AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 31st July 2025
Time 9.00 to 11.30
Venue Microsoft Teams Meeting

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/25-26/37	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.00
TB/25-26/38	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/25-26/39	3.	Personal Experience – Julie's Story	FN	Verbal	AC	09.05
TB/25-26/40	4.	Continuous Improvement Story - Improving Timely Blood Test Collections	FN	Verbal	AR	09.15
STANDING ITEMS						
TB/25-26/41	5.	Minutes of the previous meeting	FA	Paper	Chair	09.25
TB/25-26/42	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/25-26/43	7.	Chair's Report	FN	Paper	JC	09.30
TB/25-26/44	8.	Chief Executive's Report	FN	Paper	SS	09.35
TB/25-26/45	9.	Board Assurance Framework	FA	Paper	AC	09.40
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/25-26/46	10.	MHLDA Provider Collaborative Progress Report	FD	Paper	JH	09.50
TB/25-26/47	11.	Trust's Digital Plan Refresh	FD	Paper	NB	10:00
TB/25-26/48	12.	Co-creation strategic plan and framework	FA	Paper	KH	10:10
OPERATIONAL ASSURANCE						
TB/25-26/49	13.	Integrated Quality and Performance Review	FD	Paper	SS	10:20
TB/25-26/50	14.	Memory Assessment Service System Delivery Plan	FD	Paper	AR	10:40
TB/25-26/51	15.	Month 3 Finance Report	FD	Paper	NB	10:45
TB/25-26/52	16.	Freedom to Speak Up Annual Report 2024/25	FD	Paper	RC	10:50
TB/25-26/53	17.	Trust Green Plan Refresh	FA	Paper	NB	10:55
TB/25-26/54	18.	Committee Terms of Reference	FA	Paper	TS	11:00
CONSENT ITEMS						
TB/25-26/55	19.	Report from Quality Committee • Mortality Report (published externally)	FN	Paper	SW	11.10
TB/25-26/56	20.	Report from People Committee	FN	Paper	KL	
TB/25-26/57	21.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/25-26/58	22.	Report from Finance and Performance Committee	FN	Paper	MW	
TB/25-26/59	23.	Report from Charitable Funds Committee	FN	Paper	SBK	
CLOSING ITEMS						
TB/25-26/60	24.	Any Other Business			Chair	11.20
TB/25-26/61	25.	Questions from Public			Chair	
	Date of Next Meeting: Thursday 25th September 2025					

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

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

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 29th May 2025
Microsoft Teams Meeting

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Julius Christmas	JCh	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Sean Bone-Knell	SBK	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	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:			
	Jane Hannon	JHa	Programme Director
	Daryl Judges	DJ	Deputy Trust Secretary
	Victoria Nystrom-Marshall	VNM	Head of Operational Excellence (Continuous Improvement Story)
	Brett Metelerkamp	BM	Associate Specialist (Continuous Improvement Story)
	The Board was joined by members of the public and members of staff.		
Apologies:			
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Kindra Hyttner	KH	Director of Communications and Engagement
	Tony Saroy	TS	Trust Secretary

Item	Subject	Action
TB/25-26/1	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/25-26/2	**Declarations of Interest** No interests were declared.	
TB/25-26/3	**Personal Story – Living Well Together** The Board was informed that there would not be a personal story on this occasion, due to unforeseen circumstances.	

Item	Subject	Action
TB/25-26/4	**Continuous Improvement Story - Community based Memory Assessment Service – Medway and Swale Pilot** The Board received a presentation from VNM and BK who detailed the Medway and Swale Pilot of the Community based Memory Assessment Service (MAS) which included an overview of the current and forecast service demands; the need for a system-working approach; and an overview of the proposed Dementia Diagnosis operating model for the Kent and Medway Integrated Care System. Support was expressed for the direction of travel and the progress which had been made, emphasising the importance of ensuring the lessons learned were captured so that similar service improvements could be delivered across the Trust. The Board **noted** the Continuous Improvement Story - Community based MAS – Medway and Swale Pilot.	
TB/25-26/5	**Minutes of the previous meeting** The Board **approved** the minutes of the 27th March 2025. It was confirmed that "The CEO was unable to confirm whether that would be the case or not" should be amended to "The CEO was unable to confirm at that stage whether that would be the case or not".	
TB/25-26/6	**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/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: The action was superseded by a new action raised under item TB/25-26/9.	
TB/25-26/7	**Chair's Report** The Board **noted** the Chair's Report. A discussion was held regarding the positive impact of peer-support services, noting the opportunity for these to be delivered by third sector providers and that a review of the peer support operating model was being conducted as part of the Mental Health Together (MHT) programme of work. **Action: By July 2025, DHS to provide an update to the People Committee on the revised operating model for the use of peer-support at the Trust.** The Board raised concerns in relation to staff morale within the East Kent area; but, acknowledged the programme of work which had previously been commissioned to support staff resilience. The Board noted that the Leadership Development and Manager Development programme would ensure that staff voices were captured and concerns were addressed.	**DHS**

Item	Subject	Action
TB/25-26/8	**Chief Executive's Report (incl. Deloitte Well-Led review update & Review of Patient Stories)** The Board received the Chief Executive's Report and the following items were highlighted: • The NHS 10-year plan was expected to be published in early July 2025. • The appointment of AC as a Visiting Professor at Canterbury Christ Church University • There had been positive engagement at the first Mental Health summit, which provided the foundations for the development of a Mental Health Strategy for local populations. The Board expressed disappointment that the clinical strategic work plan was being developed as separate professional plans rather than a multi-disciplinary approach. **Action: By July 2025, AQ to provide a verbal update on the co-produced integrated clinical working plan that clearly incorporates the views of the clinical directors and the senior Nursing team.** The Board **noted** the Chief Executive's Report and confirmed that the outstanding Deloitte Well-Led review actions should transition to 'Business as Usual'.	**AQ**
TB/25-26/9	**Board Assurance Framework (BAF)** The Board received the BAF, noting that a risk appetite document would be circulated to Board members in due course for review. The Board was informed of the discussions which had occurred at the Audit and Risk Committee in regard to cyber risks and the associated next steps. The Board queried whether there should be a specific risk associated with the increased collaboration with third sector partners: it was acknowledged that any issues with a multi-agency approach were primarily discussed under the Mental Health Together (MHT) programme of work. A discussion was held regarding the pace of digital developments at the Trust, and the risks associated with insufficient urgency of digital developments. The Board was provided assurance that the Trust's Digital Plan had been scheduled for the July 2025 Board meeting, and predominantly focused on how digital developments could be utilised to release time to focus on patient care. It was agreed that action TB/24-25/145 should be superseded by the focus on the Trust's Digital Plan. **Action: By July 2025, NB to submit a review of the Trust's Digital Plan for consideration, which also include the potential use of AI Chatbots to support the patient experience.** **Action: By July 2025, NB to review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework.** The Board **approved** the Board Assurance Framework.	**NB** **NB**

Item	Subject	Action
TB/25-26/10	**Review of Year 2 - Strategy Delivery Plan Priorities for 2024/25** The Board reviewed the year 2 Strategy Delivery Plan Priorities for 2024/25, noting the changes to the internal governance arrangements and the progress which had been made regarding data maturity. It was highlighted that it was important to understand the forecast performance trajectory for the end of 2025/26, to provide assurance of continued improvement in relation to each of the strategic priorities and it was suggested that the total number of strategic priorities should be reduced for 2025/26, to enable the prioritisation of available resources. The Board acknowledged areas of significant achievement over the year, but also noted a number of failures to achieve strategic goals. The importance of local ownership to support the delivery of the strategic prioritises was emphasised, and it was noted that the new leadership programme would support the development of the confidence needed for local ownership. The Board noted the introduction of the quarterly pulse survey, to provide details of staff morale in a more real-time manner; which would enable targeted support. The Board **noted** the review of year 2 - Strategy Delivery Plan Priorities for 2024/25.	
TB/25-26/11	**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 focused on the variability in culture and success rates between safe havens, which impacted the number of attendances diverted from Emergency Departments. It was anticipated that the transition to a 24/7 service at William Harvey Hospital would improve performance and it was noted that Crisis House occupancy would be included in future reports. The Board **noted** the Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report.	
TB/25-26/12	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR), and was informed of the key areas of success within the reporting period, which included Care Programme Approach performance; and the percentage of patients receiving follow-up within 72 hours of discharge. <u>Memory Assessment Service (MAS)</u> The Board acknowledged that there were areas of success within the Memory Assessment Service but the consistent delivery of the improvements across Kent and Medway was dependent on the community model, an update on which would be provided to the July Board meeting. A discussion was then held in regard to the variation between the six MAS sites. It was highlighted that there was forecast to be a significant reduction in unwarranted	

Item	Subject	Action
	variation over the summer period. It was confirmed that additional granular detail on each of the MAS would be circulated to Board members, external to the meeting. **Action: By September 2025, AR to provide additional detail, as part of the IQPR, in regard to progress in address unwarranted variation between the six Memory Assessment Services.** <u>Patient Flow:</u> The Board was informed of the complexities in determining which patients could be discharged to which pathway, noting the three providers which were utilised by the Trust and the services which were provided; and was informed of the on-going discussions with Kent County Council regarding the funding which was needed to be committed to support patient flow in the short- to medium-term. Questions were raised in regard to the on-discharge functions which our Trust social workers were able to provide, and the level of delegated authority they had in terms of decision-making for care packages. Some limited assurance was provided, but it was agreed that additional context regarding the roles and responsibilities was required, external to the meeting. **Action: By July 2025, AC to circulate, via e-mail, clarification regarding the roles and responsibilities of social workers employed by the Trust and how this differed to social workers employed by local authorities.** The Board discussed contingency plans in the event that additional funding was not available, noting that the High-Intensity User Programme and the Purposeful Admission Programme would support the reduction in avoidable admissions. The Board sought and received clarification regarding the use of out of area hospital beds and the interventions which would be provided by social workers to support long-term placements. **Action: By July 2025, TS to schedule a Board Seminar on a one-year review of the Purposeful Admission Programme.** <u>Mental Health Together</u> The Board noted the engagement work which had been commissioned to refine the operating model for MHT, noting that this was intended to ensure that patients received care from the appropriate services. The Board members acknowledged the timelines associated with the programme of work and provided their reflections, which included the need for a creative workforce approach supported by the voluntary sector. Additional views were provided on the benefits associated with a digital front door which would enable patients to be triaged directly and signposted to the most appropriate service without any delays to their treatment, noting the lessons learned from Sussex Partnership NHS Foundation Trust. The Board noted the discussions as to whether patients who required social intervention from the voluntary sector should be hosted on the Trust's electronic patient record.	**AR** **AC** **TS**

Item	Subject	Action
	The Board was informed of the issues contributing to the current physical health check performance. **Action: By September 2025, DHS to produce a separate report on the Mental Health Together (HMT) programme.** The Board **noted** the IQPR.	**DHS**
TB/25-26/13	**Finance Report for Month 1** The Board received the Finance Report and noted the following: • Use of external beds had resulted in an in-month budgetary pressure of £0.95m, with the position expected to improve by the end of Quarter 1 2025/26 • There had been a reduction in both bank (10%) and agency (15%) staffing utilisation. A discussion was held on the impact of supply vs demand on the Trust's financial position, particularly in relation to the use of external beds and the Board queried what the contingency plans were in the event that the use of external beds did not reduce as forecast, to enable the achievement of the financial plan for 2025/26. **Action: By June 2025, NB to provide an update on the impact of the use of external beds on the Trust's ability to achieve the financial plan for 2025/26 and associated next steps.** The Board queried whether zonal observations were likely to deliver financial benefits and it was confirmed this was the case; however, a cultural shift was required to maximise the benefits of zonal observations in practice. The Board **noted** the Finance Report.	**NB**
TB/25-26/14	**Workforce Deep Dive: Leadership Development and Manager Development programme** The Board received the Leadership Development and Manager Development programme paper, noting that co-design approach which had been adopted and the 'go live' date which had been scheduled for June 2025. Board members expressed their support for the programme of work and questions focused on the diversity of the cohort of staff that would be involved and whether the clinical leadership was included; how the programme of work would influence the creation of a 'leadership cadre'; and how attendance would be encouraged. Board members sought, and received, assurance that there was sufficient focus on change management; and the development of effective decision-making within the programme of work. Assurance was provided regarding the scrutiny which had been afforded to the programme of work by the People Committee. The Board **noted** the Leadership Development and Manager Development programme Paper.	

Item	Subject	Action
TB/25-26/15	**Continuous Improvement Impact Report** The Board received the Continuous Improvement Impact Report, noting that the Doing Well Together Programme will include instilling a focus on benefits realisation into all improvement work. The Board emphasised the need for productivity to focus on the delivery of additional output for reduced cost, rather than an increase in output for the same cost. Discussions focused the need for the consideration of digital developments in a strategic context; the further work required to improve the impact of the quality improvement initiatives; and the need to develop the capability of local management to support local ownership of key initiatives. **Action: By July 2025, TS to schedule a Board Seminar on the Continuous improvement programme in terms of its underlying activity and proposed outcomes.** The Board **noted** the Continuous Improvement Impact Report and it was confirmed that an update should be received annually.	**TS**
TB/25-26/16	**Update on the Independent review of Nottingham and actions for the Trust** The Board received the update on the Independent review of Nottingham and actions for the Trust, noting the intention of the Kent and Medway Integrated Care Board to commission an assertive outreach hub and spoke model, with a draft service description and model to be available by Quarter 2 of 2025/26. The Board noted the similarity of an assertive outreach model compared to the early intervention in psychosis approach, but accepted that the assertive outreach model was mandated by NHS England; so, the focus was on ensuing a fit for purpose approach, which would be tested and refined to optimise patient outcomes. The Board **noted** the update on the Independent review of Nottingham and actions for the Trust.	
TB/25-26/17	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/25-26/18	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/25-26/19	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/25-26/20	**Report from Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee Chair's report.	

Item	Subject	Action
TB/25-26/21	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/25-26/22	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/25-26/23	**Use of Trust Seal** The Board received and **noted** the use of Trust Seal report.	
TB/25-26/24	**Register of Board Members Interests** The Board received and **noted** the use of Register of Board Members Interests.	
TB/25-26/25	**Safer Staffing Report (aka Nursing Establishment Review)** The Board received and **noted** the use of Safer Staffing Report.	
TB/25-26/26	**Any Other Business** None.	
TB/25-26/27	**Questions from Public** The Board received feedback from members of staff, which focused on three areas: 1) The importance of drawing on the knowledge and experience of staff that were also carers, which the Board acknowledged would be addressed through the "Working with Families" Quality Priority 2) The need to focus on getting the basics right in relation to a standardised approach to service delivery, to remove unwarranted variation, particularly in relation to administrative and corporate support services. 3) Further support was required for Core Trainees and Higher Trainees to support the transition to consultant roles at the Trust. The Board noted the work which had been commissioned with the Medical Education Team which was due to 'go live' in August 2025.	
	Date of Next Meeting An extraordinary meeting of the Board would be held on Thursday 12th June 2025 via MS Teams for the purpose of approving the Trust's Annual Report and Annual Accounts.	

Signed …….. (Chair)

Date ……..

