AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 29th May 2025
Time 9.30 to 12.00
Venue Microsoft Teams Meeting

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/25-26/1	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/25-26/2	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/25-26/3	3.	Personal Story – Living Well Together	FN	Verbal	DHS	09.35
TB/25-26/4	4.	Continuous Improvement Story - Community based Memory Assessment Service – Medway and Swale Pilot	FN	Verbal	AR	09.45
STANDING ITEMS						
TB/25-26/5	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/25-26/6	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/25-26/7	7.	Chair's Report	FN	Paper	JC	10.00
TB/25-26/8	8.	Chief Executive's Report (incl. Deloitte Well-Led review update & Review of Patient Stories)	FN	Paper	SS	10.05
TB/25-26/9	9.	Board Assurance Framework	FA	Paper	AC	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/25-26/10	10.	Review of Year 2 - Strategy Delivery Plan Priorities for 2024/25	FN	Paper	SS	10.20
TB/25-26/11	11.	MHLDA Provider Collaborative Progress Report (incl. Community Mental Health Framework Transformation)	FN	Paper	JH	10.35
OPERATIONAL ASSURANCE						
TB/25-26/12	12.	Integrated Quality and Performance Review	FD	Paper	SS	10.50
TB/25-26/13	13.	Finance Report for Month 1	FD	Paper	NB	11.05
TB/25-26/14	14.	Workforce Deep Dive: Leadership Development and Manager Development programme	FD	Paper	SG	11.15
TB/25-26/15	15.	Continuous Improvement Impact Report	FD	Paper	AR	11.25
TB/25-26/16	16.	Update on the Independent review of Nottingham and actions for the Trust	FD	Paper	AC	11.35
CONSENT ITEMS						
TB/25-26/17	17.	Report from Quality Committee • Mortality Report (published externally)	FN	Paper	SW	11.40
TB/25-26/18	18.	Report from People Committee	FN	Paper	KL	
TB/25-26/19	19.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/25-26/20	20.	Report from Audit and Risk Committee	FN	Paper	PC	
TB/25-26/21	21.	Report from Finance and Performance Committee	FN	Paper	MW	
TB/25-26/22	22.	Report from Charitable Funds Committee	FN	Paper	SBK	
TB/25-26/23	23.	Use of Trust Seal	FN	Paper	TS	
TB/25-26/24	24.	Register of Board Members Interests	FN	Paper	JC	

TB/25-26/25	25.	Safer Staffing Report (aka Nursing Establishment Review)	FN	Paper	AC	
CLOSING ITEMS						
TB/25-26/26	26.	Any Other Business			Chair	11.50
TB/25-26/27	27.	Questions from Public			Chair	
	Date of Next Meeting: Thursday 12th June 2025					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Peter Conway	PC	Non-Executive Director
Stephen Waring	SW	Non-Executive 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
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Daryl Judges	DJ	Deputy Trust Secretary
Victoria Marshall-Nystrom	VM	Head of Operational Excellence (Continuous Improvement Story)
Brett Metelerkamp	BM	Associate Specialist (Continuous Improvement Story)
Wendy Dewhirst	WD	Interim Service Director (Personal Story)
Apologies:		
Dr MaryAnn Ferreux	MAF	Non-Executive Director

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

Kindra Hyttner	KH	Director of Communications and Engagement
Tony Saroy	TS	Trust Secretary

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.15 on Thursday 27th March 2025
Canterbury Cathedral Lodge, The Precincts, Canterbury, Kent, CT1 2EH

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Julius Christmas	JCh	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Pam Creaven	PCr	Associate Non-Executive Director
	Dr Julie Hammond	JH	Associate Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Jane Hannon	JHa	Programme Director
	Tony Saroy	TS	Trust Secretary
	Daryl Judges	DJ	Deputy Trust Secretary
	Sharon Bean	SB	Non-Medical Prescriber
	Kate	Kate	Patient Story
	The Board was joined by members of the public and members of staff.		
Apologies:			
	Sean Bone-Knell	SBK	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director

Item	Subject	Action
TB/24-25/132	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/24-25/133	**Declarations of Interest** No interests were declared.	
TB/24-25/134	**Personal Story – Patient and Family Involvement in Care** The Board welcomed Kate to the meeting. The Board was informed, via a ten-minute video, of Kate's story as a family member involved in her daughter's care. The Board was informed of the challenges in terms of the customer service aspects of care, with issues of telephone calls going unanswered or not receiving any	

Item	Subject	Action
	confirmation as to whether her daughter was in hospital. Kate highlighted the additional worry caused during periods of crisis by when no information was provided. Sometimes staff interaction with families could be described as 'cold, difficult and distant'. The Trust informed the Board that there is ongoing work to improve the experience of patients and their families, led by the Chief Nurse and highlighted in our quality account priorities for 2025/26. The Board pressed the need for improvements, highlighting that patient experience had previously been a quality account priority. The Board commended Kate's bravery for attending the Board to tell her story. The Board **noted** the Personal Story – Patient and Family Involvement in Care.	
TB/24-25/135	**Continuous Improvement Story - East Kent Red Board** The Board received a presentation from SB who set out the function of a Red Board as a means of reviewing current patients who presented as the greatest risk. The presentation highlighted the East Kent Red Board's function, the challenges in the initial process, the reviewed template, and proposed improvements. Those improvements were triggered by the merger of two community mental health teams. Key learnings emphasised freeing up clinical time, implementing a mandatory approach to address issues, and ensuring inefficiency was eliminated. The Board was concerned to ensure that this approach and learning was adopted by other services to prevent unnecessary staff burdens. Support was expressed for the direction of travel, stressing the importance of providing guidance to teams as to where there was autonomy in decision-making, empowering local services to drive change. The Board **noted** the Continuous Improvement Story - East Kent Red Board.	
TB/24-25/136	**Minutes of the previous meeting** The Board **approved** the minutes of the 30th January 2025.	
TB/24-25/137	**Action Log & Matters Arising** The Board **approved** the action log, noting that all actions were completed or in progress, subject to the following. Action TB/23-24/122 – IQPR – Board seminar regarding Clinically Ready for Discharge patients: Item may be closed as private board discussion to take place. Action: TB/24-25/16 – Patient Survey Results – Patient and Participation Strategy: Mark as overdue with item to come to May Board meeting.	

Item	Subject	Action
	Action: TB/24-25/77 – Workforce model – staff model over next 2 to 5 years: close original action and open new action, with a report on the clinical model to be brought to July Board. Action for DHS, AQ, and AC.	
TB/24-25/138	**Chair's Report** The Board **noted** the Chair's Report.	
TB/24-25/139	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • The significant changes in NHS England were being operationalised, with Jim Mackey's transition team announced to oversee the changes. The Trust remains focussed on supporting its system partners and on the delivery of effective patient care, • The Trust recently had an unannounced CQC inspection and was awaiting the draft report. There was no timeframe as to when it will be available. Thanks were given to all to Trust staff for their response. • The recent Purpose Coalition launch event was well attended with at least 120 staff that joining. The Board raised questions regarding the implications for the Integrated Care Board (ICB) working relationship with the Trust and our Provider Collaborative. The 50% reduction in staff costs will be implemented by quarter 3, and in the interim, the chief executives are involved in discussions with a plan likely to emerge in May 2025. MW asked whether it would delay any of the initiatives of KMPT. The CEO was unable to confirm whether that would be the case or not. The Board **noted** the Chief Executive's Report.	
TB/24-25/140	**Board Assurance Framework (BAF)** The Board received the BAF, noting discussions around risk, finance risks, and patient experience. The Board queried if anything about patient experience should be on the BAF in light of the patient story received. The Trust confirmed that there are some risks on the risk register with a review of scoring required. The Board emphasised the importance of maintaining patient experience despite financial challenges. The Trust confirmed that the rating of the in-patient flow risk would increase, which now presents as the Trust's biggest risk. This risk and its mitigations will be captured within the next iteration of the BAF. The Board **approved** the Board Assurance Framework.	
TB/24-25/141	**Trust Strategy Plan 25/25 yr3** The Trust Strategy Plan for 2025/26 (year 3) was reviewed, following discussions from a prior Trust Board Seminar.	

Item	Subject	Action
	Discussion centred on the balance between aspirations and measurable goals, with suggestions to articulate metrics more clearly and establish timeframes for objectives. There is a greater focus on safety culture and health inequalities for year three, with a commitment to gather health inequalities data within 6-12 months. However, this was challenged by the Board, with a request for a shorter timescale given that the Trust is in the final twelve months of its current trust strategy. There was a request for greater clarity on the plan to reduce of women's self-harm and a view of project and change activities driving KPIs, alongside digital strategies supporting the plan. Sharing the workplan with the Board and setting more ambitious clinically ready for discharge (CRFD) reduction targets were proposed. **Action: By May 2025, SS to produce a high level workplan setting out key workstreams, key performance indicators and target dates.** The Board **approved** the changes for the Trust Strategy Plan for 2025/26, with a high-level workplan to be before the Board in May 2025.	
TB/24-25/142	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report (incl. Community Mental Health Framework Transformation)** The Board received the MHLDA Provider Collaborative Progress report. Discussions focussed on the feasibility of achieving progress within the next six months despite challenges linked to ICB changes. The importance of maintaining clear direction was emphasised. Questions were raised about the collaboration between social services and the organisation to improve patient flow, with ongoing efforts involving senior leaders to drive advancements. Discussions also explored the dementia model of care, including the success of crisis houses and safe havens, alongside cultural issues impacting their effectiveness. Confidence was expressed in the dementia work, and it was confirmed that GP representation was part of the model. The housing strategy was another focus, with plans for a symposium in May, which might involve reassessing the use of buildings and evolving supported living models. A strong emphasis was placed on pursuing practical and impactful outcomes throughout the discussion. The Board **noted** the Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report.	
TB/24-25/143	**Estates Strategic Workplan** The Board received and noted the Estates Strategic Workplan. The Board questioned whether there was sufficient ambition in relation to combining our estate with that of other providers in the country to achieve economies of scale	

Item	Subject	Action
	and co-working. The Board requested details of the clinical thinking behind the hub and spoke model and commented on underutilisation of existing space. The Trust explained the workplan for delivering the strategy, including the hub model, and collaboration with Kent County Council (KCC) and the Kent and Medway ICB. The Trust set out the hub and spoke model and opportunities for bringing services together, which would help patients access mental health services without a feeling of stigma that some may feel. The Board **approved** the Estates Strategic Workplan.	
TB/24-25/144	**Health Inequalities Report** The Board received the Health Inequalities Report, which highlighted four areas of focus as the initial step: age, gender, ethnicity and postcode. The board noted the unwieldy approach to data collection and generation, limiting the ability to interrogate the data. The Board noted that the use of quintiles causes data limitations, with the risk of some data becoming hidden. It was suggested that the focus should be less on gathering more raw data, and more on using the data to understand patient needs concerning access, experience, and outcomes. The importance of collaborating with partners like KCC and the ICB to leverage existing data and participate in communities of practice was also suggested by the Board. Discussion covered how the data informs daily practice and the need to advance to incorporating data on disability and sexual orientation, due to known mental health disparities in those groups. The Board was informed that ethnicity recording as standard was a priority, but other characteristics will follow. A query was raised about capturing deprivation at the population level, with the Trust committing to providing more details offline. The Board discussed the aspiration to link the estates plan with health inequalities, so that services can be placed in areas of health inequalities. The Board **noted** the Health Inequalities Report.	
TB/24-25/145	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR), highlighting three main areas of concern: • the imminent evaluation of the Mental Health Together approach in Medway, • the persistent challenges with patient flow and bed states, and • progress in dementia services, where sustainable improvements are being seen and lessons learned can be applied more widely The significant achievements in Crisis Response was also acknowledged. Discussions included the telephony contact metrics for the 111 service, particularly the abandonment rate, with the Board questioning if it is the correct metric and noting the complexity of calls received. The potential use of virtual assistants or chatbots to manage front-door access and improve website information was explored, with NB agreeing to update the Board outside of the meeting regarding the	

Item	Subject	Action
	use of AI chatbots. The importance of data on repeat callers was discussed, with the Board stating that providing better support to that cohort can improve abandonment rates significantly. **Action: By May 2025, NB to provide written update to the Board by way of email regarding the potential use of AI chatbots so as to improve patient experience.** Safe staffing fill rates metrics were clarified, with the Trust confirming that 100% or above meets clinical need. The Trust has consistently met that level over the last 12 months. The Board discussed Memory Assessment Services and the rollout of tiered accountability was noted, with early adopters showing significant improvement. This replicated the success within the Dartford, Gravesham and Swanley Community Mental Health Team, which has recently achieved 100% of patients receiving a diagnosis within six weeks of referral. An action was agreed for a more detailed performance breakdown in July 2025 to check for unwarranted variation. **Action: By July 2025, AR to produce a standalone Memory Assessment Service Paper setting out the performance data across the Trust's Community Mental Health Teams, with unwarranted variation identified.** The Board **noted** the IQPR.	
TB/24-25/146	**Finance Report** The Board received the Finance Report and noted the following: • the Trust has reported a £0.63m surplus post technical adjustments, which is in line with the financial plan; • Agency spend remains above the agreed cap (£6.10m year to date), with spend to Month 11 being £6.25m. The Trust is forecasting to spend £7.05m in year, £0.47m above the £6.58m cap; • Use of external beds remains a pressure, with 10 Acute and 12 PICU beds used in month, £0.52m budget pressure in month; • As at 28th February the overall capital position is £4.59m underspent, with a forecast spend position of £14.63m against the annual plan of £15.38m. The underspend relates to the delay in the s136 scheme and the Trust has secured support from the system to manage this position into next year. Due to wider system pressures the trust has been asked to improve its position and has identified further non-recurrent benefits and is forecasting to deliver a £2.24m surplus. The main change relates to the impact of the Littlebrook purchase. The Cost Improvement Plan was for £10.74m. £4.2m of the plans have delivered recurrent savings. The Board **noted** the Finance Report.	
TB/24-25/147	**Finance Planning 2025/26**	

Item	Subject	Action
	The Board received the Finance Planning for 2025/26, noting discussions at the system level to address the deficit and achieve a break-even plan. Given that the system level deficit is £130m, the Trust has been asked to stretch its original plan by an additional £2.2m savings. Some of the key areas to assist in achieving break even include reducing agency spend and improving our out-of-area position. The Board discussed the reduction in agency spend, seeking assurance that patient safety will not be adversely affected. The Trust confirmed that agency reduction is clinically led and will not compromise clinical care. Medical agency reduction is tied to substantive recruitment, so patient care and safety will not be affected. Registered staff numbers tend to be stable, with cost pressures related to unregistered staff. The Trust adheres to national rates for Agenda for Change staff. The Board **approved** the Finance Planning for 2025/26.	
TB/24-25/148	**Workforce Deep Dive: Staff Survey** The Board received the Staff Survey paper, noting an increase in response rate and changes in engagement scores. The Board queried how the Trust could improve engagement rates although it was highlighted that it was one of the better performers. The Trust will be using quarterly pulse surveys and local toolkits for engagement. The Board suggested that the focus on the staff survey might be decreased in the future as the Trust will receive better and more timely data from the pulse surveys. The Board **noted** the Workforce Deep Dive Paper.	
TB/24-25/149	**Use of Trust Seal** The Board received and **noted** the use of Trust Seal report.	
TB/24-25/150	**KMPT Charity Annual Return** The Board received and **noted** the KMPT Charity Annual Return. **Action: By May 2025, AR to inform Board members as to why no gift aid had been received in the last financial year.**	
TB/24-25/151	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/24-25/152	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/24-25/153	**Report from Mental Health Act Committee**	

Item	Subject	Action
	The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/24-25/154	**Report from Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee Chair's report.	
TB/24-25/155	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/24-25/156	**Any Other Business** None.	
TB/24-25/157	**Questions from Public** The Board received feedback from a staff member, who thanked AC and Kate for the personal story. The importance of open dialogue and continuity of care was raised.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 29th May 2025 via MS Teams.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22.05.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN MAY 2025								
30.05.2024	TB/24-25/16	Patient Survey Results	KH to bring an updated Patient and Participation Strategy to the Trust Board in November.	KH	November 2024	March 2025	Work on the updated Patient and Participation Strategy is underway, and the Quality Committee are being kept up to date. The final Strategy will come to the Board in July 2025.	**Over Due**
25.07.2024	TB/24-25/50	Finance Report – Month 3	NB to produce a paper addressing the continued use of external beds for the September Quality Committee.	NB	September 2024	March 2025	The report was considered at the May 2025 Quality Committee. To be closed.	**In progress**
30.01.2025	TB/24-25/123	Freedom to Speak Up – six-monthly update	Present a FTSU action plan regarding the West Kent area to the People Committee	DHS	March 2025		An update on the specific issues related to West Kent was presented at the May 2025 People Committee. To be closed.	**In progress**
27.03.2025	TB/24-25/141	Trust Strategy Plan 25/25 yr3	Produce a high level strategy workplan setting out key workstreams, key performance indicators and target dates	SS	May 2025		This is appended to the Year 2 paper	**In progress**
27.03.2025	TB/24-25/145	Integrated Quality and Performance Review	Provide written update to the Board by way of email regarding the potential use of AI chatbots so as to improve patient experience	NB	May 2025	July 2025	An update will be provided to the July 2025 Board meeting as part of the wider Digital Plan update.	**In progress**
27.03.2025	TB/24-25/150	KMPT Charity Annual Return	Inform Board members as to why no gift aid had been received in the last financial year	AR	May 2025		A small amount of gift aid is claimable for the year presented. There were originally issues with filing the charity with HMRC in early 2023 and a delay in setting the gateway account with them which have all now been addressed. We are updating our authorised officials to allow submission of our request for the money and will be able to reclaim this as we are able to claim gift aid back for 4 years. To be closed.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
27.03.2025	TB/24-25/137	Action Log & Matters Arising	Submit a report to the Quality Committee on the Trust's future clinical staffing model	DHS, AC and AQ	July 2025			**Not Due**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22.05.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
27.03.2025	TB/24-25/145	Integrated Quality and Performance Review	Produce a standalone Memory Assessment Service Paper setting out the performance data across the Trust's Community Mental Health Teams, with unwarranted variation identified	AR	July 2025			Not Due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.01.2024	TB/23-24/122	IQPR	By December 2024, DHS and AQ to deliver a Board Seminar in the future on those clinically ready for discharge, and how this links to the Purposeful Admissions Programme.	SS/AQ	December 2024		Board seminar timetable has not permitted this to occur. Added to the Board Seminar items and will be scheduled.	Closed
26.09.2024	TB/24-25/77	Workforce Deep Dive: Re-modelling and reshaping the workforce for the future	By November 2024, the People Committee is to receive an analysis of the likely skills required to deliver mental health services over the next 2-5 years, and considers how we may adjust and fill gaps on the basis of competences rather than professions.	SG	November 2024	January 2025	Workforce planning assumptions paper for 2025/26 taken to January's People Committee meeting. Future workforce planning will be dependent on the clinical model, which is currently being reviewed by AC, AQ and DHS.	Closed
30.01.2025	TB/24-25/114	Action Log & Matters Arising	Confirm the need for a seminar regarding the strategic plans for KMPT	SS/JC	March 2025		Took place in Feb 2025	Closed
30.01.2025	TB/24-25/118	Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report	Include a breakdown of the crisis house and safe havens' workstreams, timelines and impact of those workstreams within the next iteration of the Provider Collaborative update paper	JH	March 2025		Addressed within the paper	Closed
30.01.2025	TB/24-25/118	Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report	Provide more granular detail regarding the mental health conveyancing service in terms of how it will be operationally effective. Such detail to be included in the next iteration of the Provider Collaborative update	JH	March 2025		Addressed within the paper	Closed

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
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

I have been involved in a good deal of national activity, following the significant announcements impacting NHS England and Integrated Care Boards (ICB), although plans for change will only become clearer in the next two to three months. Locally, all the Kent & Medway system chairs and chief executives met for a one-day workshop and held a frank discussion regarding the challenges facing our system, and the radical action required for transformation.

During this period, I have also attended the NHS Confederation's mental health provider network conference, with very clear messaging from the incoming NHS England Chief Executive, and from the National Mental Health Director, and an update – albeit less clear – from the Director General for the 10-year health plan.

I also attended our own Kent & Medway mental health summit, and was particularly moved and impressed by the peer support organisations' narratives. In my view, KMPT could develop their work much further in this area if we partnered with the voluntary sector

2. Board Development

We held a busy board development day. NHS Providers delivered an engaging and helpful workshop on board risk appetite, and we look forward to the proposed changes to our Board Assurance Framework in due course. We spent considerable time discussing the independent review of our community mental health framework transformation process, and from our recent CQC inspection findings. The conversations were challenging at times but the Board was united in its desire to learn and improve together. As is often the case, supporting our Trust leadership to grow in confidence and skills was a key action, as well as accelerating our digital programme in order to develop efficient systems and free up clinical time for staff.

3. Trust Chair and NED visits

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

Where	Who
February 2025	
Ashford Liaison Service; Memory Assessment Service, Dover; and Mental Health Together, Ramsgate	MaryAnn Ferreux
March 2025	
Priority House and Albion Place	Pam Creaven
April 2025	
Thanet safe haven and Ashford (William Harvey) safe haven	Jackie Craissati
Littlebrook House	Julie Hammond
Acute Wards, Priority House	Julie Hammond and Kim Lowe

Chair visits

I spent the afternoon and evening at two safe havens, warmly welcomed by staff. The services undoubtedly have a crucial role in supporting patients in crisis and thereby diverting them from the hard-pressed Emergency Departments. However, it was interesting – and dispiriting – to learn how different team and organisational cultures could either facilitate or inhibit the development of the services. The delayed but now newly opened safe haven at William Harvey was flourishing with good collaboration. The established safe haven at Queen Elizabeth Queen Mother Hospital (QEQM) was struggling to demonstrate significant impact due to poor collaboration, in part instigated by our own services, as well as those of the acute trust. The team had put a number of measures in place, and were optimistic that relationships were improving and the data would evidence progress by the autumn.

MaryAnn Ferreux's visit to Ashford Liaison Service; Memory Assessment Service, Dover; and Mental Health Together, Ramsgate

William Harvey - Ashford Liaison Service

The layout of the service makes it difficult to build team relations given that the office is so far away from Emergency Department and I have provided some suggestions which could help resolve these issues. Whilst I was there, a mental health patient was in crisis in the Emergency Department and required security. Unfortunately, this patient was not referred properly to the liaison team and had been waiting in Emergency Department two days for a review and become increasingly agitated.

Despite attempts to be proactive in assessing the patient, systems and processes were not robust for several reasons and were not helped by the lack of digital infrastructure and the use of agency nursing to care for patients in the mental health liaison room. The lack of consistency in mental health nursing staff as well as variable skills and ability of agency staff in this role does seem challenging and potentially not the best value for money or care experience.

Coleman House, Dover, Memory assessment

The team spoke about Mental Health Together which has been a challenging transition with some finding the change a lot harder than others. They were keen to try some new things in relation to digital and innovation to improve productivity, but some staff lacked digital skills in completing documentation. Given the reliance on locum medical consultants, it would be

good to hear the Trust's plans for medical recruitment and if they have registrars rotating out to the service. Finally, concerns were raised regarding the condition of the estate in Dover, and the timeframes for refurbishments, which was said to compound the recruitment challenges and posed health and safety risks.

Beacon, Ramsgate, Mental Health together

It was really busy in the office with everyone clearly working very hard. I met a senior staff member who disclosed to me that the mood in the service was very low, with many staff feeling burnt out by the recent transformation. I was told that although the Executive Management Team had organised a lot of engagement activities, that staff members did not feel listened to and felt that their issues were being ignored/not addressed. There was a feeling that the engagement was not a co-design process and clinical pathways changed on nearly a daily basis. This made it hard for people on the ground to implement the changes and was creating confusion.

Pam Creaven – Priority House and Albion Place

First impressions were of a welcoming, clean modern facility, followed by a discussion with a volunteer which highlighted the benefits of Pets as Therapy. Discussions with the senior team, including the crisis team lead. focused on current challenges; the changing local population; and the recent Care Quality Commission visit. The visit to Albion Place focused on the Mental Health 111 service and the Mental Health Together+ pathway, as well as some of the current challenges associated with meeting Dementia assessment targets. In general, staff were positive of working for KMPT and supported the increased visibility of Board members. One area of concern raised was the need for enhanced business intelligence and data, to support operational delivery.

Julie Hammond's Visit to Littlebrook House

A range of good practice was highlighted during the visit which included robust staffing levels across all wards. The benefits of zonal observations and the positives of the reviewed patient visitation policy in regard to improving patient and family experience. A discussion was held as to whether CCTV footage could be used for staff involved in serious incidents as a learning tool; but, further discussions was required with the Information Governance Team.

Staff raised concerns around the continued patient flow issues, affecting timely discharges and the provisions of step-down care; the limited availability of career progression opportunities; and the improvements which were required to outdoor ward spaces to improve the patient wellbeing. Patient feedback also highlighted concerns about delays in approval for Section 17 leave due to the unavailability of a doctor on-site, despite adequate staffing to facilitate supervised leave if approved.

Dr Julie Hammond and Kim Lowe's visit to Acute Wards, Priority House

Staff outlined the positive benefits arising from the violence and aggression initiatives; and the positive impact on moral from the reduction in the vacancy rate. During the visit concerns were raised as to whether the body-worn camera pilot would be extended, so a go/no go update would be welcomed from the Executives.

Whilst staff understood that smoking is prohibited on NHS sites; concerns were raised about the potential stress of stopping smoking for some patients in crisis, which adversely impacted their condition and resulted in additional challenges for staff. A number of environmental concerns were identified including the impact of sight lines on the completion

of observations and the impact of frosted privacy screens on the completion of zonal observations, an approach which had been welcomed by patients and staff.

Chief Executive's Board Report

Date of Meeting: 29 May 2025

Introduction

There has been much said about the scale of the challenge the NHS is currently facing, I thought it was important that I open with this and be clear I absolutely remain very optimistic of the role KMPT has to play in our local system to deliver the national agenda towards community-based care, preventative health, and effective use of our collective resources. We are now into the new financial year and the start of the 3rd and final year of our Trust strategy.

We have a balanced financial plan and are leading on a number of system initiatives which will continue to strengthen our organisations role as an important leader in the local system with our patients at the heart of everything we do.

National and Regional Update

National CEO Meeting

At the end of April, I and other NHS CEOs from Integrated Care Boards and trusts met with Sir Jim Mackey, the new CEO of NHS England. We discussed the NHS' current position, as well as the plans for the future which will be presented in the NHS 10-year health plan. Over 220,000 ideas have been shared as part of the engagement carried out for the plan, including NHS organisations, partners, staff, and patients and ourselves. We expect it to remained focus on three main changes that have been shared previously:

- moving care from hospitals to communities
- using technology better
- focusing on stopping illness, not just treating it

We also discussed what our integrated care board (ICB) model will start to look like from the latter part of this financial year. The ICB blue print has now been shared. ICBs will be expected to focus on the health of the local population and become more focused on the strategic planning and commissioning of services. This means making sure the right services are in the right place to give patients the best care. These changes should be in place by the end of quarter 3.

System Chairs & Chief Executives

We have met as the leadership team for the system on two occasions in the last four weeks which demonstrates the importance we are all placing on working together as a system to provide the best care and services to the local population. We have a clear strategy of how we work together this year to deliver some of the transformation of the services we all provide, including support services. Updates on joint working programme will be provided in future.

Trust Update

Year 2 Strategy Update

At the last board we discussed the plan for the final year of our current strategy and how we intend to become a more data driven organisation and utilise our Doing Well Together improvement methodology to drive improvement in the key areas that we want to focus on this coming year and beyond. Today we bring a review of year two and what we have achieved and some of the challenges that we have encountered to refine our approach to our final year.

Planning

In April, the Kent and Medway system resubmitted their financial plan, with identified plans to deliver a break-even position in year. The Trust has agreed to deliver a £2.2m surplus in year to support this, with a focus on gaining greater efficiencies in its support functions by working collaboratively across the system. These plans are under development but will enable us to maximise expenditure on delivering patient care.

Well Lead Review

In 2023/24, the Trust underwent an external well led review, as recommended by the CQC and NHS England for all trusts. The Trust received 24 recommendations as a result of the review and the Executive Management Team created an action plan in response to the recommendations. The enclosed action plan provides the Board with an up-to-date position regarding the actions, which are monitored by the Chief Executive with the support of the Trust Secretary.

The Board is asked to note that 23 out of the 26 actions have now been completed; with the outstanding actions expected to be completed by the end of Quarter 2 2025/26.

The Board is requested to consider whether a further update is required in relation to the outstanding actions, or whether sufficient assurance has been provided regarding the progress to date to enable the outstanding actions to transition to ‘Business as Usual’.

Working with Families

Over the course of the year we had a number of patients attend Board to share their experience of our services. The feedback received from our Patient Board Stories is invaluable and we are truly grateful to all those who shared their experiences and this is included as an appendix to this report. Work is underway in the organisation being led by our Chief Nurse to improve how we engage with families and carers when providing care to their loved ones.

Mental Health Summit – 10th April 2025

On Thursday the 10th April over 200 people met in Ashford where we hosted our first ever Mental Health summit. We discussed the issues and aspirations for the future of mental health services and support in Kent and Medway. Feedback from the event gave a loud call for the genuine on-going involvement of people who use our services to help shape, inform and feedback on the future of mental health services.

The morning started with an excellent summary of the needs of people in Kent and Medway and the often confusing, overly complex and disjointed way that the system who supports them provides help and support. It also provided a crucial important platform for our Peer Support Providers and people who draw on our services to share their experiences and ‘help us to tell you how to help us’. We heard from our staff who shared their experiences of working in the NHS and deliver our services. The afternoon

consisted of 3 Themed Workshops**: Prevention** – what keeps us well? **Social work practice** – how can we deliver support more effectively, what's working and what needs to change? **Care pathways** – who decides what people need and who truly benefits? The outputs from the Workshops have been collated and attendees are going to be invited to help co-create the interpretation of the findings and make recommendations from each Workshop.

A Mental Health Summit Report will be produced and recommendations made which will be used as the foundations of developing the mental health strategy for the local population. It will be a health and care strategy to ensure we develop our care pathways as a whole person moving forward, which will improve our services and lived experience for our patients.

Dementia Turbo Week

Earlier this month KMPT hosted a Turbo Room to drive improvement in Memory Assessment and dementia care across Kent and Medway. The event brought together 32 organisations across health care, voluntary, community and social enterprises to collectively work together to deliver the following outcomes:

- An agreed Kent & Medway dementia vision and pathway and the plan to achieve this
- A shared understanding of strengths, gaps and variation
- Consensus on priority enablers for system transformation

The plan is now being drafted and will be shared widely in the coming weeks as all partners begin to work together on implementing the new community model for dementia assessment.

Canterbury Christchurch University

I am thrilled to share that we have forged a powerful partnership with Canterbury Christchurch University (CCU), formalised through a Memorandum of Understanding (MOU), to cultivate the NHS workforce of tomorrow in Kent. This exciting collaboration will empower our staff to teach, co-develop innovative curricula, and engage in joint research, fostering a dynamic learning environment for continuous improvement across staff, students, service users, and the community. Building on existing close work in simulation and curriculum, our aim is to provide rich inter-professional learning with the Kent and Medway Medical School, Allied Health Professionals, social work, and psychology, alongside outreach to Further Education colleges and community organisations to inspire future healthcare professionals. To crystallise this transformative alliance, I am also delighted to announce the appointment of our Chief Nurse, Andy Cruickshank as a Visiting Professor, ensuring a brighter academic and professional future for all who work and train in healthcare across Kent and Medway.

Well done Andy you are a brilliant leader and I know you will inspire our future workforce.

Value in Practice Awards

We continue to receive lots of nominations for our Value in Practice Awards and the winners for March and April are included in the appendix to this report. It is always the highlight of my month reading what our staff say about each other and recognising the important roles they each provide. Well done to all our staff. We are all very proud of you.

Trust Success at recent Awards

We have also won in some impressive awards recently. Our moving and handling team won the HSJ's "Patient Safety Collaboration of the Year Award" for their work with UK hospital bed manufacturer

Medstrom to develop a specialist mental health bed that reduces ligature risk, and addresses other harms, whilst better supporting patients with complex mental and physical health needs.

Our Medical Education Manager Angela Pendleton won a Medical Education Leaders UK award from the National Association of Medical Education Management, with the team also being highly commended for their outstanding contribution to teaching.

Our Equality, Diversity and Inclusivity (EDI) team won the Purpose Coalition" Breaking Down Barriers Awards 2025" in the "Fair Career Progression Category" recognising the success and impact of our EDI programme for our people and our Rough Sleepers Initiative team were rightly shortlisted for their innovative and collaborative work in the "Good Health and Wellbeing category". They were also very pleased to be selected by the NHS Strategy Unit as a case study to showcase the outstanding work of the Mental Health Rough Sleeping programme nationally.

Finally, we were thrilled to launch the Health and Wellbeing Academy with Canterbury Christ Church University to support the training of students in the University' simulation suites, sharing real-life experience and clinical skills, with our Chief Nurse Andy Cruickshank appointed Visiting Professor at the University to support the continued development of the partnership.

Summary and Conclusion

As I said at, the beginning of my report the NHS is facing some challenging times ahead but I remain confident that we are in a strong position as an organisation to navigate the coming changes and that we will continue to be a strong voice for mental health in our system and beyond.

We have made a great deal of progress in the last 12 months with the work we have undertaken on our dementia waiting times, our work to reduce violence and aggression on our inpatient wards, the importance of equality, diversity and inclusion in our organisation and the trusts new identity and new values. I look forward to launching our new identity later in this calendar year.

I want to say a massive thank you to our staff for their continued hard work and support as we move the organisation forward in our culture of caring, inclusive, curious and confident.

Sheila Stenson

29th May 2025

APPENDIX

Working with Families Update:

Over the course of the year we had a number of patients attend Board to share their experience of our services. Specifically, we heard from patients who had received a service from our Offender Personality Disorder Services, Complex Emotional Disorder Crisis Group, Fresh Start - Psychiatric Liaison Service, Service User Network Group, Acute Inpatient and our work with Veterans.

The feedback received from our Patient Board Stories is invaluable and we are truly grateful to all those who shared their experiences. I am pleased to highlight some changes we are making or have made in light of the feedback we received.

Fresh Start - Psychiatric Liaison Service has been embedded into practice following the end of the research period and is now a core offer in Dartford. The outcome of the research will determine if this initiative will be rolled out more widely across all our Liaison Services.

Changes have been made to the booking system for the Service User Network Groups in light of the feedback received along with ensuring service information is readily available for those accessing our Mental Health Together Services across the county.

It is clear that improvements should be made to the experience of patients admitted to an acute inpatient ward. Moreover, it is essential that we improve the experience for loved ones whose relatives are admitted to an inpatient setting. Work in this area includes making sure that hospital stays are therapeutic and trauma informed. In addition, that care is joined up across the health and care system with specific emphasis on improving our communication.

We heard very clearly that our staff sometimes interpret confidentially as not being able to engage or work with families and carers. This is absolutely not the case and we continue to support our staff in their understanding of how crucial it is to involve families and loved ones in the care of patients.

On this basis, we held an initial workshop which had good attendance from across the Trust of staff who work with families. The key themes from the discussion have been collated and this is to be used as the basis of the main plan of work in this area.

The main areas for development are:

1. Embed Family and Carer Involvement into Organisational Culture

2. Improve Workforce Capability, Confidence, and Supervision

3. Co-Produce Services with Families, Friends, and Carers

4. Create Flexible and Accessible Pathways for Family Involvement

5. Build Infrastructure to Sustain Change

6. Normalize Positive Risk-Taking Around Information Sharing

Next steps:

The actions outlined above will be scoped to establish what is already working in KMPT and then where the gaps are and how to manage them.

There will be 3 workshops over the next 6 months that will be themed based on the evidence above.

The training and resourcing implications will be worked through and the system changes required will need careful alignment given the scale of other change programmes that are underway. The principle is to create a timely introduction that fits with the developing models of practice.

Executive Team Visits

Sheila Stenson:
Boughton, Chartwell Wards, Priority House
Maidstone Liaison Team
Liaison - Dartford
Accident & Emergency (A&E) Darent Valley Hospital (DVH)

Donna Hayward-Sussex
Heathside, Coxheath
Albion Place
Thanet CMHT
Coleman House
Eureka Park

Sandra Goatley
Thanet Mental Health Services

Nick Brown
Perinatal Mental Health Community Service
Home treatment and rapid treatment teams for South East and North East
Eastern and Coastal Area Offices

Andy Cruickshank
Woodchurch and Sevenscore Wards

Value in Practice Awards – March and April 2025

Directorate		March	April
North	Individual	Olusola Osineye, CPN	Shannah Hall, Advanced Clinical Practitioner
	Team	EIP & ARMS North & West Kent Admin	DGS MHT/+
East	Individual	Garin Price, Operational Team Manager	Dr Brown
	Team	SKC MHT Admin Staff	Thanet MHT/MHT+ admin teams
West	Individual	Lisa Thompson, Carer Peer Support Practitioner	Lauren Beech, Community Mental Health Nurse
	Team	West Kent Quality Team	SMI Physical Health
Forensic	Individual	Kerry Fitness, Team Leader	Courtney, Team Leader
	Team	Groombridge Ward	Bridge House Detox
Support services	Individual	Sue Etherington, L&D Co-ordinator	Amy Marsh, Resuscitation Officer
	Team	Hotel Services, Priority House	Estates Team
Acute	Individual	Johanna Merlini-Moorcroft, Occupational Therapy Assistant	Paul Dadoce, Deputy Ward Manager
	Team	Willow Suite	Chartwell Admin Team

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 15/05/2024

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
Recommendation 1: Future board development activities should cover best practice in relation to challenge, style, scrutiny, and tone to support committees and the Board to operate in a unitary manner. This exercise would benefit from a 360-degree peer appraisal to customise feedback for individuals and to support content for a group workshop.						
1.	Board development planner to be adjusted to include matters of challenge, style, scrutiny, and tone	JC	May 2024		The Board has been adapting the board seminar days for relevant topics, with a positive tone for the recent CMHF discussion which illustrated the direction that the Board is travelling in.	**Completed**
Recommendation 2: The CEO should ensure that executive team development plans specifically consider best practice in relation to cross portfolio executive working in board and committees and peer-to-peer challenge and scrutiny in preparation for board level forums. This would also be supported by the 360-peer appraisal. The CEO should also ensure that the weekly EMT meeting has sufficient time for EDs to scrutinise the content and robustness of assumptions being presented to the Board and committees.						
2.	Appraisals / objectives 24/25 include cross portfolio working alongside supervision discussions to ensure broader understanding of exec portfolios.	SS	September 2024			**Complete**
3.	EMT extended to ensure peer to peer challenge and scrutiny in prep for board level forums.	SS	September 2024		EMT has been extended since November 23, this includes prep for Board meetings.	**Complete**
4.	Executive Development to be scoped and CEO to procure support to develop the Executive team in the next year.	SS	August 2024		Three Executive Development days have been conducted.	**Complete**
Recommendation 3: The Board should consider the responses to our board survey with a view to taking additional measures aimed at improving board succession planning, including using this process to further build the diversity of board membership.						
5.	Review succession plans put in place earlier in year to ensure that: 1) Longer term (3-5 year) pipeline identified 2) Personal development plans are in place (including external mentors) for all staff in talent pool.	SG	October 2024	31st May 2025	Succession plans in place for EMT, and we are currently working on updating these to reflect a longer term (3-5 year) pipeline is identified, including looking for successors into Executive Director posts who may not be current direct reports to Executive Directors. This work also includes establishing and strengthening PDPs for all staff identified through this work. We are also developing a talent programme specific for BME staff which will identify a pool of BME talent and create direct access for staff in that pool to roles at Band 7 and above	**In progress**

					where they meet the essential requirements of the role. As part of succession planning we are looking at the next level of critical roles, these will be identified by the Trust Leadership Team and then following appraisal window career discussions will take place and plans put in place to support. These critical roles will also be shared wider with the system to identify any future talent outside the Trust	
Recommendation 4: The Board should review the benefits of developing more granular enabling strategies to support delivery of the corporate plan, including greater emphasis on a clinical strategy, workforce strategy, estates strategy and digital strategy. This review should also consider the need for more specific executive responsibility for coordinating an integrated approach to the enabling strategies.						
6.	Support the clinical multi-disciplinary leadership (Medicine, psychology, nursing, Allied Health & Pharmacy) to develop a clinical work plan in line with the clinical elements of the strategy.	JC/SS	March 2025	July 2025	There is only one strategy, but various departments will need to have a strategic work plan and this is what they will be called. The strategic work plans for Allied Health Professionals and Medicine have been agreed and launched in the organisation. Andy Cruickshank, Chief Nurse, is leading the coordination of the programme of work. The workplans for Pharmacy and Psychology require further review, which is expected to be completed by July 2025	**In progress**
Recommendation 5: The Board should review the Terms of Reference and forward plans for the Board and committees to ensure that the agendas align with the Trust strategic objectives and that forums get the right balance between operational matters and strategic oversight.rich						
7.	Review of Terms of References for Committees to be completed, with recommendations to be presented to Committees in July 2024	TS	July 2024			**Complete**
8.	Amended Committees' Terms of References to be submitted to the Board by July 2024	TS	July 2024			**Complete**
Recommendation 6: The Board should consider whether the board has sufficient oversight of the People and Culture agenda or if forward plans need to be adjusted to provide enhanced coverage, especially in relation to getting some of the 'basics' right.						

