12/2025 | 04/01/2026 | 11/01/2026 | 18/01/2026 | 25/01/2026 | 01/02/2026 | 08/02/2026 | 15/02/2026 | 22/02/2026 | 01/03/2026 | 08/03/2026 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Initiation of Antipsychotic Medication | 118 | 118 | 120 | 120 | 118 | 118 | 116 | 119 | 118 | 116 | 112 | 114 | 114 | 116 | 115 |
| Total | 118 | 118 | 120 | 120 | 118 | 118 | 116 | 119 | 118 | 116 | 112 | 114 | 114 | 116 | 115 |

# 7. Scalability:

The new antipsychotic initiation and PH-monitoring process was initially deployed as a pilot in Thanet and South West Kent. Since then, adoption has grown significantly. The February 2026 audit shows that 132 intervention tabs have now been opened, with uptake seen in every team across the county.

Importantly, 85% of these tabs have had the required physical health monitoring completed, demonstrating strong early compliance.

Staff feedback has highlighted some ongoing barriers, including challenges with physical space and an increase in workload.

In addition, teams have raised questions about how best to manage patient pathways given that patients newly prescribed an antipsychotic need to remain open for 12 months; specifically, where this workload should sit and whether an additional pathway may be required to support consistency. To continue scaling effectively, these issues now need to be addressed to ensure the process can be embedded sustainably across all services.

Kent and Medway Mental Health NHS Trust

**Kent and Medway Mental Health NHS Trust Board of Directors (Public)**
**Minutes of the Public Board Meeting held at 09.30 to 12.00 on Thursday 29th January 2026**
**Via Videoconferencing**

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|---|---|---|---|
| **Members:** | | | |
| | Dr Jackie Craissati | JC | Trust Chair |
| | Peter Conway | PC | Non-Executive Director (Deputy Trust Chair) |
| | Kim Lowe | KL | Non-Executive Director |
| | Julius Christmas | JCh | Non-Executive Director |
| | Sean Bone-Knell | SBK | Non-Executive Director |
| | Dr MaryAnn Ferreux | MAF | Non-Executive Director |
| | Mickola Wilson | MW | Non-Executive Director |
| | Dr Julie Hammond | JH | Associate Non-Executive Director |
| | Pam Creaven | PCr | Associate Non-Executive Director |
| | Sheila Stenson | SS | Chief Executive |
| | Nick Brown | NB | Chief Finance and Resources Officer |
| | Donna Hayward-Sussex | DHS | Chief Operating Officer/Deputy Chief Executive |
| | Julie Kirby | JK | Chief Nursing Officer (Interim) |
| | Sandra Goatley | SG | Chief People Officer |
| | Dr Afifa Qazi | AQ | Chief Medical Officer |
| | Dr Adrian Richardson | AR | Director of Partnerships and Transformation |
| **Attendees:** | | | |
| | Kindra Hyttner | KH | Director of Strategy and Engagement |
| | Tony Saroy | TS | Trust Secretary |
| | Caterina (Katie) Powell | CP | Service User - Personal Story only |
| | Robin Smith | RS | Occupational Therapist - Personal Story only |
| | Wendy Dewhirst | WD | Service Director North Kent - Personal Story only |
| | Adeyinka Lawal | AL | Allington Centre Team Leader – Continuous Improvement Story only |
| | Tammy Parkinson | TP | Registered Nursing Associate Continuous Improvement Story only |
| | Oliver Isaac | OI | Senior Improvement Manager - Continuous Improvement Story only |
| | Julia Hart | JHa | Acting Programme Director for the Provider Collaborative - Sustainable Communities Provider Collaborative Progress Report item only |
| | Rebecca Crosbie | RC | Freedom to Speak Up Guardian - Freedom to Speak Up 6 Month Report only |
| | Lincoln Murray | LM | The Guardian Service - Freedom to Speak Up 6 Month Report only |
| | Andrew Hughes | AH | Consultant |
| | Zara Church | ZC | CQC Representative |
| | Sam Hunt | SH | CQC Representative |
| | Hannah Stewart | HS | Deputy Trust Secretary (Minutes) |
| | *The Board was joined by members of the public and members of staff.* | | |
| **Apologies:** | | | |
| | Stephen Waring | SW | Non-Executive Director (Senior Independent Director) |

| Item | Subject | Action |
|---|---|---|
| **TB/25-26/116** | **Welcome, Introduction and Apologies**<br><br>The Chair welcomed all to the meeting and noted no apologies had been received. All written reports were taken as read. | |

| Item | Subject | Action |
|---|---|---|
| **TB/25-26/117** | **Declarations of Interest**<br><br>No interests were declared. | |
| **TB/25-26/118** | **Personal Experience – My Occupational Therapy Journey**<br><br>The Board heard a powerful account from Katie (CP), supported by Robin Smith (RS), Occupational Therapist. Katie described the very positive impact of psychotherapy and occupational therapy on her wellbeing, albeit with prior difficulties in her contact with the Trust including significant delays in diagnosis, and an over-emphasis on medication.<br><br>Board members explored why occupational therapy had not been made available earlier in her pathway and questioned the limitations of current referral routes from primary care. They noted that delays in access had prolonged Katie's distress, and asked what improvements she would prioritise. Katie cited the need for more personalised care and earlier involvement of occupational therapy in treatment planning.<br><br>**Action: By 31.03.26, DHS & AQ to explore options to strengthen early Occupational Therapy access, including primary-care referral routes (Quality Committee oversight).**<br><br>The Board **noted** the Personal Experience Story. | |
| **TB/25-26/119** | **Continuous Improvement Story – Standardising Medication Storage in Allington Centre**<br><br>Adeyinka Lawal (AL) and colleagues presented their improvement project, demonstrating how the application of 5S methodology had reduced medication round times and enhanced safety.<br><br>Non-Executive Directors challenged why such a simple and beneficial intervention had not already been adopted Trust wide, and questioned whether its impact on medication error reduction had been measured. AL acknowledged that improvements were clear in practice but had not yet been supported by quantitative data. The Board emphasised the need for consistent organisational learning and a clearer framework to accelerate the spread of successful improvement initiatives.<br><br>**Action: By July 2026, AR to produce a Trust-wide scale-up plan for the standardisation of medication storage, with measurable safety metrics and report it to the Finance, Business and Investment Committee.**<br><br>The Board **noted** the Continuous Improvement Story. | |
| **TB/25-26/120** | **Minutes of the previous meeting**<br><br>The Board **approved** the minutes of the meeting held in November 2025. | |
| **TB/25-26/121** | **Action Log & Matters Arising** | |

| Item | Subject | Action |
|---|---|---|
| | The Board reviewed the action log and highlighted several overdue items. The Chair questioned the nine-month delay in progressing the clinical staffing model, stressing that such slippage undermines alignment with the new Trust Strategy. The Board also expressed concern that ethnicity recording remained at only 65% completeness, describing the 35% data gap as unacceptable and a barrier to understanding inequalities.<br><br>Members questioned why previous remedial actions had not produced sustained improvement and called for a more robust plan addressing cultural, system, and training obstacles.<br><br>The Board **approved** the Action Log subject to the following:<br><br>**Actions:**<br>• By March 2026, DHS, AQ and JK to refresh the clinical staffing model timeline with oversight by the Quality Committee.<br>• By 31.05.26, SG and AR to present a Trust wide ethnicity data improvement plan to address gaps in the Trust's ethnicity data for both staff and patients to Quality Committee.<br>• By March 2026, AR to provide an action plan to improve ethnicity recording. | |
| **TB/25-26/122** | **Chair's Report**<br><br>The Chair provided an update on system-level pressures and highlighted the need for greater proactive engagement with Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC), noting that scrutiny following recent CQC findings required improved visibility of Trust progress. | |
| **TB/25-26/123** | **Chief Executive's Report**<br><br>The Chief Executive outlined organisational priorities for quarter four, changes in the executive team, CQC preparation, and the transition of Children and Young Persons (CYP) services back to the Trust.<br><br>Board members raised concerns about a lack of clarity among middle managers regarding priority workstreams, noting that competing demands and organisational change were contributing to fatigue. They queried – and were assured that - the Trust was effectively communicating positive developments to HASC and local councillors, suggesting the need for a stronger, more coordinated narrative.<br><br>**Action: By 31.05.26, KH to strengthen the stakeholder engagement plan, including targeted communication to Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) and local councillors**<br><br>The Board **noted** the Chief Executive's Report. | |
| **TB/25-26/124** | **Board Assurance Framework (BAF)**<br><br>JK presented updates to the BAF, highlighting new and shifting risks. The Board were concerned about several inconsistencies in the narrative, including conflicting inpatient flow timelines. They requested clarity on how and when risks linked to the CYP service transfer were going to be managed within the BAF. | |

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NHS Trust

| Item | Subject | Action |
|---|---|---|
| | The Board asked that the reputational risk be reframed to reflect the potential for loss of confidence among both staff and the public, rather than general reputational harm. The Board emphasised the need for consistency between narrative assurance and underlying data.<br><br>**Action: By March 2026, KH to revise the reputational risk wording within the BAF for review by the Audit & Risk Committee.**<br><br>The BAF was **approved**. | |
| **TB/25-26/125** | **Sustainable Communities Provider Collaborative Progress Report**<br><br>The Board discussed updates on UEC pathways and Safe Haven utilisation, both of which were yielding very encouraging results. In relation to the development of the neighbourhood model, Board members challenged whether the public adequately understood the changes associated with neighbourhood-based care and stressed the need for clearer system-level communication.<br><br>Further challenge was raised regarding gaps in ethnicity and deprivation data, with NEDs noting that poor data quality undermines efforts to identify and address inequalities.<br><br>**Action: By May 2026, SS to provide a verbal update as part of the Sustainable Communities Provider Collaborative Progress Report regarding the Health Inequalities Improvement Plan and collaboration with Kent Community Health NHS Foundation Trust.**<br><br>**Action: By July 2026, AR to present a 'broader health inequalities' update for the Board.** | |
| **TB/25-26/126** | **Digital Progress Against Plan**<br><br>The Board received an update on the Trust's digital programme covering Ambient Voice Technology (AVT) rollout, automation workstreams, clinical systems optimisation and data quality improvements. While acknowledging stabilisation of core systems and progress in analytics, the Board reiterated concerns that the overall pace of digital transformation remained too slow. JC emphasised that a projected 2027 timeline for AVT was out of step with national expectations and the pace of digital adoption across the system.<br><br>Board members noted that the CYP service transfer had created significant additional workload for digital teams without extra staffing, and sought assurance that this would not delay priority programmes. The Board also asked for clearer visibility of programme dependencies across Trust-led, system-led and national workstreams, stressing the need for strengthened governance and more transparent reporting of constraints.<br><br>**Action: By March 2026, NB to provide an updated Digital Plan, including the accelerated Ambient Voice Technology (AVT) plan with clarified milestones and resource requirements.** | |

| Item | Subject | Action |
|---|---|---|
| | **Action: By May 2026, NB to present the mapping of system-level digital responsibilities and dependencies.** | |
| **TB/25-26/127** | **Trust Quality and Safety Agenda**<br><br>SS updated the Board on progress with the Quality Plan, highlighting work to strengthen governance structures, leadership capability and CQC-related actions.<br><br>While recognising improvement activity, the Board noted continued variability in leadership visibility and communication across locations and sought clearer evidence that changes were improving frontline experience.<br><br>Members endorsed the development of a framework to support Non-Executive Director visits but emphasised the need for simplicity and meaningful engagement rather than additional bureaucracy.<br><br>**Action: By May 2026, TS to finalise the Non-Executive Director Visit Insight Framework.**<br><br>**Action: By May 2026, SG to produce a plan to address fear of reprisals and strengthen leadership behaviours** | |
| **TB/25-26/128** | **Integrated Quality and Performance Review**<br><br>The Board undertook a review of the IQPR, examining performance, quality and safety indicators across all service lines. Executives highlighted areas of positive movement—including continued reductions in clinically ready for discharge (CRFD) use, improved dementia diagnostic times, and sustained high utilisation of Safe Havens—but cautioned that improvements were fragile and required ongoing focus.<br><br>Board members explored areas where performance was deteriorating or where assurance was not yet mature. The Board raised a concern that only 82% of complaints were completed within 30 days, emphasising that the 100% target should only be flexed when complexity genuinely warrants extension. It requested better categorisation of complaints, improved trend analysis, and a clearer distinction between delays caused by clinical complexity versus administrative backlog.<br><br>The Board also scrutinised rising restrictive practice figures. They queried whether the increases were driven by acuity, staffing pressures, environmental factors or inconsistent therapeutic interventions. Members sought confirmation that teams had access to appropriate training, de-escalation tools and senior clinical oversight. The Board requested triangulation with incident reports, workforce data and patient feedback.<br><br>Concerns were raised about prolonged waits for community services. Board members explored how patients were supported during extended waits, what risk stratification processes were in place, and whether services were adequately resourced to provide meaningful interim support. The Board questioned how the Trust assured itself that patient safety was not being compromised and asked for clearer reporting on the effectiveness of ‘waiting well’ arrangements. | |

| Item | Subject | Action |
|---|---|---|
| | Actions:<br><br>**By March 2026, JK to provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis.**<br><br>**By May 2026, DHS to lead a Trust-wide audit of waiting-well arrangements, incorporating patient experience data.**<br><br>**By May 2026, JK to deliver a deep-dive report on restrictive practice trends, drivers and mitigation plans.** | |
| **TB/25-26/129** | **Finance Report for Month 9**<br><br>The Board received a detailed update on the Trust's financial position at Month 9. The Trust reported sustained pressure from agency expenditure and out-of-area placements, alongside a temporary cashflow impact caused by delays in receiving provider collaborative payments. The Board scrutinised whether the Trust's current financial controls were sufficiently rigorous, particularly regarding agency usage. They queried whether rostering discipline, escalation routes and authorisation thresholds were consistently followed across all sites.<br><br>Board members pressed for clarity on the organisation's medium-term financial outlook, particularly whether continued use of temporary staff was masking underlying workforce stability issues. Executives acknowledged the challenge but highlighted ongoing work across recruitment, retention and workforce redesign to reduce reliance on agency staffing.<br><br>The Board also requested assurance that financial pressures were not compromising key strategic programmes. NB confirmed that although several cost pressures remained, mitigation measures were being implemented and no strategic priorities had been paused. The Board asked for clearer reporting on the balance between financial risk, operational resilience and the deliverability of improvement plans.<br><br>The Board **noted** the Finance Report – Month 9. | |
| **TB/25-26/130** | **Financial Planning Paper**<br><br>The Board reviewed the Trust's planning assumptions and financial modelling for the upcoming financial year. NB outlined the significant constraints shaping the planning environment, including system-wide efficiency requirements, rising demand for mental health services, and tighter capital allocations.<br><br>The Board challenged whether proposed efficiency targets were achievable given the narrowing scope for savings in recent years. They highlighted the importance of ensuring that cost improvement plans were underpinned by credible delivery mechanisms rather than aspirational targets. Executives confirmed that modelling work was still underway, incorporating sensitivity testing and iterative alignment with system partners.<br><br>Given the level of financial uncertainty, the Board emphasised the need for clear scenario planning, including risks relating to demand growth, workforce pressures and ICB funding assumptions. It was agreed that an extraordinary Board meeting | |

| Item | Subject | Action |
|---|---|---|
| | would take place before 12 February to review and approve the final version of the plan, ensuring that the Board had full oversight before submission. | |
| **TB/25-26/131** | **Workforce Deep Dive – Talent and Succession Planning**<br><br>The Board received an overview of the Trust's succession planning, talent identification, and leadership development programmes. The People Committee had reviewed the detailed analysis in advance.<br><br>Board members highlighted the importance of improving appraisal quality and ensuring more consistent moderation processes. They queried how well current programmes were identifying emerging talent, particularly among under-represented groups, and whether staff with strong technical skills but limited leadership aspirations were being adequately supported in alternative career pathways. Executives agreed that strengthening middle-leadership capability and ensuring equitable access to development remained top priorities. | |
| **TB/25-26/132** | **Freedom to Speak Up 6 Month Report**<br><br>The Guardian presented a comprehensive update on speaking-up activity over the past six months, highlighting an increase in management-related concerns. The Board discussed the themes emerging from cases, noting that consistent issues included communication during change programmes, the quality of local management support, and staff uncertainty about escalation routes.<br><br>Board members raised questions about how the organisation could strengthen psychological safety and reduce the reported fear of reprisals, which was a matter of concern. They also stressed the importance of managers being trained and supported to respond constructively to concerns raised. The Trust committed to ensuring that the new change management framework directly addressed these gaps.<br><br>**Action: By May 2026, SG is to report to the People Committee on the:**<br>• **Implementation of the principles-based Change Management Framework; and**<br>• **Embedding of closed-loop reporting back to staff**<br><br>The Board **noted** the Freedom to Speak Up 6 Month Report. | |
| **TB/25-26/133** | **CQC Community Mental Health Survey**<br><br>The Board reviewed the results of the national survey and noted that while some areas had shown incremental improvement, several remained below national averages. Board members asked for further analysis to understand which themes aligned with areas of poor performance already identified through the IQPR and external reviews.<br><br>Executives confirmed that the findings would feed into the refreshed Patient Experience Strategy, and that a new set of real-time feedback tools would allow more granular monitoring going forward. Given the delay in the survey results being presented to Board, assurance was provided that the Quality & Performance Committee were already overseeing the action plan. | |

| Item | Subject | Action |
|---|---|---|
| | The Board **noted** the CQC Community Mental Health Survey | |
| **TB/25-26/134** | **Standing Financial Instructions**<br><br>The Board received and **approved** the Standing Financial Instructions. | |
| **TB/25-26/135** | **Report from Quality Committee (including Mortality Report – Executive Summary and Terms of Reference)**<br><br>The Board received and **noted** the Quality Committee Chair's report, including the mortality report.<br><br>The Board **approved** the Quality Committee's Terms of Reference. | |
| **TB/25-26/136** | **Report from People Committee (including Equality & Diversity Report)**<br><br>The Board received and **noted** the People Committee Chair's report and the Equality and Diversity Report. | |
| **TB/25-26/137** | **Report from Audit and Risk Committee**<br><br>The Board received and **noted** the Audit and Risk Committee Chair's report. | |
| **TB/25-26/138** | **Report from Mental Health Act Committee**<br><br>The Board received and **noted** the Mental Health Act Committee Chair's report. | |
| **TB/25-26/139** | **Report from Finance, Business and Investment Committee (including Terms of Reference)**<br><br>The Board received and **noted** the Finance, Business and Investment Committee Chair's report.<br><br>The Board **approved** the Finance, Business and Investment Committee's Terms of Reference. | |
| **TB/25-26/140** | **Report from Charitable Funds Committee**<br><br>The Board received and **noted** the Charitable Funds Committee Chair's report. | |
| **TB/25-26/141** | **Any Other Business**<br><br>None. | |
| **TB/25-26/142** | **Questions from Public**<br><br>None. | |
| | **Date of Next Meeting** | |

Kent and Medway Mental Health NHS Trust

| Item | Subject | Action |
|---|---|---|
| | The next meeting of the Board will be held on Thursday 26th March 2026, via Microsoft Teams. | |

Signed …….. (Chair)

Date ……..

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 05/02/2026**

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 MARCH 2026** | | | | | | | | |
| 27.03.2025 | TB/24-25/137 | Action Log & Matters Arising | Submit a report to the Quality Committee on the Trust's future clinical staffing model | DHS, JK and AQ | July 2025 | September 2026 | Clinical plan is due for completion in September 2026. Work force plan will follow, no dates for completion agreed at this stage. Will need to be agreed with new Chief People Officer. With presentation at Quality Committee and People Committee before Board | **Over due** |
| 29.05.2025 | TB/25-26/9 | Board Assurance Framework (BAF) | Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework | NB | July 2025 | January 2026 | An update has been included within the digital paper on the agenda and the BAF will be updated ahead of the March 2026 Board meeting | **Over due** |
| 25.09.2025 | TB/25-26/72 | Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report | Bring a report to Board showing all partnership working within the Trust | SS | November 2025 | March 2026 | The partnership approach will be discussed at the March 2026 Board meeting. | **In progress** |
| 27.11.2025 | TB/25-26/99 | Board Assurance Framework (BAF) | Bring back an update to Board on both the suicide and self-harm risks to the Trust, and how these may link | JK | March 2026 | | This will be covered within the Quality Priorities paper on the agenda. Recommended to close the action. | **In progress** |
| 27.11.2025 | TB/25-26/101 | Trust Partnership Working | Revise the Trust Partnership Working report to include a partnership register, a maturity matrix, principles for working with the voluntary sector and a governance model. This should come back to the Board in March 2026 | AR | March 2026 | | A verbal update to be give, as this is being picked up in the new strategy charters and the revision of the trust SDR process | **In progress** |
| 27.11.2025 | TB/25-26/102 | Integrated Quality and Performance Review | The Board to receive a report on the use of the Royal Clarendon Hotel Age UK residential service, and what would be needed to further pursue this model across the county, at the March 2026 Board meeting. | AQ | March 2026 | | This was discussed at the February 2026 Board Development Day. Recommended to close the action. | **In progress** |
| 29.01.2026 | TB/25-26/118 | Personal Experience – My Occupational Therapy Journey | Explore options to strengthen early Occupational Therapy access, including primary-care referral routes (Quality Committee oversight) | DHS / AQ | March 2026 | | A verbal update to be given at the meeting | **In progress** |

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 05/02/2026**

NHS
Kent and Medway
Mental Health
NHS Trust

| Key | DUE | IN PROGRESS | NOT DUE | CLOSED |
|---|---|---|---|---|

| Meeting Date | Minute Reference | Agenda Item | Action Point | Lead | Date | Revised Date | Comments | Status |
|---|---|---|---|---|---|---|---|---|
| 29.01.2026 | TB/25-26/121 | Action Log & Matters Arising | Refresh the clinical staffing model timeline with oversight by the Quality Committee | DHS, AQ and JK | March 2026 | September 2026 | Clinical plan is due for completion in September 2026. Work force plan will follow, no dates for completion agreed at this stage. Will need to be agreed with new Chief People Officer. With presentation at Quality Committee and People Committee before Board | |
| 29.01.2026 | TB/25-26/121 | Action Log & Matters Arising | Provide an action plan to improve ethnicity recording | AR | March 2026 | | Closed – covered in the paper. | **In progress** |
| 29.01.2026 | TB/25-26/124 | Board Assurance Framework (BAF) | Revise the reputational risk wording within the BAF for review by the Audit & Risk Committee | KH | March 2026 | | A verbal update to be given at the meeting | **In progress** |
| 29.01.2026 | TB/25-26/126 | Digital Progress Against Plan | Provide an updated Digital Plan, including the accelerated Ambient Voice Technology (AVT) plan with clarified milestones and resource requirements | NB | March 2026 | | The digital plan has been updated and taken for discussion to the FBI committee in March. This includes clinical leadership and research. The outline plan is outlined in the Trust Strategy and will be refined once agreed. | **In progress** |
| 29.01.2026 | TB/25-26/128 | Integrated Quality and Performance Review | Provide a refined complaints improvement trajectory including complexity categorisation and bottleneck analysis | JK | March 2026 | | A verbal update will be given at the meeting. | **In progress** |
| **ACTIONS NOT DUE OR IN PROGRESS** | | | | | | | | |
| 29.01.2026 | TB/25-26/119 | Continuous Improvement Story – Standardising Medication Storage in Allington Centre | Produce a Trust-wide scale-up plan with measurable safety metrics and report it to the Finance, Business and Investment Committee | AR | July 2026 | | | **Not Due** |
| 29.01.2026 | TB/25-26/121 | Action Log & Matters Arising | Present a Trust wide ethnicity data improvement plan to address gaps in the Trust's ethnicity data for both staff and patients (Quality Committee) | SG / AR | May 2026 | | | **Not Due** |
| 29.01.2026 | TB/25-26/123 | Chief Executive's Report | Strengthen the stakeholder engagement plan, including targeted communication to Medway Council Health and | KH | May 2026 | | | **Not Due** |

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 05/02/2026**

NHS
Kent and Medway
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NHS Trust

| Key | DUE | IN PROGRESS | NOT DUE | CLOSED |
|---|---|---|---|---|

| Meeting Date | Minute Reference | Agenda Item | Action Point | Lead | Date | Revised Date | Comments | Status |
|---|---|---|---|---|---|---|---|---|
| | | | Adult Social Care Overview and Scrutiny Committee (HASC) and local councillors | | | | | |
| 29.01.2026 | TB/25-26/124 | Board Assurance Framework (BAF) | Reconcile inconsistencies in inpatient flow data with update provided to Quality Committee | JK / AQ | April 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/125 | Sustainable Communities Provider Collaborative Progress Report | Provide a verbal update as part of the Sustainable Communities Provider Collaborative Progress Report regarding the Health Inequalities Improvement Plan and collaboration with Kent Community Health NHS Foundation Trust | SS | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/125 | Sustainable Communities Provider Collaborative Progress Report | Present a 'broader health inequalities' update for the Board | AR | July 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/126 | Digital Progress Against Plan | Present the mapping of system-level digital responsibilities and dependencies | NB | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/127 | Trust Quality and Safety Agenda | Finalise the NED Visit Insight Framework | TS | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/127 | Trust Quality and Safety Agenda | Produce a plan to address fear of reprisals and strengthen leadership behaviours | SG | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/128 | Integrated Quality and Performance Review | Lead a Trust-wide audit of waiting-well arrangements, incorporating patient experience data | DHS | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/128 | Integrated Quality and Performance Review | Deliver a deep-dive report on restrictive practice trends, drivers and mitigation plans | JK | May 2026 | | | Not Due |
| 29.01.2026 | TB/25-26/132 | Freedom to Speak Up 6 Month Report | Report to the People Committee the:<br>• Implementation of the principles-based Change Management Framework; and | SG | May 2026 | | | Not Due |

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 05/02/2026**

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 |
|---|---|---|---|---|---|---|---|---|
| | | | • Embedding of closed-loop reporting back to staff | | | | | |
| **CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS** | | | | | | | | |
| 31.07.2025 | TB/25-26/50 | Memory Assessment Service System Delivery Plan | Explore the demographics of appointment cancellations, to determine whether there were underlying health inequalities | AR | September 2025 | January 2026 | Appointment cancellations and underlying health inequalities are being addressed within the dementia programme board; further analysis and any associated actions are expected by the end of Q3. A verbal update is to be given. | |
| 25.09.2025 | TB/25-26/67 | Action Log & Matters Arising | Report to the Board the milestones for the Kent and Medway Digital Plans | NB | November 2025 | January 2026 | To be closed - on the agenda to discuss. | **Closed** |
| 27.11.2025 | TB/25-26/93 | Personal Experience – Patient Safety Partner | Invite SM and the Director of Psychological Therapies to the Quality Committee in 12 months' time, to provide a further update on his role as Patient Safety Partner and the cultural change in risk management across the Trust | JK | January 2026 | | This item has been added to the QC agenda for early autumn, and Sara Casado and Christine Hemmings are aware. Action recommended to be closed. | **Closed** |
| 27.11.2025 | TB/25-26/100 | Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report | Provide a timeline and ambition for care home training for memory assessment diagnosis. | JHa and SS | January 2026 | | A verbal update will be given at the meeting. | **Closed** |
| 27.11.2025 | TB/25-26/107 | Resident Doctor 10-Point Plan | The People Committee workplan to be adjusted to include the 10-point plan, by the January meeting. | TS | January 2026 | | The workplan has been amended. Action recommended to be closed. | **Closed** |

Kent and Medway Mental Health NHS Trust

| | |
|---|---|
| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **26th March 2026** |
| Title | **Chair's Report** |
| Author | **Dr Jackie Craissati, Trust Chair** |
| Presenter | **Dr Jackie Craissati, Trust Chair** |
| Purpose | **For noting** |

## 1. Kent & Medway system and national activity

The chair of our Kent & Medway Integrated Care Board (ICB), Cedi Frederick, has announced that he is standing down with immediate effect. We would like to extend our thanks to Cedi for his leadership of the ICB during a challenging period, and on a personal note, I would like to thank him for his support to me over the past two years.

The system Joint Committee continues to meet on a monthly basis, with a primary focus on eradicating the financial deficit and driving the delivery of our savings plans for the year. The emphasis has shifted from system savings, to the responsibilities of each provider trust. Although the Sustainable Communities Provider Collaborative continues to play a key role in system transformation via neighbourhood health.

At a national level, I have been involved in the Aspiring Chairs programme for NHS England, interviewing potential candidates. This is an important route for talented non-executives to be supported to consider chair roles at a time when such roles are particularly challenging as well as immensely rewarding.

## 2. Trust Board meetings

At the February Board seminar day, the Board discussed the trust's Quality Plan and strategic direction in more detail integrating findings and actions from a variety of sources (including the Moorhouse report) into a single view of the way forward. The Board also discussed the trust's Freedom to Speak Up self-assessment tool and was updated on the trust's plans to address patient flow.

On 11 March, the Board had a final board-to-board session with North East London Foundation Trust to discuss the smooth transfer of CYPMHS and All Age Eating Disorders to the trust on 1st April. The Boards agreed that this had been an outstanding example of service transfer collaboration and expressed their thanks to all.

Immediately after the board-to-board, the Board met to discuss the new trust strategy and how the trust has engaged with key partners and the public.

## 3. Board Member Updates

This Board meeting will be the last board meeting for Sandra Goatley, Dr MaryAnn Ferreux and Peter Conway. On behalf of the Board, I would like to express thanks for their contributions which have been significant and impactful.

Recruitment is underway for a non-executive with a clinical background, and we are undertaking this search in partnership with Dartford & Gravesham NHS Trust.

On 1 April, the Board will welcome Kevin Corrigan and he will be the trust's Chair of the Audit and Risk Committee. On 11 April, Ali Layne-Smith will join the Board as the Chief People Officer.

## 4. Trust Chair and NED visits

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

| Where | Who |
|---|---|
| **December 2025** | |
| Gregory House, Older Adults Mental Health Service | Julius Christmas |
| **January 2026** | |
| Cooksditch House Care home, for Level 1 Dementia Diagnosis Training | Sean Bone-Knell |
| Maidstone housekeeping team | Jackie Craissati |
| Home Treatment & Rapid Response teams, Maidstone (West Kent) (HTT & RR) | Jackie Craissati |
| **February** | |
| Priority house inpatient wards, Maidstone | Jackie Craissati |

### Chair visits

I was immensely impressed with my visit to the Maidstone site housekeeping team. Not only did I learn a good deal about their procedures to ensure patient safety whilst using potentially dangerous chemicals, their dedication to the trust and their desire to give something back to the NHS via their work was evident, as was their knowledge of our patients and their contributions to the multi-disciplinary teams. The only issue of concern was the unacceptable slowness of our recruitment processes when trying to get staff into post; this was something I raised with our Chief People Officer.

I returned to the HTT and RR teams for an update, and it was good to hear that RR is now working well, although everyone continued to hold high levels of risk in the community. The main issue of concern was the extremely poor level of communication to the team and it's managers when there was a sudden decision to role out Dialog+ to HTT. This seemed to be reminiscent of some staff concerns that were raised in relation to Mental Health Together communications.

In February, I accompanied some of our executive team onto the wards at Priority House. I was struck again by the importance of ward environment – new ones being spacious and older ones being claustrophobic in feel – in influencing how unwell patients might feel, and the ease with which staff might be able to observe and support them. There are limits to what we can do about this, but perhaps we do not acknowledge it enough in our discussions? I was really disappointed when talking with staff, to find that they had no knowledge of any of the positive steps that we're taking to support them in managing racially abusive verbal comments; I have raised this with the CPO and the CEO.

**Non-Executive Directors**

**Julius Christmas NED Visit – Gregory House (Older Adults Mental Health)**

A visit was undertaken to Gregory House to gain an understanding of older adults' pathways, with a particular focus on dementia. The team described recent positive transformation work undertaken, including the establishment of a single centralised administrative team supporting all pathways, and reported improved digital support following recent enhancements to RIO and Power BI. The principal constraint to reducing dementia waiting times was identified as medical capacity, due to vacancies and sickness. Additional challenges arise from delays and communication friction around diagnostic MRI/CT imaging. The team noted that administrative tasks within the dementia pathway are currently well optimised.

**Sean Bone-Knell attendance at Cooksditch House Care home, for Level 1 Dementia Diagnosis Training**

It was a pleasure to be able to observe the level 1 dementia diagnosis training for care home staff, that is being provided through the KMMH Provider Collaborative. Thirteen care staff were present for the two-hour training session. It was good to see and hear, the care staff perspective of undertaking this training. This started with being unsure of why they were doing this, to being fully engaged and aware of how they can assist with a dementia diagnosis.

The team from the provider collaborative alongside Nurse Consultant Mark Kitchingham from KMMH delivered an interactive and interesting session for all of the care staff. Seeing the uptake and outcomes from care staff undertaking these Level 1 diagnosis interventions will be the effective evaluation for this project over the coming months.

Kent and Medway Mental Health NHS Trust

# Chief Executive's Board Report

**Date of Meeting: 26th March 2026**

## Introduction

It has been a busy start to the new calendar year. The beginning of March saw us welcome the Care Quality Commission (CQC) to the Trust for our Well Led Inspection, more of which I will cover later in my report. We are discussing today the transition of the Children and Young People (CYP) and All Aged Eating Disorder (AAED) services to the trust on the 1st April. We are very much looking forward to being an all-aged mental health provider, the first time ever for the county. I am also delighted to share that we are reviewing our new five-year strategy today at trust board to approve and launch in April.

## National and Regional Update

### New National Director for Mental Health, learning disability and autism

In February, Dr. Nick Broughton was appointed to the new national director role for mental health, learning disability and autism in NHS England (NHSE). Nick has already taken up his role and set out the priories for our sector in the coming year. These will include quality and safety of services, Children Young People (CYP) waiting times, adult length of stay in inpatient units, upskilling of staff to support patients with ADHD, integrated physical and mental healthcare, as part of the integrated neighbourhood health agenda and the implementation of the new mental heath act. I look forward to working with Nick and wish him the best in his new role.

### Medway Council Health & Adult Social Care Scrutiny Committee (HASC)

Dr Adrian Richardson and I attended the HASC meeting on the 12th March to provide an update on the transition of the CYP & AAED services to the trust. The update was well received by the committee, and they were supportive of the direction of travel. We were asked to report back to the committee in June post the transition. I also took the opportunity to provide an update on the recent CQC well led inspection ahead of a published report later in the year.

## Trust Update

### Changes to the Executive Team

Last autumn I shared that Sandra Goatley our Chief People Officer had announced her retirement. Today is Sandra's last Trust Board meeting and she leaves the trust on the 10th April after ten years. I want to publicly thank Sandra for her dedication and commitment to the trust in the last ten years, she has made an instrumental difference for our staff and our

patients, I wish her well in her retirement. You will be deeply missed by us all. I am pleased to announce that I have successfully recruited to the Chief People Officer role on a 12-month fixed term basis. Ali Layne-Smith has joined us starting on the 23rd March to ensure there is a robust handover. Ali has significant experience in public and private sector, having worked at Salisbury District Hospital, HMRC London Ambulance Service and West Midlands Police. I welcome Ali to the trust and my team.

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

We are only days away before the CYP and AAED services transition to us. My EMT colleagues and I have been visiting services in the past six months and have been running welcome events for our new colleagues. We wish them a warm welcome to the Trust, and we look forward to our future together shaping mental health services for Kent and Medway. I also want to thank everyone that has been involved in ensuring a smooth transition of these services.

CQC Well-Led Inspection

We were informed in the latter part of last calendar year that CQC would be undertaking a well-led inspection of our trust from Tuesday 3 - Thursday 5 March. We invited a team of 14 individuals from the CQC into the trust, they met with over 100 staff as part of their inspection, which involved a mix of focus groups and interviews. At the start of the three-day inspection, I shared with them where we are as a trust, and our plans for future direction. I want to thank our many partners for joining us at the start of our inspection and their positive feedback on what it feels like to work with us. Thank you. At this stage, we have only received high level verbal feedback from the CQC at the end of day three. We are expecting a detailed letter in the coming weeks, followed by a draft report in the coming months. From the high-level feedback we have received, there are things we can be proud of as a trust, and areas for improvement, many of which we were already aware of, and working to address. We will continue our focus in the months ahead.

CQC service inspections

In the lead up to the well-led inspection, the CQC have revisited several of our services and undertaken some new service inspections, ahead of the well-led. I am delighted that following a visit by the CQC to our Mental Health Learning Disability Community Teams on the 17 and 18 February, we received extremely positive feedback on the service. You may also remember following their visit last March that warning notices were implemented by the CQC for both community services and our Health Based Place of Safety. We welcomed the news that our community services warning notice, has now been lifted. This is testament to the care our dedicated teams provide, and the steps we have taken to act on feedback from the CQC last year. I want to congratulate the teams on their successful inspections and thank all colleagues involved in the work which resulted in the lifting of the safety notice. They should be proud of the work they are doing to deliver for our patients every day.

Senior Leaders Day

I held our quarterly leaders' event in early February which was well attended with 69 of our senior leaders present. We used the day as an opportunity to ensure we were well prepared for our up-and-coming CQC well led inspection and took time to reflect on how far we have

come as a trust in the last two years. We also used part of the day to discuss and further plan our new five-year strategy which we are launching in April. It was great to see and feel the energy in the room and the alignment between us as we move forward on the next stage of our journey.

Sharing Success - Working with our Partners

Our Allied Health Professions team were proud to host a Health, Education and Vocation Fair within our secure services at the Trevor Gibbens unit. This was an excellent example of what happens when NHS services work side by side with our third sector and voluntary partners to tackle inequalities. Recovery is about so much more than symptom reduction. It's about access to education, meaningful activity, skills, purpose, connection and hope. By bringing together partners spanning, education and digital skills, vocational pathways and employment support, men's sheds, creative and community projects, wellbeing, peer support and suicide prevention and co-production and lived experience voices, we actively reduced barriers that so often exclude people from opportunity – whether that's confidence, access, stigma, or simply not knowing what's available. By hosting this event conversations were sparked, connections made, curiosity ignited and creativity, learning – and most importantly, choice were there. A massive thanks to our voluntary and community sector partners for their commitment, compassion and creativity. This is inequality reduction in action: meeting people where they are and opening doors. This is what recovery-focused, person-centred care look like, and this is why partnership matters to us.

External recognition and awards

Building on the positive feedback from the CQC, the trust has continued to receive recognition for the quality and impact of its work across a range of services. Since the Board last met, the trust has won/been shortlisted for three awards. Our perinatal mental health services won the Healthwatch Recognition Award for Involving People in Commissioning and Delivery of Services – in recognition of their outstanding work to involve women, families, and partners in shaping care and service development. Jo Rodda, Consultant in Old Age Psychiatry and Dementia Research Theme Lead won the Healthwatch Recognition Award for Inspiring Individuals. The award recognised her leadership and contribution to dementia research, and her work to improve outcomes for older adults. Finally, the Kent and Medway Provider Collaborative received a Dementia Friendly Kent Award nomination for the roll out of Level 1 DiADeM dementia training, which was developed and delivered in collaboration with partners, to better support and care for people living with dementia.

I know the Board will join me in congratulating our winners and thanking them for their work to make a difference to the lives of people and communities we service across Kent and Medway.

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 congratulation to you all, it is the highlight of my week reading the reasons to celebrate our staff.

**Summary and Conclusion**

Today as we look to approve our new five-year strategy I look forward with hope, excitement and optimism for our future. I have said this before and will say it again this trust has a

pivotal role to play in this system as an all-aged mental health provider. I look forward to the first year of our strategy working closer than we ever have before with our staff, patients, communities and partners. Together we have the strength and opportunity to make a difference for our patients.

**Sheila Stenson**
**Chief Executive**
**26th March 2026**

## Executive Team Visits

**Sheila Stenson:**
TGU Wards
Littlebrook Wards : Amberwood and Cherrywood
Courtyard Campus, Gillingham (CYP site)
CYPMHS/AAED, Ashford

**Donna Hayward-Sussex**
CYPMHS/AAED Services Maidstone Studios
Mental Health Plus (working age), Highlands House
Mental Health Plus (older adults), Highlands House
Acute Wards, Maidstone
West Kent Place of Safety
Community Mental Health Team, Albion Place
EIS & MAS teams, Avalon House

**Julie Kirby**
TGU Wards
Littlebrook Wards : Amberwood and Cherrywood

**Kindra Hyttner**
Specialist Services, Albion Place
Mental Health Learning Disability Team, Albion Place
CYPMHS/AAED, Canterbury
Mental Health Plus (working age), Shepway
Acute Inpatient Wards, Thanet
Mental Health Plus, Thanet, Elmstone Unit

**Sandra Goatley**
Rapid Response and HTT, Littlebrook
CYPMHS/AAED, Ashford
East Kent Mental Health Plus (older age), Folkestone
CYPMHS/AAED, Folkestone
Willow Suite

**Nick Brown**
CYPMHS/AAED, Dartford
Kent and Medway Adolescent Hospital

**Adrian Richardson**

Rapid Response and HTT, Maidstone
K&M Adolescent Hospital, Staplehurst

**Afifa Qazi**

Orchards, Boughton and Upnor Wards
West Kent Home Treatment Team

**Value in Practice Awards**

| Directorate | December | January |
|---|---|---|
| North | Cheryl Lee, Deputy Service Manager | Dr Ishaq Pala |
| East | Kelly Hixon, CPN | Sinead McGettrick, Admiral Nurse |
| West | Jouko Koecher, Psychotherapist and team leader for EK Personality Disorder Service | Domine Kay, Clinical Lead Nurse |
| Forensic | Abbie Crysell, Lead Occupational Therapist | Winnifred Lindley, Learning Disability & Autism Nurse |
| Support services | Rosemary Noakes, Hotel Services Operative | Amy Draper, Learning and Development Events Co-ordinator/ Administrative Support to Head of Learning and Development |
| Acute | Elliot De-Val, Healthcare Assistant | Tatjana Krizanovska, Senior Occupational Therapist |

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

| Meeting details | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Board Assurance Framework |
| **Author:** | Louisa Mace, Risk Manager |
| **Executive Director:** | Julie Kirby, Acting Chief Nurse |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Approval |
| **Submission to Board:** | Regulatory Requirement |

## Overview of paper

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

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

## Issues to bring to the Board's attention

The BAF was last presented to the Board in January 2026 and to the Audit and Risk Committee (ARC) on 10 March 2026.

**New Risks:**
No new risks have been added to the BAF since it was presented to Board in January

**Risk Movement:**
No risks have changed their risk score since the Board Assurance Framework was presented to Board in January

**Risks recommended for Removal:**
No risks are currently recommended for removal

**Risk Appetite:**
The Risk Appetite statements continue to be applied to the BAF risks and are included in this report.

Version control 02 - **Public**

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

# The Board Assurance Framework

The BAF was last presented to Board in January and ARC on 10th March 2026. This report reflects further updates on risks since January.

## The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID 02290 – CQC Regulatory Compliance (Rating of 16 - Extreme)
- Risk ID 07960 – Reduce Self harm in our female patients on Acute Wards (Rating of 16 – Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 16 – Extreme)
- Risk ID 08157 - Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place (Rating of 16 - Extreme)
- Risk ID 04673 – Organisational Risk – Cyber Attack (Rating of 15 – Extreme)

## Risk Movement

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

## Risks Recommended for Removal

No risks are being recommended for removal at this time.

## New Risks

No new risks have been added to the BAF since it was presented to Board in January and ARC in March.

## Emerging Risks

The Executive team continues to horizon scan for emerging risks to delivery of services. The following areas continue to be evaluated for inclusion on the BAF: digitally enabled transformation, Board leadership and succession planning; and ensuring appropriate support for operational and clinical leaders. This will be explored further and the BAF, as a live document, will be updated as appropriate.

**Other Notable Updates**

- **Risk ID 07557 - Trust agency usage (Rating of 9 – High)**
  This risk was reviewed in February. While the Trust has achieved the required reduction in Agency spend, there is some concern about the Agency spend in Children and Young Peoples services as they transfer to The Trust in April. Currently the details of this risk is held within the risk register for the Transfer programme and will be aligned to existing KMMH risks once the transfer of services is complete.

- **Risk ID 08337 - Organisational Culture impact on Delivery of Strategic Ambitions (Rating of 9 – High)**
  The Staff Survey results were released mid March. These are being analysed and next steps will be added to the actions for the next iteration of the BAF. There is a paper on the Board agenda relating to the staff Survey results which will inform the update to this risk.

**Risk Appetite:**

Following the Board Session in 2025, the Risk Appetite Statements that were discussed and agreed have been incorporated in the Trust Risk Management Framework. These have been applied to the BAF risks for this report, according to the table below.