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 08.30 to 08.38 on Thursday 12th June 2025
Via Microsoft Teams Meeting

Members:			
	Peter Conway	PC	Non-Executive Director (Deputy Trust Chair)
	Julius Christmas	JCh	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director (Senior Independent Director)
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Kim Lowe	KL	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 Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Tony Saroy	TS	Trust Secretary
Apologies:			
	Dr Jackie Craissati	JC	Trust Chair
	Mickola Wilson	MW	Non-Executive Director
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Sean Bone-Knell	SBK	Non-Executive Director
	Daryl Judges	DJ	Deputy Trust Secretary

Item	Subject	Action
TB/25-26/28	**Welcome, Introduction and Apologies** The Deputy Trust Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/25-26/29	**Declarations of Interest** No interests were declared as conflicting with the Board's business.	
TB/25-26/30	**Annual Report & Accounts 2024/25** NB confirmed to the Board that the Annual Report and Accounts had been reviewed by the Audit and Risk Committee. The Trust's External Auditors had reviewed the documents and made no material findings. Compliments were given to the Trust's Communications and Engagement Team, and the Trust's Finance department for the successful Annual Report and Annual Accounts. The Board **approved** the Annual Report and Accounts	

Item	Subject	Action
TB/25-26/31	**External Audit Report** The Board **noted** the External Audit Report.	
TB/25-26/32	**Letter of Representation** The Board noted and **approved** the Letter of Representation.	
TB/25-26/33	**Audit and Risk Committee Annual Report** The Board **noted** the Audit and Risk Committee Annual Report	
TB/25-26/34	**Audit and Risk Committee Chair's Report** The Board **noted** the Audit and Risk Committee Chair's Report.	
TB/25-26/35	**Any Other Business** None.	
TB/25-26/36	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 31st July 2025, MS Teams .	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 23.07.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JULY 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	On the agenda. To be closed.	**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	November 2025	This will now come in November once consultations for various services have concluded.	**In Progress**
27.03.2025	TB/24-25/145	Integrated Quality and Performance Review	Produce a standalone Memory Assessment Service Paper setting out the performance data across the Trust's Community Mental Health Teams, with unwarranted variation identified	AR	July 2025		On the agenda. To be closed.	**In progress**
29.05.2025	TB/25-26/7	Chair's Report	Provide an update to the People Committee on the revised operating model for the use of peer-support at the Trust	DHS	July 2025		A verbal update was provided at the July 2025 People Committee. To be closed.	**In progress**
29.05.2025	TB/25-26/8	Chief Executive's Report	Provide a verbal update on the co-produced integrated clinical working plan that clearly incorporates the views of the clinical directors and the senior Nursing team	AQ	July 2025		This will be incorporated into the future clinical staffing model report to the Quality Committee in November 2025, once the consultations for various services have concluded. To be closed.	**In progress**
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Submit a review of the Trust's Digital Plan for consideration, which also include the potential use of AI Chatbots to support the patient experience	NB	July 2025		On the agenda. To be closed.	**In progress**
29.05.2025	TB/25-26/9	Board Assurance Framework (BAF)	Review, and amend, the risks within the "we use technology, data and knowledge to transform patient care and our productivity" section of the Board Assurance Framework	NB	July 2025		The risks will be updated following the agreement of the Trust's Digital Plan.	**In progress**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Circulate, via e-mail, clarification regarding the roles and responsibilities of social workers employed by the Trust and how this differed to social workers employed by local authorities	AC	July 2025		The requested information was circulated to Board members following the meeting on the 29th May 2025. To be closed.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 23.07.2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Schedule a Board Seminar on a one-year review of the Purposeful Admission Programme	TS	July 2025		This has been added to the Board Seminar and Development Planner, for consideration with the Chair and Chief Executive.	**In progress**
29.05.2025	TB/25-26/13	Finance Report for Month 1	Provide an update on the impact of the use of external beds on the Trust's ability to achieve the financial plan for 2025/26 and associated next steps	NB	June 2025		Additional information was included as part of the Month 2 Finance Report to the Finance and Performance Committee in June 2025. To be closed.	**In progress**
29.05.2025	TB/25-26/15	Continuous Improvement Impact Report	Schedule a Board Seminar on the Continuous improvement programme in terms of its underlying activity and proposed outcomes.	TS	July 2025		This has been added to the Board Seminar and Development Planner, for consideration with the Chair and Chief Executive.	**In progress**
ACTIONS NOT DUE OR IN PROGRESS								
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Provide additional detail, as part of the IQPR, in regard to progress in address unwarranted variation between the six Memory Assessment Services	AR	September 2025			**Not Due**
29.05.2025	TB/25-26/12	Integrated Quality and Performance Review	Produce a separate report on the Mental Health Together (HMT) programme	DHS	September 2025			**Not Due**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
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.	**Closed**
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.	**Closed**
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	**Closed**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 23.07.2025

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/24-25/150	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.	Closed
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. The action was replaced by TB/25-26/9	

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31st July 2025**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

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

2. Kent & Medway system and national activity

It was extremely helpful to meet with our peers from North East London Foundation Trust (NELFT) for a board to board session about the planned transfer of care in 2026 for all age eating disorders and children and young people's mental health services. Both Boards are united in their determination to ensure that this transfer of care is achieved in a way that is safe and seamless for service users and their loved ones, and which gives NELFT staff the assurance that they are warmly welcomed to KMPT who want them to flourish with their new employers.

There have been two further meetings of the Provider Collaborative Board, with progress made in approving Terms of Reference for a Joint Committee; currently the predominant focus is on the significant financial savings for the Kent & Medway system which the Provider Collaborative has undertaken to deliver, some of which are associated with significant risk.

I attended a half day NHS Providers meeting for chairs and CEOs. There was a particularly good discussion with Sir Chris Whitty (Chief Medical Officer for England) regarding the focus on secondary health prevention in the NHS 10-year plan. Of particular relevance was his emphasis on opportunities to delay the onset of dementia for five years by attending to hearing loss in the population (the single biggest predictor of dementia).

3. Board Development

The board had a productive full day of discussions in June. This included some training on Dialog+ - with thanks to James Osborne for an excellent delivery – which will become the Trustwide tool for reported outcomes, and in due course, our care planning tool. We also heard about a recent thematic review of serious incidents in the Trust, resulting in a renewed commitment from the Board to ensure that we continue to promote a learning culture across the organisation. The afternoon was devoted to strategic discussions about our potential to work more closely with our partners, and a review of our cost improvement plan and the corporate savings that are required by NHS England.

4. Trust Chair and NED visits

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

Where	Who
April 2025	
Arndale House	Julie Hammond
May 2025	
Rosewood Mother and Baby Unit	Julie Hammond
June 2025	
Ethelbert Road Rehabilitation Centre	Julius Christmas
Crisis & Recovery House, Chatham	Peter Conway
Medway liaison team and Medway safe haven	Jackie Craissati
July 2025	
Willow ward (Psychiatric Intensive Care Unit; PICU)	Jackie Craissati

Chair visits

I was delighted to meet with all of the Medway psychiatric liaison team, and we had a very frank and helpful discussion about their achievements (working hard and effectively under considerable pressure of demand) and their challenges (struggling with a detailed new suicide risk assessment proforma, which they felt was ill-suited to their needs, and the need to expand the team in response to the social deprivation and demand in their area). I also felt that the collaboration with their third sector peers at the safe haven could have been enhanced. Meanwhile, my short visit to the safe haven a few minutes' walk away was also very positive. Their main concern was the lack of access to KMPT's clinical record system, which I have raised with the relevant executive.

I had the opportunity to speak briefly with the whole PICU team at Willow Ward on their awayday, before visiting the ward itself. I was impressed by the staff commitment to the ward and their passion for the work (including leaving agency working to be an employee!). I was also impressed that the matron undertook monthly bank shifts in order to stay in touch with front line nursing practice. There are, however, ongoing problems with patient flow, and with long delays regarding maintenance which leaves staff feeling neglected/unheard even though there are reasons for these delays. Perhaps we can do a little more about communications and maintenance delays?

Dr Julie Hammond's visit to Arndale House

The team spoke positively about the Mental Health Together transformation and its tiered pathway approach, which has improved efficiency and stability. Individual Placement Support is being well-utilised to address employment-related challenges faced by service users, and there is enthusiasm for integrating more proactive, socially-informed care. Despite workforce pressures, the service is managing a caseload of 800–900 patients with 10 mental health nurses, and temporary assistant psychologist roles have helped bridge workforce gaps.

Key concerns relate to ongoing staffing difficulties: the lack of an embedded medic within the Mental Health Together programme is causing delays, and there are supervision and risk concerns related to the assistant psychologists. Estates and infrastructure issues include limited space and parking, affecting both recruitment and service expansion. The team highlighted the need for a purpose-built hub to consolidate services. Additional concerns include inappropriate referrals, long waiting times for treatment, and the absence of a social prescriber role to support patients facing complex socio-economic challenges.

Dr Julie Hammond's visit to Rosewood Mother and Baby Unit

This is the only unit in the UK that admits mothers under the age of 18. At the time of my visit, three beds were vacant, and three patients were admitted under the Mental Health Act. The unit was awarded the PQN accreditation by the Royal College of Psychiatrists in March 2025.

The ward is currently being underutilised due to a lack of awareness and there have been instances where mothers have been placed on acute wards, separated from their babies, despite bed availability at Rosewood. The unit has good staffing levels, typically having two nursery nurses, two mental health nurses, and two healthcare assistants on duty. They do not use zonal observations due to the ward layout, but their current monitoring approach is effective. They have also recently installed air conditioning to ensure compliance with Lullaby Trust guidelines. A newly recruited psychologist now supports the patients, and they are piloting the use of safety pods for safer patient restraint, especially for mothers recovering from childbirth. Although there are some ligature risks (in the bathroom and laundry room) and potential concerns with the garden fencing, these are being managed appropriately. Overall, I was pleased with the visit, as both staff and patients seemed happy and well-supported. The environment felt safe and welcoming, contributing positively to the well-being of the mothers and their babies.

Julius Christmas' visit to Ethelbert Road rehabilitation centre

The centre felt appropriate for rehabilitation, offering the comfort and ambiance of a normal shared house rather than a clinical or hospital environment. I was surprised at the 9–12-month average stay, but not by the difficulties in discharging patients, largely due to social care and accommodation challenges. We discussed enhancing community care and step-down facilities to alleviate this issue.

I also spoke with an experienced Rio user, who was positive about the platform but noted inconsistent use of its full features due to the varying digital confidence of its users. They also highlighted inefficiencies in longform patient notes, which can detract from updating more useful and reportable structured data fields.

Peter Conway's visit to Crisis & Recovery House, Chatham

I attended the formal opening of the new Crisis & Recovery House in Chatham – a partnership project between KMPT, the Pears Family Charitable Foundation, and Hestia. The service will provide recovery-focused 24-hour support for adults experiencing a mental health crisis – a community-based alternative to hospital-based care – in a six-bedroom house. The house is well located, close to the centre of Chatham and whilst in the community, with large residential buildings directly opposite, this detached property promises a calm, therapeutic, non-clinical environment. Staff who will run the facility were enthusiastic and keen to make a real impact on the lives of guests they support, and excited to be part of this new venture.

This represents an innovative new example of partnership across different sectors for Kent and Medway.

Chief Executive's Board Report

Date of Meeting: 31 July 2025

Introduction

The long-awaited ten-year plan for the NHS has now been published. My team and I have read it to ensure we understand the impact and the role that Kent and Medway NHS and Social Care Partnership Trust (KMPT) has in delivering this ambitious plan. As I have said before I am very optimistic about KMPT's future in the Kent and Medway system and how we will continue to develop how we work with our partners to deliver the best care to our local population. Our trust has a critical role in delivering neighbourhood health.

National and Regional Update

NHS 10 Year plan

The *Fit for the Future: 10-Year Health Plan for England*, published by the Department of Health and Social Care in May 2025, sets out an ambitious roadmap for transforming health and care services across the country. The plan is structured around three overarching shifts in system delivery:

- moving from hospital-based to community-centred care,
- transitioning from analogue to digitally enabled services, and
- shifting focus from reactive treatment to preventative and predictive healthcare.

As Chief Executive of KMPT, I recognise that the principles and priorities laid out in this national strategy are not only consistent with our own strategic aims but will actively support and accelerate our progress.

The plan's commitment to enhancing community-based care is directly aligned with our ambition to deliver exceptional care through local, multidisciplinary teams. KMPT has already begun the transformation of its community mental health services, in line with the Community Mental Health Framework, and we welcome the national emphasis on neighbourhood health centres and integrated models of care. These developments will help us strengthen access, improve continuity, and address health inequalities across Kent and Medway.

Digital innovation is another key pillar of both the national plan and KMPTs strategic direction. The government's aspiration to become the world's most AI-enabled healthcare system aligns well with our own efforts to improve service user experience and reduce workforce pressures through the use of technology. Our investment in digital infrastructure, including the use of data analytics, digital telephony and clinical documentation tools, positions us to benefit from expanded capabilities of the NHS App, AI-assisted care delivery, and virtual consultations.

The shift from sickness to prevention resonates strongly with KMPT's priority to improve population health and reduce inequalities. The plan's focus on genomics, early intervention, and social determinants of health complements our work with system partners to support people before they reach crisis. Furthermore, the national expansion of personal health budgets and care planning empowers service users and carers, consistent with our commitment to co-production and personalised care.

In terms of workforce reform, the health plan's proposed operating model offers clear opportunities for KMPT. Flexible working arrangements and enhanced career progression paths are crucial to our efforts in attracting and retaining talented staff. These developments are compatible with our internal programmes for leadership development, wellbeing support, and continuous improvement.

Taken together, the *Fit for the Future* health plan provides a coherent national framework that validates and reinforces KMPT's strategic aims. It encourages the further integration of services, supports investment in digital transformation, and reaffirms the importance of preventive care and staff wellbeing. KMPT is well placed to respond to this call for change and contribute meaningfully to the transformation of the NHS and our local system.

System Chief Executives

We met as system Chief Executives (CEOs) with the wider system Executives to ensure our system financial plan for this year remains on track. The Joint committee will continue to oversee this work and drive the pace of change and delivery required.

Medway Recovery House opening

I was delighted to attend the Medway Recovery House opening last month. The initiative has been led by Louise Clack, ICB Deputy Director of Mental Health. We are extremely grateful to the Pears Foundation and Sir Trevor Pears and his family for funding this new house in Medway. We were fortunate to be joined by Sir Trevor's daughter Sabrina Pears for the opening and Peter Leach who proposed this initiative following his experience with a family member in mental health crisis. Peter shared his inspiring story that has driven his ambition, to work with the NHS and Claire Murdoch CBE, the National Director for Mental Health at NHS England joined us to celebrate the grand opening. This will make a real difference to our patients who need immediate support in a crisis. The purchase and re-modelling of this house has happened in 3-4 months and is now open for our patients to access care. The house will be run by one of our partners, Hestia and we look forward to working more closely with them in the coming months. The Pears Foundation generosity is very much appreciated by our local system and population. Our ambition now is to open a third house in Thanet later this year once again supported by the Pears Foundation. We also have a crisis house in Ashford run by Turning Point.

Trust Update

Children's Young People and All Aged Eating Disorder services

I am delighted to be able to share that Children and Young People's Mental Health and All Age Eating Disorder services for Kent and Medway will be transitioning to our trust from Spring next year. There has never been one, single, provider of all mental health services for the people of Kent and Medway, so this is a really important opportunity for us to offer more joined up care to everyone no matter their age or the issue they need support with. We are working closely with their current provider - North East London Foundation Trust (NELFT) – as one NHS to safely transition these services, and greatly look forward to welcoming both the services and the expert staff who provide them to the KMPT family next year.

Open Dialogue

On Wednesday 4th June, I was invited along to an Open Dialogue event held at the Friars in Aylesford. We were joined at the event by Keith Bryan, the CEO of the Open Dialogue Centre in Australia.

What I found was truly insightful and inspiring; the conversation the team were having was a very similar conversation to the one that I had been having with my team only that morning, about improving the organisation and the services/care we offer to our patients. The team brought that to life for me with their examples of what they are seeing and how it feels now for them on a daily basis but most importantly what they think we could do differently in our approach.

I really felt the executive team were aligned to what the group were saying and that there is real power in this for us all in taking the organisation forward. I have invited the group to be a part of the doing well together improvement programme we are just launching.

Clinical Summit – June 2025

The KMPT Clinical Summit held on 13th June 2025 brought together clinicians from the Trust's five Communities of Practice (COPs), each committed to advancing clinical excellence and sharing best practice across services.

The summit featured engaging presentations from each COP, highlighting innovative work in Older People's Mental Health, Community Mental Health, Urgent Care and Hospital Liaison, Recovery and Reintegration, and Forensic and Specialist Services.

The Urgent and Hospital Liaison COP introduced the Freshstart project—an intervention supporting individuals who frequently attend A&E due to self-harm. This 12-week therapeutic programme has offered both staff development opportunities and a new treatment pathway not otherwise available through standard NHS care.

Dr Efiong Ephraim showcased pathway improvements in the North Directorate that better integrate Older Adult Mental Health Teams, inpatient wards, and palliative care, supporting a more cohesive, system-wide approach to end-of-life care for older adults.

The Recovery and Reintegration COP presented their reflective practice and family therapy work with carers, focusing on education and shared understanding of patient needs. Meanwhile, the Community Mental Health COP reported on their co-produced project with individuals with lived experience. Their initiative—providing reassurance to frequent NHS 111 (option 2) callers—demonstrated a measurable reduction in call frequency.

Forensic and specialist services COP highlighted the Neuropsychiatric services for their emphasis on broadening access through collaborative work with the voluntary sector, research participation, service evaluations, and interface consultations.

Additional presentations included a talk by Professor Ang (University of Kent) on the potential of AI in clinical practice, the important role of clinical audit in service improvement, and the contribution of Advanced Clinical Practitioners (ACPs) in addressing service gaps.

Overall, the summit exemplified KMPT's ongoing commitment to innovation, integration, and person-centred care.

National Awards

It is my pleasure to share that our Liaison, Diversion and Reconnect team (LDR) won a Veterans Award for their outstanding dedication and support to the ex-military community in Kent and Medway. By working in partnership with all aspects of the criminal justice system they make sure people get the right help, when they need it most, to break the cycle of reoffending.

Our Chief Medical Officer, Afifa Qazi, and consultant psychiatrist's Dr Bosky Nair and Dr Shivaram Chikkatagaiah were honoured to receive fellowships from the Royal College of Psychiatrists. Also, our communications and engagement team were finalists in the HSJ's 'Enhancing Workforce Engagement, Productivity and Wellbeing through Digital' award. This recognised the success of staffroom, our new app-based intranet, in its first few months. Over 90% of staff activated it, even where take up of new digital services is usually low, there were 142,000 uses of the mobile app, ensuring connection with our deskless workforce, and the swifter access to policies it provides has saved an estimated 14.5 WTE days. Well done to all our winners we are KMPT proud.

Triangle of Care

I am delighted to say that KMPT have retained our 1 and 2 star Triangle of Care (ToC) ratings from the Carer's Trust.

The Trust-wide Carer Experience Meeting, chaired by Rachael Sanderson (Strategic Lead for Allied Health Professions), brings together families, carers, staff, and external partners to embed and advance the six core principles of the ToC framework:

1. Early identification of carers.
2. Staff trained in carer engagement.
3. Clear protocols for confidentiality and information sharing.
4. Designated roles responsible for carers.
5. Accessible service introductions and information for carers.
6. A broad range of support services for carers.