9.	Prioritise this work within the organisation, and at board level – including adding to agendas for public board and board development and seminars.	KH/SG	May 2024		Culture, identity and staff experience is one of our 6 organisational priorities, and is being reported to board through strategy reporting. Agreed various touchpoints for next financial year to bring this work to board.	**Complete**
10.	Share plans for this work with board for discussion and approval and agree timelines for updates.	KH/SG	April 2025		On an ongoing basis, updates on the People and Culture agenda will be provided to the People Committee. Refresh of People Committee reporting undertaken.	**Complete**
Recommendation 7: The Trust should look at the possibility of consolidating available leadership development courses into a more structured leadership development framework that will serve the needs of divisional leaders and support the succession planning of service level leaders. In addition, going forward, the middle management leadership development programme should have a clear focus on compassionate leadership behaviours.						
11.	Implement the newly designed leadership and management competency framework and development programmes.	SG	September 2024	March 2025	Refreshed development programme launched and new leadership and management competencies (based on new values and behaviours) are embedded.	**Complete**
12.	Scope options for commissioning discrete senior leadership programme for top 100 leaders – launch programme in organisation	SG	September 2024	April 2025	Programme launched in April 2025.	**Complete**
Recommendation 8: The Trust should assign responsibility for board and committee administration to a corporate secretariat with a view to improving consistency, alignment and sharing of good practice across board and committee meetings, including the consistent use of the BAF and TRR to guide agendas (see KLOE 5). This should be done alongside reviewing scope for streamlining papers, agendas and for introducing an 'Advise, Assure, Alert' model for escalation reports						
13.	Transfer of responsibility for full committee administration from Executive Assistants to Trust Secretariat to occur by July 2024	TS	July 2024		Complete and transition back to Trust Secretariat has taken place.	**Complete**
14.	Committee Terms of References and Committee workplans to be adjusted to ensure that all committees have a consistent approach to their agendas, with prominent positioning of BAF and TRR matters	TS	July 2024		Plan to take governance review to EMT on 08.05.24; ARC on 11.06.24; Board on 25.07.24	**Complete**
15.	Committee Chair reports to be reviewed, adjusted to adopt the 'advise, assure, alert' model	KL	May 2024		Trust Secretariat circulated email to Committee Chairs on 25.04.24, new reports in use at Board meetings.	**Complete**
Recommendation 9: The Trust should consider the commentary in this report to further enhance the effectiveness of directorate leadership teams. This includes clarifying individual accountabilities; carving-out enough time for Clinical Directors to perform their leadership role; and ensuring the right balance of resourcing for central support within directorates and at the corporate level. In addition, consideration should be given to a SLT, a more structured approach to engaging directorate leaders in board committees, building awareness regarding directorate objectives and empowering leaders at the service level to address leadership styles						
16.	Accountabilities for directorate leadership to be clarified with clear outcomes	SS	July 2024		Confirmation of accountabilities meeting took place in June. The Service Directors have the ultimate accountability for the Directorates.	**Complete**
17.	Time allocation for clinical directors for the purposes of leadership to be established	AQ	Aug 2024		Expansion of CD role has taken place with each CD having 4 sessions of	**Complete**

					protected time to dedicate to CD duties. The expanded roles are currently being recruited to.	
18.	New forum for senior leadership team to be created, with focus on strategy and cohesive leadership	SS	September 2024		A new Trust Leadership Team (TLT) meeting with be set up for EMT, deputies and Directorate and Corporate leadership to attend. The meeting will take place fortnightly, this starts from the 1st week of October. TOR drafted and ready for review and sign off at the first meeting.	**Complete**
Recommendation 10: The Board should ensure that the TRR and BAF are used as dynamic documents and that the risk management framework is comprehensively updated to reflect the move to InPhase and the creation of the directorates. This refresh should also incorporate the Trust position in relation to risk appetite.						
19.	The risk management framework to be reviewed, with Risk Strategy, Policy and Standard Operating Procedure to be presented to ARC in August/September.	AC	October 24	September 2025	Interim review of the Policy and SOP to reflect the changes to InPhase and the Directorates, when the systems and structures changed over in March last year, completed in June 2023. This is being reviewed again in light of further experience of the InPhase system and to automate away from manual extraction of data from InPhase to ensure reports are timely and easy to access and cover risk descriptions and related actions. Due to complete end of September 25.	**In Progress**
20.	Re-evaluation of the Trust's risk appetite to be completed	AC	October 24		A risk appetite session was held at the Board development day on the 24th April 2025, which was facilitated by the Chief Nurse and NHS Providers.	**Complete**
21.	Create a process by which regular and timely updates to the Board Assurance Framework and Trust Risk Register may be achieved. Evaluation of the process to occur on a rolling bi-annual basis.	AC	October 24		To align the BAF and TRR (through the BAF Oversight meeting with Executives and going forward the TLT) so that movement is captured as near to real time as possible and that the quality of actions and controls is reviewed to ensure adequacy and credibility.	**Complete**
Recommendation 11: The Board should consider increasing its focus on digital with a view to accelerating progress with this critical agenda item. This would be aided by enhanced coverage from committees, a refreshed digital strategic work plan and dedicated executive digital leadership. The Trust should also use the opportunity as a mechanism for further promoting clinical engagement at the Trust.						
22.	Regular oversight of the Trust's digital plan to be carried out by the Finance and Performance Committee with escalation to Board where required.	NB	October 2024		A "Digital and IT" item has been included on the Finance and Performance Committee workplan, and any issues will be escalated to the Trust Board, via the Chair's report, as required.	**Complete**

Recommendation 12: The Board should review opportunities for further enhancing NED visibility, such as participation in webinars, improved use of directorate alignment or attendance at other staff forums. In addition, it should consider a 'You said, we did' framework to address perceptions that actions are not taken because of staff feedback and develop an engagement strategy to enhance engagement with its two Local Authorities and primary care colleagues.						
23.	Enhancement of NED visibility	KH	Nov 24		NEDs are aligned to directorates, with NEDs able to attend Staff Forums	**Complete**
24.	'You said, we did' framework shall be rolled out, framed as CEO Blogs	KH	Nov 24		These are regularly published to staff	**Complete**
25.	Engagement with Local Authorities and Primary Care Colleagues	AR and AQ	May 2025		Local authorities: We are working closely with KCC on a number of initiatives around housing and additional ways of working that will support flow through our beds, including events like the mental health summit last month, and our work on housing. We continue to work closely with our local authorities' scrutiny committees for both Medway and Kent and in March took a joint authored report by KMPT and the ICB to Kent where we updated them on mental health transformation across the system. Primary care colleagues: Along with the CMO we are beginning wider engagement with colleagues within primary care. They have formed part of engagement process for the new KMPT identity, they have been an integral part of a number of our improvement initiatives in the past 6 months (eg CMHF refinement, community memory assessment model).	**Complete**
Recommendation 13: The Trust should consider the benefits of more closely aligning and consolidating the QI portfolio with the transformation portfolio.						
26.	Transformation and QI portfolio now combined.	SS	May 24		The QI and Transformation teams merged to form the Improvement Team in April. It has resulted in a harmonisation of methodologies and further development and upskilling of the new form team is underway to assist in driving the organisational strategy and further improvements across the organisation.	**Complete**

					Closer work is now being achieved with the Research and Clinical Audit teams with a single point of access that will allow for closer tracking of interdependencies and benefits realisation.	

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29 May 2025
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

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

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in March 2025.

The Board held a session on the 24th April to debate and describe the risk appetite for the Trust. The approach to how this is articulated will build on other NHS Trusts' approach that creates a clearer path from the domains of risk (and the Boards risk appetite) to the strategic objectives of the organisation and what the assurances are around the treatment of risks connected to these.

This will be presented to the Board for discussion in the coming weeks.

New Risks:

No new risks have been added since the BAF was presented to Board in March

Risk Movement:

Five risks have changed their risk score since the Board Assurance Framework was presented to Board in March:

- **Risk ID 08065 – Inpatient Flow (Increased from 15 (Extreme) to 20 (Extreme))**
- **Risk ID 08174 – Delivery of Financial Targets (Increased from 8 (High) to 15 (Extreme))**
- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times (Reduced from 8 (High) to 6 (Moderate))**

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- **Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Reduced from 20 (Extreme) to 12 (High))**
- **Risk ID 08175 – Delivery of Underlying Financial Sustainability (Increased from 9 (High) to 12 (High))**

Risks recommended for Removal:

One risk is currently recommended for removal

- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times (Rating of 6 – Moderate)**

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)

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The Board Assurance Framework

The BAF was last presented to ARC on 17th March and the Board on 27th March 2025. This report reflects further updates on risks since the end of March.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 20 – Extreme)
- Risk ID 08174 - Delivery of Financial Targets (Rating of 15 - Extreme)

Risk Movement

Five risks have changed their risk score since the Board Assurance Framework was presented to Board in January:

- **Risk ID 08065 – Inpatient Flow (Increased from 15 (Extreme) to 20 (Extreme))**
  This risk remains under close scrutiny. A high level plan has been developed which includes the following actions: Rapid reduction of CRFD pressures across our acute beds - Reduce total CRFD position by 25% at week 4 and 50% by week 8 Effective use of voluntary and community sector (VCSE) capacity for 50% of CRFD patients Eliminate OOA bed use by week 4 of our plan Improved flow by reconfiguring a younger adult step-down ward through release of capacity by reducing the number of CRFD patients we have in our beds Strengthening of social care discharge processes The plan is for a total of 8 weeks working closely with our social care colleagues to support our patients with the next stage of their care. the Anticipated start date is mid-June, subject to contracts with Voluntary Community and Social Enterprise (VCSE) partners

- **Risk ID 08174 – Delivery of Financial Targets (Increased from 8 (High) to 15 (Extreme))**
  This existing risk has been reviewed and refreshed for the 2025/26 financial year. The Trust met the 2024/25 financial target, exceeding the early target for the year, and meeting the final position imposed by the ICB due to the challenged system financial position. The risk score has increased to the initial score position as a reset for the coming financial year. The financial plans for the coming year have been submitted to the ICB and NHS England. It is expected that there will be a further review towards the end of June, but it is not expected that this position will change significantly, unless the ICB change their position in relation to the wider system challenges. The actions have been revised and forecasting will occur on a monthly basis through to year end.

- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times (Reduced from 8 (High) to 6 (Moderate))**
  This risk has reached its target risk score and is also recommended for removal from the BAF.

Version Control: 01

- **Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Reduced from 20 (Extreme) to 12 (High))**
  The 4 Pillars remain in place and all actions have been updated accordingly. To date the most significant impact has been Data Refinement through the DNA policy and Capacity Planning through the weekly activity meeting. the numbers of people waiting has been reduced by 700+ since these actions have commenced. Model refinement is underway and when completed will support quality of interventions delivered and waiting list management. This progress has led to a reduction in the current risk score.

- **Risk ID 08175 – Delivery of Underlying Financial Sustainability (Increased from 9 (High) to 12 (High))**
  This existing risk has been reviewed and refreshed for the 2025/26 financial year. The risk score has increased to the initial score position as a reset for the coming financial year. The financial plans for the coming year have been submitted to the ICB and NHS England. The cost savings for the Trust are significant, and have increased considerably from last year. A draft cost improvement plan is being considered by FPC.

Risks Recommended for Removal

One risk is being recommended for removal at this time:

- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times (Reduced from 8 (High) to 6 (Moderate))**
  This risk has reached its target risk score and is recommended for removal from the BAF.
  1. Waiting assessed has reduced for both older and younger adults. (April 2025)
  2. Waited treatment for younger adults has improved, aside from the exception in January. We suspect reflecting Christmas break and staff not commencing treatments close to Christmas as it can be de-stabilising for patients (start treatment, have a break over Christmas then resume in January etc). The sharp drop in waits post January 2025 might support that further.
  3. Waited treatment for older adults has not reduced but remains stable. Some challenges staff turnover and vacancy/ recruitment delays. Some estates issues e.g. in swale and the closure of bay tree house and finding suitable long-term therapy rooms. All issues have been escalated and are being addressed.
  Therefore it is recommended that this risk is removed from the BAF. It is proposed that this remains open and is managed at a lower level to ensure the improvement in waiting times is sustained.

New Risks

No risks have been added since the BAF was presented to Board in March.

Emerging Risks

No new emerging risks has been identified for the BAF at this time. The Executive team continue to Horizon scan for emerging risks to delivery of services.

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Other Notable Updates

- **Risk ID 00580 – Organisational Inability to meet Memory Assessment Service Demand**
  Progress has been made in addressing quality of the service in terms of long waiting patients, with a reduction in the number of patients waiting the longest and a subsequent reduction in average waiting times to below the national average. Frontline improvement continues to address unwanted variation and further opportunities have been identified around Job Planning and defined budgets. Progress towards a Second Phase is limited until resourcing and budgeting for community services has been finalised (MAS/MHT+). Progress has also been made for the community phase with a completed planning workshop and an initial plan and trajectory for Dementia diagnosis rate to be first drafted by the end of May.

- **Risk ID 04232 - Management of Environmental Ligatures**
  There is increased confidence in the relationship between the audit cycle and the programme of capital works. Over the past year, there has been good progress on identified priority areas for anti ligature works. Prioritisation continues and this will feed into the coming year capital works programme.

- **Risk ID 07981 – Organisational Management of Violence and Aggression**
  Good progress is being made with this risk, although it is not uniform. Some wards have achieved a 90% reduction in violence and aggression, but others have not seen as great a reduction. The programme is looking to move into business as usual across the Trust.

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.

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Updated: 16 May 2025

Kent and Medway NHS and Social Care Partnership Trust

Board Assurance Framework

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

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

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	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMPT remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment or services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years.	5	5	25	System wide response to achieve improved Memory Assessment services across Kent and Medway through the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative and Ageing Well Board. - BI Functionality to drive performance at team, directorate and organisational level - Stand alone assessment model formed, currently being optimised through Tiered Accountability work - Completing the Demand and Capacity for the multi-disciplinary model for memory assessment within KMPT (to be rolled out across the organisation) - Community Model Task Force formed comprising KMPT and wider NHS and VCSE partners.	Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team Highlight reports to Trust Leadership Team, FPC and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	4	5	20	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 22/12/2025 — A System convening task and finish MHLDA Provider Collaborative task and finish to scope community and system involvement and convene pilots alongside Health Care Partnerships (HCP) — Director of Partnerships and Transformation — Completed — G Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 29/08/2025 — A Phase 2 resourcing and implementation — Director of Partnerships and Transformation — 30/06/2025 — A Focussed activity on 52 week waits — Director of Partnerships and Transformation — 29/08/2025 — A Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 29/05/2026 — A	Director of Partnerships and Transformation		3	4	12	31/03/2026

30/08/2023 — BAF 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	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 05075	Aug 2023	Chief Operating Officer	**Community Psychological Services Therapy Waiting Times** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1. Psychology Leads working with colleagues to move patients onto stepped care pathway. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3.PSYCHOLOGICAL SERVICES TO MAINTAIN SPREADSHEET DATABASE TO TRACK PATIENTS IN PATHWAY. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO. 6. Hybrid working in place as requested by patients needs 7. Expansion of psychological practice workforce use of Mental Health Wellbeing Practitioners, Clinical Associate Psychologists, Recruit to Train staff and Assistant Psychologists continues to grow. 8. Ongoing group interventions to reduce waiting times and parity of offer at place.	Assurances from dashboard data	3	2	6	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Waiting list review for mental health together — Director of Psychological Therapies — Completed — G	Chief Operating Officer		3	2	6	30/12/2025

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	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 08065	Jun 2024	Chief Medical Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	4	20	Patient flow team jointly working with acute hospital colleagues, Liaison Psychiatry, Home Treatment and community services on case by case basis twice daily reports including the Place of Safety Breaches daily system calls review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts business case approved through ICB to move to CORE 24 across all acute hospitals CRFD programme of work underway to release capacity within the KMPT bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review CRFD Programme is a system wide programme in conjunction with the ICB Local Authority and supported through the Provider collaborative.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	5	4	20	↑		Chief Medical Officer		1	3	3	12/09/2025

12/06/2024 — Risk Opened

Actions to reduce risk	Owner	Target Completion (end)	Status
Accurate recording and reporting of 12 hour breaches	Director of Digital	30/08/2024	R
Countywide Safe Haven Provision	Deputy Chief Operating Officer	02/06/2025	A
CRFD Programme	Deputy Chief Operating Officer	Completed	G
Kent and Medway MH Summit with Social Care	Chief Medical Officer	10/04/2025	A
Implementtion of CORE 24 across all Hospital Liaison Services	Deputy Chief Operating Officer	30/06/2025	A
Crisis Houses across the County	Deputy Chief Operating Officer	28/07/2025	A

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 08157	Aug 2024	Chief Operating Officer	**Community Mental Health Framework Achieving outcomes to evidence success** IF we don't complete enough paired DIALOG+ and are not able to meet the 4 week wait THEN we will a) not be able to assess outcomes for our service users and will b) delay commencement of treatment, RESULTING IN poor patient experience.	5	5	25	Daily review of waiting lists at service level, weekly review of waiting list at operational level and fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. Amendments to the front door are underway, the interface with GP's is undergoing improvement and the voluntary sector are moving resources to entry points to enable improved triage. Team level daily management. Tactical groups in all localities monitoring waits and clinical risk to patients (1c). Monthly deep dive by programme management to each locality (1a) Dashboard in place (1d) BI Team reviewing weekly MHT report to align to waits and patient flow to enable patient level data at service level. (1d) DNA policy has been reviewed and updated to support effective and safe discharge from MHT for people who do not want the service (1f) Rio updated to include ability to record onward referral to alternative provision (such as Talking Therapies). (1f)	Robust team level management Dashboards Caseload management tool Partnership Forums	3	4	12	↓		Chief Operating Officer		3	3	9	28/08/2025

12/06/2024 — Risk Opened

Actions to reduce risk	Owner	Target Completion (end)	Status
Review of Mental Health Together Front Door Processes	Deputy Chief Operating Officer	30/05/2025	A
Implementation of revised DNA policy	Deputy Chief Operating Officer	Completed	G
Review of Mental Health Together and Mental Health Together + Interventions	Director of Psychological Therapies	30/06/2025	A
Recruitment of 35 Assistant Psychologists on a 6 month contract to support the management of waiting lists.	Deputy Chief Operating Officer	21/07/2025	A
Capacity Planning	Deputy Chief Operating Officer	30/06/2025	A

1.2 - Creating safer and better experiences on our wards

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	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 04232	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	Program for removing anchor points and restricting access to staff only areas The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits (now conducted jointly with Clinical ward staff and Estates staff) [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homicides Group [2a] Safety Alerts/Protocols [1h] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Continued Capital investment in Door replacement. [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Therapeutic observations National report on the prevention of homicide and suicides Internal validated audit tool Health and Safety and Ligature Risk Assessment Audits Reduction in severe harm patient safety incidents related to anchor points and self strangulation Quality Digest reporting to Quality Committee IQPR reporting to Board CCG Quality Visit Health & Safety Audits [3d] Ligature Audits [3d] Patient Safety Incident Reports Prescribed observations in place Ligature Reduction Programme	2	4	8	↔		Chief Nurse		1	4	4	31/03/2026

04/12/2014 — BAF Risk Opened — 20/07/2023 — Risk returned to BAF

Actions to reduce risk	Owner	Target Completion (end)	Status
Capital Expenditure on Environmental Ligature risk areas	Head of Capital Planning	31/03/2026	A

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF KMPT do not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance the Continuous Improvement Approach Violence Reduction Strategy PSS Strategy Use of Force Act Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy Safer Staffing	Incident reporting via InPhase Quality Improvement Data	4	3	12	↔		Chief Nurse		2	3	6	31/03/2026

04/12/2014 — BAF Risk Opened — 20/07/2023 — Risk returned to BAF

Actions to reduce risk	Owner	Target Completion (end)	Status
Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services.	Chief Nurse	30/03/2026	A
Regular, scheduled engagement with all participating inpatient teams	Chief Nurse	Completed	G
New Violence and Aggression Policy 2025	EPR Lead	31/07/2025	A

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating 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																			
2 - We are a great place to work and have engaged and capable staff living our values																						
2.1 - Creating a culture where our people feel safe, equal and can thrive																						
30/01/2025 BAF Risk Opened																						
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Change Programmes** If KMPT's current interventions do not successfully build its capability and capacity to deliver effective change, Then change efforts are unlikely to succeed and engagement will deteriorate, Resulting in poor organisational culture, impact on our people, patients and population, reduced ability to deliver key strategic ambitions	4	3	12	Work to introduce and embed new and coherent organisational values Delivery of leadership development programme Delivery of equality, diversity and inclusion interventions Delivery of Opex and improvement capability building		3	3	9	⟷	**Actions to reduce risk** Delivery of leadership and management programmes Roll out and embedding of New Organisational Values Embedding of staff voice initiatives	**Owner** Deputy Chief People Officer Deputy Chief People Officer Deputy Chief People Officer	**Target Completion** (end) 31/03/2026 31/03/2026 31/03/2026	**Status** A A A	Chief People Officer		2	3	6	31/03/2026
2.2 - Building a sustainable workforce for the future																						
			No Risks Identified against this Strategic Objective																			
2.3 - Creating an empowered, capable and inclusive leadership team																						
			No Risks Identified against this Strategic Objective																			
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																						
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																						
			No Risks Identified against this Strategic Objective																			
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																						
			No Risks Identified against this Strategic Objective																			
4.2 - Enhance our use of IT and digital systems to free up staff time																						
			No Risks Identified against this Strategic Objective																			
4.3 - Effective digital tools are in place to support joined-up, personalised care																						
			No Risks Identified against this Strategic Objective																			
5 - We are efficient, sustainable, transformational and make the most of every resource																						
5.1 Achieve financial sustainability																						
22/08/2023 Risk Opened																						
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Sign off of Medical Agency spend at exec level. Sign off for above cap rate posts at CEO level Reporting to Trust Board [3a] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend Medical lead for recruitment appointed to support areas which are challenging to recruit to. All non medical vacant posts are reviewed at the weekly vacancy control panel. No retrospective approval of Agency shifts	Monthly IQPR (reported to each public board) Monthly statements to budget holders [1a] Monthly Finance Report [1h] Internal audit [3d]	3	3	9	⟷	**Actions to reduce risk** Reduce Nursing Agency Spend by 50% to meet the National ask	**Owner** Chief Medical Officer	**Target Completion** (end) 30/10/2025	**Status** A	Chief Medical Officer		3	3	9	30/10/2025

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
			25/06/2024 Risk Opened																			
ID 08174	Jun 2024	Chief Finance and Resources Officer	**Delivery of Financial Targets** IF the Trust fails to maintain financial sustainability THEN this could lead to an inability to deliver core services and health outcomes, and financial deficit, RESULTING IN intervention by NHS England and insufficient cash to fund future capital programmes.	3	5	15	Standing Financial Instructions Delegated budgets Agency recruitment restriction CIP Process Monthly statements to budget holders Budget holder authorisation Authorised signatories Trust Capital Group oversight Business Case review group	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	5	15	⇑	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		2	4	8	31/03/2026
													Forecast of the Trust Agency spend (signed off by Service Directors)	Associate Director of Finance	31/03/2026	A						
													Forecast of the Trust Bank spend (signed off by Service Directors)	Associate Director of Finance	31/03/2026	A						
													Review of the use of temporary staffing and identify appropriate mitigations and controls	Associate Director of Finance	31/03/2026	A						
													Review of Trust Reporting Pack	Associate Director of Finance	31/03/2026	A						
			25/06/2024 Risk Opened																			
ID 08175	Jun 2024	Chief Finance and Resources Officer	**Delivery of Underlying Financial Sustainability** IF the Trust does not focus on cost saving, productivity and efficiency to contain its run rate THEN funds will not be available to support the investment in services RESULTING IN the Trust potentially moving into financial deficit and unable to support the delivery of the Trust Strategy	3	4	12	Long term sustainability programme Cost Improvement Programme	Monthly external reporting to ICB and NHS England	3	4	12	⇑	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		3	3	9	31/03/2026
													Separate workstream for Corporate Savings to monitor delivery to include system stretch requirement	Associate Director of Finance	31/03/2026	A						
													Agreed Cost Improvement Plan programme of work with agreed timeframes	Associate Director of Finance	31/03/2026	A						
													Review of Trust controls on Non Pay	Associate Director of Finance	31/03/2026	A						
													Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising	Associate Director of Finance	31/03/2026	A						
													Refresh and review underlying position at service and commissioner level.	Associate Director of Finance	31/03/2026	A						
5.2 Exceed the ambitions of the NHS Greener programme																						
			No Risks Identified against this Strategic Objective																			
5.3 Transform the way we work																						
			No Risks Identified against this Strategic Objective																			
6 - We create environments that benefit our service users and people																						
6.1 - Maximise our use of office spaces and clinical estate																						
			No Risks Identified against this Strategic Objective																			
6.2 - Invest in a fit for purpose, safe clinical estate																						
			29/03/2024 Risk Opened																			
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	⇔	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		2	3	6	31/03/2026
													To complete the Annual ERIC Return	Deputy Director for Estates	29/09/2025	A						
													Tender for 6 Facet Survey	Deputy Director for Estates	30/03/2026	A						
			01/04/2020 Risk Opened																			
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Services Business Continuity Plans	Reporting to FPC TiAA Audit Contract Monitoring Minutes	2	4	8	⇔	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		2	3	6	31/03/2026
													Review of the implementation of the new maintenance contract	Director of Estates and Facilities	Completed	G						

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Year 2 Strategy Delivery Review
Author:	Sarah Atkinson, Deputy Director of Transformation and Partnerships
	Adrian Richardson, Director of Transformation & Partnerships
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides a review to the Board on progress against the Trust's three-year strategy 2023-2026 for the period 1 April 2024 – 31 March 2025, with a focus on our six priority areas. It also includes a summary of progress across wider areas in our strategy and challenges as well as an overview of how improvement work will transition from Year 2 to Year 3 of the Strategy.

Issues to bring to the Board's attention

In Year 2 of our 3-year strategy we have focused on 6 priority programmes which have been measured through 28 driver metrics from our trust strategy. The remaining metrics outlined in the trust strategy are categorised as 'business as usual' or 'watch' metrics. Business as usual metrics are monitored through Trust Leadership Team meetings or as part of the trust integrated quality & performance whereas 'watch' metrics are monitored and progressed within business activity without the need for an improvement approach.

The paper highlights positive progress on a number of our priority programmes, notably:

- We are pleased with the progress of the Dementia diagnosis work where a continuous improvement approach is being rolled out to drive local ownership of performance and improvement with a particular focus on those patients who have been waiting for over 52 weeks for a diagnosis. Whilst there is still work to do we have seen a significant, positive increase in the number of patients being diagnosed within 6 weeks, from 7.7% in April '24 to 33.5% in February '25.
- The work around violence and aggression this year is also extremely positive. Whilst we don't always see the improvement in the aggregated data, when we look at individual wards we have seen a reduction of 90% in incidences of violence and aggression in some cases. We also hear from our staff that they feel more in control on the wards and that they have a greater understanding of their high-risk patients as well as action plans in place for those patients.

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- We are also proud of the progress that has been made against a number of staff related metrics including the number of global majority staff who are in senior roles (Band 7 or above), which is achieving 28.5% compared to our initial target of 17.5% and also the number of leaders who have received development training in the last year which is at 70% compared to our target of 60%. This progress represents our focus on developing an inclusive culture that provides equal opportunities for all and develops our leaders to ensure the best experience for staff and patients.
- This is further supported by the launch of our new trust values; caring, inclusive, curious and confident which will further improve staff and patient experience alike.

We have set out where there is still work to do and the challenges we are facing in overcoming complex problems. For example:

- In the Patient Flow programme, we have experienced significant challenges to reducing bed occupancy despite lots of positive improvements such as the roll out of Red to Green, reduction in the number of High Intensity Users and the development of the Purposeful Admission protocol. Demand for acute psychiatric beds has been extremely high through the Winter (Jan-Mar) and this has had an enormous impact on our ability to create capacity in the system. Transferring those who are clinically ready for discharge remains a significant challenge; however, plans are in place to address this in the short term whilst longer term solutions are sought.
- Mental Health Together and Mental Health Together + has now been rolled out across the trust, however, challenges remain in addressing high numbers of referrals as well as capacity to assess and triage patients at the front door. This continues to be a priority for the organisation going into year 3 of the strategy, with work underway to review the current model to ensure process and pathways are fit for purpose as well as addressing immediate challenges such as appropriate resourcing and standardised practise across localities. In doing so, we recognise the need to learn from our previous approach to the CMHF. A recent report from Attain as well as feedback from staff has highlighted a number of lessons learned including, but not limited to, improving staff engagement and involvement, ensuring robust clinical leadership within the programme and improving process approaches such as having SOPs in place for ‘go lives’ to create clarity and setting short term, achievable goals to boost morale.

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Leadership Team (TLT), IQPR and Board Sub-Committees

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Background

The 2023-26 trust strategy sets the direction, with specific outcomes, which will need to be delivered by the organisation. The strategy is based on three strategic ambitions (our Patients, our People and our Partners) and three strategic enablers. Each ambition and enabler have a number of outcomes associated with it and as such require transformative change support to be successfully implemented.

Acknowledging the significant challenge of improving 73 outcomes all at once, in May 2024 the outcomes were separated into three groups:

Group	Number of Outcomes	Approach
Drivers	28 (6 of which are from strategic enablers)	Where an active improvement approach is supporting the strategic ambitions and enablers.
Business as Usual	25 (9 of which are Urgent and Emergency Care (UEC) and Patient Experience)	Where the metrics/outcomes are monitored and reported frequently through the Trust Leadership Team (TLT) or as part of the Trust Integrated Quality & Performance Report (IQPR) and Quality Performance Reviews (QPRs), without the need for an improvement approach.
Watch	20	Where monitoring and further progress will be made within a business as usual approach without the need for an improvement approach

Strategy Deployment Year Two

Priority Areas

In keeping with the prioritisation of year one, and phasing of our strategy delivery, we agreed to focus on six key priorities throughout year two of the strategy:

1. Patient flow, so we can see people quicker, closer to home and in the least restrictive settings
2. Dementia, so we can diagnose and care for more people who are waiting to be seen in a quicker timeframe
3. Mental Health Together, so we can transform how we care for people with complex mental health needs, alongside our partners, in the community
4. Reducing all forms of violence and aggression, including racially motivated, against our people so that they can come to work and feel safe and supported
5. Transforming our culture and identity, so that we have the right behaviours within KMPT and do more to help our patients, partners and community know who we are and what we do, ultimately making us a better place to work, be cared for and partner with.
6. Getting the basics right, so we make everyone's working day easier and enable them to deliver the best possible care

Governance

The reporting and governance structure established in the latter part of year one has continued into year two with one change. The Transformation Group and Strategy Deployment Group were replaced by the fortnightly, Trust Leadership Team (TLT) in October 2024. TLT has a wider membership including Executive Management Team (EMT), Trust Deputies, Clinical and Corporate Directors and Senior Leaders. This provides operational oversight of the progress of the strategy and has widen engagement

in its delivery. The executive sponsors provide a monthly operational update to the rest of the EMT to ensure clarity on progress, challenges and identify support where needed. Each programme also undergoes a deep dive with EMT and the Senior Responsible Officer (SRO) quarterly.

Year Two Operational Delivery Review

Overview against operational plan

Progress across our six priority outcome measures is summarised in the following pages. We have provided specific details on the work to date, acknowledging that whilst there has been great improvement on many of the metrics, there is still work to do against some metrics which will carry in to year 3. While some metrics show as ‘off target’ this indicates progress against delivery plans/ trajectories rather than performance and does not detract from the great progress made against may of our metrics.

The table below captures progress against our priorities and their associated driver metrics. Performance is captured in the latest trust scorecard in Appendix A.

Priority	Exec Sponsor	Strategic Outcome	Status	Update
Patient Flow	Afifa Qazi	Decrease our bed occupancy to 92% in year	Off Target	Baseline performance in April 2024 was 95.9% and did reach a low of 92.6% in December. However, bed occupancy increased in January to 97.4% and has remained stable around this rate – see scorecard in Appendix A. KMPT initiatives are progressing well, these are: • Red to Green fully implemented across all wards. • High Intensity User (HIU) programme live across all community teams. • Readmissions data cleansing exercise completed. • Transfer of Care Hub in the East has reassumed after initial challenges. Challenge with support from Kent County Council (KCC) on Clinically Ready for Discharge (CRfD) continues to remain. Work being progressed on reducing CRfD numbers by using Voluntary, Community and Social Enterprise (VCSE) providers with aim to reduce CRfD to 50%.
		Reduce the length of stay for patients waiting onward transfer by 75%	Off Target	Support to KCC to release capacity and resource: • Three KMPT social workers on secondment to KCC. • KMPT supporting KCC to review high cost community placements. Working with KCC on joint clinical pathways. However, engagement has been slow and no data has been shared from KCC yet to support the progress of this work
Dementia	Adrian Richardson	95% of people referred for a dementia assessment will be seen within 6 weeks	Off Target	Phase 1 of standardised model has been completed and is embedding across all Memory Assessment Service (MAS) services A localised, continuous improvement approach is being rolled out across the MAS services to engage staff in problem solving and ownership of their data. MAS teams are focused on reducing the number of patients waiting over 52 weeks for a diagnosis. There are currently (13/5/25) 180 patients who have been waiting over 52 weeks, down from 260. Work is continuing to evaluate the multidisciplinary workforce model which will support the embedding of the MAS services Further work is underway to address the system wide response to delayed dementia diagnosis, with a week-long intensive workshop taking place in early May to identify opportunities for improvement. Performance was at 7.7% in April 2024 and was 26.3% in April 2025 and reached a peak of 33.8% in February 2025 the reduction is due to concentration on the long waits, the impact of which has seen a reduction in waiting time from 189.9 days in July 24 to 143.5 days in May 2025. Waiting time in KMPT is now below the national average of 151 days for the first time. Whilst 95% has not yet been achieved this was the 3-year target and Dementia is a key area of focus as a breakthrough objective for year 3 of this strategy

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Violence and Aggression	Andy Cruickshank	Decrease violence and aggression on our wards by 15%	On Target	Improvement work has taken place to roll out Safety Culture Bundle (SCB) across all acute wards and some top contributing wards in forensic services. The Safety Culture Bundle, is a combination of tools that enables the easy capturing of incidents as well as promoting preventative mechanisms for high risk patients by identifying triggers and taking preventative measures. This has led to a greater number of incidents being reported which is why we have not yet seen improved performance against the target despite confidence that the Safety Culture Bundles are having a positive impact. We have seen through month on month reporting, some wards reporting up to 90% reduction in incidences of violence and aggression. Qualitative feedback from staff shows that there is greater awareness of high-risk patients, improved action plans to reduce risk, greater communication and improved staff wellbeing.
		Reduce racist violence and aggression incidents to 15%, in line with the national average.	Off Target	We have identified root causes to racial incidences in 3 pilot areas and are working with frontline staff, using improvement methodology to identify countermeasures and make sustainable improvements in those areas. The number of incidences is measured through the staff survey. There is still significant work needed to address data accuracy and the number of racial incidents are still significantly under reported.
Culture, identity and staff experience *(two previous outcomes have been removed due to overlap)*	Sandra Goatley/ Kindra Hyttner	Increase percentage of Global Majority (BAME) staff in roles at band 7 and above	On Target	The total number of Global Majority (BAME) staff in roles at Band 7 and above or equivalent is comfortably achieving target (28.5% against 17.5% target), and has gradually increased throughout the duration of the Trust strategy. Further work is planned to target career progression for Global Majority staff into Agenda for Change roles specifically at Band 7 and above.
		Increase our raising concerns sub-scores from 6.6 to 6.9	Off Target	This score maintained at 6.5 in Year 2 (against a Year 2 target of 6.7), illustrating that there is more work to do in this area. The Staff Survey indicates that progress was achieved in relation to staff confidence to raise concerns (95.7% of staff reported their last experience of violence and aggression, compared with 93.2% last year; 66.9% of staff who had experienced bullying and harassment reported it, compared with 63.6% last year; 63.5% of staff feel safe to speak up, compared with 62.8% last year). However, scores relating to addressing concerns did not see the same levels of improvement. Both of these sets of questions (questions related to raising concerns and questions related to addressing concerns) feed the Raising Concerns sub-score. Work planned for Y3 focuses on building leadership capability and confidence to address concerns through both the leadership and management development programmes and on the ground support to managers.
		Increase our burnout sub-score from 5.2 to 5.5	On target	This maintained at 5.3 in Year 2 (against a Year 2 target of 5.3). A pilot programme is due to begin over the next few weeks which will provide targeted psychological recovery support to staff experiencing poor mental health.
		Increase staff satisfaction with their line managers from 7.6 to 7.9 in our staff survey	Off Target	This maintained at 7.5 in Year 2 (against a Year 2 target of 7.8). It should be noted that scores relating to line managers continue to compare favourably with the national average for mental health trusts (at 7.4). Over recent months, there has been a refresh of all management development programmes, as well as the launch of the Leading Well Together (senior leadership programme), which are expected to have a positive impact in this area.