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

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

| Risk ID | Title | Current Risk Score | Appetite | Appetite Status |
|---|---|---|---|---|
| 00580 | Organisational Inability to meet Memory Assessment Demand | 16 | Cautious | Outside of Tolerance |
| 02290 | CQC Regulatory Compliance | 16 | Averse | Outside of Tolerance |

| | | | | |
|---|---|---|---|---|
| 04673 | Organisational Risk – Cyber Attack | 15 | Averse | Outside of Tolerance |
| 07557 | Trust Agency Usage | 9 | Seek | In Appetite |
| 07891 | Organisational Management of Violence and Aggression | 12 | Minimal | Outside of Tolerance |
| 07960 | Reduce Self harm in our female patients on Acute Wards | 16 | Minimal | Outside of Tolerance |
| 08065 | Inpatient Flow | 16 | Cautious | Outside of Tolerance |
| 08146 | Maintenance of a Sustainable Estate | 9 | Cautious | In Tolerance |
| 08157 | Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place. | 16 | Minimal | Outside of Tolerance |
| 08173 | Delivery of a fit for purpose estate | 9 | Cautious | In Tolerance |
| 08174 | Delivery of Financial Targets | 12 | Minimal | Outside of Tolerance |
| 08175 | Delivery of Underlying Financial Sustainability | 12 | Minimal | Outside of Tolerance |
| 08337 | Organisational Culture impact on Delivery of Strategic Ambitions | 9 | Seek | In Appetite |
| 08484 | Risk to stakeholder confidence | 12 | Averse | Outside of Tolerance |

**Recommendations**

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

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

**Updated: 16 March 2026**

# Board Assurance Framework

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

Kent and Medway Mental Health NHS Trust

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

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

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

**Action status key:**

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

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

### 1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | Action owner | Risk Appetite | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID 00580 | Jan 2022 | Director of Partnerships and Transformation | **Organisational inability to meet Memory Assessment Service Demand**<br><br>If KMMH remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model<br><br>Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services.<br><br>Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment or services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years. | 5 | 5 | 25 | System wide response to achieve improved Memory Assessment services across Kent and Medway through the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative and Ageing Well Board.<br>- BI Functionality to drive performance at team, directorate and organisational level<br>- Stand alone assessment model formed, currently being optimised through Tiered Accountability work<br>- Completing the Demand and Capacity for the multi-disciplinary model for memory assessment within KMMH (to be rolled out across the organisation)<br>- Community Model Task Force formed comprising KMMH and wider NHS and VCSE partners. | Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team<br>Highlight reports to Trust Leadership Team, FBI and QC on 6 week performance Reporting to MHLDA and Ageing Well Board | 4 | 4 | 16 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Phase 2: Launch of multi-disciplinary assessment model within KMMH — Director of Partnerships and Transformation — Parked (To review in 6 months)<br>Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 29/05/2026 — A<br>Phase 2 resourcing and implementation — Director of Partnerships and Transformation — Parked (To review in 6 months)<br>Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 29/05/2026 — A<br>Scoping impact of Improved DDR rate on Dementia pathways — Director of Partnerships and Transformation — 06/04/2026 — A | Director of Partnerships and Transformation | Outside of Tolerance | 3 | 4 | 12 | 30/06/2026 |

12/06/2024 — Risk Opened

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | Action owner | Risk Appetite | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID 08065 | Jun 2024 | Chief Medical Officer | **Inpatient Flow**<br><br>If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward<br>Then treatment maybe delayed,<br>Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk. | 5 | 4 | 20 | Patient flow team jointly working with Liaison Psychiatry, Home Treatment and community services on case by case basis to ensure each admission is purposeful, and inappropriate admissions are avoided.<br>At the same time, we are ensuring that the clinically ready for Discharge patients get the right support in a timely manner so that they spend the least amount of time, beyond what is clinically relevant, in hospital.<br>Twice daily reports including the Place of Safety Breaches<br>Daily system calls<br>Daily bed flow call chair by the Deputy Chief Operating Officer to examine demand, capacity, escalations, 7-day discharge trajectory and complex case review. This can increase twice a day if OPEL 4 is triggered.<br>Daily bed flow meeting is clarifying reasons for admission and alternative to admission to support purposeful admission.<br>Winter plan underpinned by NHSE Mental Health OPEL Framework.<br>Local and system escalation of delayed discharge as required.<br>CORE 24 rolled out across all acute hospital's liaison teams<br>CRFD programme of work underway to release capacity within the KMMH bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review<br>CRFD Programme is a system wide programme in conjunction with the ICB, Local Authority and supported through the Provider collaborative.<br>Review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts to be able to accurately measure patients waiting in EDs for Beds.<br>Use of VCSE partners to support CRFD onward transition. As at January 2026, 25 patients have used this pathway.<br>Clarendon House commissioned 13 beds to support people who are Clinically fit for Discharge with onward pathway thus improving capacity in Acute Psychiatric bed stock. This has saved 1374 bed days so far (January 2026).<br>Working with the ICB to explore additional step-down capacity.<br>Red to Green and purposeful admission methodology in operation on all wards to support discharge.<br>Temporary employment of 2 social workers to support discharge and high levels of CRFD at Littlebrook Hospital and Priority House. | Weekly CRFD report<br>Daily Bed state including Place of Safety and A&E Breaches | 4 | 4 | 16 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Recovery Houses across the County — Deputy Chief Operating Officer — BLOCKED<br>Virtual ward Model for People with Dementia — Chief Medical Officer — CANCELLED<br>Expand Step Down and Community Capacity for those patients with a higher risk profile currently as CRFD on the wards. — Chief Medical Officer — 30/04/2026 — A<br>Maximising Crisis and Home treatment team support to wards for early discharge — Chief Medical Officer — 30/04/2026 — A<br>Trusted assessment model with social workers released from KMMS to support CRFD discharge — Chief Medical Officer — 30/04/2026 — A<br>Improving proactive early discharge processes on the ward with support from the Acute Directorate. — Chief Medical Officer — 30/06/2026 — A<br>Increased use of VCSE providers for ongoing support, housing, and social inclusion — Chief Medical Officer — 31/07/2026 — A<br>Enhanced social care presence on the wards — Chief Medical Officer — 31/07/2026 — A | Chief Medical Officer | Outside of Tolerance | 1 | 3 | 3 | 30/03/2027 |

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | | | | Action owner | Risk Appetite | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | Directorate based beds | Chief Medical Officer | 31/01/2027 | A | | | | | | |
| | | | | | | | | | | | | | Shared discharge pathways | Chief Medical Officer | 31/01/2027 | A | | | | | | |
| 12/06/2024 Risk Opened | | | | | | | | | | | | | | | | | | | | | | |
| ID 08157 | Aug 2024 | Chief Operating Officer | **Delivering the Community Mental Health Framework to provide high quality care and support through Mental Health Together to the right people, at the right time and in the right place.**<br><br>If we do not provide the right intervention to the right people due to extraordinary demand that matches the right capacity to provide accessible and responsive treatment and/or support<br>THEN we will a) not be able to understand and meet peoples need in a timely manner b) delay commencement of treatment and/or support<br>RESULTING IN poor service user experience, a potential risk to safety and a delay in meeting the outcome that are important to them. | 5 | 5 | 25 | Community Mental Health Programme milestone plan to implement change to service, which will support access, waiting times and case load management.<br>- Daily review of waiting lists at service level, weekly review of waiting list at operational level (led by service directors) and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners.<br>- Actions in place to reduce the overall caseload for MHT and MHT plus, which will support transition to a new approach, which will be completed by April 2026.<br>- Review of the front door are underway as part of the Community Mental Health Programme refresh, and it is agreed that we will launch the Medway Approach.<br>- The COO agendas referrals, waiting times and caseload at their operational report meeting, to understand exception reporting. This is also scheduled regularly at the Quality Improvement Plan CQC Huddles on at least a monthly basis.<br>- Review underway to simplify the mechanism for managing contacts and waits, this includes the DIALOG plus being launched as the initial assessment, care plan and baseline outcome at the point of triage in Q4 2025/26.<br>- Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse.<br>- A new approach to managing people waiting over 15 weeks is being developed with the service directors to ensure there is a consistent approach to waiting well system.<br>- Referrals, waiting lists and caseload are subject to review and action at the directorate and trust wide SDR process.<br>- Community waits are reported weekly at the Trust wide safety huddle, which is chaired by the Chief Nurse. | Robust team level management Dashboards<br>Caseload management tool<br>Partnership Forums | 4 | 4 | 16 | ⟷ | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Chief Operating Officer | Outside of Tolerance | 3 | 3 | 9 | 31/12/2026 |
| | | | | | | | | | | | | | Capacity Planning | Deputy Chief Operating Officer | COMPLETED | G | | | | | | |
| | | | | | | | | | | | | | Effective waiting time management of people waiting over 18 weeks | Deputy Chief Operating Officer | 31/03/2026 | A | | | | | | |
| | | | | | | | | | | | | | Implementation of Demand and Capacity Modelling | Deputy Chief Operating Officer | 30/04/2026 | A | | | | | | |
| | | | | | | | | | | | | | Risk Assessment compliance<br>*All teams to deliver the Trust Quality Improvement Plan for Risk Assessment compliance* | Deputy Chief Operating Officer | 15/06/2026 | A | | | | | | |
| | | | | | | | | | | | | | Compliance with DIALOG plus at initial contact | Deputy Chief Operating Officer | 31/12/2026 | A | | | | | | |
| **1.2 - Creating safer and better experiences on our wards** | | | | | | | | | | | | | | | | | | | | | | |
| 04/12/2014 BAF Risk Opened — 20/07/2023 Risk returned to BAF | | | | | | | | | | | | | | | | | | | | | | |
| ID 07891 | Jan 2024 | Chief Nurse | **Organisational Management of violence and aggression**<br><br>IF the Trust does not manage violence and aggression effectively<br>THEN staff and patients will be exposed to physical injury and psychological harm<br>RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies. | 5 | 3 | 15 | Restrictive Practice policy and guidance<br>the Continuous Improvement Approach<br>Violence Reduction Strategy<br>PSS Strategy<br>Use of Force Act<br>Operation Cavell<br>Security strategy<br>CCTV (where available)<br>Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this.<br>How to manage challenging telephone calls Policy<br>Therapeutic observations Policy<br>Control of Ligatures Policy<br>Safer Staffing | Incident reporting via InPhase<br>Quality Improvement Data | 4 | 3 | 12 | ⟷ | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Chief Nurse | Outside of Tolerance | 2 | 3 | 6 | 31/03/2027 |
| | | | | | | | | | | | | | Improvement project is in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. Now testing directorate level assurance phrase. | Chief Nurse | 30/04/2026 | A | | | | | | |
| | | | | | | | | | | | | | New Violence and Aggression Policy 2025 | EPR Lead | COMPLETED | G | | | | | | |
| | | | | | | | | | | | | | Violence and Aggression Listening Sessions to be held with Community Teams | Diversity and Inclusion Manager | 17/04/2026 | A | | | | | | |
| | | | | | | | | | | | | | Allyship Training for Community and Children and Young People Teams | Diversity and Inclusion Manager | 12/04/2028 | A | | | | | | |

| | | | | Initial rating | | | | | Current rating | | | | | | Target rating | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | L | C | Rating | Controls Description | Top Five Assurances | L | C | Rating | Trend | Planned Actions and Milestones | Action owner | Risk Appetite | L | C | Rating | Target Date (end) |
| 01/04/2014 — Risk Opened — 25/06/2025 — Risk escalated to BAF | | | | | | | | | | | | | | | | | | | |
| ID 02290 | Apr 2014 | Chief Nurse | **CQC Regulatory Compliance**<br><br>IF we don't have effective means for assessing, measuring, monitoring and reviewing the regulations as set out in the Health and Social Care Act 2008 required to evidence compliance with fundamental standards and to uphold CQC registration<br>THEN inspections may highlight areas of poor quality of care<br>RESULTING IN avoidable harm, legal claims, regulatory breaches, enforcement action from our regulators and damage to the confidence in the Trusts reputation as a provider of choice. | 4 | 4 | 16 | Trust Quality Plan - reviewed 3x weekly to establish progress and improvement across the SDRs held within the Directorates and audits that identify areas of concern for further action<br>Learning Review Group (LRG) – learning is identified from patient safety incidents and lessons shared to prevent reoccurrence<br>CQC MHA Reviews for inpatient areas – provider action statements generated, reports to Mental Health Legislation Operational Group (MHLOG) and Mental Health Act Committee (MHAC)<br>Regulation, Compliance and Quality Group (RCQG) – meets monthly and reports to Quality Committee (QC)<br>Quarterly engagement meetings with CQC whereby areas of concern are discussed and assurance provided against quality statements and the five key questions<br>Support tools and evidence lists for staff based on CQC quality statements and five key questions. This is available on staffroom.<br>Quality improvement plans following inspection activity - these are monitored via RCQG and QC<br>Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month). | - Quality Plan maturing into sustainable improvement plan<br>Learning Review Group minutes identify learning shared from patient safety incidents<br>- The provider action statements from MHA inpatient reviews and quality improvement plans from inspection activity are reviewed for oversight and assurance purposes E56<br>- Performance and Quality Meeting (PQM) with the ICB Minutes.J56 | 4 | 4 | 16 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Place of Safety Quality Improvement Plan - aims to embed key areas for improvement including a flowchart detailing staff actions regarding consent to treatment, clarity regarding the process of patients remaining longer than 24 hours and standards of care expected. Addresses contents of the S29a warning notice. — Chief Nurse — 30/07/2026 — A<br>Community Teams & Crisis services Quality Improvement Plan - aims to deliver and embed key areas addressed from the community inspections, including the S29a warning notice. These include actions across four key themes - Safety & Risk/ Access & waiting times/ Environment, experience & equity/ Leadership, culture & governance. — Chief Nurse — 31/07/2026 — A<br>Notable areas for improvement and included in the above quality plan is Care Planning and Risk Assessment improvement work. Risk assessment trajectory is 50% in each team by end of Feb 26 and 90% by end of May. Care planning policy agreed. — Chief Nurse — 31/05/2026 — A | Chief Nurse | Outside of Tolerance | 2 | 3 | 6 | 31/03/2027 |
| 02/04/2024 — Risk Opened — 08/09/2025 — Risk escalated to BAF | | | | | | | | | | | | | | | | | | | |
| ID 07960 | Apr 2024 | Chief Nurse | **Reduce Self harm in our female patients on Acute Wards**<br><br>IF we do not take an evidence based approached to self harm across admission, discharge and inpatient care.<br>THEN we have increased frequency and severity of self harm.<br>RESULTING IN risk of serious injury and/or death, escalation in self harm, increased observations and restrictive practice, financial impact, poor patient experience, increased regulatory oversight. | 5 | 4 | 20 | Evidence based approach across the three pillars of i) decisions to admit, ii) inpatient care and, iii) timely decisions around discharge<br><br>Admissions:<br>1) Apply urgent senior clinical shared decision making to requests for admission by drawing upon NICE Guidelines (CG78) discerning between Acute and Chronic Risk. Includes 'Patient flow', 'Acute Directorate', 'Liaison Psychiatry Services'; CRHT, and MHT+. Urgent Adhoc senior clinical review/meetings focused on merits of admission for specific patients. Process requires standardising through the trustwide CED/EUPD guidelines<br>2) Stringent focus on 'Purposeful Admission Policy' and specifically the 'Gate Keeping Form'<br>3) KMMH CED Admission guidelines developed to test requests for admission against evidence based practice. Test & learn goes live in West Kent Liaison Services on 19/1/26<br><br>During Admission:<br>3) Patient specific bespoke Self Harm Care Planning including: Co created Psychological formulation & Simple PBS plans<br>4) Embedding/ and reinforcing across MDT / morning handovers<br>5) Focus on patient responsibility and ownership<br>6) Acute Clinical Risk Forum – supports positive risk taking, and discharge planning (1d)<br>7) ASH project & MWRAP - evaluation complete and roll out plan developed<br><br>Discharge:<br>8) Acute SLT focus and follow-up on discharge planning to address any barriers to discharge. Attention to specific long stay patients for whom inpatient care is not helpful/ exacerbating self harm.<br><br>Trustwide:<br>- Trust wide self harm steering group (1d)<br>- High intensity user pathway<br>- Trust risk forum | Acute SDR - Driver Metrics<br>Incident reporting- identifying trends and themes per area. New BI dashboard to support data analysis.<br>Matrons daily huddle<br>Governance Huddle<br>Clinical risk forum minutes<br>Trust wide self harm steering group meeting records<br>Yearly environmental ligature audit | 4 | 4 | 16 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Clinical risk forums have been reimplemented. These can be requested by teams and chaired by the Chief Medical Officer. TOR to be agreed and approved. — Clinical Director for Acute — 31/03/2026 — A<br>Self harm data analysis on wards — Head of Nursing and Quality, Acute — 28/02/2026 *(Awaiting Confirmation of Action Completion)* — A<br>New Style Person Centred Care Planning roll out — Head of Allied Health Professionals, Acute — COMPLETED — G<br>Alternative to Self Harm Pilot Project review — Head of Allied Health Professionals, Acute — COMPLETED — G<br>Minimal Risk Activity Pack Pilot Project review — Head of Allied Health Professionals, Acute — COMPLETED — G<br>Enhanced Therapeutic Observations and Care (ETOC) - national pilot underway, safer staffing training in January 2026 and policy refresh. — Head of Nursing and Quality, Acute — 17/04/2026 — A<br>Clinical Handover Process Review — Corporate Head of Nursing & Quality — COMPLETED — G<br>CAPLET training for all inpatient staff working in female acute wards — Head of Nursing and Quality, Acute — 04/05/2026 — A<br>Develop and launch self-harm formulation tool for staff and patients — Strategic Lead for Allied Health Professions — 01/05/2026 — A<br>Develop information leaflets / resources for patients and families in relation to self-harm — Strategic Lead for Allied Health Professions — 27/07/2026 — A | Chief Nurse | Outside of Tolerance | 3 | 2 | 6 | 12/09/2026 |

| | | | | Initial rating | | | | Current rating | | | | | | Target rating | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | L | C | Rating | Controls Description | Top Five Assurances | L | C | Rating | Trend | Planned Actions and Milestones | Action owner | Risk Appetite | L | C | Rating | Target Date (end) |
| **1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |

| | | | | Initial rating | | | | Current rating | | | | | | Target rating | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | L | C | Rating | Controls Description | Top Five Assurances | L | C | Rating | Trend | Planned Actions and Milestones | Action owner | Risk Appetite | L | C | Rating | Target Date (end) |
| **2 - We are a great place to work and have engaged and capable staff living our values** | | | | | | | | | | | | | | | | | | | |
| **2.1 - Creating a culture where our people feel safe, equal and can thrive** | | | | | | | | | | | | | | | | | | | |
| 30/01/2025 → BAF Risk Opened | | | | | | | | | | | | | | | | | | | |
| ID 08337 | Jan 2025 | Chief People Officer | **Organisational Culture impact on Delivery of Strategic Ambitions**<br><br>If there is an inconsistent culture across the trust, with pockets of excellence alongside areas of closed and poor culture,<br>then phycological safety, openness and willingness to learn and improve are not consistently embedded.<br>Resulting in the potential for reduced staff engagement and retention, weakened speaking up, further inconsistent practice, increase incidents and complaints, and increase regulatory scrutiny impacting the delivery of safe, effective and equitable care and the Trust strategic ambitions. | 4 | 3 | 12 | Leadership and Management development programmes<br>Work to introduce and embed new and coherent organisational values<br>Delivery of leadership development programme<br>Delivery of equality, diversity and inclusion interventions<br>Delivery of 'Doing Well Together' and improvement capability building<br>Prioritisations and regular review of Strategic Priorities and capacity | Staff Survey results<br>Pulse Survey results | 3 | 3 | 9 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Delivery of Leading Well Together programme / Deputy Chief People Officer / 29/05/2026 / A<br>Delivery of Management Development Programme / Deputy Chief People Officer / COMPLETED / G<br>Roll out and embedding of New Organisational Values / Deputy Chief People Officer / COMPLETED / G<br>Embedding of staff voice initiatives / Deputy Chief People Officer / 30/06/2026 / A<br>ImprovingChange Management Processes / Deputy Chief People Officer / 31/03/2027 / A | Chief People Officer | In Appetite | 2 | 3 | 6 | 31/03/2027 |
| **2.2 - Building a sustainable workforce for the future** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **2.3 - Creating an empowered, capable and inclusive leadership team** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities** | | | | | | | | | | | | | | | | | | | |
| **3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **3.2 - Working together to deliver the right care in the right place at the right time** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **3.3 - Playing our role to address key issues impacting our communities** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **4 - We use technology, data and knowledge to transform patient care and our productivity** | | | | | | | | | | | | | | | | | | | |
| **4.1 - Have consistent, accurate and available data to inform decision making and manage issues** | | | | | | | | | | | | | | | | | | | |
| 22/07/2015 → Risk Opened → 15/08/2025 Risk escalated to BAF | | | | | | | | | | | | | | | | | | | |
| ID 04673 | Jul 2015 | Chief Finance and Resources Officer | **Organisational Risk - Cyber Attack**<br><br>IF the Trust is the victim of a successful cyber attack<br>THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation<br>RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation. | 4 | 5 | 20 | Omitted for security reasons | Omitted for security reasons | 3 | 5 | 15 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Omitted for security reasons | Chief Finance and Resources Officer | Outside of Tolerance | 2 | 3 | 6 | 29/03/2027 |
| **4.2 - Enhance our use of IT and digital systems to free up staff time** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **4.3 - Effective digital tools are in place to support joined-up, personalised care** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |

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

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

# Trust Board meeting

NHS
Kent and Medway
Mental Health
NHS Trust

## Meeting details

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|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Review of the 2023-2026 Strategy |
| **Author:** | Victoria Nystrom-Marshall; Head of Improvement<br>Sarah Atkinson, Deputy Director of Transformation & Partnerships |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer |

## Purpose of paper

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| **Purpose:** | For assurance and discussion |
| **Submission to Board:** | Standing order. Board requested and to support assurance on delivery of the current strategy and transition to the new five-year strategy. |

## Overview of paper

The Trust's 2023–26 Strategy concludes at the end of March 2026. This paper provides a review of delivery across the three-year strategy and highlights the key achievements, challenges and learning that have informed development of the new five-year strategy, presented separately for Board approval.

Despite continued operational pressure, the Trust has made meaningful progress across several strategic priorities.

## Issues to bring to the Board's attention

Over the course of the 2023–26 strategy, the Trust has made meaningful progress across several important areas. This includes reducing patient harm, improving dementia waiting times, strengthening leadership and improvement capability, developing the Equality, Diversity and Inclusion agenda, improving operational efficiency, co-creating a new organisational identity and values, and maintaining financial stability.

**Key areas of improvement include**:

- Reducing harm on inpatient wards, including a significant drop in self-harm incidents among female patients. Staff-led innovations have reduced self-harm on wards by 64%.
- Dementia services, where average waiting times for diagnosis reduced from 27.1 weeks to 13.2 weeks, with long waits reducing significantly from 260 to 19, contributing to the Kent

and Medway dementia diagnosis rate increasing to 62% the highest this has ever been in the county.

- Trust identity and values were successfully co-created and launched following over 730 hours of engagement with staff, patients, carers and partners, with work now focused on embedding this within the Trust's culture.
- Leadership and organisational capability have been strengthened through leadership development activity, delivery of cultural competency and the continued growth in improvement capability through White Belt, Yellow Belt and IMS training.
- Co-creation strategic plan has been co-produced, the co-creation framework in place, and community involvement coordinators are working with communities that experience health inequalities.
- Operational efficiencies include reductions in DNA rates, unoutcomed appointments and standardisation of the Standard Operating Procedure (SOPs) and governance process.
- Crisis response services have seen over 90% of patients consistently within 4hrs in last 6 months, compared with below 80% in September 2024.
- Maintaining financial sustainability was a central part of our plans, ensuring we used resources responsibly while protecting service quality. By focusing on efficiency, working with system partners, and reducing avoidable cost we maintained financial stability.

**Key areas for continued focus**:

- Mental Health Together: This year we made good progress, like shortening waiting lists by 12.3% (Mar25 to Jan26) and shaping a clearer clinical model that will carry on into the next strategy. But we also know we still aren't getting some of the basics right yet, especially things like our digital systems. As we move forward, we will keep working hard to improve access times across the whole service so people get the help they need sooner.
- Self-harm: We will continue to build on the early improvements we've made in reducing self-harm on our inpatient wards and also extend this work to reduce harm in our communities too, so everyone can feel safer and better supported.
- Quality Plan: the lifting of the CQC S29A enforcement notice for community services is a positive milestone but not the end of our journey. Governance and leadership have been reinforced and the Quality Plan continued to remain a key trust project in delivery of the new strategy.
- Clinically Ready for Discharge (CRfD) / Bed Occupancy: despite actual CRfD patients remaining below projected trajectories, bed pressures continue and partner capacity constraints may continue to affect discharge pathways, patient flow and wider operational delivery. This will be a key focus for us in our new strategy.

**Learning for the new strategy**

While progress has been made in a number of areas, delivery has not been consistent across all priorities, and this has informed a more focused and disciplined approach in the new strategy.

Version Control: 01

Learning has reinforced the importance of:

- clearer and fewer priorities, supported by measurable outcomes
- embedding improvement methodology across services (doing well together improvement approach)
- stronger data quality and the need for insight with the ability to triangulate data and insight moving forward
- robust governance and oversight of delivery with clear accountability
- continued investment in leadership capability
- continued work to provide a consistent organisational culture
- clear, accessible communication and engagement to support delivery and ownership of the strategy.

The new five-year strategy builds on the foundations established over the last three years, while responding to the risks, opportunities and learning identified through delivery. It provides a clearer framework for improvement through defined priorities, outcome measures and delivery initiatives, and reflects extensive engagement with stakeholders across the Trust and wider system.

**The Board is asked to:**

- **Take reasonable assurance** on delivery against the 2023-26 strategy
- **Consider the key learning** from implementation and how this has informed the development of the new five-year strategy (which follows this paper on today's agenda)

**Provide feedback** on any areas where further focus or learning is required as we transition into the new strategy period

## Governance

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| **Implications/Impact:** | Trust Strategy 2023-2026 |
| **Assurance:** | Reasonable |
| **Oversight:** | Trust Strategy Deployment Review, including Board and Board Sub-Committees. |

Version Control: 01

## Strategy Journey

The 2023–26 Trust Strategy set out an ambitious programme of delivery against 73 strategic outcomes, reflecting the breadth and complexity of improvement required across the organisation. These outcomes were captured within three strategic ambitions: deliver person-centred care that is safe, high quality and easy to access; be a great place to work and have engaged and capable staff living our values; and leading in partnership to address health inequalities and improve the quality of life for our communities and within three strategic enablers.

As the strategy matured, these outcomes were intentionally reviewed to ensure that improvement efforts were targeted on initiatives that would have the greatest impact for patients, staff, and partners. There has been a focus on supporting improvement initiatives with leadership development and visible, regular systems of review. This initially involved establishing six priorities when Sheila Stenson became Chief Executive Officer in November 2023.

In 2025, the Board agreed to prioritise delivery around six strategic priorities: timely access, equitable access, staff engagement, reducing the number of patients clinically ready for discharge, reducing inpatient harms, and increasing contact time. These aligned with our vision of creating communities where mental health helps transform living into living well, where services are there at the right time for happier, more meaningful lives.

In 2025, the Trust introduced the Doing Well Together improvement programme, establishing a single improvement approach to build capability across the organisation and strengthen the connection between strategy and frontline delivery. It also introduced the co-creation plan to support triangulation of feedback from staff, patients, and the people who care for them.

Finally, the Trust has built growing momentum in strengthening data quality, improving access to reporting, and using insight more effectively to drive improvement the next stage for the trust now is using this data to turn it into intelligence and insight to support decision making.

We have made real progress and can show clear examples of improvement, however there is more work to be done as we continue our improvement journey. Through this strategy we have made progress putting in place the systems and foundations required to keep listening, learning, and working together to improve care and confidence.

## Overview of progress made across 2023-26

### Patients and Safety

**We've made our wards safer and kinder for the people we care for.**
Our teams worked together to reduce harm, especially self harm among women on our wards. One of our Occupational Therapists created special minimal risk activity packs to help people feel calmer and more in control, and these were funded through our Innovation Den. Staff also had extra training, and patients and carers were given clearer information. Frontline teams used improvement tools to understand what needed to change. Because of all this joined up work, incidents of self harm for female patients dropped from 205 in October 2024 to 76 in November 2025, which is a 62.9% reduction. The latest figure is 89 in January 2026, still far lower than before.

**People waiting for a dementia diagnosis are now getting answers much sooner.**
The average wait has dropped from 27.1 weeks to 13.2 weeks, which means people are being

diagnosed more than two months faster than the national average. The number of people waiting over a year has dropped sharply from 260 to just 19. These improvements have helped increase the dementia diagnosis rate in Kent and Medway to 62% the highest it has ever been, giving more families clarity and support when they need it most.

**We've increased autism awareness across our wards.**
In Year 1, 90% of staff completed Part 1 of their autism training, helping teams understand and support autistic people with more confidence and kindness.

**People in crisis are getting help more quickly.**
Over the last six months, more than 90% of people have been seen within four hours which is much better than the below 80% we were seeing in September 2024.

**Our liaison psychiatry teams are helping emergency patients faster.**
The number of people seen within one hour has jumped from 3 in every 10 people to nearly 9 in every 10, meaning help arrives quickly when it's needed most.

**We introduced our Quality Plan.**
We introduced and moved forward on four big themes: Safety, Access and Waiting Times, Environment and Experience, and Leadership and Culture. Our CQC Section 29A enforcement notice for community services has been lifted, and we'll keep building on this progress in the new strategy.

**We are tackling unfair differences in health outcomes.**
We have made progress delivering the Patient and Carer Race Equity Framework (PCREF) and supporting people with other protected characteristics. Our Board and senior leaders completed cultural competence and self-assessment training, and we introduced protected characteristics training that we are evaluating with system partners. The live Patient Ethnicity Diversity and Inclusion Report on PowerBI providing insight into the patients that we are caring for and working groups have been established to focus on identified variations. We set up the Equity for All group to give us clearer oversight, improved how we record inequality information through RiO "About Me," and made our services easier to use with the countywide rollout of Recite Me. Our Interact study also helped shape our new five-year strategy.

But we know there is more to do. We need to move faster on improving data quality and assurance, and we must show stronger progress on race equity outcomes, especially because people with severe mental illness still face a serious 15–20 year life-expectancy gap.

**We're improving how we understand patient outcomes.**
As part of our community transformation work, Dialogue+ has been rolled out across our community teams so staff and patients can explore their care and recovery together in a more meaningful way. We will continue to build on this as part of our new strategy and use this tool as a supporting measure to assess patients' experiences and outcomes throughout their journey.

**We have remained financially disciplined and debt-free:** We consistently balance our books while supporting the system's deficit reduction programme, hitting national productivity targets, and targeting savings where they do not compromise safe care. We are leading on the system 'financial recovery' pillar in its new transformation plan, and have committed to a cost improvement plan (CIP) above national benchmark at 4.5%, demonstrating our strong financial grip & leadership.

**We opened Ruby Ward.**
The build, handover and opening of Ruby Ward was completed early in the strategy, giving patients a safer, modern, and more therapeutic space for our older adult's patients.

Version Control: 01

## People (Our Staff, Workforce and Culture)

**We strengthened our identity and culture as a Trust.**
We launched our new, cocreated identity, name, and values on 13 October. Since then, we've been supporting staff to use a clearer, kinder tone of voice and improving how we share more accessible and inclusive information with staff, patients, and carers so everyone has a smoother experience. Our recent CQC well-led inspection said they could see the work we had put into our values and behaviours as an organisation. This recognition for us is important as we continue our improvement journey and continue to focus on kind, inclusive and accessible communication.

**Representation and inclusion have increased**

The percentage of Global Majority staff in roles at Band 7 and above increased to 31.1%. As part of our EDI 5 year plan, cultural competency training has been provided to 259 leaders and allyship training has been rolled out across the organisation. Oliver McGowan training has exceeded our targets. We have also created an EDI dashboard for internal use.

**We improved staff support**

To support staff to raise concerns we have trained mediators and introduced the early reconciliation process in Year 1. Our Chief Executive Officer hosts a monthly engagement session with staff. We have also completed a full trial of the Staff Council in Forensics for delivery across the Trust in the new strategy. Staff report feeling safer to raise their concerns.

**We are actively engaging, listening and learning from our patients, the people who care for them, and our communities.**
The Engagement and Involvement Team was established. A new co-creation strategic plan and framework have been developed. Community Involvement Co-ordinator roles have also been created to strengthen community engagement and build trusted relationships with people and communities who do not currently use our services to ensure we can tackle health inequalities together.

**We strengthened our research community and are trailing new equipment to improve services**

We grew our research community by bringing in more people to help us learn, including staff, patients, carers, and local communities. We are testing a new portable, low-field MRI scanner with Canterbury Christ Church University, which uses AI technology to make it easier and quicker to check for dementia without travelling to hospital. At the same time, we have worked closely with people from Kent's underserved communities to understand what helped them, and what made it harder, to take part in mental health research. To support this, we created simple resources and training about how research works and the different ways people could get involved. We also co-produced posters, podcasts and other materials so findings were shared in easy-to-understand ways, and we set up groups so people with real lived experience can guide and shape future research.

**We built improvement skills across the Trust**
The Doing Well Together Improvement Programme continues to grow across the Trust, with good involvement from frontline teams taking part in IMS training. Wave 2 of the training has now finished in Canterbury, and Wave 3 will begin in May. This will focus on inpatient wards in Priority House, as well as West Kent Crisis Response and Home Treatment teams. As a result,

teams are starting to build a culture of continuous improvement and are making practical changes in their own areas. For example:

- Bluebell Ward is improving the process for staff who move to work on other wards, to support better staff experience.
- Tarentfort has improved how patients' property is stored.
- Allington has improved its medication round process.

Alongside IMS training, 162 staff completed Yellow Belt training this year and 415 staff attended White Belt or awareness training. New strategy governance has also been introduced. Directorate Strategy Deployment Reviews began in September 2025, and Trust-wide reviews started in December 2025. These processes are continuing to become part of everyday practice.

**We improved workforce consistency**

Our vacancy gap remains at 10.4% but is well below the 14% target and our agency spend is at 1.3% below the 3.2% target. Staff sickness is currently higher than we want it to be at 5.1% higher than our 3.5% target. We deployed our Talent and Succession Planning Toolkit to provide consistency.

## Partners

**We strengthened our partnerships working**

Strong partnerships were formed with Porchlight, Shaw Trust and Invicta Health to deliver Mental Health Together (MHT), where we are lead provider. This was rolled out in Year 2 and has been refined in Year 3. The MHT waiting list was reduced by 12.3% between Mar25 and 9Jan26. 77% are waiting under 18 weeks and 23.4% within 4 weeks.

We also continue to work with collaborative partners for example developing the perinatal business case and care home / community-based dementia diagnostic models.

We will continue to build other key relationships in the development of Integrated Neighbourhood Health teams, and also in support of helping people to live well and stay well.

**We supported the flow of patients through the system to the best place for their care.**

Improving bed occupancy and supporting patients who are clinically ready for discharge (CRfD) to transition safely has been a focus of the strategy. The High Intensity User Project reported a 35% reduction in referrals and a 34% reduction in admissions, the Red to Green visual management system helps to reduce inefficiencies in a patient's journey, we worked with partners to develop the case for a centralised Health Based Places of Safety at Maidstone (currently being converted) and develop Crisis Houses, we are working with Kent County Council to progress Care Act Trusted Assessors and have commissioned short term beds to support our capacity. Despite these efforts, bed occupancy has not reduced to the target we set ourselves in year 3 but significant progress has been made. The new strategy will focus on bed occupancy and supporting people in the community to prevent unnecessary admissions to our services, as well as our acute colleagues' emergency departments.

Version Control: 01

## Sustainability

### Reducing Inefficiencies

Operational efficiencies include reductions in ‘did not attend’ rates, unoutcomed appointments and the standardisation of the Standard Operating Procedure (SOPs) and governance process.

### Increasing contact time with clinicians

A substantial amount of work has now been completed to establish a robust baseline and clearly define expectations. The breakthrough objective is in the early stages of maturity, with positive groundwork in place, and plans in place to deliver evidence of improvement within the new strategy.

### Increasing Social Value

We partnered with South Eastern Railway to deliver innovative staff forums; we worked with Redrow Homes to develop a unique therapeutic environment for our occupational therapist and other professions to deliver an alternative to ward based delivery. Our corporate volunteering programme has meant we were the leading mental health trust for volunteering and the best of all Kent providers.

## Responding to New Opportunities

### We successfully shifted course mid-strategy to become the lead provider for Children and Adolescent Mental Health Services and All-Age Eating Disorder Services

Children and Young People’s Mental Health Service and All-Age Eating Disorder Service transfer remains on track and demonstrates good governance, strong clinical engagement and positive partnership working. The focus moving forward is integration, leadership capacity and embedding the all-age model of care. This will make it easier for young people to get the right support and ensure that we improve the pathway for those people moving through child to adult services.

## Ongoing challenges

Although we are proud of the progress made, some barriers still make it harder to embed improvement across all programmes.

### Culture

Culture is the biggest barrier - we have pockets of excellence and then areas where we know we have inconsistent and unhappy staff, therefore impacting on the services we provide. We recognise this is one of our biggest risks for our continued improvement and it is imperative that we continue to work closely with staff in those teams where experience is the lowest to improve and close the gap. Staff experience is a key ambition of our new strategy, and we will also have a trust initiative on cultural transformation so that we can continue to focus on bringing a consistent culture across the trust. Continuing our efforts to share successes and be more proud of the great work we do will be an ongoing focus.

### Partner Capacity Constraints

Some of the pressure we are feeling in our services is because we are operating in a capacity constrained system. This means that patients who are ready to move on from our care sometimes have to wait longer than planned, which then puts extra pressure on our wards and

teams. Even though these challenges are real, we are working positively and proactively with our partners to find better ways forward.

**Data Quality and Availability**
The Trust has strengthened how it collects, accesses and uses data, although some challenges with data quality remain. For example, within the dementia programme, diagnoses are not always recorded consistently, which means the data does not always provide a fully reliable picture. Recording of ethnicity and other protected characteristics also varies across services, making it more difficult to understand and respond to health inequalities in a clear and consistent way.

**Digital maturity and operational and administrative capabilities**
Digital is still a big challenge for how we work day to day, as are our processes and administrative ways of working. We have lots of different systems that don't always link together, which means staff often have to repeat the same information in several places. This takes time away from patient care and makes our processes slower than they should be. We also know that some of our digital tools are old or not user-friendly, which can make it harder for people to do their jobs well. We need to keep improving these systems so staff can spend more time helping people and less time dealing with paperwork.

## Progress Against Year Three

Throughout this strategy we have regularly provided an update to trust board on the progress against the priorities. The year three progress is contained in appendix 1.

## What we will take forward in the next strategy

Our exciting new strategy will carry forward priority work focused on equitable access, cultural transformation, quality and safety, flow, prevention and neighbourhood working, while ensuring that sustained improvements are embedded and monitored through strengthened governance arrangements. Work transitioning to the new strategy includes:

- Ethnicity recording and health inequalities improvement will continue through the Patient and Carer Race Equity Framework, supported by targeted action in lower-performing teams and the launch of the Global Majority Hub.
- Subject to final approval, we are planning for Children and Adolescent Mental Health Services / All Age Eating Disorder Services to transition safely into our trust on the 1st April. We will continue overseeing the transition as a Key Project within the new Strategy, with a focus on digital migration, partnership working with NELFT, and improving transitions to realise the benefits of an all-age model. We are excited about expanding to an all-aged mental health service provider and working together to provide communities with more joined-up pathways and experiences.
- Engagement and involvement, Doing Well Together, continuing our identity journey and staff development will be taken forward through the Cultural Transformation Trust Initiative.
- Clinically Ready for Discharge improvement work will transition into the new Strategy through a Trust priority and a Breakthrough Objective.
- Community Mental Health Framework work will continue as our true north access to ensure the refined model of care is embedded and enabling us to see people at the right time.

Version Control: 01

- Reducing female inpatient self-harm will continue as a breakthrough objective, building on the improvement work already underway. We shall also use this learning to improve safety in our community services.
- The Quality Plan will continue as a Key Project.
- Consultant and psychologist clinical contact improvement work will continue as a breakthrough objective, building on the baseline, benchmarking and early groundwork already completed.
- Getting the Basics Right will move toward formal closure, but key elements including admin improvement and Did Not Attend (DNA)/cancellations work will be taken forward through the Mental Health Together breakthrough and the operational and administration model reset project. The new strategy provides a clear route for this work to transition with stronger alignment, clearer ownership and more consistent oversight.

## Learning from delivery of this strategy

The organisation continues its improvement journey. The current strategy recognised that previously specific, measurable outcomes had not been identified and therefore more difficult to demonstrate delivery and impact. Throughout the last 3 years there have been several learnings from both the development and delivery of the current strategy that will be taken forward in the new strategy and as we begin to mobilise the new strategic programmes and plans that support delivery.

### Engagement

Ongoing engagement with patients, carers, staff and wider communities is critical to the success of the strategy. It ensures that people feel listened to and that organisational data is considered alongside the real experiences of those who use, deliver and support our services. Engaging early and continuing that involvement throughout planning, delivery and evaluation will strengthen the quality of our programmes, support trust and transparency, help secure meaningful participation over time and ultimately build confidence.

### Too many priorities

We learned early in the 2023–2026 strategy that we had too many outcomes, which made it hard to know what to focus on and impossible to deliver everything well. Over the last three years, the new strategy planning framework has been developed through the Doing Well Together programme, which is data driven. This has helped us choose what matters most. Using this framework for our new strategy means we can set clear long-term ambitions, decide on our “True Norths,” and choose the most important breakthrough goals every 1–2 years. This keeps our work focused, flexible, and ready to respond to the changing needs of healthcare.

### Structure and methodology

When we have used our Doing Well Together approach, we have seen some of our strongest improvements, for example dementia waits, fewer incidents of violence and aggression, and fewer harms. Some programmes were already well underway before this method was introduced, which made it harder to add the approach later without slowing progress. Our new strategy gives us the chance to build improvement methodology in from the start. This will help us understand our current position, use data to choose the right actions, and check that these actions lead to real change. Strong governance will also give us clearer oversight of each programme, including the risks and links between them.

### Data

Version Control: 01

Data remains an important part of delivering our strategy and continuing to mature our data quality as well as our use and understanding of data to ensure the successful delivery of our new strategy. We now need to build on using the data we have, to turn this into intelligence and insight for us to make stronger decisions.

## Conclusion

We can see real, measurable progress across many of our priorities in the 2023-26 Strategy. This year showed stronger use of data, better governance, and growing confidence in our Doing Well Together approach. Even with day-to-day pressures, teams have delivered important improvements. The challenges we've seen, especially around data quality, staff engagement, and system pressures have set to remind us why a clear, focused approach matters.

The learning from the last three years has shaped our new strategy, helping us set clearer priorities, strengthen engagement, and apply improvement methods from the start. We now move into the next phase with a stronger foundation, clearer governance structures, and a renewed commitment to improving care for our patients, our people, and our partners.

Version Control: 01

## Appendix 1

The following table provides an overview of progress against each of the strategic priorities and the plans to transition the programmes of work going forward.

| Theme | Obj Typ | Outcome/ Driver Measure | Exec Spon | Status | Comment | Aligned Watch Metrics | Transition 2026/27 |
|---|---|---|---|---|---|---|---|
| **Patient** - We provide equitable, timely access for all | TN | 85% of community patients' (CMHF/MAS) needs met within timeframes | Donna Hayward – Sussex | Off Track | Rapid response (urgent / Crisis) response rates remain consistently over 85% seen within 4hrs.<br>Of the 5,918 waiting 82% are waiting under 18 weeks | • See 85% urgent referral in 24hrs<br>• See 85% of routine referrals within 4 weeks | MHT/ MHT+ access times will remain a True North ambition |
| | TN | Equitable access: less than 1% variation in waiting times (CMHF/MAS) between most deprived and least deprived | Adrian Richardson | Off Track | Currently sits at 1.6% (December 2025) and is monitored through Trust SDR and reviewed as part of the Equity For All Steering Group. The data has been used to drive focussed work in some existing programmes and will be embedded in future programmes. | • Improve social mobility and inequality through our commitment to deliver 14 levelling up goals | Metric will be addressed with the Equity for All Steering Group and is embedded in the new programmes of work charters to ensure variance against protected characteristics and deprivation is considered and monitored in the future programmes of work. |
| | BO | 95% of Dementia diagnosis within 6 weeks | Adrian Richardson | On Track | Phase 1 of a standardised model has been completed and embedded across all MAS services.<br><br>Focused continued improvement work on those who have been waiting over 52weeks has been number reduced from 260 to 19 (26/2/26); a reduction of 92.3%.<br><br>The impact on waiting times has been a reduction in overall waiting time from 189.9days in July 24 to 92.4 days (26/2/25), a 51.3% reduction.<br><br>Challenges remain around medical engagement and variation in clinical practise which could impact the sustainability of improvements so far. However, plans are in place to ensure suitable controls are in place before stepping the programme down. | | Plan to transition to BAU from June 2026 |

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| | | | | | Success criteria are being developed to enable to the programme to transition to BAU and a transition plan is being developed | | |
| | BO | 90% of community (CMHF/MAS) referrals have ethnicity recorded | Adrian Richardson | On Track | Current performance is 86.1%, the highest performance since October '24 and up from a low of 83.6% in Oct '25.<br>The patient portal as well as the new 'About Me' initiative well help to make the recording of ethnicity easier | | Metric will remain a watch metric and will be monitored through directorate SDQR's |
| | TI | Children and Adolescent Mental Health Services and All Aged Eating Disorders | Donna Hayward-Sussex | On Track | Services are on track to transition to KMMH on 1st April 2026.<br>Work will then focus on supporting the directorate to embed into the organisation and identify opportunities for service development. Success measures for this work will also be identified. | • Routine performance metric monitoring as part of SDRs | CYPAAEDS will become a key project in the 2026 strategy overseeing post transition |
| | KP | Patient Engagement & Involvement | Kindra Hyttner | Complete | Following the approval of the Co-Creation framework in July '25 and the mobilisation of the Patient engagement and Involvement team, work continues to mobilise the framework.<br>This work will now transition to BAU, however, there will be focused breakthrough objectives looking at patient experience in the new strategy | • 90% of transformation projects have service user involvement<br>• Increase service user and public participation in local led research by 10% | Transition to BAU |
| | KP | Trust Identity | Kindra Hyttner | Complete | On 13 October 2025 we legally became Kent and Medway Mental Health NHS Trust and launched our new identity. We prioritised updating critical, high-profile touchpoints first, continuing till March 2026. As we close the project and transition into business as usual, we begin the long-term embedding of our new identity over the next 12-18 months. This will include:<br>Aligning the organisation to our new mission, vision, and values through our new organisational strategy<br>Increasing our proactive media reach to improve our reputation and balance the narrative surrounding our position and brand<br>Responding to the quality plan and improving our patient information offer so it is accessible and easy to understand<br>Improving our physical experience, rebranding key estates, and updating information in wards and community settings<br>A sustained period of staff engagement supported by updated materials, templates, and training on voice, tone, style and accessibility. | | Closes as a key project.<br>Individual workstreams will form parts of the cultural change trust initiative and the patient experience breakthrough objective. |

Version Control: 01

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| | | | | Improving our digital communications experience so that it is accessible | | |
| **People -** We support and empower our staff | TN | Staff Engagement score from 6.9 to 7.1 | Sandra Goatley | Off Track | Engagement Score is 6.7 in 2025 staff survey, up from 6.6 in 2024<br><br>This year the Staff Council was trialled in Forensics with positive feedback<br>We have listened to feedback on the process around staff consultations and have made improvements to ensure better engagement with staff prior to consultations.<br>In the coming year work will continue to rollout Staff Voice, capture monthly data in mandatory training, talent and succession planning, relaunch staff networks and develop and launch customer care model | • Increase raising concerns sub score from 6.6 to 6.9<br>• Increase our burnout sub score from 5.2 to 5.5<br>• Reduce vacancy rate to 14%<br>• Reduce agency spend to 3.7% of pay bill | Remains a True North ambition for Staff Experience |
| | BO | Staff feel able to make improvements in their workplace | Sandra Goatley | Off Track | Able to make improvement score is 6.9 in the 2025 staff survey: down from 7.1 in 2024<br>DWT frontline training continues to roll out and is now embedding in 8 wards with plans to roll out further in 2026./27 | | Closes as a breakthrough objective however, metric will be monitored through the DWT improvement programme |
| | TI | Leadership Development & Culture | Sandra Goatley | On Track | LWT modules 1-3 has been delivered within the Trust to TLT (90%), looking now at how we morph that product into something for middle management. 60% of B7 above have attended leadership training | • 90% of B7+ leaders have attended leadership training<br>• Reduce the number of minority ethnic staff involved in conduct and capability to 0% variance<br>• Our staff feel KMPT is supportive and compassionate employer<br>• 95% supervision & appraisal rate<br>• Increase minority ethnic staff B7+ | Forms part of the new cultural transformation trust initiative with a revision of success measures. |

Version Control: 01

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| | | | | | | • Increase staff satisfaction with their line managers | |
| | TI | Doing Well Together Improvement Programme | Adrian Richardson | On Track | The Doing Well Together (DWT) Improvement programme continues to roll out across the organisation under 5 pillars of delivery:<br>Strategy Deployment – all directorate leadership teams have undergone DWT training. A few formats of directorate QPR;s, known as SDR's was launched in September '25 and was refined in February '26. We continue to embed improvement behaviours into directorate performance management.<br>IMS – the first wave of training was completed in Sept '25 and 2 wards have graduated. The second wave has completed formal training and is now in the coaching phase and the third wave, which will be in WK, is being scoped, with training starting in May.<br>Capability Building - 162 staff members have undertaken yellowbelt training this year and 415 have attended whitebelt/ awareness training<br>Improvement Projects – the improvement team has supported the delivery of all breakthrough objectives and is supporting the mobilisation of the new strategy, ensuring that A3 thinking is used to develop all new programmes.<br>A new approach to rapid Improvement will also launch in summer 2026, enabling faster methods of process improvement, engaging stakeholders over an intensive improvement workshop | • Have leaner more efficient processes<br>• Overhaul organisational governance<br>• Devise new model for transformation | Programme has established governance and will report in as part of the cultural change programme of work within the new strategy. |
| **Partners -** We create healthier communities together | TN | Reduce clinically ready for discharge (CRfD) length of stay (LoS) by 25% | Afifa Qazi | Off Track | The number of patients who are clinically ready for discharge (CRfD) has remained high although there is significant variation throughout the year due to seasonal patterns/ changes.<br>Housing remains the largest contributor to CRfD, however, challenges remain in engaging system partners in improvements<br>A number of initiatives to embed operational processes are on-going to optimise internal processes. This included reg to Green, EDD's and Purposeful admission protocols<br>Bed Occupancy is currently 97.8% and has remained steady at 96-97% throughout the year. | • Reduce the LoS for patients waiting onward transfer<br>• Decrease bed occupancy to 85% | Patient Flow will remain a priority in the new strategy |
| | BO | Eliminate all CRfD over 100 days | Afifa Qazi | Off Track | There are currently 73 patients, who are CRfD, 25 of whom have been CRfD over 100days. | • Eliminate all specialist out of area beds | Patient Flow will remain a priority in the new stratgey |

Version Control: 01

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| | | | | | Despite the use of Clarendon beds to provide some capacity pressure on beds has remained high. | • Reduce OOA PICU beds | |
| | TI | Community Mental Health Framework (CMHF) | Donna Hayward-Sussex | Off Track | Refined model agreed with partners.<br>Demand and capacity completed.<br>Focussed implementation and continuous improvement planned.<br>Compare future and current staffing requirements with co-developed workforce plan Q1 which will include training requirements.<br>Developed specifications based on operational delivery model and agree 26/27 contract approach with partners Q4. | • Increase the number of patients accessing care in MHT<br>• 85% of people with SMI presenting to MHT have a physical health check<br>• 85% of people with learning disabilities are referred for a physical health check | Plans to transition to BAU are being formed for Q2/Q3 |
| **Safety** - We work with our community to provide safe and harm free care | TN | Reduce the number of patient harms by 10% | Julie Kirby | On Track | There has been a reduction in the number of incidences of harm being reported across the trust, from 269 incidences reported in October '24 to 112 in January' 26. The lowest number recorded was 105 in November '25, which is a 64% reduction.<br>Although, we have seen a shift in performance in recent months, further work is needed to ensure we sustain these improvements as there can be variation month to month.<br>There has also been a reduction in the number of incidences of V&A across the directorates | • Decrease V&A on our wards by 15%<br>• Fulfil our role to deliver joint initiatives to reduce suicide and self-harm | Reduction in Harm to remain a True North in the new strategy |
| | BO | Reduce self-harm in female acute in-patients by 10% | Julie Kirby | On Track | • Pilots for ASH and MRAP interventions have concluded and are now being rolled out across other wards.<br>• Survey designed and undertaken to understand lived experience of self-harm perspective on how mental health input around self-harm.<br>• Developed a menu of trainings that staff could engage with to support them when working with individuals who self-harm.<br>• Developed trust wide Principles of Care – Supporting people who self-harm which has been shared across the organisation.<br>• Working with the research team in relation to (1) replicating the staff survey with Emergency Department staff at MTW and paramedics at SEACAMB and (2) placing a bid to | | Continues as a breakthrough objective in the new strategy with the additional of a community metric |

Version Control: 01

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| | | | | explore the qualitative differences between harmful stimming and self-harm<br>• A3 groups carried out by improvement team on East Kent female wards and focus group carried out with staff on West Kent female ward. An additional group is planned to take place on the North Kent female ward.<br>• Self-harm data has been incorporated into tiered accountability huddles in acute.<br>• Formulation prompt tool for staff and patients has been developed and is with comms currently.<br>• My Senses and Strategies tool developed by occupational therapy and being trialled across acute and forensic wards (registered as a service evaluation)<br>• Development of information leaflets for patients and their families, friends and carers in relation to understanding what self-harm is, what some of the drivers for it may be, what coping strategies could be explored and what community or mental health resources can be accessed, is underway. | | |
| **Sustainable care - We** invest wisely in our resources to improve our services | TN | Attendee contact time per week per FTE | Nick Brown | On Track | The trust will move to a new productivity metric which is focused on relative change in activity vs costs. (% change in cost-weighted outputs minus % change in real-terms inputs) based on recent guidance from NHS England.<br>Contributing areas to improved productivity include:<br>- Use of out of area beds which is supported through the delivery of the Patient Flow programme<br>- Agency Spend specifically related to medical agency which is being addressed through targeted recruitment campaigns<br>- Job panning/ clinical contact time – this is the focus of the breakthrough objective with workshops taking place in March to rationalise the activity data and seek medical engagement in identifying top contributors and opportunities for improvement. | • Reduction in time spent capturing and revalidating data by 25%<br>• Reduce unwarranted variation in services<br>• Forecast mental health capacity and demand | This metric will become a watch metric with the True North changing to the NHSE productivity measure with a target of 2% increase in overall productivity |
| | BO | Number of consultant and psychologist clinical contacts | | On Track | | | This will remain a breakthrough objective with refinement to the measure itself |
| | TI | Getting the Basics Right | Donna Hayward-Sussex | On Track | There are a number of workstreams contributing to the optimisation of administrative processes in the trust:<br>• Un-outcomed appointments - improvements have focused on improving data quality and the recording of outcomes. Between April '22 – Mar '25 there were c. 8300 unoutcomed appointments. This has now reduced by over 60% (to slightly under 3,000). There also continues to be more of a reduction in the monthly figures. | | GTBR will close as trust initiative but workstreams will continue within the Operational Reset Key project.<br>Trust cancellations will become a breakthrough objective |

Version Control: 01

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| | | | | | • Reducing Trust Cancellations – improvements in NK directorate have reduced trust cancelled appointments from an average of 11.8% per month to 10%. Target is 7%<br>• Standardisation of Standard Operating Procedure (SOPs) and governance process<br>• Admin Improvement - Value stream mapping complete – purpose of mapping is to review admin functions and processes. Over 100+ admin individual teams were shadowed across the trust, resulting in over 160+ of shadowing time. | | |

Version Control: 01

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

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| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Five-year trust strategy 2026-2031 |
| **Author:** | Kindra Hyttner, Director of Strategy and Engagement |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer<br>Kindra Hyttner, Director of Strategy and Engagement |

## Purpose of paper

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| **Purpose:** | Approval |
| **Submission to Board:** | Regulatory requirement and Board requested. |

## Overview of paper

The Trust's current strategy (2023-2026) concludes in March. A separate paper, on the Board's agenda today, summarises delivery against this strategy and learnings from its implementation.