Over the past year, KMPT has continued to strengthen its commitment to families, friends, and carers as essential partners in care. We recognise there is still more for us to do and this will remain a priority for us this year. Through sustained focus, multi-disciplinary engagement and partnership working with those with lived experience, KMPT is steadily building a system where carers are not only acknowledged, but actively supported and empowered. We remain resolute in our ambition to make carer involvement a golden thread through all we do, ensuring better outcomes not just for those who use our services, but for those who support them on our patients' treatment journeys.

Meeting with Kent MPs

On Friday 27th June, myself, Donna Hayward-Sussex, Dr Afifa Qazi and Vicky Stevens (Deputy Chief Operating Officer) met with some of the Kent and Medway MPs who had accepted the invitation to come along to the Trust to hear from us first hand our ambitions for KMPT and the launch of our new trust values and identity in the autumn. We also discussed the transition of Children and Young People Services back to KMPT in Spring next year. It presented the MPs with an opportunity to also provide direct feedback on our services from their constituents. We will continue to build our relationships with our local MPs moving forward.

Visit to KMPT by NHS Providers

On Friday 27th June, Saffron Cordrey, Deputy Chief Executive of NHS Providers visited the Maidstone site. Saffron was accompanied on two ward visits to Ruby Ward and also a forensic ward in the Trevor Gibbens Unit by Dr Jackie Craissati, Trust Chair and Donna Hayward-Sussex, Deputy Chief Executive. Saffron was particularly impressed by the new Ruby Ward and the calm, light and airy feel to the ward and access that the patients had to outside gardens.

Value in Practice Awards

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

Summary and Conclusion

As I said at, the beginning of my report the ten-year plan has been published and I will now work with my team to ensure KMPT have an active role in delivering key parts of the plan and what this means for our local population.

KMPT is currently in its third and final year of the Trust strategy and as we move from the summer into the autumn we will be developing our new 5 year strategy setting out our bold ambitions for our organisation. I look forward to working with our staff, patients and their loved ones and our partners in doing this.

Sheila Stenson
Chief Executive
31st July 2025

Executive Team Visits

Sheila Stenson:
New Recovery House Medway
Emmetts ward
Clinical Summit
Open Dialogue event

Donna Hayward-Sussex
Dartford Wards
Highlands House
Canterbury Wards
Ash Eaton

Sandra Goatley
West Kent Services

Nick Brown
Mental Health Together Teams – Dover

Andy Cruickshank
Swale CMHT

DGS CMHT

Adrian Richardson
Allington/Tarentfort/Pinewood/Amberwood Improvement Management Training Days

Value in Practice Awards – May and June

Directorate		May	June
North	Individual	Terry Huggett, Community Mental Health Nurse	Titilayo Bayode, Support Worker Michael Asong, Staff Nurse
	Team	DGS MHT+	-
East	Individual	Liz James, Community Mental Health Practitioner	Blaise Berry, Admin Co-Ordinator
	Team	Ashford and Canterbury MAS	Rehab – Ethelbert Road
West	Individual	Joe Hesketh, Patient Flow Team Leader	Rachel Weston, Senior Occupational Therapist and Discharge Co-Ordinator
	Team	Clinical Leads out of hours, Patient Flow	South West Kent MHT and MHT+
Forensic	Individual	Gill White, Nursery Nurse	Olaniran Gentry, Healthcare Assistant
	Team	Emmetts Ward, TGU	Security and Reception - Trevor Gibbens Unit
Support services	Individual	Simone Frisby, Executive Assistant	Mark Gainsford, Porter
	Team	Volunteers and Volunteers Team	E-Meds, Karen Bartlett and Sukhy Bassi
Acute	Individual	Natalie Boorman, Clinical Lead, Occupational Therapist	Vicki Fernandez, Ward Manager
	Team	Heather Ward	North Kent Psychological therapies Team

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31 July 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 May 2025 and to the Audit and Risk Committee in June.

Following the Board session in April to describe the risk appetite for the Trust, this has now been incorporated into the Risk Management Framework and is being taken through the governance route for sign off. The approach to how this is articulated has been built 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.

New Risks:

Three new risks have been added since the BAF was presented to Board in May

- **Risk ID 02290 - CQC Regulatory Compliance (Rating of 12 – High)**
- **Risk ID 04673 - Organisational Risk - Cyber Attack (Rating of 15 – Extreme)**
- **Risk ID 04682 - Organisational Risk - Industrial Action (Rating of 4 - Moderate)**

Risk Movement:

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

- **Risk ID 08065 – Inpatient Flow (Decreased from 20 (Extreme) to 16 (Extreme))**
- **Risk ID 02290 - CQC Regulatory Compliance (Increased from 6 (Moderate) to 12 (High))**
- **Risk ID 04673 - Organisational Risk - Cyber Attack (Increased from 8 (High) to 15 (Extreme))**

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Risks recommended for Removal:

One risk is currently recommended for removal

- **Risk ID 04083 – Management of Environmental Ligatures (Rating of 8 – High)**

Governance

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

Version Control: 01

Kent and Medway
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The Board Assurance Framework

The BAF was last presented to Board on 29th May and ARC on 3rd June 2025. This report reflects further updates on risks since the beginning of June.

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 16 – Extreme)
- Risk ID 04673 – Organisational Risk – Cyber Attack (Rating of 15 – Extreme)
- Risk ID 08174 - Delivery of Financial Targets (Rating of 15 - Extreme)

Risk Movement

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

- **Risk ID 08065 – Inpatient Flow (Decreased from 20 (Extreme) to 16 (Extreme))**
  This risk remains under close scrutiny. There has been progress on some actions, with the accuracy of breach data having been improved and allowing for accurate tracking of breaches. Out of Area Placements for acute inpatients has reduced from 30 in April to 8 currently (14 July 2025), excluding PICU. As at 14 July the total number of CRFD patients is 50. This has reduced to 15% for younger Adults, Older adults has increased to 25%. Whilst remaining a challenge, this is an overall reduction from April, which has enabled the reduction in risk score.

- **Risk ID 02290 - CQC Regulatory Compliance (Increased from 6 (Moderate) to 12 (High))**
  This existing risk has been reviewed and refreshed following the CQC Warning Notice received in April, with an increase in risk score. Quality Improvement Plans are in place for the areas identified in the warning notice and are being tracked through daily calls.

- **Risk ID 04673 – Risk ID 04673 - Organisational Risk - Cyber Attack (Increased from 8 (High) to 15 (Extreme))**
  This risk has been reviewed and refreshed following discussion at the Audit and Risk Committee. It has been added to the BAF due to our current risk profile against risk proximity and the ability of cyber-criminal advances in attack methodology

Risks Recommended for Removal

One risk is being recommended for removal at this time:

- **Risk ID 04083 – Management of Environmental Ligatures (Rating of 8 – High)**
  As this risk has remained stable, and is considered well controlled, it is being recommended for removal from the BAF. This risk will remain open, and can be returned to the BAF If anything changes.

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New Risks

Three risks have been added since the BAF was presented to Board in May.

- **Risk ID 02290 - CQC Regulatory Compliance (Rating of 12 – High)**
  The update on this risk has been included above

- **Risk ID 04673 - Organisational Risk - Cyber Attack (Rating of 15 – Extreme)**
  The update on this risk has been included above

- **Risk ID 04682 - Organisational Risk - Industrial Action (Rating of 4 - Moderate)**
  This risk has been added to the BAF due to the announcement by the BMA that Resident Doctors will go on Strike for 5 days in July. All Industrial action plans remain in place and are up to date.

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.

Other Notable Updates

- **Risk ID 08175 – Delivery of Underlying Financial Sustainability**
  The draft cost improvement plan was presented to FPC in April and has formed part of the Annual financial plan which have been submitted to the ICB and NHS England. It is not expected that a further submission of the annual plan for the coming year will be required in June. Delivery of the plan is in the very early stages at this time, but external bed use is currently the greatest concern.

- **Risk ID 08174 - Delivery of Financial Targets**
  Year end position for 2024/25 has been completed and submitted. The Financial Plans submitted to the ICB and NHS England have been accepted, and it is not anticipated that there will be a need for any further submissions at the end of June. The Trust plan is for a £2.2 million surplus at this time. Currently this feels challenging, in part due to the number of external beds currently required.

- **Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand**
  Work is still ongoing, addressing the variation and we are continuing to see the improvement with reducing the 52+ week waits and average waiting times are reducing. the community model is being finalised and this will aim to have a positive impact on the KMPT performance as well. System Dementia Diagnosis rate continues to improve alongside the KMPT improvement as well.

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.

Version Control: 01

Updated: 17 July 2025

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Board Assurance Framework

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

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

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 Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 29/08/2025 — A Phase 2 resourcing and implementation — Director of Partnerships and Transformation — 29/08/2025 — A Focussed activity on 52 week waits — Director of Partnerships and Transformation — 29/08/2025 — A Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 29/05/2026 — A	Director of Partnerships and Transformation		3	4	12	31/03/2026

12/06/2024 — Risk Opened

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

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)
12/06/2024 Risk Opened																			
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	⟷	**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 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	Chief Operating Officer		3	3	9	28/08/2025
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 BAF Risk Opened — 20/07/2023 Risk returned to BAF																			
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 [1e] 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	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Capital Expenditure on Environmental Ligature risk areas — Head of Capital Planning — 31/03/2026 — A	Chief Nurse		1	4	4	31/03/2026
04/12/2014 BAF Risk Opened — 20/07/2023 Risk returned to BAF																			
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF KMPT do not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance the Continuous Improvement Approach Violence Reduction Strategy PSS Strategy Use of Force Act Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy Safer Staffing	Incident reporting via InPhase Quality Improvement Data	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. — Chief Nurse — 30/03/2026 — A New Violence and Aggression Policy 2025 — EPR Lead — 31/07/2025 — A	Chief Nurse		2	3	6	31/03/2026

				Initial rating				Current rating						Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
01/04/2014 — Risk Opened — 05/06/2025 — Risk escalated to BAF																			
ID 02290	Apr 2014	Chief Nurse	**CQC Regulatory Compliance** IF we don't have effective means for assessing, measuring, monitoring and reviewing the regulations as set out in the Health and Social Care Act 2008 required to evidence compliance with fundamental standards and to uphold CQC registration THEN inspections may highlight areas of poor quality of care RESULTING IN avoidable harm, legal claims, regulatory breaches, enforcement action from our regulators and damage to the confidence in the Trusts reputation as a provider of choice.	4	4	16	QPRs held within the Directorates and audits that identify areas of concern for further action Learning Review Group (LRG) – learning is identified from patient safety incidents and lessons shared to prevent reoccurrence CQC MHA Reviews for inpatient areas – provider action statements generated, reports to Mental Health Legislation Operational Group (MHLOG) and Mental Health Act Committee (MHAC) Regulation, Compliance and Quality Group (RCQG) – meets monthly and reports to Quality Committee (QC) Quarterly engagement meetings with CQC whereby areas of concern are discussed and assurance provided against quality statements and the five key questions Support tools and evidence lists for staff based on CQC quality statements and five key questions. This is available on staffroom. Quality improvement plans following inspection activity - these are monitored via RCQG and QC Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month).	QPR minutes and audit results within the Directorates identify areas of concern and actions are then generated to rectify these Learning Review Group minutes identify learning shared from patient safety incidents Quarterly engagement meeting with CQC minutes The provider action statements from MHA inpatient reviews and quality improvement plans from inspection activity are reviewed for oversight and assurance purposes at the Regulation, Compliance and Quality Group, with points of escalation/concern highlighted to Quality Committee and Mental Health Act Committee Workplan for Regulation, Compliance and Quality Group which has set items that are regularly reported to these meetings i.e. Rapid tranquilisation data, supervision/training data, complaints, serious incidents etc. Quality statement presentation slides have been shared within directorates so that staff are aware of what evidence would be required under each quality statement. Quality improvement plans – when actions are complete, these move to the assurance check phase and are monitored via the Regulation, Compliance and Quality Group. Regulations set out in the Health and Social Care Act – Trust assessment against these identifying good compliance and gaps in assurance. (This is a new process starting this month). Quarterly Performance and Quality Meeting (PQM) with the ICB Minutes.	3	4	12	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of Place of Safety Quality Improvement Plan / Chief Nurse / 30/07/2025 / A Delivery of Community Teams Quality Improvement Plan / Chief Nurse / 30/10/2025 / A	Chief Nurse		2	3	6	31/03/2026
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																			
			No Risks Identified against this Strategic Objective																
2 - We are a great place to work and have engaged and capable staff living our values																			
2.1 - Creating a culture where our people feel safe, equal and can thrive																			
30/01/2025 — BAF Risk Opened																			
ID 08337	Jan 2025	Chief People Officer	**Organisational Culture impact on Change Programmes** If KMPT's current interventions do not successfully build its capability and capacity to deliver effective change, Then change efforts are unlikely to succeed and engagement will deteriorate, Resulting in poor organisational culture, impact on our people, patients and population, reduced ability to deliver key strategic ambitions	4	3	12	Work to introduce and embed new and coherent organisational values [2e] Delivery of leadership development programme [2a] Delivery of equality, diversity and inclusion interventions [2a] Delivery of Opex and improvement capability building [2a]		3	3	9	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Delivery of leadership and management programmes / Deputy Chief People Officer / 31/03/2026 / A Roll out and embedding of New Organisational Values / Deputy Chief People Officer / 31/03/2026 / A Embedding of staff voice initiatives / Deputy Chief People Officer / 31/03/2026 / A	Chief People Officer		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																

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)
3.2 - Working together to deliver the right care in the right place at the right time																			
04/12/2014 Risk Opened 04/06/2021: Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award. 03/11/2021: Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing. 13/03/2023: So far there has been little impact from Industrial action. Business continuity plans and Command and control arrangements are in place and have so far proved adequate. This is being kept under review. 15/05/2024: This risk is recommended for removal from the BAF. It will remain open and be managed on the EPRR risk register. 15/05/2024: This risk has been escalated to the BAF due to the announcement by the BMA of Industrial Action in July by Resident Doctors.																		
ID 04682	Jan 2019	Chief Nurse	**Organisational Risk - Industrial Action** IF industrial action is enacted within KMPT by Unison, Unite, BMA, RCN etc, or any external service affected by industrial action, which may have an effect on the business continuity of the Trust THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services and a backlog of delivery due to cancellations.	3	3	9	Industrial Action SOP inclusive of Command and Control [2e] Unique operational order/s. Significant Incident Plan [2e] Business Continuity Plans [2e] Workforce and OD Industrial Action Monitoring Group EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side Situation Reporting to ICB via OCC	Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance Strikes are planned and therefore mandates are known in advance when they overlap or and concurrent. Operational Directorate backlog monitoring against demand and capacity risk.	2	2	4	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** (no actions recorded)	Chief People Officer		2	2	4	29/07/2026
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																
4 - We use technology, data and knowledge to transform patient care and our productivity																			
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																			
22/07/2015 Risk Opened 15/06/2025: Risk escalated to BAF																			
ID 04673	Jul 2015	Chief Finance and Resources Office	**Organisational Risk - Cyber Attack** IF KMPT is the victim of a successful cyber attack THEN this is likely to impact on the availability or accessibility of key business systems including patient records and other sensitive data held by the organisation RESULTING IN clinical risks due to a loss of access to patient records (including pharmacy information), breaches of IG, financial cost, penalty or fine from the ICO and damage to trust reputation.	4	5	20	Robust security firewalls in place [1d] Cyber Resilience and Response plan [2e] Disaster Recovery Plan [2e] End point devices are patched [1d] Horizon scanning [1h] Link with National Alerting and Notification systems (1h) 'Nexthink' alert system [1h] Links to HSCN/KPSN [2f] Annual Pen Test and Audit [3d] DSPT [2c] ISO 27001 [3f] Evidence gathering from suppliers (stored in Spoint) [1c] IT Health [1h] Pentera [1h] Automatic driver and firmware updates [1d] Moving systems on to Same Sign On [1d] Business Continuity Plans - Service and IT Systems Annual Audit of IT systems Business Continuity Plans Cyber Resilience Exercises Cyber Essentials Multi-Factor Authentication	ISO27001 Internal Audit Cyber Essentials (2019) DSPT EPRR Annual Assurance Programme	3	5	15	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Completion of short term actions from the Cyber Exercise / EPR Lead / 20/08/2025 / A Completion of medium term actions from the Cyber Exercise / EPR Lead / 30/03/2026 / A Cyber Essentials + / Deputy Director of Digital / 01/07/2025 / A 2025 IT system BCP Audit / EPR Lead / 07/11/2025 / A	Chief Finance and Resources Office		2	3	6	29/03/2026
4.2 - Enhance our use of IT and digital systems to free up staff time																			
			No Risks Identified against this Strategic Objective																
4.3 - Effective digital tools are in place to support joined-up, personalised care																			
			No Risks Identified against this Strategic Objective																
5 - We are efficient, sustainable, transformational and make the most of every resource																			
5.1 Achieve financial sustainability																			
22/08/2023 Risk Opened																			
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Sign off of Medical Agency spend at exec level. [3a] Sign off for above cap rate posts at CEO level [3a] Reporting to Trust Board [3a] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend Medical lead for recruitment appointed to support areas which are challenging to recruit to. All non medical vacant posts are reviewed at the weekly vacancy control panel. No retrospective approval of Agency shifts	Monthly IQPR (reported to each public board) Monthly statements to budget holders [1a] Monthly Finance Report [1h] Internal audit [3d]	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Reduce Nursing Agency Spend by 50% to meet the National ask / Chief Medical Officer / 30/10/2025 / A	Chief Medical Officer		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	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 Office	**Delivery of Financial Targets** IF the Trust is unable to deliver its financial targets THEN additional scrutiny will be attached to its financial position RESULTING IN sanctions from NHS England	3	5	15	Standing Financial Instructions [2e] Delegated budgets [1a] Agency recruitment restriction [2e] CIP Process [2e] Monthly statements to budget holders [1a, 1h] Budget holder authorisation [2a] Authorised signatories [2a] Trust Capital Group oversight [2b] Business Case review group [2b]	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	5	15	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Forecast of the Trust Agency spend (signed off by Service Directors) — Associate Director of Finance — 31/03/2026 — A Forecast of the Trust Bank spend (signed off by Service Directors) — Associate Director of Finance — 31/03/2026 — A Review of the use of temporary staffing and identify appropriate mitigations and controls — Associate Director of Finance — 31/03/2026 — A Review of Trust Reporting Pack — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Office		2	4	8	31/03/2026
	25/06/2024 Risk Opened																		
ID 08175	Jun 2024	Chief Finance and Resources Office	**Delivery of Underlying Financial Sustainability** IF the Trust fails to maintain financial sustainability THEN this could lead to an inability to deliver core services and health outcomes, and financial deficit, RESULTING IN intervention by NHS England and insufficient cash to fund future capital programmes.	3	4	12	Long term sustainability programme [1g] Cost Improvement Programme [1d]	Monthly external reporting to ICB and NHS England	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Separate workstream for Corporate Savings to monitor delivery to include system stretch requirement — Associate Director of Finance — 31/03/2026 — A Agreed Cost Improvement Plan programme of work with agreed timeframes — Associate Director of Finance — 31/03/2026 — A Review of Trust controls on Non Pay — Associate Director of Finance — 31/03/2026 — A Out of Area Placements - detailed reporting of external beds utilisation and financial risk arising — Associate Director of Finance — 31/03/2026 — A Refresh and review underlying position at service and commissioner level. — Associate Director of Finance — 31/03/2026 — A	Chief Finance and Resources Office		3	2	6	31/03/2026
5.2 Exceed the ambitions of the NHS Greener programme																			
			No Risks Identified against this Strategic Objective																
5.3 Transform the way we work																			
			No Risks Identified against this Strategic Objective																
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
	29/03/2024 Risk Opened																		
ID 08173	Mar 2024	Chief Finance and Resources Office	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of needs of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership Capital Working Group in place and assesses the requested capital schemes with input from clinical colleagues, giving priority against a range of criteria for consistency. Regular Reviews of clinical environments with Estates and Clinical Teams (Inc. PLACE inspections) Seven facet building surveys (EstateCode - Building Condition assessment)	Trust Capital Group - Estates annual capital works programme Trust Strategy - Estates Strategy Delivery annual report Estates Capital Delivery Resource structure (sub-EFM Org Structure) Annual ERIC backlog data (building functional condition)	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** To complete the Annual ERIC Return — Deputy Director for Estates — 29/09/2025 — A Tender for 6 Facet Survey — Deputy Director for Estates — 30/03/2026 — A	Chief Finance and Resources Office		2	3	6	31/03/2026
	01/04/2020 Risk Opened																		
ID 08146	Aug 2024	Chief Finance and Resources Office	**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 Office		2	3	6	31/03/2026