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		Reduce our agency spend to 3.7% of the trust total pay bill	On Target	Performance has remained at target since August 2024 following the successful recruitment to a number of consultant posts. There remains some targeted work in areas where agency use remains above target
		Our people feel KMPT is a supportive and compassionate employer (increase compassionate culture sub-score from 6.9 to 7.2)	Off Target	This score deteriorated slightly from 6.9 in Year 1 to 6.8 in Year 2 (against a Year 2 target of 7.0). This theme incorporates feedback from staff around feeling valued, respected and treated kindly by colleagues. Work around values and behaviours is underway, but this work is still in its early stages. Similarly, work around violence and aggression is expected to lead to improvements in these scores, but this work is also in its early stages.
		Increase engagement score from 6.9 to 7.1	Off Target	This score deteriorated slightly from 6.9 in Year 1 to 6.8 in Year 2 (against a Year 2 target of 7.0). Although still too early to see impact on these scores, significant work has been undertaken over recent months which is expected to impact on them in Year 3. This includes the introduction of the staff intranet, the roll out of the Doing Well Together programme, and the refresh of the Trust's values and behaviours. Staff survey scores indicate that a key challenge in relation to engagement in Year 2 has been engagement through organisational change.
		90% of leaders and managers at Band 7 to have attended KMPT leadership and management development	On Target	At the end of Year 2, around 70% of leaders and managers at Band 7 had attended leadership and management development since the target was set (this is ahead of the 60% anticipated). This has included the new managers' programme, and bespoke management development for Mental Health Together Managers.
Mental Health Together (MHT) **(*Community Mental Health Framework*)**	Donna Hayward-Sussex	Patients receive treatment within 4 weeks of a referral into Mental Health Together	Off Target	Data is now available across all services with accuracy / cleansing well underway. Full reporting should be in place for September 2025. The stretch from an 18-week target to 4 is proving challenging and will take time to meet. Partners are actively working through the model refinement to ensure patients are able to access the most appropriate service in timely way.
		Increase the number of patients accessing care in the Mental Health Together service to levels representative of the local population.	Off Target	Data quality around population measures remains an issue although work is being carried out to improve this data Dashboard is now available which identifies the accurate recoding when referrals are received. Initial work within GTBR looked at DNA rates in community setting and found the use of SMS reminders significantly improve access to services. This is now in the process being rolled out across community teams
		85% of people with a severe mental health illness presenting through Mental Health Together will have a physical health check	Off Target	Currently 65% across all services.

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		See 85% of routine referrals within 4 weeks	Off Target	As above - data is now available across all services with accuracy / cleansing well underway. Full reporting should be in place for September 2025. The stretch from an 18-week target to 4 is proving challenging and will take time to meet.
		Forecast mental health capacity and meet demand	On Target	Demand and capacity planning has commenced alongside the model refinement.
Getting the Basics Right	Donna Hayward-Sussex	Reduce unwarranted variation in services	Off Target	We are reviewing services to ensure that clinical time is maximised. We are working with clinical teams to map demand and capacity. With capacity modelled and compared against present performance to understand any challenges in this. Presently modelling is focusing on the delivery of the community service function
		Reduction in time spent capturing and revalidating non-value adding data by 25%	Off Target	Good progress being made in community services. Standardised ways of working across community service, supported by a Business Analyst and Clinical Leads is leading to a reduction in non-value adding time.
		Process Re-Engineering of operational support systems	Off Target	Work has begun to address variations in administrative services across community services, looking at variation in processes as well as differences in staffing models. Upcoming workshops will identify success measures and opportunities for digital solutions. Corporate admin is currently out of scope of this work, A separate piece of work is underway to review corporate services inline with recent national guidance
	Adrian Richardson	Process Re-Engineering of corporate support systems	Off Target	Work began on this outcome prior to the national direction in terms of corporate workforce size. The initial phase of this work is working alongside the CFO to drive the necessary workforce efficiencies and additional support system opportunities will then be scoped. in Q3

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In addition to the driver metrics within the six priority programmes, there are six outcomes that form part of the strategic enablers that are driver metrics for 2024:

Outcome	Exec Sponsor	Status	Update
Clinical staff report that our Electronic Patient Records System is quicker and easier to use.	Nick Brown	On Target	In relation to Rio, considerable effort has been focused on improvement to support Mental Health Together, Mental Health Together Plus and Memory Assessment Service. Rio has been redesigned to support new business processes and made it much easier to identify exactly where a patient is on their pathway. A new physical health portal has been implemented which enables all clinicians to collaborate across teams, rather than each team having a separate physical health form. The team has been working to enable access to GP systems (EMIS) from within Rio in the same way that the Kent and Medway Care Record is accessed, this will be available in the next few weeks. The Digital Skills Survey has identified that 20% staff do not feel confident using digital we are now able to identify specific areas that need to be targeted to improve confidence, including use of Rio. It was pleasing to see that the national EPR survey found improvement in KMPTs staff opinion of Rio.
Sharing information and data internally is smoother and quicker and we have one version of the truth		On Target	A new suite of power BI dashboards have been developed and deployed over the previous 12 months, making it much easier to share information and support the work of corporate initiatives.
Electronic solutions have been deployed for medicines, ordering investigations, patient safety alerts and bed management		Off Target	Electronic Prescribing and Medicines Management have been implemented for inpatient settings. There has been a delay implementing to community settings as the Civica product does not yet have integration with pharmacy systems.
Electronic solutions have been delivered for referrals and consultations		Off Target	. This outcome is partially delivered in that electronic solutions have been delivered for video consultations. However, there have been delays in the delivery of e-referrals but a project is in-flight to implement a solution.
A service user portal has enabled access to personalised information and freedom to control their own care		On Target	KMPT has procured the Patient Knows Best, Patient Portal utilising Frontline Digitisation Funding from NHS England which was awarded in November 2024. The design and name of the portal has been assisted by patients with experience of our services. Perinatal and EIP are likely to be the first services to go live with PKB, with an anticipated go live date September this year. Many patients across Kent and Medway already use Patients Know Best as this product is used by a number of Acute Trusts and so many patients are already familiar with accessing their record and receiving their letters electronically.
Embed hybrid working		Off Target	The Hybrid working policy was reviewed last year and has now been fully implemented and embedded in the organisation. We are monitoring the utilisation of room/desk bookings and bookable space is part of the criteria for any new accommodation.

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			Work still required to map hybid roles in line with the accommodation available within the Trust. This work has been delayed due to the loss of Magnitude House but will be recovered quickly once a new site is secured.
Secure shared clinical spaces with our partners		Off Target	KMPT now has access to the use of Healthy Living Centres in the Rochester & Swale area. We continue to seek opportunities for shared spaces across the system, however, many of our partner organisation have a greater need for space than they can accommodate and therefore we have not progressed as we would have liked in securing more shred spaces.

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Wider progress and issues

Data and Reporting

Across our strategic priorities we are continuing to take a more data driven approach. This is a more mature and improvement-led way of problem solving for our organisation and has meant the scoping phases have taken us longer so that we can benchmark effectively. It has also highlighted the importance of having clear operational definitions for all strategic metrics to ensure progress can be measured.

A number of programmes have experienced difficulty in terms of availability and quality of data over the last 2 years. Much of this issue is due to the culture around data within the organisation and our people understanding the importance of this, why it must be collected, and how it can be used to improve services, we have continued to develop and embed this way of thinking throughout year 2 of the strategy.

We have also started to use performance data within frontline services to encourage shared ownership of problem solving and improvement. An example of this is the introduction of 'tiered accountability' in the Dementia programme. We have introduced visual management across our memory assessment services over the last 4 months. This visual management includes performance data around the 6-week diagnosis target as well a specific focus on patients who have been waiting over 52 weeks for a diagnosis.

Frontline staff then meet weekly to review their data and discuss opportunities to make improvements locally. This has contributed to the significant increase in diagnosis within 6 weeks performance form 7.7% in April 2024 to a peak of 33.8% in February 2025 with a significant step change from 18.3% in October '24 to and 26.1% and 25.6% in November & December respectively when tiered accountability was introduced and we have seen a steading increase in performance month on month.

Since February, individual MAS teams have been focusing on seeing and diagnosing those patients that have been waiting the longest, over 52 weeks. By using the same approach of reviewing their performance data, engaging in problem solving and shared ownership of the problem. We have seen the number of patients waiting over 52 weeks reduce from 260 in February to 180 in May, a reduction of 31.3% in approximately 12 weeks.

As we rollout the Doing Well Together improvement programme in year 3, we will utilise this approach across many of our programmes through the improvement management system such as CRfD, Dementia and elements of CMHF

Transition to year 3 of the 2023-2026 strategy

In March, the board agreed the metrics and approach for year 3 of the current strategy. Year 3 builds on the more focused approach of year 2 by categorising metrics, in 4 areas:

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

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

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

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

Appendix B shows an overview of the agreed metrics for year 3 of the strategy. To note; two key projects; housing and in-patient rehabilitation have had initial review and a paper will come to Board in July for a decision.

Work is under way to transition the year 2 priority programmes into the agreed approach for year 3. This will involve transitioning some projects to business as usual activity, ensuring that performance will continue to be monitored in the appropriate forums as well as mobilising new projects/ programmes.

Appendix C is the high-level plan to show when each of these transitions will take place.

Resourcing and support for these programmes will change as we embed the Doing Well Together Improvement programme and move towards a more de-centralised, frontline driven approach to most of our improvement work

Conclusion

In March 2023 we set an ambitious strategy to transform KMPT, which set out key deliverables to improve what we do for our patients, our people and our partners.

The first year of our strategy we focused on building the foundations which would enable us to deliver the year 2 outcomes we set ourselves. In Year 2, we have achieved progress in a number of our complex improvement programmes despite the challenging operational environment. Whilst also acknowledging that there are a number of internal challenges we are yet to overcome. We have made improvement in our use of data, there is still work to do to further improve both the quality and availability of data to enable us to drive sustainable improvements, which have the biggest impact on the priorities and drive better care for our patients. In addition to this changing the culture in the organisation to data being recognised as a tool to drive improvement of our services.

As we enter year three of the strategy there are learnings from years one and two that are built into both the delivery plan and how the organisation functions especially in terms of data, culture and leadership. The rollout of the Doing Well Together Improvement programme is underway with regular training underway to upskill individuals in problem solving techniques, with priority being given to those directly involved in our year 3 priorities.

The improvement management system is also being rolled out to embed continuous improvement into the daily business to create a culture of shared ownership and understanding around our strategy and the associated improvement programmes.

The following Appendix can be found in the reading room;

Appendix A – Trust Performance Scorecard (April 2025)

Appendix B – Overview of year 3 strategic delivery plan

Appendix C – High-level Transition Plan

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Update
Author:	Jane Hannon, Programme Director Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview of the programme and delivery metrics for the Mental Health, Learning Disability and Autism Provider Collaborative (MHLDA PC).

We will be working to update our vision and deliverables for each programme, including a focus on our 2 June MHLDA workshop.

Issues to bring to the Board's attention

The Dementia Turbo-week in May 2025 had strong engagement from across sectors and was able to validate and further define our system dementia diagnosis model.

Governance

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

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

Programme	2025			2026		
	29 May	31 Jul	25 Sep	27 Nov	29 Jan	26 Mar
Community Mental Health Framework						
Dementia Diagnosis Pathway						
Urgent and Emergency Care						
Out-of-area LDA placements						
New joint board with community						
Joint Clinical Care Pathways						
Physical and Mental Health Ward						

2. Programme updates May 2025

Joining up work to provide sustainable community services

Senior Responsible Officers (SROs) Sheila Stenson and Mairead McCormick (Chief Executive Officer, Kent Community Health Foundation Trust - KCHFT) have agreed there is a need to bring together the work of the two boards in order to:

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

We have a number of programmes in existing Provider Collaboratives, that now need to align. The information below sets out the areas we will focus on together.

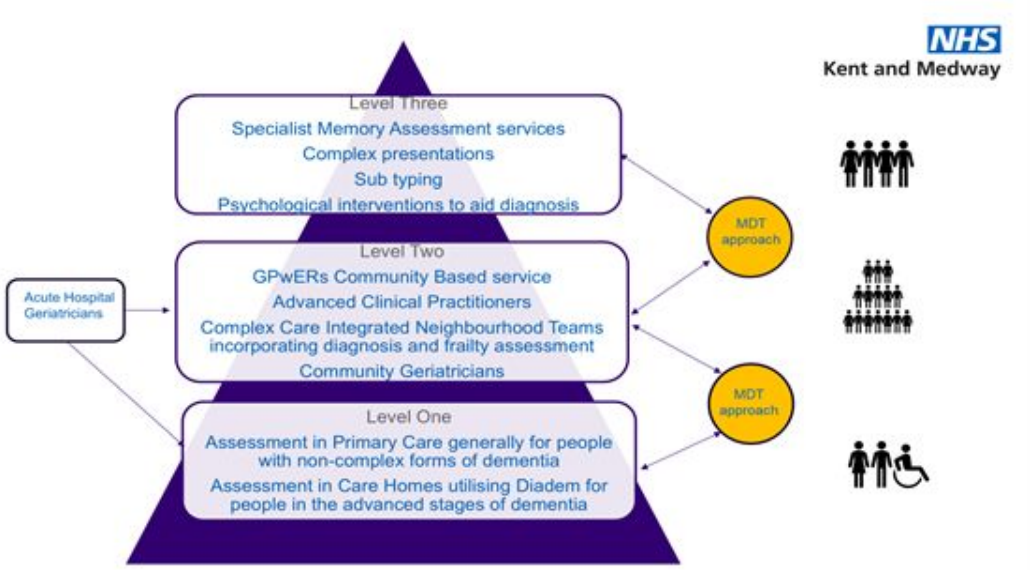
- **Community Mental Health Framework**. Embedding the improved front door function, implementing learning and stabilising the new model
- **Integrated Neighbourhood Teams**. Confirming the model and funding framework including agreeing the number of teams and developing an implementation plan
- **Dementia and Aging Well**. Agreeing the model and implementation plan with timescales and rolling it out across the system
- **Better Use of Beds**. Full implementation of the county wide programme including confirming the impact on beds and finance
- **Back office**. Devising an implementation plan for Finance, HR and Digital and agreeing timescales for delivery across KCHFT and KMPT
- **Mental Health Urgent and Emergency Care.** Embedding and building on improvements to the Mental Health Crisis Pathway
- **Physical Health/Mental Health Ward**. Establishing an Elderly / Frail ward in Thanet as a mental and physical health ward

Dementia Diagnosis Pathway

A Turbo-week was held at the beginning of May 2025. This was led by the joint Senior Responsible Officers (SROs) Adrian Richardson and Rakesh Koria. The Provider Collaborative provided overall coordination with support from KMPT and Integrated Care Board (ICB) Colleagues.

During the week existing work was mapped and the details of "who does what" in each level of the new model were explored. There was a high level of consensus and some quick wins were identified.

The new model is as follows:



Level one relates to people (65 years and above) in a residential or nursing home with undiagnosed dementia and housebound patients with advanced symptoms of dementia.

Care staff can undertake triage and support with pre-assessment paperwork. 70% of people in care homes are thought to have dementia, but a lower percentage is recorded within the dementia register. This group will likely be at a more advanced stage of dementia. GPs with Extended Roles will lead the diagnosis for this group, with access to consultant psychiatrists for advice and input where there are more complex diagnoses.

This model is already in place in some areas and the action plan will involve systematising this and spreading it across Kent and Medway, including working with primary care colleagues to ensure we have best use of their time and capacity.

Level two relates to people living in community settings who have dementia. It was agreed at the workshop that the default source of diagnosis will be in primary care, within a primary care multidisciplinary model mobilised to support this work. At the workshop we explored and confirmed some of the flags that would lead to a referral to secondary services such as Complex atypical presentations requiring psychological input or diagnostic uncertainty despite community level interventions. At the current time these people are all being triaged in secondary care. Going straight to primary care will reduce waits and redirects, but there will be a requirement for a shift of resources from secondary to primary care. We now have the first cut of the capacity and demand model for this and a timeframe for working through the more detailed implementation planning.

Level three relates to people whose diagnosis is more complex and need the specialist input of a secondary care psychiatric multidisciplinary team overseen by a Consultant Psychiatrist. For example, people with cognitive issues who are under 65 (early-onset), complex atypical

presentation, or a learning disability These referrals will take place in the Memory Assessment Service.

Running through each of these levels will be a multidisciplinary approach, person centred planning, flexible transition between levels with clear protocols to guide this, based on need.

Outputs of the turbo-week

- The turbo-week gained validation of the new model including co-creation of criteria and pathways
- We now have a detailed map of voluntary sector provision across Kent and Medway
- A capacity and demand model has been built in partnership between KMPT and the ICB. This includes a number of assumptions and the plan is to validate these through clinical pilot work.
- Implementation plans and timelines have been drafted for each level of the model. These aim to have all levels implemented by the end of 2025, embedding in early 2026 (quarter four 2025-2026.

Next steps

- Validate capacity and demand assumptions
- Use the model to generate a clear picture of our funding gaps and draft timelines for meeting our targets (95% of people diagnosed within 6 weeks and 66.7% Dementia Diagnosis Rate)
- Present draft timelines and capacity gaps to MHLDA provider Collaborative and Aging Well Board in June 2025
- Work with the ICB to agree how funding gaps will be addressed during June and July 2025
- Continue with implementation, aiming to complete this by the end of 2025.

3. Collaborative Programme Visions and Deliverables

We will be meeting on 2 June 2025 with stakeholders to firm up our visions for each programme and our expected milestones and we will bring these back to the July Board.

Areas to note here are that:

- The CMHF workplan is being refreshed following the peer review
- Core 24 services are now funded across all sites and recruitment is in progress, with good performance against the one-hour triage target
- Centralised Health Based Place of Safety (HBPOS) was due to be completed in Q1 and will now be implemented in Q3 due to estates challenges

4. Current performance data

Measure	Agreed trajectory	Current data						Trend
		Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	
Programme: Dementia Pathway Transformation								
Increase dementia diagnosis rate	66.7% by March 2026	60.5%	60.4%	60.3%	60.5%	60.9%	-	→
Programme: Mental Health Urgent and Emergency Care								
Reduced MH A&E attendance and increase in attendance at safe havens	Reduction	*A&E attendances for adult patients with primary MH need*						↑
		878	805	798	824	893	-	
		Safe Haven attendance						↓
		1436	1515	1630	1522	1585	-	
Reduced mental health in ambulance/ police conveyances to A&E	Reduction	*Primary MH A&E presentation - Ambulance conveyance*						→
		389	342	326	320	429	-	
		Primary MH A&E presentation - Police conveyance						
		36	39	31	49	32	-	
Reduction in incidence of Section 136	Reduction	69	52	64	81	63	-	→
Programme: Out-of-area Autism placements								
Reduction in patient cohort out of area	Reduce 25% by Mar 2025	Against target - 25% of original cohort reduced						↓

Exception reporting on performance

Urgent and Emergency Care

- The number of A&E attendances with a primary presentation of mental health increased in March. This was in the context of an overall increase in A&E attendances and the percentage of primary mental health presentations was flat at 1.3%.
- From July we will bring percentage crisis house occupancy.

Community Mental Health Framework

- There has been a reduced percentage of MHT and MHT+ referrals starting treatment within 4 weeks. There is improvement focus on front door multidisciplinary team patient allocation. Recruitment of voluntary sector 'navigators' is complete.

Dementia Pathway Transformation

- The 6-week diagnosis rate has shown improvement but still below target of 95% and dipped to 26.3% in April 2025.
- The overall Dementia Diagnosis Rate is not yet showing overall improvement, despite high performance in some areas. A new model is in development to address this, including spreading the learning from Dartford.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

A paper setting out the Trust's performance across the three Ps' ("People we care for"; "People who work with us"; and "Partners we work with") from our trust strategy with aligned the targets and metrics.

Issues to bring to the Board's attention

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 stat along with dementia services. Key areas of improvement in recent months are also noted. The reporting against each domain additionally highlights area of improvement and concern with additional details.

Governance

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Integrated Quality & Performance Report

(IQPR)

May 2025

Contents

1. Chief Executive Overview

This report highlights trust performance, focussing on areas of concern and where performance is improving and what actions we are taking to address areas of concern. This month I have focussed my overview on our current bed state and what we are doing to manage this on a daily basis.

Patient flow / Bed state

Our bed state continues to require an un-relented focus. Bed occupancy is at 94.2%, our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients has increased in the last 6 months from below 50 to 92.3 days in April. We have 15 acute patients currently placed out of area as at 13th May, to ensure we can admit patients in a timely manner to a bed when required.

As an executive team we have developed a plan being led by our Chief Medical Officer supported by the whole team to approach how we manage flow in a different way to how we have in the past. We will be taking the following short-term actions over the coming weeks:

1. Rapid reduction of CRFD pressures across our acute beds - Reduce total CRFD position by 25% at week 4 and 50% by week 8
2. Effective use of voluntary and community sector (VCSE) capacity for 50% of CRFD patients
3. Eliminate OOA bed use by week 4 of our plan
4. Improved flow by reconfiguring a younger adult step-down ward through release of capacity by reducing the number of CRFD patients we have in our beds
5. Strengthening of social care discharge processes

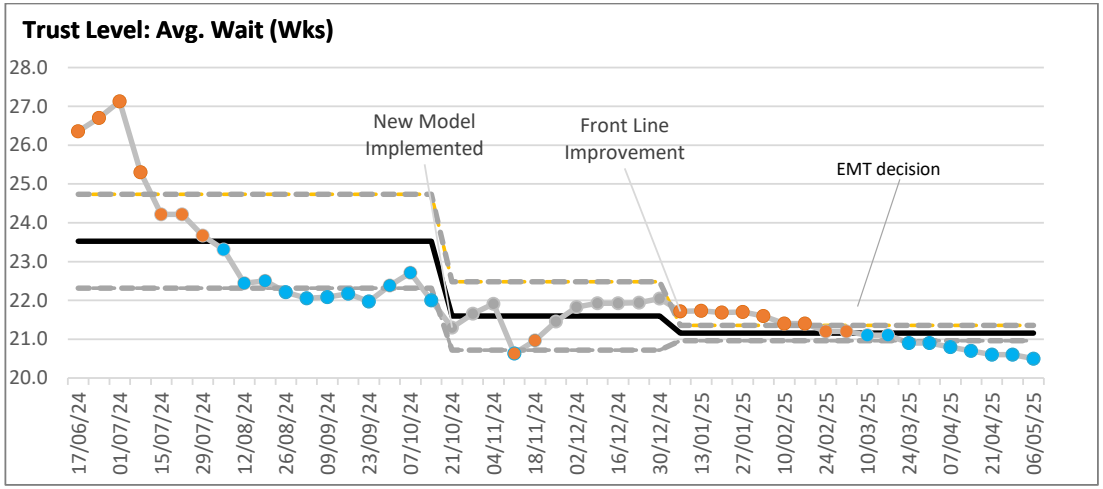
The plan is for a total of 8 weeks working closely with our social care colleagues to support our patients with the next stage of their care.

Dementia

Earlier this month KMPT hosted a turbo week with the aim to accelerate collective system-wide progress in line with the NHS Long Term Plan and Kent & Medway's ageing well priorities. 36 organisations across health care, voluntary, community and social enterprises came together to collective work together to deliver the agreed community model. The plan is being finalised with the aim to implement care home and community assessment and diagnosis through 2025/26.

Progress continues within KMPT in embedding the standalone Memory Assessment Services (MAS). 26.3% of patients were diagnosed within six weeks in April across KMPT.

April's performance is a reduction compared to the previous two months which is attributed to the work on long waits. In February the decision was made to focus on the longest waits (over 52 weeks) and since February we have seen a 30% reduction in the number of patients waiting over 52 weeks.
The impact on this work is reflective in the average wait time for assessments which has continued to reduce to 20.5 weeks which is 7.5 days below the national average. There is a drive across all directorates to eliminate waits over 52 weeks (where not clinically relevant) by the end of summer.



In April our DGS team achieved 63.6% for the month and it is noted there is variation in performance across the six teams. Work is underway to address variation across teams and our front-line improvement work as well as closer operational and clinical review will continue to reduce variation for the rest of this year.

Further areas I'd like to note;

Mental Health Together: We continue to experience high demand for Mental Health Together (MHT) services, with an average of 3,627 referrals per month since July 2024. As of the May 8th 2,379 patients are awaiting the first contact with MHT, a reduction of 777 over the last two months. Of those awaiting their first contact 1,916 (67.6%) have been waiting under four weeks for their first contact. There are 4,012 patients who have received their first contact and are currently awaiting the commencement of an intervention.

Our ongoing focus remains on:

- Reducing long waits and prioritising patients that have been waiting between over 18+ weeks
- Model refinement in partnership with our partners to support swifter access to treatment
- Activity oversight to ensure capacity is utilised appropriately across all teams
- Improvement of data quality

Collaboration with partners and those with lived experience is excellent with good engagement from staff working in all elements of the services. Over the coming months and in addition to model refinement, focus will centre on data, digital solutions and workforce.

On a positive note, there are some areas of performance to be celebrated.

- Improvements have continued in the percentage of Liaison Psychiatry referrals closed within 12 hours for those not requiring a bed, 80.4% in April compared to consistent levels below 30% in 2024. The percentage of liaison referrals triaged within an hour also continues to be achieved for close to 90% of all referrals.
- Care plans for those on CPA continue to see compliance at around 90% for the third successive month, an increase of 10% since the start of the year.
- It is positive to reflect on consistent achievement of over 80% for patients receiving follow-up within 72 hours of discharge following changes implemented in early 2024.
- Workforce metrics for vacancies, training and turnover continue to show sustained improvements and attainment of the targets set.

Dialog assessments in community services exceeded 2,000 in a month for the first time, building an enhanced baseline of scores to allow greater application of analysis of outcomes to help inform future service provision.

Report Guide

Statistical Process Control (SPC) is used to assist in the identification of significant change (see appendix for detailed information regarding this process), the tables within the next section of this report summarises variation in performance over time and assurance where targets exist. The intelligence from this analysis is used alongside wider intelligence within the organisation to highlight the areas of celebration and challenging within the Chief Executives Overview.

Section four presents a 12-month trend for all indicators by domain, within the summary tables levels of performance are colour coded against stated target (where they exist). Where an indicator is rated as amber, this denotes that the current level of achievement is within 10% of achieving its target. Red denotes a metric breaching the target and green where achieving.

Within each domain the indicators identified as subject to significant variation through the use of SPC are analysed further with supporting information regarding the definition, any known data quality and key variances across the directorates.

The latest published position for the Single Oversight framework is shown in the appendix. The majority of the indicators are annual measures and therefore not contained within the monthly IQPR, however it is important to ensure the trust continues to work to improve in these areas alongside those included within the IQPR.

2. Integrated Quality and Performance Summary

Variation Summary (where targets exist)

The following table summarises trends of variation and assurance for those indicators where targets are identified.

Variation	Assurance: Variation indicates consistently (P)assing the target.	Assurance: Variation indicates inconsistently passing and falling short of the target.	Assurance: Variation indicated consistently (F)alling short of the target.
Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	3.1.02: Vacancy Gap – Overall 3.1.03: Essential Training For Role 3.1.05: Leaver Rate (Voluntary)	3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected. 4.1.07: Agency spend as a % of the trust total pay bill	1.1.05a: Liaison Psychiatry referrals discharged within 12 hours 1.2.10: %Patients with a CPA Care Plan
Common cause – no significant change.	3.1.06: Safer staffing fill rates	1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral 1.2.01: Average Length Of Stay (Younger Adults Acute) 1.2.02: Average Length Of Stay (Older Adults - Acute) 1.2.06: Readmissions within 30 days (YA & OP Acute) 1.3.01: Mental Health Scores from Friends And Family Test – % Positive 1.3.08: Complaints acknowledged within 3 days (or agreed timeframe) 1.3.09: Complaints responded to within 25 days (or agreed timeframe) 1.4.04: Restrictive Practice - No. Of Prone Incidents 1.4.05: Decrease Violence and aggression on our wards 2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge) 3.1.01: Staff Sickness – Overall	1.1.05b: Liaison Psychiatry referrals identified as requiring a bed discharged within 12 hours 2.1.05: Clinically Ready for Discharge: OP Acute 4.1.01: Bed Occupancy (Net)
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	3.1.07: Increase percentage of BAME staff in roles at band 7 and above	1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans 2.1.04: Clinically Ready for Discharge: YA Acute

Variation Summary (No targets)

The following indicators do not currently have an identified target nationally or locally and therefore can only be measured against trends in variation. Work is under way to establish local targets for an increased number of IQPR indicators.

Variation

Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	1.1.03: Assess people in crisis within 4 hours 1.1.04: People presenting to Liaison Services: triaged within 1 hour 1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks 1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)	
Common cause – no significant change.	1.1.02: Open Access Crisis Line: Abandonment Rate (%) 1.1.06: Place of Safety LoS: % under 36 hours 1.1.09: % MHLD referrals commencing treatment in 18 weeks 1.2.03: Adult acute LoS over 60 days % of all discharges 1.2.04: Older adult acute LoS over 90 days % of all discharges 1.2.05: Patients receiving follow-up within 72 hours of discharge 1.3.02: Complaints – actuals 1.3.03: Compliments – actuals 1.3.04: Compliments - per 10,000 contacts 1.3.05: Patient Reported Experience Measures (PREM): Response count	1.3.06: Patient Reported Experience Measure (PREM): Response rate 1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly % 1.4.02: All Deaths Reported And Suspected Suicide 1.4.03: Restrictive Practice - All Restraints 1.4.06: Medication errors 4.1.02: DNAs - 1st Appointments 4.1.04: In Month Budget (£000) 4.1.05: In Month Actual (£000) 4.1.06: In Month Variance (£000)
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) 1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end 2.1.01: Referrals to MHT commence treatment within 4 weeks 2.1.02: MHT waiting list size 4.1.03: DNAs - Follow Up Appointments	
Special cause variation where movement is not necessarily improving or concerning	1.1.01: Open Access Crisis Line: Calls received 2.1.03: MHT 2+ contacts	

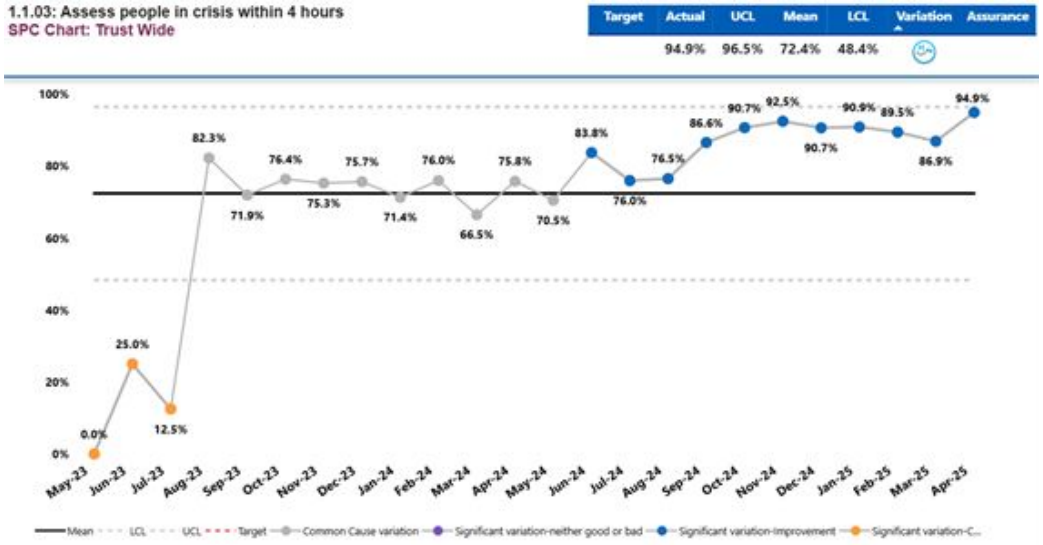
3. Trust Wide Integrated Quality and Performance Dashboard

People We Care For: Access

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
1.1.01: Open Access Crisis Line: Calls received		3,258	3,022	3,640	3,415	3,607	3,509	3,195	3,287	3,373	2,920	3,362	3,229
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		34.1%	25.0%	28.1%	22.5%	23.2%	24.1%	20.4%	22.1%	26.8%	30.9%	33.6%	31.5%
1.1.03: Assess people in crisis within 4 hours		70.5%	83.8%	76.0%	76.5%	86.6%	90.7%	92.5%	90.7%	90.9%	89.5%	86.9%	94.9%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		46.0%	58.4%	69.5%	77.4%	81.1%	81.5%	88.3%	87.6%	90.6%	83.4%	88.0%	88.6%
1.1.05a: Liaison Psychiatry referrals closed within 12 hours	95.0%	23.5%	24.4%	25.4%	25.7%	29.4%	23.3%	27.7%	39.2%	53.0%	61.9%	78.1%	80.4%
1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	0.0%	3.8%	4.2%	3.6%	4.8%	0.0%	0.0%	6.3%	6.1%	3.3%	5.4%	6.8%
1.1.06: Place of Safety LoS: % under 36 hours		57.8%	74.5%	69.8%	79.7%	61.7%	56.0%	60.0%	79.2%	69.8%	75.0%	69.0%	75.0%
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%	76.5%	100.0%	61.1%	60.0%	61.9%	59.1%	85.0%	66.7%	58.3%	75.0%	61.5%	52.6%
1.1.08: % of people referred for a dementia assessment and diagnosed within the month that were diagnosed within 6 weeks		8.8%	25.5%	11.1%	16.9%	14.5%	18.3%	26.1%	25.6%	28.3%	33.8%	31.2%	26.3%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		78.6%	79.3%	67.7%	78.1%	75.0%	72.1%	83.3%	87.1%	85.4%	94.1%	92.1%	88.6%
1.1.10: Perinatal assessments (against annual target)	2,103	138	157	160	114	127	155	166	146	193	136	158	514

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

Areas of Improvement & Sustained Achievement of Target

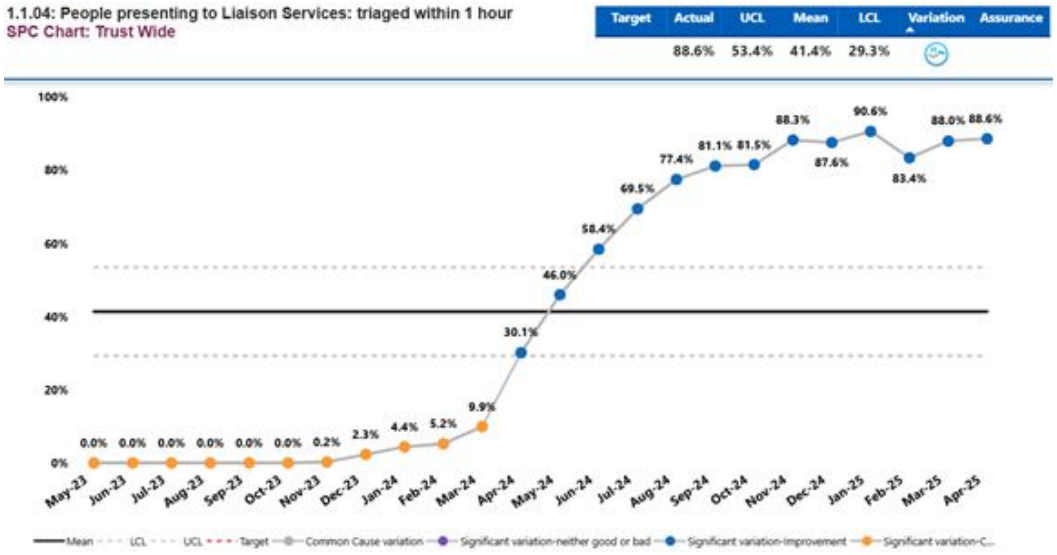


Data Source
Rio

What is being measured?
Time from referral to 1st assessment, where the referral urgency is recorded as 'emergency'. This relates to Rapid Response and Home Treatment Teams.

Data Quality Confidence
Previous issues identified with recording of referral urgency have seen improvements.

What is the data telling us?
Overall trust activity for this measure reflects 158 crisis assessments in month. West Kent was previously an outlier but in recent months directorate comparisons are more aligned.

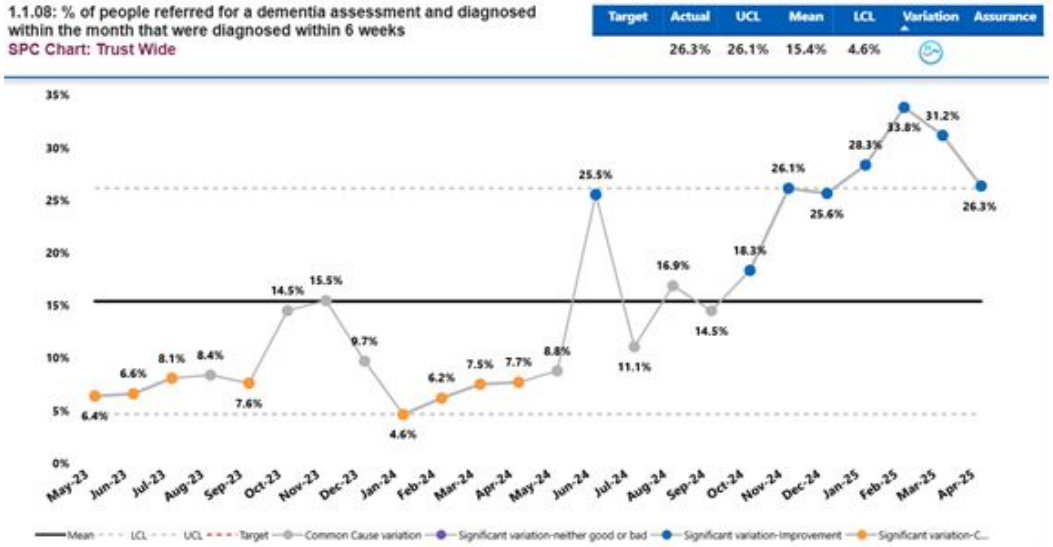


Data Source
Rio

What is being measured?
Time from referral to a 'triage' assessment within 1 hour.

Data Quality Confidence
A new code of 'Triage' was implemented to support a new model of care. This took some time to embed but increasingly reflecting a level of completeness in line with comparable historic data. Small variations continue to be investigated individually

What is the data telling us?
Regardless of the category used, all patients seen by a KMPT mental health professional within A&E settings will be triaged even when this is part of a fuller assessment.
Performance dropped in all three directorates in February, corrective action was taken and improvements evidenced.



Data Source

Rio

What is being measured?

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

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 the data telling us?

372 diagnoses were recorded in April. This number is below what is needed to positively impact the Kent and Medway system dementia diagnosis rate (DDR) target.