This paper presents the Trust's proposed, new five-year strategy and one pager, alongside the engagement findings that have informed its refinement, the proposed delivery framework for year one, and a summary of the digital improvement plan.

The Board is asked to:

1. **Approve** the Trust's five-year organisational strategy, setting the strategic direction for the next five years.
2. **Take assurance** from the engagement and insight that has shaped the draft strategy.
3. **Take assurance** from the proposed strategy deployment framework, including the True North five-year strategic measures, draft year one breakthrough objectives, strategic initiatives and trust projects, and governance arrangements.
4. **Provide feedback** on any areas of strategic risk, ambition or focus ahead of final publication and implementation planning.
5. **Take assurance** from the digital improvement plan summary outlining the initiatives and expected outcomes aligned to the strategic priorities.

Version 2 - **Public**

## Issues to bring to the Board's attention

The strategy sets out a clear and focused direction for the Trust, grounded in two years of organisational learning, insight and engagement with staff, patients, partners and communities. It reflects a deliberate shift from broad ambition to disciplined delivery, with a strong emphasis on outcomes, accountability and measurable impact. This approach is designed to provide greater clarity, transparency and grip on delivery, and to support continued improvement.

**Strategy development process**

- The strategy reflects a **two-year journey of organisational learning, insight gathering and engagement** with staff, patients, partners and communities.
- During this time, the Trust has **strengthened how it develops and delivers strategy**, drawing on operational data, patient experience insight and ongoing conversations with stakeholders to maintain focus on what will deliver meaningful change.
- Last year, at our December Board development day we agreed **five areas of strategic focus for the new strategy** – these were tested and further refined by internal and external feedback.

**Foundations of the new strategy**

- The **new co-created organisational identity** and **Doing Well Together improvement approach**, underpin the strategy and guide how we will deliver improvement.
- Alongside the strategy, the Trust is continuing its development journey to **strengthen quality oversight, structures and corporate governance**, reflecting recent organisational learning and feedback from external reviews.

**Strategic focus**

- The strategy provides a clear mandate for **improving access, quality and safety, and experiences for all,** and recognises that helping our communities to live well cannot be achieved alone but will require continued partnerships and working differently together.
- The five priorities have been **tested and refined through further recent engagement**, providing confidence that they reflect the issues that matter most to staff, patients and partners and inform the focus for year one delivery.

**Delivery and oversight**

- Delivery will be driven through defined outcome measures, year one breakthrough objectives, trust initiatives and key trust projects and supported through the **Doing Well Together** improvement approach**.**
- Oversight will be strengthened through alignment with the Trust's **governance and performance framework**, including integration with the Board Assurance Framework (BAF), ensuring that strategic priorities and organisational risks are consistently tracked, managed and reported.
- Over the next three months **a focused programme of work will translate the strategy into delivery plans** at all levels of the organisation. This will include the development of detailed delivery plans, targeted engagement and communication activity to build

awareness and understanding, and the use of the Doing Well Together approach to enable teams to embed the strategy into day-to-day practice.

- The strategy will inform the development of a **clinical plan**, that will be co-developed as a key project. Emerging areas of focus will come to the May Public Board, with an aim to develop the plan and present to the Board in September for approval.
- Following the development and launch of the clinical plan, a **workforce plan** will be developed.
- The strategy is a key mechanism for strengthening the **Trust's Well-Led position**, by improving alignment between strategy, risk, performance and governance, and embedding clearer accountability for delivery across the organisation.

## Governance

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| **Implications/Impact:** | Approval of the strategy will set the strategic direction for the Trust over the next five years and shape organisational priorities, resource deployment and improvement activity; and provide a clear framework for delivery, risk management and performance oversight. |
| **Assurance:** | The strategy has been developed through iterative engagement and triangulation of operational data, patient, staff and partner insight, and external feedback. It has been subject to review and challenge through the Executive Management Team and Board discussions, providing confidence in both the strategic direction and its deliverability. |
| **Oversight:** | Delivery of the strategy will be overseen through the Trust's governance and performance framework, with clear alignment to the Board Assurance Framework (BAF). Strategic priorities, risks and performance will be routinely reported through Board and committee structures, enabling effective oversight, scrutiny and timely decision-making. |

# Doing well together: our organisational strategy
## (2026 to 2031)

NHS
Kent and Medway Mental Health
NHS Trust

### Our vision

We are creating communities where mental health care helps people not only live with mental illness but live well

### Our mission

To be a united health service that delivers better mental health care for communities across Kent and Medway

### What we are committed to

High quality care | Shaping services together | Working as one system

## Our 5 priorities

**- Access -**

**Help when you need it**

**- Safety -**

**Keeping people safe in our care**

**- Experience -**

**Positive experiences for staff, patients and families**

**- Resources -**

**Using our time and resources wisely**

**- Prevention -**

**Supporting people with mental illness to live well and stay well**

**What will help us deliver this**

Improved quality | Better technology | Stronger workforce | Modern spaces | Financial stability | Open culture | Clear communication | Leadership accountability

**How we will work**

Caring | Inclusive | Curious | Confident

NHS
Kent and Medway
Mental Health
NHS Trust

# Doing well together: organisational strategy

## (2026 to 2031)

# Who we are


**Kent and Medway Mental Health NHS Trust provides specialist secondary mental health, learning disability and autism services for around 1.9 million people across Kent and Medway.**

We care for people whose needs require specialist support beyond what can usually be provided by GPs. This includes people experiencing severe or complex mental illness who need support from specialist community teams, crisis services, inpatient care or forensic services.

As we begin this strategy, we are also excited to become an all-age provider, **expanding our services for children and young adults and all-age eating disorders, strengthening support across the whole life course.** Each year, we now expect to care for more than 1,700 people in our hospitals and over 81,000 people through our community and neighbourhood services.

Our **4,700 colleagues** represent more than **76 nationalities,** bringing a wide range of skills, experience and perspectives. Together they show expertise, compassion and dedication, often supporting people at the most difficult moments in their lives.

We are **part of the Kent and Medway Integrated Care System**, working with partners to improve health and care for local people. As the only NHS provider covering all of Kent and Medway, **we play a key role in ensuring the voice of mental health and our communities is heard.** This places us in a unique but strong position for the communities we serve.

Working alongside our partners, we are the lead provider delivering Mental Health Together, a new approach to community mental health care. This programme brings NHS, local authorities and voluntary organisations together so people receive joined-up support in their communities and access help more easily.

We are also **strengthening our partnership with Kent Community Health NHS Foundation Trust,** recognising the opportunity to better join up mental health and community health services so people can receive more coordinated care closer to home. This aligns with the **NHS Ten Year Health Plan** which centres on an Integrated Neighbourhood Care approach - moving services from hospitals to community settings to provide proactive, personalised care.

**Together with our partners, we are determined to improve mental health care across all of Kent and Medway with a relentless focus on safe, high-quality care and better outcomes for the people we serve.**

# How far we have come

Over the past three years we have made significant progress on our journey to improving services for patients, supporting our staff and strengthening partnerships across Kent and Medway. We have also worked with staff, patients, partners and communities to co-create a new organisational identity and values. This work has helped shape the culture we have started to build and how we will together deliver this strategy. Key achievements from our previous strategy include:

## For our people

**We co-created a new identity as a Trust,** together with our people

**Our workforce is more stable** – we have reduced our vacancies and reduced our spend on temporary staff

**We are empowering staff** to make practical changes and build a culture of continuous improvement

## For our patients

People waiting for a dementia diagnosis are getting answers quicker – the average waiting time has reduced from **27 to 13 weeks.**

**9 out of 10** emergency patients needing mental health support are now seen within 1 hour

**Our wards are safer and kinder** – the number of self-harm incidents on our wards has more than halved

## For our partners

We formed **strong partnerships** to deliver Mental Health Together which joins up mental health and community health services

We are continuing to **improve flow of patients** across our services, supporting those that need a bed and those ready for discharge

Regulators and external reviewers have also recognised our:

- growing improvement capability
- strengthening learning culture
- focused leadership delivering results

We are proud of this progress, but we know there is more to do.

# The reality for Kent and Medway

**Mental health services across the country face rising demand and limited capacity.** Kent and Medway is no exception.

**Our population is growing and rates of mental illness are rising.** Some of our most deprived communities experience far higher levels of severe mental illness, poorer physical health and shorter life expectancy. Many people who need support do not currently access mental health services due to barriers such as stigma, culture, awareness or how services are designed.

**Demand for services often exceeds capacity.** Compared nationally, we have fewer inpatient beds. Some people must receive care outside of Kent and Medway, while others stay in hospital longer than they need to because support after discharge is not readily available.

**This means some people are waiting longer than we would like.** During this time, their needs can become more complex and urgent, increasing demand on services across the system, including A&E.

**This puts extra pressure on our partners and our own staff.** Although vacancy rates have improved, teams continue to manage high levels of clinical risk and complexity. This pressure, alongside making big changes to how services are delivered is affecting resilience and wellbeing.

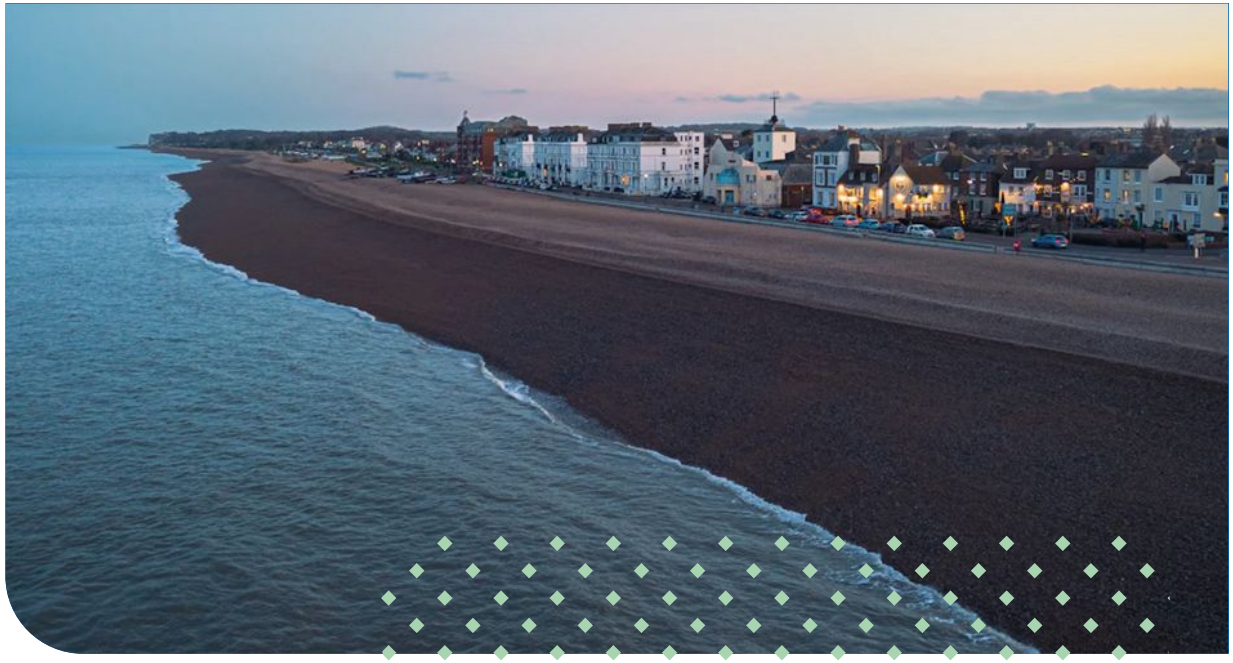
**Quality of care is not always as consistent as it should be.** External scrutiny, independent reviews and our own learning have highlighted areas where we must continue to improve – including culture, quality and safety, how we manage risk and how we use information and experience to run our services and make decisions.

**Patients, families, carers and partners told us that:**

- getting access to help can be confusing
- communication with patients and between services and providers must improve
- they want greater involvement in their care
- prevention and early intervention must be stronger
- all health and care services must work together around the person

The scale of the challenge means we cannot continue with the same approaches. We must work differently with partners to improve outcomes for our communities. And above all, we must maintain a relentless focus on safety and quality so that people receive care they can trust.





# Our wider strategic environment

This strategy is in line with national ambitions set out in the NHS 10 Year Health Plan, including commitments to:

- create new neighbourhood health services, shifting care from hospitals to communities and investing more in crisis support in the community.
- focus on prevention not just treatment. For mental health that means working together to help people live well with mental illness, and expanding mental health support teams in schools and colleges.

We also work within the NHS England Oversight Framework, which measures performance across access, quality, outcomes, productivity and financial sustainability.

The Kent and Medway Integrated Care System faces significant challenges in terms of clinical outcomes and financial pressure, meaning we must transform the way our clinical services are delivered, work more closely together across organisations, and better join up patient pathways.

Mental health services in Kent and Medway have historically received less investment than other areas across the country. We are determined to change this by investing in community services, working with our partners to ensure our patients receive the care they deserve and that mental health plays a central role in local planning and transformation.

# Our ambition

We have started to build the foundations for improvement, but we know this is not yet consistent across all of our services. Over the next five years, we will focus relentlessly on delivering consistency across everything we do, including safety and quality.

We worked with colleagues, patients and partners to co-create a new identity, vision, mission and values. In response to feedback, we also changed our name from Kent and Medway NHS and Social Care Partnership Trust to Kent and Medway Mental Health NHS Trust, to better reflect who we are and what we do.

## Our vision describes the future we are working towards:

Creating communities where mental health care helps people not only live with mental illness, but live well.

## Our mission sets out what we will do to get there:

We are an active, united mental health service for communities across Kent and Medway.

## Our values and principles guide how we behave and the choices we make every day:

### Values:

**Caring** **Inclusive** **Curious** **Confident**

### Principles

- Quality and safety always come first
- We co-create solutions from the start
- Our values drive every decision
- We deliver measurable impact that lasts
- Our leaders are visible and accountable
- We act as one system, in genuine partnership
- We communicate openly and clearly
- We advocate for our communities and mental health

Together, these define not only what we will achieve, but how it feels to work here, receive care and partner with us - and shape how we deliver this strategy



# Our True Norths

To deliver our vision, we will focus on five strategic priorities - our True Norths.

## Help when you need it (Access)

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

### Why this matters

Demand for mental health support is growing. People with severe mental illness in Kent and Medway die 15 to 20 years earlier, often from preventable physical conditions. People living in the most deprived communities are twice as likely to experience anxiety and depression.

Too many people are waiting longer than they should, and access can vary depending on where people live and which community they belong to. GPs told us that access to mental health support needs to be more straightforward and the easiest, although not the best option was sometimes to refer people to A&E.

Patients and carers told us that waiting for care can feel frightening, confusing and at times unsafe. Many feel left in the dark without updates. Staff say they feel overwhelmed and constrained by processes that make it harder to give timely support.

People want quicker access, clearer communication and support while they wait.

### What will be different - we will:

- help people get the care they need more quickly
- make it easier for people and GPs to access care
- improve our data so we can spot where people are accessing services and address barriers when they're not
- provide regular updates to patients and their loved ones while they wait

### How we will measure success

- 85% of patients referred to Mental Health Together are treated within 18 weeks of referral

> **"If we know what's happening and someone is checking in, we can cope with the wait. When there's silence, it feels unsafe."**

## Keeping people safe in our care (Safety)

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

### Why this matters

People often come to us at their most vulnerable moments in their lives. The care we provide can be life-changing and, at times, lifesaving.

Safety is not only about preventing physical harm. It also means protecting people's psychological safety and dignity.

Patients told us they want to feel believed, respected and understood. Staff emphasised the importance of consistent practice, the right skills and training, and a culture that listens and learns.

Providing high-quality, safe care supports faster recovery and builds lifelong trust in our services.

### What will be different - we will:

- improve safety by being open, learning from our mistakes and reducing patient harms on our wards and in our communities
- ensure high-quality care is delivered consistently across all our services, by setting clear standards and expectations and learning quickly when things may go wrong
- use data to better understand and improve outcomes for different groups of people
- listen more to patients, families and carers and involve them in shaping care or our learning
- ensure children and young people transition safely to our care and with seamless continuity into adult services
- develop a clinical plan that sets out how we will organise our services around pathways of care, and do more to actively support people to improve their wellbeing and prevent chronic illnesses
- further train and support our staff so they can better care for patients with neurodiversity, complex needs and trauma

### How we will measure success

- Improved management of patient harm, with a focus on wards and community home treatment teams.
- Patient outcomes are consistent across protected characteristics.
- More clinical services are accredited for meeting high-quality standards.

> **"Feeling safe comes from knowing who is responsible, being treated with respect, and being believed when we raise concerns."**

## Positive experiences for staff, patients and families (Experience)

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

### Why this matters

Many patients recommend our services. However, people told us they want care that feels more relational. That means: clear communication, continuity of care, involvement in their care planning and updates they can understand.

Many people described the value of having one trusted point of contact and services where staff have the time and support to care properly. People who need urgent mental health support often feel they are directed to A&E which is rarely the most appropriate place for their needs.

Our staff also shared their experiences. They described frustration with digital systems, internal processes and buildings that are not fit for purpose.

Some staff feel that leadership and management support varies, and they do not always feel heard, supported or empowered. Strengthening communication and making sure all voices are heard and listened to is key to doing well together.

Positive patient experiences support recovery and better outcomes. Supporting staff wellbeing is equally important, because supported staff provide more consistent and compassionate care.

### What will be different:

**For patients, we will:**

- ensure patients and families are actively and fairly involved in making decisions and planning their care
- create a more consistent and increasingly digital experience so people can communicate with services more easily, stay informed and live well
- use tools such as DIALOG+ to understand people's experience and outcomes throughout their care journey and identify where improvements are needed
- involve patients and their families in redesigning pathways and improving services

**For staff, we will:**

- equip them with the processes, technology and estates needed to support relational care rather than transactional care
- strengthen inclusive leadership and meaningful staff involvement in improvement
- improve the ways in how we communicate
- make sure everyone is treated fairly and included, guided by our five-year Equality, Diversity and Inclusion plan and new values
- focus on wellbeing, creating more moments that ensure staff feel happy and proud at work

### How we will measure success

- Significantly improved staff experience and engagement, moving closer to the best-performing mental health trusts in the country.
- Continued progress against our Equality, Diversity and Inclusion plan.
- 90% of patients are extremely likely/likely to recommend the trust to their friends and family if they needed similar care or treatment.

**Patient:**

> **See me as a person, not a diagnosis - and don't disappear when I leave.**

**Families:**

> **I know my mum best. I only wish the team would ask me what works for her.**

**Staff:**

> **We waste time fixing the system instead of helping people.**

## Using our time, money and resources wisely (Resources)

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

### Why this matters

Staff and patients told us they want simpler processes and better technology. This will free up more time for care, improve patient experiences and help us build a more sustainable system that can meet the needs of our communities.

We are part of a health system facing significant financial pressures where service demand continues to grow across all services, including mental health. As an organisation we are financially sustainable, but we know our system spends less on mental health than others across the country and we need to work with our local commissioners to change this in the coming years. We also recognise that we spend more than we would like in some areas and need to be more efficient, particularly where we rely on temporary staffing or out-of-area placements.

Long-term sustainability means more than financial balance. We have a responsibility to reduce our environmental impact, strengthen our communities and deliver lasting value through how we operate and invest.

With demand continuing to grow, we will need to work differently, making the best use of our time, money and effort on what makes the greatest difference to patient care and clinical outcomes.

### What will be different - we will:

- reduce waste and focus spend on what makes the biggest difference to patient care and outcomes
- invest in new technology that saves time for our workforce, allowing more time to be redirected to patient care
- continue our commitment to protecting the environment, supporting our communities and acting with integrity in everything we do

### How we will measure success

- Continue to be financially sustainable, with efficient services
- Spend more of our time and resources on patient care
- Significant progress towards achieving net zero by 2040, giving back to our communities and working with socially responsible suppliers

> **We spend more time on systems and doing admin than caring for people**

## Supporting people with mental illness to live well and stay well (Prevention)

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

### Why this matters

More people are struggling with their mental health and come to us when they are already in crisis. High demand for beds, and delays in discharging people who are ready to leave hospital, reduce our ability to care for people when they need it. This creates avoidable pressure across the whole system. As a result, people who need inpatient care cannot access a hospital bed when they need it and this adds more pressure and longer waits for community care.

Mental health is shaped by many factors beyond healthcare, including physical health, housing, employment, family life and community support. Clinical treatment alone cannot meet these needs. As an organisation that spans the whole of Kent and Medway, we recognise our responsibility to work more closely and influence our partners to focus on prevention.

Integrated leadership and prevention mean stepping in earlier, joining up support around the person, and building a system in Kent and Medway that helps people live well in the community, not just treats them when they are unwell.

### What will be different - we will:

- use our inpatient capacity purposefully, with clear clinical criteria for admission and timely discharge planning from day one
- work with our partners to jointly improve flow across the whole patient pathway
- create integrated neighbourhood health centres to offer true, joined up care closer to home
- work more closely with local charities, community organisations, schools, primary care, and local authorities to support people earlier, shifting from reactive care to prevention and early intervention

### How we will measure success

- Ward beds are available and people can access one quickly and safely.
- More people get help earlier, with fewer crises and avoidable admissions.
- Fewer people already known to our services needing emergency department care because they are receiving the right support earlier.

**"I would have been dead a long time ago if it wasn't for the support I received in the community. It wasn't the NHS that got me through it was the people who volunteer locally. If we lose them, more lives will be lost."**

# The capabilities we must strengthen

We have already begun strengthening some of the foundations that support our services, a renewed focus on quality and safety via our quality plan, strengthening our governance and organisational structures and starting to improve digital systems. However, to successfully deliver this strategy and respond to the growing needs of our communities, we need to build on this progress and further strengthen the following key capabilities across the organisation.

## Improving safety and quality measures

We will strengthen how we assure and improve the quality and safety of our services so that our communities are confident in us. This means making sure we have clear oversight of performance, risk and learning across the organisation – from frontline teams through to the Board. We will bring together our strategy delivery, leadership, data and insight and patient experience so that we can identify issues earlier, learn quickly and make consistent daily improvements across our services.

## Accelerating digital, data and technology-enabled care

We will invest in digital tools and technology, aligned with national priorities such as the "digital front door," to make it easier for people to access services. Our focus will be on solutions that reduce duplication and free up staff to spend more time delivering care. The way in which we use our data needs to improve – this will give us a clearer, more joined-up view of how we are performing, helping us to make informed decisions. We will bring this together into a data, digital, and AI strategy that supports new care pathways and better outcomes.

## Strengthening our workforce

Over the next five years we will work with staff and partners to develop a workforce strategic plan. This will ensure we have the right people, in the right roles, with the right skills, now and in the future. We have already introduced an Equality, Diversity and Inclusion Plan and we will continue to make progress to address equity and representation, ensuring opportunities are accessible to all groups. We will focus on attracting and keeping talented staff, supporting their development and making the most of their skills and experience so they feel valued and able to do their best work for patients.

## Strengthening leadership, improvement and innovation

We will continue to support and develop leaders and managers so they can empower colleagues, champion innovation and drive this strategy forward. We will research and explore new ways of working, test and scale promising initiatives, and encourage staff to try new approaches safely so that patients can benefit more quickly from innovations.

## Making our estates and infrastructure fit for purpose

We will modernise our buildings and use our spaces more flexibly, bringing health services closer to people's homes. We will ensure we have the right number of sites, in the right locations organised in a way that means we can deliver the highest standard of care to our communities, especially as our footprint has expanded to include children and young people services, and all-age eating disorder services.

## Embedding a strong organisational culture

We will build on the foundations created through our co-created identity and values. While there are many examples of excellent practice, we know culture is experienced differently across the organisation. Our focus is to create an open, inclusive and consistent culture where our values shape how we work every day – celebrating great care and teamwork, addressing behaviours that fall short, supporting staff to speak up and be heard and ensuring communication is two-way across all levels.

## Accessible patient communication and co-creation

We will provide clear, accessible communications so people understand what support is available and how to access our services. We will align patient experience, engagement and co-creation so we better listen to patients, families and communities, involve people earlier in shaping services and ensure feedback leads to meaningful improvement. We will work more closely with communities who do not currently access our services, helping us understand barriers and co-create support that better meets their needs.

# How we will deliver this strategy

We will deliver this strategy through our **Doing Well Together Improvement Programme.**

This programme turns strategic priorities and plans into action and ensures improvements happen in practice, not just on paper. Directorates and corporate and support teams will develop aligned annual plans and measurable improvement goals linked to the five True North priorities.

This approach creates clarity, focus and shared accountability across the trust, from Board to frontline teams.

# How we will measure progress

We will measure progress through a set of Year 1 breakthrough objectives, focusing on the changes that move us closest to our True North ambitions.

These will be supported by a wider set of measures covering quality, performance, workforce and finance. Progress will be reviewed regularly through our governance structures and reported publicly through the Board, ensuring transparency, accountability and continuous learning.

# Strategy engagement summary report

## Introduction

This strategy has been shaped by a sustained programme of listening and learning over the past two years, grounded in one clear principle: our direction must reflect the experiences of the people who work for us, the people we care for, the partners we work with and our communities.

Ahead of this phase of engagement, we brought together over 700 hours of insight from staff, patients, families and partners carried out as part of our identity and culture development; alongside staff survey insight, ongoing conversations and engagement events with stakeholders; complaints; performance and operational data and risks; and business intelligence.

This enabled the Board to identity five consistent themes - access, safety, positive experiences, purposeful stays and better use of resources – which were then tested and refined through further engagement.

Our engagement approach used language aligned to our new identity and responding to feedback that we heard during its development, keeping it relevant, simple and ‘non-NHS’. We tested and spoke to stakeholders about making sure patients: feel safe when they are in our care; have a good experience with our services; don’t have to wait a long time to get care; see us use our time, money and resources well; and being cared for closer to home and not staying in longer than they need to.

Encouragingly, people recognised their earlier feedback in these priorities. Many described this as the first time they had seen their input clearly sharping the Trust’s direction, strengthening confidence in both the process and the emerging strategy.

## Who we spoke to and how

This was the widest engagement the trust has undertaken on its future strategy involving direct engagement with over 300 staff and more than 150 patients, carers, families and partners.

We engaged through staff events, patient and carer sessions, community conversations across 13 sites, an online survey, and direct discussions with:

- Voluntary, community and social enterprise organisations and grassroots support groups
- GPs, Primary Care Networks and NHS partners
- Local authorities, councillors and statutory committees
- Community interest companies
- Healthwatch

We also used informal routes and existing leadership sessions to have conversations about the direction and gather further views.

Feedback on the process itself was overwhelmingly positive. People described it as open, inclusive and meaningful, with a strong sense that their voices were being heard and would influence change.

**What we heard – strengths and confidence**

Across all groups, there was strong alignment with the five strategic priorities, providing confidence that they reflect what matters most.

There was also clear recognition of the Trust's progress in listening, co-creation and the cultural development from the new identity. Staff, patients and partners welcomes the visible shift towards more open engagement and values-led working, and spoke positively about the Trust's direction of travel.

In particular:

- Staff felt more connected to the organisation's direction when they could see their feedback reflected
- Patients and families valued being listened to and treated with dignity
- Partners recognised the Trust's intent to work more collaboratively across the system
- There was strong support for continuing the Trust's culture journey, including embedding values and strengthening pride in the organisation
- There was positive engagement from staff around the opportunity to develop a clear clinical strategy, with appetite to shape this further

These strengths provide a solid foundation for delivery and indicate growing confidence in the Trust's leadership and approach.

**What we heard – what gets in the way**

Alongside this confidence, engagement highlighted a consistent set of foundational challenges that risk limiting delivery if not addressed.

**Systems, processes and administrative burden** - Staff consistently described the impact of complex systems, duplication and high administrative workload, which reduce the time available for patient care and contribute to frustration and inefficiency.

**Digital and information access -** Colleagues highlighted the need for more intuitive, joined-up digital systems and clearer access to information to support decision-making and communication.

**Physical environments -** Staff and patients spoke about the impact of estate quality, describing how working in environments that are not fit for purpose can affect both experience and outcomes.

**Communication and navigation -** Across all groups, communication and signposting emerged as one of the most immediate and addressable opportunities for improvement.

- Patients and families want clearer and kinder communication and a better understanding of what to expect when they or their loved one is in our care.
- Staff and partners highlighted the challenge of accessing and navigating services, communicating with us, and supporting others to do so. GPs specifically noted the impact this had on them including the increased risk to support people who 'fall through the gaps'.
- All stakeholders wanted us to do more to signpost support in the community that is available to help prevent people from getting into a crisis, and to keep them living well after they've been in our care.
- Staff wanted us to talk to them in clear, non-corporate and NHS language.

**Complexity and capability** – staff spoke about the increasing complexity of need, including supporting people who are more unwell and those with neurodivergent needs. There was a clear ask for further development, confidence and capability-building to ensure staff feel equipped to provide the right care.

This reinforces that improving how people access information and how we communicate with them is critical across a number of our strategic priorities.

**Cross-cutting insight**

A consistent message across all engagement was that experience, access and outcomes are closely linked to how well the system works around people.

Five cross-cutting themes emerged:

- Clear, timely and accessible communication and information
- More personalised, person-led care that reflects our values
- Better coordination and continuity across services
- Earlier, community-based support to prevent crisis
- Supporting staff to feel informed, valued and able to deliver high-quality care

**Strategic refinement informed by engagement**

Engagement has not only confirmed the relevance of the Trust's five priorities but has directly shaped how they have been framed and refined.

In particular, feedback has led to:

- A clearer emphasis on outcomes and lived experience, moving from feeling safe to being safe
- A strengthened focus on prevention and supporting people with mental illness to live well, not just responding to crisis
- Greater emphasis on care closer to home and reducing reliance on inpatient care where appropriate
- Recognition that safety must extend beyond inpatient settings, taking a whole-system view, addressing risks and harms in community settings as well
- The embedding of communication and navigation as a core thread across priorities
- A stronger case for developing a supporting clinical plan, particularly responding to increasing complexity and neurodiversity of those we care for

**What this means for the strategy**

These refinements ensure the strategy is sharper, more outcome focused and better aligned to the realities of how care is experienced and delivered. It also highlights where delivery effort must be concentrated to achieve meaningful impact.

In particular, it reinforces the need to:

- Address foundational enablers (systems, operational and administrative processes, digital and data, estate and communication) to unlock productivity and improve staff, patient and partner experience
- Continue to embed co-production and values-led culture as core to how the organisation operates
- Improve coordination across pathways and partners, supporting more joined-up, preventative care
- Maintain a clear focus on outcomes and experience, ensuring that improvements are both delivered and felt
- Strengthen opportunities to work differently with existing and new partners to truly help our communities and those will mental ill health live well.

These insights have directly informed the strategy and will continue to inform the year one delivery plans.

**Conclusion**

This engagement provides a high level of confidence that the Trust's strategy reflect the needs and expectations of staff, patients and partners. It also offers clear, actionable insight into the conditions required for successful delivery. Together, this positions the Trust to move from strategy development to disciplined, outcomes-focused delivery, with a clear line of sight between what people have told us and how we will respond.

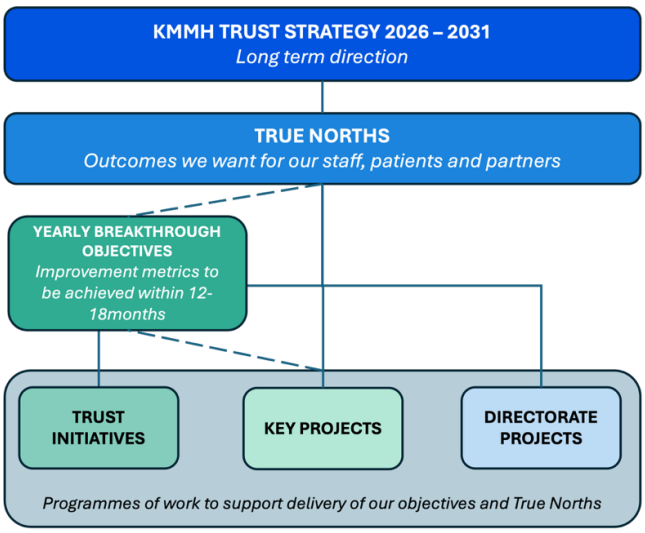
## Proposed Strategy Delivery Framework

The Doing Well Together improvement programme will be used to deliver the Trust strategy; a structured framework that links long-term ambition with practical improvement activity.

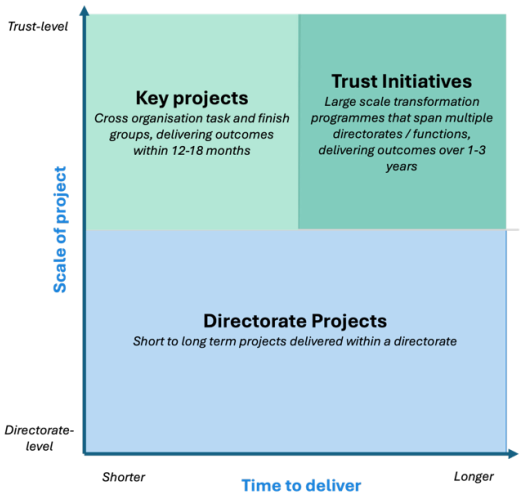
At the highest level, the strategy sets the Trust's True Norths, which describe the strategic priorities and outcomes we want to achieve over the next five years.

Each year, a small number of breakthrough objectives will be identified to focus organisational effort on the areas where improvement will have the greatest impact and contribution towards each of these "True Norths".

Delivery of these specific objectives and our True Norths will be supported through a combination of **Trust Initiatives**, **Key Projects** and **Directorate Projects.**




Together, this approach ensures that the Trust's long-term strategic ambitions are clearly connected to measurable improvement activity across services. Depending on the scale of the project, progress will be monitored through the directorate's and/or Trust's governance and performance framework and oversight provided through directorate Quality Performance Reviews and Board reporting.




## Delivery timelines

Once the strategy is approved, we will move at pace into delivery. The proposed timeline and key approval milestones are as follows:

| | Deliverable | |
|---|---|---|
| **Board dates** | **Five-year strategy deployment** | **Clinical Strategic Plan** |
| Public Board - May 2026 | Directorate catchball outputs | Board paper detailing emerging themes and key priority areas from initial baseline analysis and engagement |
| Board Seminar - June 2026 | Completion of plans for breakthrough objectives and project charters | |
| Public Board - September 2026 | Mid-year strategy review | Completion of Clinical Strategic Plan |

The oversight and assurance arrangements have been mapped to reflect our current structure. However, this may change in response to the external review carried out by Moorhouse, as we take steps to improve the effectiveness of our governance arrangements.

## Governance arrangements

| True Norths | True North Goals | Rationale | Executive lead | Oversight and Assurance |
|---|---|---|---|---|
| | ***5-year key metrics to deliver with interim step 'breakthrough objectives' to be achieved.*** | | | |
| **Help when you need it (access)** | Achieve 18-week referral to treatment target for 85% of patients in Mental Health Together community care. | Target in national operational planning guidance. | Donna Hayward-Sussex, Chief Operating Officer and Deputy Chief Executive | Assurance – Finance and Business Investment Committee, Board through Integrated Quality and Performance Report<br><br>Oversight – Trust Strategy Deployment Review |
| **Keeping people safe in our care (safety)** | 10% reduction in total number of harms. | Patient safety is a foundation of our purpose and regulatory frameworks. We want to keep people free from harm when we're caring for them on our inpatient wards and in the community. | Julie Kirby, Interim Chief Nurse | Assurance – Quality Committee, Board through Integrated Quality and Performance Report<br><br>Oversight – Trust Strategy Deployment Review |
| **Positive experiences for staff, patients and families (experience)** | Increase our staff survey engagement score from 6.7 to 7.3, moving us closer to the best | Staff survey and the engagement score is our annual assurance measure. Despite progress in some areas, participation in the survey and | Chief People Officer (Ali Layne-Smith to join on 23 March) | Assurance – People Committee, Board through Integrated Quality and Performance |

| | | | | |
|---|---|---|---|---|
| | performing mental health trusts.<br><br>90% of patients feel that the overall experience of our services was good/very good. | engagement has been declining overall.<br><br>Patient experience is one of our external assurance measures. While our current patient survey and friends and family test surveys show positive responses, the response rate is very low and we know from wider insight, feedback and surveys from patients and partners that we must improve - especially when it comes to communication, care coordination and people being involved in their care. | | Oversight – Trust Strategy Deployment Review<br><br>Report Assurance – Quality Committee, Board through Integrated Quality and Performance Report<br><br>Oversight – Trust Strategy Deployment Review |
| **Using our time, money and resources wisely (resources)** | Increase our productivity by 2% year-on-year to return to pre-pandemic levels. | National guidance has set all NHS trusts a productivity and efficiency improvement requirement to achieve year on year. To maintain our financial balance, we must continue to focus on reducing agency spend, improving operational efficiency and improved bed flow. | Nick Brown, Chief Finance and Resources Officer | Assurance – Finance and Business Intelligence Committee, Board through Integrated Quality and Performance Report<br><br>Oversight – Trust Strategy Deployment Review |

| | | | | |
|---|---|---|---|---|
| **Supporting people with mental illness to stay well and live well (prevention)** | Reduce total bed occupancy to 90% | Achieving below 100% bed occupancy levels is critical to accommodate variations in demand and ensure that patients can flow through the system, it is also a reflection of improvements needed in upstream and downstream care. | Dr Afifa Qazi, Chief Medical Officer | Assurance – Finance and Business Intelligence Committee, Board through Integrated Quality and Performance Report<br><br>Oversight – Trust Strategy Deployment Review |

## True North Year one breakthrough objectives

| True North Goals | Year one breakthrough objectives | Rationale | Oversight and Assurance |
|---|---|---|---|
| **Help when you need it (access)** | Reduce the percentage of lost appointments from 'did not attends' or cancelled appointments from 20% to 15% | Over 4,000 appointments are lost each month due to did not attend and cancellations.<br>Benchmarking against other MH trusts suggests an average 'did not attend rate' of c15% against our peers | *As above* |
| **Keeping people safe in our care (safety)** | 10% reduction in in-patient female self-harm. | Female self-harm is the most frequent cause of harm in our inpatient wards with an average of 85 incidences a month on our in-patient wards | |

| | | | |
|---|---|---|---|
| | Improve the management of self-harm in the community – *metric TBC.* | We know self-harm in the community is a top contributor. However, there are also know data quality issues around reporting. Further performance analysis is needed to understand the problem to solve and determine the breakthrough measure. | |
| **Positive experiences for staff, patients and families (experience)** | Increase the percentage of staff that would recommend KMMH as a place to work from 54% to 65%.<br><br>95% of patients feel that we are good/very good at including them in decisions about their care (currently 86%). | If we can improve the number of staff that recommend KMMH as a place to work, this will be the biggest contributor to helping us improve our overall engagement score.<br><br>We want all our patient to feel that have received a good service and have been involved in making decisions. Our current response rate is only 2.4% so we will also have a watch metric to increase the response rate to 10%, alongside improving the experience. | |
| **Using our time, money and resources wisely (resources)** | Increase clinical contact time by X%– *target TBC.* | We need to improve the effectiveness of our IT systems, reduce bureaucracy and simplify processes so that clinicians can spend more time caring for patients and less time on admin. | |
| **Supporting people with mental illness to stay well and live well (prevention)** | Reduction in the number of bed days lost – *target TBC* | We want our patients to be discharge as soon as they are ready, without unnecessary delays and we want to ensure that each day of admission counts | |

## Trust initiatives

| Trust initiatives | Rationale | Executive lead | Oversight and Assurance |
|---|---|---|---|
| ***1-3 year large scale change initiatives that future proof our organisation*** | | | |
| Cultural Change Programme | To build a consistent, values-led culture across the trust by aligning our identity, values, leadership behaviours and improvement approach. While there are strong and positive team cultures, this experience is not yet consistent for all staff and patients. This programme will strengthen expectations of what good likes like and support staff to live our values. Building on the leadership development already underway, we will extend this focus to managers at every level so that inclusive leadership, accountability and improvement are consistently embedded across the organisation, enabling us to deliver high-quality, compassionate and consistently safe care. | Kindra Hyttner, Director of Strategy and Engagement | Assurance – People Committee and Quality Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |
| Integrated Neighbourhood Working | Neighbourhood Health Teams are an ambition in the NHS 10-Year Health Plan and provide an opportunity to deliver more joined-up care closer to home. East Kent has been chosen as one of the national pioneer sites. This initiative will strengthen our role in working alongside Kent Community Health NHS Foundation Trust and other partner organisations to support people earlier and improve outcomes across Kent and Medway, starting first in East Kent. | Donna Hayward- Sussex, Chief Operating Officer and Deputy Chief Executive | Assurance – Finance and Business Investment Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |

| | | | |
|---|---|---|---|
| Supporting recovery and living well with mental illness | Many people reach services when their needs have already escalated into crisis. Our long-term ambition is to work more closely with our communities to support people will ill mental-health earlier and help them live well in their communities, recognising both our role as an anchor institution and the direction set out in the NHS 10-Year plan. No single organisation can achieve this alone, so this initiative will focus on strengthening partnership working. While some early steps can begin, such as improving signposting and support, the full development of this work will take place later in the strategy period as the foundations are established. | Dr Adrian Richardson, Director of Partnerships and Transformation | Assurance – Finance and Business Investment Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |

## Key projects

| Key projects | Rationale | Executive Lead | Oversight and Assurance |
|---|---|---|---|
| ***0-18 months task and finish trust wide key projects*** | | | |
| Patient and Carer Race Equality Framework (PCREF) | PCREF is a national statutory requirement for mental health trusts to improve racial equity in access, experience and outcomes. We have already made progress across a number of initiatives, and this project will bring that work together into a single, coordinated programme to strengthen impact and accountability. The focus will be on embedding racial equity and equity across all our communities into routine practice. | Dr Adrian Richardson, Director of Partnerships and Transformation | Assurance – People Committee and Quality Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |

| | | | |
|---|---|---|---|
| Administration and operational model reset | Effective care relies on strong operational foundations. We will focus on strengthening how our operational and administrative functions support our services - ensuring clearer, more consistent and efficient ways of working. | Dr Adrian Richardson, Director of Partnerships and Transformation | Assurance – Finance and Business Investment Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |
| Quality Plan | The quality plan provides the framework for delivering improvements identified through internal learning, external reviews and regulatory feedback. This project continues from our current strategic projects and will ensure a clear and coordinated approach to improving the consistency of quality and safety across the trust. | Julie Kirby, Interim Chief Nurse | Assurance – Quality Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |
| Clinical Plan | The Trust will develop its first clinical plan to set out how services will evolve over the coming years to meet changing population needs. This will include reviewing and improving key care pathways, including transitions between children and adult services and for specific groups as women with complex needs. This will be co-produced with clinicians, staff, patients and partners and will provide a clear clinical direction aligned to the strategy. | Dr Afifa Qazi, Chief Medical Officer | Assurance – Quality Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |
| Children and Young People Mental Health and all age eating disorders integration | As we become an all-age provider in April, this project will focus on integrating our new services, people and patients into the organisation. The aim is to ensure safe, high-quality care while building stronger pathways across the life course. | Donna Hayward- Sussex, Chief Operating Officer and Deputy Chief Executive | Assurance – New interim Children and Young People Committee |

| | | | |
|---|---|---|---|
| | | | Oversight – Trust Strategy Deployment Review and Programme Board |
| New Electronic Staff Record (ESR) implementation | The NHS is introducing a new national ESR system. As an early adopter Trust, this project will implement the new platform with support from NHS England, improving workforce systems and enabling more efficient staff processes. | Chief People Officer (Ali Layne-Smith to join on 23 March) | Assurance – Finance and Business Investment Committee and People Committee<br><br>Oversight – Trust Strategy Deployment Review and Programme Board |

# Digital – True North: Plan on a Page

| | True North | Outcomes / Improvements | Digital Programmes |
|---|---|---|---|
|  | **Help when you need It** | Improve timely help by reducing delays, providing faster routes into services and enabling clinicians to make quicker, better-informed decisions. | • Two way messaging.<br>• Electronic Referrals.<br>• Connected devices. |
|  | **Keeping people safe in our care** | Enhance patient safety by ensuring accurate, up-to-date clinical information, reducing documentation and prescribing errors, and enabling earlier identification of risks through clearer, faster and more reliable communication between patients and clinicians. | • Two way messaging.<br>• Electronic Prescribing Service. |
|  | **Positive experiences for staff, patients and families** | Give patients faster, clearer and safer care while reducing admin for staff and making their work more satisfying. | • Ambient Voice Technologies.<br>• Remote Care.<br>• Electronic Referrals.<br>• Connected Devices. |
|  | **Using our time and resources wisely** | Reduce costs by cutting duplication and paper processes, lowering DNAs, reducing admin time, eliminating inefficient manual workflows, and enabling faster decisions that avoid unnecessary appointments and admissions. | • Two way messaging.<br>• Ambient Voice Technologies.<br>• Electronic Referrals. |
|  | **Supporting people with mental illness to live and stay well** | Remote care and electronic prescribing enable care to be delivered in the community by supporting safe, proactive monitoring at home and providing accurate, paper-free medicines management wherever clinicians and patients are | • Remote Care.<br>• Electronic Prescribing Service. |

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

| Meeting details | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Sustainable Communities Provider Collaborative Progress Report |
| **Author:** | Julia Hart, Acting Director Provider Collaborative |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Board requested |

## Overview of paper

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

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

This report includes:

- An update on progress in Community Mental Health Framework and Mental Health Together element of the community mental health transformation.
- An update on progress in the dementia diagnosis pathway.
- An update on neighbourhood team programme plans.
- An update on key performance metrics including UEC.