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 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:	Discussion
Submission to Board:	Board requested

Overview of Paper

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

It includes:

- An update on timelines and capacity and demand for dementia diagnosis implementation.
- An overview of joint working with social care supported by the collaborative
- Updated performance information
- Updated visions for each workstream following the workshop in June.

Issues to bring to the Board's attention

There is now an outline capacity and demand model and timelines for implementation of the new Dementia model

Governance

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

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

Programme	2025		2026	
	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 Mental Health Pathways				
Physical and Mental Health Ward				

2. Programme updates July 2025

2.1 Dementia next steps

The programme team is now working to implement the agreed clinical model with the three levels outlined in previous board reports (level 1, people in a care or nursing home or housebound, level 2, people in community settings with no additional complexity of diagnosis, level 3, complex diagnoses). Governance will include an overall steering group across levels 1-3 and task and finish groups for levels 1 and 2.

Outline implementation plan

Area	Tasks	Status Update	Key Milestones
Level 1	Implement a test and learn/ pilot in East Kent to inform implementation roll out Embed learning from test and learn and then implement across Kent and Medway.	Fortnightly task and finish group set up to agree specific tasks and roles and responsibilities - first group is booked for early July 2025.	Start date for implementation August 2025 Spread to other areas October – December 2025
Level 2	Develop detailed model Implement a test and learn in one HCP area to inform wider roll-out as above	Fortnightly task and finish group set up– first group is booked for early July 2025. Identified that contracting methods are to be finalised.	The target is to develop a detailed MDT model by the end of August 2025, with test and learn starting in September.
Level 3	Optimise a standalone memory assessment service	Phase 1 currently being carried out – aims to be completed in Summer 2025.	The target start date for phase 2 (fuller MDT involvement) is September 2025 onwards.

In addition to the above, stakeholders are developing a series of workstreams to support the change and improvement for Dementia, such as an ongoing education programme with webinars.

Capacity and demand

The team have developed an outline capacity and demand model, which shows that to reach 66.7%, including allowing for deaths of people on the register, 5,246 diagnoses are required in year altogether.

We expect that 2,361 of these will be delivered within Memory Assessment Services, level 3.

Current feedback from practitioners and modelling suggests that 1,467 diagnoses can be delivered within level one using the 30 GPwER sessions identified. However, this will need to be validated during the test and learn. We currently estimate that approximately 2000 people in care homes in Kent and Medway have dementia and are undiagnosed.

The above leaves 1,438 diagnoses to be delivered in year via the level 2 model. The implementation for levels 1 and 2 are being developed via task and finish groups.

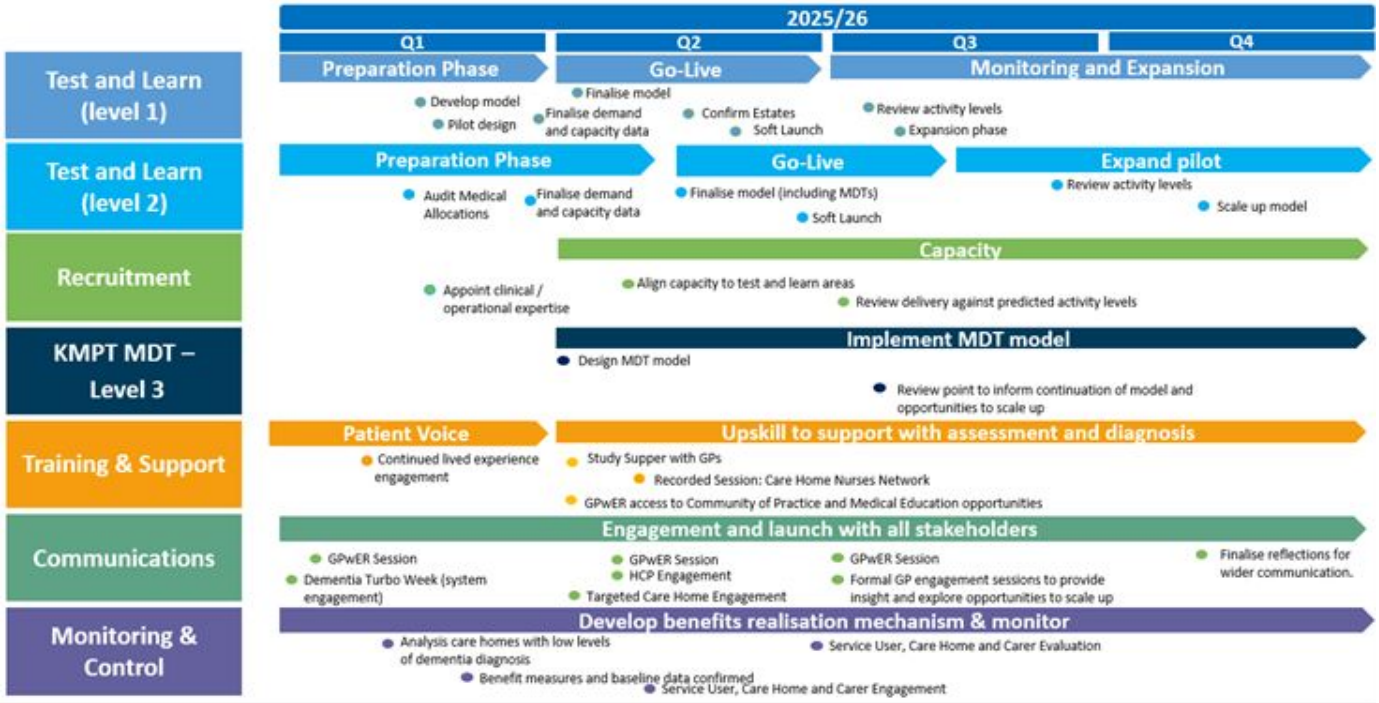
For future years, the make-up of the diagnoses will shift, as the backlog in care homes is addressed and less complex diagnoses shift to community MDT settings, with support from the voluntary sector.

The model will need to be updated and iterate over time using real time data as implementation progresses.

Overview of first cut capacity and demand figures

Item	Number
Forecast dementia prevalence at May 2025	26,902
66.7% of prevalence at May 2025	17,404
Number on register at May 2025	15,939
Number required to be on the register to reach 66.7%	17,404
Additional diagnoses required to reach 66.7%	1,465
Plus diagnoses to account for deaths	3,781
Total Diagnoses required in year	**5,246**
Predicted Level 3 diagnosis delivered	2,361
Predicted Level 1 diagnosis delivered*	1,467
Remaining gap to be filled via Level 2 work	**1,418**
Number of further assessments required assuming 75% conversion rate	1,891

*note that this modelling allows for diagnosing patients not previously referred to MAS services



2.2 Joint Mental Health Pathways

KMPT, Kent County Council (KCC), and Medway Council (Medway) are working together to align health and social care mental health pathways. The aim is to support independent living, ensure inpatient beds are available when needed, use resources more effectively and promote prevention. The provider collaborative team supported the Mental Health Summit follow up workshops and are working to ensure the joint working programme links closely with the KMPT internal work and Clinically Ready for Discharge Oversight Group.

There are three workstreams

1. Joint Mental Health Pathways led by Afifa Qazi in partnership with Janine Hudson and Kim Nicholas from KCC and Martina Gilligan from Medway Council.
2. Social worker collaboration led by Andy Cruikshank (Operational lead – Shurland Wilson) in partnership with Tricia Pereira from KCC and Martina Gilligan from Medway Council.
3. Prioritising prevention led by Donna Hayward-Sussex from KMPT in partnership with Helen Gillivan from KCC and Sara Moreland from Medway Council.

1. The joint pathways workstream held a workshop on 2 June, with multi-agency representation and a strong lived experience voice. It identified a large number of existing joint initiatives and will initially focus on improving the effectiveness of these.

   It is looking to review and streamline joint meetings. The effectiveness of the work will be measured by its impact on the number of people clinically ready for discharge (CRFD) and length of stay. Other measures are being discussed with Social Care Colleagues.

2. Partners are working to improve joint working between practitioners and skill up health colleagues in a holistic strengths-based approach with increased awareness of social work processes. Three social work roles have been identified within KMPT to support us collectively in meeting people's social care needs in a timely manner to enable a return to their lives. These roles will also have a remit to support the overall aim of upskilling staff and making our work more holistic.

   Two of the roles have been filled and the other is being recruited to. KMPT and Local Authority leads are working together to fine tune the remit of these roles and ensure they add value to the discharge pathway. Measures of success will include increasing the proportion of days in hospital that can be described as green or adding value to someone's recovery, rather than red and simply waiting.

3. The prioritising prevention workstream is working to develop a strategic prevention framework between KMPT and local authorities. This is beginning with mapping commissioned services across KMPT and local authorities. This will inform a workshop to develop the strategy in the Autumn.

3. Current performance data

Measure	Agreed trajectory	Current data						Trend
		Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	
Programme: Dementia Pathway Transformation								
Increase dementia diagnosis rate	66.7% by March 2026	60.3%	60.5%	60.9%	60.8%	61.1%	-	↑
Programme: Mental Health Urgent and Emergency Care								
Reduced MH A&E attendance and increase in attendance at safe havens	Reduction	*% MH A&E presentations against total presentations*						→
		1.76%	1.89%	1.92%	1.64%	-	-	
		A&E attendances for adult patients with primary MH need						
		798	824	902	772	810	-	
		Safe Haven attendance						↑
		1630	1522	1585	1525	1623	-	
Crisis house bed occupancy	85%	*Medway bed occupancy*						→
		72%	63%	54%	71%	-	-	
		Ashford bed occupancy						
		34%	77%	43%	64%	-	-	
Reduced mental health in ambulance/ police conveyances to A&E	Reduction	*Primary MH A&E presentation - Ambulance conveyance*						→
		326	320	433	336	329	-	
		Primary MH A&E presentation - Police conveyance						
		31	49	32	33	34	-	
Reduction in incidence of Section 136	Reduction	64	81	63	55	57	-	↓

Exception reporting on performance

Urgent and Emergency Care

- **A&E attendances.** Spring is traditionally seen as a period of high demand for mental health crisis support and attendance at A&E with mental health as a primary presentation was particularly high in March. In April and May it has fluctuated but is broadly in line with previous months.
- **Safe Havens** There has been an increase in Safe Haven use to 1,623 in May 2025. The ICB recently convened a workshop facilitated by the ICB Mental Health Clinical lead for KMPT Consultants and Service Managers/Team Leaders to build confidence in the Community Crisis Alternative Services ability to manage risk.
- The ICB are in the process of working with an independent film company to produce two short information films (one for the public and one for professionals) to promote the safe havens.
- **Ashford crisis house:** since opening in November there have been some challenges during the mobilisation period. These are being addressed by working to increase mental health clinicians' confidence in referring individuals to Crisis Houses (which KMPT gatekeep) as opposed to admitting to a psychiatric inpatient hospital bed with the expectation that this will realise a reduction in Mental Health long waits in ED for admission.

Dementia Diagnosis rate

There was an increase in the Dementia Diagnosis Rate, which improved to 61.1% in May.

4. Programme milestones for 2025-2026

Community Mental Health Framework			
Milestones	**Q2**	**Q3**	**Q4**
Attain to support delivering on review recommendations	X		
Review, communicate and agree a baseline of what is currently live	X		
Staff and service user engagement and feedback events take place	X		
Review and then communicate the revised model of care	X		
Implementation of agreed refinements		X	
Transition and sustainability of model to BAU			X
Dementia Pathway Transformation			
Milestone	**Q2**	**Q3**	**Q4**
Go live with pilots	X		
Finalise GPwER and GP capacity increase (level 1)	X		
Design MDT model (levels 2 & 3) using learning from Medway Pilot	X		
Review MDT model to inform continuation and scaling opportunities		X	
Expand pilot and scale up		X	
Continue expansion of pilots and scale across system			X
Finalise reflections on pilots and new model and communicate			X
Mental Health Urgent & Emergency Care			
Milestone	**Q2**	**Q3**	**Q4**
Publication of MH Housing Strategy		X	
Publishing of revised Crisis 136 Standards		X	
Centralised HBPOS Go Live		X	
William Harvey Safe Haven increase to 24-hour service			X
Margate Crisis House opens			X
Bespoke Conveyance (to include sit and wait) go-live			X

Procurement of Thanet and Medway Crisis Houses			X
Joint Mental Health Pathways			
Milestone	**Q2**	**Q3**	**Q4**
Working group established to deliver on mental health pathways development	X		
Mapping of existing programmes of work and meetings to ensure alignment across KMPT and Local Authorities			
KMPT Social Workers commence internal secondment	X		
Obtain and assess contracting data for current services across health and social care, identifying overlaps/gaps	X		
Proposed workshop surrounding prevention across health and social care takes place		X	
Embedding joint working practices and culture of inter-organisational collaboration			X
Evaluation of KMPT Social Worker secondment work takes place			X

5. MHLDA Reporting Programmes – Vision and Deliverables

CMHF	Dementia	MH UEC	Joint MH Pathways
The right mental health support at the right time for our communities, delivered in partnership	Delivering efficient dementia assessment and care systemwide, ensuring patients timely and appropriate diagnosis which feed into the best future pathways to promote living and dying well with dementia	Timely, evidence based and high quality, therapeutic care and support for people in mental health crisis, in the least restrictive setting possible and close to home	Aligning clinical and social care pathways to provide seamless transitions from hospital and support independent living
Place-based care, accessible when and where it is needed. Integrated care, delivered in collaboration with system partners. Person-centred care, focused on individual needs and preferences. Community-based care, maximising use of community resources and assets.	Dementia diagnosis rate to reach national standard of 66.7% by March 2026. 95% of patients diagnosed within 6 weeks following referral. Delivery of responsive model for triage and assessment across care homes by 2026. Delivery of an MDT model across K&M responding to those with moderate complexity or diagnostic uncertainty.	Increase investment in alternative crisis support services that offer more therapeutic and person-centred interventions, enhancing the patient experience and reducing reliance on statutory emergency services such as Emergency Departments, psychiatric inpatient units, and NHS ambulance services. Reduce primary mental health crisis presentations to Emergency Departments, including both self-presentations and those brought in by ambulance. Reduce the use of Section 136 of the Mental Health Act (1983) through early intervention and access to appropriate community-based crisis support. Promote a culture of confidence and uptake among service users, professionals, and clinicians in Kent and Medway in using VCSE-provided crisis alternatives. Increase utilisation of local crisis beds and reduce reliance on inappropriate out-of-area acute admissions.	Greater transparency and alignment of KMPT, Kent County Council and Medway Councils work streams and improved joint working leading to better patient flow, reduced admissions and length of stay. Strengthened collaboration between health and social care on patient needs, leading to improved patient management and clinical outcomes. Joint development of a strategic framework on prevention between health care and local authorities.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 2025
Title of Paper:	Data and Digital Update
Author:	Claire Hursell, Director of Digital and Performance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

To provide the Board an update on the digital plan for the following 12 months.