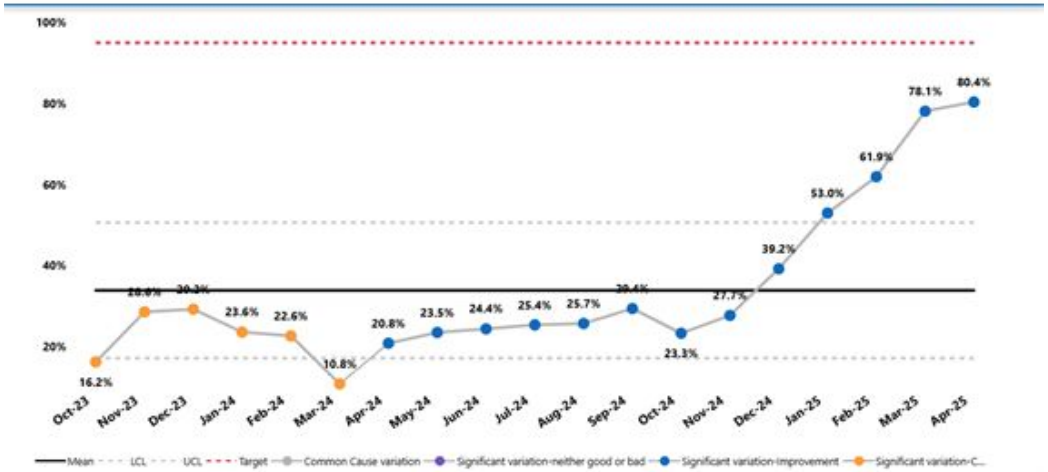
2,725 patients remain waiting for a diagnosis as at 12th May with an average wait to date of 20.5 weeks (which is 7.5 days below the national average).

Performance against the 6 weeks objective has reduced since February due to a focus on eliminating patients waiting un-necessarily over 52 weeks. On 12th May there were 180 patients with waits in excess of 52 weeks.

Areas of Concern

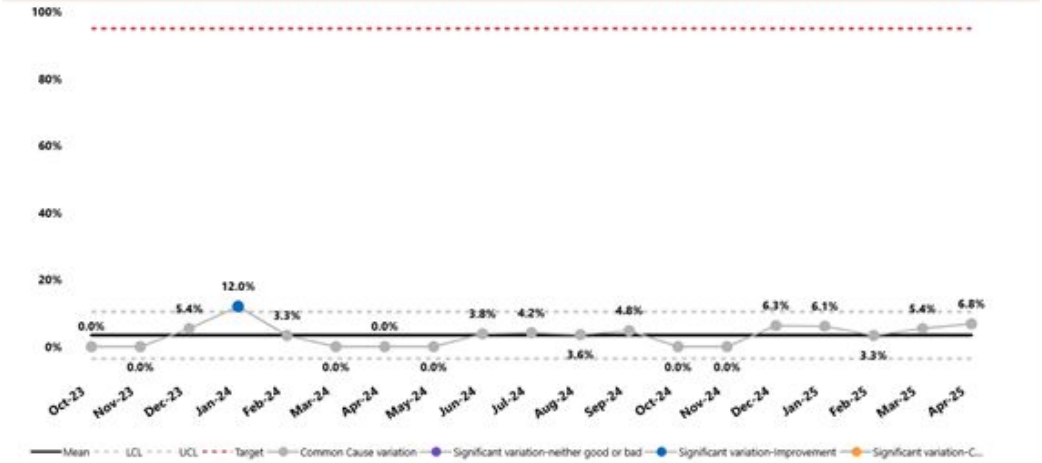
1.1.05a: Liaison Psychiatry referrals closed within 12 hours
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
95.0%	80.4%	50.6%	33.9%	17.2%		



1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
95.0%	6.8%	10.4%	3.4%	(3.6%)		



Data Source

RiO

What is being measured?

1.105a: Referrals closed to Liaison in period where referral urgency is urgent or emergency and discharge reason is not 'Admitted elsewhere (at the same or other Health Care Provider)'
1.1.05b:Referrals closed to Liaison in period where referral urgency is urgent or emergency where discharge reason is 'Admitted elsewhere (at the same or other Health Care Provider)'
% where the total referral length was 12 hours or less from the date and time referral to liaison team

Data Quality Confidence

New measure in February 2025, weekly monitoring and investigation establishing data quality confidence

What is the data telling us?

These are measures to reflect pressures in the Liaison teams and a consequent impact of delays on acute trusts Emergency Departments.

989 Liaison referrals were closed in April for those patients not identified as needing a bed. Variation in performance across teams has narrowed, all teams achieved in excess of 72%.

44 Liaison referrals were closed in April for those patients identified as needing a bed. This patient group is experiencing longer lengths of referral with only three patients being discharged from liaison within 12 hours from the referral time.

As a new indicator support is being provided to teams to ensure all referrals are close on RiO in an accurate and timely manner to ensure the data is an accurate representation.

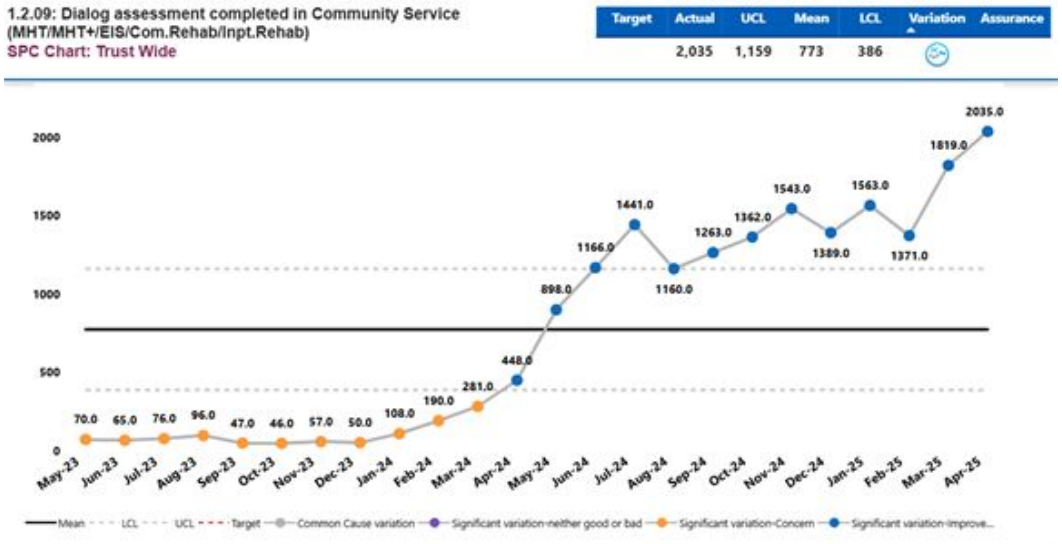
People We Care For: Care Delivery

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	35.1	42.9	35.2	42.3	36.3	34.0	34.6	40.3	35.0	51.5	49.4	36.9
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	81.2	97.9	102.1	79.8	82.5	85.8	95.2	103.2	63.3	124.4	125.8	87.7
1.2.03: Adult acute LoS over 60 days % of all discharges		11.9%	15.3%	15.5%	14.9%	12.9%	13.9%	13.9%	16.5%	19.1%	17.3%	22.6%	18.4%
1.2.04: Older adult acute LoS over 90 days % of all discharges		29.0%	34.8%	37.0%	44.4%	37.9%	42.3%	41.4%	31.3%	28.0%	57.1%	48.0%	35.1%
1.2.05: Patients receiving follow-up within 72 hours of discharge		81.7%	80.7%	87.2%	82.3%	86.9%	82.3%	85.5%	78.2%	84.3%	85.0%	84.5%	82.8%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	11.0%	13.1%	10.4%	13.2%	12.7%	18.0%	11.7%	13.1%	12.2%	8.8%	11.9%	11.5%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		291	245	340	377	454	373	303	264	467	596	926	1,026
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end		8	9	13	13	17	11	9	9	27	24	36	31
1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab)		898	1,166	1,441	1,160	1,263	1,362	1,543	1,389	1,563	1,371	1,819	2,035
1.2.10: %Patients with a CPA Care Plan	95.0%	86.0%	87.8%	86.6%	85.6%	82.5%	80.6%	82.4%	80.0%	87.1%	90.1%	89.3%	89.5%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	75.2%	73.8%	73.7%	72.9%	72.3%	71.4%	72.2%	72.1%	72.4%	71.4%	70.7%	71.6%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	68.8%	69.0%	67.0%	65.0%	64.0%	62.3%	60.1%	55.8%	58.6%	62.4%	61.1%	56.4%

Notes:

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. 1,026 bed days were used in April 2025, 282 were female PICU patients within contracted beds resulting in 744 out of area placement days as an accurate reflection of trust performance.

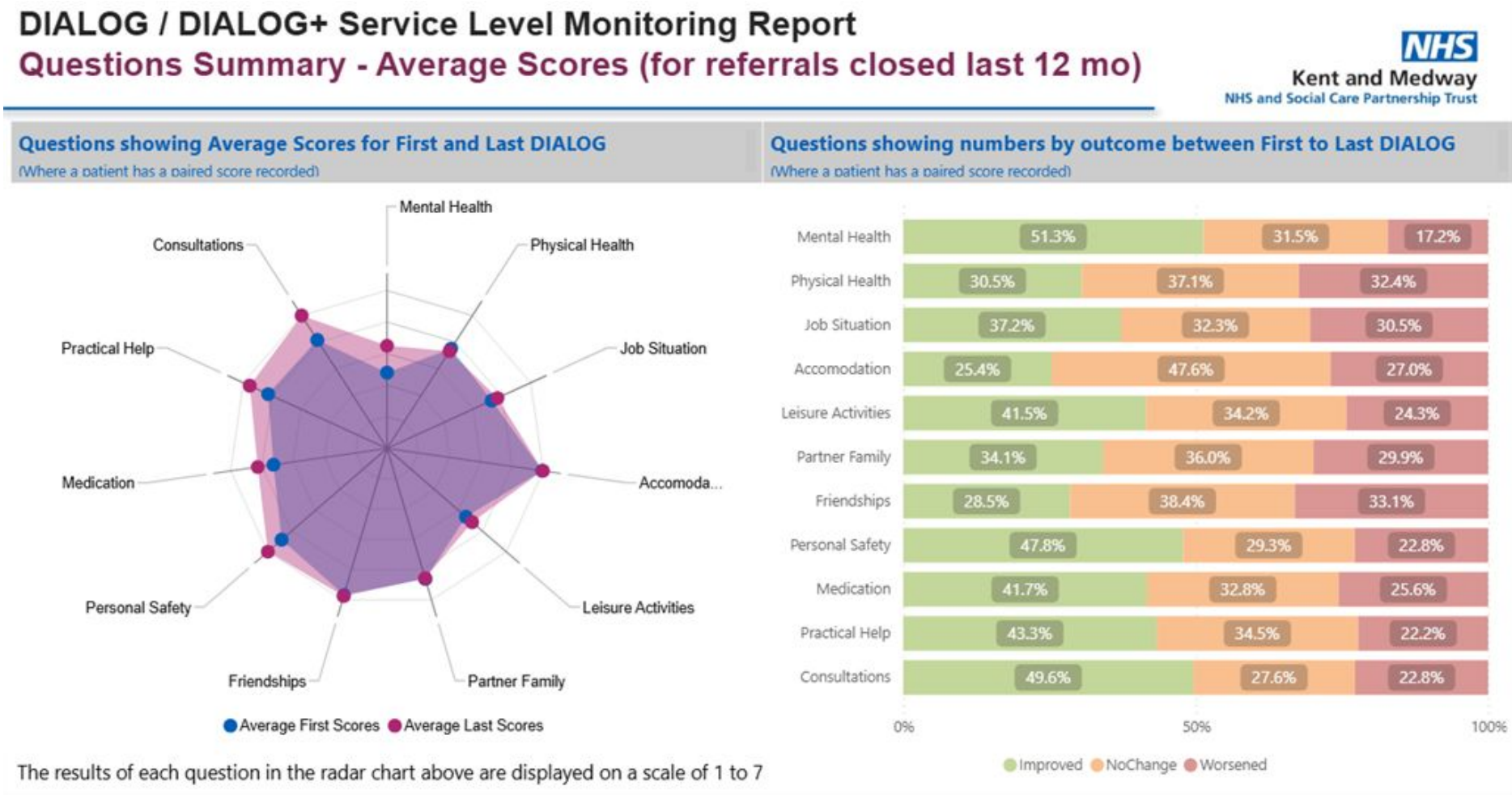
Areas of Improvement & Sustained Achievement of Target



Data Source
Rio
What is being measured?
The number of Dialog+ assessments recorded on Rio for all community teams.
Data Quality Confidence
No known issues
What is the data telling us?
The ability to benchmark across teams is emerging now that MHT has been implemented in all localities. A significant increase in the number of Dialog+ assessments across community teams has been observed in the last two months, April saw the first month in which over 2,000 dialog scores were recorded. Subsequent work is underway to monitor paired scores, insights into patient presentations and measurable improvements. These measures will become more robust as more Dialog+ roll out continues and more patients' complete interventions.

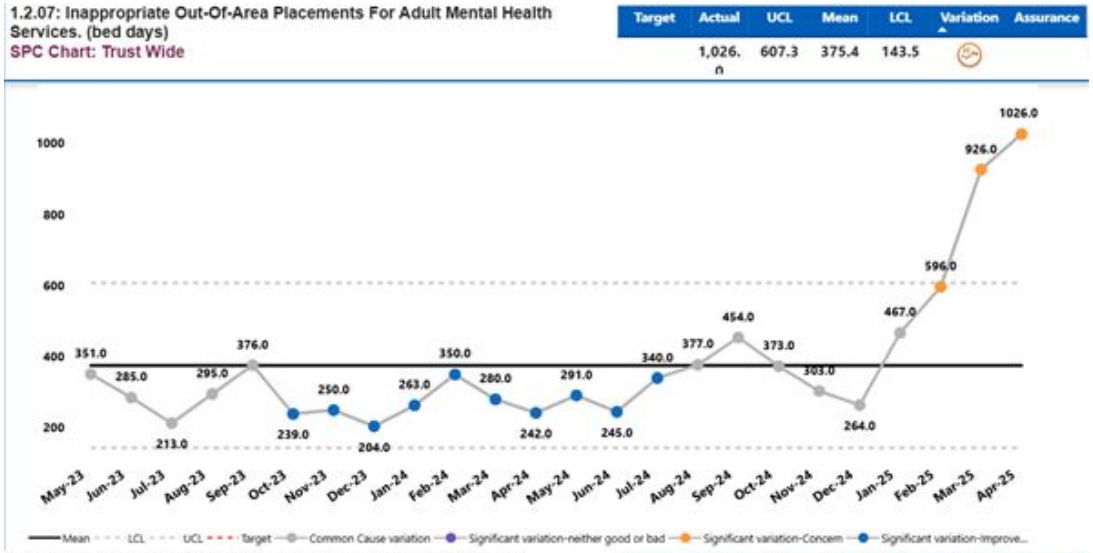
DIALOG+ will eventually be used in place of the Care Programme Approach (CPA) across Community Adult Mental Health services. Dialog+ is a set of questions where patients rate their satisfaction with life domains and treatment aspects. The scale has been shown to have good psychometric properties and is widely used to evaluate treatment. Measuring outcomes provide a way for patients, clinicians, services and the Trust to understand the impact of the care provided. Services using DIOLOG+ are already using the data to inform practice.

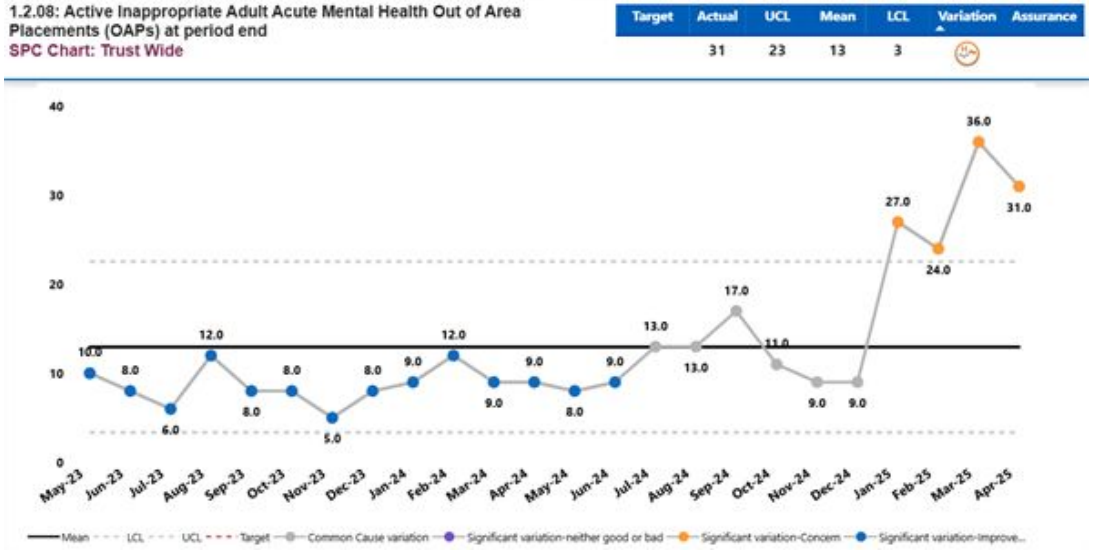
Whilst the focus of this measure in 2024/25 is to measure the uptake of Dialog+ the intention remains to develop this further to extract the resulting intelligence from the outcome scores captured. There are increasing numbers of paired scores being created as patients move through their episodes of care but sample sizes for in depth analysis remain low. Monitoring tools exist to allow analysis of paired scores where they exist as per the example below for those discharged from MHT with a paired score demonstrating improvements, particularly in the domains of Mental Health, Personal Safety and Medication.



The above extract from the Power BI report is demonstrating that improvements are being evidenced in all domains captured by DIALOG. The left had chart shows the presenting need (blue dots) and the subsequent scores (pink dots) for patients with paired scores, the greatest difference being evidenced in Mental Health, Job Situation and Consultations. The second chart shows what percentage of each domains paired scores are demonstrating improvement. The data represents a sample of 408 patients who have been discharged with a paired Dialog score

Areas of Concern





Data Source

Rio

What is being measured?

Total number of occupied bed days in external / out of area placement in the period

Total number of patients occupying bed days in external / out of area placement at the end of the period

Data includes Cygnet Hospital Godden Green (female PICU), whilst under a contract within Kent MHSDS submissions do not allow for separation and therefore methodology reflected here to align with national data

Data Quality Confidence

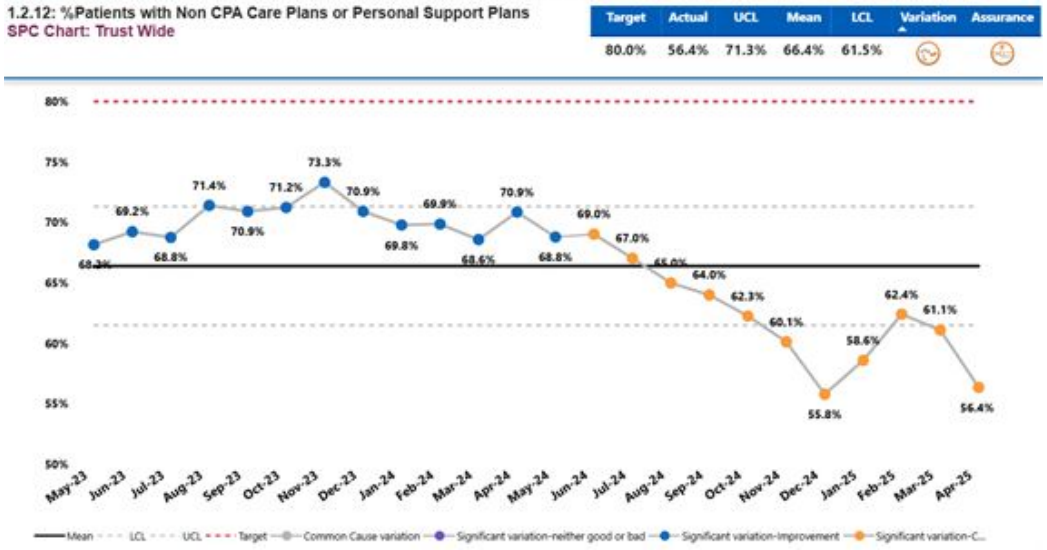
No known issues

What is the data telling us?

Both Indicators have shown special cause variation of a concerning nature in recent months due to significant increases in bed use.

In April 282 Female PICU beds were used which equates to 9.4 per day compared to a 12 month average of 6.6 per day.

Acute beds and Male PICU external bed days were 495 and 249 respectively. As a group this equates to 24.8 per day on average in April compared to a 12 month average of 7.6 per day



Data Source

Rio

What is being measured?

The % of patients where a CPA Care or Personal Support Plan created or updated in the last 6 months.

Data Quality Confidence

Care Plans and Personal Support Plans are not always recorded within the appropriate Rio Form and therefore not counted. Some are held as separate documents and uploaded into Rio.

These measures report against pathways on RiO (care coordinator/lead HCP), MHT does not use this functionality and are therefore not reflected in the measures, despite the agreed use of dialog+ as a care plan in this service.

Note: some patients are accessing depots and therefore do not require a Care or Personal Support Plan.

What is the data telling us?

1.210 has demonstrated special cause variation of a positive nature due to recent increase, however remains short of target overall. All directorates have achieved comparable levels of performance ranging from 85.9% in West Kent to 90.8% in East Kent

Workstreams continue to define future requirements for care planning alongside the work on risk management.

People We Care For: Patient Experience

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	89.8%	89.4%	89.0%	89.5%	88.5%	88.8%	87.3%	89.4%	88.1%	88.7%	87.9%	87.7%
1.3.02: Complaints - actuals		38	43	42	49	35	31	37	32	51	44	60	45
1.3.03: Compliments - actuals		114	124	135	109	141	140	130	151	147	122	122	131
1.3.04: Compliments - per 10,000 contacts		33.5	38.6	38.4	34.4	42.2	37.8	37.2	48.9	40.7	37.5	34.5	35.5
1.3.05: Patient Reported Experience Measures (PREM): Response count		674	538	721	542	478	580	510	594	540	529	563	513
1.3.06: Patient Reported Experience Measure (PREM): Response rate		4.5	4.0	4.7	3.8	3.2	3.6	3.3	4.1	3.7	3.6	3.6	3.2
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.4	8.5	8.5	8.5	8.2	8.5	8.2	8.3	8.5	8.6	8.5	8.5
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	93%	94%	95%	93%	92%	85%	97%	95%	100%	98%	97%	96%
1.3.09: Complaints responded to within 25 days (or agreed timeframe)	100%	95%	93%	83%	78%	70%	60%	66%	87%	92%	82%	81%	89%

**Please note that following a review of indicators and automation of data from InPhase for reporting purposes the following indicators have seen a variation in methods applied resulting in small changes in historically reported figures: 1.3.02, 1.3.03, 1.3.04, 1.3.08 & 1.309*

Areas of Concern

No areas of concern or improvement identified form SPC analysis in month

People We Care For: Safety

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
1.4.02: All Deaths Reported And Suspected Suicide		144	127	145	98	144	142	137	113	197	174	157	108
1.4.03: Restrictive Practice - All Restraints		107	69	78	61	70	97	87	67	63	77	109	103
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	1	5	2	4	6	6	6	7	3	7	8	5
1.4.05: Decrease violence and aggression on our wards	(7.5%)	29.6%	31.5%	52.8%	16.7%	2.5%	37.3%	9.0%	(1.3%)	14.8%	28.3%	12.2%	34.1%
1.4.06: Medication errors		49	55	60	43	49	32	54	46	50	39	54	46

**Please note that following a review of indicators and automation of data from InPhase for reporting purposes the following indicators have seen a variation in methods applied resulting in small changes in historically reported figures: 1.4.06*

Areas of Concern

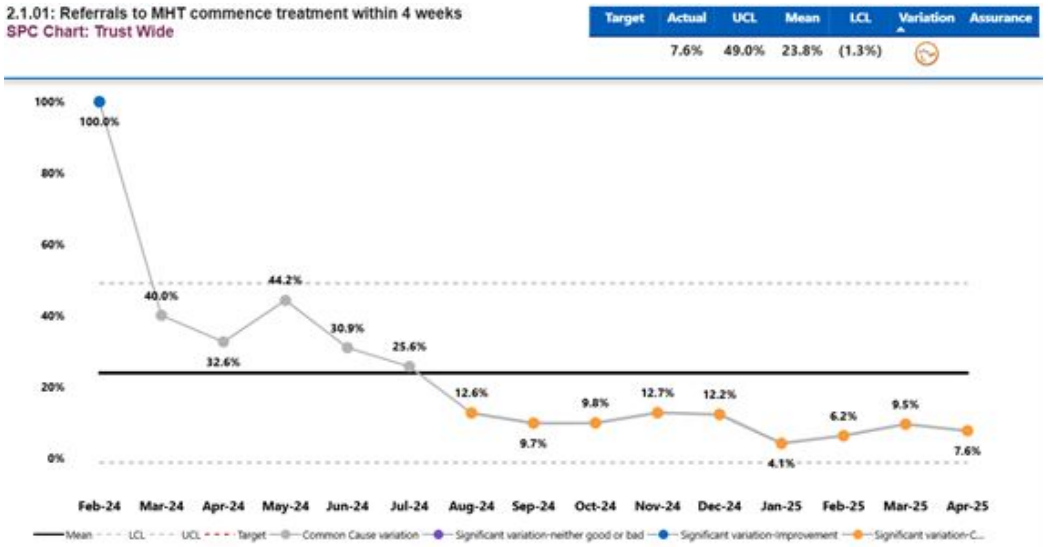
No areas of concern or improvement identified form SPC analysis in month

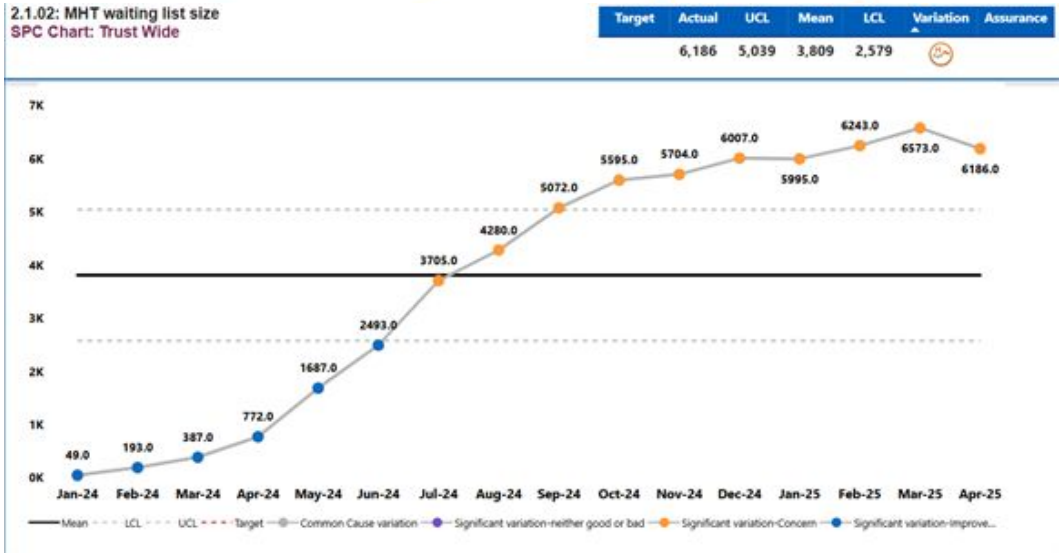
Partners we work with

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
2.1.01: Referrals to MHT commence treatment within 4 weeks		44.2%	30.9%	25.6%	12.6%	9.7%	9.8%	12.7%	12.2%	4.1%	6.2%	9.5%	7.6%
2.1.02: MHT waiting list size		1,687	2,493	3,705	4,280	5,072	5,595	5,704	6,007	5,995	6,243	6,573	6,186
2.1.03: MHT 2+ contacts		16,590	16,559	16,627	16,684	16,602	16,833	17,246	17,866	18,507	19,137	18,987	19,797
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	16.4%	14.8%	12.2%	15.2%	19.8%	20.9%	21.3%	20.6%	19.6%	24.3%	21.7%	22.0%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	30.0%	28.0%	31.9%	31.1%	27.4%	37.7%	32.2%	29.9%	37.6%	36.1%	32.9%	29.3%
2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge)	44.0	74.7	89.2	89.9	45.1	46.8	46.7	47.0	67.8	62.0	112.6	69.0	92.3

Note: *MHT 2+ contacts (2.1.03) is measured nationally as a measure of Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses and highlighted as an area of concern by the ICB as is subject to special cause variation of a negative nature and an Oversight Framework bottom decile metric, This has presented a high degree of complexity in establishing methodology applied to MHSDS data, work is ongoing with the current position being that local KMPT data does not support what is published nationally.*

Areas of Concern





Data Source

RiO

What is being measured?

2.1.01: Referrals with a "clock stop" within 4wks of referral. The clock is stopped by: a 1st contact (patient seen) **&** a meaningful assessment **&** a baseline outcome measure **&** either a Clinical or Social Intervention or a co-produced care plan
2.1.02; Open referrals to MHT not yet received requirements above

Data reflects MHT activity only discussion ongoing to establish how best to monitor activity across different team types, specifically MHT+, in line with national guidance.

No national target has been set for 2025/26

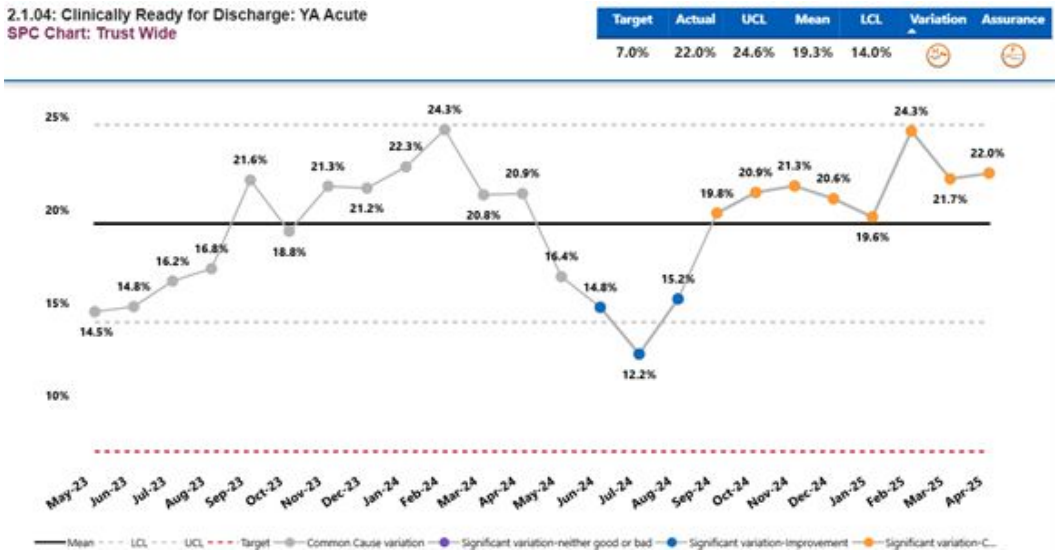
Data Quality Confidence

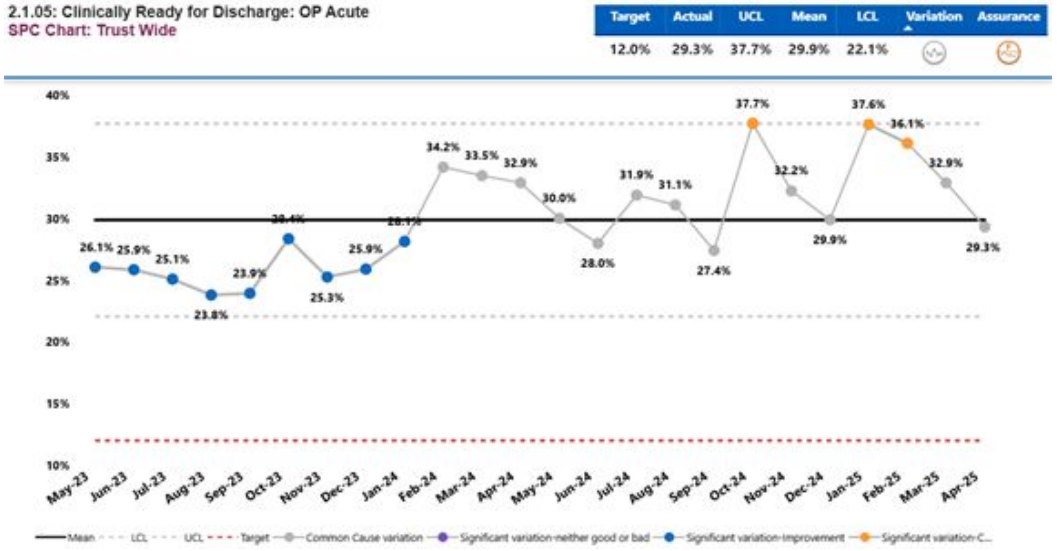
Requires correct coding of appointments to ensure national criteria is met, ongoing improvements.
Data only reflects interventions delivered by KMPT or activities recorded by partners, potentially patients may be in receipt of social interventions from other providers.

What is the data telling us?

The total MHT waiting list at the end of April was 6,186, of these approx. 37% are awaiting their first contact with the remaining 63% having had an initial contact and are awaiting commencement of a clinical or social intervention.

The numbers of patients entering treatment is improving whist volumes of new referrals remain challenging.





Data Source

RiO

What is being measured?

% of bed days lost to CRFD's of all occupied bed days

Data Quality Confidence

No known issues

What is the data telling us?

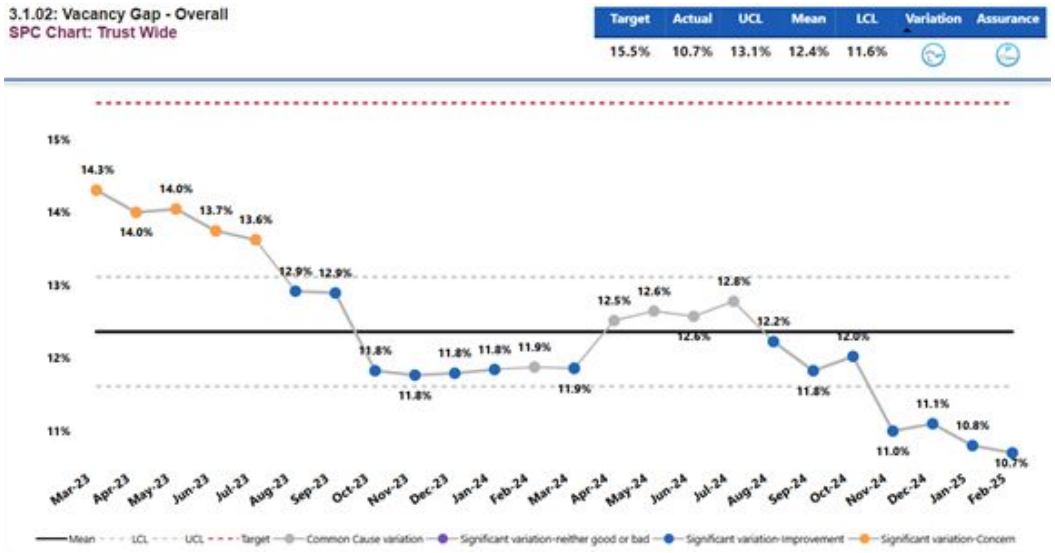
1009 YA acute bed days were lost in April (33.6 beds per day).

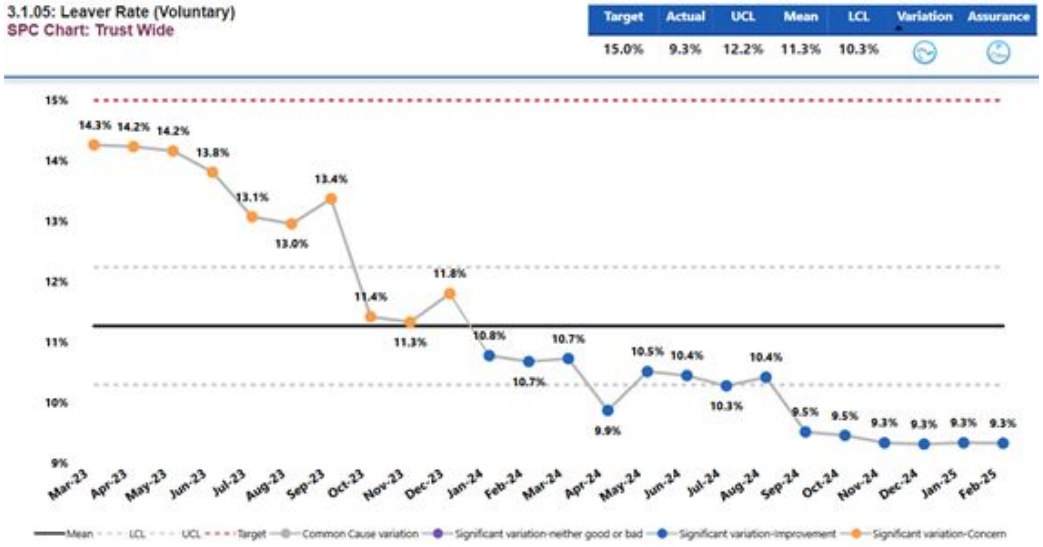
732 bed days were lost in OP acute wards (24.4 beds per day), the greatest impact continues to be those awaiting nursing home placements and funding decisions.

People who work for us

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
3.1.01: Staff Sickness - Overall	4.5%	4.5%	4.4%	4.5%	4.4%	4.8%	5.1%	4.6%	5.1%	5.2%	5.0%	4.6%	4.3%
3.1.02: Vacancy Gap - Overall	15.5%	12.6%	12.6%	12.8%	12.2%	11.8%	12.0%	11.0%	11.1%	10.8%	10.7%	9.8%	10.0%
3.1.03: Essential Training For Role	90.0%	94.2%	94.4%	94.7%	94.8%	93.8%	94.3%	94.7%	95.1%	95.0%	95.2%	95.5%	95.4%
3.1.04: Leaver Rate	16.5%	14.6%	14.6%	14.6%	14.6%	14.3%	14.1%	13.4%	13.3%	13.4%	13.4%	12.5%	12.8%
3.1.05: Leaver Rate (Voluntary)	15.0%	10.5%	10.4%	10.3%	10.4%	9.5%	9.5%	9.3%	9.3%	9.3%	9.3%	9.1%	9.2%
3.1.06: Safer staffing fill rates	80.0%	108.9%	103.7%	114.8%	116.4%	108.2%	112.0%	116.1%	108.7%	109.6%	110.1%	108.8%	110.7%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	26.5%	15.5%	15.2%	26.2%	26.7%	26.7%	27.0%	27.0%	27.1%	28.1%	28.4%	28.5%	28.5%
3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.75%	0.47%	0.80%	0.44%	0.31%	0.63%	0.02%	0.27%	0.18%	0.35%	0.21%	0.21%	0.05%

Areas of Improvement & Sustained Achievement of Target





Data Source

ESR

What is being measured?

Vacancy- Calculated using in post FTE against the Vacant FTE on the 1st of each month.

Leaver Rate: For Voluntary Leavers we use a selected set of reasons. The calculation is average staff in post (FTE) against the leavers (FTE) in that same period (Usually reported as 12 Months).