## Areas to bring to the Board's attention

- Neighbourhood Health Programme Board agreed the Kent and Medway Clinical Care Model and the 45 Single Neighbourhood footprints based on the current Primary Care Networks.
- Dementia diagnosis - progress made in scaling the level 1 care home pilot through a structured training and implementation model**.**
- CMHF: Clinical model of care was approved by the Partners Oversight Group in December 2025.
- Drop in mental health crisis houses occupancy rates in December 25/January 26
- Further slippage in some UEC mental health milestones.

Version control 02 - **Public**

## Governance

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

Kent and Medway Mental Health NHS Trust

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

| Programme | 2025 | 2026 | |
|---|---|---|---|
| | 28 May | 30 July | September |
| Community Mental Health Framework | | | |
| Dementia Diagnosis Pathway | | | |
| Urgent and Emergency Care | | | |
| Enhanced Therapeutic Observation Care (ETOC) | | | |
| Joint Working Across Health and Social Care | | | |
| Neighbourhood Health (Frailty, Dementia, End of Life Care) | | | |

## 2. Programme updates January 2026

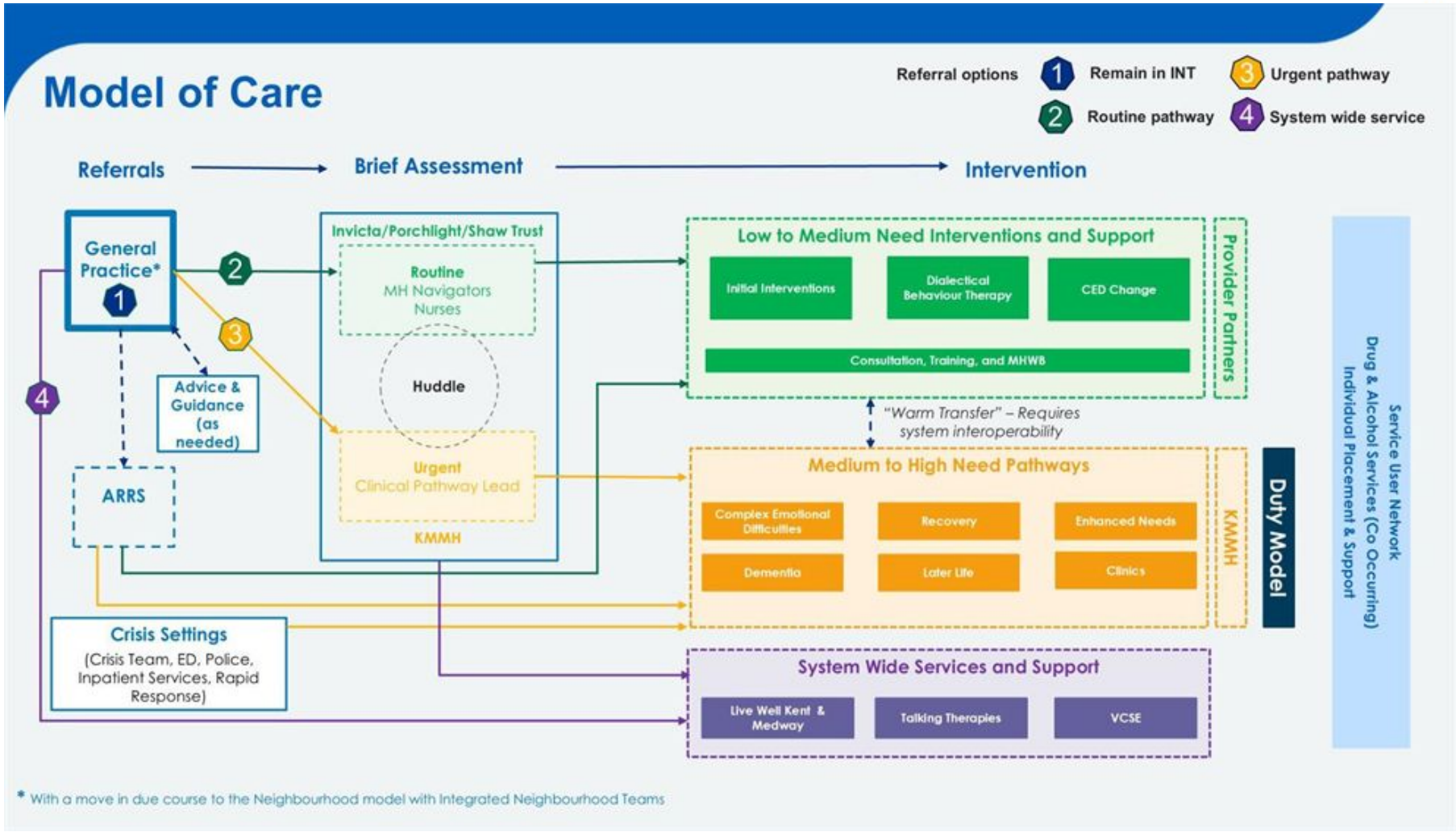
### 2.1 Kent and Medway Community Mental Health Framework

This section provides an update on the Mental Health Together (CMHF) element of the community mental health transformation. The CMHF team, have been making further refinements to the model of care, working through multi-disciplinary and multi-agency workstream structure to ensure meaningful engagement across the partnership.

As part of the refinement process, they have reviewed: the clinical interventions available through the model, the key operational functions and the partnership structures which underpin it. In considering the options they have addressed the drivers for change identified through extensive staff and user feedback, and aligned with the core programme goals to improve access to safe, high quality effective services that are tailored to enabling our communities to live well.

The refined clinical model of care was approved by the Partners Oversight Group in December 2025 and is illustrated below:

NHS
Kent and Medway
Mental Health
NHS Trust




2

Kent and Medway Mental Health NHS Trust

**Strong, inclusive governance**

Robust governance structures have been established bringing together partners across the system, including Voluntary, Community, and Social Enterprises (VCSE) organisations, operational leaders and people with lived experience - ensuring shared ownership and accountability. Workstreams and clear escalation routes have been established, enabling operational, clinical and strategic alignment.

**Co-production and collaborative model development**

A communications plan has been implemented to keep staff informed, and incorporate feedback at every stage. This is supported by ongoing listening events for staff to adapt the model in real time and maintain trust and momentum. Workshops to socialise the refined model of care have already reached out to over 450 staff.

**Relationships with partners and primary care**

Successful working with partners and primary care is an integral part of the Partnership Delivery Model and will further strengthen partnerships to effectively deliver ambitions for community mental health care. This has been accomplished through close working with partners throughout the refinement process and will now be building momentum and structure around wider system engagement, including primary care.

**Next steps**

As this moves into the delivery phase, the team are working with localities to develop local plans. The roll out of the model of care will take a continuous improvement approach, whilst staying true to the overarching clinical model of care. This approach will support staff in testing change and adapting elements of the model in their localities, acknowledging they may have different challenges to address.

The table below outlines immediate next steps/milestones by workstream:

| Workstream | Milestones | Timelines | Comments (as at 16/3/26) |
|---|---|---|---|
| **Model of Care** | Working with partners to further define the triage model (based on the Medway approach) | April -May 2026 | Meeting with partners to review demand and capacity modelling outputs on 26th March. Partners will then review the impact of the modelling ahead of a further workshop after Easter to start to define the triage model |
| | Review the duty and urgent referral process | May 2026 | Duty process end of May<br>Urgent referral process TBC |
| | Consolidate criteria for interventions and pathways: | | Medium to high pathway information agreed March 2026 |

| Workstream | Milestones | Timelines | Comments (as at 16/3/26) |
|---|---|---|---|
| | • Medium to high pathways<br>• Low to medium interventions | March 2026<br>May 2026 | Two Task & Finish groups set up as part of Model of Care Delivery workstream in March to specifically look at criteria for low to medium and medium to high. These should be completed by the end of May |
| | Intervention mapping at locality level to support transition | See comment | Currently being picked up as part of the locality BAU transition plans |
| | Locality planning | March 2026 | Locality plans for April-July in development |
| **Workforce** | Review demand and capacity modelling and costing to inform workforce planning | April 2026 | Modelling complete and costing underway<br>Workforce workstream to take forward week commencing 23rd March |
| | Training needs analysis and plan to transition from existing to refined interventions/pathways | May 2026 | Task and finish group in place<br>Some training has commenced |
| | Staff and partner engagement | Ongoing | Linked to comms and engagement workstream |
| **Comms and engagement** | Ongoing engagement with staff and partners, using a range of media, as part of a wider campaign | Ongoing | FAQs released<br>Video completed<br>Animation approved |
| | Development of FAQs | Complete | 1st set of FAQs circulated |
| | Patent engagement approach | May 2026 | |
| | Feedback tools in place | Feb-May 2026 | Staff feedback mechanisms in place.<br>Patient feedback tools to be developed in May |
| **Data/digital** | Options paper to define the impact of the refined model of care on data and digital usage/practices | April 2026 | |
| | Confirm core KPIs to measure success | April 2026<br>(see comment) | KPIs have been developed and work is underway to align them with strategic KPI development |

| Workstream | Milestones | Timelines | Comments (as at 16/3/26) |
|---|---|---|---|
| | | | Localities defining own measures of success in the interim |
| **Finance & commissioning** | Co-design specifications, timeframes and outcomes | May 2026 | Date TBC |
| | Evaluate impact of the refined model and plan for longer term procurement | Aug 2026 | |

### 2.2 Dementia Diagnosis Pathway Updates

Building on the Board's previous reports and discussions, the programme continues to focus on improving earlier identification, reducing unwarranted variation, and strengthening systemwide collaboration to enable timely and person-centred dementia diagnosis. Strong partnership working across secondary and primary care, local authorities, care providers and VCSE colleagues has been instrumental in supporting engagement and preparing for wider implementation.

**Level 1: Diagnosis in Care Homes**

Progress has been made in scaling the level 1 care home pilot through a structured training and implementation model. 11 in person training sessions have now been delivered, reaching 68 staff across 7 pilot care homes, supported by primary care colleagues to ensure consistent understanding of the Diagnosing Advanced Dementia Mandate (DiADeM) based diagnostic process.

To inform phase 2 of the Level 1 implementation, we analysed prevalence data, dementia register figures and current diagnosis rates to identify areas with the greatest inequity in access to diagnosis. This enabled us to prioritise localities with the highest unmet need and ensure the next phase of roll out is targeted and proportionate.

We remain on track to deliver training across identified pilot areas by the target end date of March 2026. A systemwide webinar is also planned for April to provide mop-up training for colleagues who were unable to attend earlier sessions due to other commitments.

Training evaluation shows a marked increase in staff confidence in identifying symptoms of dementia across all participating sites, with improvements ranging from +23.5% to +71% in pre/post training survey results. This enhanced capability will have a tangible impact to support faster and more accurate and earlier identification of dementia within care home settings, enabling more timely intervention and ensuring staff are better equipped to recognise emerging signs, escalate appropriately, and support residents through swift assessment.

Despite these encouraging developments, challenges have been encountered in securing broader clinical engagement, particularly with GP practices where capacity constraints continue to limit participation. In parallel, scaling the Level 1 care home pathway has been restricted by logistical difficulties in accessing and training staff across all 500+ care homes within a short timeframe.

These issues are being actively managed through prioritisation of high-need localities and a forthcoming Locally Enhanced Service Contract; which is now progressing through ICB governance, with a planned go live date of 1 April 2026.

Next steps:

- Rolling out phase 3 of the training implementation plan across Kent and Medway, ensuring all HCP localities have been reached through a schedule of webinars by the end of March 2026.
- Strengthening communication activity with system partners, including sharing supporting materials, capitalising on local authority channels, and enhancing engagement through targeted press releases.
- Continued data collection on user experience from care home staff, GP teams, residents and their families.
- Embedding the LES into primary care contracts to support consistent level 1 diagnostic activity.

**Level 2: Diagnosis in the Community**

Work on Level 2 continues to advance through system engagement and pathway alignment Programme leads recently met with colleagues from the Folkestone, Hythe and Rural Neighbourhood Health pilot, part of the national NHSE neighbourhood pioneer programme. The aim is to co-design a multi-disciplinary community diagnostic model that aligns with national direction and can be tested and adapted before wider rollout.

A site visit has taken place with the Folkestone, Hythe and Rural PCN team to outline a draft diagnostic process for their adult/care home team. A further visit is scheduled for March, alongside KMMH Consultant Psychiatrist and Clinical Director for East Kent, to refine the components, agree on interface and define systems and workforce requirements.

Next steps:

- Finalising the co-designed MDT model and developing a clear operating framework for community diagnosis.
- Sign-off from clinical leads for model.
- Testing the level 2 model through the Folkestone, Hythe and Rural Neighbourhood Health pilot.
- Continuing engagement with the Test and Learn Group to refine clinical model and ensure this will uphold the quality standards, such as Memory Services National Accreditation Programme (MSNAP) accreditation.

The programme has also established a Dementia Transformation Lived Experience Working Group, meeting monthly with open membership for people with a dementia diagnosis and their families, to ensure the pathway development remains grounded in lived experience. The first meeting in February included representatives, who saw the value in enabling an organic feedback loop between this group and the Test and Learn Group, further strengthening co-production.

Work is underway to broaden membership, supported by KMMH service user group leads and Alzheimer's and Dementia Support Services, to ensure diverse voices are included. This group is integral to keep the programme focused on what matters most to those with dementia and will enhance our understanding of health inequalities affecting diagnosis experience and access.

### 2.3 Kent & Medway Neighbourhood Programme Update

The Neighbourhood Health Programme Board: The Board has now agreed the Kent and Medway Clinical Care Model and the 45 Single Neighbourhood footprints based on the current Primary Care Networks.

As per national guidance, Kent and Medway ICB are working with Health and Wellbeing Boards to develop strategic plans for Neighbourhood Health which will inform the review of Health and Wellbeing membership by April 2026.

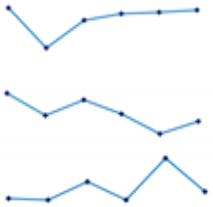
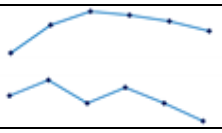
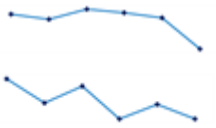
The ICB have been running an initial series of public-facing, "What Matters Most" events across Kent and Medway which will provide targeted engagement as the Neighbourhood model evolves and is implemented.

- Canterbury – 29 January 2026
- Chatham - 4 February 2026
- West Kent – 17 March
- Dartford, Gravesham and Swanley – 18 March

The ICB are now seeking to establish options to strategically commission to the Neighbourhood Care Model agreed by the Board on the 17th of December.

## 3. Current performance data

| Measure | Agreed trajectory | Current data | | | | | | AVG | Line Graph | RAG |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | | | |
| **Methodology:** RAG is determined by two factors;<br>• Agreed target, or<br>• Averages. These are compiled based on performance data for the financial period covered (year to date) and may therefore change for the report period being covered. The RAG rating will therefore cover the reporting period since the last report. | | | | | | | | | | |
| | | **Programme: Dementia Pathway Transformation** | | | | | | | | |
| Increase dementia diagnosis rate | 66.7% by March 2026 | 62.1% | 62.1% | 62.3% | 62.3% | 62.1% | 62.0% | N/A |  | |
| | | **Programme: Mental Health Urgent and Emergency Care** | | | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Reduced MH A&E attendance and increase in attendance at safe havens | Reduce<br>Reduce<br>Increase | *% MH A&E presentations against total presentations*: 1.20% \| 1.00% \| 1.14% \| 1.17% \| 1.18% \| 1.19%<br>*A&E attendances for adult patients with primary MH need*: 897 \| 799 \| 866 \| 805 \| 713 \| 771<br>*Safe Haven attendance*: 1758 \| 1751 \| 1811 \| 1753 \| 1887 \| 1778 | 1.22%<br>831<br>1698 |  |  |
| Crisis house bed occupancy | 85% | *Medway bed occupancy*: 64% \| 78% \| 85% \| 83% \| 80% \| 75%<br>*Ashford bed occupancy*: 85% \| 90% \| 80% \| 90% \| 80% \| 68% | N/A |  |  |
| Reduced mental health in ambulance/ police conveyances to A&E | Reduce | *Primary MH A&E presentation - Ambulance conveyance*: 373 \| 333 \| 410 \| 381 \| 346 \| 110<br>*Primary MH A&E presentation - Police conveyance*: 45 \| 32 \| 38 \| 24 \| 31 \| 23 | 343<br>35 |  |  |
| Reduction in incidence of Section 136 | Reduce | 74 \| 67 \| 68 \| 58 \| 66 \| 73 | 65 |  |  |

**Exception reporting on performance**

- MH A&E attendances remain below 1.20% of total A&E presentations. This has been accompanied by an increase in attendance at safe havens
- Both Ashford and Medway crisis houses saw a decline in occupancy rates in December and January. The East Kent KMMH psychiatry liaison team have attributed the Ashford position to the significant increase in the amount of presentations at ED that were not suitable for Recovery House consideration, due to the degree of the mental health presentation. The admissions data for January identified the majority of clients were assessed and detained under the Mental Health Act, requiring an acute in-patient admission. The ICB have clarified there was a dip in referrals over Christmas and at the beginning of January at both crisis houses but resident numbers have now picked up.
- A systemwide quality summit was convened with a focus on East Kent which KMMH's Deputy Chief Executive Officer and Chief Operating Officer are sighted on; following this an improvement plan for the locality was established to take forward actions.
- Though numbers of S136 cases increased for December and January they are comparable with autumn figures and seasonal variation throughout the year.
- The number of people with a primary mental health presentation conveyed to A&E by ambulance reduced significantly in January 2026. Police conveyance remains low.

## 4. Programme Milestones for 2025-2026 & 2026/2027

**Milestone Tracking Key**

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

Kent and Medway Mental Health NHS Trust

| Community Mental Health Framework | | | | |
|---|---|---|---|---|
| **Milestone** | **25-26** | | | **26-27** |
| | **Q2** | **Q3** | **Q4** | **Q1** |
| Evaluation of Medway pilot – revised front door model will be reflected in the model of care refinement | X | | | |
| Demand and capacity for MHT+ workforce productivity | X | X | | |
| Proposal/recommendations for refinement of MHT/+ clinical model – underway, workstream and T&F groups established | X | X | | |
| Development of refined operating model to support delivery of agreed clinical model (to incorporate demand/capacity, workforce, digital, estates and contracting) | | | X | |
| Transition and sustainability of refined clinical and operating model to BAU | | | X | |
| Implementation of new CHYPS AMS pathway into the CMHF | | | | X |
| **Dementia Pathway Transformation** | | | | |
| **Milestone** | **25-26** | | | |
| | **Q2** | **Q3** | **Q4** | |
| Finalise GPwER and GP capacity increase (level 1) | X | | | |
| Design multi-tiered MDT model (levels 1,2 & 3) | X | | | |
| Go live with pilots in care homes (level 1) | X | | | |
| Expand pilots and scale up (level 1) | | X | X | |
| Finalise reflections on pilots and new model and communicate (level 1) | | X | X | |
| Develop MDT community model, exploring pilots and scaling opportunities (level 2) | | X | X | |
| **Mental Health Urgent & Emergency Care** | | | | |
| **Milestone** | **25-26** | | | |
| | **Q2** | **Q3** | **Q4** | |
| Publishing of revised Crisis 136 Standards | | X | | |
| Centralised HBPOS Go Live | | X | | |
| William Harvey Safe Haven increase to 24-hour service | | | X | |
| Bespoke Conveyance (to include sit and wait) go-live | | | X | |
| Procurement of Thanet and Medway Crisis Houses | | | X | |
| **Joint Working Across Health & Social Care** | | | | |
| **Milestone** | **25-26** | | | |
| | **Q2** | **Q3** | **Q4** | |
| Working group established to deliver on mental health pathways development | X | | | |
| Mapping of existing programmes of work and meetings to ensure alignment across KMMH and Local Authorities | X | | | |
| KMMH Social Workers commence internal secondment | X | | | |
| Complete mapping exercise of contracted services across the system covering health and social care | X | | | |
| Planning for a workshop surrounding commissioning gaps and needs, based on outputs from the mapping exercise | | X | | |

| | | | | |
|---|---|---|---|---|
| Embedding joint working practices and culture of inter-organisational collaboration | | | X | |
| Evaluation of KMMH Social Worker secondment work takes place | | | X | |

**Exception reporting on milestones**

**Community Mental Health Framework**

- Implementation of the new CHYPS AMS pathway into the CMHF will be established in line with the transfer of the children's service from NELFT in Q1 2026.

**Joint Working Across Health & Social Care**

- The ICB Adult Mental Health Commissioning Team are taking a recommendation to the 31 March 2026 Integrated Partnership Committee for an external agency to be appointed to undertake mapping exercise due to capacity issues. If approved, it is expected this work would commence in Q1 26/27 with a workshop following shortly afterwards. This milestone will be revisited once progress has been made.
- It should also be noted that KCC public health are planning workshops that include mental health prevention and centres on system synergy and governance to build an overall mental health plan for Kent and Medway.

**Urgent and Emergency Care**

- Centralised Health Based Place of Safety expected to open Q3 26/27 (delays due to construction issues); team will continue to use current health-based place of safety (HBPoS) in the meantime.
- Revision of S136 standards will now be implemented in Q3 26/27 as above in line with the changed HBPOS go live date.
- Ashford Safe Haven build delayed until July 2026 with a revised go live date of November 2026. This is part of the wider William Harvey Hospital capital build programme. A temporary location is in use during the day but the service is unable to move to 24/7 operations due to limited estate capacity.
- Margate crisis house opening delayed from Q4 2025 to most likely Q4 26/27 as a suitable building is yet to be identified. The capital investment is from the Pears Foundation.

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Proposal for a Structured Partnership Framework |
| **Author:** | Hannah Roberts; GMTS Trainee & Improvement Practitioner |
| **Executive Director:** | Adrian Richardson; Director of Transformation & Partnerships |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Board requested/Committee requested |

## Overview of paper

Kent and Medway Mental Health NHS Trust does not currently have a formal, organisation-wide definition or framework for partnership working, which has led to inconsistency in governance, accountability and oversight. In response to the Board's request for greater clarity, this paper introduces a clear definition of what constitutes a partnership, the principles that should guide collaborative arrangements, and a tiered System – Place – Neighbourhood model that ensures governance is proportionate to risk and strategic significance. The framework is informed by national guidance and benchmarking with NHS peers, providing a coherent foundation for consistent, transparent and well-governed partnership working.

## Issues to bring to the Board's attention

The absence of an agreed definition and set of partnership principles poses a strategic risk, with variable practice and inconsistent oversight across the Trust.

National policy and CQC Well-Led expectations require Boards to demonstrate robust governance of partnerships, making the adoption of a formal framework necessary.

The proposed framework addresses current gaps by establishing shared standards and a structured, risk-based governance pathway aligned to strategic impact and organisational exposure.

## Governance

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|---|---|
| **Implications/Impact:** | Engagement and consultation |

Version 2 - **Public**

| | |
|---|---|
| **Assurance:** | Reasonable |
| **Oversight:** | Board |

## Background

Kent and Medway Mental Health NHS Trust has not previously operated within a structured partnership framework. The development of the Community Mental Health Framework model has highlighted variation in how partnerships are currently managed and governed, reinforcing the need for a formalised approach to provide consistency, clarity, and appropriate oversight.

The proposed Partnership Framework has been informed by national guidance, regional policy, and benchmarking with NHS organisations across England. It introduces a proportionate, risk-based approach to defining, categorising, and governing partnerships, enabling consistent oversight, accountability, and evaluation of impact across the system.

The Health and Care Act 2022 positioned partnership working as a core expectation of the health and care system, requiring organisations to collaborate across system, place, and neighbourhood levels to improve outcomes and reduce inequalities. National guidance from NHS England and the Care Quality Commission further emphasises the need for clear governance structures that provide board-level oversight of partnership risks, benefits, and performance.

Benchmarking with organisations including Nottingham University Hospitals and the Royal Wolverhampton NHS Trust identified tiered models as effective in aligning governance with partnership scale, complexity, and strategic impact. This informed the development of a System, Place, and Neighbourhood model, ensuring governance is proportionate to risk and strategic importance.

## Definition

For the purposes of this framework, a partnership is defined as follows:

A partnership is a collaborative arrangement in which two or more organisations work together around a clearly defined shared purpose, with joint responsibility for design and/or delivery, to achieve outcomes that cannot be delivered as effectively by one organisation alone (The King’s Fund, 2017).

A defining feature of a partnership is co-delivery at one or more points, such that the arrangement is experienced as joined-up by those who receive benefit, including patients, carers, staff, communities, or partner organisations. Partnerships may be established to support outcomes that primarily benefit another organisation or population group, where there is a clear and agreed rationale aligned to wider system aims and shared values (NHS England, 2022).

Arrangements that involve the procurement of products, services, or workforce without shared delivery or shared ownership of outcomes do not constitute partnerships.

This definition establishes the boundary for what is included within the Trust's Partnership Framework and Register.

## Principles

The following principles set out how the Trust approaches partnership working. They provide the behavioural and governance foundation for the Partnership Framework and ensure that partnership arrangements remain purposeful, proportionate, and aligned to system ambitions.

### 1. Shared Purpose, Outcomes and Success Factors

All partnerships should be grounded in a clearly articulated shared purpose and intended outcomes. The rationale for partnership working must be explicit, justified, and aligned to wider system priorities and shared values.

Effective partnerships are defined not by structure or formality, but by the experience, outcomes and successes of those who receive benefit. Clarity of purpose supports transparency, accountability, and meaningful evaluation of delivery.

### 2. Mutual Benefit and Value Creation

Partnerships should be entered into with a clear understanding of how value is created. This value may be shared equally, may be unevenly distributed, or may primarily benefit another organisation or population group where there is a justified and agreed rationale.

The Trust will engage in partnership working where it contributes to shared objectives, wider system benefit, or improved outcomes for communities, while remaining proportionate to the nature and intent of the arrangement.

### 3. Identify Uniqueness

Partners should be clearly able to identify and articulate what unique contributions each are able to contribute.

### 4. Trust, Transparency and Accountability

Trust, transparency and openness underpin effective partnership working, particularly where arrangements span organisational, sectoral, or statutory boundaries.

Roles, responsibilities, decision-making processes, and risk ownership must be clearly articulated. It is key to articulate and understand the risk in terms of proportionality and type. Consideration must be given to an organisation ability to hold the risk.

Governance arrangements should reflect the scale, complexity, and maturity of the partnership, supporting collective ownership while maintaining clear lines of accountability.

### 5. Proportionality

Governance, reporting, and assurance mechanisms should be proportionate to the scale, risk, and strategic significance of the partnership.

Not all partnerships require the same level of formal oversight. The framework is designed to ensure that arrangements are governed appropriately without creating unnecessary bureaucracy or duplication of existing processes.

**6. Learning, Review and Continuous Improvement**

Partnerships should be subject to ongoing review to ensure they remain purposeful, effective, and aligned to changing needs and priorities. Partnerships should be able to understand their level or maturity and able to discuss and plan how and if they should aim to mature further.

**7. Co-Design of Processes**

Partnerships should be able to co-design the processes they are entering into and not as default adopt a process that is already established or one from a majority partner.

The framework itself will also be kept under review. This is a base model designed to be adapted to context and refined over time through learning and reflection.

These principles underpin the Partnership Model set out below, which translates this approach into a structured and proportionate governance pathway.

## Framework Structure and Governance

### Overview

The proposed Partnership Framework offers a clear and proportionate approach to classifying and governing partnerships. It would ensure that oversight, accountability, and assurance are applied consistently and scaled according to strategic influence, financial exposure, and risk.

At the centre of the Partnership Framework is the bull's-eye diagram, which shows how the Trust's partnerships would be organised and prioritised. The model uses a tiered structure, placing System, Place, and Neighbourhood partnerships in rings., with the innermost tier representing 'system' partnerships with the greatest strategic importance. The middle and outer layers cover 'place' and 'neighbourhood' partnerships focused on local delivery and community collaboration.

This bull's-eye diagram makes demonstrates how all partnerships would form part of one connected system, with governance and assurance increasing in line with risk, influence, and strategic impact. It also reinforces the principle that decisions and accountability sit at the lowest effective level, while providing a clear route for escalation when partnerships carry significant strategic or financial implications.

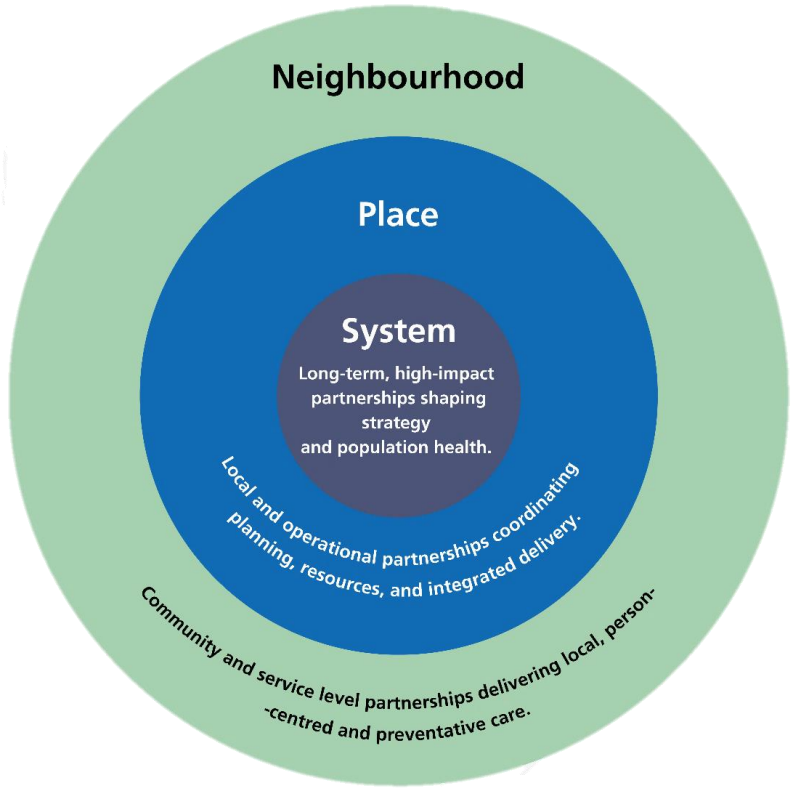



***Figure 1. Core partnership bull's-eye diagram***

The Partnership Governance Pathway Flowchart (Appendix 1) supports this process by determining whether a partnership requires high, medium, or low levels of governance within the System, Place, and Neighbourhood tiers. This assessment is being developed based on weighted criteria, including strategic alignment, level of exposure, and financial risk.

## Governance Framework

The accompanying System, Place, and Neighbourhood tables (Appendices 2-4) set out how each tier would be governed, who holds accountability, how risks would be managed, and how outcomes are evaluated. They provide a consistent structure for oversight and would ensure that partnerships of varying scale and complexity receive governance that is proportionate to their strategic or operational significance.

The table below outlines the three partnership tiers used within the framework. It shows how partnerships operate at different population scales and purposes, ranging from system-level strategic collaboration to place-level coordination and neighbourhood-level delivery of integrated care:

| Level | Population Size | Focus | Main Role |
|---|---|---|---|
| **System** | ~ 1 – 3 Million | Strategy | Set priorities and allocate resources |
| **Place** | ~ 250k – 500k | Coordination | Plan and deliver services locally |
| **Neighbourhood** | ~ 30k – 50k | Frontline Care | Deliver integrated care to individuals |

***Figure 2. Partnership Tier Overview Table***

In sum:

- System: Big picture strategy
- Place: Local service planning
- Neighbourhood: Care delivery close to people

## Current State

Kent and Medway Mental Health NHS Trust currently holds 31 active partnerships across statutory, voluntary and independent sectors (Appendix 5). The largest proportion of these partnerships are with NHS providers, representing 32% of the total. Partnerships with VCSE organisations account for 26%, while 23% sit within the private sector. A smaller proportion relate to system bodies, including the Integrated Care Board and NHS England, which comprise 13%, and 6% are formal partnerships with local authorities.

This distribution demonstrates a broad and diverse collaborative footprint. While NHS provider partnerships represent the single largest category, nearly half of all partnerships operate outside the statutory NHS structure, reflecting the Trust's increasing reliance on VCSE and independent sector organisations to support delivery, innovation and community-based care.

Although system body and certain NHS provider partnerships are fewer in number, they are likely to carry disproportionately higher levels of strategic influence, financial exposure and reputational risk. Conversely, a significant proportion of partnerships operate at neighbourhood or delivery level, where governance requirements should remain proportionate and supportive rather than overly bureaucratic. At present, there is no formal stratification of partnerships by risk, exposure or strategic impact, meaning collaborations of differing scale and complexity may receive similar levels of oversight.

The current profile therefore reinforces the need for a structured, tiered and risk-based Partnership Framework. Governance should increase in proportion to strategic alignment, financial exposure and organisational risk, rather than partnership volume alone. The proposed System, Place and Neighbourhood model would provide clearer differentiation, strengthen Board assurance for high-impact collaborations, maintain

agility for local partnerships, and ensure consistency of oversight across sectors in line with statutory and CQC Well-Led expectations.

## Proposed next steps

The following actions are suggested as the next steps in the development of the proposed Partnership Framework:

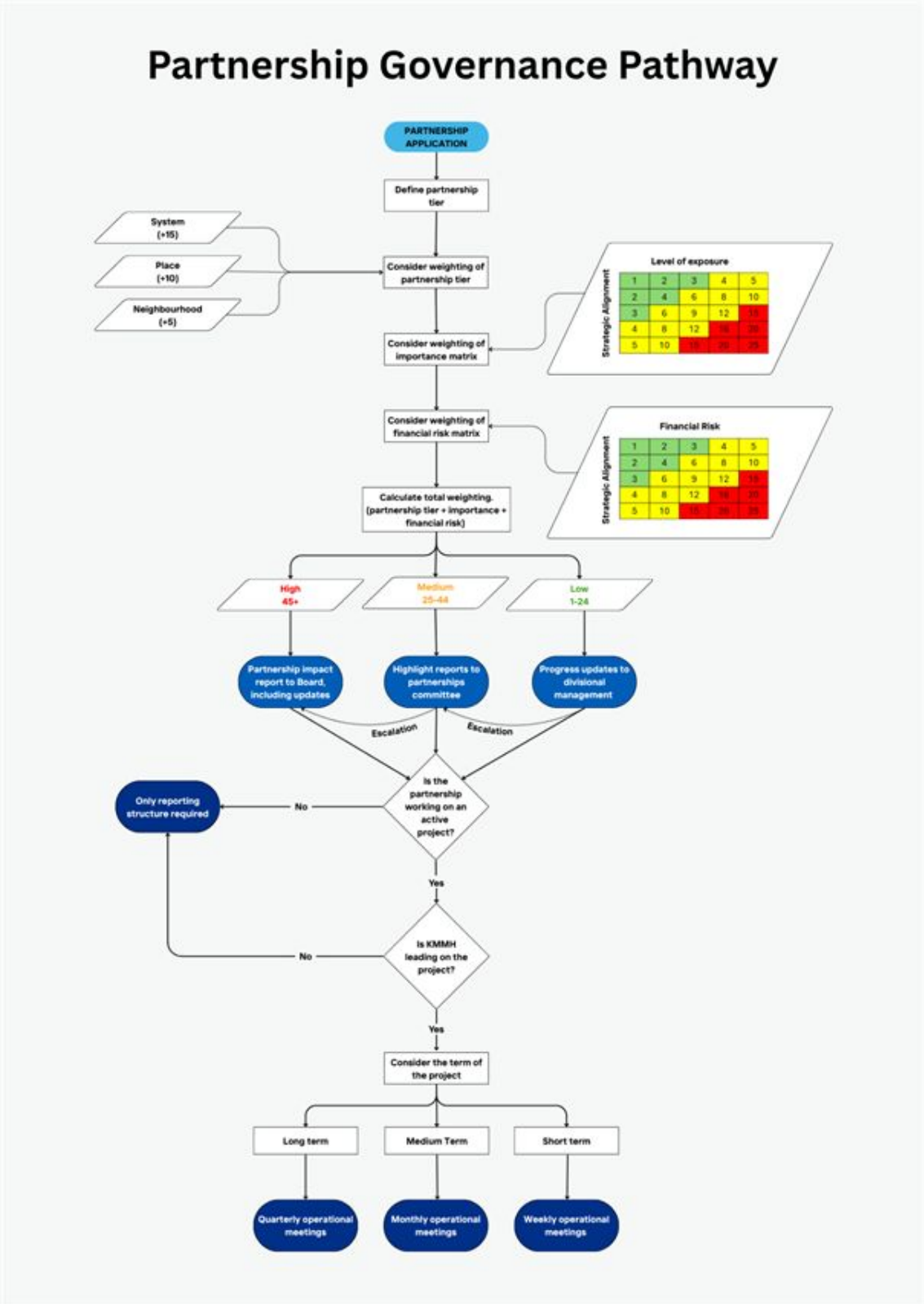
| Action | Due |
|---|---|
| Paper presented to board on current partnerships, mapped to proposed format. | Mar 2026 |
| Confirm alignment and agreement on the weighting matrices by engaging with the relevant committees. | May 2026 |
| Confirm alignment and agreement on the proposed levels of governance and assurance through discussion at relevant committees. | May 2026 |
| Partnerships Committee to be established. | June 2026 |
| Partnerships Framework / Policy sign off. | June 2026 |

The proposed Partnership Framework offers a structured, risk-based approach to governing collaborations across System, Place, and Neighbourhood levels, ensuring consistency, accountability, and alignment with statutory requirements. By adopting a tiered governance model informed by national guidance and best practice benchmarking, it can help the Trust further strengthen oversight, mitigate risks, and enable proportionate assurance while supporting innovation and integrated care. This framework would provide a clear mechanism for escalation and adaptability, positioning the Trust to deliver coordinated, sustainable services and improved population health outcomes.

This work is also critical to delivering the ambitions of the NHS 10 Year Plan and supporting new ways of working across NHS organisations. Establishing a clear, risk-based partnership framework will enable the Trust to collaborate effectively, drive innovation, and meet expectations for joined-up care over the next decade.

## Appendices

**Appendix 1 –** Partnership Governance Pathway Flowchart



**Appendix 2 -** System-level governance assurance table

| Tier & Level | Governance Lead | Accountable Lead | Reporting Structure | Risk Management | Financial Assurance | Evaluation |
|---|---|---|---|---|---|---|
| **System – High** | EMT | Executive Lead | Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF. | Board Assurance Framework | Open-book finance and EMT level reporting | Assurance reviews, impact reports, feedback and learning to EMT. |
| **System – Medium** | Partnerships Committee | Project / Partnership Lead in Partnerships Committee | Highlight reports to Partnerships Committee including escalations from directorate Management | Partnerships Risk Register | Monitored via finance meetings and reported to Partnerships Committee | Evaluation Framework to Partnerships Committee |
| **System – Low** | Directorate Management | Service / Project Lead & Partnerships Manager | Progress updates to directorate management | Partnerships Risk Register | Monitored via finance meetings and reported to Partnerships Committee | Self-evaluation with feedback to partnerships committee. |

System partnerships represent the highest tier of collaboration.

High-level partnerships are suggested to be overseen directly by the Executive Management Team to ensure alignment with strategic objectives and maintain visibility of any shared financial or reputational risk. Medium and low-level partnerships proposed to be managed through the Partnerships Committee or directorate-level structures, allowing proportional oversight without duplicating reporting. Even low-risk system partnerships would retain a degree of financial monitoring to maintain transparency and compliance with NHS England's guidance on good governance and collaboration (NHS England, 2022)

**Appendix 3 -** Place-level governance assurance table

| Tier & Level | Governance Lead | Accountable Lead | Reporting Structure | Risk Management | Financial Assurance | Evaluation |
|---|---|---|---|---|---|---|
| **Place – High** | EMT | Executive Lead | Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF. | Trust Risk Register | Open-book finance and EMT level reporting | Assurance reviews, impact reports, feedback and learning to EMT. |
| **Place – Medium** | Partnerships Committee | Project / Partnership Lead in Partnerships Committee | Highlight reports to Partnerships Committee including escalations from directorate Management | Partnerships Risk Register | Monitored via finance meetings and reported to Partnerships Committee | Evaluation Framework to Partnerships Committee |
| **Place – Low** | Directorate Management | Service / Project Lead | Progress updates to directorate management | Local Risk Register | Budget tracking, reported to directorate management. | Self-evaluation with feedback to partnerships manager |

Place partnerships sit between system-wide strategy and local delivery, bringing together organisations within a defined geography to plan and coordinate integrated care across that area.

While the suggested governance approach at this tier is similar to that for system-level partnerships, it is not predisposed to the highest levels of oversight. This is because place-based partnerships cover a specific area (albeit large) rather than the whole system. As a result, governance is scaled to reflect their more localised scope and risk profile, ensuring proportional oversight without unnecessary escalation.

**Appendix 4 -** System-level governance assurance table

| Tier & Level | Governance Lead | Accountable Lead | Reporting Structure | Risk Management | Financial Assurance | Evaluation |
|---|---|---|---|---|---|---|
| **Neighbourhood – High** | EMT | Executive Lead | Impact report and updates to EMT, including escalations from Partnerships Committee. Board kept sighted when relevant to BAF. | Partnerships Risk Register | Open-book finance and EMT level reporting | Assurance reviews, impact reports, feedback and learning to EMT. |
| **Neighbourhood – Medium** | Partnerships Committee | Project / Partnership Lead in Partnerships Committee | Highlight reports to Partnerships Committee including escalations from directorate management | Local Risk Register | Monitored via finance meetings and reported to Partnerships Committee | Evaluation Framework to Partnerships Committee |
| **Neighbourhood – Low** | Directorate Management | Service / Project Lead | Progress updates to directorate management | Local Risk Register | Budget tracking, reported to directorate management. | Self-evaluation with feedback to partnerships manager |

Neighbourhood partnerships represent the most local tier of collaboration, focusing on smaller, community-based areas where care is delivered closest to people's everyday lives.

Neighbourhood partnerships focus on the most localised areas, smaller and more community-based than Place partnerships. Because they operate at this scale, governance is proposed to be deliberately lighter and more flexible, while still connected to the wider assurance framework. This ensures that local initiatives can remain agile and responsive without unnecessary bureaucracy, while any partnership that grows in scope or risk can be escalated for stronger oversight when needed

**Appendix 5 -** Current State of Partnerships Table

| Type of Partner | List of Organisations |
|---|---|
| NHS Providers | East Kent Hospitals University NHS Foundation Trust (EKHUFT)<br>Kent Community Health NHS Foundation Trust (KCHFT)<br>Maidstone & Tunbridge Wells NHS Trust (MTW)<br>Medway Community Healthcare (MCH)<br>Sussex Partnership NHS Foundation Trust<br>NELFT<br>Oxleas / CNWL<br>St George's<br>King's Hospital<br>Hampshire, Isle of Wight and Southern Health |
| ICB/System Bodies | Kent & Medway Integrated Care Board (ICB)<br>NHS England<br>KSS Provider Collaborative<br>Health Education England |
| Local Authorities | Kent County Council (KCC)<br>Gravesham Borough Council |
| VCSE | Porchlight<br>Shaw Trust<br>Change Grow Live (CGL)<br>The Forward Trust<br>Kenward Trust<br>Langley House<br>Invicta CIC<br>D&G Trust |
| Private Sector | Cygnet Health Care Limited<br>Steeper<br>iCOM (BDR)<br>Cartref Homes<br>Athena<br>LMN Care<br>NHSP |

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# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Independent Quality and Safety Governance Review – Board Consideration and Next Steps |
| **Author:** | Moorhouse Consulting |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer |

## Purpose of paper

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|---|---|
| **Purpose:** | Approval |
| **Submission to Board:** | At the request of the Chief Executive Officer |

## Overview of paper

The attached paper presents the verbatim findings of the Independent Quality and Safety Governance Review that I commissioned in November 2025. The review provides an evidence-based assessment of the Trust's quality governance maturity and identifies priority actions required to strengthen assurance from frontline services to the Board.

Following two Care Quality Committee (CQC) warning notices and a cluster of serious incidents in community services, I commissioned an independent review.

As the report states, "the Trust cannot yet demonstrate a consistently reliable, end-to-end assurance system from ward/team to Board" and quality governance is assessed as **Developing with significant Lagging features.**

I am bringing the report to the Public Board in line with my commitment to transparency with patients, families, staff, and communities.

### Strategic context and alignment

The findings of this review directly relate to the delivery of the Trust's refreshed five-year strategy, which is also being considered on this Board's agenda. The review highlights that the golden thread between existing strategic priorities and measurable outcomes is not yet reliable, noting that "quality, risk, workforce and experience intelligence are often presented in parallel rather than synthesised into a single view of risk and improvement".