Issues to bring to the Board's attention

The paper covers three main areas,

- Firstly, the digital projects being undertaken in this year, with a link to the Trust's true North's and strategic approach.
- The development of a SolveIT approach to support innovation and to provide a vehicle for delivering improved operational efficiencies. This work will need support and engagement beyond the Trust.
- An update on the present delivery

Governance

Implications/Impact:	KMPT is reliant upon technology to deliver safe services to patients. Investment in digital can ultimately deliver savings and increase patient facing time supporting Doing Well Together.
Assurance:	Assurance is provided via the monthly Data and Digital Strategy Board.
Oversight:	Finance and Performance Committee

Version Control: 01

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DIGITAL, DATA AND TECHNOLOGY

STRATEGIC PLAN

July 2025

"Striving to transform healthcare to increase workforce capacity and empower patients".

Claire Hursell

Director of Digital and Performance

INTRODUCTION

The Strategic Plan sets out how the Digital and Business Intelligence Teams will support the delivery of the trust's 2023-2026 Corporate Strategy.

As a key enabler we aim to "use technology, data and knowledge to transform patient care and our productivity".

Our approach is to consider a trust-wide approach, aligning this work to the emerging impact of the NHS's 10-year plan. This prioritises a shift from analogue to digital; including the expansion of access to the NHS App, enabling easier access to services, leveraging AI and using automation to streamline operations. Using data to drive proactive, preventative care.

'Digital' Definition:

Culture, practices, data, processes and technologies that support the digital delivery of mental health services.

KMPT 2023-2026 STRATEGY

This plan has been devised to support the delivery of the Corporate Strategy, particularly in relation to the following Digital Corporate Objectives.

- 4.1 Have consistent, accurate and available data to inform decision making and manage issues.
- 4.2 Enhance our use of IT and digital systems to free up staff time.
- 4.3 Effective digital tools are in place to support joined-up personalised care.

These three objectives have informed the work that is to be prioritised to ensure that Digital delivers against the commitments made within the Strategy and are aligned to the Trust's strategic priorities, risk and trust corporate projects.

A review of present delivery is provided in Appendix A.

DOING WELL TOGETHER

The Trust is implementing its new strategy delivery framework, Doing Well Together. This approach supports the trust in aligning its resources to support delivery of its strategic goals. From a digital perspective it will underpin how we prioritise investment, to support a cohesive response across the Trust.

The main projects for this year are set out below against their True North

True North	Title	Benefit
TNPat1: Timely Access	Electronic Referrals	Streamline Referral Pathway, making it easier for a GPs to refer patients to KMPT and improving the efficiency and processing of referrals received.
TNSus1: Attendee contact time per week per FTE clinician	Corporate Service Management	Integrate Corporate Service Functions, enabling the coordination of activities across HR, Finance, Digital and Facilities to reduce the burden on managers and staff when interacting with these departments.
	Patient Portal	Enable patient access to their information via an online portal and the NHS App. Provides appointment notifications, letters and correspondence electronically reducing the cost of sending physical letters.
	Rio Improvement	Simplify clinical workflows and reduce duplication by reviewing processes within RiO In addition, reduce reliance upon progress notes through training and behaviour change. Automate where appropriate.
	Artificial Intelligence/Automation	Maximise the use of AI and automation for high volume, low skill clinical and corporate services tasks. Put forward a business case for ambient voice.
TNPar1: Reduce CRFD LOS	Bed Management	Optimise bed utilisation and discharge planning, improving the management of planned admissions whilst improving visibility of the current situation and discharge profile.
TNSaf1: Reduce the number of patient harms	Electronic Prescribing and Medicines Administration	Deploy a community prescribing solution to improve safety and reduce the resource burden in relation to medication prescribing.
TNPat2: Equitable access	Data	Review the presentation of data for clinicians and implement a dashboard to identify patients likely to enter crisis.

25-26 STRATEGIC ENABLING PROJECTS AND INITIATIVES

Future Readiness and Capability Building

To support the reduction in clinically ready for discharge patients, near real-time data is needed to better manage planned admissions into acute beds. In addition, we need to make better use of existing Rio functionality that enables the greater insight of discharges and any barriers that prevent a bed being available to another patient.

Colleagues from within KMPT are now working side by side with partner organisations in the delivery of community mental health services. The new model of care has required new ways of working to assess and treat patients through a single front door. Technology will further assist with GP referrals, making it easier to allocate patients to a suitable pathway to speed up the triage processes within Mental Health Together and the Memory Assessment Service.

Digital solutions can make it easier for patients to arrange appointments, provide pre-assessment information and meet with a clinician. The deployment of the Patient Knows Best product will reduce the cost and speed of sending patient correspondence, supporting the Getting the Basics programme as we digitise appointments and letters via the NHS App.

We know that significant resource within KMPT is spent administering medications. To reduce this burden, it is important that we implement an electronic prescribing system which enables patients to collect their medication from their local pharmacy, improving patient experience whilst at the same time freeing up time for both clinicians and admin colleagues.

Increasing capacity within our workforce by automating low skill, high volume activities is a major feature of this plan. Work will focus on both corporate and clinical activities. Within digital, colleagues with specialist skills are working on the simplification and standardisation of processes to enable these to be automated. The implementation of a new service management system for HR, Digital and Facilities will revolutionise processes for staff joiners, movers and leavers which are notoriously time consuming for managers. The new product, Halo, has specialist modules for HR, Digital and Facilities and provides out of the box functionality that will make it easier to consolidate and manage requests into these teams. The product has chatbot capabilities and self-service functionality to reduce the cost of responding to simple enquiries whilst improving staff experience. Work will also continue to remove duplication and simplify Rio, to prevent information being stored multiple times on different forms. We will also continue to deploy bots within Rio to automate tasks that do not require human input.

Improving digital skills across KMPT to make sure that colleagues can make maximum use of digital products is important work too. The development of a Digital Skills Framework has benchmarked the current level of digital literacy across the organisation and it is now possible to start to address gaps through targeted learning. The work has been recognised nationally as best practice and many Trusts are now following our approach. The Digital Champion Network is now established with over 170 champions. These digital champions receive early access to digital solutions and training so they are able to pass on their new knowledge to others.

Evidence based decisions are fundamental to good decision making but rely upon good data. As we work through delivering new digital solutions and simplifying and standardising ways of working, it is evident that our data is often of poor quality with an over reliance on narrative information held in progress notes rather than data stored in a structured way, making it time consuming to locate information related to patients but also making it difficult to extract data for monitoring and improvement purposes. There is more to do before we have confidence that the corporate objective to increase access to reliable data and knowledge to help decision making is met. We will be reviewing how data is presented to clinicians and clinical managers to ensure that they are able to make sense of the data that is provided to them. Over the past year, we have provided a comprehensive suite of business intelligence reports that are supporting the delivery of many services across KMPT, particularly helping with the management of waiting lists, however, we now need to review that the presentation of that data is suitable for those that need to use it. We have been working to integrate Rio with InPhase to reduce duplicate data entry and improve data quality of patient information held within InPhase. We have also provided access (through Rio) to GP systems, so it is quicker and easier to check information held by GPs. A new caseload tool is also needed to pull together information from across the Trust into a single dashboard, to make it easier to identify patients that may be entering crisis. All this activity supports the statement in the corporate strategy that sharing of information and data internally would be smoother and quicker and we have one version of the truth and underpins the True North metrics.

Business Critical Developments/ Risk Mitigation

The Trust will be migrating Children's Mental Health and Eating Disorder Services into KMPT. The decoupling of systems and data from the current provider will be complex. However, there is a significant opportunity to elevate the digital systems used in KMPT by onboarding the technologies used within the current provider. To support the migration, we will firstly be undertaking a discovery stage, to assess how best to move forward safely to provide digital services to staff that transfer to KMPT on 1st April, recognising that it will not be possible to migrate all digital services by this date. We will then put a comprehensive plan which is likely to span 18 months to fully migrate the digital services across to KMPT.

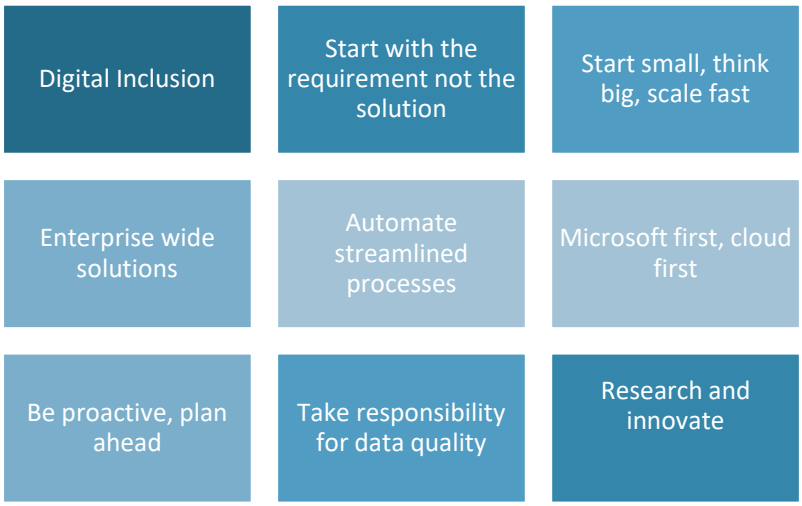
The threat from cyber criminals is ever present and there is a continuous need to respond to both emerging and known threats. It is important to recognise that significant demand is placed upon the both budget and personnel to minimise the likelihood of a successful attack. The Trust will continue to prioritise this activity, and make use of external expertise to monitor and mitigate risks.

DIGITAL PRINCIPLES

The success of this plan will be judged by end users of the data, digital services and technology that we provide. This will require working in partnership to support colleagues to rethink how work is done and challenging us all to think differently.

As part of this, we will ensure digital tools are designed with inclusion in mind, recognising the barriers many people face in accessing services and embedding accessibility and equity into the decision making process.

In undertaking this work our digital decision making will be guided by the following principles to ensure alignment with both clinical needs and financial sustainability.



DIGITAL INNOVATION

The NHS 10 Year Plan focuses heavily on the use of technology to modernise the NHS, to improve patient experience and increase efficiency. An injection of funding and focus will drive further innovation across the NHS.

To ensure we are well placed to take advantage, we have been developing an innovation approach which has already helped KMPT to explore innovative ways to solve old problems. Not all solutions will be successful and we fully accept that some will fail. But this new SOLVE-IT approach enables us to quickly test out ideas and concepts with clinical colleagues. These SOLVE-IT events will move digital to a way of working that enables research and innovation to be undertaken quickly that then informs the projects of the future, based on input from end users.

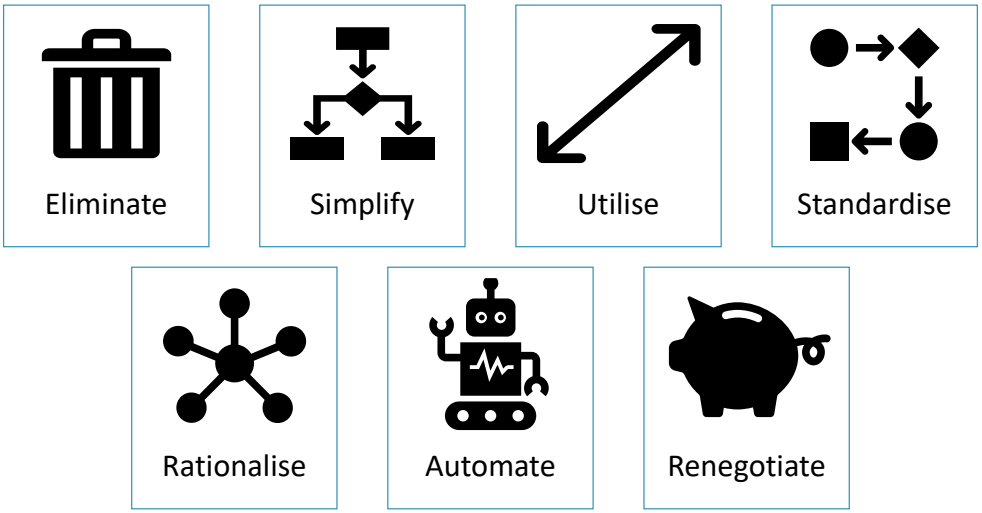
The SOLVE-IT approach is based upon a tried and tested hackathon method to problem solving, concentrated into a week sprint. At the conclusion of the sprint, a report is produced with a recommendation on how to proceed. This may be do nothing or the start of a new project and could range from a small internal development to a collaboration with wider partners.

The approach focuses in on a business problem and seeks to apply a technology solution to it, often showcasing different solutions to clinicians to gain feedback and inspiration.

This will be the trust's vehicle for reviewing digital opportunity and structures are being implemented to support engagement with internally as well as wider system partners.

COST OPTIMISATION

We recognise the challenging budget situation across the system and use the following cost optimisation approaches to reduce cost.



We have already achieved significant savings from re-negotiating supplier contracts, rationalising products and maximising use of the NHS England central Microsoft offering. However, we take a broader view on cost optimisation than simply considering digital operational costs. We are working with teams to examine processes so that waste can be eliminated and variation can be removed. By simplifying and standardising, work can be centralised and automated. In addition, we will be working with partners across the system to drive down costs through collaborative procurements whilst also improvement the ability to share data.

APPENDIX A: STRATEGY PROGRESS TO DATE

Since the launch of the strategy, the digital and data teams have delivered some key capabilities across prescribing, digital literacy and data integration. These have directly supported the wider trust in its transformation of community mental health services.

- A Dialog+ dashboard is available to show average patient scores across the 11 themes when presenting at MHT. It shows that housing is the biggest issue.

Dialog+

- To simplify the technology for staff and to avoid costs, Microsoft Teams is now the single video conferencing product deployed across the Trust.

Virtual Consultations

- Crisis Resolution Home Treatment Team staff have been provided with tablet devices with SIM connectivity to access Rio when visiting patients in their homes.

Mobile Working

- Electronic Prescribing and Medicines Management has been deployed to all InPatient settings. The Mental Health Act Module is currently being piloted.

eMeds (Inpatients)

- A solution has been provided to enable speech to be converted into text dictated directly into Rio.

Speech to Text

- A new suite of Power BI dashboards and reports have been provided to support transformation activities including MHT and MAS.

Dashboards

- Rio has been re-designed to support the deployment of a shared caseload model. This has enabled patients to be tracked throughout their pathway.

Caseload Management

- The Digital Champions Network currently has 170 members. A Digital Skills Framework has been created and baseline literacy identified.

Digital Champions Network

- Creation of a Digital Hub on iLearn to provide a single place for digital training support and guides.

iLearn Digital Hub

- All clinicians can access GP information.

EMIS Integration

- A bot has been deployed into Rio.

Rio Bots

- A new risk management portal has been deployed

Risk Management

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31 July 2025
Title of Paper:	Co-creation strategic plan and framework
Author:	Holly Till, Head of Involvement and Engagement
Executive Director:	Kindra Hyttner, Director of Communications and Engagement

Purpose of Paper

Purpose:	For approval
Submission to Board:	Board request

Overview of Paper

In September 2024, the Board approved a new direction for involving and engaging patients and the public in the trust. This new direction included:

1. Establishing a dedicated team to replace the Engagement Council;

2. Developing a co-creation strategic plan and framework; and

3. Broadening and diversifying engagement with our communities.

This paper includes our newly developed co-creation strategic plan and co-creation framework for the Board's approval.

Issues to bring to the Board's attention

We are entering a pivotal new phase in our trust's approach to involvement and engagement. Following formal consultation and targeted recruitment, we have established a fully appointed involvement and engagement team, including five dedicated Co-creation Facilitators – each aligned to a directorate – who bring their own experience and a personal lens to how we work. They will work side by side with patients, families, carers, communities and staff to deliver meaningful change.

Our recruitment process intentionally broke from NHS norms. In partnership with our People team, we removed barriers and held an inclusive assessment day in the heart of our local community, enabling us to attract a diverse and passionate team. We are especially proud to welcome one of our former Engagement Council members into a lead role — a testament to our values in action.

Our new strategic plan and framework has been co-produced with staff, patients, carers and community groups. It builds on insights from our recent work on culture, identity and staff experience. Between April and July, we engaged stakeholders through community events, one-to-one conversations, and targeted feedback sessions to shape and test the framework.

Feedback was clear and consistent: The framework must:

- Champion equity of voice, go beyond the familiar and ensure we hear from those who are too often excluded or unheard.
- Be simple, accessible and values-led.
- Focus on action and accountability, not just listening.