Data Quality Confidence

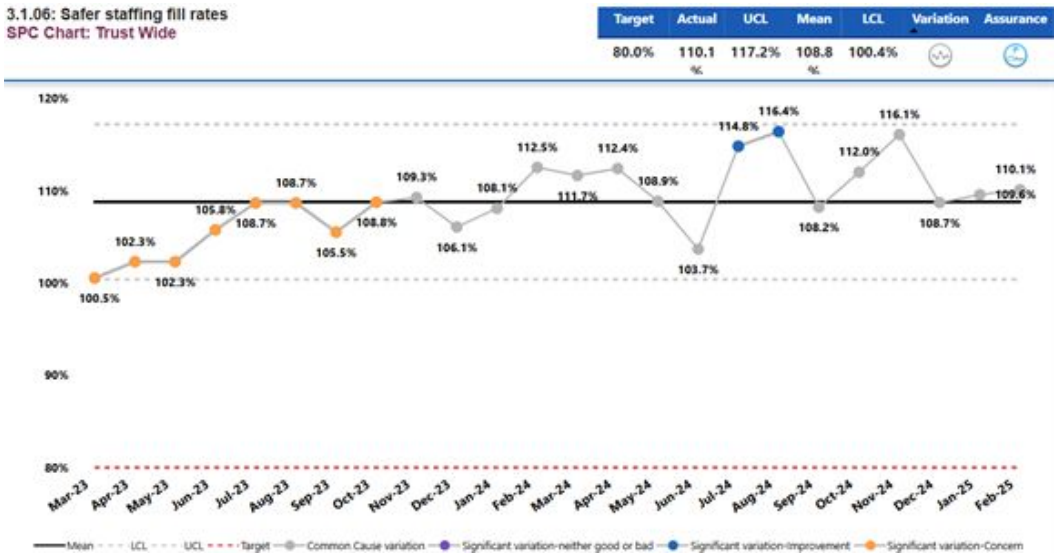
No known issues

What is the data telling us?

Sustained improvements below mean of last 24 months in both indicators.

Individual targets exist for each directorate based on historic performance, all directorates achieving their vacancy gap target with exception of East Kent who are within 1%, although this has been steadily decreasing since June 2024.

Voluntary turnover has continued to improve in most areas, with all directorates comfortably achieving individual targets. The trust overall voluntary turnover has remained consistent since November 2024



Data Source

Eroster & NHSP

What is being measured?

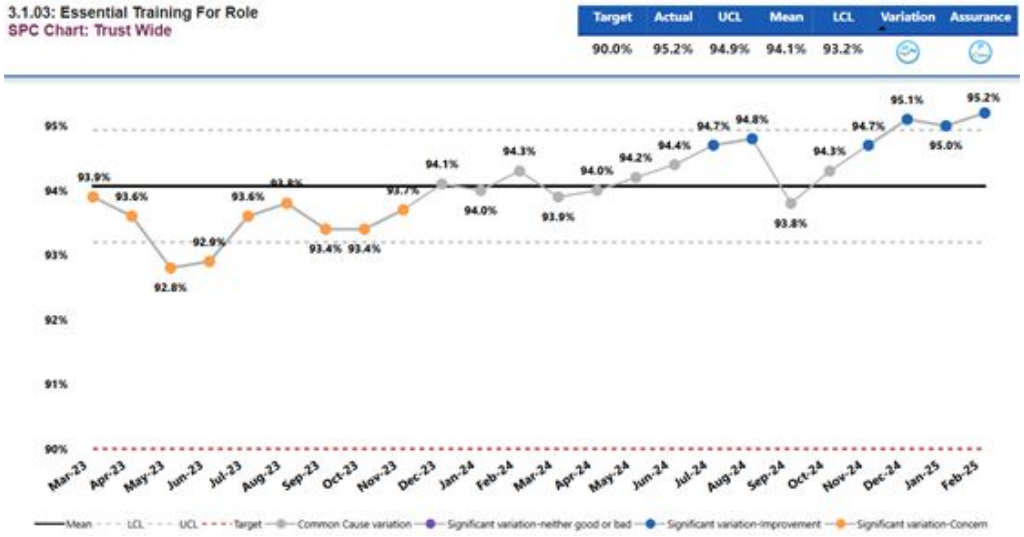
Planned vs Worked hours

Data Quality Confidence

Difficulty obtaining data from NHSP between May and July in a timely manner due to a reporting platform closing. This has now been resolved

What is the data telling us?

A slight increase in fill rates since December 2024. The target of at least 80% fill rate for the safe staffing return is met throughout



Data Source

iLearn

What is being measured?

Data Quality Confidence

No known issues

What is the data telling us?

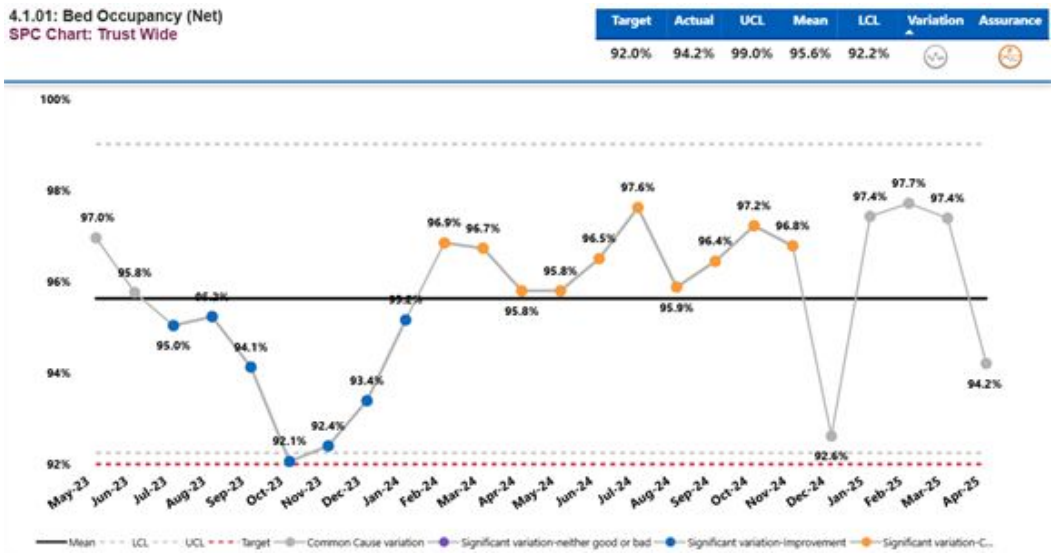
Overall, essential training has improved slightly in the last month. We have seen reduced compliance in Immediate Life Support, Basic Life Support Paediatric, Moving and Handling Patient and Physical Interventions but improved compliance in Clinical Risk Assessment, Basic Life Support, Breakaway and Rapid Tranquilisation.

We are continuing to highlight the availability of data through BI reporting and have seen increased requests for granular data from Directorates to help with monitoring and improving local training compliance.

Efficiency

Measure Name	Target	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
4.1.01: Bed Occupancy (Net)	92.0%	95.8%	96.5%	97.6%	95.9%	96.4%	97.2%	96.8%	92.6%	97.4%	97.7%	97.4%	94.2%
4.1.02: DNAs - 1st Appointments		10.9%	11.6%	10.5%	10.4%	10.5%	10.4%	10.7%	11.6%	10.2%	10.3%	10.7%	10.9%
4.1.03: DNAs - Follow Up Appointments		9.2%	10.0%	9.9%	9.6%	9.5%	9.5%	10.1%	10.9%	10.7%	9.9%	10.0%	10.5%
4.1.04: In Month Budget (£000)	0	(13,619)	(13,850)	(13,767)	(13,735)	(14,233)	(19,323)	(14,814)	(15,042)	(14,756)	(14,708)	(14,742)	(15,122)
4.1.05: In Month Actual (£000)		(14,655)	(14,437)	(13,900)	(14,555)	(13,822)	(18,717)	(14,756)	(14,960)	(15,863)	(15,637)	(15,488)	(16,169)
4.1.06: In Month Variance (£000)		(1,035)	(587)	(133)	(820)	411	606	58	82	(1,107)	(930)	(746)	(1,047)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	3.6%	2.9%	3.5%	3.8%	3.5%	2.9%	3.2%	2.8%	2.6%	2.5%	1.9%	2.7%

Areas of Concern



Data Source

RiO

What is being measured?

Occupied bed days as a % of available bed days. Acute wards only.

Data Quality Confidence

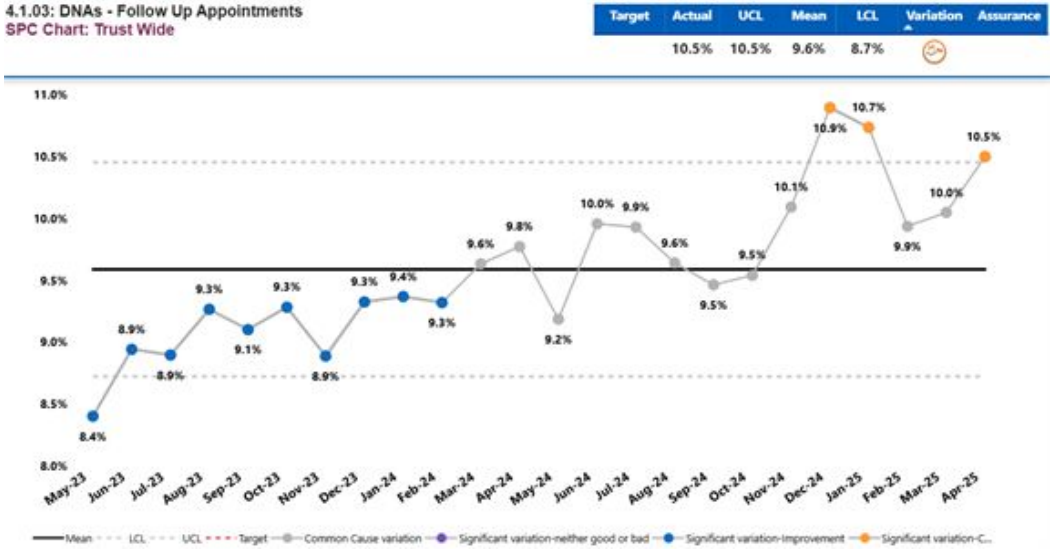
No known issues.

What is the data telling us?

Levels of bed occupancy are driven by other aspects such as CRFDs, numbers of admissions and length of stay.

The 92% target is the level the trust had hoped to achieve by March 2025. Occupancy is significantly impacted by the levels of CRFD experienced (see 2.1.04 & 2.1.05)

Level of occupancy between YA acute and OP Acute in April were 95.6% and 91.8% respectively.



Data Source

RiO

What is being measured?

% of appointments outcomed on RiO as DNA

Data Quality Confidence

Potential of DNA's to be recorded inappropriately when unplanned phone calls that are unsuccessful are recorded as a DNA.

What is the data telling us?

This equates to an average of 723 1st appointments and 3,324 follow up appointments being recorded as DNA's per month.

As is to be expected there is wider variation in DNA levels across different service types, MHT services accounted for 56.4% of 1st contact DNA's in April

For follow up appointments Mental Health Together Plus teams account for 35.5% of all DNA's followed by MHT with 32.7%.

The trusts DNA policy has been reviewed and ratified by CEOG in March 2025.
The revised policy supports MHT to safely discharge patients with low risk profiles who DNA. Each locality has a daily DNA huddle to ensure all people who have DNA'd are individually reviewed and a forward plan agreed.

5. Appendices

System Oversight Framework

The Single Oversight Framework (SOF) sets out how NHS England (NHSE) oversees Integrated Care Boards (ICB) and NHS trusts, using one consistent approach. The purpose of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

NHSI monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs. KMPT's current segmentation is 2 as highlighted below, this is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met:

Segment	Description	Scale and nature of support needs
1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities.	No specific support needs identified. Trusts encouraged to offer peer support. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues.	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.
4	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme

The following tables represent the latest position for KMPT's Provider Oversight against which the trust responds to Key Lines of Enquiry. It is recognised that delays exist in nationally published data for a number of metrics, many as a result of being reflective of the annual staff survey results. It is provided to board for assurance around the position, and to allow oversight of the national position. Following a national consultation an updated version of the Single Oversight Framework is expected in spring 2025.

Indicator	Period Frequency	Period	Value	National Display Value	Target or Standard	Rank
S000a: NHSOF Segmentation	Month	2025 01	2:Flexible			
S035a: Overall CQC rating	Month	2025 01	3 - Good			13/62
S059a: CQC well -led rating	Month	2025 01	3 - Good			13/62
S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual; calendar year	2023	8.88%	9.94%		49/66
S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual; calendar year	2023	15.20%	17.70%		49/66
S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, their relatives or other members of the public	Annual; calendar year	2023	28.10%	25.10%		60/66
S067a: Leaver rate	Month	2024 12	7.67%	6.94%		49/67
S068a: Sickness absence rate	Month	2024 09	4.77%	5.01%		16/67
S069a: Staff survey engagement theme score	Annual; calendar year	2023	6.89/10	6.89/10		56/66
S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2023	11.30%		12%	25/64
S071b: Proportion of staff in senior leadership roles who are women	Month	2024 12	60.70%		62%	37/43
S071c: Proportion of staff in senior leadership roles who are disabled	Annual; calendar year	2023	7.22%		3.20%	11/64
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	Annual; calendar year	2023	57.50%	56.40%		48/67
S086a: Inappropriate adult acute mental health placement out -of-area placement bed days	Month	2024 03	0		0	1/52
S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2023	6.88/10	7.09/10		61/66
S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2023	6.5/10	6.46/10		53/66
S125a: Adult Acute LoS Over 60 Days % of total discharges	Month	2024 03	13%			5/50
S125b: Older Adult Acute LoS Over 90 Days % of total discharges	Month	2024 03	38%			19/50
S133a: Staff survey - compassionate and inclusive theme score.	Annual; calendar year	2023	7.42/10	7.3/10		54/66
S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual; calendar year	2023	1.9		1	45/64
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1.2		1	51/64

Note: *some areas exist where KMPT does not recognise national data there is ongoing work with NHSE colleagues to align methodology. Within the SoF it is known that S086a, Inappropriate acute out of area placements, is under representing the accurate position due to issues faced with national reporting portals.*

Exception Reporting Guide

The IQPR identifies exceptions using Statistical Process Control (SPC) Charts. SPC charts are used to study how a process changes over time. Data is plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). Full details on SPC charts can be found at: https://improvement.nhs.uk/resources/making-data-count/

Variation/Performance	Assurance			
	P	?	F	
H	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
	Good **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change.	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change.	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
				Unsure **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
				Unsure **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
				Unknown **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Finance Report for Month 1 (April 2025)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 1 (April 2025).

Items of focus

For the period ending 30th April 2025, the Trust has reported a pre-technical adjustments deficit of £0.26m and a surplus of £0.18m post technical adjustments, this is in line with the financial plan.

Points to note:

- Use of external beds remains a pressure with an increase in month; 17 Acute and 17 Psychiatric Intensive Care Unit (PICU) beds used in month resulting in an in-month budgetary pressure of £0.95m.
- Year to date agency spend is £0.51m with a forecast for agency of £4.27m as per plan.
- Bank spend decreased by £0.24m in month. Run rates remain high in some areas with all Acute Inpatient wards using bank staff above rostered staffing levels due to additional observations for multiple patients on each ward.

Governance

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Finance Report
April 2025

Trust Board

Brilliant care through brilliant people

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Key Messages

For the period ending 30th April 2025, the Trust has reported a pre technical adjustments deficit of £0.26m and a surplus of £0.18m post technical adjustments, this is in line with the financial plan.

The key financial challenges for the Trust are:

External beds

- The Acute beds usage increased again in month, with an average of 17 beds utilised costing £0.34m. The Trust doesn't hold a budget for external acute beds.

- The Trust utilised an average of 9 external Female PICU beds, and an average of 8 external Male PICU beds, costing £0.84m. The Trust holds a budget for 7 PICU beds.

Agency spend

- Year to date agency spend is £0.51m, the highest usage is in East Kent medical agency and West Kent nursing agency. As part of planning for 2025/26 the agency spend limit is £4.27m and work is on-going with Directorates in order to identify whether this target will be exceeded and what mitigations maybe required.

- In month spend levels were highest in East Kent, with 45.7% of overall agency spend, due to medical vacancies, but also West Kent (34.7%) and North Kent (37.2%) due to pressures within Liaison services, Community Mental Health Teams and Crisis teams.

Bank spend

- Bank spend decreased by £0.24m in month. Run rates remain high in some areas with all Acute Inpatient wards using bank staff above rostered staffing levels due to additional observations for multiple patients on each ward.

- Bank usage reduced on Forensic wards as sickness and operational pressures reduced, and on Mother & Baby Unit (MBU) as bed occupancy was reduced.

At a Glance - Year to Date

Income and Expenditure	
Efficiency Programme	
Agency Spend	
Capital Programme	
Cash	

Key

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

Capital Programme

As at 30th April the overall capital position is £0.56m underspent, this is due to delays in IFRS 16 lease remeasurements which will be completed by the end of May 2025. The forecast spend position is £17.53m which is as per plan.

Cash

The closing cash position for April was £11.15m, a £0.86m decrease in month following the settlement of the increased levels of payables reported last month.

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Income and Expenditure

Statement of Comprehensive Income

	Current Month			Year to date		
	Budget	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	24,621	24,862	240	24,621	24,862	240
Employee Expenses	(18,560)	(18,743)	(182)	(18,560)	(18,743)	(182)
Operating Expenses	(5,601)	(5,657)	(55)	(5,601)	(5,657)	(55)
Operating (Surplus) / Deficit	**460**	**463**	**3**	**460**	**463**	**3**
Finance Costs	(277)	(279)	(2)	(277)	(279)	(2)
System control Surplus / (Deficit)	**183**	**184**	**1**	**183**	**184**	**1**
Excluded from System control (Surplus) / Deficit:						
Technical adjustments	**(476)**	**(447)**	**29**	**(476)**	**(447)**	**29**
Surplus / (deficit) for the period	**(293)**	**(263)**	**30**	**(293)**	**(263)**	**30**

Commentary

The Trust is reporting a surplus of £0.18m at the end of April, in line with plan.

As at the end of April the Trust reported a year to date overspend on pay of £0.18m. This consists of an underspend on substantive pay of £1.43m, offset by overspends on temporary staffing which total £1.61m; £1.24m on bank staff and £0.51m of agency spend.

Employee expenses includes an increase in substantive pay, reflecting the increased rate for Employers' National Insurance contributions (£0.33m) and an accrual for anticipated pay awards (£0.42m).

The overall level of WTE provided by substantive staff rose from an average 86.7% in 2024/25 to 88.2% in April; in overall terms WTE fell by 8 wte in month (0.2%), with reductions being seen in bank and agency usage.

The Trust spent £0.51m on agency in month, 2.7% of pay spend. In staff group terms, spend within the Medical and Nursing staff groups were highest with spend equating to 47.4% and 43.3% of overall agency spend, respectively. This is driven by medical agency usage in East Kent and Nursing agency in North and West Kent – within Community, Liaison and Crisis services.

Non-pay

In month, the Trust utilised 17 external PICU beds (7 PICU beds funded) and 17 external Acute beds were used all of which are unfunded and this presents a financial pressure to the end of April of £0.95m

Cost improvement plans 25/26

Scheme	CIP Target £'000s	Scheme start date
Support Services	3,941	Apr-25
Provider Collaborative Risk Share	1,000	Apr-25
Perinatal	500	Apr-25
Community Review	2,439	Apr-25
Budget Management	1,798	Apr-25
Rota Management	1,700	Jul'25
Estates	1,600	Jul-25
Forensic Inpatient	1,000	Sep-25
Non-Pay Review	1,000	Oct-25
Unidentified	459	Apr-25
System Stretch target	2,200	TBC
Total	**17,637**	

Commentary

The Trust submitted a surplus plan of £2.24m for 2025/26 and this is predicated on delivery of a 5% efficiency target (£15.4m) plus an additional £2.24m stretch target to achieve the required surplus.

Schemes commencing in April:

- Support Services – a 10% reduction in costs, reflecting NHS England benchmarking and growth analysis . Structure reviews are underway with some savings delivered from month 1.
- 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.
- Perinatal service review – underspends delivered, service review required to identify opportunities for recurrent reductions.
- Community review – underspends delivered, service review underway to finalise models for MHT and MHT+.
- Budget management – 1% non-recurrent savings identified from slippages.
- Estates – a 10% reduction in costs

Plans under development:

- Forensic Inpatient – review of all costs, building on benchmarking work
- Rota Management – reducing run rate on inpatient staffing levels
- Non-Pay Review – working with system partners supported by NHS England productivity packs

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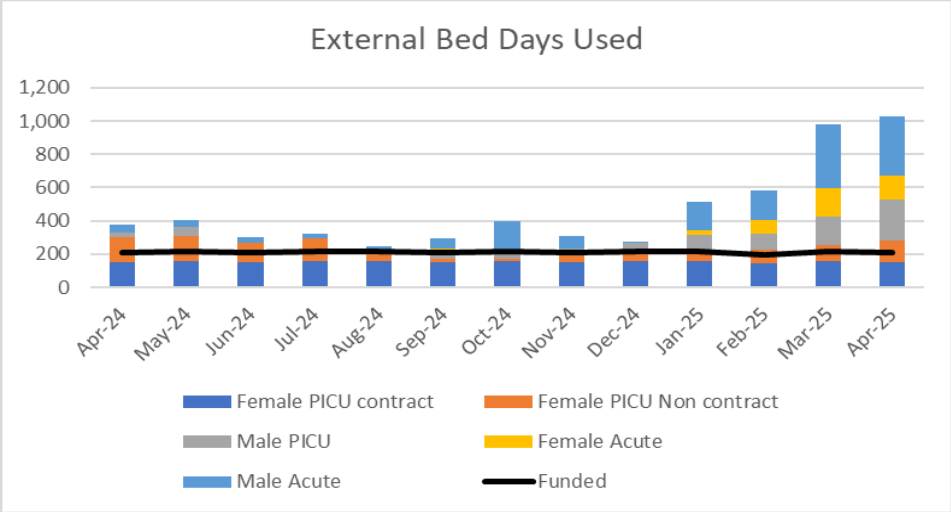
Exception report – External beds



The pressure on external bed usage over and above the funded levels has been driven by an increasing need for external Acute beds and male PICU beds. A significant increase in January was followed by a further increases and have continued into April.

Contributing factors

- Demand for external Acute beds due to:
  - Numbers of bed days lost to Clinically Ready for Discharge (CRfD) patients
  - Levels of bed occupancy
  - System demand for beds

Risks to delivery

- Increasing demand for Acute beds
- Increasing complexity of PICU patients increasing demand for PICU beds

Key actions taken

- Review of options for internal or externally purchased step down beds over Winter

Exception report – Temporary Staffing

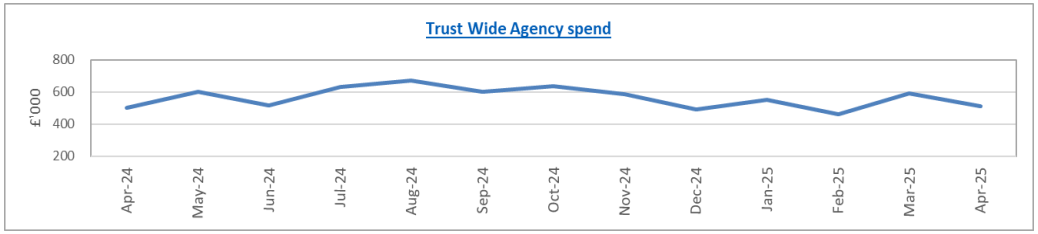
Though agency spend has reduced over March levels, the overall trend is static since December with no significant reductions seen and levels still remaining high. A 30% reduction in agency spend is planned to be delivered this year.

Contributing Factors

- Medical vacancies in East Kent keeping medical agency costs high
- MHT backlogs in East, North & West Kent increasing nursing agency use
- Core24 Liaison posts being recruited to
- Additional observations and EPCs on wards utilising high levels of bank and agency HCAs.

Risks to delivery

- Observation levels rise
- Unsuccessful medical recruitment leads to continued use of agency
- Pressure to reduce MHT waiting lists increases need for temporary staffing
- Additional clinics to increase dementia diagnosis required



Bank Spend £'000

	24/25 Qtr 1	24/25 Qtr 2	24/25 Qtr 3	24/25 Qtr 4	25/26 M1
Nursing	2,339	2,291	2,071	2,331	624
HCAs	2,955	2,881	2,756	3,011	937
Other	282	332	257	268	81
Total	**5,576**	**5,505**	**5,084**	**5,610**	**1,642**

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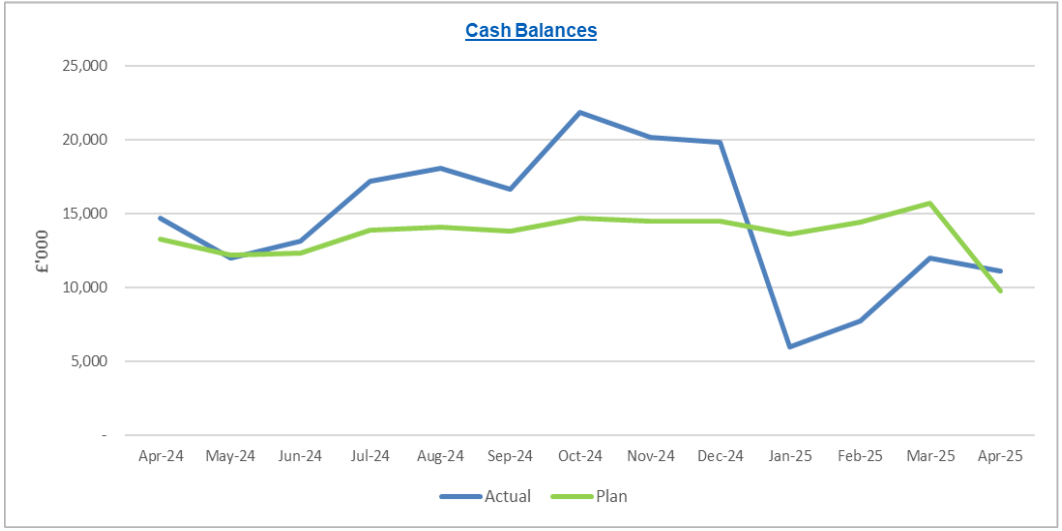
Appendices

Balance Sheet

Statement of Financial Position

	31st March 2025 Actual £000	30th April 2025 Actual £000
Non-current assets	174,925	174,192
Current assets	20,902	20,105
Current liabilities	(31,724)	(30,182)
Non current liabilities	(38,743)	(39,058)
Net Assets Employed	**125,360**	**125,057**
Total Taxpayers Equity	**125,360**	**125,057**



Commentary

Total Assets

Overall total assets decreased by £1.53m in month.

Non-current assets have decreased by £0.73m in April predominantly due to depreciation.

Current assets have decreased by £0.80m, mainly due to a reduction in the overall cash position due to the reduction in trade and other payables (as below).

There was minimal movement within trade receivables.

Total Liabilities

Overall total liabilities decreased by £1.23m in month.

Non-current liabilities decreased marginally in month by £0.32m due to planned movements in lease liabilities

Current Liabilities decreased by £1.54m with the main driver being a reduction in trade and other payables of £1.42m.

This related to the settlement of invoices relating to the capital programme, temporary staffing provided by NHS Professional (£1.86m) and Softcat plc invoices for digital infrastructure costs (£1.00m).

This is offset by an increase in deferred income which mainly relates to NHS England (£1.59m).

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Capital Position

	Annual	Year to Date		
	Plan	*Plan*	*Actual*	*Variance*
	£'000	**£'000**	**£'000**	**£'000**
System Capital allowance				
Capital Maintenance and Minor Schemes	4,164	187	18	(169)
Information Management and Technology	1,761	0	3	3
Section 136 development	3,000	0	15	15
Other	200	0	0	0
IFRS 16 Leases	3,375	384	0	(384)
Total system funding	**12,500**	**571**	**36**	**(535)**
PDC Funding				
Out of Area Placement (Female PICU)	3,940	0	0	0
Total system funding	**3,940**	**0**	**0**	**0**
Other				
PFI 2025/26	461	38	10	(28)
Public Decarbonisation	629	0	0	0
Total other	**1,090**	**38**	**10**	**(28)**
Total Capital Expenditure	**17,530**	**609**	**46**	**(563)**

Year to date and forecast performance against Plan

As at 30th April the overall capital position is £0.56m underspent. This is due to IFRS 16 lease remeasurements which will be completed by the end of May 2025.

The forecast spend position is £17.53m which is as per plan and delivery plans are in place to ensure schemes are completed by the end of March 2026.

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Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	KMPT Leadership Development and Management Development Programme
Author:	Xanthe Whittaker, Head of Organisational Development.
Executive Director:	Sandra Goatley, Chief People Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The purpose of this paper is to provide an update to Board on KMPT's newly launched senior leadership development programme – Leading Well Together.

This programme aims to develop confident and capable leaders who can create environments where everyone can challenge and contribute, influence partners and communities, and navigate complex healthcare challenges with purpose and resilience.

This paper also provides;

- Insight into how we plan to embed the programme to become a permanent programme for leaders,
- An overview of how this programme ties into the KMPT Management and Leadership Development offer and how this will align to the new national NHS Management and Leadership Framework (release expected summer 2025)

Issues to bring to the Board's attention

We recognise that to achieve our strategy, improve staff experience and to manage change and transformation effectively we need to focus on creating the right internal culture and behaviours within KMPT, which starts with our senior leaders.

Leaders equipped with the right tools, knowledge, and skills can effectively drive and manage the culture change process. They become role models who can inspire, motivate, and guide their teams through the transition, addressing resistance and fostering acceptance of the new culture.

- We recognise that we need a clear leadership philosophy to reinforce and complement our new values and behaviours
- We acknowledge that having a strong, well-defined leadership programme and management development offer is pivotal to clarifying and embedding standards of leadership behaviour

Version Control: 02

- The initiatives and progress described in this paper set out to achieve this through building capability and confidence of managers and leaders throughout our organisation
- We know that managing change is an issue (as evidenced by the staff survey and anecdotal feedback from staff) and it is vital that the programmes we are running upskill our leaders and managers in change management and the role they play.

Governance

Implications/Impact:	Staff development, retention, employee capability, culture, delivery of Trust strategy
Assurance:	Reasonable
Oversight:	People Committee

Version Control: 02

1. Background

1.1. In 2024, we set out to design a programme which supports leaders by better equipping them to guide the culture change, reinforce desired behaviours, address resistance constructively, and build a cohesive, sustainable, and high-performing organisational culture. The context in which our leaders and their teams work is significantly changing. To ensure our leaders can deliver effectively in a changing environment, it is imperative that we provide them with the necessary support and skills.

1.2. In addition to capable individual leaders, collective leadership is crucial. This type of leadership hinges on the ability to unite individual leaders, not just around a single vision or strategy, but also with a well-defined leadership philosophy to support that strategy.

1.3. We strive for our culture at KMPT to closely align with the NHS direction of travel, embracing positivity, compassion, and inclusivity - principles firmly grounded in the 7 elements of the NHS People Promise and further emphasised in the NHS People Plan:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

2. Our KMPT Leadership Philosophy

2.1. KMPT has considered the right leadership philosophy to support its organisational strategy and transformation plans. These considerations have focused on the commitment in the strategy:

- to deliver person-centred care
- to work in partnership
- to build and empower our people.

2.2. With these commitments in mind, our leadership philosophy supports the delivery of our strategic aims by developing leaders who are self-aware, inclusive, and accountable. It is structured around four interconnected dimensions:

KMPT's strategy		**KMPT's leadership philosophy**
Delivering person-centred care Working in partnership Building and empowering our people	→	Leading Self Leading the Team Leading the Organisation Leading the System

Version Control: 02

The feedback from our leaders

2.3. Some more definition around this is set out below and the first steps in our planning process have been to engage with senior leaders to test whether they believe this is the 'right' philosophy for us. See **Appendix 1 and 2**. This approach builds on our new Trust values and behaviours, defines expectations of leaders, and underpins the capability that we aim to build through the programme. Communicating it clearly to leaders is a critical part of creating the conditions for this expectation to be met.

Version Control: 02

3. Programme design

3.1. The planned approach to the leadership programme draws on a range of methodologies:

Face to face learning events	Full day facilitated workshops for each module (min 2 days for each) exploring leadership theory and application
Self-directed reflection and learning (reading/listening list)	Creation of an online portal to store, share and access leadership resources: articles, websites, podcasts, books and reading materials etc…
Action learning set	Each module will be supported by a facilitated action learning set. Groups are mixed disciplines/directorates to support variety of input and improve collaboration.
Continuous applied practice	Leaders will establish personal leadership objectives and professional objectives (taken from the breakthrough objectives of the KMPT strategy)
Cohort connection-self-directed (coffee/shadowing etc)	Leaders are encouraged to take ownership to connect across the group using methods to suit them. We also aim to create a Staffroom Community for the group.

3.2. The programme is broken down into a Programme Foundations module and 4 further modules which parallel the leadership philosophy (self, team, organisation and system). All modules will contain Equality, Diversity and Inclusion (EDI) elements and a specific module has been allocated to this in Module 3.

3.3. See **Appendix 3** for how the modules are broken down into the programme timeline.

3.4. The aims of the Programme Foundations module are to set the direction of travel for the programme through; engaging with participants and getting their feedback and input on programme methodology and content, setting up the new 360 process, clarifying logistics, agreeing expectations and establishing key data points to create effective programme evaluation measures.

3.5. The Programme Foundations module is now almost complete. In the coming weeks participants will set their personal and business objectives and evaluation measures and milestones will be agreed. Module 1 delivery is planned for June and July and will be facilitated by Sheila Stenson, Sandra Goatley and Xanthe Whittaker. See **Appendix 4.**

3.6. 360 reports will also be shared over the coming weeks. In designing the questionnaire, we considered: the journey we are on in transforming KMPT, the leadership programme, improvement leadership behaviours, our leadership philosophy, NHS frameworks and our new KMPT values. 360 elements can be reviewed in **Appendix 5**.

3.7. Module 4 (“System”) – will commence in Spring 2026. We have taken a different approach to develop this module by creating an opportunity to collaborate with colleagues across the system. This piece of work will be led by KMPT and initially supported by Kaleidoscope. Initial discussions on how we could proceed have begun. The aims are to develop leadership capability for tackling shared system challenges (ICB term ‘knotty problems’) through real-world problem-solving, action

learning and cross-boundary working. Module 4 will essentially become a programme within itself and co-designed with partners. A model is expected to include:

- Modular learning: Leadership across boundaries, systems thinking, improvement methodology, EDI, citizen voice.
- Action Learning Sets: System-wide groups tackling real cross-organisational problems.
- System Projects: Live projects with teams reporting back on impact.
- Expertise input: Drawn from within our Trusts and other partner organisations, potentially supplemented by external expertise (e.g. The Kinds Fund).

3.8. Following the initial scoping work for Module 4, we intend to produce a Programme Blueprint to include:

- Purpose and intended outcomes
- Programme structure and timelines (we anticipate 6 months)
- Audience
- Governance and delivery model
- Resources and any required additional funding
- Evaluation plan.

3.9. As Module 4 will feel distinctly different than the first 3 modules for our KMPT participants we intend to evaluate the first 3 modules and consolidate this part of the programme with participants in January 2026.

4. Evaluation and impact measurement

4.1. We aim to employ a number of evaluation methods throughout the programme to measure individual growth, organisational benefit, and system-level outcomes. These include:

Method	**What is shows**	**Tools**
Pre/Post Self-Assessment	Changes in confidence, skills, mindsets	Custom surveys aligned to module objectives
360 Feedback	Perceived change in leadership behaviours	Custom multi-rater feedback
Reflective Journals	Insight into personal growth and application	Structured reflection toolkit
Attendance/Engagement	Uptake, drop-out	Attendance logs
Method	**What is shows**	**Tools**
Participant satisfaction	Reaction to content, delivery & support	Post module feedback
Action learning/Project outcomes	Practical application and real world problem-solving	Project impact reports sponsor feedback
Staff survey/pulse survey indicators	Impact on leadership culture	Staff survey/pulse data - focus on ‘leadership’,

		'morale', 'support'.
Service Improvements	Change resulting from leader-led initiatives	QI dashboards/data, project evaluations
Cultural Indicators	Alignment with Just/Compassionate culture	Pulse surveys, EDI engagement scores, FTSU feedback

Included in **Appendix 6** is an example of the impact pathway we are currently working to agree with programme participants. This will be actioned at the beginning of Module 1 to set a baseline for the programme.

5. Taking the Programme forward as our KMPT Leadership programme

5.1. Our intention is to extend this programme to all leaders at KMPT beyond 2025 to become our ongoing Trust Leadership Programme. Over the course of our pilot programme we intend to take the lessons learnt and structure the methodology and content into a credible and manageable programme to deliver in-house.

5.2. As part of this current programme we will be engaging with participants (TLT) to obtain their ideas and support in designing the ongoing programme, and potentially supporting the delivery of some elements moving forward. This will provide a fantastic opportunity for leaders to role model, influence and further embed what they have learnt.

5.3. Our aim is to launch Cohort 1 of this extended programme in Spring 2026.

6. Alignment with the KMPT Management and Leadership development offer

6.1. In 2024 we set out the intention to redevelop the existing management and leadership development offer. It was recognised that the offer in recent years was fragmented and would benefit from improvement to better align with the organisation's direction and the KMPT strategy.

6.2. It has also been widely acknowledged for some time that the development of quality leadership and management is not adequately embedded in the NHS. Rather, it often exists through the endeavors of an individual rather than as a consequence of proper talent management. It is common practice to put staff into leadership roles without any leadership training, despite the complexity of the role and the huge impact poor leadership has on staff morale and patient care.

6.3. The creation of a core behavioural and development programme and embedding this throughout KMPT is one of a number of interventions we intended to address alongside: recruiting for leadership, setting clear expectations and goals, improving the appraisal process, assessment of leadership competency and bringing together teams of leaders to collaborate and work on our shared objectives.

6.4. In 2024 we took a number of actions to include:

- Introduction of our Management Foundations Programme for all new or newly promoted managers, which follows on from induction
- Creating an all KMPT offer of courses, available to everyone and introduced at induction and marketed through our Comms – they include Acting with Compassion, Managing Change, Managing my Personal Impact, Living our Values, Developing Self and Understanding Myself and Others. These have been relatively well attended. We have started to include as team days and are planning to run as off-site training events later in the year
- Redesigning a new manager induction – including an in person welcome, check-in sessions through probationary and for newly appointed managers internally. These have been very positively received – evaluation shows that people feel more informed about our strategy, journey within transformation and challenges, our values and behaviours and have a clearer understanding on how to manage their development journey and the support available
- The creation of an online Learning Zone – with resources and tools for all staff and specific management and leadership tools. This has been invaluable in supporting people to access the things they need on demand and help managers become more self-sufficient.

6.5. We have recently launched our in-house Mary Seacole Programme after obtaining a local licence and training our own facilitators.