The review therefore highlights the importance of strengthening our quality governance alongside the work already underway through the Trust's **Doing Well Together** improvement approach and wider organisational capabilities – including leadership, culture, workforce, data, digital and insight – in order to deliver our strategic priorities to:

- Help people when they need it
- Keep people safe in our care
- Provide positive experiences for patients and staff

Version 2 - **Public**

- Use our time and resources wisely
- Supporting people with mental illness to live well and stay well

Strengthening this alignment is essential for the Trust to demonstrate measurable progress against its strategic ambitions.

This review provides a clear baseline for the Trust's improvement journey and will inform the priority actions required to strengthen quality governance, assurance and improvement across the organisation

### Link to the Board Assurance Framework

The Board Assurance Framework will be updated to reflect the refreshed Strategy and the findings of several external reviews, including the Moorhouse Consulting work. The review identifies material gaps in assurance that directly impact several risks on the current BAF, including:

- Quality and safety risk (various), due to inconsistent reliability of core safety controls (risk formulation, care planning, MHA compliance)
- Regulatory compliance risk (ID 02290), with the review noting that "regulatory readiness is not yet robustly evidenced)
- Workforce and culture risk (ID 08337), linked to change fatigue, variable middle-management capability, and low confidence in follow-through

Governance and assurance risk (no current entry), due to fragmented governance architecture, weak action discipline, and data quality issues.

The current BAF content, scores and controls are not adequate in light of the independent findings and must be reviewed.

## Issues to bring to the Board's attention

**Safety-critical control failures**
Moorhouse identified persistent weaknesses in risk formulation, care planning, and Mental Health Act compliance, reinforced by CQC enforcement and serious incidents.

**Governance discipline and architecture**
Moorhouse called out fragmented forums, inconsistent Terms of Reference, weak action tracking, and reliance on individuals rather than systems.

**Data quality and insight**
Moorhouse highlighted data quality issues and manual workarounds that undermine assurance and triangulation.

**Culture and leadership capability**
Moorhouse raised mixed staff confidence in follow-through, high change fatigue, and variable middle-management capability.

**Patient, family and carer involvement**
Moorhouse found that experience insights are not routinely or reliably used in governance nor assurance.

**Regulatory readiness**
Moorhouse concluded that the Trust cannot yet evidence compliance or verified impact of actions.

The trust has just had its Care Quality Commission (CQC) well-led inspection. I have shared the independent review with CQC prior to their inspection, so it is not a surprise that some of the CQC's initial, verbal feedback is aligned to the findings of the independent review.

Our refreshed five-year strategy responds to several of Moorhouse's findings. In addition to the Strategy, I believe that I need to implement a developmental programme specifically to address the quality and corporate governance recommendations and to ensure these changes are embedded. The developmental programme will be available to the Board by mid-April for approval. The developmental programme will be shared with CQC once Board has approved.

## Recommendations for Board decision

The Board is asked to:

- **RECEIVE** the Moorhouse Report for assurance
- **ACCEPT** the review's findings and recommendations in full
- **APPROVE** the development of a Trust-wide Quality and Corporate Governance Development Programme. This will address the priority recommendations in the Moorhouse report and other level 3 assurance documents, including the CQC's findings from unannounced visits.
- **INSTRUCT** a BAF review. This will ensure that the Development Programme has clear ownership, controls, metrics, and evidence requirements, and the BAF's scores, controls and assurances reflect the findings of the independent reviews.
- **AGREE** enhanced Board oversight arrangements. There will be quarterly progress reporting to the Board and monthly deep-dive assurance by the Quality Committee. The Development Programme will include explicit assurance ratings and evidence of impact, not just action completion.
- **SEND** to the CQC the Minute and papers relating to this item to advise them of the Trust's proactive approach to improvement.
- **APPROVE** sharing of the Development Programme with the CQC. After the Programme is received and approved by the Board, it will be shared with the CQC in line with regulatory expectations and the CEO's commitment to transparency.

## Governance

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| **Implications/Impact:** | The review identifies gaps in the Trust's quality governance, including inconsistent safety-critical controls, fragmented governance structures, and weaknesses in data quality and assurance. These issues present risks to patient safety, regulatory compliance, workforce confidence and the Trust's ability to demonstrate delivery of its strategic priorities. There are also implications for resource and leadership capacity. |
| **Assurance:** | The review provides limited assurance over the effectiveness of the Trust's quality governance arrangements. Evidence from the report includes: |

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|---|---|
| | • "Governance discipline and assurance are weak and fragmented"<br>• "Safety-critical controls are inconsistently reliable"<br>• "Patient, family and carer voice is not yet a dependable source of Board-level assurance"<br>• "Data quality and documentation workflow issues reduce confidence in assurance"<br><br>The review identifies credible building blocks for the future (Doing Well Together, Patient Safety Incident Response Framework (PSIRF) learning systems, refreshed Strategy), but these are not yet embedded or delivering reliable assurance. |
| **Oversight:** | Strengthened through the proposed Quality and Corporate Governance Programme, with monthly deep-dive through the Quality Committee and quarterly reporting to the Board. The Board Assurance Framework will be updated to align risks, controls, and evidence with the findings of the review and wider external assurance. |

Kent and Medway Mental Health NHS Trust

# Quality Governance Review

## 23 January 2026

## Final Report (v.F)

# Glossary

| Term / Abbreviation | Definition |
|---|---|
| AHP | Allied Health Professional |
| BAF | Board Assurance Framework |
| BAU | Business as Usual |
| BI | Business Intelligence |
| Breakthrough Objectives | High-priority goals designed to drive significant improvement in key areas within a defined timeframe. |
| CEO | Chief Executive Officer |
| CMHF | Community Mental Health Framework |
| Closed-Loop (assurance) | A governance approach where actions are tracked from initiation to verified completion, ensuring issues are resolved, learning is embedded and assurance is demonstrable. |
| CNO | Chief Nursing Officer |
| CPO | Chief People Officer |
| CQC | Care Quality Commission |
| CRAM | Child Risk Assessment Model |
| CREM | Carer Reported Experience Measure |
| DHR | Death Harm Review |
| Doing Well Together (DWT) | The Trust's improvement operating model structured around five pillars: strategy deployment, capability building, improvement management system, improvement projects, and leadership behaviours. |
| EMT | Executive Management Team |
| Exec | Executive Director |
| FFT | Friends and Family Test |
| FTSU | Freedom to Speak Up |
| Golden Thread | A clear line of sight from Board priorities to frontline delivery, ensuring strategic objectives are consistently translated into operational practice. |
| HBPoS | Health-Based Places of Safety |
| InPhase | A data warehouse and reporting integration tool used alongside RiO for quality and performance reporting. |
| IPC | Infection Prevention and Control |
| IQPR | Integrated Quality & Performance Review/Report |
| KMMH | Kent & Medway Mental Health NHS Trust |
| L&D | Learning and Development |
| Learning Review Groups | Forums introduced under PSIRF to replace traditional serious incident panels, focusing on system learning rather than blame. |
| LFPSE | Learning from Patient Safety Events |
| LWT | Leading Well Together (Trust's leadership development program) |
| MAS | Memory Assessment Service |
| MHA | Mental Health Act |
| MHT | Mental Health Together |
| MHT+ | Mental Health Together Plus |
| NED | Non-Executive Director |
| NHSE | NHS England |
| Pareto Analysis | A statistical technique used to identify the most significant factors contributing to a problem (often applied in incident analysis). |

| | |
|---|---|
| PICU | Psychiatric Intensive Care Unit |
| PREM | Patient Reported Experience Measure |
| PSIRF | Patient Safety Incident Response Framework |
| QG | Quality Governance |
| QGRF | Quality Governance Review Framework |
| QI | Quality Improvement |
| QIP | Quality Improvement Plan |
| RAG | Red-Amber-Green (status indicator) |
| Red Board Escalation | A governance mechanism for urgent escalation of high-risk issues to senior leadership or Board level. |
| RiO | Electronic Patient Record system used in NHS |
| SBAR | Situation, Background, Assessment, Recommendation |
| SDR | Strategy Deployment Review |
| SJR | Structured Judgement Review |
| SLT | Senior Leadership Team |
| SOAD | Second Opinion Appointed Doctor |
| SOP | Standard Operating Procedure |
| SPC | Statistical Process Control |
| ToR | Terms of Reference |
| True North Domains | Strategic themes that define the Trust's overarching priorities and direction, used to anchor improvement work. |

# Executive Summary

## Purpose & Scope of Review

This review of quality governance at Kent & Medway Mental Health Trust (KMMH) was commissioned in November 2025 by the Chief Executive Officer in response to two CQC warning notices and a cluster of serious incidents in community services. Its purpose is to provide an evidence-based assessment of the effectiveness of current quality governance arrangements at the Trust and provide recommendations to strengthen governance and assurance from ward/team to Board. A Quality Governance Review Framework, based on national guidance, regulatory expectations and best practice, was used to underpin the assessment. It covered strategy and vision; leadership and culture; governance, assurance and risk management; patient safety; workforce, learning and development; digital, data and insight; patient, family and carer experience; continuous improvement; and regulatory readiness.

## Overall Assessment of Quality Governance Maturity

Overall, KMMH's quality governance has been assessed as Developing with significant Lagging features in safety-critical assurance, patient and carer experience assurance, core governance controls and regulatory readiness. The Trust has, however, established several important established several important building blocks to improve its position, including clearer vision and intent for quality through the refreshed Trust Strategy, Quality Plan, the Doing Well Together (DWT) operating model and more mature safety learning systems from implementation of PSIRF (Patient Safety Incident Response Framework). However, the Trust cannot yet demonstrate a consistently reliable, end-to-end assurance system from frontline services to the Board. Quality, safety, workforce and experience intelligence are not consistently triangulated into a coherent view of risk and improvement and there is reliance on individuals rather than systems.

## Key Strengths

- **Clearer strategic intent and improved delivery architecture:** The Trust Strategy, Quality Plan and DWT infrastructure (e.g. Strategy Development Reviews) provide a stronger framework for translating the Trust's quality priorities into action.
- **Good practice aligned continuous improvement approach:** There is clear intent to strengthen learning and improvement, underpinned by a coherent improvement system (DWT) and early signs of quantifiable improvement (e.g. dementia diagnosis rates reduced from 27.1 weeks to 12.6 weeks – the Trusts is now among the best nationally for assessments and diagnosis within 6 weeks)
- **Visible leadership commitment**: Senior leaders recognise the scale of the challenge and have initiated reforms across quality, safety and governance, including this review, a separate independent review into serious incidents in the community and resource to support preparation for Well-led inspection.
- **Strengthening workforce and leadership development enablers:** Alongside investment in DWT, the Trust has introduced the Leading Well Together leadership development programme to support longer-term cultural and behavioural change. Early improvement has been seen in appraisal completion and work is also underway to review the Mental Health Together staffing model to address rising demand in community services.

- **Improving patient safety learning capability:** PSIRF implementation and learning from patient safety events analytics demonstrate a more mature approach to learning from incidents is emerging, with improved thematic analysis and system-focused learning.

## Key Areas for Development

- **Inconsistent reliability of core safety controls** (e.g. risk formulation, care planning quality, MHA compliance) coupled with regulatory breaches and recent serious incidents revealing governance and safety control concerns.
- **Mixed organisational culture and staff engagement**. Staff lack confidence that speaking up leads to action and follow through, coupled with high change fatigue amongst staff and mixed capability at middle management level.
- **Poor governance discipline, control and housekeeping and fragmented governance architecture**. Assurance is implicit and relies on individuals and narrative reporting rather than systematic, closed-loop approach. Risk management is not consistently driving action to reduce risk in a timely fashion and staff report being unclear on their role in risk management and mitigation.
- **Data quality, documentation workflow issues reduce confidence in assurance** and create manual workarounds. Reporting maturity varies across directorates, limited integration and triangulation of soft and hard intelligence and IQPR and safety insights.
- **Routine use of patient, family and carer experience input into governance and assurance products.** Patient/family voice is not consistently visible in quality and safety governance forums and reporting below Public Board. Insufficient levels of family and carer involvement observed in the independent review of community incidents.
- **Ability to routinely and robustly evidence regulatory readiness**. Demonstration of sustained compliance and embedded improvement through consolidated tracking and verification of impact, not just completion of actions, is a gap.
- **"Golden thread" from priorities to measurable outcomes** needs to be strengthened to support staff engagement and enable impact to be clearer demonstrated.

## Priority Recommendations

1. **Strengthen safety-critical controls and escalation**, particularly for risk formulation, care planning and MHA statutory compliance. Build standardised local quality control mechanisms to build ownership at ward/team level with more clearly defined escalation criteria.
2. **Improve governance discipline and assurance standards** through standardised reporting requirements for forums, explicit assurance grading, more robust action tracking and consequences for slippage. Rationalise governance forums.
3. **Build leadership accountability, capability and psychological safety** by improving responsiveness to concerns, including timely "you said, we did" feedback loops, developing skills and environment to constructively challenge, foster ownership and reflect on practice.
4. **Continue to develop data quality and insights used for assurance** by prioritising data quality improvement for safety-critical datasets (e.g. risk documentation, MHA, waiting times, streamlining and integrating and triangulating quality, safety and performance reporting and hard and soft intelligence.
5. **Embed patient, family and carer involvement and equity in assurance** by making experience insights a standing requirement in quality governance forums (including outcomes not activity) and learning from incidents/patient safety reviews

6. **Strengthen approach to regulatory readiness** by ensuring that quality improvement activity demonstrates learning, measurable impact and sustained change. Introduce a single inspection ready tracker and evidence library and routinely test whether completed actions have changed practice.
7. **Further develop translation of Quality priorities into operational action** by improving understanding of quality priorities, how they're delivered and measured, and what impact they'd had at all levels of the organisation through simple 'quality priorities on a page' document, linked to tracking in quality governance reporting packs and escalation to Trust Risk Register/BAF, where required.

# Introduction

This report provides an independent review of quality governance arrangements at Kent & Medway Mental Health NHS Trust (KMMH).

**What is Quality Governance?**

Quality governance refers to the system of structures, processes and behaviours that ensure an organisation consistently delivers safe, effective and person-centred care. It integrates accountability for quality with risk management, assurance and continuous improvement, creating a clear line of sight from frontline practice to Board oversight. A robust quality governance framework combines reliable data, clear escalation routes and disciplined decision-making to monitor performance, identify risks early and verify that corrective actions are implemented and sustained. Its purpose is to provide confidence that care standards are met, learning is embedded, and improvement is demonstrable across all services.

## Background and context

This review of KMMH's quality governance arrangements was commissioned by the Trust's Chief Executive Officer (CEO) in November 2025 in response to two significant quality and safety events - receipt of two Care Quality Commission (CQC) warning notices and a group of serious incidents in community services within a confined period.

### CQC Warning Notices

In March 2025, the Care Quality Commission inspected two of the Trust's services and found a decline in the quality of care being provided. In April 2025, Community-based mental health services for adults of working age received a warning notice and was re-rated as Requires Improvement overall, with the Safe category being downgraded from Requires Improvement to Inadequate. Shortcomings in the robust assessment and management of risk, creation of individualised care plans and governance processes providing timely assurance were cited as the primary drivers. As well as 4 regulation breaches in relation to safe care and treatment, buildings and premises, governance and staffing. It should be noted that the inspection report refers to increased demand on these services and staffing challenges, as a result of the Community Mental Health Transformation. Details of which are provided below and provide important context for this review.

In the same month, mental health crisis services and health-based places of safety were downgraded from Good to Requires Improvement overall (as were ratings for Safe, Effective, Responsive and Well-led). The service was also given a warning notice. The inspection highlighted breaches of the Mental Health Act (MHA), with patients often detained beyond the legally permitted period and receiving treatment with the correct legal permissions. The CQC published reports for community and crisis services in October and November 2025 respectively.

The Trust subsequently developed a Quality Plan in October 2025 to respond to the CQC's findings but also bring together learning themes from other existing mechanisms within the Trust. The plan identified four themes of improvement activity required relating to: (1) Safety & Risk, (2) Access & Waiting Times, (3) Environment, Experience & Equity and (4) Leadership, Culture & Governance. Each theme is led by an Exec although they have

purposefully not been assigned to themes relating to their portfolios to allow for “fresh eyes” and new perspectives. At the time of writing (January 2026), the Trust is entering Phase 3 of the plan ‘Embed and Demonstrate Impact’. This review is therefore able to comment on how the plan and its governance arrangements pertain to the review framework but not on its delivery.

**Community Serious Incidents**

Also in November 2025, a cluster of serious incidents resulting in self-harm or death also took place in KMMH’s community services within a 10-day period. In parallel to this review, an independent rapid review was also commissioned by the CEO to undertake an objective assessment of the incidents and the internal investigations that followed. The rapid review found governance and safety concerns including poor quality investigation documentation, inconsistent risk assessment and safety planning practice, insufficient communication and support for families and an overreliance on telephone consultations (Independent Rapid Review of a Focused Group of Incidents (Nov 2025)). Findings from the rapid review have fed into the findings of this review. Recommendations relating to that review are being followed up separately.

This review is intended to complement the Rapid Review and will provide a broader picture of quality governance, including patient safety, at the Trust.

**Mental Health Together (MHT) & Mental Health Together Plus (MHT+)**

MHT/MHT+ is the transformation of services in line with the NHS Community Mental Health Framework (CMHF) for Adults and Older Adults for Kent and Medway. The transformation started to be rollout in January 2024 and involves bringing together partners across the voluntary, community and social enterprise sector, as well as primary care, into delivering one single unified mental health service. The Trust’s vision for this transformation was ambitious and co-created with communities. It also involved bringing together the Trust’s community mental health services for younger adults aged 18-65 (i.e. adults of working age) and community mental health services for older adults aged 65+ amongst other changes (note. Access for early intervention in psychosis or at-risk mental state services is from age 14+).

MHT provides support to people with complicated and long-term mental health needs. MHT+ offers support to people who need more intensive care and provides specialised support for those with more complex needs – this aspect is delivered by KMMH staff, and wider support and interventions are delivered by partners. MHT and MHT+ mainly receives referrals from GPs, but also from other parts of the mental health system, such as acute and crisis mental health services.

Transformation exposed previously unmet demand – around 2,000 additional referrals annually than expected and planned for through demand modelling (equivalent to c.4.6% increase; Joint Chair & CEO Briefing Medway Council HASC, January 2026). This has been felt across all place-based directorates: East, North and West Kent.

Overall MHT activity has increased by 26% in the last 12 months to manage incoming demand, but this has been coupled with a 10% reduction in waiting times indicating improving access and performance. Since April 2025, the Trust has received 29,958 referrals into MHT services. If referrals continue at this average then the Trust expects to receive 44,922 for the full year 2025/26 (Joint Chair & CEO Briefing Medway Council HASC, January 2026). The Trust is current revising its community model to manage growing demand.

CQC inspected community services while the Trust was mid-transition and addressing already known challenges from the Attain review and feedback from stakeholders and staff. That said, the CQC reinforced the need to accelerate and embed this work. The MHT/MHT+ transformation is cited by CQC as a factor in the Inadequate Safe rating for Community-based mental health services for adults of working age. It therefore is important context for review findings and recommendations.

## Review Objectives

The objectives for the Quality Governance Review were to:

1. Review the effectiveness of current quality governance structures and processes across KMMH, including how assurance and learning flow from frontline services up to Board;
2. Examine how safety, quality and patient experience are monitored and escalated robustly ensuring alignment between governance, risk management and the Board Assurance Framework; and
3. Deliver a review report detailing evidence-based findings and recommendations to strengthen assurance, culture and governance, allowing the Trust to take proactive steps to mitigate the quality, safety and governance risks.

## Methodology

To conduct the review research into quality governance national guidance, regulatory expectations and best practice was completed. This was used to form a Quality Governance Review Framework (QGRF) with 11 categories in it, as illustrated below.


Each category had a number of key lines of enquiry which formed the basis of the assessment of evidence provided by the Trust.

Evidence sources included:

- **Stakeholder interviews** - Executive Directors (Execs), Non-Executive Directors (NEDs), wider corporate/Trust-wise and Directorate senior leadership
- **Document review** - including quality, safety, governance, business intelligence, workforce and transformation documentation
- **Focus groups feedback** - with c.60 frontline and middle management staff from across Directorates focusing on leadership, culture, governance structures, assurance, risk management, continuous improvement and feedback loops.
- **Survey responses** - sent out via Directorates to frontline and middle management staff covering the same topics as the focus groups.

Following analysis of each of the evidence sources, each category of the QGRF was assessed using a standard maturity rating scale:

**Maturing:** Governance is integrated, evidence-led and inspection-ready. There is a reliable golden thread from Board priorities to frontline practice, with routine triangulation of hard metrics, soft intelligence and independent assurance into a coherent risk narrative and trajectory. Safety-critical controls are dependable, escalation is consistently applied and actions show verified closure and sustained impact.

**Developing:** Intent and credible foundations are in place, but maturity is inconsistent and not embedded at scale. The golden thread works in parts of the organisation but varies by service/directorate; intelligence is often presented in parallel, and triangulation can be person dependent. Action tracking and benefits realisation are uneven and data quality/workforce pressures reduce confidence in assurance conclusions.

**Lagging:** Governance does not yet provide consistently reliable, closed-loop assurance in one or more safety-critical domains. Persistent control failures and/or recurrent non-compliance indicate core processes are not dependable, escalation and accountability are unclear or inconsistently applied. Intelligence is available but not consistently synthesised into a single risk story and recovery trajectory and follow-through is not reliably evidenced through to verified risk reduction.

Finally, the report was constructed, initially by:

1. Agreeing a report structure with the CEO and Senior Responsible Officer for the review (CNO)
2. Developing a draft set of ratings, key findings and illustrative examples for each category which was tested with the CEO and SRO
3. Drafting the full report, section by section.

It should be noted that during stages 1 and 2 it was agreed with the CEO to combine some of the categories where there was repetition of findings and evidence - namely, Governance, Assurance and Risk Management categories have been combined into one.

## Limitations

The review was conducted between the 19th of November 2025 and 23rd January 2026, which included one week of annual leave and two weeks pause for Christmas/New Year.

- **Stakeholder Interviews:** were confined to Exec, NED and SLT members. With more time/resource, the Review Team would have engaged broader stakeholders e.g. staff in the Quality and Governance Teams. Interviewee feedback has not been verified.

- **Documents:** have not been verified as accurate. It has been assumed that the Trust has provided us with the most up to date versions of documents. The Trust was provided with a data/information request suggesting documentation. It has been assumed the Trust has shared additional documentation where they believe it to be pertinent to the review.
- **Focus groups:** c.55-60 staff attended in total (i.e. >1% of KMMH's staff population). Representation skewed towards Nursing (c.70%) with some AHP and Ops attendance. Very limited medical input. Strongest representation from West Kent and Forensic & Specialist Directorates.
- **Survey:** 93 responses (i.e. c.2% of KMMH's staff population). Majority of staff were from East Kent Directorate (44%), followed by North and West Kent (20%, 19%). Only 2% of staff were from the Acute Directorate. The majority of responses were from nursing staff (41%) followed by psychological professions (22%) and 'Other' (19%). The Review Team did not have staffing data for the whole trust so are unable to comment on whether this is representative.

# Overall Maturity Assessment

Overall, KMMH's quality governance maturity is best characterised as Developing, with significant Lagging features across safety-critical assurance, patient/carer experience assurance and regulatory readiness. The Trust has strengthened elements of its operating architecture for strategy deployment and improvement (notably the Quality Plan and the Doing Well Together improvement operating model which includes true north domains and Strategy Deployment Review (SDR) cadence), and there are credible signs of maturing in learning systems (e.g., Patient Safety Incident Response Framework (PSIRF) capability and analytics).

However, the review evidence indicates that the Trust cannot yet demonstrate a consistently reliable end-to-end assurance system from ward/team to Board. Across multiple governance forums and papers, quality, risk, workforce and experience intelligence are often presented in parallel rather than synthesised into a single view of what is changing in the risk profile, why and with what confidence. This increases reliance on individuals (particularly Chairs of meetings and senior leaders) to connect the dots, reducing consistency of grip and weakening the audit trail of decision-making and follow-through.

The most material constraint on overall maturity is the dependability of safety-critical controls, with the strength of assurance in this domain already subject to regulatory concern. Patient safety maturity is rated Lagging because, despite improving safety learning infrastructure through PSIRF, there is evidence of persistent reliability failures (e.g., risk assessment and oversight) alongside recent enforcement and adverse safety ratings for community adult mental health and health-based places of safety services. Similarly, governance, assurance and risk management maturity is also rated Lagging due to inconsistent action discipline, governance housekeeping weaknesses that reduce clarity and inspection readiness, and repeated statutory non-compliance examples that are not consistently converted into explicit assurance conclusions and tracked risk reduction.

Patients, Families and Carers maturity is also assessed as Lagging because experience and engagement intelligence is not yet a dependable source of Board-level assurance. Triangulation with safety and risk is inconsistent, outcome/impact measures are under-developed, co-production is variable and feedback loops ("you said, we did") are not yet evidenced at scale - particularly in safety-critical pathways. This limits the Trust's ability to

demonstrate equitable, person-centred care and to evidence the contribution of lived experience insight to risk reduction and improvement decisions.

Enablers of effective governance also remain constrained. Digital/data maturity is Lagging because data quality issues and variable reporting maturity across directorates reduce confidence in assurance and increase manual workarounds. Workforce and improvement maturity are Developing - there is visible intent and some strengthening of enablers, but sustained issues with capacity, variable supervision quality/oversight and uneven capability and engagement limit the Trust's ability to embed improvement at pace and scale.

Taken together, this means KMMH has several credible building blocks, but overall quality governance maturity is not yet inspection-ready - particularly for Safe and Well-led domains where regulators and system partners will expect a clear, evidence-based narrative of sustained compliance, reliable safety controls and demonstrable risk reduction over time.

## Summary of QGRF Category Maturity Ratings

This table below summarises KMMH's maturity rating for each category in the QGRF and provides a short summary of the rationale behind each rating.

| Category & Maturity Rating | Rationale |
|---|---|
| **Vision & Strategy - Developing** | • The Trust has developed a clearer vision and identity, following extensive engagement with its stakeholders and has developed its approach to strategy delivery through the Doing Well Together improvement operating model. This has enabled stronger ways of turning priorities into plans and reviews.<br>• However, the "golden thread" from priorities to measurable outcomes is not yet consistent across directorates (e.g., variable outcome evidence and improvement impact; Community Mental Health (CMH) survey performance; Focus Group feedback).<br>• Delivery is held back by the basics not consistently being in control (e.g., policy and governance documents out of date; variable quality of directorate reporting). |
| **Leadership & Culture - Developing** | • There is visible investment in learning and leadership development (e.g., growing PSIRF capability; Leading Well Together roll out).<br>• But staff feedback suggests they are still not confident that speaking up leads to action and that follow through is consistent (e.g., NHS Staff Survey "confidence concerns will be addressed"; increasing Freedom to Speak Up (FTSU); Focus Group feedback; Review Team survey).<br>• Workload and change fatigue reduce headroom to embed culture change consistently, particularly in community services where staff are still in the midst of MHT/MHT+ transformation (HASC Briefing, Jan 2025; EMT & Directorate Interviews and Focus Groups). |
| **Governance Structures, Assurance & Risk Management - Lagging** | • Governance is not consistently joined up (parallel but separate SDR/IQPR); assurance often depends on individuals to connect the dots and drive follow-through (quality governance observations; Focus Groups).<br>• Governance groups appear to have grown reactively, creating duplication and unclear purpose (e.g., governance structure charts out of date/internally inconsistent; NEDs describe blurred lines and duplication between committees; Quality Committee becoming a "hopper for everything"). |

| | |
|---|---|
| | • Governance housekeeping and action discipline weaken confidence (e.g., out-of-date policies/SOPs; missing Terms of Reference (ToR); ambiguous delegation from sub-Board committees; unwarranted variation in ToR structure and content; actions rolling without clear consequence; wrong owners listed on Board Assurance Framework (BAF); risks not appropriately formulated in Trust Risk Register (TRR) and BAF; poorly documented SBAR (situation, background, assessment and recommendation) & Death Harm Review (DHR)).<br>• The Independent Rapid Review of a Focused Group of Incidents (v.9 Nov 2025) also identified the need to strengthen end-to-end assurance routes from clinical teams through to Directorates and Board citing instances where Red Board escalation was not evident despite risk indicators being present. |
| **Patient Safety - Lagging** | • Some examples of PSIRF learning systems (e.g. Daily Huddles, Learning Review Groups etc.) and analytics (e.g. LFPSE/PSRIF learning review) strengthening, but reliability of core safety controls is still inconsistent (e.g., risk formulation, care planning quality and MHA rights processes, TIAA Assurance Review of PSIRF). This was reinforced by the Independent Rapid Review of a Focused Group of Incidents (v.9 Nov 2025) which found similar safety control concerns.<br>• External regulatory evidence reinforces the gap between learning and dependable control (e.g., CQC Warning Notice (9 Apr 2025); Safe ratings in community adult MH and crisis/HBPoS services).<br>• The Independent Rapid Review of a Focused Group of Incidents (v.9 Nov 2025) identified material governance concerns including variable SBAR and DHR documentation and cases were learning, and follow-up action were unclear or absent. |
| **Workforce, Learning & Development - Developing** | • Some workforce enablers are strengthening (e.g. appraisal completion, Leading Well Together and DWT.), but service pressure limits equitable access to time to learn and engage in improvement. (especially in community services which are currently going through transformation because of MHT/MHT+).<br>• Supervision quality and consistency remain a material gap (including evidence of unrecorded supervision in samples).<br>• MHT/MHT+ transformation and resulting demand increases (c.4.6% increase in referrals above plan, equivalent to 2000 extra patients, HASC Jan 2025 Briefing) have increased pressure and oversight requirements - a risk for the sustainability of service quality and performance. Although the model is currently being revised to support demand.<br>• Staff experience data (NHS Staff Survey, Pulse Survey, Focus Groups) highlight widespread change fatigue amongst staff as well as concerns with organisational culture and staff wellbeing as key themes. |
| **Digital, Data & Insight - Lagging** | • Interviewees advise that KMMH's business intelligence (BI) capability has developed significantly over recent years, and this is evident in examples of progress including improved BI products (e.g. SDR & IQPR packs), RiO/InPhase integration and positive feedback and observations of directorate-aligned BI Partners.<br>• However, the Trust's assurance is still materially constrained by data quality, fragmented reporting architecture and manual workflows. Quality governance reporting also often relies on narrative updates and has minimal triangulation across soft and hard intelligence sources.<br>• Data quality and documentation workflow issues reduce confidence in assurance and create manual workarounds (e.g., RiO scanning/uploading |

| | |
|---|---|
| | inconsistency; paper reliance for statutory processes; self-harm data and reporting issues encountered by Independent Rapid Review Team).<br>• Reporting maturity is varied across directorates, limiting consistent triangulation and escalation (e.g., community dashboard packs still developing; multiple interim products).<br>• EMT describe "multiple versions of the truth" and reactive BI demand slowing decisions and weakening assurance. |
| **Patients, Families & Carers - Lagging** | • There are some credible initiatives and intent (e.g. Working with Families, Patient Council and new Involvement & Engagement function), but experience intelligence is not yet a routine, dependable input into assurance and governance artefacts tend to focus on activity rather than impact (Quality Plan intent vs. quality governance forum papers and observations).<br>• Patient/family voice is not consistently visible in quality and safety governance forums and reporting below Public Board (e.g., Quality Committee observation: patient voice not routinely presented alongside safety assurance discussions).<br>• Quality governance forum papers and indicate that equity analysis is not routinely integrated into reporting and rarely discussed in local governance (Directorate Interviews).<br>• Family and carer involvement described as a tick box exercise rather than meaningful partnership and building of trust in the Independent Rapid Review of a Focused Group of Incidents (v.9 Nov 2025). |
| **Continuous Improvement - Developing** | • A coherent improvement approach exists through DWT, but it is the early stages of roll out and is not yet consistently embedded as business as usual everywhere. Rollout slippage has also been seen, and interviews have highlighted reliance on finite QI adequately skilled QI resource.<br>• Where applied and embedded the DWT approach has demonstrated improvement. The example frequently cited by EMT and NEDs is the Memory Assessment Services (MAS) project where the proportion of dementia patients diagnosed within 6 weeks now exceeds the national and regional average (MAS presentation, Oct 2025).<br>• NHS Staff Survey & Pulse Survey results suggest reduced involvement in change and ability to influence improvement.<br>• Evidence of benefits realisation and sustainment are limited and weaker than the pace and scale of change required by the Trust to address live transformation, quality and safety challenges. |
| **Regulatory Readiness - Lagging** | • Quality Improvement Plans (QIPs) show positive intent/trajectory, but the Trust cannot consistently evidence basic controls and consistent closed-loop assurance. SLT members have also commented on the achievability and sustainability of actions within QIPs.<br>• Tracking and verification of regulatory actions is not disciplined enough (e.g., actions can roll; focus is on action completion rather than demonstrable outcomes and embedding of change).<br>• Ongoing compliance risks and document control gaps increase inspection vulnerability (e.g., 77 policies/SOPs out of date including safety-critical areas; regulatory enforcement and Safe ratings in key pathways). |

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

| Meeting details | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Integrated Quality and Performance Report (IQPR) |
| **Author:** | All Executive Directors |
| **Executive Director:** | Sheila Stenson, Chief Executive |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Standing Order |

## Overview of paper

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

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

## Issues to bring to the Board's attention

The Trust has remained in segment one in the NHS oversight framework which reviews trusts performance looking at a wide set of measures, including patient experience, clinical outcomes and financial sustainability. We are in the highest segment (segment 1), and are ranked 11th out of 61, across all the non-acute trusts in England

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

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

Version control 02 - **Public**

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

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

NHS
Kent and Medway
Mental Health
NHS Trust

# Integrated Quality & Performance Report

(IQPR)

March 2026

# Contents

# 1. Chief Executive Overview

This report highlights the trust performance for February, focussing on where performance is improving, areas of concern and what actions we are taking to address these. I have agreed with my team that we will have a refreshed IQPR for July Board that will ensure we have stronger reporting of quality and safety from front line services to Board. The areas of focus I wish to bring to the board's attention this month are quality and safety, patient flow, liaison services and Mental Health Together.

**Quality and Safety Overview**

As per above the work to strengthen our quality and safety reporting is on-going and will be finalised for July Board. We will be ensuring there is clearer triangulation of harm-related metrics, a broader inclusion of quality and safety metrics and will be based on learning from our peers within the sector.

Reflecting on February, I would highlight that we saw a significant increase in self-harms, the Acute directorate accounted for 151 incidents in February. This increase was due to a small cohort of patients with high rates of self-harm, and the consequent destabilisation this has had on the presentation of other patients on the wards. Foxglove went from 20 incidents in January to 91 incidents in February, Upnor also saw an increase from 18 incidents in January to 35 incidents in February. Ligature is the most prevalent form of self-harm reported, with the majority of incidents being of a non-fixed ligature type, followed by cutting. We are taking the following action in response to this:

- Focused improvement work on female wards, including pre admission professionals' meetings, sensory regulation training and resources, specific self-harm reduction pilots
- Principles for supporting people who self-harm established across inpatient wards (focusing on female acute wards)
- Monthly cross directorate self-harm steering group established
- Self-harm integrated into inpatient safety huddles
- Self-harm designated as a strategic breakthrough objective

In addition to this,

- Violence and aggression incidence totalled 151 in month, below the 13-month average of 234 but in line with normal variation.
- The use of restrictive practices, saw 140 incidents recorded in February, a continued downward trend from 141 in December and 170 in November.

**Patient flow / Bed state**

Management of our beds remains a key priority for us. Bed occupancy across our acute beds has remained high throughout quarter 4, in excess of 98% in February. Our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 53.7 days in February against a target of 68.3 days, despite this CRFD continues to be a significant pressure accounting for over 20% of bed days. We have often been in Operational Pressures Escalation Level (OPEL) 4 for the last 3 months. Our CRFD cohort of patients in acute beds has increased in the last two months to 66 as of 9th March compared to 52 as of January 9th, approaching a comparable high of 70 in January 2025. A short- and medium-term plan was discussed and agreed at our February Board seminar. The following actions will be taken:

- Short term – commissioned 17 step-down beds from the Priory. As of Monday 16th March, 13 beds will be utilised.
- Medium term:
    - ICB will commission 20 step-down beds by the end of June.
    - Crisis and Home treatment teams support to wards for early discharge and prevent admissions by the end of June.
    - Liaison support to reduce informal admissions with a focus on East Kent (EK) – to be completed by the end of June. There is a system urgent ad emergency care plan in place to support EK hospitals to which we are part of.
    - Trusted assessment model in place by the end of April.

**Liaison**

Liaison performance for referrals closed within 12 hours remains strong at 81.8%. However, in managing our bed flow as stated above we will have a particular focus on our liaison teams in the coming months commencing with the East Kent teams. Our focus will be on the following: Escalation process, conversion rates, known patients, self-harm, use of safe havens and ambulance conveyances. We will keep the Board sighted utilising this report.

**Community Mental Health, Mental Health Together (MHT)**

The refinement of the model is completed with good engagement from staff, our patients and partners in relation to next steps, which will include a phased implementation building upon the success of the Medway pilot. The critical path is built around the operational model to underpin the clinical model, which will be delivered in Q4 2025/26. The key next step will be communicating this to the organisation and partners in a clear way, involving and taking stakeholders with us on this next crucial stage of our journey.

I am pleased to report that for Mental Health Together (MHT) we have seen a reduction in waiting times. The MHT waiting list has reduced from 6,949 at the end of March 2025 to 6,404 (March 9th), which is an 8.5% reduction. Of the 6,404 waiting (as of 9th March) 78% are waiting under 18 weeks and 33% are within 4 weeks. The waiting list reflects all those open to MHT awaiting the commencement of an intervention

We have been focussed on eliminating those patients who have sadly waited over 52 weeks which is reported as 109 patients (1.7% of total list) as of 9th March. All these patients have been seen in MHT and are awaiting the recording of an intervention and/or commencement of an intervention. All patients reported as waiting over 52 weeks are reviewed weekly to ensure safety plans are in place.

The Trust is currently reviewing the waiting time measures across all services within the Community Mental Health Framework to ensure they effectively reflect the experiences of patients accessing local services alongside the requirements of national reporting. It has been agreed that two measures will be implemented, a measure of time to assessment within 4 weeks and a one of time to commencement of intervention (including outcomes measures and care planning) within 18 weeks. These measures will reflect the entire patient journey across MHT and MHT+, whereas the current measure is limited to MHT only. Methodologies are currently being finalised and plans being made for implementation.

Draft analysis of the data indicates an assessment waiting list of about 3,000, with 55-60% stopping the clock within four weeks. The treatment waiting list is expected to be around 6,500, similar to current figures due to comparable methods, with 70-75% of patients being seen within 18 weeks.

Further areas I'd like to note include:

- Sickness rates rose in line with seasonal pressures, including flu-related absence. The rate for February was 0.7% lower than in December. The hotspots areas we are reviewing are Community Teams in East and North Kent.
- We will be receiving a staff survey report to our Board today. The paper will highlight that there is much work to do to support better engagement with our community. The paper reflects the next steps we will be taking
- Older adult length of stay has been adversely impacted by the discharge of a few long stay patients. This has seen a positive movement in the OA CRFD position.
- We have set a new target 12% which was adopted in March for the Open Access Crisis Line: Abandonment Rate percentage (%).

# 2. Trust Wide Integrated Quality and Performance Dashboard

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

**Executive Sponsor: Adrian Richardson, Director of Transformation & Partnership**

### True North

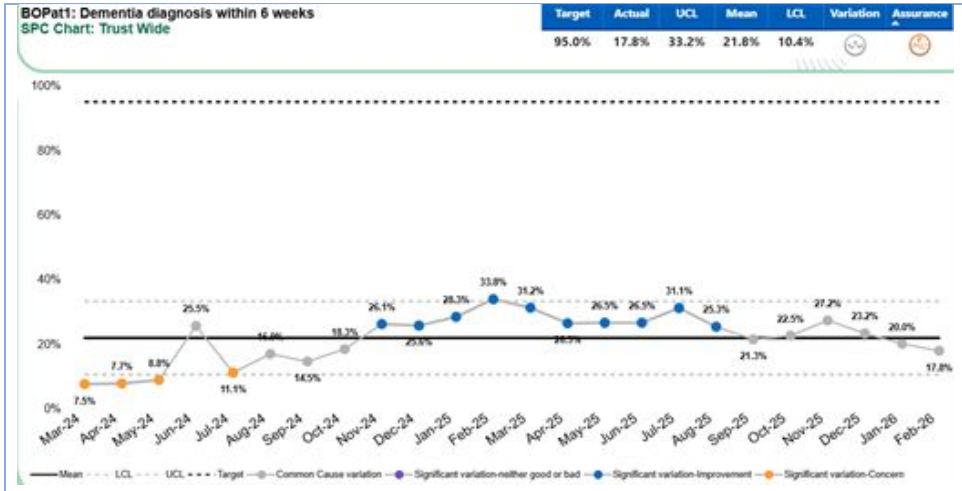
| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TNPat1: Timely access: Community (CMHF/MAS) patients needs are met within timeframes | 85.0% | 17.5% | 13.9% | 12.7% | 15.5% | 16.5% | 17.3% | 13.3% | 16.5% | 16.1% | 16.2% | 13.4% | 16.1% |
| TNPat2: Equitable access: <1% variance in waiting time (MHT/MAS) between most deprived and least deprived. | 1.0% | | | | (3.5%) | | | (9.2%) | | | (1.6%) | | |

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

### Breakthrough Objectives

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BOPat1: Dementia diagnosis within 6 weeks | 95.0% | 31.2% | 26.3% | 26.5% | 26.5% | 31.1% | 25.3% | 21.3% | 22.5% | 27.2% | 23.2% | 20.0% | 17.8% |
| BOPat2: Community (CMHF/MAS) referrals have ethnicity recorded | 90.0% | 84.0% | 83.8% | 83.9% | 84.0% | 83.9% | 84.0% | 83.6% | 83.6% | 84.1% | 85.5% | 86.1% | 86.1% |

## Focus on Breakthrough Objectives




| Data Source | RiO | Data Quality Confidence | |
|---|---|---|---|

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

**What is being measured?**

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

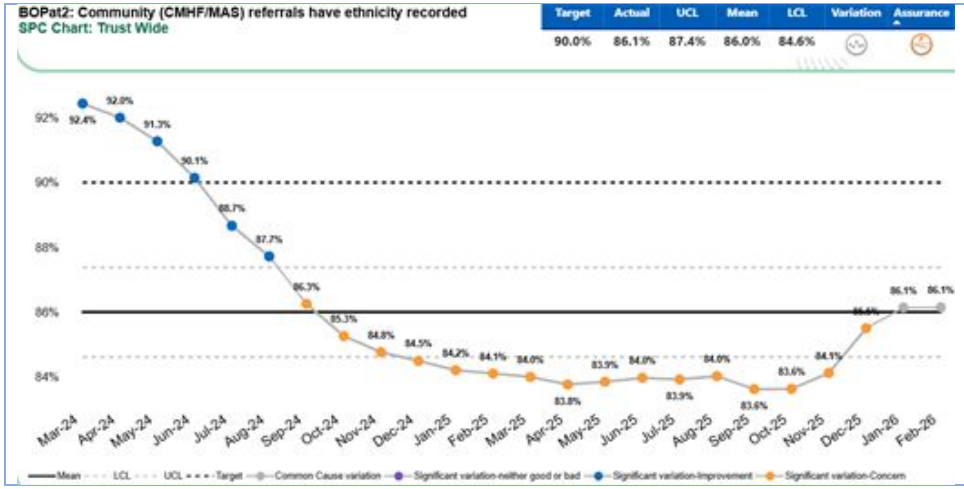
**What is the data telling us and key actions in place**

The SPC chart shows that the Trust is consistently failing the 95% target (not a national target, locally agreed) for compliance with the mean for compliance since March 2024 being 21.8%. Compliance has dropped below the mean reverting to common cause variation. KMMH performance remains above national and regional data reporting on 6-week performance from the NHS England MAS dashboard.

Since February 2025 there has been a focus on eliminating non-clinically necessary waits of over 52 weeks. This has seen a reduction in patients waiting over 52 weeks from 260 to 21 (6th March). Work continues to eliminate these non-clinically necessary waits

The improvement noted here is also reflected in the Kent and Medway system dementia diagnosis rate (DDR) which has increased from 59.1% in January 2024 to 62% in January 2026.

The review of the ethnicity of MAS patients who experience a Trust-led cancellation has highlighted that a) ethnicity is under-recorded (ethnicity was not recorded for 31.1% of MAS patients seen) and b) where ethnicity is recorded, trust led cancellations are proportionately more likely for Asian or Asian British patients. To address under-recording, the Trust implemented the 'about me' page on RIO in January 2026 which brings information together in one place and launched Health Inequalities training in December 2025. The impact of these initiatives, subsequent learning, and next steps will be considered in April 2026. In the interim, focused work through the Getting the Basics Right programme is seeking to address the reasons for trust-led cancellations including a focus on those of Asian and Asian British ethnicity.




| Data Source | RiO | Data Quality Confidence | |
|---|---|---|---|

**What is being measured?**

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

**What is the data telling us and key actions in place**

The SPC chart shows the Trust is consistently failing the 90% target for completeness, recent increases has seen this measure mover special cause variation of a concerning nature to common cause variation.