- Involve people meaningfully in shaping what matters – not just consulting on what's already decided or what we think we know.
- Remove barriers to engagement – physical, emotional, cultural and institutional.
- Build trusted relationships and shared responsibility through genuine co-creation.
- Support staff with the confidence, skills and tools to do this well.

There is shared recognition that we haven't always got this right in the past. But we now have momentum, commitment, and a clear opportunity to lead from the front, both within our trust and across the wider system.

This is not just the right thing to do. It is a legal duty. NHS trusts have a statutory obligation to involve patients and the public in the planning and delivery of services.

Our new approach goes beyond that duty, bringing to life our new identity and commitment of *Doing Well Together*, making co-creation not just a principle but a practice. It places patients and people are the heart of what we do, enabling us to weave mental health care into our communities and building a future where patients and communities are equal partners in the design and delivery of care, and where every voice contributes to helping transform living into living well.

Attached:

- Co- creation strategic plan 2025 - 2028
- Appendix A: Involvement and engagement co-creation framework
- Appendix B: Development of the co-creation framework and strategic plan

Governance

Implications/Impact:	Trust strategy; reputation; patient quality,
Assurance:	Reasonable
Oversight:	Board

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Co- creation strategic plan 2025 - 2028

Our Foundation: A new identity and a new cocreation beginning

Our new identity, centred on *Doing Well Together*, and guided by our values of being caring, inclusive, curious and confident – sets the tone for how we involve and engage our patients, their families and carers, and communities in shaping our services.

This strategic plan builds on the most extensive engagement the trust has ever undertaken: more than 700 hours of listening and collaboration across all our audiences. Through that work, we have heard clearly that we must do better – to involve more people, more meaningfully, and to reach communities who haven't accessed our services before.

Working alongside patients, carers, staff and community groups, our new involvement and engagement team has developed this plan and the accompanying co-creation framework. At its core is a commitment to build trust, rebalance power, and improve the experience, equity and quality of our care – in ways we can see, measure and sustain.

We will live our values by:

Caring: approaching every activity with compassion, empathy, and a focus on the wellbeing of our Co-Creation Community and our staff.

Inclusive: ensuring people from every background and circumstance can shape the services they use now and in the future, and trust us.

Curious: being open to learning from diverse voices and willing to explore new ways of working, every day.

Confident: empowering patients, their families, carers and staff to speak up, make changes and lead the future of mental health care.

Our vision

We're creating a new relationship between people and our care – where patients, families and communities are equal partners in shaping Kent and Medway mental health care that works for them today and in the future.

A co-creation first mindset based on partnerships

We aim to become a truly patient-led organisation where every voice helps design and improve the services they use, based on what matters most to them – their needs, experiences and hopes.

We heard clearly from our communities, patients, their families and carers and staff – people don't always feel listened to. And when we do listen, we don't always act, feedback, or empower people to influence change. This plan is about doing things differently.

We are embedding a **co-creation first mindset** across the trust. One based on relationships, not transactions. One that priorities listening, working side by side and making lasting change together.

Our approach goes beyond one-off engagement. It's about building long-term, psychologically safe partnerships that result in measurable improvements in care and experience. We're not just gathering views, we're co-creating the future of our services.

We want to move beyond relying on a single voice to represent the experience of many. Instead, we are working to reflect the full diversity of our communities – those we serve now and those we need to reach.

This means:

- Actively protecting, valuing and supporting co-creation, making sure all voices feel heard, seen and respected.
- Creating trusted community relationships, working with local groups and organisations to build lasting partnerships based on trust and shared purpose.
- Designing inclusive and accessible routes for involvement, especially for those with the least access to power, influence or previous opportunity to engage.

This new approach is underpinned by our new co-creation framework (see Appendix A), which sets out our shared definitions, expectations and commitments.

Levels of engagement: building deeper partnerships

We recognise that not all engagement is the same, and that meaningful involvement looks different depending on the goal, the people involved and the stage of the journey. We want to shift the centre of gravity of change towards deeper, more sustained co-creation where people are equal partners in shaping change – measured through service improvements and improved co-creator experience.

Below are the five levels of engagement we use, adapted from national best practice. Each level adds value, but our goal is to grow the number of activities happening at the deeper end of this spectrum:

Inform	Engage	Involve	Collaborate	Co-create
Us sharing one-way communication or information to keep people updated	We ask for people's views on a specific topic or project	People help shape the process and outcomes by contributing insight, experience and ideas	We work together in partnership, sharing decisions and responsibilities in projects	People and staff work side by side throughout – from idea to implementation

From co-creation to impact: how we'll measure what matters

We're not interested in measuring activity for its own sake. Our focus is on outcomes – on whether co-creation leads to better experiences, stronger relationships and meaningful improvements in care.

We will measure the difference co-creation makes, not just whether it happened.

Our two overarching outcomes are:

1. Improved experience from being involved

We want everyone who takes part in co-creation to feel values, empowered and supported. Their voices should lead to change, and their wellbeing should benefit as a result.

We'll measure this through:

- % of co-creators reporting improved confidence, connection of sense of purpose (via regular surveys or reflective tools after involvement)
- % of co-creators reporting that their input led to change or made a difference

- % of co-creators reporting improved mental wellbeing or recovery outcomes (need to use adaptive measures developed with patient experience and improvement team pre and post involvement)
- Rich case studies showing how involvement has helped people reframe past experiences, gain purpose or return to work/education

2. Improved quality and equity of services because of improvement

We want to show how co-creation improves the care we provide – through better access, experience, safety and outcomes.

We'll measure this through:

- % of service improvement projects demonstrating measurable change as a result of co-creator input (e.g. shorter waits, fewer complaints, better uptake)
- % increase in satisfaction or experience scores in services that have been co-designed
- % increase in participation from underrepresented groups
- Thematic alignment between co-creator insight and other data sources (e.g. complaints, incidents, PALS feedback)
- Evidence of improved access, equity, and staff-patient relationships in services shaped through co-creation
- % of staff involved in co-design reporting increased understanding of patient, family and carer needs

Bringing it all together in practice

To make sure we capture the full value of co-creation, we'll take a structured, transparent approach to learning and accountability.

A new Involvement and Engagement Strategic Steering group – led by a member of the new team and made up of cross-functional clinical team members and co-creation community members – to oversee this work, monitor its effectiveness, champion accountability and drive continuous improvement.

The Involvement and Engagement Strategic Steering Group's role will be to:

- **Provide strategic oversight**: Guide the direction and priorities of the involvement and engagement team to ensure all activity aligns with the strategic plan
- **Monitor implementation**: Agree key workstreams/ project groups to ensure that the strategic plan is implemented effectively across the organisation, with clear ownership, milestones and accountability
- **Evaluate and monitor impact:** Measure impact and adapt activities based on learning and feedback
- **Reporting**: Take on responsibility for providing regular reports to relevant groups and or/ or committees

To measure our impact, we will develop a simple co-creation impact tool. It will help teams and co-creators track:

  - What changed (experience/service?)
  - How did co-creation influence that?
  - What data/ evidence shows the impact / improvement?

We also plan to develop a deeper understanding of the impact of this work, alongside the work of our patient experience team and through the launch of our new identity – all of which should tell us how we are improving patient experience and outcomes. Our aim is to triangulate different sources of data, feedback

and information to build a richer and deeper understanding of what matters most to patients, their loved ones, carers and communities, and enable us to identify trends, highlight areas of success, and uncover opportunities for further improvement. Crucially, our co-creation approach will inform how we respond to patient experience data, in a sustainable way, in the future.

Objectives and key activity

Objective 1: Developing a caring, diverse and empowered co-creation community

We want to grow and sustain a diverse and inclusive network of patients, family members, carers, staff and community partners who help shape and improve our services – and feel supported, valued and empowered as they do.

What success looks like

- **Greater diversity:** More voices from underrepresented groups are involved, and their insights directly shape improvements.
- **Improved experience:** Patients, their families and carers feel listened to, respected and involved in decision making – so their confidence and satisfaction with services significantly increases.
- **Service insight:** Gaps, unmet needs and local challenges are better understood through lived experience and acted on**.**
- **Co-created solutions:** Ideas are co-created with the people they affect, making them more practical, inclusive and sustainable.
- **A shared sense of purpose:** People feel part of something meaningful, untied by the belief that better care is possible, and achievable together.

KEY ACTIONS:

July – December 2025

- Audit the demographics of our current co-creation community and develop a plan to increase diversity and reach.
- Strengthen existing partnerships with Voluntary, Community, and Social Enterprise (VCSE) groups (e.g. MEGAN CIC, Carers First, Speak Up CIC) as well as religious/faith groups to increase engagement with communities that are typically hard to reach.
- Launch a community engagement calendar, aligned to key cultural events and local networks and gatherings.
- Expand our Community Co-creation Champion programme in collaboration with trusted VCSE organisations.

January – June 2026

- Build long-term relationships with community organisations, prioritising trust and continuity in our engagement efforts.
- Develop targeted strategies to grow and sustain diverse representation - ensuring service users feel truly seen, heard and valued.

June 2026 – Onwards

- Evaluate the long-term impact of outreach programmes on community relationships and service change.
- Advocate for sustainable, independent funding for grassroots user-led organisations, enabling them to lead from within.

Objective 2: Ensuring inclusive communication and engagement

We want everyone in Kent and Medway to feel they can take part in shaping our services, and that starts with how we communicate and engage.

Too often language, systems and assumptions get in the way. This is about removing those barriers, creating clear, accessible, and inclusive communications and engagement ways for people to help drive change.

It's about showing that involvement is for everyone not just those who already know how the system or our trust works.

What success looks like

- **Higher participation:** More people, from more backgrounds take part because they feel welcome, respected and able to contribute.
- **Shared ownership:** People see their input reflected in what we do and feel genuinely invested in the outcomes.
- **Mutually beneficial relationships:** Building on previous research engagement approaches, spending time amongst communities to build genuine connections with people, understand their experience and what they need improves outcomes for both communities and the organisation.
- **Trust**: Honest, open communication strengthens relationships and makes future collaboration easier.
- **More equitable outcomes:** Communication that reaches and reflects all communities help reduce inequalities in who engages and who benefits.

KEY ACTIONS

July – September 2025

- Launch a multi-channel engagement strategy using social media platforms and other media to meet people where they feel most comfortable.
- Publish a quarterly newsletter with updates, opportunities and outcomes, written in accessible, plain English.
- Establish a digital presence for our community offering extended opportunities for engagement and reaching a wider audience.

October 2025 – June 2026

- Take co-creation into informal settings (e.g. libraries, food banks, Job Centres) to actively reduce barriers to participation and ensure more equitable access for all.
- Launch flexible event options (evenings, weekends) to reach people beyond traditional hours
- Co-develop a set of inclusive communication principles – using the communications and marketing team's new brand and identity guidelines which have been co-produced.
- Launch a 'You Said, We Did' feedback model to clearly show how co-creator feedback leads to action.

July 2026 – December 2027

- Expand digital accessibility through live chat, virtual forums and SMS updates – building on and ensuring the co-creators needs are embedded in wider trust projects and developments (like the new external website, SMS and patient portal developments).
- Create tailored content for underrepresented groups, ensuring materials reflect the people we serve.

January – December 2028

- Conduct annual reviews of our communication tools and channels, using community feedback to refine and improve.

Objective 3: Creating a curious and psychologically safe co-creation environment

Curiosity is at the heart of great co-creation. We want to build a culture where people feel safe to ask bold questions, share different perspectives, and challenge assumptions without fear of judgement. A space

where disagreement can be respectful, ideas can be tested and everyone feels confident that their voice matters.

What success looks like

- **Better problem solving**: We did deeper into the 'why' tackling root causes, not just surface issues and coming up with solutions before we fully understand the challenges and opportunities from all perspectives.
- **Positive disruptive**: People feel safe to challenge the status quo, helping us improve outdated practices and find better ways to improve.
- **Deeper empathy:** Curiosity encourages active listening, helping us understand different experiences and design more inclusive solutions.
- **Authentic participation**: people bring their whole selves – contributing ideas, experience and energy with confidence and purpose.

KEY ACTIONS

July – September 2025

- Develop a series of guidance documents to clearly outline departmental policies and procedures
- Launch a series of "curiosity conversations"—safe, informal spaces for people to explore ideas and challenges together and to be part of the team problem-solving. We will start with a conversation on integrated and collaborative clinical care models.
- Develop "curious questions" workshops to support co-creators and staff to ask open, insightful questions that lead to deeper understanding.

January – June 2026

- Develop a process to outline our pathway to impact to map how we expect our work to make a meaningful difference
- Introduce reflective practice journals for co-creators and staff to record learnings, perspectives, and ideas sparked through engagement activities.
- Embed curiosity prompts into all co-creation sessions (e.g. "what's missing?", "what haven't we thought of?", "whose voices are still unheard?").

July 2026 – December 2027

- Co-create "learning labs" in partnership with clinicians, communities, academics, local organisations, and other innovation teams to explore mental health themes identified by the community in creative and meaningful ways.
- Host an annual "curiosity in co-creation" event to share creative ideas, unexpected insights, and community-led provocations from across the system.

January – December 2028

- Evaluate how curiosity has influenced service design and co-creation practices through community feedback and case studies, and service design reviews.
- Launch a curiosity toolkit for teams and co-creators to support safe exploration, critical thinking, and imaginative engagement across projects.

Objective 4: Building confidence and capacity in co-creation

To make co-creation real, we need people who feel confident doing it. Not just in our trust but across the wider health and care system in Kent and Medway.

This objective is about developing skills, confidence and leadership of everyone involved. It's also about recognising that being involved in shaping care can be part of recovery, growth and purpose.

We want people to feel capable and empowered with the tools, training and trust to lead change in partnership. As we grow our internal capability, we're also increasingly being asked to support others – from the ICB to local universities – to embed inclusive, co-produced approaches in their own work. That

demand reflects the strength of what we're building and it's something we embrace with pride. This is not just a movement within our trust, but a system wide shift in how people are heard, valued and involved.

What success looks like

For co-creators

- **Greater agency:** people feel their ideas matter and that they're supported to influence real decisions.
- **Personal growth:** Involvement builds confidence, skills and purpose, supporting recovery and self-belief.
- **Recognised expertise:** people's lived experience is valued as professional knowledge – and they're seen as equal partners.
- **Practical skills:** co-creators gain transferable skills and tools that open up new opportunities.

For the organisation - and the system

- **Better insight:** staff and services learn from co-creators' perspectives, driving more inclusive and effective change.
- **Co-creation Accreditation -** We are keen to learn from our colleagues at East London NHS Foundation Trust and will seek to develop an internal accreditation for services as a way to demonstrate their commitment to embedding co-creation within their practice.
- **Stronger solutions:** services shaped by people who use them are more likely to work – and to last.
- **A more inclusive system:** as co-creators grow in confidence, they help shift culture and expectations across the trust.
- **System influence:** as we embed co-creation into our culture and county wide due to our unique geographical spread, we're increasingly asked to lead this work beyond mental health (we have already been asked to support Canterbury Christ Church University and our system partners to build more inclusive and trusted approaches and relationships on their behalf).
- **A more equitable future:** our co-creators help shift how decisions are made – not just in mental health and our trust, but across Kent and Medway.

KEY ACTIONS:

July – December 2025

- Launch a modular co-creation training offer in partnership with Canterbury Christ Church University covering trauma-informed engagement, inclusive communication, and partnership working for everyone.
- Develop tailored personal development plans for all co-creators.
- Create a trust co-creation offer for system partners (e.g. system partners universities, councils) including training, mentoring and practical toolkits to support embedding co-creation across the system.
- Gain a further understanding of the accreditation developed by East London NHS Foundation Trust and begin to develop our own accreditation system.
- Work in collaboration with communications and patient experience colleagues to triangulate multiple sources of data, feedback and information to enable us to identify trends, highlight areas of success, and uncover opportunities for further improvement

January – June 2026

- Expand training to include digital access, safeguarding and facilitation skills, helping co-creators shape and lead engagement.
- Share a Co-Creation Resource Pack, including jargon busters, best-practice guides, and role expectations to support confidence and consistency.
- Identity and train 'system co-creation ambassadors' to represent our trust in system-level forums, steering groups and innovation projects.
- Formalise partnerships with system organisations who request co-creation support.

- Together with patient experience colleagues, we will pilot a new Co-creation accreditation with a small number of services. Then refine the process before wider role out.

July 2026 – December 2027

- Pilot cross-system co-design projects on joint priority projects (e.g. greater alignment with community and mental health services).
- Establish informal peer support and mentoring sessions to offer emotional and developmental support.
- Adapt training based on feedback from co-creators, ensuring it stays relevant, reflective and empowering.
- Host an annual Kent & Medway co-creation learning event led by us, spotlighting lived experience leaders, innovation and co-designed outcomes across sectors.
- Campaign and role out of new Co-creation accreditation for services to serve as a clear bench mark, encouraging teams to actively involve co-creators in meaningful collaboration throughout service design and delivery. By establishing and recognised organisational standard, the accreditation would not only encourage consistent and authentic co-creation but lend itself to wider celebrations, creating a culture where everyone, working in equal partnership, are central to improving outcomes.

January – December 2028

- Evaluate the long-term impact of training and support outcomes.
- Create a structured, trust-wide support network that champions co-creation and builds leadership pathways across services.
- Develop and publish a system wide co-creation impact report.