6.6. The Management Foundations Programme has recently launched and will continue to be built over the course of 2025. The programme is aimed at new/newly promoted managers. However, the course offer is also available to existing managers as we recognise we need to narrow the capability gap across all our managers.

6.7. The Management Foundations Programme is being built to not only include the behavioural OD offer but also to bring together the elements of development available to build the comprehensive skillset needed for all managers and leaders. Feedback showed us that the training offer comes from multiple directions and managers can find that difficult to navigate and effectively plan their learning. The programme and it's supporting materials will help managers ability to better navigate and plan their development. An example of this is our newly launched training for Recruitment, our Digital Training Hub and our EDI training. Bringing it together for managers reduces confusion whilst supporting all functions across the organisation to amplify their areas of training and development.

6.8. Alongside the training outlined above we set out to create a competency and behavioural framework. The absence of a framework adds to the challenge of building management and leadership competency across the organisation that is aligned to the Trust strategy and the principles of the NHS.

7. Alignment with the pending national NHS Management and Leadership development offer

7.1. In 2024 we learnt that there is an NHS ambition to create a shared management and leadership framework and introduce a Management and Leadership Code. We contributed our feedback for the initial draft of this and are following this work closely. It is timely for us as there will be a requirement to embed this within each Trust and for us to ensure we have a robust development offer and performance management processes (appraisal, recruitment, managing performance etc…) in place to support the framework.

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7.2. After reviewing the framework and code so far, we would like to bring to the Board's attention that we have confidence that our Management and Leadership development programmes and initiatives are complimentary to what we have seen so far. Our Leading Well Together Programme and the structure of our management offer fit well around the proposed code. We will continue to follow the progress closely and it will only help in further supporting us to identify potential gaps in our development approach.

The Proposed Code

8. Summary and Conclusion

8.1. We have outlined in this paper a clear leadership philosophy which supports the mission of KMPT in *'doing well together'*. The philosophy and leadership habits will become a clear focus in the assessment of all leaders and managers in KMPT.

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8.2. We have provided an overview of the new Leading Well Together Programme for senior leaders, including our planning approach, programme content, evaluation methods and desired outcomes. We have also stated our intention to create a permanent offer for leaders at KMPT.

8.3. We have updated on the progress of the broader OD work communicated in previous plans which includes the wider KMPT development offer and Management and Leadership development.

8.4. We have provided assurance to acknowledge the importance of the proposed new NHS Management and Leadership Code and Framework and how this will strengthen the work currently in train within the organisation.

Version Control: 02

Appendices

1. **Feedback from Leaders –** taken from in person and online sessions and feedback to help inform programme content and structure.
2. **Response from Feedback** – a summary of how what we had heard was shaped into the programme structure and content.
3. **Programme Timeline**
4. **New Leadership 360 elements**
5. **Programme Breakdown –** an overview of Programme Foundations and Modules 1- 4
6. **Programme Outcomes model**

1

Appendix 1:Feedback from Leaders

What we heard on leadership culture...

Communication and language

- You need space for quality conversations that allow exploration, curiosity, and challenge
- Questions like "why" can be unproductive; you need better ways to explore root causes
- Messages need to be simpler, more relevant, and tied together across initiatives
- You need a shared language that everyone can understand, leaving no one behind

Leadership approach and practice

- "Slow down to speed up" - properly implement actions rather than continuously adding more
- Empowerment is key, but you first need to enable people to be empowered
- You need to cultivate a growth mindset which supports learning from mistakes and models curiosity for continuous improvement

What we heard on development needs...

Leadership capacity and skills

- Leaders need to build the resilience to thrive in a fast paced, challenging and ambiguous context
- Leaders could benefit from developing the confidence and psychological safety to address difficult matters fairly
- You need frameworks to understand leadership in a VUCA world
- You'd like to explore "leadership in the digital world" and how to harness its potential
- You need help developing a sense of belonging and high performance across your teams, especially after significant change

Leadership mindset and behaviours

- You feel you need to role model a shift from being insular, judgemental and risk-averse to being inclusive, curious and brave
- You want an increased understanding of the academic and industry research underpinning best practice in leadership
- Leaders would benefit from exploring the role of leaders beyond the boundaries of KMPT

Appendix 2: Response from feedback

We have designed a comprehensive Leadership development programme that:

- **Structures learning around four key dimensions**: Self, Team, Organisation, and System
- **Includes dedicated full-day face-to-face sessions** on leading with purpose and values, coaching your team, and collaborative leadership, **supported by action learning sets, a resource library and developing cohort relationships.**
- **Includes a new bespoke 360** followed by personal objective setting
- **Incorporates EDI** (Equality, Diversity & Inclusion) throughout, with specific MOT sessions
- **Provides action learning sets** throughout the programme for peer support and reflection
- **Delivers content on change leadership, high-performing teams, and team dynamics**

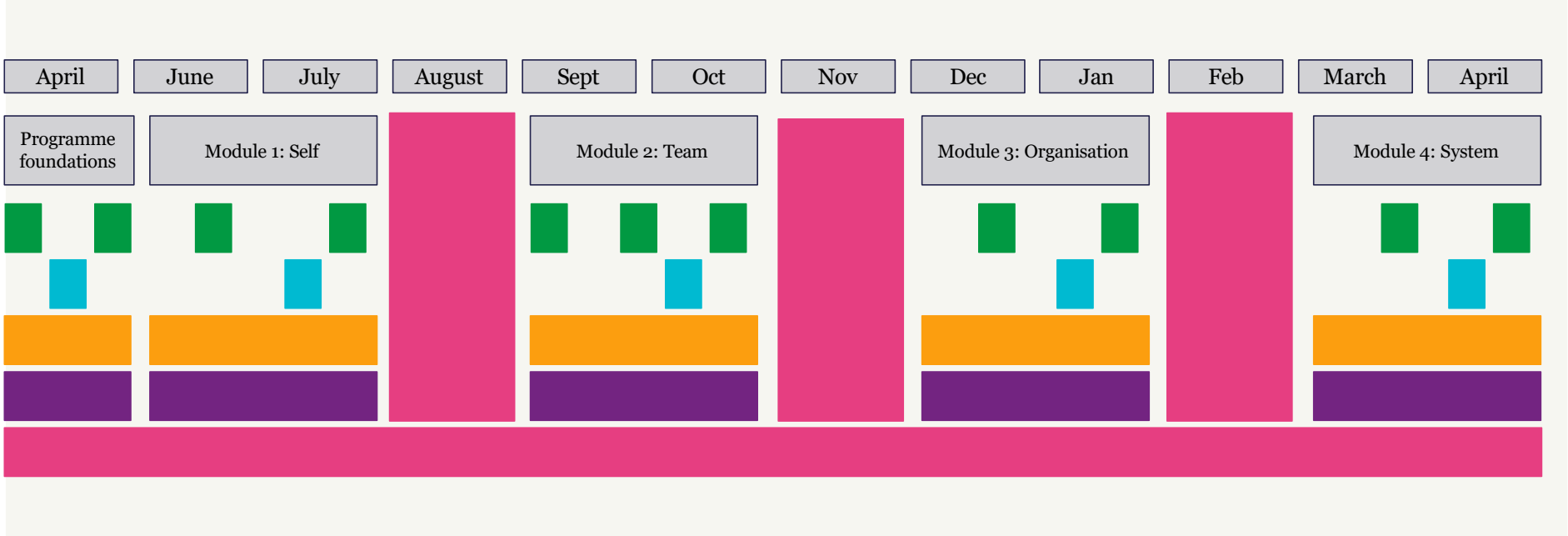
Designed with built in practical application through:

- Leadership reflection to apply learning directly to breakthrough objectives
- Team health assessments using A3 thinking
- Focus on collective leadership impact
- Self-directed reflection with resource libraries for each module
- Regular cohort connections for ongoing peer support

Designed with flexibility to:

- Allow time between modules to apply learning (with breaks built in)
- Balance face-to-face learning with digital components
- Provide continuous applied practice opportunities
- Build leadership capabilities that align with KMPT's values and behaviours

Appendix 3: Programme timeline



Key: | Cohort connection | Face to face learning events | Reading/listening list circulation (self-directed) | Action learning set | Continuous applied practice

Appendix 4: Programme Breakdown

Programme Foundations

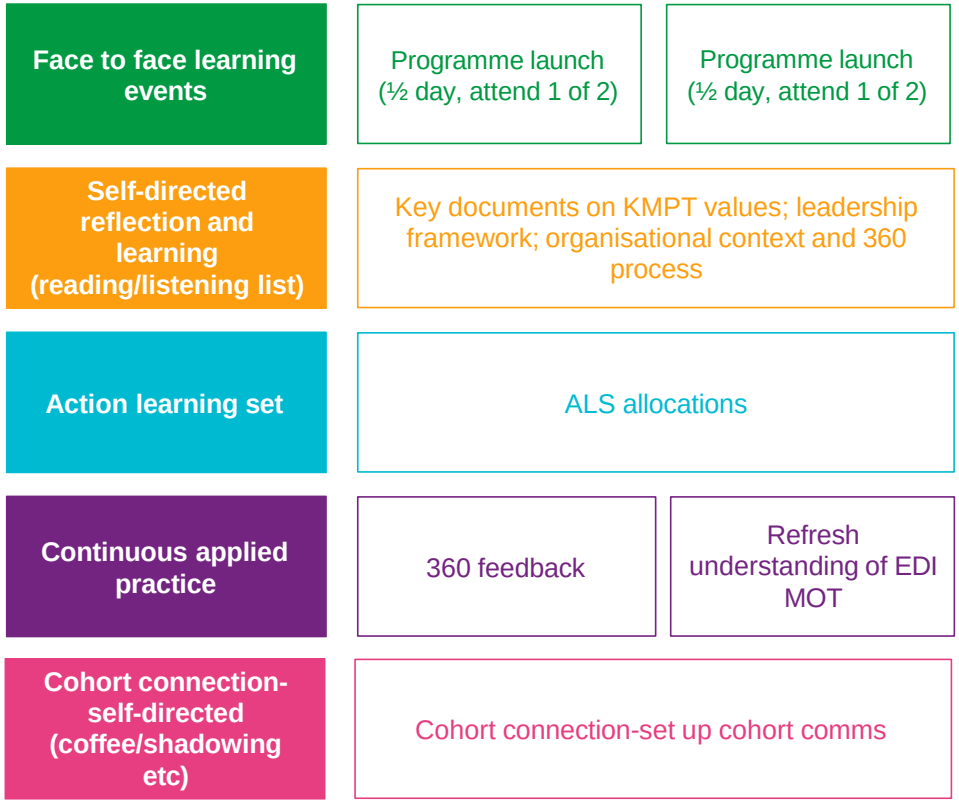
This module is all about getting the foundations in place for participants to get the most out of the leadership development programme. The module concerns itself with logistics, scheduling and gathering key data points to set the direction of travel for the programme.

The core qualities you will focus on include: reflection, curiosity, self awareness and responsibility.

The skills and capabilities you will develop are: understanding self; impact awareness; critical thinking and confidence.

At the end of this module you will be able to:

- Understand the ambition and logistics of this leadership development programme
- Critically reflect on your leadership impact and development priorities in the context of KMPT purpose, values and breakthrough objectives
- Establish a personal development baseline through seeking feedback and re-visiting your EDI MOT report.
- Demonstrate reflective practice as a leader



Module 1: Self

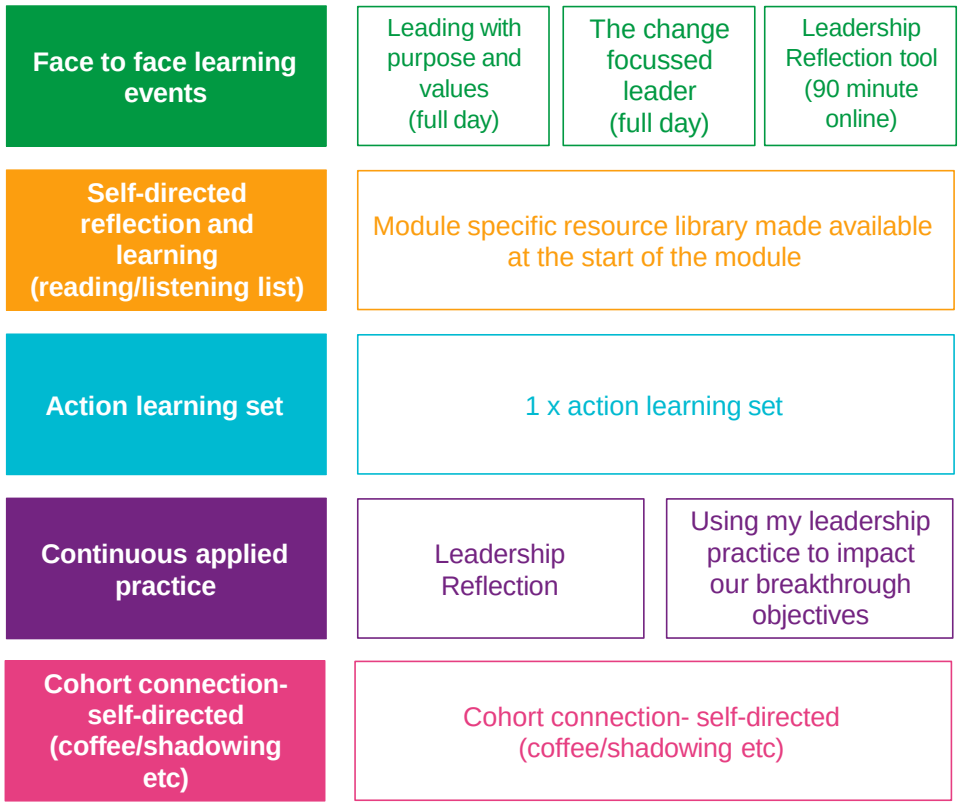
A high performing leader commits to the work of increasing their self-awareness and taking responsibility for themselves and their impact on the world around them. They understand that the work of a leader is inside out. The work starts with them. This module explores the personal qualities that are important in living out our KMPT values and delivering our KMPT vision. It is an opportunity to reflect on your personal mission as a leader in KMPT. Providing space and time to reflect on what makes you tick, how you stay 'match fit', and the impact you have on the world around you.

The core qualities you will focus on include: reflection, curiosity, humility, self-discipline and ownership.

The skills and capabilities you will develop are: communicating effectively; building resilience; personal risk taking; authentic leadership and purpose driven leadership.

At the end of this module you will be able to:

- Describe your personal purpose as a leader
- Demonstrate the ways in which your leadership embodies KMPT values
- Draw on key data points to deepen personal understanding of bias and the impact this has on you as a leader.
- Understand the impact of your personal leadership style
- Identify a set of development ambitions for yourself as a leader.



Module 2: Team

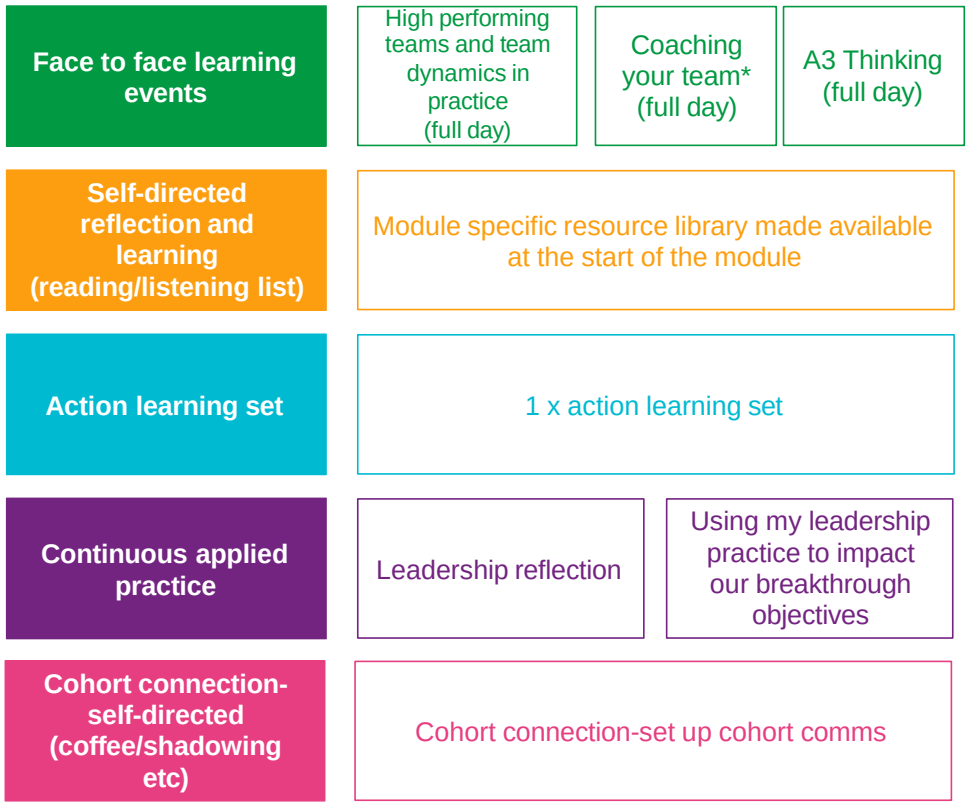
A high performing leader is able to create and sustain the conditions of a high performing team in service of the mission, vision and values of KMPT. This module examines the role you play, the mindsets and beliefs you hold and the practical actions you can take to enable your team do to their best work.

The core qualities you will focus on include: kindness; empowerment; transparency; trustworthiness.

The skills and capabilities you will develop are: coaching; critical thinking; feedback and difficult conversations; prioritisation; active listening; creating the conditions for psychological safety.

At the end of this module you will be able to:

- Describe the 8 characteristics of a high performing team
- Understand and apply core leadership models to create the conditions for high performance within your team
- Generate practical actions that you can take to nurture diversity and inclusion within your team
- Apply a coaching approach to leadership interactions
- Identify key areas of development for your team and your role as a leader in creating the conditions for high performance.



Module 3: Organisation

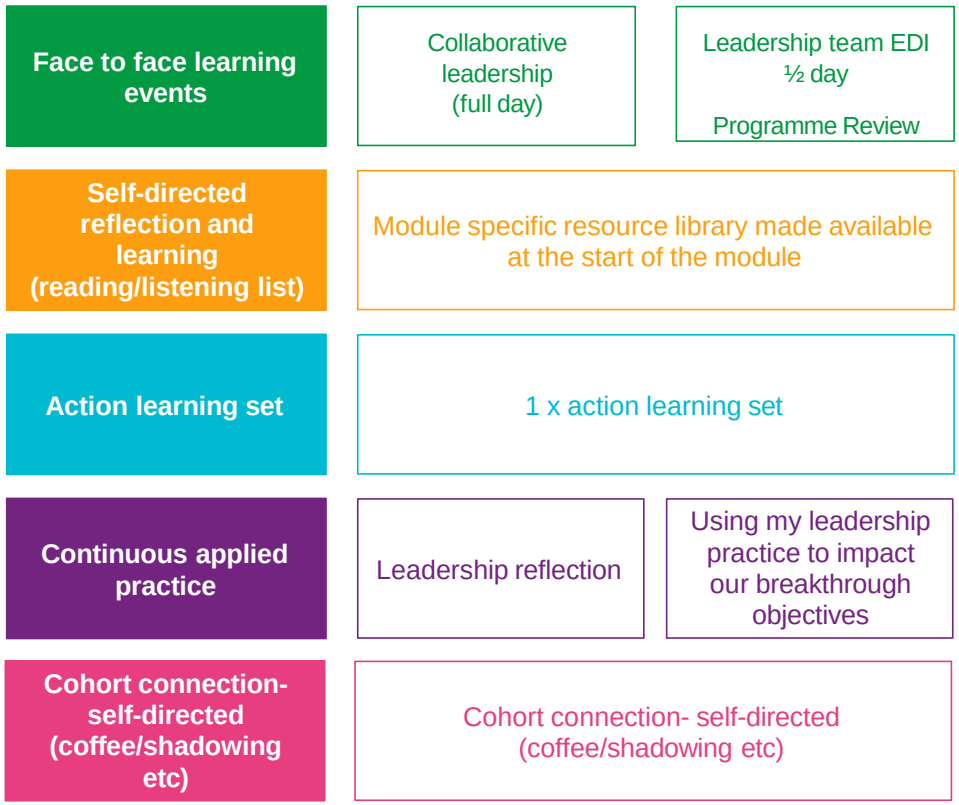
A high performing leader is able to embody a leadership team and organisation first, portfolio second mindset. This module will challenge participants to understand that the 'whole is greater than the sum of its parts'. Through developing a sense of belonging to the 'team' you will explore the collective endeavour of leading organisational change, pulling together in the same direction.

The core qualities you will focus on include: curiosity, kindness, 'we not I' mindset; self awareness

The skills and capabilities you will develop are: Collaboration, joint decision making, empowering leadership, change management

At the end of this module you will be able to:

- Understand the characteristics of collaborative leadership
- Generate personal commitment and belonging to a leadership team
- Understand the impact of the collective EDI MOT as a team of leaders.
- Describe key interdependencies across the organisation and the importance of working together to deliver key organisational objectives and culture changes such as the adoption of key EDI interventions.
- Commit to a shared set of development actions



Module 4: System (TBC)

We are working across the system to develop this module and more information will be shared later.

Appendix 5: New 360

Supporting teams
Is visible to the team, engaging with and listening to staff and taking action where needed
Is courteous and respectful in the way they deal with others
Is considerate to the needs and feelings of others
Provides support to team members
Encourages people by praising and valuing their effort and contribution
Promotes flexible working and wellbeing across the organisation

Leading inclusively
Actively seeks input and ideas from others to increase understanding and create better solutions
Encourages others to be open and honest, to say what they think
Draws on the knowledge, skills, experience and expertise of others
Involves the team in solving problems and making decisions
Values diverse thinking and encourages this with the team
Challenges the organisation to reduce workforce inequalities and promote inclusive and compassionate leadership

Acting with emotional intelligence
Interacts positively with others using a combination of confidence and warmth
Stays calm, even when things might be demanding or stressful
Demonstrates empathy, understands the perspectives of others
Behaves in a predictable and consistent way so people always know where they stand
Is positive and optimistic

Building collaboration
Encourages the team to review how it works together
Facilitates people with differing views to achieve consensus and commitment to decisions
Empathises with other points of view to establish common ground
Asks questions in order to understand issues fully
Considers the whole organisation as opposed to working in isolation
Builds relationships across the organisation to enhance collaboration and cooperation to drive improvement in services

Appendix 6: Outcomes

IMPACT PATHWAY: Leadership development programme

Objective	Activities/Outputs	Outcomes	Broader impact
To improve the confidence and capability of the leadership group in relation to: **- Leading self** **- Leading team** **- Leading organisation** **- Leading system**	Face to face learning events Self-directed reflection and learning (reading/listening list) Action learning set Continuous applied practice Cohort connection - self-directed (coffee/shadowing etc)	Leaders critically reflect on their leadership impact and demonstrate reflective practice **Self:** Leaders are able to articulate their personal purpose as a leader **Self:** Leaders understand the impact of their leadership style **Self:** Leaders have each identified a set of development ambitions **Team:** Leaders are familiar with the High Performing Teams model and apply leadership models to foster high performance **Team:** Leaders use a coaching approach for their leadership interactions **Team:** Leaders have identified key areas for team development **Organisation:** Leaders understand collaborative leadership and demonstrate increased commitment to the leadership team **Organisation:** Leaders have a set of shared development actions	Increased autonomy, accountability, and strategic confidence among leaders Strengthened leadership team and organisational culture A sustainable leadership development culture within the organisation Teams and individuals feel able to do more of their best work Improved organisational effectiveness and performance Improved patient care

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Impact of the Improvement Collaborative
Author:	Sarah Atkinson, Deputy Director of Transformation & Partnerships
	Sarah Dickens, Deputy Director of Research & Innovation
	Sue Venables, Clinical Audit & Effectiveness Manager
Executive Director:	Adrian Richardson, Director of Transformation & Partnerships
	Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper outlines the individual and collective impact, over the last year, of the services which makes up the Improvement Collaborative; the Improvement Team, Research & Innovation and Clinical Audit and Effectiveness Team.

The paper also describes the steps which have been taken for these 3 services to work more closely together to create a unified approach to change/improvement in KMPT and also sets out the plans for 2025/26 to further develop the Improvement Collaborative.

Issues to bring to the Board's attention

Benefits realisation will form a key component of the new Doing Well Together Improvement Programme launched in April.

Strengthening of the close working of the Improvement Team, Research and Innovation and Clinical Audit and Effectiveness will continue this year through the Improvement Collaborative.

Governance

Implications/Impact:	Identification of any risks/impact on patient safety/resource
Assurance:	Reasonable
Oversight:	Quality Committee and Finance & Performance Committee

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Background/ Context

Prior to April 2024, there were four distinct teams promoting improvement and change within the organisation:

- The Quality Improvement (QI) team
- Research and Innovation
- Clinical Audit and Effectiveness
- Transformation.

QI, Research and Innovation and Clinical Audit and Effectiveness sat within the Chief Medical Officer's portfolio and Transformation team within the Director of Transformation and Partnerships' portfolio.

In January 2024, the decision was made to review the executive portfolios and the QI team moved to the Director of Transformation and Partnerships. This was to help address siloed working and duplication between large transformational change programmes and QI, Research and Clinical Audit.

In April 2024, the Transformation team and the Quality Improvement Team merged to become the new Improvement team, committing to a single Improvement methodology. It was acknowledged that alignment with Research and Clinical Audit is crucial to ensuring clarity for colleagues when embarking on change initiatives and also the intrinsic links between the work of the 3 teams.

This paper outlines the impact of the individual teams but also the progress that has been made in creating the Improvement Collaborative and the plans to grow this single approach to influence change in the organisation.

Improvement Team

The focus of the last year has been on a transition to a single way of working for the two merged teams (QI and Transformation) and upskilling them. This has been a significant adjustment for the team. The impact over the last year has been categorised below in terms of the individual approaches/ methodologies which have previously existed; QI & Transformation. From April 2025, they will report their impact as a single team with a single approach to improvement and the benefits realisation achieved for the organisation.

Quality Improvement Projects

At the time of the team's merger, there were 30 open QI projects. Closer evaluation determined that only 10 were active and the remaining 20 had not progressed and were no longer viable projects. Support for new projects paused in July 2024 in order to evaluate the current workload and review the improvement methodology.

The active projects had been started using the previous quality improvement methodology and have been supported to completion. The table below highlights each project and the benefits realisation of each.

Project Title	Summary	Indirect Benefit	Direct Benefit	Update
HTT (Dartford) Reasonable adjustment for service users with Autism *Presented at Board July 2024*	Implementation of the Ask, Listen, Do (ALD) Framework and using visual management to identify Autistic patients	• Staff perception of the effectiveness of the team to support patients with autism increase from 2.8 to 3.8 (out of 5) and qualitative data showed that staff felt their care plans were now more patient centred		
South Kent Coast RED board meetings *Presented at Board March 2025*	Process improvements to red board meetings	• Non-cash releasing from time saved approx. £400k per annum	• 2 hours' time saved per staff member, per day (approx. 40 hours per month) This has allowed more clinical activity.	In May the CMO and CNO reviewed the effectiveness of this and we are now subsequently creating a training package for other teams to review how this is being done and supporting them to roll this out across the Trust. This will be taken forward by the CMHF Programme to increase activity within teams.
Art therapy mural – Jasmine ward	Improving the therapeutic environment on the ward – a mural painted by staff & patients	• Before the project 63% of staff and patients were less than satisfied with the environment. This reduced to 58% after the project.		
Delays to treatment initiation due to incomplete Electrocardiograms (ECGs)	Trial of portable ECGs	• Enhanced patient experience • Research opportunity for wider implementation	• Reduction in delayed in ECGs from 6.93 days to 0.5 days • Reduction in the percentage of patients waiting over 3 days for an ECG from 24.1% to 7.14%	The use of portable ECG's is currently being rolled out across community teams led by our physical health team. It is currently in procurement phase and all ECGs are expected to be in use by July 2025.
Annual training in Serious Incidents Investigations and Coroner's Inquest for resident doctors		Benefits not specifically measured although noted impact to: • Enhanced patient safety • Reduced defects in reporting • Increased reputation • Increased staff confidence 93.3% of trained doctors felt they understood the process of conducting an SI investigation compared to 28.2% at commencement.		

Version Control: 01

Electroconvulsive Therapy (ECT) clinic utilisation	Optimisation of existing capacity to enable the provision of maintenance ECT treatments where required.	• Better utilisation of existing capacity, with the ECT clinic now able to see 7 patients instead of 6 in each clinic. However, throughput did not increase during the project as demand reduced.		This example will be used within the Doing Well Together programme as a learning opportunity for teams to address demand and capacity.
Reduce active review waiting list in Dartford Gravesham and Swanley	Process improvements to reduce patients waiting for active review	• Waiting list reduced by 46% in June 2024 – project was rolled into the rollout of Community Mental Health Framework		
Improve Physical Health monitoring	Increased monitoring for patients in the DGS depot/ clozapine clinics in line with approach used in other localities	• Accurate monitoring of patients accessing the service improved patient safety. • Reported a better experience for both staff and patients as the service transitioned from being reactive to proactive	• Physical Health monitoring compliance increased from 22% to 70%	
Rollout of Peer Supported Open Dialogue training	240 training spaces made available over 2 years	• Positive feedback from training and staff feeling better equipped for clinical work • Improved organisational reputation • Future income generation for training outside of KMPT		
Well Aware	Wellbeing awareness training for speciality DR's	• Improved access to wellbeing services. Work highlighted that speciality doctors were not accessing wellbeing events (73.3%) and had not accessed wellbeing services (13.3%). Outputs included wellbeing information leaflets, wellbeing forums, and adaptations to the supervisions		

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Transformation Projects

By their nature, transformation projects are longer term programmes and whilst the team have been supporting the 6 strategic priorities since 2023, some of these initiatives have not yet concluded and so it is difficult to derive tangible and sustained benefits realisation until the programmes conclude. However, the table below highlights both the projects where benefits have been realised in-year.

Strategic Priority	Project Title	Summary	Indirect Benefits	Direct Benefits	Update
Benefits realised					
Getting the Basics Right Presented at Board September 2024	SMS appointment reminder	Increased utilisation of appointments at DGS Mental Health Together (MHT)	Non- cash releasing £21,052.30 (estimated) calculated by reducing Did Not Attends (DNA's) by 79 over 10 weeks (this is approximately 5% of appointments)	79 DNA's avoided	The use of SMS reminders is now incorporated into the Community Mental Health Framework programme and a trust wide approach is being explored.
Urgent and Emergency Care (UEC) (Crisis Line)	Reduction in agency spend		Cost avoidance £360,689.30 – difference in agency spend from 23/24 to 24/25 in the crisis line team and the impact on long-term quality provision through the use of substantive staff.		
Dementia Improvements presented at Board January 2025	Improved access to data	Dashboard launched in Nov 24 allowing more effective caseload management	Reduction in waiting times from 189.9 days in July 24 to 143.5days in April 25 Reduction in 52 weeks waits from 260 to 180 (13/5/25)		Greater access to data at a more granular level has enabled a frontline approach to improvement focused on waiting times and long waits. With improvement huddles and visual management now being rolled out across all Memory Assessment Service.

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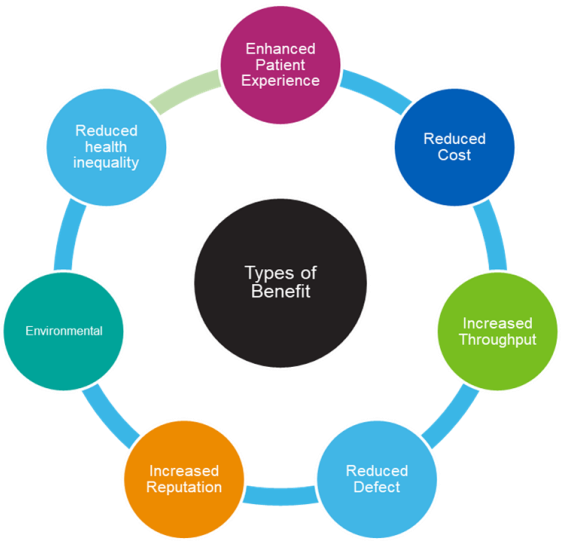
Continuous Improvement/ Doing well Together

In September 2023, KMPT became accredited by the Lean Competency system to deliver A3 Thinking training which seeks to build organisational capability and ensure a more sustainable approach to improvement. As part of this training and to become accredited, delegates must undertake an improvement project using the A3 methodology. To date, 34 delegates have been accredited with 10 of those completing projects which are aligned to the trust priorities and will form part of the wider benefits realisation for the programmes. Examples of completed A3 projects can be seen in Appendix A.

In March, the board agreed the rollout plan of Doing Well Together, the trusts single improvement methodology. This will embed daily continuous improvement across the organisation. Part of this methodology is to instil benefits realisation more definitively into all improvement work, however large or small. Going forward this will ensure a more robust approach to capturing the impact and benefits of all of our improvement work, using the 8 types of benefits highlighted below and identifying where the monetary benefits are cash releasing, non-cash releasing or cost avoidance.



Research & Innovation (R & I)

Recent investment into R&I is starting to be realised, as we move forward to be a truly research active organisation.

Work of the department is split between several teams to develop, set up, provide governance for, manage and deliver Clinical Research. From July 2024 we had completed recruitment to KMPT funded posts, that ensure we are able to increase the number and variety of those involved in our research.

We are starting to increase the ways we add value to operational issues within the organisation. An example being where we have received recognition from members of the Executive Management Team (EMT) for bringing a research lens to the clinical flow challenges we were facing. We applied for research funding to help address the challenges in the KMPT MHT programme.

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Working as part of the Improvement Collaborative, and therefore better aligning activity with the strategy of the organisation, gives us more opportunity going forward to be able to address these sorts of trust concerns.

People who work for us

- We now have 15 KMPT staff members who have a split role across research, clinical care and/or academic work at the University of Kent which enables us to develop more KMPT led research ideas.
- KMPT has its first National Institute for Health and Care Research (NIHR) Academic Clinical Fellow – a trainee doctor receiving joint research and clinical training– fully funded by the NIHR – so in effect a completely free resource for KMPT.
- We were awarded £20,000 to comprehensively upskill and give new opportunities to 5 KMPT Pharmacists, thus expanding our capabilities in clinical trials.
- 49 KMPT clinicians contributed to 38 publications which included book chapters, journal articles and editorials. These activities develop their skills, research reputation as well as KMPT's profile.

Patients we care for

- KMPT is the only UK NHS Trust with a low field MRI scanner. Our staff are currently being trained ahead of its use for a variety of research including looking at how we can improve our dementia assessments. In due course it could be available for clinical care.
- Dr Jo Rodda has collaborated with other organisations to ensure we are part of a successful £3.8million grant focussed on dementia diagnosis.
- After hosting a commercial study that required physical health measurements, we donated the 2 SECA scales provided by the company (circa £8000 each) to two of our community sites to improve their monitoring of patient physical health & wellbeing. Prof Shergill, in his KMMS role, secured funding of £1.7 million from the Wellcome Trust and with this funding we are hosting CHIP – D. This study explores the dynamic relationship between circadian biomarkers, sleep, cognition, and mental health. Our shift workers as well as patients with psychosis will have the opportunity to receive an in-depth sleep report, which will help us understand the impact of sleep on their mental health and daily functioning using brain scans and cognitive assessments.
- We host up to 30 national, multi-site, NIHR Portfolio studies each year, with 10,000 patients, carers and staff participating since 2009. Here is a small example of some of the recent benefits to our patients;
    - We have run the FRESHStaRT study since 2022, training 16 KMPT liaison psychiatry clinicians to deliver two different types of psychological therapy. This is he first time an intervention has been modified and adapted for those who self-harm (Cognitive Behavioural Therapy or Acceptance Commitment Therapy). 53 of our KMPT patients have taken part in the trial (26 receiving therapy, 27 standard care), with results expected soon.
    - PHARMACOGENTICS - 58 of our patients diagnosed with psychosis have taken up the opportunity for genetic testing. Their resulting report provides doctors individualised insights on how their metabolism responds to specific medications, which in turn allows doctors to make an informed decision about reducing dose of anti-psychotic medication, augmenting it with another medication or swapping for another entirely.
    - 143 KMPT patients have taken part in the PPiP2 Study which aims to better understand the prevalence of pathogenic anti-neuronal membrane antibodies within patients currently presenting with psychosis symptoms. The test, not otherwise available in the NHS, has identified 6 antibody positive patients, which has led to change in treatment, change in diagnosis and more patient centred care. They also go on to screening for a further trial that offers a potentially curative immunotherapy treatment.

Partners we work with

- Over £100,000 funding from local partners helped us to develop research with academic partners in areas of underserved populations and health inequalities in Kent & Medway. Topics included exploring Sikh mental health and dementia in coastal communities. This funding secured several roles, that enabled us to develop and launch our Research Community and research identity.
- Our partnership working model has now been adopted by the organisation in the newly formed Involvement & Engagement team. 1.6 WTE of this team has transferred directly from our establishment.
- We have been working with system partners across Kent and Medway examining the suicide risk factors in areas of health inequalities in Kent. This has developed excellent links with partners in the Kent and Medway System but also led to KMPT becoming partners of the National Suicide Prevention Alliance
- There are now 9 University of Kent academics with KMPT honorary contracts to further strengthen our collaborative working.
- We are now working closely with radiology colleagues at Dartford & Gravesham NHS trust, enabling us to move forward with readying the Hyperfine Scanner for use.

Finance and Sustainability

The table below shows £918,7666 in income in 24/25. Of this, £786,818.26 was capital income, to be used to start to develop our Clinical Research Facility and a second Hyperfine low field Scanner. Both of which will enable us to generate more of our own research and attract commercial studies.

	2023_2024		2024_2025	
	Number	**£**	**Number**	**£**
Total Bid Submissions	12	£2,298,878	33	£14,649,764
Grant Income success	**7**	**£557,584**	**12**	**£918,766**

Clinical Audit and Effectiveness Team

Clinical Audit and Service Evaluation Projects

During the last financial year to 31st March 2025, 150 new CASE projects were initiated, 67 projects were completed and 22 were cancelled. Reasons for cancelling projects were most commonly connected to key staff moving roles and being unable to complete the project or a change in circumstances which meant that continuing the project was no longer appropriate. A copy of the programme is available to Care Quality Commission (CQC) and Integrated Care Board (ICB) on request and is reported through CEOG, the Quality Committee and the Quality Account.

Completed CASE projects provide assurance about compliance with either trust policy, national guidance or both. Of the completed local projects, 41 provided assurance or improvements against trust policies or protocols. Assurance and improvements were demonstrated from completed projects for recommendations from the following NICE guidelines: psychosis, dementia, self-harm, patient experience, infection prevention & control, healthcare associated infections, antimicrobial stewardship, older people independence & mental wellbeing, rehabilitation for psychosis, borderline personality disorders, violence & aggression, vitamin B supplements, antenatal & post-natal mental health, transition between inpatient mental health and community settings, stroke rehabilitation, shared decision making, alcohol dependence.