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

## Watch Metrics

*Note:*

*1.1.02: Open Access Crisis Line: Abandonment Rate (%): A new target of 12% was adopted in march 2026*

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

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1.01: Open Access Crisis Line: Calls received | 3,274 | 3,362 | 3,229 | 3,110 | 3,266 | 3,383 | 3,047 | 2,976 | 3,227 | 2,794 | 2,968 | 3,174 | 3,070 |
| 1.1.02: Open Access Crisis Line: Abandonment Rate (%) | 12.0% | 33.6% | 31.5% | 34.3% | 36.9% | 37.1% | 38.9% | 40.2% | 28.3% | 21.2% | 25.0% | 22.4% | 25.7% |
| 1.1.03: Assess people in crisis within 4 hours | | 86.9% | 94.9% | 94.7% | 86.9% | 93.7% | 91.4% | 93.6% | 91.0% | 90.9% | 84.9% | 91.4% | 85.1% |
| 1.1.04: People presenting to Liaison Services: triaged within 1 hour | | 88.0% | 88.6% | 90.7% | 92.3% | 92.1% | 89.4% | 90.8% | 90.9% | 89.2% | 93.9% | 92.3% | 88.8% |
| 1.1.05a: Liaison Psychiatry referrals closed within 12 hours | 95.0% | 78.1% | 80.4% | 80.0% | 81.6% | 84.6% | 82.1% | 81.8% | 82.8% | 81.5% | 82.6% | 82.8% | 81.8% |
| 1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours | 95.0% | 5.4% | 6.8% | 6.7% | 2.0% | 5.7% | 8.8% | 6.1% | 1.6% | 8.1% | 5.9% | 6.7% | 6.4% |
| 1.1.06: Place of Safety Length of Detention: % under 24 hours | 75.1% | 77.6% | 75.0% | 75.0% | 79.0% | 80.0% | 78.7% | 86.9% | 86.4% | 89.8% | 90.5% | 85.2% | 87.8% |
| 1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral | 60.0% | 61.5% | 52.6% | 69.6% | 72.2% | 70.0% | 85.7% | 92.3% | 87.0% | 76.5% | 76.9% | 50.0% | 75.0% |
| 1.1.09: % MHLD referrals commencing treatment in 18 weeks | 86.1% | 92.1% | 88.6% | 100.0% | 81.3% | 92.9% | 84.8% | 83.8% | 83.7% | 70.7% | 95.8% | 87.7% | 87.5% |
| 1.1.10: Perinatal assessments (against annual target) | 2,000 | 158 | 514 | 216 | 182 | 183 | 163 | 177 | 180 | 161 | 144 | 174 | 148 |
| 1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab) | | 1,819 | 2,035 | 2,205 | 2,053 | 2,281 | 1,861 | 2,231 | 2,321 | 2,067 | 2,141 | 2,246 | 2,287 |
| 1.3.01: Mental Health Scores From Friends And Family Test – % Positive | 86.0% | 87.9% | 87.7% | 88.7% | 91.2% | 90.8% | 88.4% | 88.8% | 87.4% | 83.6% | 86.9% | 87.4% | 88.3% |
| 1.3.02: Complaints - actuals | | 60 | 45 | 61 | 58 | 51 | 53 | 66 | 44 | 46 | 38 | 71 | 51 |
| 1.3.03: Compliments - actuals | | 122 | 131 | 122 | 159 | 174 | 118 | 139 | 153 | 150 | 178 | 124 | 128 |
| 1.3.04: Compliments - per 10,000 contacts | | 34.5 | 35.5 | 32.8 | 41.0 | 40.8 | 31.8 | 34.5 | 35.8 | 37.0 | 46.7 | 29.4 | 33.6 |
| 1.3.05: Patient Reported Experience Measures (PREM): Response count | | 563 | 513 | 626 | 605 | 577 | 424 | 456 | 507 | 353 | 434 | 405 | 501 |
| 1.3.06: Patient Reported Experience Measure (PREM): Response rate | | 3.6 | 3.2 | 3.7 | 3.5 | 3.2 | 2.6 | 3.1 | 2.8 | 2.0 | 2.5 | 2.2 | 2.8 |
| 1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly % | | 8.5 | 8.5 | 8.5 | 8.4 | 8.4 | 8.5 | 8.4 | 8.1 | 8.1 | 8.4 | 8.4 | 8.4 |
| 1.3.08: Complaints acknowledged within 3 days (or agreed timeframe) | 100% | 97% | 96% | 94% | 93% | 93% | 95% | 89% | 84% | 86% | 98% | 97% | 94% |
| 1.3.09: Complaints responded to within 30 days (or agreed timeframe) | 100% | 81% | 89% | 76% | 81% | 86% | 80% | 83% | 89% | 75% | 81% | 79% | 72% |
| 1.4.05: Decrease violence and aggression | | 210 | 246 | 226 | 237 | 276 | 224 | 277 | 256 | 242 | 205 | 205 | 151 |
| 1.4.06: Medication errors | | 54 | 46 | 62 | 50 | 54 | 45 | 55 | 54 | 36 | 40 | 31 | 49 |
| 2.1.01: Referrals to MHT commence treatment within 4 weeks | | 9.0% | 5.5% | 4.2% | 8.2% | 7.6% | 11.5% | 8.5% | 12.7% | 10.9% | 13.2% | 11.7% | 15.7% |
| 2.1.02: MHT waiting list size | | 6,884 | 6,290 | 6,062 | 5,664 | 5,825 | 5,782 | 5,903 | 6,098 | 5,837 | 5,759 | 6,113 | 6,198 |
| 2.1.03: MHT 2+ contacts | | 18,987 | 19,797 | 20,600 | 21,641 | 22,623 | 23,316 | 24,150 | 24,931 | 25,568 | 26,116 | 26,430 | 26,956 |
| 4.1.02: DNA Rate – All Appointments | | 10.4% | 10.8% | 10.7% | 11.0% | 10.7% | 10.1% | 10.5% | 10.4% | 9.8% | 10.0% | 10.6% | 10.4% |

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

**Executive Sponsor: Sandra Goatley, Chief People Officer**

## True North

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TNPeo1: Staff Engagement score from 6.8 to 7.3 by 2030 | 7.1 | 6.8 | | | | | | | | | | | |

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

**2025 Staff survey result will show against March 2026 in the next iteration of the report, this will be a staff engagement score of 6.7.**

## Breakthrough Objectives

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BOPeo1: Staff feel able to make improvements in their workplace | 60.3% | 58.5% | 54.8% | | | 58.7% | | | | | | 57.3% | |

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

## Focus on Breakthrough Objectives

**BOPeo1: Staff feel able to make improvements in their workplace**

*Insufficient data points to analyse by SPC*

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

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

**What is being measured?**

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

**What is the data telling us and key actions in place**

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

| Directorate | Target | Mar-25 | Apr-25 | Jul-25 | Jan-26 | Mar-26 |
|---|---|---|---|---|---|---|
| Acute | 58.8% | 61.6% | 57.1% | 64.7% | N/A | 63.7% |
| East Kent | 44.6% | 36.4% | 43.3% | 29.3% | 21.4% | 37.3% |
| Forensic and Specialist | 68.7% | 65.1% | 66.7% | 64.8% | 63.6% | 58.7% |
| North Kent | 51.5% | 55.4% | 50.0% | 60.0% | 50.0% | 59.1% |
| West Kent | 54.9% | 50.2% | 53.3% | 69.4% | 51.7% | 47.8% |
| Support Services | 79.0% | 70.5% | 77.2% | 71.9% | 72.1% | 71.2% |

March 2026 data reflects the National Staff Survey 2025 for which the sample size was 2001. The Pulse survey was conducted in January 2026 following the completion of the national staff survey, both sets of results are shown here. East Kent is undertaking a focused piece of work in relation to the clinical and operational leadership within MHT and MHT+, specifically in relation to Operational Team Managers, Lead Nurses and Lead Clinicians. Line management structures and job plans have been revised with the intention this will result in clarity of job role and clear lines of responsibility and accountability for post-holders and the wider teams. This took place in Thanet last Autumn and has seen positive results. The change was implemented in Ashford and Canterbury in December and is being worked through in South Kent coast now. We are working with the Improvement Team as to how we can measure the impact and correlate it to more positive staff experience.

The approach to improving Staff Experience and Engagement has evolved for 2026. All directorates will be producing an action plan which is tied into the True North and Breakthrough objectives of the 2026-2031 Trust strategy. Directorates will be sharing their results, holding staff focus groups and developing these plans in the coming months. Actions will be regularly reviewed during SDR or as per directorate review process as applicable.

The annual employee engagement survey has now closed; the indicative Trust response rate is 50.6% which is a decline of approx. 4.62% on last year.

The two programmes of work expected to drive improvements in these results relate to the roll out of the Staff Voice (trialled as Staff Council in Forensics), and the delivery of the Doing Well Together programme.

**The Staff Council** has been piloted in Forensic and Specialist services and will be rolled out across the organisation Spring 2026, with new councils being in place in all directorates by late spring 2026. This was agreed at TLT on the 21st January.
**Leadership Behaviours** – improvement leadership behaviours have been incorporated in the trust leadership programme – Leading Well Together. Behaviours were assessed to gain a personal benchmark through the creation of a new 360 tool, this is currently being repeated.

| | |
|---|---|
| | The programme commenced in April 2025 and will end in May 2026. There are 4 modules Leads Self, Leads Team, Leads Organisation and Leads System. Leads Self, Leads Team modules and Leads Organisation have been completed. Leads System module is planned to be completed in conjunction with senior leaders at KCHFT as a joined approach.<br>**Health and Wellbeing -** In December we submitted wellbeing intervention proposals (1 system bid led by DGT and 1 KMMH submission) to the NHS Charities Together Workforce Wellbeing Programme.<br>• The system Transformation category bid was submitted by DGT on behalf of K&M ICB trusts requesting up to £250k focussed on mental health support through a wellbeing retreat programme.<br>• The KMMH submission was to the Immediate Impact category requesting £50k proposing to further develop our clinical health psychology staff support service offer.<br><br>Engagement underway to consult staff on health and wellbeing plans as current plan nears the end of it's 3-year period. |

## Watch Metrics

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1.01: Staff Sickness - Overall | 3.5% | 4.6% | 4.3% | 4.3% | 4.1% | 5.0% | 5.2% | 4.9% | 4.9% | 5.5% | 5.9% | 5.1% | 5.2% |
| 3.1.02: Vacancy Gap - Overall | 14.0% | 9.8% | 10.0% | 10.1% | 10.3% | 10.2% | 10.3% | 10.2% | 10.2% | 10.3% | 10.2% | 10.4% | 10.4% |
| 3.1.03: Mandatory Training For Role | 90.0% | 95.5% | 95.4% | 95.4% | 94.8% | 95.4% | 95.6% | 94.8% | 95.4% | 95.3% | 95.6% | 95.7% | 95.5% |
| 3.1.04: Leaver Rate | 15.0% | 12.5% | 12.8% | 12.6% | 12.6% | 11.9% | 11.9% | 11.4% | 11.2% | 11.7% | 12.1% | 12.3% | 12.6% |
| 3.1.05: Leaver Rate (Voluntary) | 14.0% | 9.1% | 9.2% | 8.9% | 9.0% | 8.2% | 8.1% | 7.8% | 7.7% | 7.4% | 7.4% | 7.5% | 7.6% |
| 3.1.06: Safer staffing fill rates | 80.0% | 108.8% | 110.7% | 112.1% | 109.6% | 110.2% | 109.2% | 110.3% | 109.0% | 108.6% | 109.6% | 109.4% | 110.3% |
| 3.1.07: Increase percentage of BAME staff in roles at band 7 and above | 20.0% | 28.5% | 28.5% | 27.0% | 27.5% | 29.8% | 30.6% | 30.9% | 30.9% | 30.7% | 30.5% | 31.1% | 31.0% |
| 3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected. | 0.50% | 0.21% | 0.05% | 0.17% | 0.32% | 0.44% | 0.39% | 0.23% | 0.12% | 0.11% | 0.27% | 0.35% | 0.23% |

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

**Executive Sponsor: Dr Afifa Qazi, Chief Medical Officer**

## True North

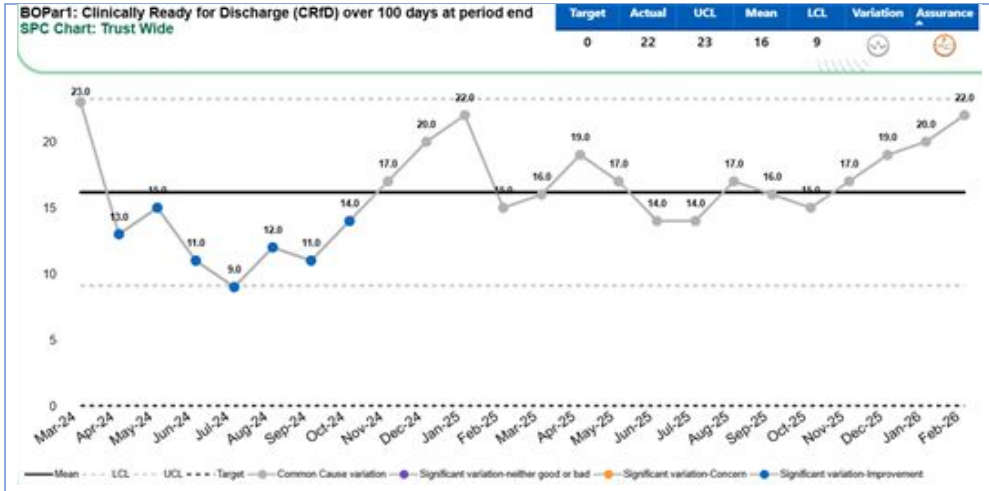
| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TNPar1: Reduce Clinically Ready for Discharge (CRfD) length of stay (LoS) by 25% by 2030 | 68.3 | 67.2 | 94.5 | 86.9 | 69.6 | 46.3 | 82.2 | 81.9 | 92.9 | 45.8 | 69.9 | 116.1 | 53.7 |

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

## Breakthrough Objectives

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BOPar1: Clinically Ready for Discharge (CRfD) over 100 days at period end | 0 | 16 | 19 | 17 | 14 | 14 | 17 | 16 | 15 | 17 | 19 | 20 | 22 |

## Focus on Breakthrough Objectives




| Data Source | RiO | Data Quality Confidence | |
|---|---|---|---|

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

**What is being measured?**

Total number of patients with a CRfD on the last day of the month with a CRfD Length to date of over 100 days

**What is the data telling us and key actions in place**

The data shows normal variation over the last 2 years with no periods of significant change, resulting in an average of 16 patients CRFD at month end over this period. There is consistent failing of the target of 0. CRFD LoS has decreased in March (53.7 days)

CRFD in total and CRFD >100days has increased as part of an annual seasonal variation. Staff changes within KCC has led to a reduced level of engagement which is also impacting CRFD.

Short term (5 months) stepdown bed provision (17 beds) agreed at Priority Ticehurst to support reduction in CRFD numbers and release capacity. Provisional start date of transfers to start in mid-March.

Data analysis of bed use and CRFD Deep dive used to create medium term (3 to 6 months) plan as follows:

1) ICB commissioned step- down beds
2) Liaison Psych teams improvements to reduce informal admission for EUPD
3) Crisis team improvement to support people in the community to prevent admission and improved support to wards with early discharge.
4) Support to Care providers in the Community to manage more complex patients with discharge from wards.
5) Joint work with KCC on trusted assessment model

## Watch Metrics

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.2.01: Average Length Of Stay (Younger Adults Acute) | 34.0 | 49.4 | 36.9 | 38.9 | 35.1 | 36.2 | 32.8 | 42.6 | 50.9 | 27.5 | 31.5 | 61.3 | 44.1 |
| 1.2.02: Average Length Of Stay (Older Adults - Acute) | 77.0 | 125.8 | 87.7 | 102.4 | 88.8 | 71.4 | 69.1 | 104.3 | 79.7 | 76.0 | 81.6 | 71.1 | 120.4 |
| 1.2.03: Adult acute LoS over 60 days % of all discharges | 16.0% | 22.6% | 18.4% | 17.0% | 14.9% | 14.5% | 12.2% | 14.4% | 22.9% | 12.9% | 13.3% | 20.4% | 15.6% |
| 1.2.04: Older adult acute LoS over 90 days % of all discharges | 37.7% | 48.0% | 35.1% | 40.0% | 33.3% | 30.3% | 30.0% | 43.3% | 31.3% | 24.0% | 42.9% | 25.9% | 29.6% |
| 1.2.06: Readmissions within 30 days (YA & OP Acute) | 8.8% | 11.9% | 11.5% | 6.3% | 11.4% | 10.4% | 16.7% | 12.6% | 12.0% | 10.3% | 12.2% | 12.3% | 11.8% |
| 1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) | 608 | 926 | 1,026 | 875 | 775 | 625 | 608 | 574 | 590 | 561 | 482 | 407 | 453 |
| 1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end | 21 | 36 | 31 | 28 | 28 | 19 | 17 | 22 | 18 | 17 | 14 | 13 | 17 |
| 2.1.04: Clinically Ready for Discharge (CRfD): YA Acute | 7.0% | 21.7% | 22.0% | 18.9% | 15.2% | 14.4% | 17.5% | 17.9% | 15.2% | 20.3% | 22.0% | 19.9% | 21.9% |
| 2.1.05: Clinically Ready for Discharge (CRfD): OA Acute | 12.0% | 32.9% | 29.3% | 21.3% | 25.4% | 31.9% | 36.2% | 31.8% | 30.6% | 28.7% | 23.6% | 24.6% | 29.6% |
| 4.1.01: Bed Occupancy (Net) | 92.0% | 97.4% | 94.2% | 94.0% | 95.8% | 95.3% | 96.8% | 97.7% | 96.4% | 97.9% | 97.0% | 97.7% | 98.4% |

*1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 453 bed days were used in February 2026, 140 were female PICU patients within contracted beds resulting in 313 out of area placement days as an accurate reflection of trust performance.*

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

**Executive Sponsor: Andy Cruickshank, Chief Nurse**

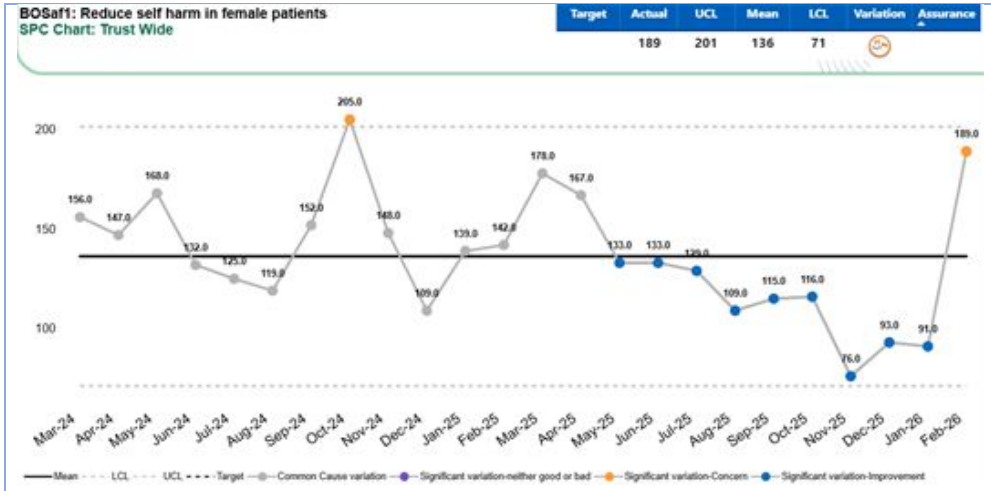
## True North

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TNSaf1: Reduce the number of patient harms | | 232 | 207 | 165 | 175 | 178 | 149 | 146 | 152 | 105 | 127 | 116 | 228 |

## Breakthrough Objectives

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BOSaf1: Reduce self harm in female patients | | 178 | 167 | 133 | 133 | 129 | 109 | 115 | 116 | 76 | 93 | 91 | 189 |

## Focus on Breakthrough Objectives




| Data Source | InPhase | Data Quality Confidence | |
|---|---|---|---|

Some potential data completeness issues being investigated within community services

**What is being measured?**

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

**What is the data telling us and key actions in place**

SPC is showing special cause variation of an improving nature due to 9 months below the mean. The mean since March 2024 is 136.

February saw a significant increase within the trust's acute wards linked to a small number of patients with high rates of self-harm, and the consequent destabilisation this has had on the presentation of other patients on the wards, leading to an increase in their self-harming behaviours. Foxglove went from 20 incidents in January to 91 incidents in February, Upnor also saw an increase from 18 incidents in January to 35 incidents in February

The Acute directorate accounted for 151 incidents in February 2026. The services with the highest number of self-harm incidents over the past 12 months are: Chartwell, Fern, Foxglove, Upnor and Walmer wards. Ligature is the most prevalent form of self-harm reported, with the majority of incidents being of a non-fixed ligature type, followed by cutting.

The A3 workshops on the East Kent female wards have been undertaken and the information gained from these aligned with the feedback gathered via the staff survey at the beginning of the year. The "lived experience of self-harm" survey has now closed and the results are being reviewed. A set of principles for supporting individuals who self-harm have been created based on patient and staff feedback and best practice guidance, and we are awaiting a confirmation of a trust launch date of these from the communications team. A staff room page has also been developed and is with the communications team to action. Both the ASH and MRAP pilots have concluded and work is underway to plan how these pilots can be operationalised and rolled out across the acute inpatient estate.

## Watch Metrics

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.2.05: Patients receiving follow-up within 72 hours of discharge | | 84.5% | 82.8% | 83.9% | 89.9% | 91.3% | 85.8% | 88.5% | 87.0% | 88.7% | 85.9% | 90.8% | 86.7% |
| 1.2.10: %Patients with a CPA Care Plan | 95.0% | 89.3% | 89.5% | 90.7% | 89.7% | 84.7% | 81.8% | 82.2% | 81.5% | 78.0% | 75.6% | 73.8% | 72.7% |
| 1.2.11: % Patients with a CPA Care Plan which is Distributed to Client | 75.0% | 70.7% | 71.6% | 71.9% | 70.4% | 74.1% | 74.7% | 76.1% | 75.9% | 74.5% | 73.5% | 59.9% | 54.5% |
| 1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans | 80.0% | 61.1% | 56.4% | 54.7% | 57.1% | 53.1% | 48.7% | 46.8% | 45.9% | 44.0% | 39.0% | 37.4% | 44.3% |
| 1.4.01: Occurrence Of Any Never Event | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1.4.02: All Deaths Reported And Suspected Suicide | | 159 | 120 | 149 | 152 | 135 | 113 | 137 | 146 | 105 | 164 | 177 | 143 |
| 1.4.03: Restrictive Practice - All Restraints | | 109 | 103 | 95 | 57 | 100 | 87 | 111 | 163 | 170 | 141 | 99 | 140 |
| 1.4.04: Restrictive Practice - No. Of Prone Incidents | 0 | 8 | 5 | 2 | 12 | 8 | 4 | 7 | 16 | 12 | 4 | 10 | 3 |

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

**Executive Sponsor: Nick Brown, Chief Finance and Resources Officer**

## True North

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TNSus1: Clinician Contact time per FTE | | | 0.31 | 0.33 | 0.33 | 0.32 | 0.32 | 0.35 | 0.33 | 0.34 | 0.32 | 0.34 | 0.34 |

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

## Breakthrough Objectives

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BOSus1: Psychology & Medic contact time per FTE | | | 0.35 | 0.40 | 0.40 | 0.38 | 0.36 | 0.38 | 0.40 | 0.39 | 0.34 | 0.39 | 0.36 |

## Focus on Breakthrough Objectives

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

## Watch Metrics

| Measure Name | Target | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1.04: In Month Budget (£000) | 0 | (14,742) | (15,122) | (15,315) | (15,413) | (15,303) | (17,957) | (15,725) | (15,710) | (15,553) | (15,537) | (15,537) | (15,514) |
| 4.1.05: In Month Actual (£000) | | (15,488) | (16,169) | (16,064) | (15,684) | (15,469) | (17,979) | (16,362) | (16,355) | (16,094) | (16,332) | (15,992) | (16,128) |
| 4.1.06: In Month Variance (£000) | | (746) | (1,047) | (749) | (271) | (166) | (23) | (637) | (645) | (541) | (795) | (455) | (614) |
| 4.1.07: Agency spend as a % of the trust total pay bill | 3.2% | 1.9% | 2.7% | 2.5% | 2.6% | 1.9% | 2.0% | 1.8% | 2.2% | 1.7% | 2.2% | 1.3% | 1.8% |

# 5. Appendices

## NHS Oversight Framework

NHS England » NHS Oversight Framework 2025/26

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

**As of Q2 2025/26 KMPT is in segment one, the highest segment available**: *The organisation is consistently high-performing across all domains, delivering against plans*.

| Headlines | Data period | Provider value | Peer average | | National value | National value method | Chart |
|---|---|---|---|---|---|---|---|
| Adjusted segment | | | Q2 2025/26 | 1 | NOF Score | Provider value | |
| Average metric score | | | Q2 2025/26 | 1.94 | NOF Score | Provider value | |
| Unadjusted segment | | | Q2 2025/26 | 1 | NOF Score | Provider value | |
| Financial override | Q2 2025/26 | No | Yes | | Yes | Provider median | |
| Is the organisation in the Recovery Support Programme? | Q2 2025/26 | No | No | | No | Provider median | |

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

| Domain Scores | Data period | Provider value | | Chart |
|---|---|---|---|---|
| Access to services domain segment | Q2 2025/26 | 1 | NOF Score | |
| Effectiveness and experience of care domain segment | Q2 2025/26 | 1 | NOF Score | |
| Patient safety domain segment | Q2 2025/26 | 3 | NOF Score | |
| People and workforce domain segment | Q2 2025/26 | 3 | NOF Score | |
| Finance and productivity domain segment | Q2 2025/26 | 1 | NOF Score | |

*Extract as at 03/12/2025*

# Report Guide

## True North

***The guiding direction of the organisation***

**Timeframe: 3-5 years**

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

## Breakthrough Objectives

***The improvement focus of the organisation***

**Timeframe: 0-12 months**

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

## Watch Metrics

**Important metrics to understand department performance**

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

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Finance report for Month 11 (February 2026) |
| **Author:** | Nicola George, Deputy Director of Finance |
| **Executive Director:** | Nick Brown, Chief Finance and Resources Officer |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Regulatory Requirement |

## Overview of paper

The attached report provides an overview of the financial position for month 11 (February 2026).

## Issues to bring to the Board's attention

For the period ending 28th February 2026, the Trust has reported a surplus of £2.02m (post technical adjustments) this is in line with the financial plan.

The key financial challenges for the Trust are:

- Use of external beds remains a pressure, with 11 Acute and 6 Psychiatric Intensive Care Unit (PICU) beds used in month and a year-to-date budgetary pressure of £5.19m.
- Year to date agency spend is £4.37m. Expected agency spend for 25/26 is £4.62m.
- The Trust's Acute Inpatient wards pay pressures have continued to utilise additional Nursing staff (both registered and unregistered) over and above established levels causing an average financial pressure of £0.35m per month. The year-to-date pressure now totals £3.35m.

The Trust's cash position closed at £12.72m, this is back in line with plan following the lower figure reported at the January Board.

## Governance

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

NHS
Kent and Medway
Mental Health
NHS Trust

# Finance Reporting Pack

## Trust Board
## February 2026

# Contents



Caring | Inclusive | Curious | Confident

# 1. Executive Summary

### Key Messages

For the period ending 28th February 2026, the Trust has reported a surplus of £2.02m (post technical adjustments) this is in line with the financial plan.

Key pressures for the Trust are:

### External beds

- External bed expenditure continues to be a financial pressure. In month, usage of external Acute beds increased to 11 beds compared to the 7 last month. External PICU usage remained at 6 beds. The year-to-date pressure for external bed usage totals £5.19m.

- To help ease bed pressures, the Trust has continued utilising step-down capacity, supporting the repatriation of patients from external Acute beds to internal beds. A total of 3,549 block bed days have been purchased at a cost of £0.67m, with estimated usage of 1,860 bed days since June. At this level of utilisation, the Trust has achieved cost avoidance of £1.12m.

### Acute Inpatient staffing

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

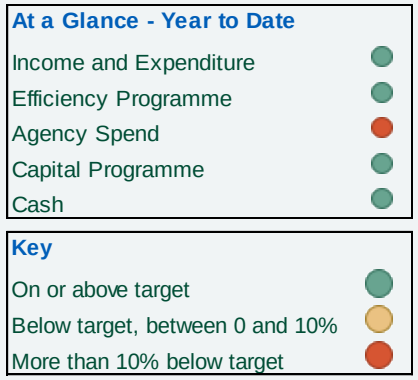
- In February, 61.3 additional WTE above establishment, decreasing from 63.6 WTE in January. The year-to-date pressure now totals £3.35m.

### Agency spend

- In month agency spend increased to £0.34m, due to retrospective adjustments for agency medics taking leave suppressing the spend in January. Year to date agency spend is £4.37m, with East Kent medical agency and East Kent and West Kent nursing agency being key areas of pressure.

- In month spend levels were highest in East Kent, with 50.3% of overall agency spend, due to medical vacancies, but also West Kent (24.1%) due to pressures within Liaison services, CMHTs and Crisis teams.

- For 2025/26 an agency spend limit has been set for the Trust of £4.27m. Based on current forecasts, the Trust would spend £4.62m, £0.35m over the cap.




### Capital Programme

As of 28th February, the overall capital position is £0.71m behind plan driven by delays in the Female PICU project. The forecast remains unchanged from January at £17.50m.

To maximise the use of available funding this financial year, considerable efforts have been made to advance work scheduled for next year, particularly within Estates and IT.

The Trust is planning to spend £5.87m in March for the Trust to deliver this forecast. This is under close review by the senior Finance and Estates teams.

### Cash

The closing cash position for February was £12.72m reflecting an increase of £3.89m and is £0.49m higher than the January forecast of £12.24m. This is the result of earlier-than-expected receipts from ICBs in relation to complex patients .

The overall forecast has increased by £1m from January's position due to the expected timings for completion of the capital programme. The closing cash position is heavily dependent on the timing of capital spend in relation to the major capital projects being undertaken this financial year.

# 2. Finance KPIs

## I&E YTD position

| | |
|---|---|
| **M11 YTD actual** | **£2.02m surplus** |
| Forecast outturn | £2.20m surplus |

Year to date position on plan with a reported £2.02m surplus. Key pressures include Acute Inpatient staffing and External beds and are mitigated with non-recurrent benefits and pay slippage.
The Trust is forecasting an outturn position of a £2.20m surplus as per plan.

## Efficiency delivery

| | |
|---|---|
| **M11 YTD actual** | **£15.59m** |
| Full year identifed | £17.64m |

The CIP programme is currently on plan. Work is completed on the CIP programme for 2025/26 and focus moved to plans and pipeline schemes for 26/27.

## Capital spend

| | |
|---|---|
| **M11 YTD actual** | **£11.66m** |
| Forecast outturn | £17.50m |

As of 31st January, the overall capital position is £0.71m behind the plan driven by delays in the Female PICU project. Significant progress was made on the Section 136 project again during February, which will support the Trust in meeting its annual forecast. The forecast remains unchanged from January at £17.50m

## Bank spend

| | |
|---|---|
| **M11 actual** | **£1.73m** |
| Planned Run Rate | £1.67m |

In month, bank spend decreased by £0.02m (1.6WTE), offset by an increase of 1.2WTE agency staff. Due to the shorter month, a temporary staffing decrease in spend of £0.08m would be anticipated, if usage remained the same. The smaller reduction in spend suggests a relative increase in usage.

## Agency spend

| | |
|---|---|
| **M11 actual** | **£0.34m** |
| Planned Run Rate | £0.36m |

Agency spend increased in month following a suppressed position in Month 10 due to retrospective adjustments. The current forecast for agency is £4.62m, which against a cap of £4.27m results in the annual cap being exceeded by £0.35m.

## WTEs utilised

| | |
|---|---|
| **M11 actual** | **3,949** |
| Planned Staffing | 4,004 |

WTEs utilised are monitored by NHS England against the Trust's workforce plan. Actual staffing figures include contracted substantive staff as well as any bank and agency usage within the reporting month. The in month decrease is due to decreases in bank and agency staff in month.

## External beds spend

| | |
|---|---|
| **Year to date overspend** | **£5.19m** |
| Average Beds in Month | 17 |

External beds increased to an average of 17 beds, with Acute increasing from 7 to 11 beds and PICU beds remaining at 6. This remains a key area of financial pressure for the Trust.

## Cash position

| | |
|---|---|
| **M11 cash balance** | **£12.72m** |
| Operating Expenditure Days | 14.1 |

The closing cash position for February was £12.72m reflecting an increase of £3.89m and is £0.49m higher than the January forecast of £12.24m.

## Principles

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

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

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

# 3. Primary statements

## Statement of Comprehensive Income

| | Annual | Current Month | | | Year to date | | |
|---|---|---|---|---|---|---|---|
| | Plan | Plan | Actual | Variance | Plan | Actual | Variance |
| | £000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Income | 296,077 | 24,509 | 26,896 | 2,387 | 271,568 | 280,504 | 8,936 |
| Employee Expenses | (230,307) | (19,084) | (19,172) | (88) | (211,223) | (211,024) | 200 |
| Operating Expenses | (58,679) | (4,834) | (7,179) | (2,345) | (53,845) | (63,923) | (10,078) |
| **Operating (Surplus) / Deficit** | **7,090** | **591** | **546** | **(45)** | **6,499** | **5,557** | **(942)** |
| Finance Costs | (4,890) | (408) | (362) | 45 | (4,483) | (3,541) | 942 |
| **System control Surplus / (Deficit)** | **2,200** | **183** | **183** | **0** | **2,017** | **2,017** | **0** |
| **Excluded from System control (Surplus) / Deficit:** | | | | | | | |
| **Technical adjustments** | **(194)** | **(10)** | **(22)** | **(12)** | **(577)** | **(479)** | **98** |
| **Surplus / (deficit) for the period** | **2,006** | **173** | **162** | **(12)** | **1,440** | **1,538** | **98** |

## Statement of Financial Position

| | 30th April 2025 | 31st December 2025 | 31st January 2026 |
|---|---|---|---|
| | *Actual* | *Actual* | *Actual* |
| | £000 | £000 | £000 |
| Non-current assets | 174,192 | 174,210 | 175,706 |
| Current assets | 20,105 | 20,032 | 21,074 |
| Current liabilities | (30,182) | (29,006) | (29,746) |
| Non current liabilities | (39,058) | (38,658) | (38,353) |
| **Net Assets Employed** | **125,057** | **126,578** | **128,681** |
| **Total Taxpayers Equity** | **125,057** | **126,578** | **128,681** |

The Trust is reporting a surplus of £2.02m at the end of February. This is in line with plan.

### Income

Year to date there is a favourable position against plan due to increased income for Forensic Provider Collaborative following a review of unit costs, as well as additional income owing as part of the Risk Share agreement with the Collaborative.

Additional income for VAT recovery, covering CYP transition costs, covering Industrial Action costs, covering some Inpatient pressures and Education & Training is also recognised.

### Employee expenses

The Trust is reporting a year-to-date underspend on employee expenses of £0.20m. This consists of an underspend on substantive pay of £0.45m with an additional underspend of £0.21m on bank (where bank is planned to support rotas), offset by overspends on agency of £0.46m.

In-month agency spend reduced to £0.34m due to retrospective adjustments in January suppressing costs. Medical agency continues to be the highest driver of spend (67.0%), with nursing agency accounting for (29.6%).

### Operating expenses

Operating expenses are over plan by £10.08m which is driven by external bed spend. The Trust utilised 6 external PICU beds (7 PICU beds funded) and 11 external Acute beds in February, all of which are unfunded, and this presents a financial pressure to the end of February of £5.19m. Other drivers of spend include increased costs in maintenance costs, redundancy, depreciation and external support for key programmes or work such as Community remodelling and the transition of Children and Young People Services.

### Total assets

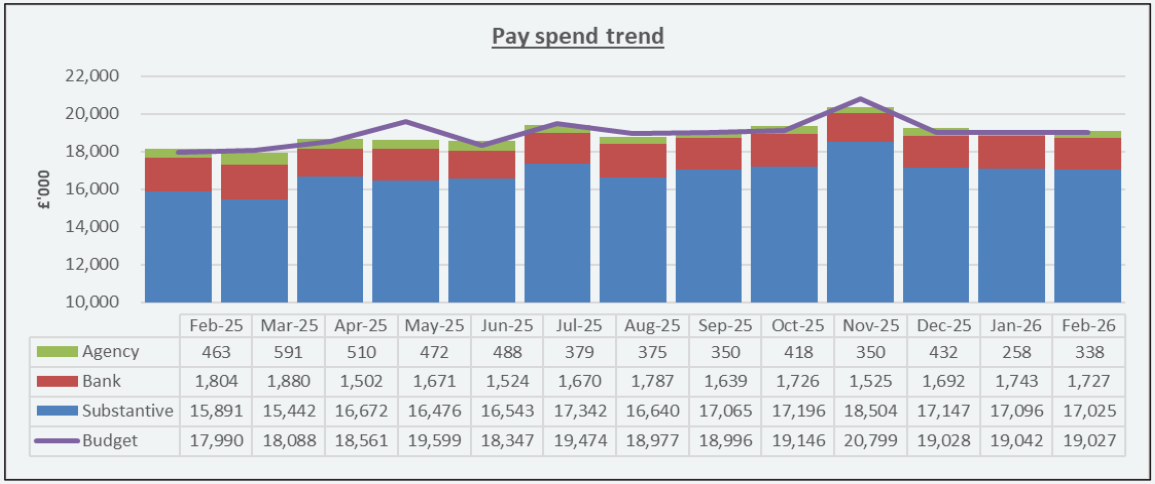
Total assets increased by £6.73m in the month. £5.70m relates to material capital works commencing on the Trust's major capital projects and the remaining £1.03m relates to capital works in the month offset by depreciation.

### Total liabilities

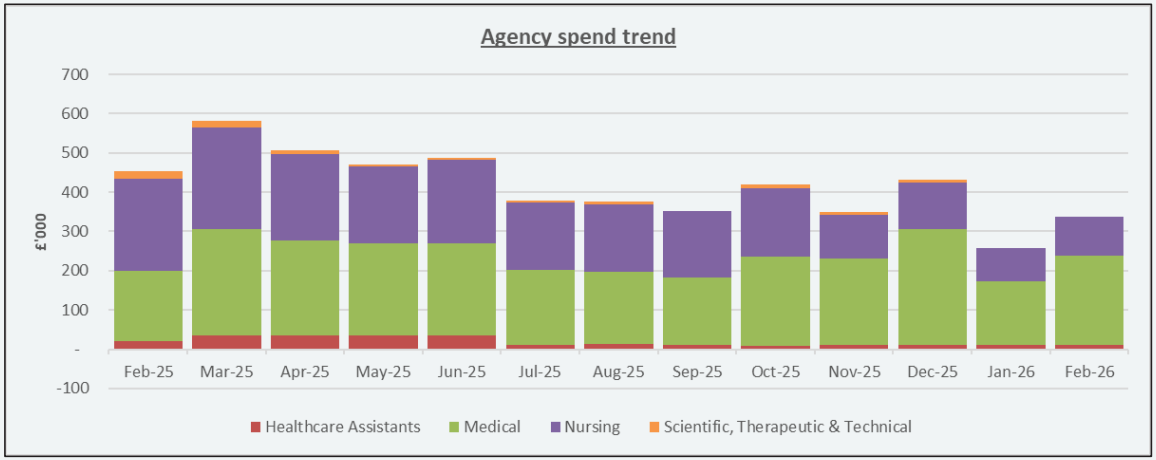
Total liabilities increased by £0.86m in the month, driven by a £0.91m increase in invoices relating to routine and capital spend.

# Appendices

# 4. Exception report – Pay trend



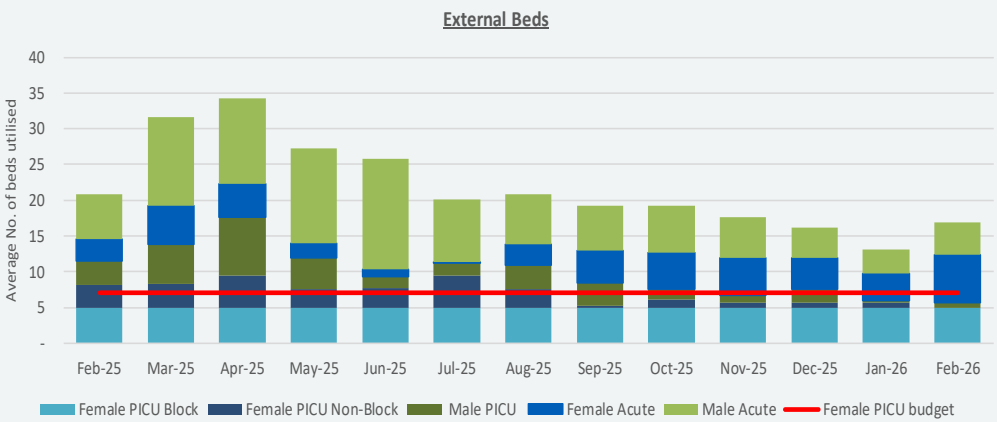

| | Feb-25 | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Agency | 463 | 591 | 510 | 472 | 488 | 379 | 375 | 350 | 418 | 350 | 432 | 258 | 338 |
| Bank | 1,804 | 1,880 | 1,502 | 1,671 | 1,524 | 1,670 | 1,787 | 1,639 | 1,726 | 1,525 | 1,692 | 1,743 | 1,727 |
| Substantive | 15,891 | 15,442 | 16,672 | 16,476 | 16,543 | 17,342 | 16,640 | 17,065 | 17,196 | 18,504 | 17,147 | 17,096 | 17,025 |
| Budget | 17,990 | 18,088 | 18,561 | 19,599 | 18,347 | 19,474 | 18,977 | 18,996 | 19,146 | 20,799 | 19,028 | 19,042 | 19,027 |




As at the end of February the Trust reported a year-to-date underspend on pay of £0.20m.

- There is a high level of focus from the system and NHS England to ensure pay run rates and WTEs are not increasing in year. The Trust is presently 43.2 WTE above plan, 3.69 WTE less than January.
- Overall bank spend reduced by 1.0% in the month. This is less than the reduction expected due to the shorter month. Whilst cover for sickness reduced, cover for training and study increased to compensate across Acute and Forensic wards.
- Agency spend in February totalled £0.34m, which represents a 27.1% reduction on spend seen for the same period in 2024/25, and a 31.0% increase on spend in January. Overall usage for both medical and nursing was similar to January, but retrospective adjustments were made to the financial position in January which suppressed the spend last month.
- Of the Nursing agency utilised, 38.5% is supporting community teams covered by Mental Health Together and Mental Health Together plus. A further 47.2% of the total supports Liaison and Homecare teams. Recruitment continues to these teams and agency is forecast to reduce in coming months.
- Medical agency WTE was 9.7 WTE in February, 5.4 WTE of which were in East Kent. One of these has recently left the Trust, the forecast for agency Consultants remains 4wte for the foreseeable future. 1.6 WTE were utilised to cover sickness on wards, this has reduced to 1WTE which remains into March.
- HCA agency usage was 3.2 WTE, the largest user being Upnor Ward (0.9 WTE).
- The unadjusted current forecast for agency spend is £4.66m, £0.39m above a cap of £4.27m.

# 5. Exception report – External beds




**Commentary**

In February, usage of external Acute beds increased, from average 7 beds to 11. PICU usage remained 6 beds.
The Trust is funded for the equivalent of 7 Female PICU beds, which is predominantly used to fund a block contract for 5 Female beds. The Trust doesn't hold funding for external acute beds.

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

To help alleviate this pressure, the Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to KMPT beds.
3,549 block bed days have been purchased at a cost of £0.67m, with usage recorded as 1,860 bed days since June; at this level the trust has seen cost avoidance of £1.12m.

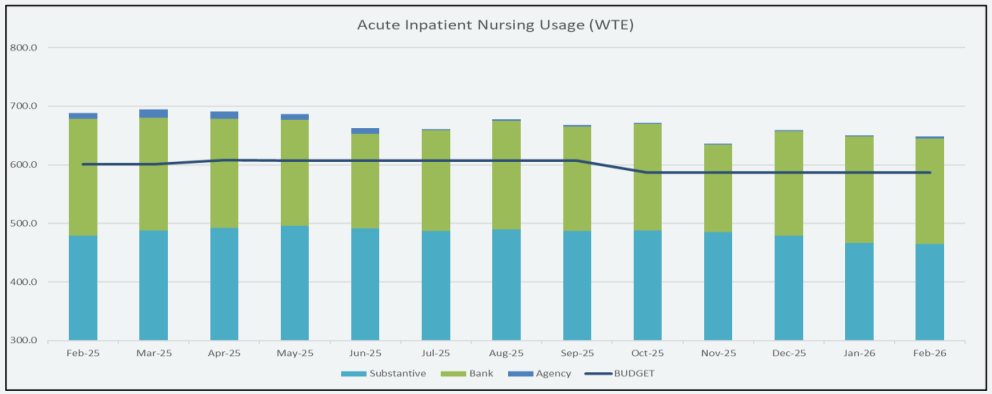
# Exception report – Inpatient staffing

**Commentary**

In February, bank spend decreased by £0.02m (1.6WTE), offset by an increase of 1.2WTE agency staff. Due to the shorter month, a temporary staffing decrease in spend of £0.08m would be anticipated, if usage remained the same. The smaller reduction in spend suggests a relative increase in usage.

**In month changes**

- Levels of additional observations increased in month, costing approximately £0.15m in additional staffing to support; £0.01m more than last month.
- Following management review of rotas, the cost of cover for activities including away days, management days and maternity leave reduced from £0.11m in November to £0.02m in February, with no cost associated with covering away days in month.
- Annual leave cover decreased from £0.29m to £0.26m
- Sickness cover decreased from £0.13m to £0.09m
- Study leave cover increased from £0.09m to £0.10m

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# 6. Income and Expenditure Forecast

**Commentary**

The below represents the expected forecast outturn for the financial year which results in the Trust reporting a post technical adjustment surplus of £2.2m.

The Month 12 forecast reflects known workforce changes, controlled agency assumptions, and capped external bed usage. Delivery of the planned surplus relies on identified non-recurrent mitigations. No benefit from system stretch savings or late-year improvements has been assumed, providing a prudent year-end position against known risks.

| | | Actual (£'000) | | | | | | | | | | | Forecast (£'000) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | Total | Variance |
| **Income** | | | | | | | | | | | | | | | |
| Income from Activities | 276,412 | 22,376 | 22,365 | 23,068 | 23,076 | 22,688 | 22,699 | 22,746 | 22,676 | 22,488 | 22,657 | 24,228 | 22,832 | 273,899 | (2,513) |
| Other operating Income | 19,665 | 2,485 | 2,295 | 2,445 | 2,721 | 2,303 | 2,381 | 2,575 | 3,911 | 3,281 | 2,515 | 2,446 | 2,618 | 31,978 | 12,313 |
| **Total Income** | **296,077** | **24,862** | **24,661** | **25,513** | **25,797** | **24,992** | **25,080** | **25,321** | **26,587** | **25,769** | **25,172** | **26,674** | **25,451** | **305,877** | **9,800** |
| **Expenditure** | | | | | | | | | | | | | | | |
| Substantive | (205,952) | (16,672) | (16,476) | (16,543) | (17,344) | (16,671) | (17,065) | (17,165) | (18,461) | (17,147) | (17,096) | (17,025) | (16,824) | (204,488) | 1,464 |
| Bank | (20,086) | (1,502) | (1,671) | (1,524) | (1,670) | (1,787) | (1,639) | (1,726) | (1,525) | (1,692) | (1,743) | (1,727) | (1,686) | (19,891) | 195 |
| Agency | (4,270) | (510) | (472) | (488) | (379) | (375) | (350) | (418) | (350) | (432) | (258) | (338) | (250) | (4,619) | (349) |
| Locum | | (58) | (76) | (53) | (41) | (86) | (82) | (63) | (43) | (99) | (102) | (83) | (76) | (863) | (863) |
| **Total Employee Expenses** | **(230,308)** | **(18,743)** | **(18,696)** | **(18,608)** | **(19,435)** | **(18,918)** | **(19,137)** | **(19,372)** | **(20,379)** | **(19,369)** | **(19,199)** | **(19,172)** | **(18,836)** | **(229,863)** | **445** |
| Clinical Supplies | (11,048) | (294) | (333) | (286) | (428) | (765) | (482) | (1,106) | (919) | (467) | (15) | (1,312) | (663) | (7,069) | 3,979 |
| Drugs | (3,825) | (286) | (290) | (288) | (299) | (294) | (311) | (297) | (289) | (316) | (318) | (280) | (299) | (3,566) | 259 |
| Other Non Pay | (34,087) | (4,125) | (3,882) | (4,761) | (4,225) | (3,691) | (3,762) | (3,333) | (3,537) | (4,642) | (3,827) | (4,496) | (4,275) | (48,554) | (14,467) |
| Non Exec Director | (183) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (15) | (184) | (1) |
| Redundancy Costs | - | (10) | (39) | - | (30) | (61) | 0 | - | - | (25) | (175) | (160) | (21) | (521) | (521) |
| Depreciation | (9,536) | (1,323) | (856) | (855) | (842) | (767) | (899) | (720) | (968) | (486) | (997) | (677) | (708) | (10,097) | (561) |
| **Total Non Pay** | **(58,679)** | **(6,052)** | **(5,414)** | **(6,206)** | **(5,839)** | **(5,593)** | **(5,469)** | **(5,470)** | **(5,728)** | **(5,952)** | **(5,347)** | **(6,939)** | **(5,981)** | **(69,990)** | **(11,311)** |
| Other (Post EBITDA & technical) | **(4,890)** | 117 | (367) | (516) | (340) | (297) | (290) | (295) | (297) | (265) | (443) | (380) | (450) | (3,824) | 1,066 |
| Total expenditure | **(293,877)** | **(24,678)** | **(24,477)** | **(25,329)** | **(25,614)** | **(24,808)** | **(24,896)** | **(25,138)** | **(26,404)** | **(25,586)** | **(24,988)** | **(26,491)** | **(25,267)** | **(303,677)** | **(9,800)** |
| **System control Surplus /(Deficit)** | **2,200** | **184** | **183** | **183** | **183** | **183** | **183** | **183** | **183** | **184** | **184** | **183** | **184** | **2,200** | **0** |

# 7. Cost Improvement plans 2025/26

## Savings plans

| Scheme | Planned CIP | Identified to date | % identified | Programme update |
|---|---|---|---|---|
| | £'000 | £'000 | | |
| Support Services | 3,700 | 2,205 | 59.6% | Programme progressing, with further plans and schemes being worked through for 26/27 |
| Estates | 1,600 | 1,348 | 84.3% | |
| Forensic Inpatient | 1,000 | 1,844 | 184.4% | £1.3m additional income secured following review of bed day prices with commissioners |
| Provider Collaborative Risk Share | 1,000 | 800 | 80.0% | Secured |
| Perinatal | 500 | 493 | 98.6% | Review completed with report being shared March 2026 to identify next steps. |
| Community Review | 2,400 | 4,240 | 176.7% | Non recurrent delivery whilst plans finalised |
| Rota Management | 1,700 | - | 0.0% | Further work required and prgoramme will continue in 26/27 |
| Budget Management | 1,800 | 2,502 | 139.0% | Non recurrent budget management |
| Non-Pay Review | 1,000 | 640 | 64.0% | Non pay savings delivered in year with wider non pay deep dive planned for July 2026. |
| Other | 700 | 1,000 | 100.0% | Delivered |
| **Trust schemes total** | **15,400** | **15,072** | **97.9%** | |
| | | | | |
| System Stretch target | 2,200 | 2,528 | | Non recurrent benefit |
| **Total** | **17,600** | **17,600** | **100.0%** | |

**Commentary**

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

**Schemes underway:**

- Support Services – a 10% reduction in costs, reflecting NHS England benchmarking and growth analysis . Further plans continue to be developed with system partners.
- Estates – a 10% reduction in costs. Following the decision to permanently remove administration estate, the whole estate is being reviewed for consolidation opportunities.
- Forensic Inpatient – review of all costs, building on benchmarking work, has commenced with the Directorate team and discussions continue with the Provider Collaborative to review the contracted bed day price.
- Provider Collaborative Risk Share – Working with KSS PC to reduce out of area placements with funding secured through risk share arrangements, as per prior financial years. Discussions are progressing with the Provider Collaborative to confirm in year arrangements.
- Perinatal service review – underspends delivered, service review continues to identify opportunities for recurrent reductions. Review of benchmarked costs and productivity metrics is underway in conjunction with the Service specification to ensure ethe envelope is sufficient for the service commissioned.
- Community review – Service review for Early Intervention & At Risk Mental State services underway with Consultation now complete and new structure live/ This work has brought cost in line with contractual envelopes. Proposed establishments for MHT+ were shared with Directorate teams with final plans expected to be finalised by the end of March 2026.
- Rota Management – This savings is targeting the management of the rota pressures within the Inpatient Directorate.
- Budget management – 1% non-recurrent savings identified from slippages.
- Non-Pay Review – working with system partners supported by NHS England productivity packs. Areas of focus include taxi spend, policy and process, discretionary spend and interpreting costs.