Barriers and mitigations in taking this approach

Subject	Barrier	Mitigation
Cultural resistance	Staff or service users/carers resist changing from traditional engagement approaches	Provide training and awareness on co-creation its benefits, highlighting success stories. Develop a cohort of staff champions
Engagement fatigue	Service users, carers and community members feel tired of repeatedly sharing experiences without visible change, leading to disengagement and mistrust.	Communicate clearly how feedback has led to changes, provide regular updates on progress, celebrate small successes and demonstrate impact. Expand Community Co-creation Champion programme.
Lack of clarity around the term ‘co-creation’	Unclear definition and purpose of co-creation leads to confusion or inconsistency.	Develop clear definitions and a shared language. Communicate this widely and incorporate in training.
Representation issues	Limited diversity in co-creation community undermines inclusivity.	Proactively recruit diverse voices, ensure accessibility, work with community champions and partner organisations who are trusted within those communities. Match diversity of pool with diversity of our communities.
Technology barriers	Digital exclusion limits participation in virtual co-creation.	Provide digital support, training and offline options to co-creators adapted to the needs of the project. Combine with in-person community-based activity.
Confidentiality concerns	Co-creators have fears around sharing information or experiences in open forums.	Develop trusting, authentic relationships. Set clear ground rules, offer anonymised options, provide safe spaces for participation.
Evaluation challenges	Difficulty measuring the impact or value of co-creation	Develop clear metrics aligned to strategic goals, triangulation of patient experience data to measure impact.

Reporting on our impact internally and beyond

We are committed to being open and accountable for the impact of this strategy. To strengthen governance and assurance, the new Steering Group will report directly to the Trust's Quality Committee. We will also share what we're learning more widely – through six monthly updates, annual impact summaries and opportunities for co-creators and community voices to present their voices and work directly to Board, system partners and peers. We will offer leadership and support across Kent and Medway – working with partners to embed this in the wider system because doing well together means learning together. And sharing power means sharing responsibility – for what we do, how we do it, and the different it makes.

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APPENDIX A: Involvement and Engagement Co-creation Framework

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Involvement and engagement co-creation framework

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Introduction

This framework sets out how we'll work together to build genuine partnerships between patients, carers, staff, and community partners. We want lived experience to shape everything we do, every day. From service design to patient care.

What we're focusing on most:

- Recruiting a thriving and diverse **co-creation community**, where creativity and innovation can flourish.
- Growing our **community outreach** and preventing health inequalities. Through making sure people from all backgrounds and marginalized or hardly reached groups have a voice.
- Making **communication open and accessible**. Through using plain English, jargon-free language and clear feedback loops.
- Strengthening **training and support**. Meaning co-creators have the skills, confidence and safeguards they need.
- Expanding **mentoring**, with structured peer networks and professional partnerships to guide new co-creators.

By putting lived experience at the heart of all our work, we're showing our commitment to empowering communities to help shape, improve, and drive mental health services forward. Ultimately, to help our communities live well.
This framework has been shaped by patients, carers and VCSE partners across Kent and Medway. They joined our co-creation events in Rochester, Canterbury and Maidstone in April 2025. It's an outline for sustainable co-creation, built on equal partnerships, skill-sharing, continuous learning, and fresh ideas.

Values and expectations

Everything we do is grounded in our trust values – **caring, inclusive, curious** and **confident**.

This framework gives a clear, structured approach to co-creation. It's designed to:

- empower everyone to get involved
- build trust and transparency
- make sure everyone has an equal chance to contribute

By living our values, we create spaces where people feel heard, respected and ready to help shape mental health services across Kent and Medway.

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Caring

Person-centred, emotionally intelligent and trauma-informed

We communicate with empathy and understanding. We know co-creators may share personal or difficult experiences. We'll always put their needs first and create safe spaces for them to speak openly.

Trusting relationships before involvement

Trust comes first. We build genuine, long-term relationships. Especially with communities who may feel cautious or have been let down before.

We don't just drop in to ask questions and disappear. We share back what we've heard, show how people's insights are used, and keep the door open for continued involvement.

Inclusive

Sharing equal power

We will create genuine collaboration where everyone shares power equally. We're moving away from a top-down approach. Instead, we'll make sure all participants can contribute fully and shape outcomes.

Reaching underrepresented groups

We don't limit ourselves to familiar networks. We actively reach out to individuals and communities who are often left out. We use creative, targeted, and culturally appropriate approaches to involve everyone.

Accessible to all

We make sure information works for everyone. We use plain English, avoid jargon and acronyms unless we explain them clearly, and offer information in different formats.

Accessibility is more than just words. It's about shaping opportunities so people can get involved in ways that meet their needs.

Curious

Multiple voices informing decisions

We don't rely on one person to speak for everyone. We listen to a wide range of voices to guide how we design and improve services. people with lived experience.

Measure what matters

We'll measure what really counts. That means focusing on the value, impact and outcomes that matter most to the people involved. Not just what's easiest to count.

Confident

Supportive upskilling

We're committed to helping co-creators build skills for personal and professional growth.

We'll offer chances to learn in areas that interest them, so they can gain confidence and new opportunities beyond co-creation itself.

Reciprocal learning

We believe learning goes both ways.

Training sessions will be interactive and reflective. Led jointly by people with lived experience and professionals working together.

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APPENDIX B: Development of the Co-creation Framework and Strategic Plan

The development of the framework and strategy followed an inclusive methodology, rooted in co-creation principles. It included the following:

Listening Phase – As part of our commitment to meaningful involvement and engagement, we held three listening events with patients, carers, families, VCSE colleagues and local communities during the month of May. We focused on areas of engagement stakeholders felt we had done well, what we had not done so well and how they would like our approach to change in the future. We held one event in Medway, one in Canterbury, and one in Maidstone. These sessions provided a valuable opportunity to gather direct insights, experiences, and ideas from those who use and support our services on how they would like the organisation to engage with them moving forward. The feedback and intelligence collected during these events played a crucial role in shaping the key principles of our co-creation framework and strategic plan, ensuring it is grounded in the real needs and priorities of the people that we serve.

Staff are also a key stakeholder in ensuring that our approach to co-creation is embedded across the organisation. Many staff within our organisation have vast experience of engaging with patients and carers to improve our services, and it would have been prudent to not ask of staff what they believe is important when engaging with patient's carers and families in the communities. A series of online listening sessions were held with staff over the course of 1 week, and were attended by individuals from a variety of professional backgrounds.

Drafting and 'Feedback Week' - The Involvement and Engagement team worked collaboratively to develop a first draft of the framework and strategic plan by carefully reviewing and drawing together the ideas, experiences and priorities shared by the participants at the co-creation events. To ensure the first draft accurately captured the diverse range of perspectives and feedback, we circulated it to all attendees of the events. This step allowed participants to review the content, sense check our interpretation of their input, and assess whether their views had been understood and represented appropriately. To further support this process, we then hosted a series of online feedback sessions, creating space for open dialogue and collaborative reflection. These sessions provided an opportunity for individuals to highlight anything that may have been missed or misinterpreted, offer additional insights, and help refine the document. This inclusive and iterative approach ensured that the final version of the framework and strategic plan was genuinely written in collaboration with our co-creators.

Final Testing and Endorsement - Participants in the co-creation events responded with strong support and enthusiasm for the new framework. Many offered positive and appreciative feedback, noting that the process felt inclusive, transparent and genuinely collaborative. They highlighted that their contributions had been actively listened to, respected and thoughtfully incorporated into the final version of the documents. There was a clear sense among attendees at their lived experiences, perspectives and priorities were not only acknowledged but also meaningfully represented in the direction and content of the strategic plan. This collective endorsement reflects the success of the co-creation approach and demonstrates the importance of continued partnership working in shaping services that truly reflect the needs of our communities**.**

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 2025
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

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

The Chief Executives Overview at the start of the report highlights the key areas of focus: patient flow and bed state along with dementia services and mental health together waiting times. Key areas of improvement in recent months are also noted.
The reporting against each domain additionally includes a focus on the relevant Breakthrough Objective.

Governance

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

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Integrated Quality & Performance Report

(IQPR)

July 2025

Contents

1. Chief Executive Overview

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

Patient flow / Bed state

We continue to manage our beds with an un-relented focus. Bed occupancy is at 95.8% for June, our Length of Stay (LOS) for Clinically Ready for Discharge (CRFD) patients was 75.3 days (19 discharges) in June, a reduction from recent months yet remains higher than the position of late 2024 where there was consistent achievement of under 50 days. We have enacted our 8-week bed plan last month and are currently commencing week 7 of the plan as of 21st July. The actions we have taken so far are:

- Moved 5 patients into their new care setting to continue their recovery.
- Reduced our CRFD cohort of patients to 51 as at the end of June compared to a high of 70 in January
- Reduced our CRFD Length of Stay (LOS) at discharge to 75.3 days in June compared to 90+ in April and May
- Reduced our patients currently placed out of area to 18 as at 18th July

We continue to work very closely with our partners in the Kent and Medway system to manage our bed state, in particular with our acute sector colleagues and emergency departments to ensure our patients are supported.

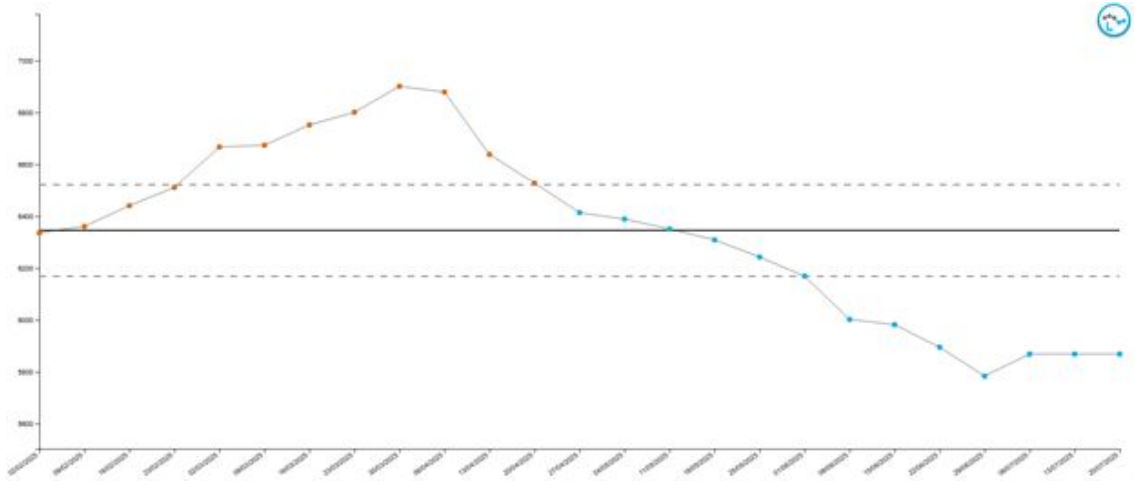
Community Mental Health, Mental Health Together (MHT)

Good progress is being made within the Community Mental Health Programme. The refinement of the model is underway with good engagement from staff and partners. It is expected that the proposed refinements along with the demand and capacity modelling will be available from September this year.

In the meantime, I am pleased to report that for Mental Health Together we have seen a reduction in wait times:

- Reduced our MHT waiting list from 6,949 at the end of March to 5,874 in Mid July.
- This has been achieved through data quality and ensuring appointments are outcomed;
- Correct adherence to the trust revised DNA policy to ensure that people who want and need the service are seen in a timely way and
- An increase in the lower level clinical interventions offered, such as group interventions.
- A weekly productivity meeting is in place to monitor progress and ensure productivity and activity are maximised and job plans are followed.

MHT Waiting list size 01/02/25025 – 21/07/2025. Showing special cause variation of an improving nature across all teams



- Of the 5,874 waiting 83% are waiting under 18 weeks
- 39% are within the 4 weeks
- The average time to commence treatment is currently 72.0 days or 10.2 weeks

Our focus in the next month is to eliminate those waiting over 52 weeks which stands at 42 patients as at 21st July. The majority of these are patients that were previously open to CMHT prior to the implementation of MHT and have been seen more than once, data quality is being investigated to ensure the correct codes are being used to demonstrate the clinical or social interventions within national guidance. All teams have reviewed those waiting longer then 18 weeks.

Dementia

This month we have included in our Board papers the comprehensive system dementia plan that will enable the wider system to move to a new model of care (phase 3 of our priority) for our dementia patients, ensuring our patients are seen and diagnosed as swiftly as possible. We have made significant progress internally in the last 6 months with our performance, below are the positive steps that have been taken:

- All six standalone Memory Assessment Services (MAS) are now utilising performance data to identify areas of improvement and working with the improvement team to increase the number of patients seen and diagnosed within six weeks. We have seen an improvement from 8.8% in May 2024 to 26.5% in June 2025. This is above both the national performance (16.6% for May 2025) and south-east England performance of 3.4%.
- We have focussed on reducing long waits, with patients waiting over 52 weeks for a diagnosis reducing by 53% from 260 in February to 122 in July and work in place to eliminate non-clinically necessary waits over 52 weeks in September.
- Average waiting time has reduced by 37% in the past year (190 days to 119 days) and continues to reduce. Average waits at KMPT are below the national average wait reported in the national dementia audit of 151 days.
- Work is now underway with individual MAS services to identify further unwarranted variation and to address this where necessary and appropriate. In quarter one DGS MAS team achieved 56.9% of 174 diagnosis within six weeks. West Kent MAS team continues to have challenges in achieving the timescale having diagnosed 1.8% of 284 diagnosis within six weeks.

Further areas I'd like to note;

- Improvements have been sustained in the percentage of Liaison Psychiatry referrals closed within 12 hours for those not requiring a bed, achieving in excess of 80% for three successive months compared to consistent levels below 30% in 2024. The percentage of liaison referrals triaged within an hour achieved over 90% in both May and June.
- The perinatal service achieved its nationally set annual assessment target.
- YA acute length of stay has been below 40 days for three successive months, the first time since November 2024
- The % positive scores from the Friends and Family Test was 91.2% in June, the highest position of the last 12 months
- Workforce metrics for vacancies, training and turnover continue to show sustained improvements and attainment of the targets set.

2. Trust Wide Integrated Quality and Performance Dashboard

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

Executive Sponsor: Adrian Richardson, Director of Transformation & Partnership

True North

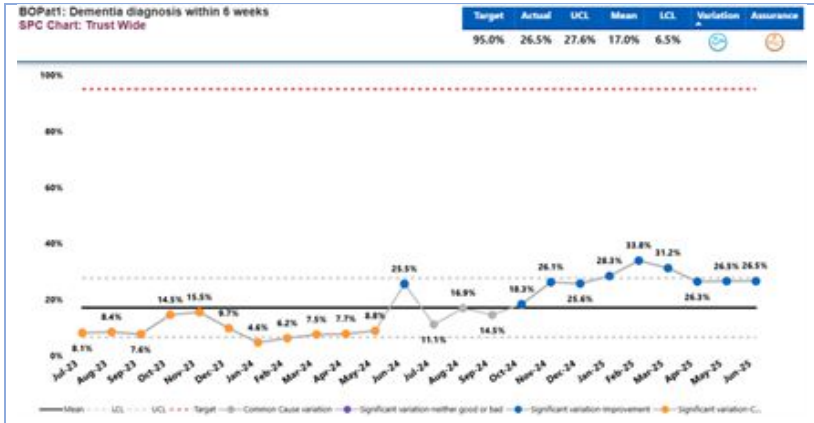
Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TNPat1: Timely access: Community (CMHF/MAS) patients needs are met within timeframes	85.0%	14.4%	15.0%	12.0%	15.0%	18.7%	19.9%	15.5%	16.2%	17.5%	13.9%	12.7%	15.5%
TNPat2: Equitable access: <1% variance in waiting time (MHT/MAS) between most deprived and least deprived.	1.0%												(3.5%)

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

Breakthrough Objectives

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
BOPat1: Dementia diagnosis within 6 weeks	95.0%	11.1%	16.9%	14.5%	18.3%	26.1%	25.6%	28.3%	33.8%	31.2%	26.3%	26.5%	26.5%
BOPat2: Community (CMHF/MAS) referrals have ethnicity recorded	90.0%	88.7%	87.7%	86.3%	85.3%	84.8%	84.5%	84.2%	84.1%	84.0%	83.8%	83.9%	84.0%

Focus on Breakthrough Objectives



Data Source	RiO	Data Quality Confidence	

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

What is being measured?

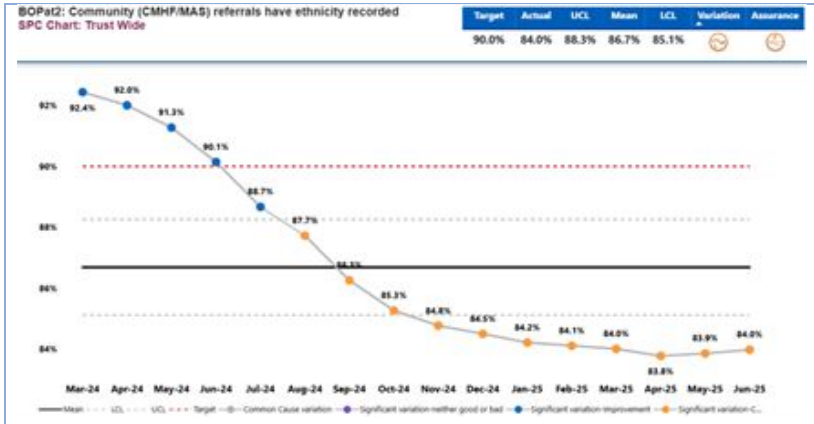
Time between a referral into the Memory Assessment Service and a confirmed diagnosis.