Version Control: 01

Most completed local projects demonstrated increased effectiveness in clinical practice at re-audit. Examples include the following, with number of projects in brackets. Prescribing practice (13), various monitoring of patients (40), timeliness of investigations (7), patient satisfaction with services (18), communication with internal and external colleagues (24), documentation (42) and staff training (11). A full list of all the actions from clinical audit projects will be reported in the Quality Account and improvements from all CASE projects will be included in the clinical audit and effectiveness annual report.

The team provides high level support for trustwide high priority “must do” clinical audit projects. The following were completed during this reporting 2024/25.

- Mattress audit: 11% of mattresses condemned and replaced.
- Medical devices audit: individual local action plans developed and monitored by matrons, medical devices training developed into 2 e-learning packages.
- Infection prevention and control: assurance provided, site visits by infection team increased, local action plans implemented where required.

Actions from the results of national clinical audits during the last year have included:

- Designing Lithium Pro-forma covering pre-prescribing requirements ready to be put onto RiO.
- Introducing Lithium cards to Lithium patients
- Developing and sharing an anticholinergic effect on cognition (AEC) guideline
- Producing and sharing a list of AEC medication with burden details
- Adding AEC to junior doctors training
- Producing and sharing a list of low AECs
- Providing guidance for older adult patients prescribing antidepressants with AEC effects.
- All staff using one recognised rating AEC scale (provided in this Prescribing Observatory for Mental Health (POMH) project) when prescribing and ward pharmacists providing training to clinical staff on how to use.
- Further training for staff inputting Systemised Nomenclature of Medicine (SNOMED) Codes for all physical health
- Review how many people across the North Kent Directorate are trained in Phlebotomy and to enable them to take up the training

Overall this demonstrates that the CASE programme supports both patient safety and efficacy, in addition to promoting consistency across the trust and contributing to staff development. The flexible nature of the proposal process means that there is scope for the system to be sensitive to any issues identified on the front line, because most project topics are identified by frontline colleagues.

Software

Web based software called Gather is hosted through the clinical audit and effectiveness team. The team oversees the management of users and facilitates improvements and fixes to the system with the supplier.

The software is used for the following purposes

- Questionnaires, reports and posters for the friends and family test.
- On line questionnaires for clinical audit and service evaluations projects, including both trust wide “must do” projects like infection control and medical devices, as well as directorate level projects.
- Database for all clinical audit and service evaluation projects and reporting on the overall project programme.
- Online questionnaires for some improvement projects.

NICE

The clinical audit and effectiveness team supports the implementation of relevant NICE guidelines, via the NICE implementation policy and the NICE governance group. This entails working with nominated clinicians to identify relevant new recommendations published by NICE and working with directorates to complete a gap analysis of current practice against those recommendations. The NICE governance group have also supported work to improve recording of prescribing outside licence on Rio and recommendations from the CQC special review of mental health services at Nottinghamshire Healthcare NHS during this financial year. A group of service users and carers looked at increasing trust compliance with the NICE recommendations on shared decision making, which led to new training being added to iLearn and the creation of a new patient leaflet.

Improvement Collaborative

In June 2024, following feedback from staff that it is difficult to know which team/ function to approach when undertaking change/ improvement ideas, the clinical audit and effectiveness team, the improvement team and the research and innovation team worked together to set up a new one stop process. Staff can submit their project ideas via a short online form. These ideas are then discussed at a weekly meeting attended by representatives from all 3 teams, where agreement is reached about which team the project is most likely to sit with. A member from that team then contacts the staff member to discuss next steps and provide support where possible. This has the advantage providing better customer service to staff by ensuring that they are directed to the most appropriate team. They do not waste time being passed from one team to another, as had been an issue in the past. A total of 137 projects have been submitted via this route since setup.

The table below shows the number of projects that went to each team.

	Clinical audit & service evaluation	Improvement	Research	Other	Total
Number of Projects	81	39	13	4	137

Whilst the improvement collaborative has been beneficial, we recognise there is more to do to maximise its potential and impact on the organisation. Work is underway to increase clinical engagement in the improvement collaborative by ensuring that support is offered from the collaborative to clinicians who are undertaking improvement work or those that are required to participate in audits or research. The Improvement Collaborative also provides opportunities to share learning across the organisation and identify interdependencies in improvement projects which might otherwise happen in silo. As such we have invited digital colleagues to be part of the collaborative and are working with the new patient engagement and involvement team to ensure that we maximise the opportunities to co-create our improvement work with service users wherever possible. We also intend to embed benefits realisation approach from Doing Well Together to ensure that we have consistency of approach and have robust reporting of benefits and impact going forward.

In the Diligent Reading Room, you can find Appendix A – Examples of Improvement Projects using A3 Thinking.

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Update: Notts Homicide Review and Assertive Outreach
Author:	Jacqui Wilson, ICB MH Transformation Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Standing Order

Overview of Paper

NHS England (NHSE) have required all mental health Trusts to undertake a review of cases that might require assertive and intensive community treatment, beyond that which is already offered through the community mental health pathways in Community Mental Health Framework (CMHF).

Issues to bring to the Board's attention

The Integrated Care Board (ICB) and KMPT have identified a cohort of patients who may come under this umbrella term and are working to develop and commission a model of care that will work across the county.

Progress is being made, with a team outline and model in development. NHSE expects trusts to develop their services through the course of 2025 and are issuing guidance on the model and outcomes.

Governance

Implications/Impact:	If we do not develop this resource for this patient cohort, then they may require more and longer admissions, be involved in serious incidents resulting in harm to them or the public.
Assurance:	To be assigned
Oversight:	Quality Committee

Version Control: 01

NHSE

Community Mental Health Service Review

ICB Maturity Index Self-Assessment Tool

Kent and Medway Integrated Care System

NHS Kent and Medway NHS and Social Care Partnership Trust

Background and Timetable

- Valdo Calocane - 13th June 2023 – Nottingham.
- CQC review into care states:

  “systemic issues with community mental health care which, without immediate action, will continue to pose an inherent risk to patient and public safety”.
- NHS England » Guidance to integrated care boards on intensive and assertive community mental health care – 2024 – All ICBs to review local services, and policies .
- The Kent and Medway System review was then submitted to NHSE Sept 23
- Independent Mental Health Homicide Review into the tragedies in Nottingham Feb 5th 2025

Assertive Outreach/Intensive Case Management Function

- Review of policies and practice in relation to the hard to engage Serious Mental Illness population as requested by NHSE, submitted to NHSE Sept 23. The review found some policies need refreshing but that there was no specific AOT/ICMF service, all ICBs are expected to commission such a model going forward.
- A Steering group was set up to:

A) identify the numbers of this patient cohort in K&M. (Numbers appear to be approx. 80) ensure that there is good quality clinical oversight in place for this group.

B) Submit a plan to NHSE outlining current provision and a costed AOT model by Nov 24 (complete although it appears little or no funding will be allocated by the centre to introduce the model)

C) Identify a more affordable model to meet the need and commission this from existing resources.

Kent and Medway - Self Assessment

- Kent and Medway ICB engaged an interim Mental Health Transformation manager to complete and submit the Kent and Medway Self – Assessment (complete).
- Kent and Medway Social Care Partnership NHS Trust (KMPT) – identified Senior Staff to support the Self-Assessment Process.
- The process included :
- Reviewing key policies and procedures
- Data Systems
- Governance

Kent and Medway Integrated Care System

NHS Kent and Medway NHS and Social Care Partnership Trust

Kent and Medway Outcome

- The review found that the there was good clinical oversight for this patient group in the services but that there are some gaps in meeting the needs of this patient population. It was established that there is a need for a clear Assertive Outreach Team offer in Kent and Medway.

- All the required Policies and Procedures were in place and there was a rolling review programme to ensure they were still relevant and updated where new guidance had been issued.

- Data systems would need some amending to ensure this cohort could be easily identified as a distinct patient group.

- Governance systems need reviewing to ensure that there is oversight in place.

Next Steps

- Following the review the local steering group is already working on an action plan that covers all the areas of the review, and this for some areas will involve working with providers, other statutory services such as Social Services, Voluntary, Community and Social Enterprise services, patients , carers and families.

- NHS Kent and Medway ICB and KMPT are working on an Assertive Outreach Service to be introduced across Kent and Medway. The model being developed is based on a hub-and-spoke approach - so central oversight of those individuals that the teams are most concerned about and resource to increase engagement being provided across the county. This will require testing and refining to integrate it into existing teams and their operating processes.

- NHSE will also be developing enhanced guidance - around intensive and assertive community treatment, and these will then be fed into local action plans. This should help to aid the discussions around movement in and out of the service and how this is outcome-based.

- NHSE have said they will review and offer feedback on the plans in the next few months, and that plans should be reviewed on a six-monthly basis, so that progress can be measured going forward.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Andy Cruickshank, Chief Nurse**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quality Account Priorities update • Violence and Aggression Report • Suicide Prevention and training update • Safer Staffing Report (aka Nursing Establishment Review) • Research and Innovation Strategy Update • Quality Digest • Quality Impact Assessments • Mortality Report • Continued use of external beds update • Annual Policy Report	• Chief Nurse's Report • Quality Risk Register • CQC Report

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse Report:	Following the recent CQC inspection, the Trust has identified three areas of change: 1) Clinical Leadership 2) Measurement and Data 3) Method of improving. These will be rolled out by the Trust with further updates to be provided. The Trust's engagement with child protection conferences has improved significantly with 100% attendance achieved.	**Reasonable Assurance**	
Quality Risk Register	The Committee received assurance regarding the measures aimed at risks connected to: a) Patient flow and patients who are Clinically Ready For Discharge (CRFD); and b) Access to Mental Health Together. The Committee also discussed Ashford liaison psychiatry and interactions with William Harvey staff. The effective use of safe havens will support staff at this site.	**Reasonable Assurance**	The Committee requested further details relating to risks associated with changes in the Botox service, for its next meeting.
Quality Account Priorities discussion	The Committee received updates regarding the Quality Priorities for 2025/26 of 1. Women's Health 2. Self-harm 3. Working with Families	**Reasonable Assurance**	

	There has been some progress in quarter one, but there needs to be an increase in the pace of delivery.		
Violence and Aggression Report	An improving picture on the Trust's wards indicate effective solutions being rolled out. CRFD continues to adversely affect mood on the ward – tackling CRFD will result in improvements in various performance areas. The body worn cameras pilot has ended and the Trust is carrying out an evaluation, noting that there was very variable experience and outcomes around the country.	**Reasonable assurance**	
Suicide Prevention progression update training	The Trust has achieved a good level of success in the rollout of training, with 1174 out of 1752 staff members trained. Digital alignment of forms will be rolled out on 28.05.25.	**Reasonable assurance**	
Research and Innovation Strategy Update	The Committee was updated on the work undertaken by the Research and Innovation Team, noting the range of successful funding applications. The Committee noted plans to identify a suitable alternative location for the clinical research service, to better deliver income-generating research.	**Reasonable assurance**	
Annual Policy Report	The Committee noted the policy report, with a number of policies requiring a review. It is unclear if there is a material effect on the Trust's operations.	**Limited assurance**	The Committee to be updated at the next meeting regarding the status of the policies that need reviewing

QUALITY COMMITTEE

Q4 2024/25 MORTALITY REPORT

1. INTRODUCTION

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

2. HOW MORTALITY IS REVIEWED IN KMPT

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

2.2 The Patient Safety Incident Response Framework (PSIRF) sets out how the NHS responds to these patient safety events so we can learn from them and improve patient safety.

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

2.4 KMPT implemented PSIRF on 30th September 2024. A weekly patient safety incident decision panel was set up, to replace the Serious Incident and Mortality Panel. Mortality is reported and reviewed by the Directorate Governance teams. The purpose of the group is to review incidents (including mortality) that may require further exploration, such as a thematic review, After Action Review (AAR) or Patient Safety Incident Investigation (PSII).

2.5 In addition to this panel and PSIRF processes, the trust has a monthly Mortality Review Group meeting, chaired by Interim Director of Quality and Safety or appointed Deputy. In this meeting, a monthly mortality report is presented to enable discussion relating to local and National mortality data. This group is made up of various Governance leads, Heads of Nursing, Complaints, Legal, and medical representation.

2.6 The trust also has a learning review group, that meets once a month, chaired by the Chief Nurse, where learning from deaths can also be discussed.

3. ANALYSIS OF INFORMATION

Figure 1: Mortality reported cases

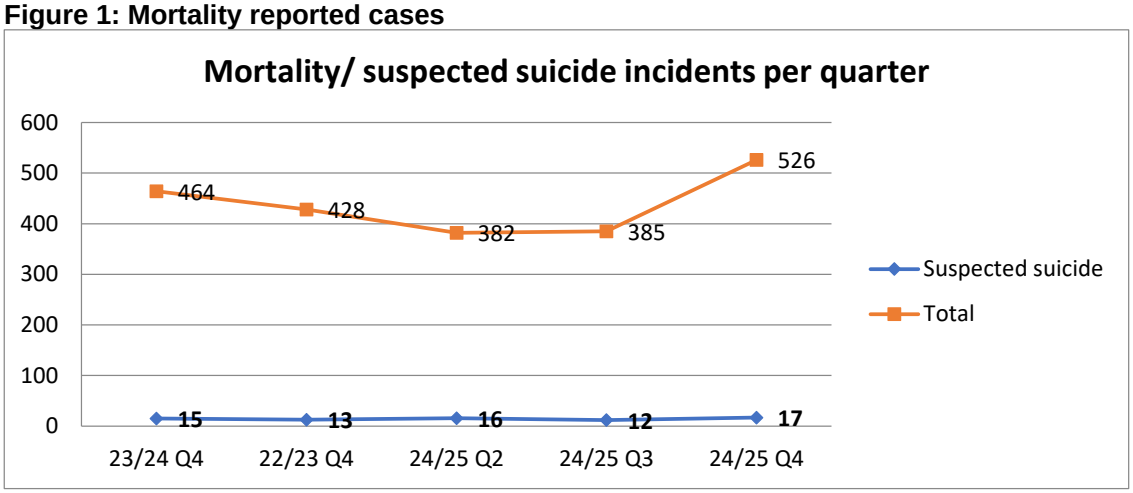


Figure 2: Mortality rates compared to death notifications

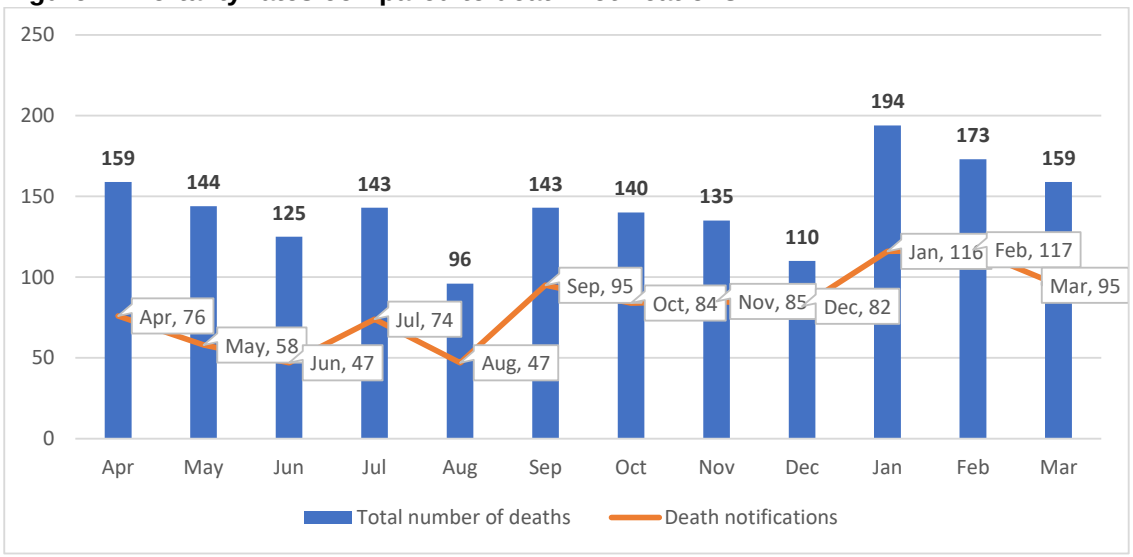


Figure 3: Mortality SPC

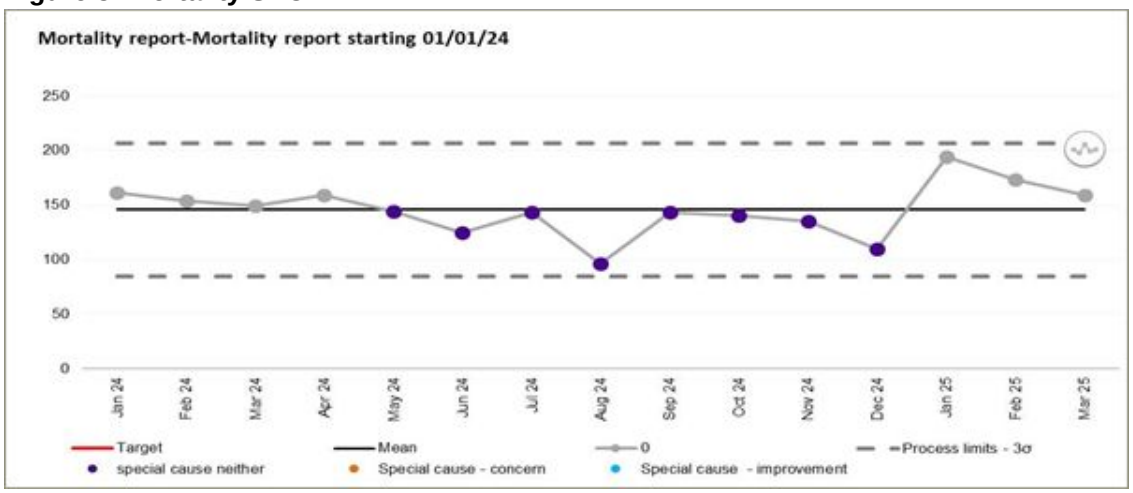
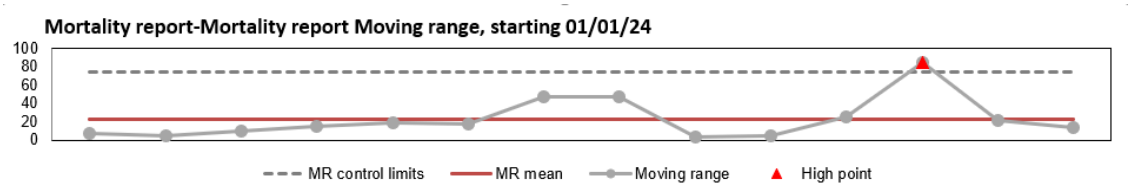


Figure 4: Mortality moving range chart



3.1 The rate of death notifications has fluctuated throughout the months as mortality rates rise and increase (Figure 2). The process in place for capturing all patient deaths is well embedded within the BI and RiO systems and well established with Governance teams.

3.2 Mortality rates increased in January and February 2025. In January alone, 42% of the patients died in 2024 (January to December). This indicates that the increase in reporting was reflective of retrospective reporting, as opposed to death rate increasing in these months.

3.3 Of 174 deaths that were reported in February 2025, 100 patients had a date of death of February 2025.

3.4 84% of deaths reported in Q4 were patients who were over the age of 65 years. 136 patients were open to the memory assessment service. Most died of an expected, natural cause death.

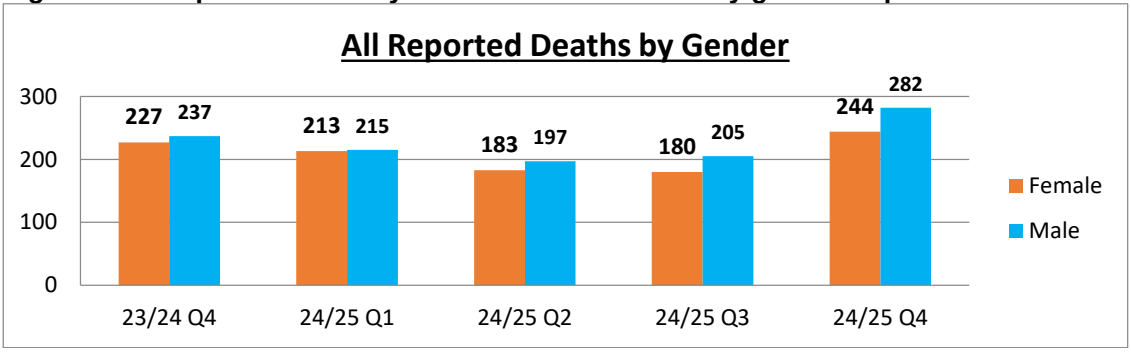
3.5 There was an even split of expected and unexpected deaths reported in Q4. Focussing on the sub categories, the majority of the unexpected deaths are where the cause of death is unknown, but there are no care or service delivery issues noted. It is not always possible for our services to obtain or confirm a cause of death. This can be for a number of reasons, including the patient living in a care or nursing home, or the cause of death not being listed on shared healthcare records.

3.6 Those that are pending investigation either relate to an incident where there is an ongoing investigation or review, or where (mostly) the team investigation and learning page is yet to be completed.

Figure 5: Death/unexpected death in Q4 2024/25

Death (Expected Death)	**263**
Expected death within an Acute Trust unrelated to mental health	70
Natural causes	46
On end of life / palliative care unrelated to mental health	147
Death (Unexpected Death)	**263**
Cause of death unknown, care and service delivery issues identified	6
Cause of death unknown, no care and service delivery issues identified	183
Drug / alcohol related death	1
Natural causes	41
Pending investigation	15
Suspected or actual suicide	17
Total	**526**

Figure 6: All reported mortality incidents within KMPT by gender of patients

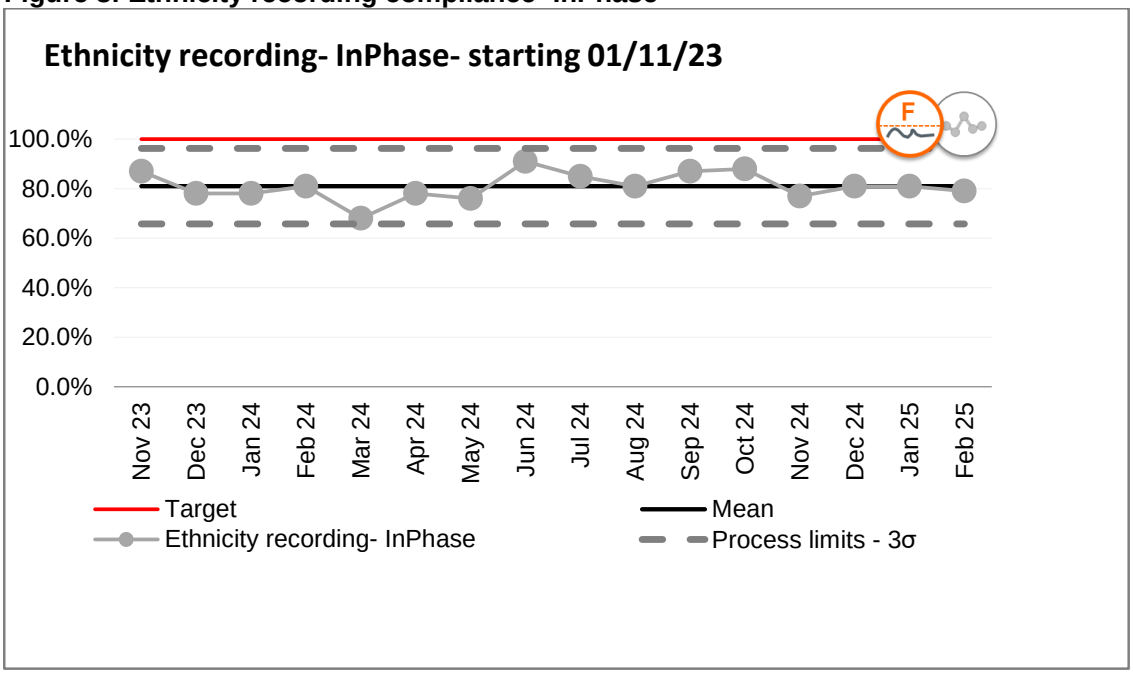


3.7 There are no indications that there are variations in the data in Figure 6 that would require further exploration. Naturally, the rate of male and female deaths in Q4 is higher with the overall increase in mortality reported. Nationally, male deaths are higher than female deaths.

Mortality review by ethnicity
Figure 7: Deaths by ethnicity

	23/24 Q4	24/25 Q1	24/25 Q2	24/25 Q3	24/25 Q4	Total
Asian or Asian British - Any other Asian background	2	0	0	1	0	3
Asian or Asian British - Bangladeshi	0	0	0	1	0	1
Asian or Asian British - Chinese	0	0	1	0	0	1
Asian or Asian British - Indian	2	1	2	4	2	11
Asian or Asian British - Pakistani	1	0	0	0	2	3
Black, African, Caribbean or Black British – African	1	0	1	2	1	5
Black, African, Caribbean or Black British – Caribbean	0	0	3	2	0	5
Black, African, Caribbean or Black British - Any other Black, African or Caribbean background	0	0	0	0	1	1
Mixed or Multiple groups - White and Asian	1	2	0	0	1	4
Mixed or Multiple groups - White and Black Caribbean	2	0	1	1	0	4
Mixed or Multiple groups - Any other mixed or multiple ethnic background	1	0	0	1	2	4
Not stated / Unknown	117	82	62	77	116	454
White - British	329	338	300	286	375	1628
White - Irish	2	2	0	1	1	6
Any other ethnic group	0	1	2	2	10	15
White - Any other White background	6	2	10	7	15	40
Total	464	428	382	385	526	2185

Figure 8: Ethnicity recording compliance- InPhase



3.8 The findings regarding ethnicity are unchanged from previous mortality reports. 71% relate to people who are from a white–British background, which is consistent with what our local and national data tells us.

3.9 There is still little to be understood about deaths of patients of ethnic minority/other ethnic backgrounds. 4% of all deaths reported in Q4 were of patients of ethnic minority. After reviewing the data, it is not possible to identify any commonalities. There is work to be done to ensure that the trust is actively exploring ways we can understand if there are any barriers in ethnic monitories receiving mental health care.

3.10 There are consistent gaps in ethnicity recording, with 22% (116) in Q4 where the ethnicity was recorded as *ethnicity not known* or *not stated* according to the InPhase record.

3.11 The March 2025 monthly mortality report highlighted that the average of non-compliance over a 16 month reporting period (November 2023- February 2025) was 19% per month. With a target of 100% compliance, Figure 8 evidences that improvement work is required.

3.12 The linking of digital systems (RiO to InPhase), although will help with InPhase data quality, won't be the primary solution. This is because ethnicity data is not shared between RiO and the national Spine when a record is synchronised. The ethnicity field however is mandatory in RiO, and therefore a selection must be picked before being able to progress with the patient record. There are options to state that ethnicity is not stated or known, and therefore 100% compliance may not always be achieved.

3.13 There are ongoing initiatives via the Equity For All working group to improve data quality. This includes a goal that KMPT protected characteristic data being 100% complete by 2027, is considered for the trust's strategy. Work is also ongoing to re-

launch the protected characteristics training in the trust, which will be co-produced with frontline staff.

4 KMPT SUSPECTED SUICIDES

Figure 9: Suspected suicide by month

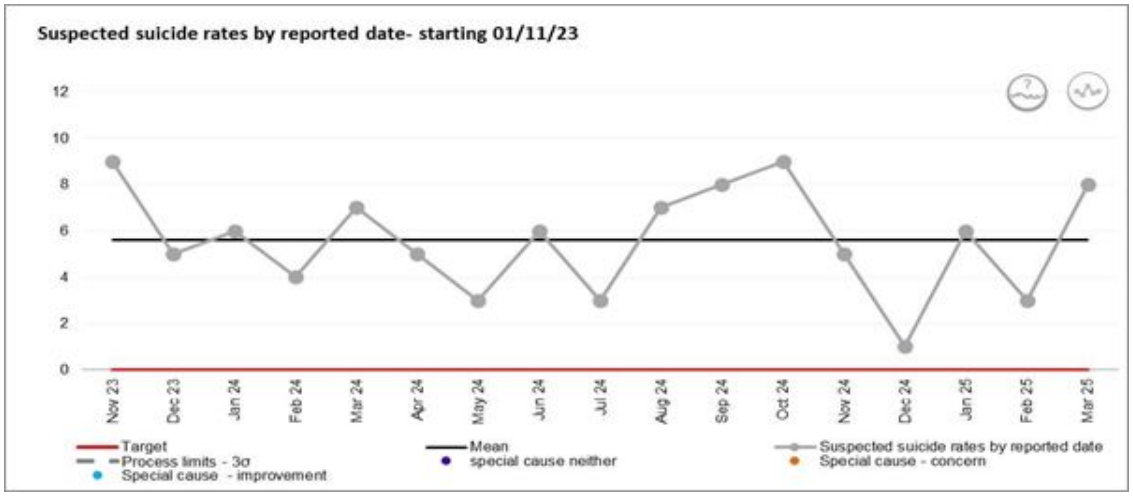
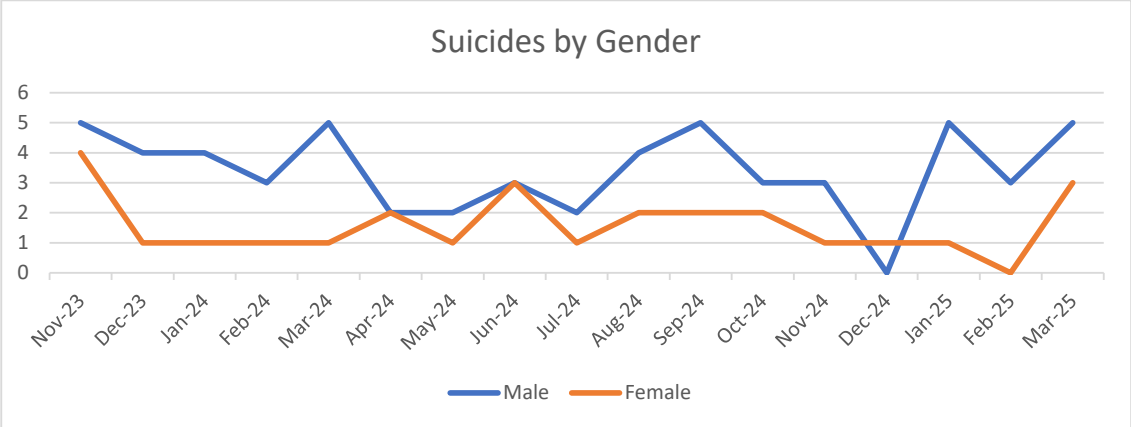


Figure 10: Suspected suicides by age

SUICIDES - Age Band	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
100+	0	0	0	0	0	0	0	0	0	0	0
90 - 99	0	0	0	0	0	0	0	0	0	0	0
80 - 89	0	0	1	0	0	0	0	0	0	0	0
70 - 79	0	0	0	0	1	0	0	0	0	2	3
60 - 69	2	1	1	0	0	0	1	0	0	1	6
50 - 59	2	2	3	1	1	0	0	2	2	2	15
40 - 49	0	0	0	3	2	1	0	0	0	1	7
30 - 39	1	0	0	2	0	2	0	1	1	1	8
20 - 29	1	0	0	1	1	1	0	1	0	1	6
18 - 19	0	0	1	0	0	0	0	2	0	0	3
Total	6	3	6	7	5	4	1	6	3	8	49

Figure 11: Suspected suicide by gender



4.1 As previously highlighted to the board, the most recent ONS stats for the period 2021-2023 placed the Kent (11.7) and Medway (12) rates at slightly higher than the average for England (10.7).

4.2 Figure 9 shows that there has been variation in the rate of suspected suicides reported each month. With the target being zero suicides, the data indicates that there are gaps in either systems or that more work is required to understand and identify any emerging themes where improvements can be made. There is ongoing work to progress with the digital changes to RiO risk assessment, which will align to the Clinical Risk Assessment and Management training and NICE guidance. The aim is that after a period of implementation, there will be visible changes to the quality of risk assessments, which in turn should improve patient experience and reduce the number of suspected suicides.

4.3 The trust are currently undertaking a review of the suicide prevention approach progress, one year on from implementation.

4.4 Figure 10 highlights that suspected suicide numbers in middle-aged patients is higher than any other age category, however there have been variations in some months. Two patients in their seventies (one male one female) died by suspected suicide in March 2025. Both patients had been discharged from services some months prior to their death.

4.5 KMPT are now members of the National Suicide Prevention Alliance (NSPA). This is a great opportunity to work collaboratively with external colleagues.

4.6 The Trust are working with the Kent and Medway Suicide Prevention Programme team to promote the Baton of Hope tour which is coming to Kent and Medway on 22nd September 2025. The Baton of Hope UK tour uses an Olympic style torch to promote awareness and offer inspiration, acknowledgment and support to those who have survived suicide and/or lost someone to suicide.

5 STRUCTURED JUDGEMENT REVIEW

5.1 Improvements have been made to the SJR process. This includes training of staff, timely allocation and completion of reviews, and clearing the agreed 25% of the backlog of cases. The process has been working affectively since relaunch on 1st February 2025.

5.2 Completed SJRs in Q4 have been reviewed, which includes some retrospective deaths. Ratings over care have been listed below in Figure 12.

Figure 12: ratings of care

Allocation and initial assessment or review (entry into services)	Good care- 47% Adequate care- 40% Poor care- 13%
Ongoing care	Good care- 42% Adequate care- 33% Poor care- 25%
Psychiatric inpatient care	Excellent care- 19% Good care- 60% Adequate care- 20% Poor care- 10%
Discharge	Good care- 60% Adequate care- 20% Poor care- 20%
Overall care	Excellent care- 4% Good care- 54% Adequare care- 26% Poor care- 14%

5.3 Overall care was rated good and above in 58% of the cases reviewed. Learning (including poor care), has been shared across the Directorates, and has followed the escalation process if poor care identified, including 2nd SJR completion and discussion at the Patient Safety Incident Response Panel for agreement on the response and any actions required.

5.4 SJR learning has been grouped in the following areas:

Risk assessment	**Medication**	**Treatment and management plan**	**Physical healthcare**	**Communication**	**Other areas**

5.5 Most SJR findings for both good care and areas of learning in January and February 2025 were within the treatment and management plan and physical healthcare categories. Each category includes sub-categories to describe the area of care. The top three areas of good care and areas for learning are listed below.

Figure 13- Areas of good care

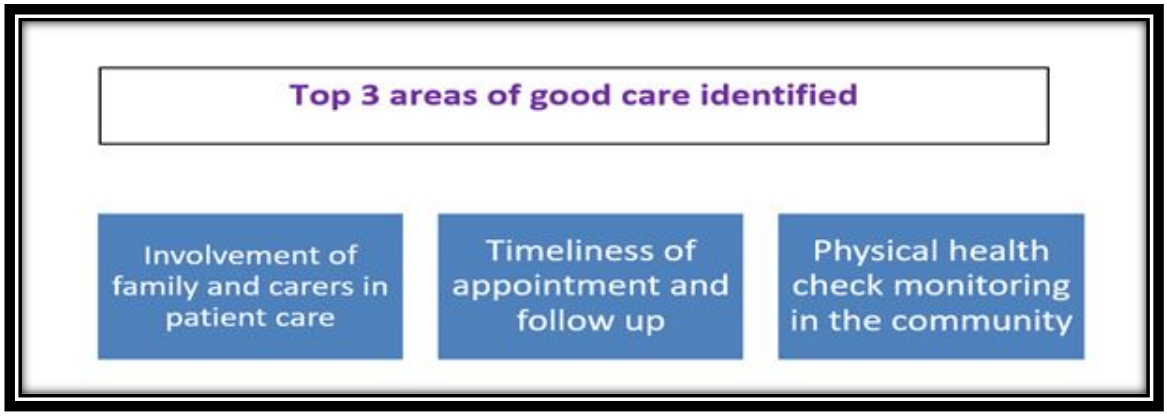
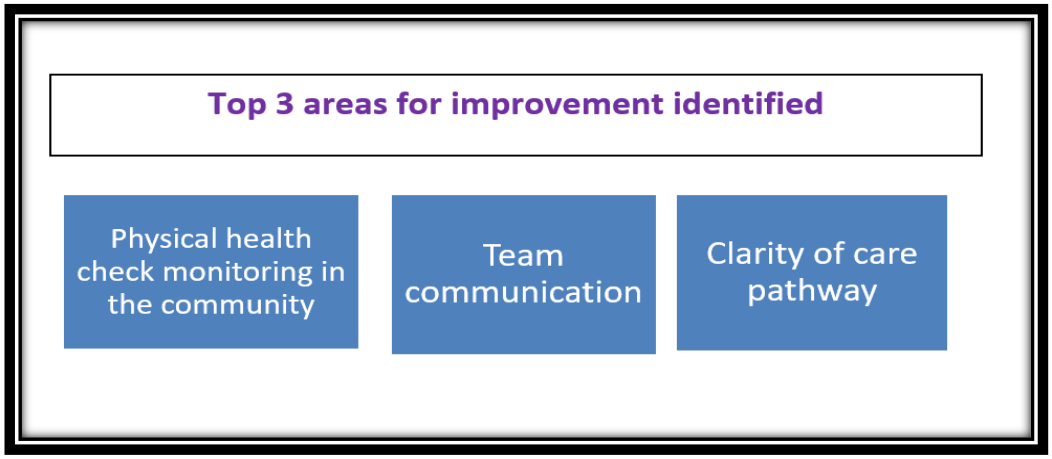


Figure 14- Areas for improvement



5.6 Good care was highlighted in a number of SJRs relating to the involvement of family and carers in the patients care. This includes family being informed of the plan of care, and family views being considered.

5.7 Appointments were mostly met in a timely manner, including initial assessment and review.

5.8 Physical health check monitoring in the community was a common area of good practice identified, including depot management, frequency and documentation of health checks.

5.9 Physical health check monitoring in the community was also highlighted as an area of learning for others. Learning points included documentation of physical health checks, escalation of physical health concerns, and completion and communication (with the GP) of ECGs.

6 LEARNING FROM DEATHS RISK

6.1 The Learning from Death risk, has been updated in this quarter to reflect the improvements made to the SJR process in Q3 and Q4 204/25.

6.2 The risk is now adequately controlled with a current rating of 9. Work is to be done to further reduce the risk rating, by evidencing that learning from mortality reviews are contributing to improvements across the trust and there is a reduction in patient safety mortality incidents.

7 THE MEDICAL EXAMINER

7.1 KMPT have worked with the Medical Examiner Officers in Kent and Medway to agree a joint process. KMPT will only need to refer a death to the ME if the death occurred on a KMPT ward and was expected (not referred to the Coroner).

7.2 A Medical Examiner Standard Operating Procedure (SOP) has been developed to guide staff through the process of referring to the Medical Examiner and for completion of the Medical Certificate Cause of Death (MCCD).

7.3 From implementation (9th September 2024) to the date of this report (April 2025), there have been no KMPT deaths that has required a referral to the Medical Examiner.

7.4 Deaths will continue to be monitored via the Directorate Governance teams and Mortality Review Manager, and referrals to the Medical Examiner will actioned accordingly as and when required.