# 8. Capital position

| | Annual | | | In month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|---|---|
| | *Plan* | *Forecast* | *Variance* | *Plan* | *Actual* | *Variance* | *Plan* | *Actual* | *Variance* |
| | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| **System Capital expenditure** | | | | | | | | | |
| Capital Maintenance and Minor Schemes | 4,164 | 4,716 | 552 | 405 | 468 | 63 | 3,688 | 3,255 | (433) |
| Information Management and Technology | 1,299 | 2,108 | 809 | 297 | 197 | (100) | 575 | 1,190 | 615 |
| Section 136 development | 3,462 | 5,567 | 2,105 | 1,250 | 481 | (769) | 1,785 | 4,089 | 2,304 |
| Public Decarbonisation | 200 | 0 | (200) | 0 | 0 | 0 | 0 | 0 | 0 |
| IFRS 16 Leases | 3,375 | 1,338 | (2,037) | 0 | 0 | 0 | 3,375 | 1,313 | (2,062) |
| **Total system expenditure** | **12,500** | **13,729** | **1,229** | **1,952** | **1,146** | **(806)** | **9,423** | **9,847** | **424** |
| **External expenditure** | | | | | | | | | |
| Out of Area Placement (Female PICU) | 3,940 | 1,973 | (1,967) | 1,000 | 310 | (690) | 2,440 | 964 | (1,476) |
| PFI 2025/26 | 461 | 461 | 0 | 39 | 39 | 0 | 422 | 423 | 1 |
| Public Decarbonisation | 629 | 0 | (629) | 0 | 0 | 0 | 0 | 0 | 0 |
| Estates Safety Fund | 0 | 400 | 400 | 0 | 62 | 62 | 0 | 290 | 290 |
| R&D - Hyperfine Swoop Imaging System | 0 | 210 | 210 | 0 | 11 | 11 | 0 | 26 | 26 |
| Section 136 development | 2,250 | 0 | (2,250) | 620 | 0 | (620) | 1,138 | 0 | (1,138) |
| VAT Reclaim | (2,250) | 0 | 2,250 | (300) | 0 | 300 | (1,050) | 0 | 1,050 |
| Cyber Risk Reduction | 0 | 297 | 297 | 0 | 0 | 0 | 0 | 0 | 0 |
| Solar Installation | 0 | 425 | 425 | 0 | 109 | 109 | 0 | 109 | 109 |
| **Total external expenditure** | **5,030** | **3,766** | **(1,264)** | **1,359** | **531** | **(828)** | **2,950** | **1,812** | **(1,138)** |
| **Total Capital Expenditure** | **17,530** | **17,495** | **(35)** | **3,311** | **1,677** | **(1,634)** | **12,373** | **11,659** | **(714)** |

**Commentary:**
As of 28th February, the overall capital position is £0.71m behind plan driven by delays in the Female PICU project. The forecast remains unchanged from January at £17.50m which includes anticipated system brokerage requirements.

A total of £5.87m must be expended in March for the Trust to meet this forecast. This is under close review by the senior Finance and Estates teams.

Weekly meetings are scheduled during March to ensure this is delivered. The current YTD shortfall is being made up by digital spend on devices pulled forward from 2026/27 of £0.45m along with accelerated spend on estates projects.

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | National Staff Survey 2025 Results and Analysis |
| **Author:** | Xanthe Whittaker, Head of Organisational Development |
| **Executive Director:** | Sandra Goatley, Chief People Officer |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | For discussion and decision |
| **Submission to Board:** | Requested |

## Overview of paper

The 2025 National Staff Survey provides a clear and honest picture of staff experience across Kent and Medway Mental Health Trust (KMMH). While there are notable strengths - particularly in appraisal quality, line management and pockets of high performing teams - the overall engagement score has declined (6.7 from 6.8), the response rate has fallen to 51%, and variation across the organisation has widened significantly.

Advocacy and psychological safety remain areas of concern, with “happy with the standard of care for a friend/relative” now at 49.7% (vs Picker 61.6%) and “feeling safe to speak up” at its lowest since 2021. Disability inclusion has also deteriorated.

The results reflect a Trust undergoing significant transformation, with inconsistent leadership capability and a gap between raising concerns and seeing action. The organisation has strong cultural insight and a clear People Engagement framework. The next phase requires strengthened accountability, consistent leadership behaviours and disciplined follow through.

## Issues to bring to the Board’s attention

- Engagement decline and widening variation (range 5.7–7.0) indicate inconsistent staff experience and leadership practice.
- Advocacy and organisational pride continue to fall, posing strategic risks to recruitment, retention and reputation.
- Psychological safety has deteriorated, with reduced confidence that concerns lead to action.
- Inclusion and reasonable adjustments show a significant drop, signalling inconsistent application of policy.
- Leadership capability is improving in some areas but remains variable across the Trust.
- High performing teams demonstrate that excellent culture is achievable and replicable.

Version 2 - **Public**

### The Trust's Response

The Board is asked to endorse the following eight management actions:

1. **Directorate-level accountability:**
   Require each Directorate to produce and deliver a People Engagement Plan, with quarterly reporting to the People Committee.
2. **Quarterly engagement assurance cycle:**
   Introduce structured reporting on motivation, involvement, advocacy and psychological safety.
3. **Targeted OD support for low scoring teams:**
   Prioritise teams with scores <6.0 and the East Directorate.
4. **Strengthen psychological safety and follow-through**
   Implement Staff Voice Forums focused on closing the loop on concerns and improving visible leadership. Embed into management development.
5. **Embed engagement as a core leadership competency**
   Embed engagement expectations into objectives, appraisal and performance management.
6. **Rebuild advocacy and organisational pride**
   Use the identity and values work to rebuild confidence and belonging.
7. **Improve inclusion and reasonable adjustments**
   Require directorate-level accountability for timely adjustments, inclusive leadership, monitoring and reporting.
8. **Embed the "insight action impact" cycle**
   Require all cultural initiatives to demonstrate measurable impact.

## Governance

| | |
|---|---|
| **Implications/Impact:** | • Quality: Engagement, psychological safety and advocacy are direct predictors of care quality.<br>• Workforce: Declining advocacy and inconsistent staff experience pose risks to retention and recruitment.<br>• Regulatory: Variation and psychological safety are key Well Led concerns.<br>• Financial: Improved engagement supports productivity, retention and reduced agency spend. |
| **Assurance:** | Limited |
| **Oversight:** | Oversight by People Committee |

## 1. PURPOSE OF THE PAPER

**1.1.** This paper provides the Board with an objective, evidence-based analysis of the 2025 National NHS Staff Survey results. It builds on last year's report, incorporates the Trust's enhanced People Engagement approach, and sets out what the results mean for culture, quality, and organisational performance.

**1.2.** The Trust must now move from insight to accountability**.** The data shows pockets of excellence but there is also persistent and widening variation. The Board's role is to ensure that engagement is not treated as a People function but as a core leadership responsibility and a determinant of quality and safety.

## 2. EXECUTIVE SUMMARY

**2.1.** The 2025 Staff Survey results present a mixed picture:

- Engagement has declined from 6.8 to 6.7, with a fall in response rate to 51% (4% lower than 2024 and 5% below the Picker average).
- People Promise domains are broadly aligned with peers, but all except "We Are Always Learning" have declined.
- Advocacy and confidence in care quality continue to deteriorate, with "If a friend/relative needed treatment…" now at 49.7% vs Picker 61.6%. This indicator has fallen 9.7% since 2021.
- Variation across the organisation has widened, with directorate engagement ranging from 5.7 to 7.0, and East Kent, West Kent and several locality teams showing sustained low scores (range in locality teams is 4.7 to 8.4).
- Psychological safety and speaking up have deteriorated, with "feeling safe to speak up" at its lowest since 2021.
- Line management and appraisal remain strengths, with appraisal quality improving and now above Picker averages.

**2.2.** The results reflect a Trust that is working hard, delivering major transformation, and investing in culture, but where staff experience is inconsistent and where the pace of improvement is not yet matching the scale of challenge.

## 3. CONTEXT AND INTERPRETATION

The data points to four underlying drivers.

### 3.1. Organisational change fatigue

The 2024 report highlighted the impact of the Community Mental Health Framework transformation, particularly in East Kent, where staff described "challenges… impacting workload, clarity of roles, staffing levels and the complexity of the changes required".

The 2025 results show this has not yet stabilised.

### 3.2. Inconsistent leadership visibility and capability

High-performing teams (e.g., Compliance & Risk, Willow Suite, Pinewood, Recovery College) demonstrate what is possible. The variation in scores in other teams suggests leadership quality is the single biggest differentiator of staff experience.

### 3.3. A gap between raising concerns and seeing action

Last year's report noted that while staff felt safer to raise concerns, fewer believed the organisation acted on them. This year, psychological safety has deteriorated further, suggesting that staff speak up but do not see follow-through.

Table 1

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| Feel safe to speak up about anything that concerns me in this organisation | 63.9% | 59.5% | 63.5% | 62.8% | 63.7% | 65.8% |
| Feel organisation would address any concerns I raised | 51.6% | 46.5% | 48.7% | 50.8% | 51.8% | 55.0% |

### 3.4. A weakening sense of organisational pride

Advocacy indicators have declined for five consecutive years. The 2024 report noted a 1.5% drop in "happy with standard of care for a friend/relative" and an 11.8% fall since 2020. The 2025 results show a further decline.

This is not simply about care quality. It is about confidence in the organisation's direction, leadership, and identity.

Table 2

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| If friend/relative needed treatment would be happy with standard of care provided by organisation | 61.6% | 49.7% | 51.8% | 53.2% | 56.8% | 59.4% |

## 4. ALIGNING THE RESULTS WITH WELL-LED

### 4.1. Leadership

KMMH has strengthened leadership capability through improved appraisal quality, clearer objectives and enhanced line-management practice. The 2025 Staff Survey shows that staff experience of appraisal is now above the Picker average, with a 2.4% increase in staff reporting that appraisal helped them improve their job performance.

Leadership experience remains inconsistent, however. High-performing teams demonstrate strong visibility, psychological safety and cohesive cultures, but variation across directorates (e.g., East and West Kent) indicates that leadership standards are not yet applied uniformly.

**What this means for Well-Led**

Leadership capability is improving but variability remains a key risk to culture, quality and staff experience.

Table 3

| 2025 Locality 1 | Comparator (Organisation Overall) | 380 Acute Directorate | 380 East Kent Directorate | 380 Forensic and Specialist Services | 380 North Kent Directorate | 380 Support Services | 380 West Kent Directorate |
|---|---|---|---|---|---|---|---|
| Description | n = 2001 | n = 371 | n = 334 | n = 352 | n = 204 | n = 535 | n = 205 |
| Received appraisal in the past 12 months | 90.0% | 88.2% | 86.5% | 92.4% | 89.2% | 92.8% | 88.5% |
| Appraisal helped me improve how I do my job | 28.9% | 40.2% | 17.9% | 32.1% | 30.2% | 27.8% | 22.9% |
| Appraisal helped me agree clear objectives for my work | 40.9% | 47.7% | 24.8% | 42.9% | 41.9% | 45.4% | 37.7% |
| Appraisal left me feeling organisation values my work | 36.8% | 41.1% | 24.5% | 38.5% | 33.9% | 41.8% | 34.3% |

| 2024 Locality 1 | Comparator (Organisation Overall) | 380 Acute Directorate | 380 East Kent Directorate | 380 Forensics and Specialist Services Directorate | 380 North Kent Directorate | 380 Support Services | 380 West Kent Directorate |
|---|---|---|---|---|---|---|---|
| Description | n = 2095 | n = 332 | n = 340 | n = 375 | n = 252 | n = 560 | n = 236 |
| Received appraisal in the past 12 months | 90.7% | 86.9% | 93.7% | 94.3% | 91.2% | 90.2% | 87.1% |
| Appraisal helped me improve how I do my job | 26.5% | 37.7% | 13.8% | 27.1% | 29.1% | 27.4% | 24.3% |
| Appraisal helped me agree clear objectives for my work | 38.9% | 45.1% | 24.5% | 38.2% | 44.4% | 44.2% | 34.3% |
| Appraisal left me feeling organisation values my work | 37.2% | 38.2% | 27.7% | 38.9% | 38.6% | 43.3% | 31.7% |

| 2023 Locality 1 | Comparator (Organisation Overall) | 380 Acute Directorate | 380 East Kent Directorate | 380 Forensics and Specialist Services Directorate | 380 North Kent Directorate | 380 Support Services | 380 West Kent Directorate |
|---|---|---|---|---|---|---|---|
| Description | n = 1916 | n = 287 | n = 300 | n = 355 | n = 188 | n = 518 | n = 268 |
| Received appraisal in the past 12 months | 87.8% | 86.1% | 87.8% | 91.4% | 81.6% | 87.9% | 88.6% |
| Appraisal helped me improve how I do my job | 27.3% | 36.9% | 20.4% | 28.8% | 28.5% | 28.3% | 20.1% |
| Appraisal helped me agree clear objectives for my work | 39.5% | 45.4% | 29.6% | 40.1% | 40.4% | 45.2% | 32.2% |
| Appraisal left me feeling organisation values my work | 36.6% | 34.9% | 26.9% | 38.2% | 32.5% | 44.0% | 35.2% |

## 4.2. Culture

The Trust has a mature, data-driven understanding of its culture, drawing on annual staff surveys, quarterly pulse surveys and deep dives into directorate-level variation. The People Engagement framework provides a structured approach to improving motivation, involvement and advocacy.

The 2025 results show that psychological safety has declined by 4%, however, and is now at its lowest since 2021. Advocacy indicators have also deteriorated, with only 49.7% of staff saying they would be happy with the standard of care for a friend or relative (vs Picker 61.6%).

See Table 1

**What this means for Well-Led**
The Trust understands its culture well but must now focus on consistent leadership behaviours, follow-through on concerns and rebuilding organisational pride.

## 4.3. Governance and assurance

The Board receives comprehensive cultural intelligence, including triangulated data across People Promise domains, directorate variation, pulse surveys and qualitative insights. The organisation has a clear strategy for culture, identity and staff experience.

The widening variation in engagement (5.7 - 7.0) and declining advocacy, however, indicate that assurance is not yet translating into consistent improvement.

**What this means for Well-Led**
Governance structures are strong but accountability for improvement must be strengthened at directorate level.

### 4.4. Engagement and involvement

The Trust has invested in mechanisms to strengthen staff voice, including the Staff Council trial, Speak-to-Sheila, listening events and refreshed values. Reporting of violence and harassment has improved, and staff feel clearer about their roles.

Staff report reduced ability to influence change, however, with involvement scores declining. The gap between raising concerns and seeing action remains a key issue.

**What this means for Well-Led**
The staff voice is encouraged but confidence in follow-through must improve.

### 4.5. Continuous improvement and learning

"We Are Always Learning" is the only People Promise domain that improved in 2025. This reflects investment in leadership development, OD & L&D support and learning infrastructure.

Motivation and the perceived ability to make improvements have declined, signalling early risk to quality improvement capability.

**What this means for Well-Led**
Learning culture is strengthening but improvement capability is constrained by morale and change fatigue.

## 5. DETAILED ANALYSIS OF RESULTS

### 5.1. Engagement

Engagement score: 6.7 (down 0.1)

Range across directorates: 5.7 to 7.0

The widening variation is the most significant governance concern. Engagement is a proxy for morale, psychological safety, discretionary effort, quality of care, and retention.

The People Engagement framework emphasises that engagement is shaped by "everyday leadership behaviours and consistent team conversations". The data shows this is not yet embedded.

Table 4

| | Comparator (Organisation Overall) | 380 Acute Directorate | 380 East Kent Directorate | 380 Forensic and Specialist Services | 380 North Kent Directorate | 380 Support Services | 380 West Kent Directorate |
|---|---|---|---|---|---|---|---|
| **2025** | n = 2001 | n = 371 | n = 334 | n = 352 | n = 204 | n = 535 | n = 205 |
| | 6.7 | 7.0 | 5.7 | 6.9 | 6.7 | 7.0 | 6.3 |
| **2024** | n = 2095 | n = 332 | n = 340 | n = 375 | n = 252 | n = 560 | n = 236 |
| | 6.8 | 7.1 | 5.9 | 7.0 | 6.8 | 7.0 | 6.6 |
| **2023** | n = 1916 | n = 287 | n = 300 | n = 355 | n = 188 | n = 518 | n = 268 |
| | 6.9 | 7.0 | 6.5 | 7.1 | 6.7 | 7.0 | 6.9 |

## 5.2. People Promise Domains

All domains except “We Are Always Learning” declined. This suggests that staff development is improving but the broader cultural environment is not yet enabling staff to thrive.

This aligns with the Trust’s investment in leadership development and OD but highlights the need for greater consistency and accountability.

Table 5

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| Overall 'We are always learning' score | 5.8 | 5.9 | 5.9 | 5.9 | 6.0 | 5.9 |
| Overall 'We work flexibly' score | 6.8 | 6.7 | 6.8 | 6.8 | 6.8 | 6.7 |
| Overall 'We are a team' score | 7.1 | 7.0 | 7.1 | 7.1 | 7.2 | 7.2 |
| Motivation sub-score | 7.0 | 6.8 | 6.9 | 7.1 | 7.0 | 7.1 |
| Involvement sub-score | 7.0 | 6.9 | 7.0 | 7.1 | 7.2 | 7.1 |
| Advocacy sub-score | 6.8 | 6.3 | 6.4 | 6.5 | 6.5 | 6.7 |
| Overall 'Staff Engagement' Score | 6.9 | 6.7 | 6.8 | 6.9 | 6.9 | 7.0 |
| Overall 'Morale' score | 6.1 | 6.0 | 6.1 | 6.1 | 6.0 | 6.1 |

## 5.3. Advocacy and Reputation

Two indicators remain the Trust’s weakest:

- Would recommend KMMH as a place to work
  54.2% (Picker 61.5%)
- Happy with standard of care for a friend/relative
  49.7% (Picker 61.6%)

These are the Trust’s most important reputation metrics. They are also the most sensitive to leadership behaviour, organisational identity, confidence in change, and perceived quality and safety. The decline is therefore a strategic risk.

Table 6

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| Would recommend organisation as place to work | 61.5% | 54.2% | 56.7% | 57.8% | 57.6% | 60.1% |
| If friend/relative needed treatment would be happy with standard of care provided by organisation | 61.6% | 49.7% | 51.8% | 53.2% | 56.8% | 59.4% |

## 5.4. Psychological Safety and Speaking Up

The 2025 results show a 4% reduction in feeling safe to speak up, the lowest score since 2021 despite improvements in reporting violence and harassment in 2024.

The issue is not whether staff speak up, it is whether they believe it leads to action. This is a core Well-Led concern.

See Table 1

### 5.5. Inclusion and Reasonable Adjustments

A 5.1% drop in disability inclusion (to 73.2%) is significant and now below the Picker average (78.2%).

Given the Trust's investment in EDI, this suggests inconsistent application of reasonable adjustments, variable line manager confidence, and a need to strengthen accountability for inclusive practice.

Table 7

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| Disability: organisation made reasonable adjustment(s) to enable me to carry out work | 78.2% | 73.2% | 78.3% | 78.4% | 77.9% | 79.2% |

### 5.6. Leadership and Appraisal

This remains a relative strength and a foundation to build on. Results show appraisal quality has improved, responsibilities are clearer, disagreements are being better handled, and the line management score (7.4) is aligned with peers.

Table 8

| Comparator Information | Picker Average 2025 | Organisation 2025 | Organisation 2024 | Organisation 2023 | Organisation 2022 | Organisation 2021 |
|---|---|---|---|---|---|---|
| Description | n = 57783 | n = 2001 | n = 2095 | n = 1916 | n = 2229 | n = 2311 |
| Appraisals sub-score | 5.1 | 5.2 | 5.3 | 5.1 | 5.3 | 5.2 |
| Line management sub-score | 7.4 | 7.4 | 7.5 | 7.5 | 7.6 | 7.5 |

## 6. COMPARISON WITH OTHER TRUSTS (Picker groups = 19 MHT's)

**6.1.** KMMH remains broadly aligned with other mental health trusts on most People Promise domains. The Trust is below average, however, on advocacy, psychological safety, involvement in change, reasonable adjustments, and motivation.
These are the domains most closely linked to leadership behaviour and organisational culture.

**6.2.** The Trust is above average on appraisal, resourcing, reporting violence, MSK health, and immediate manager feedback.
This reflects targeted investment and should be recognised as progress.

## 7. ASSURANCE TO THE BOARD

**7.1.** The Board can take reasonable assurance that:

→ the Trust has a mature, data-driven understanding of culture – established through the Culture and Identity work started in 2024, continued through focus groups and listening events, introduction of Staff Voice (formerly Staff Council).

→ the People Engagement framework provides a coherent mechanism for improvement – clearly driving accountability for directorate and team ownership and embedded into key strategic objectives in the 2026-2031 Trust strategy.

→ leadership development and OD investment are beginning to show impact - mainly demonstrated through qualitative mechanisms such as; feedback from development sessions and new check-in process, quality of management conversation, engagement and contribution, new appraisal approach aligned to Trust objectives, Leading Well Together programme.

→ high-performing teams demonstrate that excellent culture is achievable within KMMH - as demonstrated by exceptional staff engagement results maintained consistently across some locality 4 teams.

**7.2.** The Board can only take limited assurance on:

↘ consistency of staff experience - there is considerable work needed on upskilling managers to achieve the performance standards we expect - this work was started in 2025 and will continue into 2026. Through Leading Well Together programme, Management Induction and Foundations Programmes and the introduction of the New NHS Competency framework in late Spring 2026.

↘ psychological safety

↘ advocacy and organisational pride - we have recognised a need to improve how we tell stories and share examples of 'good work'. We have a new engagement and communications plan which will help but this will take time to have an effect.

↘ directorate-level accountability for engagement - we are taking a new approach and will need to monitor, evaluate and challenge/support where needed to ensure this is embedded leadership activity.

↘ the pace of improvement in East and West Kent - significant transformation in these areas over the last 3 years has impacted confidence which will take time to re-build.

## 8. FUTURE ACTIONS

The Executive Management Team has targeted the following management actions.

### 8.1. Directorate-level accountability

Quarterly reporting to the People Committee on engagement, advocacy, psychological safety, and variation.

**Through** - Attendance at People Committee to share insights into progress, challenges and learning.

**Intended Impact** - Increases leader accountability by requiring directorates to publicly report their results, demonstrate action, and respond to scrutiny on engagement and psychological safety. Cultural indicators become their KPIs, not "corporate" ones.

**Timescale** - Requests for Directorate attendance commence from July 2026.

### 8.2. Quarterly engagement assurance cycle

Every directorate and team within to maintain a live plan, reviewed in SDR's and team meetings, as set out in the People Engagement framework and in line with the true north objective (7.3 engagement score) and breakthrough objective (65% would recommend as a place to work).

**Starting Point** - Directorates will cascade survey results through their teams and run focus groups to listen to staff feedback and determine areas of key focus. Action plans will be drawn and targets set.

**Intended Impact** - Improve confidence in speaking up and action taken culture. Improved leadership accountability for staff experience and engagement.

**Timescale** – Cascade of results and focus groups commence from March (post embargo). Directorate and team plans drawn by 1st June. Reviews of Directorate plans in line with Directorate process (SDR's/regular meetings) on an ongoing basis.

### 8.3. Targeted OD support for low-scoring teams

OD (new Staff Engagement and Experience role) and HRBP support prioritised for teams <6.0. Focussed on teams who have consistently scored below average for the last 3 years. Initial time investment will be prioritised in the East Directorate as area of most concern and decline.

**Intended Impact** - To accelerate improvement in the Trust's most challenged areas by addressing deep-rooted cultural issues, reducing variation in staff experience, and building leadership capability where it is most needed.

**Timescale** – Currently in planning stage with East Kent. Action timescales will be determined in action plan, expected to be continuous throughout 2026/27.

### 8.4. Strengthen psychological safety and follow-through

The Trust's averages mask significant variation and/ this must be addressed.

**Through** - Staff Voice (following trial of 'Staff Council') launched Spring 2026. Manager will attend training on speaking up culture, listening and following up. This will also be embedded into core management development.

**Intended Impact** - The new Staff Voice model will ensure staff feedback consistently informs decisions and leads to visible change. Training managers in listening and speaking-up culture will strengthen leadership behaviours and reduce variation in staff experience.

**Timescale** – All Staff Voice Forums to be established by late May, quarterly meetings will follow.

### 8.5. Embed engagement as a core leadership competency

Focus on follow-through, transparency, visible leadership, and learning from concerns.

**Through** - Staff Voice forums, new Staffroom Communities for directorates providing real time sharing. Consistent messaging of expectations - communication and meetings, appraisal, performance management.

**Intended Impact** - create consistent, transparent, and responsive leadership behaviours that strengthen trust, improve follow-through, and enhance overall staff experience across the Trust.

**Timescale** – Staff Voice as above. Staffroom Communities Spring 2026.

### 8.6. Rebuild advocacy and organisational pride

Use the identity and values work to rebuild confidence and belonging.

### 8.7. Improve inclusion and reasonable adjustments

Require directorate-level accountability for timely adjustments, inclusive leadership, monitoring and reporting**.**

**Starting point** - considerable work was undertaken in 2025 to re-align and clarify the process. A deeper dive by EDI lead will be delivered to enable a better understanding of barriers to progress. This will result in a more effective way forward to be determined.

**Timescale** – Deep dive analysis to start in April 2026.

### 8.8. Embed the "insight action impact" cycle

Require all cultural initiatives to demonstrate measurable impact.

**Timescale –** An expectation we need to embed, an ongoing behavioural shift required.

## 9. CONCLUSION

The 2025 Staff Survey results are a clear signal. KMMH has strong foundations, committed staff, and pockets of excellence, but variation is widening, advocacy is weakening, and psychological safety is fragile.

The Board's role is to ensure that:

- ↗ engagement becomes a leadership discipline not just a People function responsibility
- ↗ variation is addressed with urgency
- ↗ Staff Voice leads to visible action
- ↗ culture is treated as a driver of quality, not an adjunct to it.

## 10. RECOMMENDATIONS

The Board is asked to:

- ☐ **NOTE FOR ASSURANCE** the findings of the 2025 National Staff Survey.
- ☐ **DISCUSS** the implications for culture, leadership and quality.
- ☐ **ENDORSE** the management actions and the strengthened accountability framework.
- ☐ **CONFIRM** the Board's expectations for quarterly assurance and directorate-level ownership.

## Supporting Documents (Reading Room)

- Staff Survey 2025 – Executive Summary
- People Promise 2025 Engagement Results
- Red, Amber, Green – Full Trust 2025 Engagement Results
- People Engagement – Strategic Planning Instructions

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | CYP and AAED Service Transfer |
| **Author:** | Helen Pyecroft, Programme Director |
| **Executive Director:** | Donna Hayward-Sussex, Chief Operating Officer |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Approval to proceed with the transfer on the 1st April 2026, subject to the completion of all actions on the critical path |
| **Submission to Board:** | Board requested |

## Overview of paper

This paper provides the Board with a comprehensive update on the planned transfer of Children & Young People's Mental Health (CYPMHS) and All Age Eating Disorder (AAED) services from North East London NHS Foundation Trust (NELFT) to Kent and Medway Mental Health NHS Trust (KMMH) on 1 April 2026. It consolidates the assurance, due diligence, readiness assessments, and contractual preparations completed to date, and sets out the remaining critical-path activities that must be concluded prior to go-live.

Over the past year, both organisations have undertaken extensive joint planning, supported by a robust governance structure including the Assurance Group, Delivery Oversight Group, and Steering Group. These forums have provided structured challenge, triangulation of evidence, and consistent oversight of operational, clinical, workforce, digital, estates and contractual readiness. The Board-to-Board meeting on 11 March 2026 confirmed that both Trusts are now assured that the transfer can proceed safely, lawfully and in full alignment with national NHS requirements.

The paper highlights the small number of residual risks, including digital continuity, completion of supplier contracts, and finalisation of data-sharing documentation along with describing the active mitigations that are in place. The updated contractual position with the ICB, the financial implications of the transfer, the status of the Transaction Agreement, and the proposed Digital SLA with NELFT are also set out for the Board's consideration.

Given the scale and complexity of the service transfer, it is recommended that for a time-limited period a CYPMH & AAED Subcommittee of the Board is established. Its purpose is to provide targeted scrutiny and assurance, enabling the early detection and escalation of any emerging quality, safety, performance, workforce, or financial issues as the services transition and embed within KMMH.

The Board is asked to:

- Approve the transfer of services on 1 April 2026, subject to all remaining critical-path items being completed.

- Note the residual risks and the mitigations in place to manage them.
- Approve the establishment of a CYP & AAED Board Subcommittee to provide enhanced governance during the transition period.

## Issues to bring to the Board's attention

The Board is asked to note the following key issues, each of which has material relevance to the safe transfer of Children Young People's Mental Health and All Age Eating Disorder Services on 1 April 2026:

**1. Residual Operational Risks**

Although all previous red-rated risks have been successfully downgraded, several important residual risks remain. These include digital continuity risks related to finalising the Data Sharing Agreement, Data Protection Impact Assessment **(**DPIA) updates, and Power BI access, as well as the completion of outstanding supplier contract negotiations and the confirmation of agency staff arrangements. All areas have active mitigations in place and are under close oversight through programme governance.

**2. Contractual Position with the ICB**

The Trust's contract with the ICB has been formally updated to reflect the transfer, moving to a fixed-term £44.54m contract that supports a multi-year commissioning approach for Children's Young People and All Age Eating Disorder services. As part of this arrangement, the Trust has agreed a 2% (£854k) incentive payment linked to transformational outcomes. While this is considered proportionate and deliverable, performance against the incentive scheme will require continued Board oversight.

**3. Financial Exposure and Sustainability**

The transferring services remain loss-making. The current assessed deficit is £1.09m, improved from the original £1.87m primarily due to temporary vacancy-driven underspend. The Board should note that this improvement may not persist once recruitment stabilises. Short-term mitigations are incorporated into 2026/27 financial plans, with an expectation of moving toward a sustainable position over the medium term. Ongoing monitoring will be essential.

**4. Status of the Transaction Agreement**

The Draft Transaction Agreement sets out the legal basis for the transfer of services, staff, assets, liabilities, contracts and property interests. While substantially complete, final conditions precedent must be met prior to 1 April. Completion is expected, but the Board should remain sighted on this dependency.

**5. Digital SLA and Transition Dependencies**

The Digital Services SLA (annual value £1.87m) has been agreed in principle, with a phased mobilisation planned to ensure KMMH is in a position to assume full digital responsibility by April 2027. While confidence in Day 1 access to clinical systems remains high, the Board should note the residual risk linked to shared system dependencies.

**6. Property and Lease Arrangements**

While the majority of lease transfers have been completed or renewed, where this hasn't been possible, interim arrangements (e.g., tenancy-at-will) are in place to ensure continuity of service. These pose low operational risk but will require ongoing management as part of the post-transfer workplan.

### 7. Governance Requirements

Given the scale and complexity of the transfer, additional oversight is recommended for the first 12 months of mobilisation. The Board is asked to approve the establishment of a time-limited CYPMH & AAED Subcommittee to ensure robust scrutiny of quality, safety, workforce, digital continuity, operational performance and risk during the embedding period

## Governance

| | |
|---|---|
| **Implications/Impact:** | Covered within the report. |
| **Assurance:** | Assurance is provided through review by the Service Transfer Assurance Board and Service Transfer Steering Group supported by monthly RAG-rated milestone tracking and risk register review.<br><br>Additionally, close working with the ICB who have established a Service Transfer Assurance Group and an accompanying Assurance Framework. |
| **Oversight:** | Board |

# Board Summary – CYPMHS & AAED Transfer to KMMH

## Introduction

This paper presents the most up-to-date position on the CYPMHS and AAED service transfer and provides the Board with its final assurance milestone prior to implementation on 1 April 2026.

On 23 February 2026, the Assurance Group confirmed that there is sufficient organisational, operational and clinical readiness to support a safe and effective transfer on 1 April 2026. This conclusion formed the basis for the Boards-to-Boards final collective decision.

The Board-to-Board meeting held on 11 March 2026 provided the formal mechanism for both Trust Boards to confirm that the transfer of CYPMHS and AAED services can proceed safely, lawfully, and in line with national requirements. This discussion built on the significant assurance work undertaken to date and enabled both organisations to reach a shared, evidence-based judgement on service readiness. Both Boards concluded that the transfer should proceed.

Board members are asked to approve the transfer of services on 1 April 2026, subject to the completion of all activities on the critical path. Based on current progress, there remains strong confidence that all required tasks will be successfully completed by 31 March 2026.

Board members are also asked to approve the establishment of a dedicated CYP & AAED Subcommittee to oversee the first 12 months post transfer.

## Overview of the Process to Date

At the Board-to-Board meeting held in July 2025, NELFT and KMMH committed to jointly delivering and assuring a safe and legally compliant transfer of CYPMH and AAED services. A set of shared principles and success measures was agreed at that time, and these have since guided the management of the transfer. Ongoing assurance has been overseen and coordinated through the Assurance Group.

The Assurance Group is chaired by Jules Christmas (KMMH Non-Executive Director) and includes Colin Lynch (NELFT Non-Executive Director), both Chief Executive Officers, and the Senior Responsible Officers from each organisation. The group has met six times since July 2025.

The Assurance Group has overseen the joint work between the trusts, providing structured review, appropriate challenge, and confirmation that all key elements of the transfer have been fully considered. In particular, assurance has been sought and received in relation to the following areas:

- Progress against success measures
- Progress against Day 1 milestones
- Progress against the critical path
- The legal and contractual transfer arrangements – including the due diligence carried out by Hill Dickinson

- The relevant requirements for commercial and statutory transactions, and assurance documentation that trusts are expected to provide as part of NHS England's oversight of transfers. This aligns with the national expectations that participating trusts demonstrate robust preparation, risk mitigation, and board-level scrutiny when progressing service transfers
- Programme, service and Day 1 risks and mitigations
- Sub-group activity – including the safe transfer of quality and governance, HR and people, digital, finance, estates and contracting and communication and engagement activities
- Readiness for the safe transfer and safe delivery of services from April 1st 2026

Four board-to-board meeting have also been held since July 2025 where assurance of progress and risks has been sought and received.

Through this process, the Assurance Group has been able to provide assurance to both Boards that the necessary due diligence and preparation have been completed.

The Assurance Group concluded that there is sufficient evidence of organisational, operational, and clinical readiness to enable the safe and effective transfer of services on 1 April 2026. This was also the conclusion of the board-to-board meeting held on the 11 March 2026.

In December 2025, the KMMH Board approved the proposed transfer scheduled for 1 April, ahead of NELFT beginning its formal staff consultation in January. The Board reaffirmed its confidence in a safe transfer in January 2026 and is now being asked to give final approval at its meeting on 26 March 2026.

Alongside the KMMH Board discussions, the Trust's Quality Committee, Audit & Risk Committee, Finance Business and Investment Committee, Joint Negotiating Forum, and Strategic Deployment Review have each examined various aspects of the programme.

## Summary of Workstreams and Overall Readiness

The subgroups' work has been strongly supported by the programme's governance arrangements, particularly through the Delivery Oversight Group and the Programme Steering Group. These groups have provided clear direction, effective coordination, and constructive challenge, ensuring that all workstreams remained aligned to the agreed Day One priorities.

A critical path with defined milestones was established and closely monitored, enabling progress to be tracked, dependencies managed, and any emerging issues addressed promptly.

In parallel, programme-wide and day one-specific risks have been systematically identified, evaluated, and mitigated through established reporting and escalation mechanisms. This governance approach has ensured disciplined delivery, robust oversight, and a high level of assurance as we move toward the safe transfer of services.

Below is a brief summary of each of the workstreams.

**HR, People and Training**

TUPE consultation has concluded, with no significant concerns raised by staff or Trade Union representatives. Employee Liability Information (ELI) has been received, reviewed to identify data gaps or inconsistencies, and the team are collaborating with NELFT to resolve these. A robust set of inductions for transferring staff has been planned, with welcome packs and KMMH-branded lanyards to be provided at the inductions.

A significant recruitment programme is in progress to recruit to new critical posts, including medical consultants, pharmacy, safeguarding (all to be in post ahead of April), infection and prevention control (IPC) and physical health, resus, practice education, promoting safe services (PSS), and security.

Some operational risks remain, particularly in relation to compressed timeline for payroll validation and non-medical agency contracts, however, these are understood and are being actively managed.

**Digital**

The digital road map and accompanying action plan have guided the work of the digital workstream, ensuring coordinated preparation for transfer. The Assurance Group has received regular updates on progress and on the testing undertaken to confirm readiness. The agreed transfer position is supported by a Digital SLA.

Clinical systems will remain under NELFT management on 1 April, while corporate systems will transfer to KMMH. Digital continuity carries some residual risk, as real-world conditions during the transfer may surface issues that could not be fully identified through testing. The creation of NHS.net accounts for transferring staff (needed to enable access to corporate systems) could only begin once the confirmed staff transfer list was received. This has reduced the window available for training and may result in minor, short-term access issues for corporate systems. However, confidence remains high regarding uninterrupted access to clinical systems and staff have access to helpdesk support from day 1.

Although progressing, the data-sharing agreement has not yet been signed. This will not affect the provision of patient care, as staff will continue to be able to access clinical records. It is anticipated this will be in place prior to go live, however, it may temporarily limit access to some supporting information.

**Finance, Contracting and Estates**

The Trust's assessment of the underlying position on CYP and AAED services is an underlying deficit of £1.87m. As part of the planning round this position has been reassessed and the present exit run rate indicates a loss-making service of £1.09m. This movement is driven by the present vacancy rate within the service. The Trust's financial plan recognises this position and has mitigations for this with ongoing discussions with commissioners around additional funding, vacancy management and corporate integration. Due to this it anticipates that the impact can be managed in the short term and moved to a sustainable footing within the 3-year planning cycle.

The financial assessment has made some allowance for the fact that in some areas incomplete information is available (NELFT operate across three geographies, and some contracts are held at that level), so this position will be monitored in year.

A comprehensive and collaborative review process of supplier contracts supporting the services has been completed. Of the services required, the majority of these will move to a KMMH supplier for Day 1. Contracts are in place for business-critical areas, with the remaining variations being finalised with suppliers, with these anticipated to be concluded prior to go live.

Digital services, energy and utilities will be continued via a Service Level Agreement with NELFT for an interim period.

The majority of lease transfers have been completed or renewed. Where this hasn't been possible, interim arrangements (e.g., tenancy-at-will) are in place to ensure continuity of service. While there are no operational concerns, KMMH are entering into new leases for several sites where existing leases had expired. This will have an impact on the Trust's capital budget, and we are in conversation with NHS England around the mitigations for this. A lease agreement will also be entered into with NELFT for the Kent and Medway Adolescent Hospital (KMAH) at go-live, with discussions on-going around the potential purchase of the site.

**Quality and Governance**

Quality and Governance have completed a full programme of work allowing for the safe transfer of clinical responsibility for Day 1. This includes the alignment of:

- Policies, which were largely ratified at a 24 February extraordinary Trust-wide Patient Safety Group meeting, with the remaining to be ratified at the 13 March meeting;
- Patient Safety Incident Response Framework (PSIRF), whereby the transferring services will adopt the PSIRF pathways used at KMMH, and two additional local priorities will be added for CYPMHS and AAEDS;
- Governance within the directorate, and reporting pathways up through the Trust governance structure;
- Complaints and compliments processes, which will be managed by KMMH's central team;
- Medicines supply arrangements, where current processes will be maintained for community prescriptions, and Rowlands Pharmacy, who currently dispense medicines for KMMH, will supply medicines to KMAH;
- Incident and risk reporting, which will move to KMMH's InPhase system;
- Escalation and on call procedures, with service business continuity plans (BCPs) being transferred and added to KMMH templates, the directorate being added to Resilience Direct, and the directorate on call layer remaining live and escalating upwards to the KMMH Manager on call layer where required; and
- Safeguarding arrangements, with new resource in place ahead of transfer to ensure no disruption in statutory requirements, and all safeguarding policies being updated to include children-related content.

This workstream is assured that patient care will be uninterrupted by NELFT maintaining clinical systems at go-live, with virtual support being provided as required through established helpdesks. Furthermore, additional clinical oversight (named clinical leads, an enhanced senior clinical leadership presence, and a dual-layer local on call model), will be in place for go-live to support any required clinical escalations.

Discussions are still underway regarding responsibility for performance reporting, with KMMH set to take on this function in May for the April reporting period.

KMMH remains in close communication with the CQC and has confirmed its intention for the new services to be added to the Trust's registration. CQC rating posters will be updated ahead of the transfer to include the transferring core services. In line with CQC guidance, these have been marked as 'Not Rated' until the services are rated post-transfer.

**Communications and Engagement**

The communication and engagement group has delivered consistent, aligned strategic messaging across the priority programmes, supported leadership and staff engagement channels, and implemented planned campaigns on schedule, receiving strong reach and positive feedback. Ongoing monitoring of reputation and stakeholder sentiment has highlighted no areas of concern, with indicators remaining stable throughout. Overall, no communications or engagement risks have been identified that would negatively impact the transfer of services.

**Legal Review and Status of the Transfer Agreement**

Hill Dickinson have led the legal due diligence process and development of a transaction agreement, which includes a list of all assets and liabilities transferring to KMMH. It also sets out an ongoing intention for KMMH and NELFT colleagues to work together in partnership post-transfer in the spirit of the principles and success measures set out in the first CYPMH/AAEDs Board to Board meeting held in July 2025. The due diligence report identified no red risks.

The Transaction Agreement and non-digital SLA will be signed by the KMMH and NELFT CEOs between now and 1st April 2026.

This SLA will include provisions for the continuation of energy and utilities services, with costs recharged to KMMH for an initial period following go live. This will allow time to obtain the necessary information to setup contracts from suppliers, who are unable to provide this until KMMH is the leaseholder for the transferring estates.

**Management of Residual Liabilities**

The legal due diligence report reviewed the liabilities transferring to the Trust; however, the information relating to clinical risk was incomplete. While the number of inquests is relatively low and it is positive that no Prevention of Future Deaths Reports have been issued, the detail relating to current inquests, outcomes of previous inquests, and historical risk-register information has not been provided. The general disclosure warranty and the fact that NELFT retains responsibility for pre-transfer matters, including clinical claims, offer some mitigation.

**Ongoing Joint Working Arrangements**

NELFT and KMMH will continue to work collaboratively beyond April 2026. Key commitments include:

- Overarching Partnership SLA defining joint working expectations and contract and supplier coordination, avoiding service disruption.
- Digital SLA ensuring continuity of shared system dependencies.

- Ongoing joint assurance through Steering and Assurance Groups – see Appendix 7.5 below for forums through which integration and post-transfer activity will be managed.

## Contractual Update

In agreeing the CYP and AAED transfer, the board are asked to agree the following key contractual items, noting legal position and the present financial position of the service.

**Contractual**

The Trust's contract with the ICB has been updated to reflect the CYP and All Age Eating Disorder Services transfer, with a move to a new all age contract with a fixed contract length and inclusion of CYP and AAEDS services contained within a £44.54m increase to the Trusts contract. The move to a fixed contract length supports a longer-term approach to commissioning within Kent and allows for a multi-year approach to service improvement. As part of the contract the Trust has agreed a 2% incentive payment (£854k) against the transferring services. This is in-line with the approach agreed with NELFT and is focus on the transformational aspect of the integration of services. The envelope is unchanged in the first year whilst the plan is developed, the incentive fund will be reimbursed on delivery of the plan and achievement of the items detailed within it. The Trust considers this approach to be deliverable and the incentive proportionate. We will work with commissioners to see what opportunity this provides the Trust in the longer term

The contract has been reviewed across the Trust and is seen as deliverable by relevant parties.

**Transaction agreement**

A Draft Transaction Agreement between KMMH and NELFT has been developed with support from Hill Dickenson, the legal advisors commissioned to support the transfer process.

It sets out the legal mechanism for the transfer of:

- Services
- Staff (TUPE)
- Assets and liabilities
- Contracts and property interests

The agreement provides the formal legal framework for completion on 1 April 2026, subject to final conditions precedent. The draft is being reviewed by the NELFT senior team and will be jointly signed by KMMH and NELFT as part of the formal transfer of services.

**Digital Services SLA**

A Digital Services SLA has been agreed in principle, with an annual value of £1.87m. To reduce transition risk, the trust is working with NELFT to develop a phased mobilisation plan to ensure the trust is able to take on the digital elements of the contract from 1st April 2027.

The contract with NELFT has been reviewed by all parties (KMMH, NELFT and the ICB), as well as subject to external review. All parties are assured it will enable the trust to deliver its services in year.

**Property and Lease Arrangements**

Lease arrangements associated with CYP / AAED services, including sites involving Kent and Medway Adolescent Hospital, are addressed within the Transaction Agreement. Where lease assignment cannot be completed by go-live, interim arrangements (e.g. tenancy at will) are provided for to ensure continuity of service.

**Governance and Approvals**

Given the fixed transfer timetable and associated risks, several approvals were progressed via Chair's Action between Board meetings. These actions were taken to:

- Secure contractual continuity
- Enable mobilisation
- Avoid operational or legal risk at go-live

These covered the contract award for maintenance, catering and soft FM services, extending existing arrangements within the Trust. In addition, the trust has awarded a contract to liaison to allow the continuation of the agency arrangements for medical staff.

All actions are within the scope of the Board's previously agreed decision to proceed with the CYP transfer.