Title of Meeting	**Public Board Meeting**
Meeting Date	**29th May 2025**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Sandra Goatley, Chief People Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• **People Committee Main Report** • **People Risk Register** • **Staffroom evaluation** • **West Kent workforce paper** • **Safer Staffing**		• **Employment Tribunal Annual Report** • **HR Policies and Procedures** • **Annual Policy Report**

Agenda Items by Exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Main Report	<u>Sickness</u> The Trust continues to face challenges in meeting its sickness absence target of 3.5%, with current rates at 4.69%. Pressures remain particularly high in the North. It was noted that this is a consistent picture across the NHS. A targeted programme is underway to support staff using the Psychology service and a new handbook is being launched offering advice to manage long term absence.	**Reasonable Assurance**	• Pilot launch of the staff psychology service. • Implement expanded staff benefits and Employee Assistance Programme. • Launch a wellbeing innovation project to support positive health behaviour change.
	<u>Apprenticeships</u> <u>C</u>oncerns raised around the low availability of clinical apprenticeships across the system despite a high number of potential applicants. If this isn't resolved, it could lead to significant workforce gaps projected for the future.	**Limited Assurance**	A shared Academy model is being explored to consolidate apprenticeship efforts across the system. This would potentially allow unused levy funds to be transferred to organisations that can make full use of the system.
Staffroom evaluation	The implementation of our app-first intranet, Staffroom, has delivered clear progress against our 2023–2026 Communications and Engagement Plan. It has significantly improved access to information, boosted	**Reasonable Assurance**	• Enable team and directorate-level communication tools for leaders and managers. • Resolve access issues

	engagement, particularly among non-desk-based staff, and demonstrated strong uptake across all directorates. Staff feedback, usage data, and national recognition provide assurance that the platform is delivering tangible benefits and driving a positive shift in our digital workplace culture.		• Launch groups and communities to support staff collaboration around shared interests or priorities. • Further embed the Staffroom into the employee digital experience. • Shift the communications approach from top-down to more self-directed and peer-led engagement. • Roll out new product features to enhance the staff experience.
West Kent workforce paper	The People Committee received a detailed update on the workforce challenges and improvements within the West Kent Directorate. The Directorate has taken proactive steps to address these challenges, including increased senior visibility, targeted interventions, and restructuring within administrative teams. Improvements in key workforce indicators and positive movement in staff survey responses relating to line management provide further assurance.	**Reasonable Assurance**	The Directorate will continue to build on recent improvements by implementing a focused engagement plan, including workshops to support new leadership roles and structured communication plans for team changes. There will also be continued monitoring of staff well-being and inclusion, particularly in admin teams, and follow-up visits by the Freedom to Speak Up Guardian to assess sustained improvements. Change resilience and capability was seen as a key skill we need to build at pace.
Safer Staffing	A comprehensive process that included professional judgment meetings with every ward has provided a more rounded and inclusive view.	**Reasonable Assurance**	The conclusion to the review was that we are staffed safely but more work to do in improving both the Multi-Disciplinary Team focus and improving knowledge and understanding of the processes involved in the data collection. There was recognition of a gap in data relating to community services, with ongoing work being undertaken to address this through demand and capacity modelling

			Key points raised included the need for enhanced focus on the female inpatient ward due to self-harm concerns, This report was also going to Quality Committee and to the Board.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
Title	**Mental Health Act Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
	• Chief Medical Officer's Report • Report from MHLOG • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • Mental Health Act Monitoring Report • CQC MHA Reviews Report • MHA/MCA Training Report • Report from Associate Hospital Managers • Legislation Update	

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Medical Officer's Report	Electronic Prescribing System (EMed) system implementation • Positive digital transformation step; improving patient safety and documentation.	**Reasonable Assurance**	The system now allows for the uploading of T2/T3 and S62 forms, replacing the previous paper-based process, which was prone to errors and loss. This improvement will initially be piloted in forensic wards with a plan for a wider rollout.
Chief Medical Officer's Report	Mental Health Act (MHA) team staffing issues: • Risk to service delivery, internal compliance, and Care Quality Commissions (CQC) inspection preparedness. • Lack of adequate MHA team support on wards has adversely impacted consultants due to the impact on their ability to prepare for tribunal hearings and meetings.	**Limited Assurance**	• Acting-up arrangements are in place to fill Mental Health Act (MHA) coordination gaps temporarily, but these arrangements are not intended to be permanent. • Further interviews are scheduled, but there remained recruitment challenges due to external factors.
Chief Medical Officer's Report	Scrutiny visit shortfall • The Trust is significantly below its expected internal audit levels which impacts CQC preparedness. The shortfall is directly linked to the MHA Team's staffing challenges,	**Limited Assurance**	Assurance was provided regarding the mitigations which had been implemented and it was noted that further interviews had been scheduled to support recruitment into the vacant MHA Team posts.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
Title	**Audit and Risk Committee Chair's Report**
Author	**Peter Conway, Audit and Risk Committee Chair**
Presenter	**Peter Conway, Audit and Risk Committee Chair**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Board to endorse/amend the actions proposed**

Agenda Items

Finance and Regulatory items	
● Accounting Policies ● Annual Accounts ● Annual Governance Statement ● Remuneration Report ● Digital Opportunities at KMPT ● External Audit Report ● Internal Audit Report ● Anti-Crime Report ● Year End Update and Draft Timetable ● Director of Finance Items	● KMPT AI Policy ● Trust Policy Effectiveness and Compliance

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.
Annual Report and Accounts	<u>Accounting Policies</u> Adjustments to the Trust's Accounting Policies were approved, which supports the Trust's Annual Accounts. The Committee supports the Trust's Going Concern statement. <u>Annual Accounts</u> The Trust's three statutory financial targets of the External Financing Limit, Capital Resource Limit and breakeven duty have been met. The Annual Accounts are currently being scrutinised by external audit. <u>Annual Governance Statement</u> A robust Annual Governance Statement was received, with a recommendation of particularising top-level risks. <u>Remuneration Report</u> Report sufficiently deals with all relevant matters.	**Reasonable Assurance**	Queries raised regarding staff composition and its impact upon the Trust's underlying finances. Trust Secretary to confirm if amendments are necessary, and if so, what amendments have been made.
Internal Audit Report	Four final reports have been issued – one receiving substantial assurance (Financial Assurance), three receiving reasonable assurance (Estates & Facilities, Clinical Supervision Follow-Up, Compliance with Job Plans Follow-Up)	**Reasonable Assurance**	Annual Opinion likely to be ''Reasonable Assurance''
Digital Opportunities at KMPT	Discussion paper on clinical digital opportunities operating successfully elsewhere in the NHS. Some are being considered by KMPT and others in early stages of introduction	**Limited Assurance**	Disagreement on -clinical leadership's willingness to embrace new technologies and ways of working -how well technology is currently deployed

			General feeling that our Digital Enablement is lagging other Trusts and our own ambitions, and there would be merit in the Board spending time on this key enabler
AI Policy	New policy	**Reasonable Assurance**	Policy noted, with recommendation, that the Trust balances performance opportunities and pragmatism while meeting minimum legal requirements. The policy needs to be more user friendly
Trust Policy Effectiveness and Compliance	397 policies of which 25% are overdue, mainly clinical.	**Limited Assurance**	ARC suggested that this might need to be included on the AGS. The Committee volunteered to sponsor the effort to -reduce the number of policies -make them more user friendly (a lot of process could be moved onto the intranet and AI adopted for writing) An interim report on progress will be received in December including metrics evidencing progress

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
Title	**Finance and Performance Committee Chair's Report**
Author	**Mickola Wilson, Non-Executive Director**
Presenter	**Mickola Wilson, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
•	• IQPR • Dementia Diagnosis Update	• Finance Report for Month 12 • Planning update 2025/26 • Finance Risks 2025/26 • Cost Improvement Plan (CIP) Update • Digital Update

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.
IQPR	Patient Flow: Progress noted, but significant delays persist—primarily due to external factors (e.g. housing, care packages). Mental Health: Pressures remain, but waiting times are improving (long waits down from 8 to 4 patients). There is a focus on ensuring that patients receive care in the appropriate setting.	**Limited Assurance**	The Trust is exploring a number of short-to-medium term solutions to support patient flow whilst maintaining patient safety.
Dementia Diagnosis Update	The Board can be assured that focused work is underway to address longstanding challenges in dementia diagnosis and care. Average waiting times have started to improve, and the number of patients waiting over 52 weeks has reduced significantly. A system-wide Community Model is being developed, with strong collaboration now in place across providers to improve coordination and reduce duplication. Particular attention is being given to underperformance in West Kent, with leadership oversight and enhanced collaboration with primary care to speed up assessments.	**Reasonable Assurance**	Where cultural challenges have been identified as a barrier this is being actively addressed through leadership engagement and revised job planning.
Finance Report for Month 12	The Committee received a draft Month 12 finance report showing a year-end surplus of £3.5m and a closing cash balance of £12m, both in line with the forecast. While bed pressures and a small agency overspend were noted, overall financial	**Reasonable Assurance**	

	performance was well-managed, and the Committee was assured by the position.		
Planning update 2025/26 & Cost Improvement Plan (CIP) Update	The Committee received updates on financial planning and the cost improvement programme. The Committee acknowledged the wider Integrated Care System position, and the associated risks; as well as the efficiency requirements outlined by NHS England.	**Reasonable Assurance**	Delivery has begun in some areas, with further proposals in development. The approach remains strategic, with emphasis on prioritising areas like digital and collaboration with partners.
Digital Update	The Committee also reviewed the E-Referrals project, which is in the planning stage with a high-risk status. The project aims to streamline the GP referral pathway through electronic referral management. While 28% complete, technical and process-related issues are being addressed.	**Limited Assurance**	Key next steps include exploring ERS and Rio system integration and re-baselining the project plan.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29th May 2025**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
•	• Quarterly Impact Report	• Finance Report • Charity Operational Plan • Charity Risk Register

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Quarterly Impact Report	There had been a significant focus on the promotion of 'challenge events' during the reporting period with positive engagement from staff across the Trust; although, it was noted that activity numbers should be included in future reports. It was acknowledged that further staff engagement was required to increase awareness of the charity and the availability of charitable funds to support service areas Donations and support from corporate volunteers had increased, which had a positive impact on green spaces across the Trust.	**Reasonable Assurance**	The Committee highlighted the importance of the involvement of the Board in 'challenge events' to support engagement and awareness of the charity. Further discussions will be held with the Communications Team regarding the measures which can be implemented to increase engagement and awareness of the charity.
Charity Operational Plan	There are a range of activities planned for 2025/26; with a clear deadline for grant applications. The Committee was assured that the operational plan was reasonable and achievable. Concerns were expressed regarding the challenges associated with the Micro-hive donation approach.	**Reasonable Assurance**	The Committee requested further details of the number of individuals involved with the planned activities. It was agreed that the Chief Finance and Resource Officer would explore a resolution to the Micro-hive issues and provide an update at the Committee's next meeting.
Finance Report	The charity achieved a positive year-end position for 2024/25;	**Reasonable Assurance**	The income and expenditure of the charity continued to growth in 2024/25; however, it was acknowledged that further work was required in 2025/26 to ensure the delivery of a self-sufficient position.
Charity Risk Register	The Committee received the latest iteration of the Charity Risk Register and noted the further work required to	**Reasonable Assurance**	

	articulate the risk in regards to the resilience of the charity in the event of the loss of key staff members.		
The Committee commended the work of the Charity and Volunteer Lead during their tenure at the Trust and wished them the best for their next opportunity; but, acknowledged the potential short-to-medium term impacts on the operation of the charity.			

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Trust Sealing Report
Author:	Nicola Legge, Legal Services Manager
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Committee:	Standing Order

Overview of Paper

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

Three documents have been signed and sealed as a deed during from Q4 24/25 This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact:	No risks/impact
Assurance:	Substantial Assurance
Oversight:	Board

Version control: 1

Number	Date of Sealing	Description	Signatures	Comments
161	09.01.25	Deed of Variation for Littlebrook	Sheila Stenson Jackie Craissati	
162	28.01.25	Deed of Novation for Pharmacy Services	Sheila Stenson Jackie Craissati	
163	27.02.25	Deed of Variation for Alexander House	Sheila Stenson Jackie Craissati	

Version control: 1

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Register of Board Members Interests – May 2025
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

This paper sets out the 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

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable
Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee

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Register of Board Members Interests – May 2025

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS
May 2025

Director	Position	Interest declared
Dr Jackie Craissati	**Trust Chair**	Jackie is Director of Psychological Approaches CIC, which is on the NHS England framework for Independent Serous Incident Investigations. However, the company does not undertake investigations relating to KMPT. Jackie is chair of Crohn's & Colitis UK. The charity works closely with the NHS but is not commissioned to deliver services. Jackie is Independent Governor on the Board of the University of East London. There is the unlikely possibility that a particular serious safeguarding incident in relation to Lasting Power of Attorney has links to Kent & Medway. Jackie is Chair at Dartford and Gravesham NHS Trust
Kim Lowe	**Non-Executive Director**	Kim is a Non-Executive Director and Deputy Chair at Kent Community Health Foundation Trust.
Mickola Wilson	**Non-Executive Director**	Director of Seven Dials Fund Management and advisor to private investors in Real Estate. Former CEO of Teesland plc and MD of Guardian Properties. Non-Executive director of Mailbox Investment Company.

		Member of the Property Committee of the Mercers Livery Company. Member of the Council for Essex University Non-Executive Director BBRC (NFP Residential Company specialising in Key Worker Housing Member of the Chartered Surveyors Livery Company
Sean Bone-Knell	**Non-Executive Director**	Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (From January 2024)
Peter Conway	**Non-Executive Director** (Deputy Chair)	Independent Member of the West Kent Housing Association Audit Committee (until 24/09/24) Non-Executive Director of the West Kent Housing Association (from 25/09/24) Non-Executive Director and Chair of the Audit Committee for Medway NHS Foundation Trust (from 01/05/2025)
Stephen Waring	**Non-Executive Director** (Senior Independent Director)	Employed (on a part-time basis) at Greater London Authority, Health and Wellbeing Team
Dr MaryAnn Ferreux	**Non-Executive Director**	Trustee - Royal College of Physicians Edinburgh Company Director - Health Innovation Kent Surrey Sussex Founder M&K Consulting services Non-Executive Director at Kent Community Health Foundation Trust.
Julius Christmas	**Non-Executive Director**	Non-Executive Director at Dartford and Gravesham NHS Trust
Pam Creaven	**Associate Non-Executive Director**	None declared.
Julie Hammond	**Associate Non-Executive Director**	Health Governor for Kent Community Health NHS Foundation Trust GP for Dartford East Health Centre
Sheila Stenson	**Chief Executive Officer**	Chair of the South East Finance Academy Partner Non-Executive Director to the Kent and Medway Integrated Care Board and one of their Board Sub-Committees
Donna Hayward-Sussex	**Chief Operating Officer & Deputy CEO**	None declared
Dr Afifa Qazi	**Chief Medical Officer**	None declared
Andrew Cruickshank	**Chief Nurse**	On the Board of Directors for the Council of the National Mental Health Nursing Directors forum

		Visiting Professor on the Faculty of Medicine, Health and Social Care at Canterbury Christchurch University
Nick Brown	**Chief Finance and Resources Officer**	Spouse is an employee of KCHFT
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

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th May 2025
Title of Paper:	Safer Staffing – Annual Establishment Review 2025
Author:	Julie Kirby, Deputy Chief Nurse
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

This paper gives an overview of the methodology and conclusions of the annual establishment review. Included in the review were KMPT acute wards, Forensic and specialist wards, community inpatient rehabilitation wards, Health Based Places of Safety (HBPoS) and our community inpatient detoxification service.

Issues to bring to the Board's attention

- In conclusion, it is felt the establishments are appropriate and the wards are safely staffed however noting there is a need for a further review of our female acute wards.
- There was a new process introduced this year to include direct feedback from teams with professional narrative discussions being held for every service reviewed. Feedback on this process has been encouraged and will be collated and considered for future reviews.
- The process included triangulating various safer staffing data sets (Mental Health Optimal Staffing Tool (MHOST), fill rates, Care Hours Per Patient Day (CHPPD)) with incident data, workforce data and a professional narrative. It is important the inputting of the acuity/ dependency scoring is improved as this was a cofounder in establishing a clear picture of need.
- There are notable differences in the conclusions of reviews for our female younger adult wards, which is explained within the paper.
- Teams continue to under report compliments. The exceptions to this are Bridge House and Mother & Baby Unit (MBU) who have good levels of reporting.

Governance

Implications/Impact:	Patient Safety
Assurance:	Reasonable
Oversight:	People Committee

Version Control: 1

1. Background and context:

The safer staffing and establishment reviews are a statutory responsibility of the Chief Nurse. The review must comply with set requirements detailed in the following:

- National Quality Board report, 2016
- Developing Workforce Standards – NHS Improvement, 2018
- Health & Social Care Act 2008 – Regulation 18

It is also imperative that staff understand safer staffing levels, including understanding the relationship between skill mix, safety and quality of care. The NMC provides clear expectations in their nursing proficiency standards for registered nurses under platform 6.2:

'Understand the relationship between safe staffing levels, appropriate skills mix, safety, and quality of care, recognising risks to public protection and quality of care, escalating concerns appropriately.'

2. Methodology

The trust has previously undertaken cycles of reviewing staffing using the MHOST. This tool is a 'multi-disciplinary tool, evidence-based system that enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms.'

It is advised that the tool is used in conjunction with quality metrics. The information collated for this review included:

- MHOST data for 21 days between 3rd – 24th March 2025
- Current agreed establishment
- Current vacancies
- Sickness levels over 6 months (Sep 24 – March 25)
- Incident data over 6 months (Sep 24 – March 25)
- Complaints and compliments over 6 months (Sep 24 – March 25)
- No of Clinically Ready for Discharge (CRFD) patients over 6 months (Sep 24 – March 25)
- Professional Judgement Discussion meetings for each service

Initial feedback from ward visits indicated that ward leadership teams did not always feel involved in previous safer staffing reviews, and there was enthusiasm for a new process.

The professional judgement discussion meetings were held over three days between the 28th – 30th April as hybrid events. Each service had their own slot and were encouraged to discuss the relationship between the data and 'on the ground' reality. The invitees for these meetings were HoNQ, Service Director, HR Business Partner, Finance Business Partner, Governance Lead, General Manager and for each ward their Matron, Ward Manager, Consultant and AHP lead. Attendance was variable across directorates however notably the matron representation was consistently high.

Once all the reviews were complete the results were analysed before being grouped into service specific areas in order to gain a trust wide analysis as well as a closer analysis at service areas.

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The purpose of CHPPD and Fill Rate data is to monitor and record the extent of which rota hours on a roster are filled and care hours provided. The following shows a breakdown and is discussed within each service section throughout the report.

Ward	Actual CHPPD	MHOST CHPPD Recommended	Actual FTE * Nursing, HCSW, apprentices (exc WM)	MHOST FTE Recommended
Allington Centre	207.67	98.27	43.72	18.20
Amberwood	150.79	104.78	30.25	19.38
Bluebell	122.03	98.11	32.00	18.32
Boughton	119	99.42	31.00	18.56
Bridge House	68.47	50.90	13.95	9.51
Brookfield Centre	136.39	73.17	30.29	13.45
Chartwell	169.77	173.89	28.25	31.78
Cherrywood	128.78	91.26	28.25	17.00
Emmetts	161.52	101.72	35.62	18.99
Ethelbert Road	59.77	59.34	13.80	11.08
Fern	141.08	124.95	28.00	23.33
Foxglove	119.89	116.93	29.00	21.53
Groombridge	101.09	86.62	22.99	16.16
Heather	141.01	92.76	27.00	14.89
Jasmine	137.83	74.13	28.25	13.83
MBU	109.53	50.01	26.43	9.33
Newhaven Lodge	62	39.53	13.20	7.38
Penshurst	267.54	219.88	43.82	39.70
Pinewood	139.39	94.48	28.25	17.53
Rivendell	54.71	84.34	14.00	15.61
Rosebud Rehab	70.96	54.34	14.50	10.15
Ruby	157.97	60.72	29.00	11.33
Sevenscore	136.74	86.27	31.00	15.83
Tarentfort Centre	209.57	93.60	42.64	17.13
The Grove	56.72	44.12	12.70	8.23
The Orchards	154.12	136.54	32.00	24.86
Tonbridge Road	71.16	43.82	14.60	8.18
Upnor	130.53	141.41	24.00	26.37
Walmer	170.82	143.46	39.29	26.52
Willow Suite	249.53	101.10	31.00	18.09
Woodchurch	126.69	61.06	20.85	11.38

Fill Rate Data:

		Mar-25				
		Day		Night		
Care Group	Ward	RN	HCA	RN	HCA	Overall
Acute	Amberwood	73.2%	114.5%	96.9%	100.9%	98.6%
Acute	Bluebell	98.1%	97.3%	98.4%	117.9%	101.6%
Acute	Boughton Ward	116.0%	94.2%	99.9%	113.0%	103.5%

Version Control: 1

Acute	Chartwell Ward	101.3%	149.1%	100.2%	238.5%	147.6%
Acute	Cherrywood Ward	66.0%	116.6%	100.0%	117.7%	99.1%
Acute	Fern	109.7%	115.5%	100.2%	172.6%	122.7%
Acute	Foxglove	114.4%	95.4%	96.8%	119.4%	104.3%
Acute	Heather	89.1%	107.3%	103.2%	118.1%	105.2%
Acute	Jasmine	91.9%	82.0%	100.0%	82.0%	86.3%
Acute	Pinewood Ward	112.6%	123.7%	101.6%	144.4%	121.2%
Acute	Ruby Ward	87.1%	114.8%	98.4%	143.3%	113.6%
Acute	Sevenscore	99.2%	94.6%	100.0%	115.8%	102.0%
Acute	The Orchards	98.0%	104.7%	98.2%	131.1%	108.7%
Acute	Upnor Ward	86.0%	111.0%	97.8%	123.7%	104.3%
Acute	Willow Suite	99.8%	204.9%	149.9%	240.3%	176.3%
Acute	Woodchurch	79.4%	83.9%	100.0%	100.0%	89.4%
East Kent	Ethelbert Road	116.3%	64.5%	100.3%	103.2%	89.4%
East Kent	Rivendell	78.5%	68.5%	100.5%	99.9%	80.9%
East Kent	The Grove	78.2%	55.1%	100.0%	99.4%	75.5%
Forensic & Specialist	Allington Centre	103.0%	137.7%	100.4%	106.3%	118.0%
Forensic & Specialist	Bridge House	102.1%	97.0%	100.0%	99.6%	99.2%
Forensic & Specialist	Brookfield Centre	98.8%	105.7%	100.0%	150.0%	111.8%
Forensic & Specialist	Emmetts	115.5%	100.4%	99.4%	99.3%	102.9%
Forensic & Specialist	Groombridge	110.4%	97.2%	100.1%	101.5%	101.6%
Forensic & Specialist	Penshurst	110.1%	148.6%	100.8%	189.2%	142.7%
Forensic & Specialist	South Central EDMBU	74.9%	62.3%	99.9%	66.5%	63.9%
Forensic & Specialist	Tarentfort Centre	113.9%	107.5%	100.5%	125.3%	112.1%
Forensic & Specialist	Walmer	106.5%	98.0%	95.6%	108.4%	101.4%
North Kent	Newhaven Lodge	93.4%	143.7%	99.4%	102.1%	124.0%
West Kent	111 Tonbridge Road	114.0%	159.7%	101.9%	99.2%	129.5%
West Kent	Rosewood Lodge	105.1%	205.4%	98.9%	97.2%	141.9%
Grand Total	**Grand Total**	**96.69%**	**109.97%**	**101.36%**	**125.31%**	**108.83%**

Following an analysis of the MHOST data it was evident that there is a training need with regards to the acuity descriptors and how these relate to individual services. This significantly affected the MHOST data returns and recommendations and therefore the triangulation of data and professional narratives were of higher importance.

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3. Medium Secure Units (MSU)

Within KMPT we have three male MSU's and one female MSU based on one site. The directorate leadership team are already considering a review of AHP provision across MSU and LSU services and this is supported from this review. Notably there was a lack of AHP representation at the meetings and several wards fed back that a review of this provision would beneficial.

Zoning observations are not currently in place and a recommendation was for this to be considered in the future.

There is no clear definition for clinically ready for discharge (CRFD) patients across these services and it was recommended to the directorate that this is agreed. It does however appear that these patients impact safer staffing, often significantly if requiring extra care packages. For example, if we look at Penshurst fill rates below this increase was directly attributed to extra care packages.

Penshurst	110.1%	148.6%	100.8%	189.2%	142.7%

The team also fed back that the current agreed % of headroom does not reflect the needs required for the workforce. It is difficult to ascertain this from a data perspective due to the data inputting.

Significant work is underway in the directorate with regards to racial abuse to staff, which is being led by the leadership team.

It was noted that nursing recruitment and retention is positive and well managed.

Additionally, Walmer Bedgebury and Emmetts Bedgebury were included within their respective wards as staff work across these for a fluid and cohesive workforce. This impacts their staffing and required establishment considerably as these are separate units from the main wards, focusing on recovery.

4. Low Secure Units (LSU)

Within KMPT we have three LSU's based on one site. As stated above the directorate leadership team are considering a review of AHP provision across MSU and LSU wards. Within the professional discussions a lack of OT support due to vacancies and maternity leave was noted and there was a local action for this to be reviewed.

With regards to CRFD patients, the same narrative applies as above for MSU. Local leadership teams are working closely with social care partners, particularly in regards to delays with care act assessments.

Zoning observations are being used in two wards.

Nursing recruitment and retention is notably positive.

5. Mother & Baby Unit (MBU), Bridge House (Detox) & Willow Suite (PICU)

Bridge House has a small but sufficient staffing team. There are risks however due to such low numbers on shift in the event of sickness but this is mitigated by a reliable and effective use of known bank staff, skilled to work in this area. They are a positive outlier for reporting compliments and this was acknowledged in the professional discussion.

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MBU was also notably good for recording compliments in addition to a positive recruitment and retention culture.

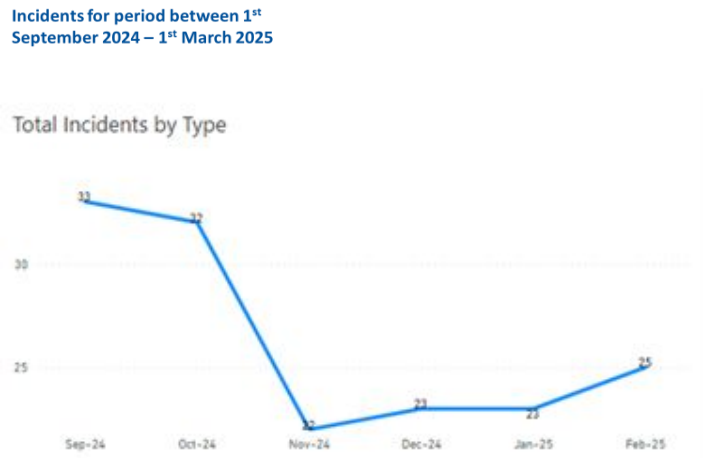
During the period of March, 50% of beds on MBU were closed due to the installation of air conditioning. This has affected the fill rate as seen below and was considered when analysing the data. It is not recommended from this review that MBU is over staffed.

South Central EDMBU	74.9%	62.3%	99.9%	66.5%	63.9%

Willow suite is showing as a significant outlier with a considerable fill rate as seen below. Upon exploration of this in the review this can be financially and staffing wise solely attributed to the delayed discharge patient in the ECA. The team felt that in the absence of our patient who is a CRFD the ward establishment meets the needs required safely.

Willow Suite	99.8%	204.9%	149.9%	240.3%	176.3%

There is a decrease in incidents for Willow suite (shown below) and there was feedback that they are experiencing delays in stepping down to acute wards. It was also noted that the incident decrease was further to a direct impact of the team working effectively together managing a complex patient in the ECA with a clear management, care and treatment plan, which has effectively seen the decrease. The team was acknowledged for their impact on both care and patient safety.



6. Acute - Older Adult Wards

There are six older adult wards within KMPT, three of each gender and these are located across the county. When looking at establishments there was some inconsistency with the number of deputy ward managers which require clarification with some having two and some three.

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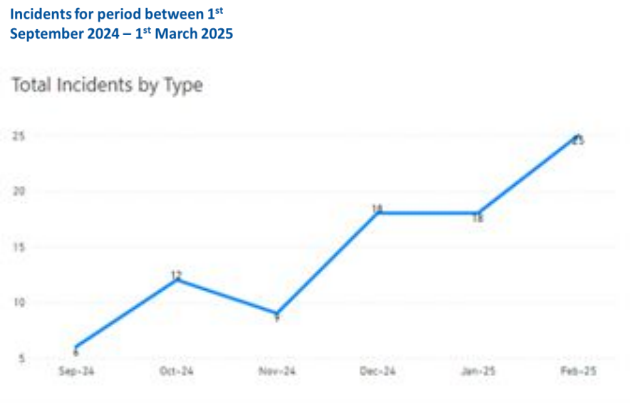
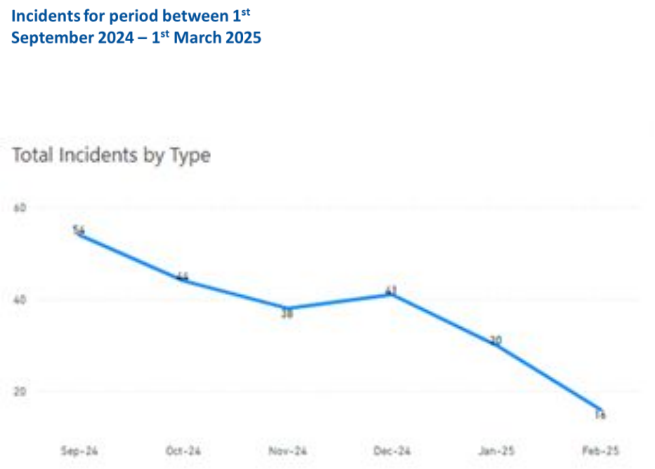
There was positive feedback consistently received regarding the directorate HR business partner and her support in sickness management.

Older adult wards saw a significant decrease in incidents with many teams attributing a factor being the introduction of zonal obs. The main incident category was falls with the exception of Woodchurch where this featured second to violence and aggression.
There is a significant increase in Sevenscore's incidents (falls) as shown below however it should be noted the ward was at 50% capacity following bed closures due to the flooring replacement and most incidents attributed to one patient.



Jasmine Ward saw more than a 50% reduction in incidents (shown below). The team reported contributing factors as zonal observations, patient mix and MDT (particularly OT and PSS) effective working.



7. Acute - Younger Adult Wards

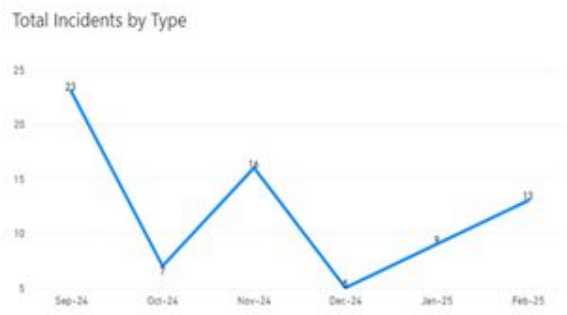
There are four male younger adult wards, and five female younger adult wards spread across Maidstone, Dartford and Canterbury sites.

All wards are undertaking zoning observations with the exception of Chartwell where this is being re-introduced. Many spoke about how this impacted staffing positively and decreased incidents. It is acknowledged that there is an environmental challenge on Chartwell and it may be the directorate consider this in line with reviewing the patient population. Fern ward also reported inconsistent use and have been encouraged to fully implement.

Male younger adult wards all had violence and aggression as their highest incident category however there were notable decreases in both Pinewood and Boughton (see below). Both attributed this to the violence and aggression improvement work, with Pinewood further commenting that they have effective MDT working which has directly impacted this.

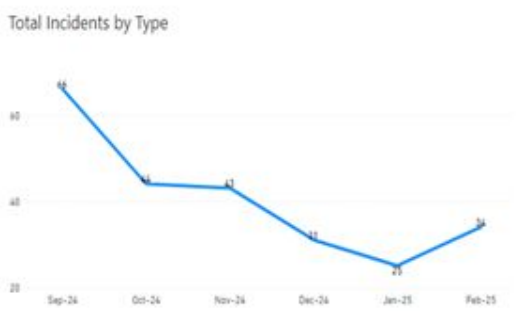
Pinewood Ward:

Incidents for period between 1st September 2024 – 1st March 2025



Boughton Ward:

Incidents for period between 1st September 2024 – 1st March 2025



The high fill rate for Pinewood as shown below was discussed and during March there were four new staff on supernumery induction which accounts for the increase.

Pinewood Ward	112.6%	123.7%	101.6%	144.4%	121.2%

Bluebell Ward has seen an increase in violence and aggression incidents and discussed that they attribute this to both delays to PICU and CRFD patients awaiting social care placements.

Female younger adult wards show significant differences in several areas. Four of the five wards report work related stress is a reason for sickness, which is not a theme seen in other areas.

Fern ward has high fill rates as shown below and attributes this to higher levels of observation required, with zonal observations inconsistently used, and the team reporting a high admission and discharge rate.

Fern	109.7%	115.5%	100.2%	172.6%	122.7%

It was identified that for acute wards the MHOST only returned two wards are recommending higher levels of staffing, and these were both female younger adult wards, Chartwell and Upnor (as per below). It should be noted with caution however as we are aware of the need for further support with a full understanding of MHOST acuity levels.

Chartwell	169.77	173.89	28.25	31.78
Upnor	130.53	141.41	24.00	26.37

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Chartwell ward are an outlier for both high fill rates and incident data. It should be noted that Chartwell are currently being supported in these areas.

As seen below in the fill rates, the team attributed this to higher levels of observation, particularly at night.

Chartwell Ward	101.3%	149.1%	100.2%	238.5%	147.6%

When reviewing self-harm data there is an increase of almost 50% in Chartwell incidents compared to other female younger adult wards, notably 219 incidents compared to 149, 113, 72 and 37.

Incidents for period between 1st September 2024 – 1st March 2025

Row Labels	2024 Sep	Oct	Nov	Dec	2025 Jan	Feb	Grand Total
Self-Harming Behaviour	35	46	27	39	27	45	219
Disruptive, Violent and Aggressive Behaviour (Patient, Anti-Social Behaviour)	12		4	9	3	2	30
Medication	4	2	2	3	4	4	19
Missing Patient	2	4	3	2	2	2	15
Property		2	5	2		3	12
Violent and Aggressive Behaviour (Patient to Staff)	4		1	5			10
Access, Admission, Transfer and Discharge	2		1	2		1	6
Disruptive, Violent and Aggressive Behaviour (Patient to Patient)			4		1		5
Physical Health	1	2			2		5
Treatment / Procedure					1	2	3
Disruptive, Violent and Aggressive Behaviour (Staff to Patient)		1		1	1		3
Patient Accidents and Falls			2			1	3
Fire					2		2
Documentation			1	1			2
Estates / Facilities		1					1
Violent and Aggressive Behaviour (Visitor / Other to Staff)						1	1
Service Disruptions		1					1
Communication and Consent						1	1
Patient Personal Property / Data / Information						1	1
Grand Total	60	59	47	66	44	63	339

Cherrywood Ward is an outlier in several areas. They do not report work place stress as an area of concern for sickness, their highest type of incident is violence and aggression as opposed to all other female younger adult wards being self-harm. They strongly attribute this to effective working with psychology and OT. The team feel the staffing levels are safe, and the ward have regular collaborative psychology input

With the exception of Cherrywood, the four other female younger adult wards all stated that further psychology and peer support workers would make a significant impact on the ward, with one comment being they felt as if they were ‘specialist wards without specialist input’.

8. Community Inpatient Rehabilitation Services

There are six community inpatient rehab wards across the county. Across these services it was clear that MHOST requires further support and understanding to how the tool can be applied for rehab

services. The leadership team at Ethlebert Rd have done some work on this during this review and it is intended that this work is shared. Their MHOST and CHPPD recommendations are shown below and the team feel these are close to accurate.

Ethelbert Road	59.77	59.34	13.80	11.08

In East Kent the establishments had been reviewed prior to this process and there were proposed reductions in some establishments through vacancies. This review supports those proposals.

It was discussed within several rehab services that at times there is increased acuity due to delays with admissions to acute wards. Escalation in these instances was discussed. Social care delays, especially with care assessments in East Kent were also a factor causing a delay in discharges.

All of the services spoke of the importance of physio/ sports tech provision which compliments OT however feel this could be improved as currently this is an additional 'drop in' service. Each team felt an increase would be beneficial.

9. Health Based Place of Safety (HBPoS)

There are currently three HBPoS's across the county. These were not included in the MHOST collection as the tool is not adequate for this setting. However, the establishment was reviewed including vacancies and quality data to aid a professional narrative discussion.

There is one team leader across the services and a consultant lead. The team reported the staffing numbers currently feel safe and there is a daily medical rota which works effectively.

Vacancies and sickness are generally covered well with regular staff on NHSP.

10. Trust Wide Analysis

There are some overall themes which have emerged, notably the impact of long-term sickness (16 wards) and CFRD's (21 wards) across the organisation. It is only female younger adult wards where work related stress is a significant contributing factor. It is noted that generally ward managers feel supported with managing sickness.

With the exception of Bridge House and MBU compliments are not being formally recorded and we have encouraged teams to improve this.

Fill rates on several wards appear to show a concern that staffing may be low at times however on every occasion the teams reported this wasn't reflecting accurately. The wards indicated have been advised to meet with the e roster lead for further exploration and advice.

Notably staff reported feel less supported at night, which further supports the case for 24/7 Duty Senior Nurse onsite cover.

Throughout the professional narrative discussions, we often heard of 'patient population' being the main cause for any decreases in incident data however when we explored the safety culture bundle and zoning observations implementation, it was then they realised their impact. We encouraged staff to take

pride in their achievements in these areas and acknowledge the considerable work undertaken by teams in changing cultures on their wards.

11. Summary and Conclusion

Overall the MHOST and CHPPD data generally indicates that most wards are over staffed however when considering the data inputting and professional narrative sessions this appears inaccurate. The recent review in East Kent rehab services which showed some reductions is supported from this review.

The amount of CRFD patients is notably affecting staffing across all areas.

Within acute, three female wards (1 OA and 2 YA) discussed how the multi-disciplinary working within the ward team could be more effective and how this impacts staffing, including decisions regarding observations levels for example, which directly impacts staffing. It is also noted that it is two of our female acute wards who have not fully implemented zoning observations.

All teams with the exception of female acute wards identified their wards establishments as being appropriate for their services. Female acute wards are recognised as requiring reviews of the therapeutic model and approach, with Cherrywood evidencing that effective inter professional working, particularly with psychology and OT directly impact incident levels, staff sickness and therefore safer staffing levels.

The establishment review process undertaken this year has enabled teams to fully explore the understanding of safer staffing, however this requires embedding and further support.

12. Recommendations

- Completed establishment review packs including service specific recommendations have been shared with directorate leadership teams
- Feedback has been encouraged regarding the new process used and will directly feed into future establishment reviews
- Safer Staffing training to be delivered per team by DCN and Corporate HoNQ
- Review of actions and further 21-day cycle of MHOST to be completed in six months

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