## Engagement with System Partners

Throughout the transfer programme, KMMH and NELFT partners have worked closely with the Integrated Care Board (ICB) with senior colleagues contributing regularly to the work of the sub-groups. Both teams have worked closely with the ICB to provide the necessary evidence to support completion of their readiness and to ensure alignment in planning and assurance processes. In addition, KMMH have collaborated with ICB partners to attend both Health and Adult Social Care Scrutiny Committee (HASC) and Health Overview and Scrutiny Committee (HOSC) meetings, offering joint assurance and demonstrating our collective commitment to ensuring a safe and well-managed transfer of services.

KMMH have worked closely with NHS England (NHSE) throughout the preparation phase to ensure a safe and robust transfer of services, particularly through the NHSE self-certification process. As required for statutory and significant transactions, participating trusts must submit board-approved self-certifications covering key areas such as quality and patient benefits, integration planning, finance and risk, supported by appropriate due diligence and external advice.

In line with NHSE's commercial transfer oversight framework, KMMH and NELFT colleagues have collaborated with NHSE colleagues to provide the necessary evidence, documentation and assurance demonstrating organisational readiness and risk mitigation to support NHSE's assessment of the transaction.

Through this process, strong and transparent working relationships have been maintained with the ICB and NHSE, ensuring that all requirements are met and that the transfer is progressing safely and in accordance with regional and national expectations. NHS England has signed off the transfer. The ICB will continue to monitor readiness up to transfer date, but have expressed

consistent confidence in the process since January 2026 and there is no reason to believe this will change before 31st March 2026.

## Next Steps and Future Governance

It is proposed to establish a CYPMH & AAED Sub Committee to the KMMH Board to provide focused, time-limited assurance on the quality, safety, performance and operational stability of Children & Young Peoples Mental Health and All-Age Eating Disorder services during the 12-month period following their transfer from NELFT to KMMH.

Its primary purpose is to ensure that any emerging risks, quality or performance concerns arising during the post transfer mobilisation are identified early, escalated appropriately, and mitigated in a timely manner.

The Assurance Group will continue to play a central role in overseeing the safe and effective transfer of services, maintaining rigorous scrutiny across all operational, clinical, and governance workstreams. It will remain the main forum for tracking progress, identifying emerging risks, and ensuring that any issues are escalated promptly and appropriately to both organisations. This is considered essential until such time that the transfer (including digital systems) has been completed.

In doing so, the Group provides an ongoing mechanism for transparency, shared problem-solving, and collective decision-making, supporting strong partnership working between NELFT and KMMH. This structure ensures that both trusts stay aligned throughout the transition period and that any matters requiring executive or Board-level attention are escalated without delay, safeguarding service continuity and quality.

## Recommendation to the Boards

Board members are asked to confirm their assurance and approve the transfer, recognising the small residual risk, the contractual position and endorsing the continued collaborative approach between NELFT and KMMH.

Board members are asked to approve the establishment of a CYP & AAED subcommittee.

# Appendices

1. Overall readiness

Workstreams are on track to deliver all their milestones by the 1st April 2026 with confidence remaining high in the ability of all parties to deliver a 1st April transfer.

| Readiness Area | Assurance Summary |
|---|---|
| Scope & Deliverables | All deliverables identified and baselined; no major scope gaps |
| Critical Path | All key activities monitored; remaining items on track |
| Risk Management | Risks understood, mitigations active, no blockers |
| People & Workforce | Leadership and operational capacity in place |
| Business Readiness | Organisational impact, KPIs and dependencies understood |
| Stakeholder Engagement | Staff, partners and ICB fully engaged |
| Governance | Clear route to approval and go-live through Steering and Assurance Groups |

2. Critical Path

The remaining critical-path items are actively managed with clear accountability.

| Critical Path Area | Remaining Actions | Status |
|---|---|---|
| Digital | Finalisation of DSA, DPIA, BI reporting | Amber – mitigated<br><br>Data sharing agreement is agreed in principle. The DPIA has been produced and, as a living document, will continue to be updated as needed. Access to the KMMH Power BI environment has been received and a further assessment of impact will be undertaken by BI at go-live. |
| Finance, Estates and Contracting | Completion of contract handovers; procurement plan and confirmation of charging mechanisms | Amber – progressing<br><br>Supplier conversations being finalised (with completion anticipated by go-live). SLA to be finalised with NELFT for energy and utilities. Recruitment difficulties with cleaning have meant urgent engagement with NHSP underway to confirm temporary staffing for April. Capital conversations remain outstanding with NHSE. |
| Workforce | Final recruitment, onboarding, agency continuity through NHS Professionals | Amber – progressing<br><br>The non-medical agency setup with NHSP is in the final stages. |

| | | |
|---|---|---|
| | | Call-off agreements will be issued once the remaining self-billing agreements and rate cards are received from the agencies and approved. There are some operational issues relating to the onboarding of bank staff to NHSP, which have been escalated with NHSP and are being actively progressed. |
| Quality & Governance | Final policy alignment, safeguarding appointments | Green |
| Communication & Engagement | Website, staffroom and launch comms scheduled and ready for publication | Green |

3. Success Measures and Day 1 Deliverability

Progress against key success measures indicates strong readiness for Day 1.

| **Success measure** | **Indicators** | **Assessment** |
|---|---|---|
| Clinical Continuity | Safeguarding, governance, PSIRF alignment | High confidence |
| Digital Continuity | System access, email plan, reporting | Medium–High confidence |
| Workforce Transition | TUPE, induction, agency planning | High confidence |
| Estates Readiness | Access, safety, asset mapping | High confidence |
| Communications & Engagement | Staff, SU, partner messaging | High confidence |

4. Progress of legal and sign-off gateways

The table below provides a snapshot of key contractual elements required for the service transfer.

| Item | Purpose | RAG | Note |
|---|---|---|---|
| Digital SLA | Definition of digital service to be provided by KMMH to NELFT, means to manage / monitor ongoing digital support | | A Digital Services SLA has been agreed in principle, with an annual value of £1.87m. |
| Overarching SLA | To include principles of partnership and specifics on a small number of areas (e.g. contracting) | | The draft SLA is being finalised by KMMH colleagues, engagement between Phil Lawrence (KMMH) and Robert Neale/Kevin Garner to finalise. Support being provided by Hill Dickinson |
| Transaction Agreement | Describing the transferring assets (people, contracts, | | A Draft Transaction Agreement between KMMH and NELFT has been developed |

| | | | |
|---|---|---|---|
| | equipment, records, properties) | | setting out the legal mechanism for the transfer |
| Legal DD report for KMMH | Set out the risks of transfer for KMMH Board | | A draft has been received, and this will be shared with the KMMH Board on the 26th March. Support being provided by Hill Dickinson |
| NHSE Self Cert | To secure sign-off for the transfer from NHE England | | NHSE have approved the Self-Cert with three caveats that are being resolved 1) Reworking of the financial information, 2) a couple outstanding assurance on quality (policies/PSIRF) and (3) the digital SLA. |
| ICB Contract | New contract from April 1st | | Contract to be signed in March. |
| Provider Collaborative Agreement | New contract from April 1st | | Transfer of contract agreed, letters sent / signed. |
| Data sharing agreement (DSA) | To facilitate legal sharing of key information on staff and services | | Data sharing agreement is agreed in principle |

## 5. Post Transfer Partnership Working

NELFT and KMMH will continue to work collaboratively beyond April 2026. The following governance will set beneath the proposed CYPMH & AAED Service Subcommittee.

| Forum | Purpose | Membership | Frequency |
|---|---|---|---|
| Assurance Group | Assurance of transfer and escalation to ensure ongoing partnership working between NELFT and KMMH | KMMH and NELFT NEDs, CEOs and SROs | Quarterly |
| Steering Group | Oversight of transfer and integration – focus on measuring success, escalation and risk and digital transfer | NELFT, KMMH and ICB | Monthly (dropping to bi-monthly in Q2) |
| Delivery Oversight Group | Day to day responsibility for the transfer and integration of services (alongside operational colleagues) | Deputies forum, chaired by Nick Brown | Fortnightly (dropping to monthly in Q2) |
| ICB Assurance Group | Provide enhanced contractual monitoring in early mobilisation period | ICB and KMMH exec representation | Monthly |

## 6. Risk Overview

Day 1 readiness risks have significantly reduced, with all previous red risks downgraded. Remaining pre-transfer risks relate to access to key operational data and confirmation of essential contracts, both of which have active mitigation and close PMO oversight.

| Activity | RAG | Comment |
|---|---|---|
| Bi Reporting | | • Discussions continuing between organisations. Agreement in principle for operational data to remain under the management of NELFT (due to the link with Rio).<br>• Access to KMMH Power BI will be provided for clinical and operation staff negotiation on going into access for the KMMH BI team.<br>• Data sharing agreement agreed in principle |
| Data Sharing Agreement | | |
| Procurement Go-Live Plan | | • Procurement go-live support plan in development, information to be provided to relevant staff ahead of go-live.<br>• Majority of contract variations have been drafted but not yet signed. Still some ongoing negotiations with KMMH suppliers.<br>• Primary outstanding contracts to confirm are for non-medical agency.<br>• Developing SLA with NELFT for energy and utilities.<br>• Agreeing process with NELFT to engage with KMMH prior to terminating services after go-live to ensure these aren't use in K&M. |
| (Supplier) Contract Negotiations | | |
| Staff room | | • Content has been drafted and is awaiting final policy approval before upload.<br>• Dedicated resources are in place to complete the upload. |

Late but in progress

7. Subcommittee TOR

## Draft - Terms of Reference

| | | |
|---|---|---|
| **Name of Committee** | **CYPMH & AAED Services Committee** | |
| **Date** | **13th March 2026** | |
| **Version** | **V.1** | |
| **Approval** | **Trust Board** | **Date: 26th March 2026** |
| **Next review due** | **March 2027** | |

### Review - Document Control

| Version | Status | Date | Author | Summary of Changes |
|---|---|---|---|---|
| V1 | Draft | 13.03.26 | Service transfer PMO | 1st Draft |

### 1. Constitution

The Board hereby resolves to establish a Committee, to be known as the Children and Young Persons Mental Health (CYPMH) and All Age Eating Disorders (AAED) Services Committee for a period up to 12 months. The Committee holds no executive powers. The Board may resolve to remove this Committee at a point it feels that transitional risks have become standard business risks.

Any amendments to the Terms of Reference must receive formal approval from the Trust Board.

The Committee is authorised by the Board to examine any matter within its remit and may request any information it considers necessary from any member of staff.

All staff are required to cooperate fully with any such requests.

## 2. Purpose

The Committee provides assurance to the Trust Board on the post-transfer transitional risks related to quality, safety, performance, workforce stability, and operational resilience of CYPMH and AAED services during its 12-month post transfer period. The transfer date is 01.04.26.

The Committee will ensure that any deterioration, risks, or emerging concerns are identified, and managed in a timely manner so far as possible. Where it is not possible to manage those matters, the Committee may either escalate to the Board or cross-refer to another sub-Board Committee.

## 3. Aims

To assure the Board that the structures, systems and processes are in place and functioning to support post-transfer matters and allow for transitional risks to be effectively managed.

To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality and safe health care with respect to CYPMH and AAED that these are being managed in a controlled and timely way.

To seek assurance regarding the Trust's performance for CYPMHS and AAED provided via the Integrated Quality and Performance Report (IQPR). This will cover performance against set Key Performance Indicators (KPIs) and the management of waiting lists.

## 4. Objectives

Specific to All CYPMH community services and AAED services:

To seek assurance through formal reporting that during the 12 months post service transfer that:

**1. Robust quality and governance systems support safe, high-quality CYPMH and AAED care**

Structures, policies, systems, and processes for quality assurance, continuous quality improvement, and all aspects of clinical, information, and quality governance are effective, consistently applied, and aligned with the needs of Children and Young People's Mental Health and All Age Eating Disorder services.

**2. Regulatory and statutory compliance is actively achieved and maintained**

Effective mechanisms are in place to ensure full compliance with relevant regulatory requirements—including CQC standards—and that recommendations or actions arising from CQC inspections or other regulatory bodies are implemented and monitored appropriately.

**3. Risks to quality, safety, and service continuity are identified and managed proactively (including the Phase 2 digital full transfer programme)**

Current and emerging risks to patient safety and service delivery, related to the transition from NELFT to KMMH, are clearly recorded, understood, mitigated, and escalated in a timely and proportionate manner.

**4. Performance and quality metrics drive continual improvement**

The Trust uses meaningful, child- and family-focused quality indicators, performance metrics, and outcome measures that support continual improvement in service quality, accessibility, experience, and effectiveness across CYPMHS. These indicators also extend to all-age eating disorder services, ensuring consistent monitoring and improvement across the full care pathway.

**5. Complaints, incidents, and patient safety events inform learning and improvement**

Trends, themes, and learning arising from complaints, incidents, safeguarding concerns, and patient safety events, impacted by the transfer of services are recognised, shared, acted upon, and used to strengthen a positive safety and learning culture.

**6. Workforce capability and culture support safe and effective CYPMH and AAED delivery**

Workforce capacity, training, development, and wellbeing are monitored and supported to ensure staff are equipped to deliver safe, compassionate, and high-quality care, particularly during and after the service transition.

## 5. Methodology

To discharge its remit, the CYPMH & AAED Services Committee will adopt a structured assurance-based methodology, focused on the systematic oversight of quality, safety, performance, workforce and risk during the post-transfer period.

The Committee will seek assurance through the receipt, scrutiny and triangulation of formal reports, exception reporting and escalation from established programme and operational governance arrangements supporting the CYPMH and AAED service transfer.

Specifically, the Committee will:

- Receive and review regular assurance reports on the safety, quality and effectiveness of CYPMH and AAED services, including performance against agreed quality indicators, access standards, waiting times, caseloads, outcomes and experience measures.
- Receive assurance on workforce capacity, stability, capability and wellbeing, including recruitment, retention, training, agency usage and vacancy management, and the impact of workforce risks on service continuity and quality.

- Receive and scrutinise reports on incidents, safeguarding concerns, complaints, serious incidents and patient safety events relating to CYPMH and AAED services, and seek assurance that learning is identified, disseminated and acted upon.
- Receive and review risk reports relating to the service transfer, including risks recorded on programme and corporate risk registers, and seek assurance that risks are appropriately mitigated, escalated and reviewed.
- Receive assurance on compliance with statutory, regulatory and commissioning requirements, including progress against any actions arising from CQC reviews, internal audits or external scrutiny relevant to CYPMH and AAED services.
- Receive reports from established programme governance forums, including the Service Transfer Programme Steering Group and any associated delivery or oversight groups, which will provide structured assurance on transfer milestones, integration progress, digital readiness and benefits realisation.
- Direct the provision of exception reports where performance, quality or safety thresholds are not met, and escalate matters of concern to the Trust Board where appropriate.
- Approve and oversee an annual workplan aligned to the defined post-transfer assurance period, setting out the Committee's planned areas of focus, including deep dives, thematic reviews, reporting cycles and key assurance checkpoints.
- Where required, request additional information, presentations or assurance from Executive Directors, programme leads, clinical leaders or operational managers to support the Committee in fulfilling its assurance role.

## 6. Membership

The Committee will be appointed by the Board and its membership shall consist of the following:

- Two Non-Executive Board members (one of whom will Chair the Committee);
- Chief Operating Officer
- Chief Nurse
- Chief Finance and Resources Officer
- Head of Quality
- CYPMHS / AAED Service Director
- CYPMHS / AAED Head of Nursing
- Workforce/HR Business partner
- Finance Business Partner

In Attendance and on request:

Any Executive Director, senior manager, or employee may be invited to attend as appropriate by decision of the Committee or the Committee Chair. This includes representative members of the directorate leadership teams.

Meetings shall generally be monthly, with the exception of August, with additional meetings as necessary to fulfil the Committee Workplan.

## 7. Quorum

A quorum shall be four members, which must include two non-executive members and one executive Board members.

## 8. Methodology (Duties, Reporting, Annual Workplan,)

To discharge its remit, the Committee will adopt the following methodology:

1. **Seek Assurance Through Established Programme Governance Structures**
   The Committee will obtain regular assurance on operational performance and service stability through the existing Service Transfer Programme governance arrangements, specifically:

   - **Service Transfer Programme Steering Group** – to provide strategic oversight, risks, emerging issues, and programme-level assurance relating to the successful transfer and mobilisation of CYPMH & AAEDs functions.
   - **Delivery Oversight Group** – to provide operational assurance, including progress against transition milestones, workforce and capacity planning, quality and safety indicators, and any mitigations in place where performance deviates from plan.

2. **Review Assurance Reports and Escalations**
   The Committee will receive and review:

   - Formal assurance reports submitted from the Steering Group
   - Escalations relating to operational risks, safeguarding concerns, workforce pressures, quality indicators, or delivery constraints.
   - Exception reports where delivery, safety, or performance thresholds are not met.

3. **Triangulate Information with Core Operational Data**
   The Committee will triangulate information from the governance groups with:

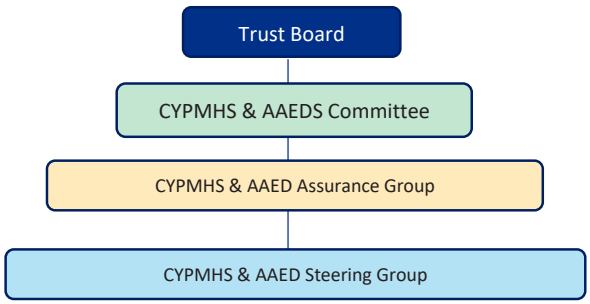
   - Routine CYPMHS & AAEDS performance dashboards.
   - Quality and safety reports, including incidents, complaints, and feedback.
   - Workforce metrics and capacity modelling.
   - Any independent review or audit outputs commissioned during the transition period.

4. **Maintain a Forward-Looking Oversight Perspective**
   The Committee will focus on both immediate post transfer operational performance and the medium-term embedding of the new service model, ensuring that:

   - Risks are actively managed and mitigated.
   - Children, young people and families continue to receive safe, timely, high-quality services.
   - Transition to “business as usual” governance is achieved within the 12-month window.

5. **Engage with Relevant Stakeholders When Required**
   The Committee may request additional information, presentations, or clarification from programme leads, operational managers, clinical leaders, or partner agencies to support assurance activity.

## 9. Accountability and Reporting – Group Structure




## 10. Committee rules and administration arrangements

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees, and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee on matters that assist in the Committee's discharge of its duties to the Board
- Ensuring the agenda, papers, and corresponding minutes reflect confidential items

The Secretary may delegate some or all of these duties as required.

The minutes of Committee meetings shall be formally recorded and stored by the Secretary.

## 11. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Chair of the Committee shall report to the Trust Board each meeting and draw to the attention of the Board any issues that require disclosure to the full Board or require executive action including details of any matters in respect of which actions or improvements are needed.

The Chair of the CYPMH & AAED Services Committee has the Board's authority to report to other organisations working in partnership any matter the Committee considers impacts on clinical quality.

## 12. Review and Monitoring

The Committee will automatically dissolve at the end of its 12-month lifecycle, unless the Board determines otherwise.

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

| | |
|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Quality Account Priorities 2025/26 |
| **Author:** | Julie Kirby - Acting Chief Nurse *with contributions from Glenda Boutell – Nurse Consultant & Rachael Sanderson – Allied Health Professionals (AHP) Strategic Lead* |
| **Executive Director:** | Acting Chief Nurse |

## Purpose of paper

| | |
|---|---|
| **Purpose:** | Discussion & Approval for 2026/27 quality account priority |
| **Submission to Board:** | Board requested |

## Overview of paper

This paper provides an update on delivery against the Trust's Quality Account Priorities (QAP) for 2025/26 and sets out the ongoing work and next steps for 2026/27. The three priority areas were:

1. Women's Health
2. Working With Families
3. Self-Harm

Significant progress has been achieved in all areas, including the launch of new digital dashboards, strengthened governance, improved clinical resources, and meaningful engagement with patients, carers, staff, and academic partners. Future work focuses on embedding improvements, strengthening staff capability, and evaluating impact.

Following discussion at the February Quality Committee, it is proposed that the Quality Account priority for 2026/27 will focus on implementing the Quality Plan through a structured programme of work designed to drive demonstrable quality improvement and deliver sustainable, Trust-wide enhancements in areas identified through both internal and external reviews.

## Issues to bring to the Board's attention

Further work is required in all three areas to continue improvement against current progress. Women's health will now become a local project within the Acute directorate with oversight delivered through the Acute Strategy Deployment Review (SDR) meetings.

Working with families will be included in the Quality Plan and oversight and assurance sought through the programme board.

Self harm and working with families are both included in the upcoming trust strategy and oversight will be included in the trust wide SDR.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Patient Experience/ Patient Safety/ Family & Carer Experience |
| **Assurance:** | Reasonable |
| **Oversight:** | Quality Committee |

**1. QUALITY ACCOUNT PRIORITY – WOMEN'S HEALTH**

**Problem Statement**

It was identified there was limited organisation-wide awareness and knowledge of the impact of menopause and other women's health needs on staff and patients. Women's mental health inpatient wards do not currently have a bespoke, evidence-based training programme addressing the specific needs and experiences of women receiving mental health inpatient care.

**Progress to Date**

- **Launched**: Women's Health Dashboard on iLearn.
- **Ward resources**: All women's wards now stocked with sanitary products and aligned safe-use protocols.
- **Menopause audit completed** with key actions implemented:
    - Ward-based menopause information
    - QR code feedback
    - Continuing Professional Development sessions scheduled for medical colleagues
- **Women's Health Conference (March 2026)** at Canterbury Christchurch University (CCCU) St Augustine House delivered.
- **Academic partnerships** initiated with CCCU to explore research opportunities.

**Forward Plan (2026/27)**

- Continued delivery as part of the **Acute Directorate local project**.
- Regular updates via Acute SDR and Transformation meetings.
- Ongoing **women's health promotion programme** (menopause, PMMD etc.).
- Evaluation of:
    - Dashboard impact
    - Menstrual health resources on wards
    - Staff and patient feedback
- Identification of new improvement areas in collaboration with frontline teams.

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**2. QUALITY ACCOUNT PRIORITY – WORKING WITH FAMILIES**

**Problem Statement**

The Trust identified inconsistent approaches to involving families, friends, and carers across services. Tools and systems for recording carer information lacked standardisation, completion rates were low, and staff confidence in working collaboratively with families varied. There was no single Trust-wide Standard Operating Procedure (SOP) or accessible resource hub to support operational practice.

**Progress to Date:**

***Raising Awareness***

- Trust-wide *Working with Families Workshops* delivered by the Chief Nurse and Strategic AHP Lead.
- Continued roll-out of **Open Dialogue**, Clinical Risk Assessment & Management (**CRAM)**, and carer e-learning packages.
- Communications campaigns aligned with national carer events.
- Directorate carer champion forums maintained.
- Launch of the new **Carer Information form on RiO**, now integrated into e-learning.
- Publication of the **Trust's first Family, Friends and Carers SOP**.

***Supporting Families***

- Strengthened partnership working through the **Trust-Wide Carer Experience Meeting**.
- Ongoing support delivered by:
    - Carer leads
    - Family engagement and liaison leads
    - Admiral Nurses
    - Family therapists
- Relationship-building with North East London Foundation Trust (**NELFT) systemic family therapists**.
- Launch of a **central staff resource hub** on the Staffroom.
- Identified need to improve **consent and information-sharing recording**:
    - Information Governance -led working group to review the form
    - Communications plan to follow
- Carer Information Leaflet under review following Trust rebranding.

***Listening and Responding***

- Continued collaboration with external carer agencies.
- Feedback used to improve resources, practice, and communication pathways.

**Forward Plan (2026/27)**

- Submission of **Triangle of Care annual report** with aim to retain 2-star accreditation.
- Review of **CQC Community Mental Health Survey** results to benchmark family involvement.
- Launch of the new **Trust Experience Measure** (April 2026).
- Continued expansion of Open Dialogue and CRAM training.
- Formal inclusion of CYP/AAED colleagues into Trust-Wide Carer Experience Group.

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**3. QUALITY ACCOUNT PRIORITY – SELF-HARM**

**Problem Statement**

Self-harm incidents are a key patient safety concern within the organisation. Historically, the Trust lacked consistent data recording, a standardised practice framework, and coordinated governance to understand, prevent and respond to self-harm. Staff feedback highlighted the need for more confidence, clearer formulation tools, and improved resources for supporting service users and families.

**Progress to Date**

**Data**

- Improved recording via Business Intelligence (**BI)** and **InPhase dashboards**.
- Data shows a **downward trend** in reported self-harm incidents.
- Improved ability to differentiate single vs multiple incidents.
- Enhanced reporting accuracy through RiO-linked incident entry.
- Increased insight into patterns, service hotspots, and types of self-harm.

**Governance**

- Monthly cross-directorate **Self-Harm Steering Group** established.
- Self-harm designated as a **strategic breakthrough objective**.
- Presentations delivered across Trust forums and to the Trust Board.
- Integration into **inpatient safety huddles**.
- Strengthened alignment with Patient Safety Incident Response Framework (**PSIRF)** and the patient safety team.

**Developing the Offer**

- Staff and lived-experience surveys completed.
- A3 work across East Kent female wards.
- Developed:
    - *Principles for Supporting People Who Self-Harm*
    - Training menu
    - Self-harm intranet hub
    - Formulation prompt poster
- Expanded:
    - Pre-admission professionals meetings
    - Sensory regulation training and resources
    - Embrace and Assist pilot
    - Specific self harm reduction pilots Trust-wide
- Case study reviews completed.

**Research**

- Funding bid development for neurodivergence-related self-harm/stimming research.
- Planned comparative staff surveys with Maidstone & Tunbridge Wells (MTW) and South East Coast Ambulance (SEACAMB).
- Exploring publication routes for lived-experience work.

**Forward Plan (2026/27)**

- Self-Harm Steering Group will remain in place beyond the QAP.
- Expected continuation as a strategic breakthrough objective in the new Trust strategy.
- Sign-off and dissemination of:
    - Formulation prompt tool
    - Patient and family resources
- Embedding formulation into practice, supervision, and clinical documentation.
- Progressing research projects.
- Continued A3 improvement work in acute wards.

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**ADDITIONAL NOTE: Suicide and Self-Harm Link**

While not a formal QAP objective, thematic review (Q1–Q2 2025) identified:

- **68%** of patients who died by suspected suicide had a history of self-harm.
- Higher-than-expected prevalence among men during this period.
- Most had depression/anxiety; Emotionally Unstable Personality Disorder cases predominantly female.

This reinforces the importance of sustaining organisational focus on self-harm prevention and therapeutic formulation.

**2026/27 Quality Account Priorities:**

Following discussion at the February Quality Committee, it is proposed that the Quality Account priority for 2026/27 will focus on implementing the Quality Plan through a structured programme of work designed to drive demonstrable quality improvement and deliver sustainable, Trust-wide enhancements in areas identified through both internal and external reviews.

NHS
Kent and Medway
Mental Health
NHS Trust

| | |
|---|---|
| Title of Meeting | **Quality Committee** |
| Meeting Date | **26th March 2026** |
| Title | **Quality Committee Chair's Report (February and March 2026)** |
| Author | **Stephen Waring, Non-Executive Director** |
| Presenter | **Stephen Waring, Non-Executive Director** |
| Executive Director Sponsor | **Julie Kirby, Acting Chief Nursing Officer** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance & Governance items** |
|---|---|---|
| • East Kent Directorate Staff Experience – narrative and action plan | • Chief Nurse Report<br>• Quality Risk Register<br>• CAMHS Medical Agency and Waiting Lists Risks<br>• Violence and Aggression/Restrictive Practice Report<br>• Women's Health<br>• Self-Harm<br>• Working with Families<br>• IQPR<br>• Annual Medicines Management Report<br>• Clinical Risk Assessment & Manangement Compliance Report - February 2026<br>• Quality Digest<br>• Annual Ligature Audit Report<br>• Privacy and Dignity - Delivering Same Sex Accommodation - Annual Declaration<br>• East Kent Directorate Staff Experience | • Quality Impact Assessments<br>• Section 29 Warning Notice Report<br>• CQC Report |

NHS
Kent and Medway
Mental Health
NHS Trust

| Agenda Items by exception | Assurance narrative by exception. Key items to be raised to the Committee. | None Limited Reasonable Substantial | Actions, mitigations and owners Refer to another committee. |
|---|---|---|---|
| Chief Nurse Report | The Committee was assured of continued progress against the Quality Plan, which is evolving into a more structured programme to support sustained improvement.<br><br>Members noted continued significant improvement in self-harm incidents compared to 2023, alongside early indications of a reduction in physical violence across inpatient services.<br><br>Members were pleased to note the lifting of the CQC S29A Warning Notice for community services.<br><br>Members were, however, disappointed to note that gaps in good physical healthcare practice were identified through learning from deaths, despite a strong focus on physical health over recent years. | **Reasonable** | The Committee emphasised the importance of clear narrative reporting to the Trust Board, particularly in evidencing improvement trajectories over time. |
| Quality Risk Register | The Committee received the updated Quality Risk Register and was provided with assurance regarding improved risk oversight and management. Members noted a reduction in the number of poorly controlled risks, acknowledging | **Reasonable** | Overall, the Committee was assured that appropriate oversight arrangements are in place, with actions identified to strengthen narrative clarity and reporting transparency. |

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| | this as positive progress while recognising that it remains an area requiring continued focus.<br><br>High-scoring risks continue to be subject to enhanced scrutiny. Variations between directorates were discussed, with clarification provided regarding differences in service composition, including West Kent's profile of well-controlled risks. | | |
| Violence and Aggression/Restrictive Practice Report | The Committee reviewed trends in violence, aggression and restrictive practice. A high number of restraints on Heather Ward was linked to the needs of one patient with dementia, and a clinical review is underway. Ongoing concerns were noted regarding under-reporting of verbal and racially motivated abuse, although police engagement has improved and zero-tolerance materials are ready for rollout.<br><br>The Committee emphasised the importance of trauma-informed and behavioural approaches for dementia-related distress and requested clearer assurance in future reports on actions taken, including alignment of Positive Behaviour Support work with LD&A and self-harm governance structures.<br><br>At March Committee, reductions in the use of all restrictive practice were reported, and prone | **Reasonable** | |

| | | | |
|---|---|---|---|
| | restraint is now subject to mandatory rapid reviews, with a large reduction in instances in February. | | |
| IQPR | The Committee reviewed the Integrated Quality Performance Report (IQPR) and noted continued improvement in the quality of narrative commentary, particularly sections explaining what the data indicates.<br><br>The Committee discussed several performance areas, including increases in the Mental Health Together waiting list to over 6,000 in February following a rise in post-Christmas referrals, and the ongoing challenge of high Did Not Attend (DNA) rates, estimated at over 50,000 missed appointments. Work is underway with GP practices and referral pathways to improve attendance and productivity.<br><br>Progress was noted in reducing out-of-area placements, with 13 patients currently placed at Trust and 33 remaining in private placements. The planned opening of the Female PICU service in August is expected to support further reductions.<br><br>Members also reviewed complaints performance, noting that while compliance with the 30-day response target has declined, | **Limited** | The Committee asked for consideration of adding concise commentary on the 'watch metrics' where there were either adverse spikes in performance, or ongoing or long-term poor performance against these metrics. |

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|---|---|---|---|
| | improvements have been seen in the quality and tone of responses. | | |
| East Kent Directorate Staff Experience – narrative and action plan | The Committee had requested a report following staff and Pulse Survey results showing poor morale, and staff dissatisfaction with Mental Health Together. Work to date, and a future action plan were set out. Members were disappointed to hear that meaningful improvement could take several years. | **Limited** | Whilst the report presented some valuable analysis of the issues and recognised the potential to impact quality, as many of the issues concerned staff morale, they asked for it to be referred to People Committee for additional scrutiny and assurance. |
| Clinical Risk Assessment and Management | The Committee had requested a progress report on the target of 50% compliance with risk formulation and safety plan completion by February and 90% compliance by the end of May.<br><br>Significant work has been done, and great progress made, with Acute and Forensic achieving 50% and above compliance, though the compliance picture remains varied (and low in Mental Health Together services) with limited likelihood of achieving the May target in all services. | **Limited** | The Committee will receive further progress reports and look for further assurance. |
| The Committee noted the valuable recent additional external scrutiny of quality and the work of this Committee. This included the importance of focus on areas where the Trust needs to do more, or better, whilst recognising and celebrating successes. The Committee noted the need to move from descriptive papers, to outcome-focused evidence and from data (raw material) to information (processed structured, and organised data) to intelligence (analysed to identify patterns, trends, and relationships) to insights (actionable knowledge - why something happened and suggest what to do about it). The IQPR focus on Breakthrough Objectives goes some way to providing such insights. | | | |

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| Title of Meeting | **Public Board Meeting** |
| Meeting Date | **26th March 2026** |
| Title | **People Committee Chair's Report** |
| Author | **Kim Lowe, People Committee Chair, Non-Executive Director** |
| Presenter | **Kim Lowe, People Committee Chair, Non-Executive Director** |
| Executive Director Sponsor | **Sandra Goatley, Chief People Officer** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance & Governance items** |
|---|---|---|
| • People Committee Main Report incl: Strategic Delivery Plan<br>• People Risk Register<br>• Statutory and Mandatory Training Streamline work<br>• National Staff Survey<br>• Managers Guide - Supporting people through change and restructure<br>• Workforce 5-year plan<br>• EDI Dashboard<br>• KMMH Quarterly Guardian of Safe Working Hours Report August to October 2025<br>Nov 2025 to Jan 2026 | | • HR Policies and Procedures |

| Agenda Items by Exception | Assurance narrative by exception. Key items to be raised to the Board. | None Limited Reasonable Substantial | Actions, mitigations and owners Refer to another Committee. |
|---|---|---|---|
| People Committee Main Report incl: Strategic Delivery Plan Update with risks identified | The Committee discussed progress against the People Plan, including development of initiatives to improve inclusion, access to opportunities, and awareness of staff support services. Early work on succession planning and talent development is underway, alongside continued progress in medical job planning.<br><br>There was a focus on aligning workforce priorities with the emerging Trust strategy, with plans to strengthen delivery through clearer directorate-level planning and ownership.<br><br>Challenges remain in recruitment, particularly increasing time-to-hire, with actions in progress to address provider performance and improve processes. | **Limited Assurance** | The Committee emphasised the importance of strengthening leadership capability across the organisation, ensuring staff are supported to develop the skills required for leadership roles. Recruitment approaches were also discussed, with a need to modernise practices and maintain high standards.<br><br>A key theme was the need to move from planning to delivery, with a stronger focus on accountability, visible cultural change, and improving staff experience to support better patient care. |
| National Staff Survey | The Committee reviewed the Staff Survey results, noting improvements in appraisal rates and pockets of strong team engagement. However, variation across the organisation remains significant, with lower scores in some areas, alongside concerns regarding change fatigue, declining organisational pride, and limited confidence that concerns raised by staff are consistently acted upon. | **Reasonable Assurance** | Next Steps:<br><br>A more targeted approach to staff engagement will be developed, focusing on areas of low performance and sustained challenges. This will be escalated to the Trust Leadership Team (TLT), with a proposed delivery approach to be presented at the May meeting. |

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| | The discussion emphasised the importance of strengthening leadership visibility and accountability, alongside promoting positive behaviours and learning from high-performing teams. | | |
| EDI Dashboard | The Committee welcomed the launch of the new EDI workforce dashboard, which provides improved visibility of workforce demographics, including diversity, age profile, and retirement risk. The dashboard enables analysis at directorate level and is expected to support more informed workforce planning, succession planning, and inclusion priorities.<br><br>Members noted the significant progress made in data quality and the opportunity to use the dashboard to better understand inequalities within the workforce. The tool also highlights gaps in staff declaration data, supporting a more focused approach to improving data completeness. | **Reasonable Assurance** | Next Steps:<br><br>Focus will be placed on supporting teams to effectively use the dashboard, alongside continued improvement in data quality and further development of functionality to strengthen workforce insight and planning. |
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NHS
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| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | 26th March 2026 |
| Title | Audit and Risk Committee Chair's report |
| Author | Peter Conway, Non-Executive Director |
| Presenter | Peter Conway, Non-Executive Director |
| Executive Director Sponsor | N/A |
| Purpose | Noting |

**Agenda Items**

| **Key Finance and Regulatory items** |
|---|
| • Board Assurance Framework<br>• Trust Risk Register<br>• Risk Deep Dive Trust Risk Register (including NELFT and CAMHS)<br>• External Audit Plan<br>• Internal Audit Plan<br>• Internal Audit Progress Report<br>• Assurance Review of Fit and Proper Persons Test<br>• Anti-Crime Progress Report<br>• Director of Finance Items<br>• Fire Safety Report<br>• Emergency Preparedness, Resilience and Response Assurance Report 2025/26<br>• Information Governance Assurance<br>• Gifts and Hospitality Register |

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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. |
|---|---|---|---|
| Risk Management | Board Assurance Framework (BAF)<br>The Committee recognised substantial improvement in the BAF's structure and currency but highlighted the need to (i) shorten and sharpen the "top five" controls/assurances; (ii) clearly distinguish between controls, assurance sources and gaps (particularly on the CQC regulatory compliance risk); and (iii) ensure that staff survey results on the culture risk are treated as evidence of gaps where results are poor rather than as positive assurance; management agreed these refinements will be made before the BAF is presented to the Board. | Reasonable | The Committee requested that the BAF is reviewed ahead of the January 2026 Board meeting to ensure there are clear, up-to-date action tracking and risk ownership. |
| | BAF risk – Organisational culture (Risk ID 08337) –<br>Committee welcomed the clearer articulation but challenged the use of poor staff survey and pulse survey results as assurances; agreed these should be treated as evidence of gaps in culture, not positive assurance, and that narrative should be updated accordingly | Limited | |
| | Trust Risk Register<br>The deep dive confirmed that the TRR captures the correct high-level risks but also revealed that many entries lack clear, up-to-date actions to reduce risk, defined success measures and concise assurance narrative, especially for patient flow, estates, telephony and TGU; the Acting Chief Nurse and Risk Manager acknowledged that, now the BAF has improved, strengthening the TRR will be the next priority, as its current form limits its usefulness as an assurance tool. | Limited | |

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| | Trevor Gibbens Unit (TGU) estate risk: In discussing the TRR and BAF estate risks, the Committee was concerned that the description, scoring and actions for the TGU estate risk may under-represent the strategic and regulatory implications of operating a medium secure service | Limited | Board should consider and agree its risk tolerance and preferred strategic response to the TGU estate risk |
| | Telephony Contract Arrangements (ID 08490): The Committee challenged how the Trust had reached a position where a critical telephony contract was close to expiry without a replacement solution being in place; management cited historic capacity and complexity issues but provided assurance that (i) the current contract has now been extended, (ii) a route to market using an existing framework has been identified, and (iii) contract management capacity has been strengthened; residual risk remains until the replacement solution is procured and implemented. | Reasonable | Confirmation needed regarding the telephony mitigation plan (including implementation timetable for the replacement solution and assurance on continuity of service) and report to the Audit & Risk Committee |
| Audit and Assurance | Internal Audit Report<br>Committee noted completion of several audits with reasonable/substantial assurance and the change of one planned audit (quality and safety framework) to patient property due to overlapping external reviews; no significant concerns were raised.<br><br>Anti-Crime Report<br>Committee received the report, noted progress against the counter-fraud work plan and did not identify any new significant concerns. | Reasonable<br><br>Reasonable | |
| Internal Controls - Trust | Fire Safety and capital dependency:<br>The Committee took assurance from ongoing statutory compliance and delivery of the three-year fire safety capital | | Nick Brown to provide an interim briefing on capital position and assurance that safety |

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| | programme but highlighted that some further risk reduction is dependent on capital schemes and that increasing estate complexity (e.g. CYPMHS buildings) will require sustained oversight; the Board should be aware of this dependency when considering capital prioritisation | Reasonable | risks are appropriately controlled (not subordinated to finances). |
| | Assurance Review of Fit and Proper Persons Test: Committee noted a limited assurance opinion linked to historic practice (template and DBS arrangements) and took assurance that corrective actions have been completed and processes aligned to national expectations. | Reasonable | Review "passporting" approach where NED checks are evidenced by another trust; propose a sensible approach while recognising exceptions. |
| **Free Text -**<br><br>The Committee identified an emerging risk regarding Succession planning / leadership continuity given the upcoming changes at Board level. | | | |

Kent and Medway Mental Health NHS Trust

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| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **24th March 2026** |
| Title | **Finance, Business and Investment Committee Chair's Report** |
| Author | **Mickola Wilson, Non-Executive Director** |
| Presenter | **Mickola Wilson, Non-Executive Director** |
| Executive Director Sponsor | **Nick Brown, Chief Finance and Resources Officer** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance items** |
|---|---|---|
| • | • Strategic Transformation Programmes-Dementia Update | • Chief Finance and Resources Officer Report<br>• Financial Planning 2026/27<br>• Digital Update<br>• Estates Update<br>• Finance report for Month 11<br>• Service Line Reporting and Costing Update |

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Mental Health
NHS Trust

| 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. |
|---|---|---|---|
| **Financial Planning 2026/27** | The Committee reviewed the 2026/27 financial plan, which is now built on a run-rate methodology following intensive system-level scrutiny. The Trust's revised financial gap has reduced from £17.6m to £10.35m, supported by external review and standardised assumptions across Kent & Medway | **Substantial Assurance** | The Committee recognised improvement in financial reporting transparency and triangulation with workforce and activity plans.<br><br>The Committee noted the ongoing work to align the budget to demand and capacity modelling, and the initial out-turn from the system-level review of the Cost Improvement Programme maturity and delivery plans. |
| **Strategic Transformation Programmes- Dementia Update** | The Committee noted the positive progress which had been made in terms of Memory Assessment Service performance and supported the enhanced focus on unwarranted variation. | **Reasonable Assurance** | |
| **Chief Finance and Resources Officer Report** | The Committee discussed the continued focus on aligning workforce, Quality and financial assumptions, in conjunction with the Trust's strategy. The Committee emphasised the need for clearer, regularly refreshed BAF risk descriptions.<br><br>The Committee noted the significant system-level activity which had commenced, including the appointment of a System Recovery Director. | **Reasonable Assurance** | Next steps focused on further refinement of Board Assurance Framework (BAF) risk descriptions, controls and mitigation trajectories; and providing further assurance on the system-related patient flow risks, once further clarification was received regarding support from Kent County Council.<br><br>The Committee noted that managing patient flow would be a key criterion for the delivery of financial balance during 2026/27 onwards, |

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| | | | as well as ensuring a positive patient experience. |
| **Digital Update** | The Committee was joined by clinical digital representatives across the Trust to support strong clinical engagement with the discussion which focused on a forward-looking digital initiatives portfolio, and a research-linked digital innovation proposal. The Committee emphasised the important of a prioritisation approach which focused on four key areas, reward, deliverability, pace and productivity. | **Reasonable Assurance** | Next steps included:<br>1) Development of a Board-level report which outlined prioritised digital deliverables for 2026/27<br>2) Review governance processes to enable a streamlined approach<br>3) Confirmation of which research linked digital projects the Trust would take forward initially. |
| **Note:**<br>**The Committee agreed to a deferral of the Estates update to its meeting in April 2026, to ensure it was afforded sufficient scrutiny** | | | |

# Trust Board meeting

Kent and Medway Mental Health NHS Trust

## Meeting details

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|---|---|
| **Date of meeting:** | 26th March 2026 |
| **Title of paper:** | Register of Board Members Interests – March 2026 |
| **Author:** | Tony Saroy, Trust Secretary |
| **Executive Director:** | Sheila Stenson, Chief Executive |

## Purpose of paper

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| **Purpose:** | Noting |
| **Submission to Board:** | Regulatory Requirement |

## Overview of paper

This paper sets out the updated Trust's Register of Board members' interests, which will be published on the Trust website.

## Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

It is the Trust's practice to formally update the Register of Interests twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board is attached.

All Board members have made declarations to the Trust Secretary who has the responsibility of maintaining the Register of Interests including where the member had no interests to declare.

This information will be made publicly available on the Trust website following the meeting.

## Governance

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| **Implications/Impact:** | Compliance with regulatory requirements |
| **Assurance:** | Reasonable |
| **Oversight:** | Audit and Risk Committee/Remuneration and Terms of Service Committee |

Version 2 - **Public**

**Register of Board Members Interests – March 2026**

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

## REGISTER OF BOARD MEMBERS INTERESTS
## FEBRUARY 2026

| Director | Position | Interest declared |
|---|---|---|
| **Dr Jackie Craissati** | **Trust Chair** | Director of Psychological Approaches CIC, which is on the NHS England framework for Independent Serous Incident Investigations. However, the company does not undertake investigations relating to KMPT.<br><br>Chair of Crohn's & Colitis UK. The charity works closely with the NHS but is not commissioned to deliver services.<br><br>Independent Governor on the Board of the University of East London.<br><br>Chair at Dartford and Gravesham NHS Trust |
| **Kim Lowe** | **Non-Executive Director** | Non-Executive Director and Deputy Chair at Kent Community Health Foundation Trust.<br>Ad Hoc unpaid consultancy work with University of Kent<br>Lay Member of University of Kent Council |
| **Mickola Wilson** | **Non-Executive Director** | Director of Seven Dials Fund Management and advisor to private investors in Real Estate.<br>Former CEO of Teesland plc and MD of Guardian Properties. |

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| | | Non-Executive director of Mailbox Investment Company.<br>Member of the Property Committee of the Mercers Livery Company.<br>Member of the Council for Essex University<br>Non-Executive Director BBRC (NFP Residential Company specialising in Key Worker Housing<br>Member of the Chartered Surveyors Livery Company |
| **Sean Bone-Knell** | **Non-Executive Director** | Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services |
| **Peter Conway** | **Non-Executive Director**<br>(Deputy Chair) | Non-Executive Director and Chair of the West Kent Housing Association Audit Committee<br><br>Non-Executive Director and Chair of the Audit Committee for Medway NHS Foundation Trust |
| **Stephen Waring** | **Non-Executive Director**<br>(Senior Independent Director) | Employed (on a part-time basis) at Greater London Authority, Health and Wellbeing Team<br><br>Non-Executive Director at Kent Community Health Foundation Trust. |
| **Dr MaryAnn Ferreux** | **Non-Executive Director** | Trustee - Royal College of Physicians Edinburgh<br><br>Company Director - Health Innovation Kent Surrey Sussex<br><br>Founder M&K Consulting services<br><br>Non-Executive Director at Kent Community Health Foundation Trust. |
| **Julius Christmas** | **Non-Executive Director** | Non-Executive Director at Dartford and Gravesham NHS Trust<br><br>Technology Advisor, Lantern UK |
| **Pam Creaven** | **Associate Non-Executive Director** | Owner and Director of Creaven Consulting Ltd |
| **Dr Julie Hammond** | **Associate Non-Executive Director** | Health Governor for Kent Community Health NHS Foundation Trust<br><br>GP for Dartford East Health Centre<br><br>NED at Elles Bliss<br>CEO and Founder of mamAR, Dr Hammond Aesthetics Ltd, DH-GP Locum Ltd<br>Private GP at LycaHealth Orpington Hospital<br>NHS Clinical Entrepreneur<br>Health Columnist at The Voice Newspaper<br>Steering Group Member for the London Inspire Programme |
| **Sheila Stenson** | **Chief Executive Officer** | Chair of the South East Finance Academy |

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| | | Partner Non-Executive Director to the Kent and Medway Integrated Care Board and one of their Board Sub-Committees |
| **Donna Hayward-Sussex** | **Chief Operating Officer & Deputy CEO** | None declared |
| **Dr Afifa Qazi** | **Chief Medical Officer** | None declared |
| **Julie Kirby** | **Interim Chief Nursing Officer** | None declared |
| **Nick Brown** | **Chief Finance and Resources Officer** | Spouse is an employee of Kent Community Health Foundation Trust. |
| **Sandra Goatley** | **Chief People Officer** | Member of the Remuneration Committee and People Committee for University of Kent |
| **Dr Adrian Richardson** | **Director of Partnerships and Transformation** | Spouse is an employee of Frimley ICS |