What is the data telling us and key actions in place

The SPC chart shows that the Trust is consistently failing the 95% target for compliance with the mean for compliance since July 2023 being 17%. However, the last 9 months' compliance has been above the mean triggering an SPC rule that signifies special cause variation of improved performance.

Since February there has been a focus on eliminating non-clinically necessary waits of over 52 weeks. This has seen a reduction in patients waiting over 52 weeks from 260 to 122 (17th July). Work continues to eliminate these non-clinically necessary waits by September.

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



Data Source	RiO	Data Quality Confidence	

What is being measured?

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

What is the data telling us and key actions in place

The SPC chart shows the Trust is consistently failing the 90% target for completeness and there is been special cause variation of a concerning nature with the last 10 months' performance falling below the mean of 86.7%.

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

Watch Metrics

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
1.1.01: Open Access Crisis Line: Calls received		3,640	3,415	3,607	3,509	3,195	3,287	3,373	2,920	3,362	3,229	3,110	3,266
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		28.1%	22.5%	23.2%	24.1%	20.4%	22.1%	26.8%	30.9%	33.6%	31.5%	34.3%	36.9%
1.1.03: Assess people in crisis within 4 hours		76.0%	76.5%	86.6%	90.7%	92.5%	90.7%	90.9%	89.5%	86.9%	94.9%	94.7%	86.9%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		69.5%	77.4%	81.1%	81.5%	88.3%	87.6%	90.6%	83.4%	88.0%	88.6%	90.7%	92.3%
1.1.05a: Liaison Psychiatry referrals closed within 12 hours	95.0%	25.4%	25.7%	29.4%	23.3%	27.7%	39.2%	53.0%	61.9%	78.1%	80.4%	80.0%	81.6%
1.1.05b: Liaison Psychiatry referrals closed identified as requiring a bed within 12 hours	95.0%	4.2%	3.6%	4.8%	0.0%	0.0%	6.3%	6.1%	3.3%	5.4%	6.8%	6.7%	2.0%
1.1.06: Place of Safety Length of Detention: % under 24 hours		77.8%	88.1%	74.5%	70.0%	60.0%	77.1%	76.2%	76.6%	77.6%	75.0%	75.0%	79.0%
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%	61.1%	60.0%	61.9%	59.1%	85.0%	66.7%	58.3%	75.0%	61.5%	52.6%	69.6%	72.2%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		67.7%	78.1%	75.0%	72.1%	83.3%	87.1%	85.4%	94.1%	92.1%	88.6%	100.0%	81.3%
1.1.10: Perinatal assessments (against annual target)	2,000	160	114	127	155	166	146	193	136	158	514	216	182
1.2.09: Dialog assessment completed in Community Service (MHT/MHT+/EIS/Com.Rehab/Inpt.Rehab)		1,441	1,160	1,263	1,362	1,543	1,389	1,563	1,371	1,819	2,035	2,205	2,053
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	89.0%	89.5%	88.5%	88.8%	87.3%	89.4%	88.1%	88.7%	87.9%	87.7%	88.7%	91.2%
1.3.02: Complaints - actuals		42	49	35	31	37	32	51	44	60	45	61	58
1.3.03: Compliments - actuals		135	109	141	140	130	151	147	122	122	131	122	159
1.3.04: Compliments - per 10,000 contacts		38.4	34.4	42.2	37.8	37.2	48.9	40.7	37.5	34.5	35.5	32.8	41.0
1.3.05: Patient Reported Experience Measures (PREM): Response count		721	542	478	580	510	594	540	529	563	513	626	605
1.3.06: Patient Reported Experience Measure (PREM): Response rate		4.7	3.8	3.2	3.6	3.3	4.1	3.7	3.6	3.6	3.2	3.7	3.5
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.5	8.5	8.2	8.5	8.2	8.3	8.5	8.6	8.5	8.5	8.5	8.4
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	95%	93%	92%	85%	97%	95%	100%	98%	97%	96%	94%	93%
1.3.09: Complaints responded to within 30 days (or agreed timeframe)	100%	83%	78%	70%	60%	66%	87%	92%	82%	81%	89%	76%	81%
1.4.05: Decrease violence and aggression on our wards	(7.5%)	52.8%	16.7%	2.5%	37.3%	9.0%	(1.3%)	14.8%	28.3%	12.2%	34.1%	23.8%	23.8%
1.4.06: Medication errors		60	43	49	32	54	46	50	39	54	46	62	50
2.1.01: Referrals to MHT commence treatment within 4 weeks		24.2%	11.8%	8.4%	10.6%	11.0%	10.7%	4.0%	4.6%	9.0%	5.5%	4.2%	8.2%
2.1.02: MHT waiting list size		3,705	4,280	5,072	5,595	5,704	6,007	5,995	6,243	6,573	6,186	5,687	5,472
2.1.03: MHT 2+ contacts		16,627	16,684	16,602	16,833	17,246	17,866	18,507	19,137	18,987	19,797	20,600	21,641

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

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

Executive Sponsor: Sandra Goatley, Chief People Officer

True North

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

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

Breakthrough Objectives

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

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

Focus on Breakthrough Objectives

BOPeo1: Staff feel able to make improvements in their workplace

Insufficient data points to analyse by SPC

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

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

What is being measured?

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

What is the data telling us and key actions in place

The pulse survey (April 2025) produced lower results than those reported in March 2025 which reflects the national staff survey completed in autumn 2024. Variation exists across directorates with targets set accordingly as shown below:

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

The two programmes of work expected to drive improvements in these results relate to the roll out of the Staff Council, and the delivery of the Doing Well Together programme. The Staff Council has been piloted in Forensic and Specialist services and is anticipated to be rolled out across the organisation in the Autumn. The Doing Well Together programme is also gaining traction, with the strengthened strategy deployment (with refreshed governance also having just been developed with the Trust Leadership Team), and coaching support for improvement in place. The second Innovation Den has also just closed for bid submission, and capability building is taking place with directorates and local teams.

Watch Metrics

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
3.1.01: Staff Sickness - Overall	3.5%	4.5%	4.4%	4.8%	5.1%	4.6%	5.1%	5.2%	5.0%	4.6%	4.3%	4.3%	4.1%
3.1.02: Vacancy Gap - Overall	14.0%	12.8%	12.2%	11.8%	12.0%	11.0%	11.1%	10.8%	10.7%	9.8%	10.0%	10.1%	10.3%
3.1.03: Essential Training For Role	90.0%	94.7%	94.8%	93.8%	94.3%	94.7%	95.1%	95.0%	95.2%	95.5%	95.4%	95.4%	94.8%
3.1.04: Leaver Rate	15.0%	14.6%	14.6%	14.3%	14.1%	13.4%	13.3%	13.4%	13.4%	12.5%	12.8%	12.6%	12.6%
3.1.05: Leaver Rate (Voluntary)	14.0%	10.3%	10.4%	9.5%	9.5%	9.3%	9.3%	9.3%	9.3%	9.1%	9.2%	8.9%	9.0%
3.1.06: Safer staffing fill rates	80.0%	114.8%	116.4%	108.2%	112.0%	116.1%	108.7%	109.6%	110.1%	108.8%	110.7%	112.1%	109.6%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	20.0%	26.2%	26.7%	26.7%	27.0%	27.0%	27.1%	28.1%	28.4%	28.5%	28.5%	27.0%	27.5%
3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.50%	0.44%	0.31%	0.63%	0.02%	0.27%	0.18%	0.35%	0.21%	0.21%	0.05%	0.17%	0.32%

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

Executive Sponsor: Dr Afifa Qazi, Chief Medical Officer

True North

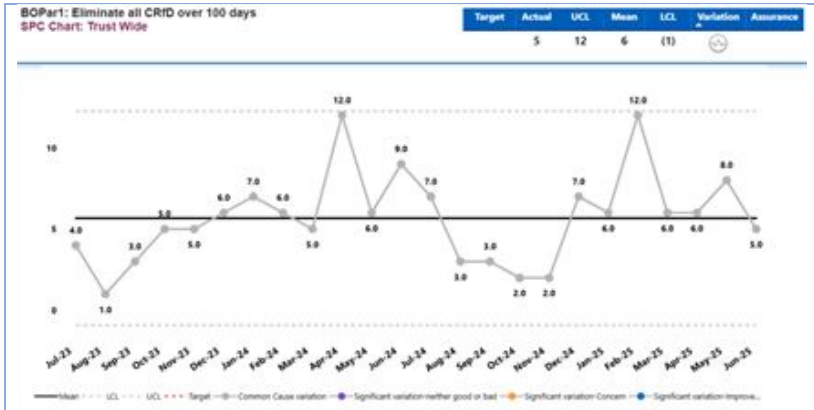
Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TNPar1: Reduce clinically ready for discharge (CRfD) length of stay (LoS) by 25% by 2030	71.8	89.9	45.1	46.8	46.7	47.0	67.8	62.0	112.6	69.0	90.6	93.1	75.3

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

Breakthrough Objectives

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

Focus on Breakthrough Objectives



Data Source	RiO	Data Quality Confidence	

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

What is being measured?

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

What is the data telling us and key actions in place

The data shows normal variation over the last 2 years with no periods of significant change, resulting in an average of six per months.
Over this period YA acute accounts for 46% of these instances and OP acute 54%.

The Flow programme has had a change in SRO to a consultant psychiatrist who is also the consultant for the Flow team helping to find solutions to challenges faced on the ground in addition to the bigger system wide challenges addressed by the programme. The key workstreams under the programme are Purposeful Admission, Transfer of Care Hub, High Intensity User project, Social care Interface work and introduction of the Collaborative care pathway.
5 patients have currently used the Collaborative care pathway with the VCSE provider Age UK run facility in Gravesend with good feedback from patients. Support from KMPT teams and from a dedicated social worker is in place and is working well. It is expected that the patient numbers going through this pathway will increase in the coming weeks as the confidence of the VCSE staff around providing support to people with mental health needs is building.
Social care interface work is progressing at pace under three strands of work 1) KMPT social workers on secondment to KSS 2) KMPT reviewing high cost community placements 3) Joint pathways for mental health needs, identifying these early and supporting both early discharge and prevention of admissions.
The HIU project will be evaluated in September and a detailed analysis of impact om admission will be available.
Purposeful admission protocol is being rolled out across all CRHT, Liaison, Older adults and other teams for all patients who are referred for an admission. This also includes maximising the use of the Crisis houses in Medway and Ashford to support patients who present with needs that can be better met in these settings.

Watch Metrics

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	35.2	42.3	36.3	34.0	34.6	40.3	35.0	51.5	49.4	36.9	38.9	35.1
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	102.1	79.8	82.5	85.8	95.2	103.2	63.3	124.4	125.8	87.7	102.4	88.8
1.2.03: Adult acute LoS over 60 days % of all discharges		15.5%	14.9%	12.9%	13.9%	13.9%	16.5%	19.1%	17.3%	22.6%	18.4%	17.0%	14.9%
1.2.04: Older adult acute LoS over 90 days % of all discharges		37.0%	44.4%	37.9%	42.3%	41.4%	31.3%	28.0%	57.1%	48.0%	35.1%	40.0%	33.3%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	10.4%	13.2%	12.7%	18.0%	11.7%	13.1%	12.2%	8.8%	11.9%	11.5%	6.3%	11.4%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		340	377	454	373	303	264	467	596	926	1,026	875	775
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end		13	13	17	11	9	9	27	24	36	31	28	28
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	12.2%	15.2%	19.8%	20.9%	21.3%	20.6%	19.6%	24.3%	21.7%	22.0%	18.9%	15.2%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	31.9%	31.1%	27.4%	37.7%	32.2%	29.9%	37.6%	36.1%	32.9%	29.3%	21.3%	25.4%
4.1.01: Bed Occupancy (Net)	92.0%	97.6%	95.9%	96.4%	97.2%	96.8%	92.6%	97.4%	97.7%	97.4%	94.2%	94.0%	95.8%

1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 775 bed days were used in June 2025, 231 were female PICU patients within contracted beds resulting in 544 out of area placement days as an accurate reflection of trust performance. As at 18th July there are 18 patients in external placements of which 9 are female PICU placements.

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

Executive Sponsor: Andy Cruickshank, Chief Nurse

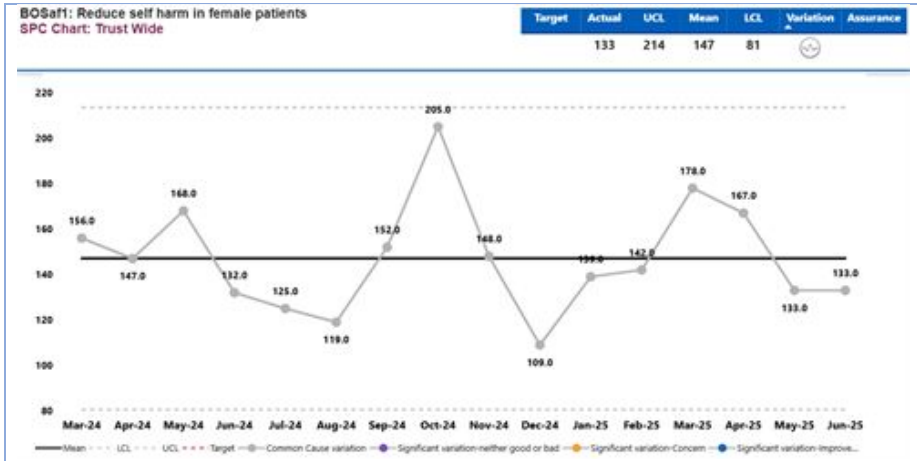
True North

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TNSaf1: Reduce the number of patient harms		165	189	225	269	200	148	179	176	233	210	168	174

Breakthrough Objectives

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
BOSaf1: Reduce self harm in female patients		125	119	152	205	148	109	139	142	178	167	133	133

Focus on Breakthrough Objectives



Data Source	InPhase	**Data Quality Confidence**	

Some potential data completeness issues being investigated within community services

What is being measured?

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

What is the data telling us and key actions in place

SPC is showing normal variation but there is a lot of variation in the number of female self-harms from month to month. The mean since March 2024 is 147 with lower and upper process limits sitting at 81 and 214 respectively.

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

BI and Inphase reports have been created to improve accessibility of self-harm data for individual teams, provide breakdowns of the services with the highest and lowest rates of self-harm incidents and the types of self-harming behaviours reported. There are still some data quality issues in terms of Rio ID not being included in the Inphase reports. A survey is live to collect staff views of what is working well, what isn't working and where the gaps are in terms of supporting individuals who present with self-harming behaviours. Preliminary analysis of the responses of has been undertaken. A monthly cross-directorate, interprofessional steering group has been established to oversee this work.

Watch Metrics

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
1.2.05: Patients receiving follow-up within 72 hours of discharge		87.2%	82.3%	86.9%	82.3%	85.5%	78.2%	84.3%	85.0%	84.5%	82.8%	83.9%	89.9%
1.2.10: %Patients with a CPA Care Plan	95.0%	86.6%	85.6%	82.5%	80.6%	82.4%	80.0%	87.1%	90.1%	89.3%	89.5%	90.7%	89.7%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	73.7%	72.9%	72.3%	71.4%	72.2%	72.1%	72.4%	71.4%	70.7%	71.6%	71.9%	70.4%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	67.0%	65.0%	64.0%	62.3%	60.1%	55.8%	58.6%	62.4%	61.1%	56.4%	54.7%	57.1%
1.4.01: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
1.4.02: All Deaths Reported And Suspected Suicide		145	98	144	142	137	113	198	174	157	120	148	142
1.4.03: Restrictive Practice - All Restraints		78	61	70	97	87	67	63	77	109	103	95	57
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	2	4	6	6	6	7	3	7	8	5	2	12
4.1.02: DNAs - 1st Appointments		10.5%	10.4%	10.5%	10.4%	10.7%	11.6%	10.2%	10.3%	10.7%	10.9%	10.7%	10.7%
4.1.03: DNAs - Follow Up Appointments		9.9%	9.6%	9.5%	9.5%	10.1%	10.9%	10.7%	9.9%	10.0%	10.5%	10.4%	10.5%

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

Executive Sponsor: Nick Brown, Chief Finance and Resources Officer

True North

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
TNSus1: Clinician Contact time per FTE											0.31	0.34	0.33

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

Breakthrough Objectives

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
BOSus1: Psychology & Medic contact time per FTE										

Focus on Breakthrough Objectives

BOSus1: Psychology & Medic contact time per FTE *Insufficient data points to analyse by SPC*	**Data Source**	ESR & RiO	**Data Quality Confidence**	
	Significant data validation and increased data integration required to acquire a higher degree of confidence in the outputs of this new measure			
	What is being measured?			
	This breakthrough objective aims to improve the efficiency and effectiveness of clinical time by increasing the proportion of available working time spent in direct clinical contact. The measure reflects the total duration of all appointments recorded in RiO—including attended, DNA, and cancelled sessions—against the available working minutes derived from ESR data. **Numerator:** Duration (mins) of all appointments in period divided. Includes unoutcommed appointments, DNAs and all Cancellations. Includes any staff who record 1 or more contacts in period on RiO **Denominator:** total working mins available in period (using 21 working days) based on FTE. Does not account for individual Annual Leave or Sickness; an uplift is generically applied to all staff for average absence per annum. Includes staff on ESR with a role that is under the ESR staff group for consultants and psychologists as per agreed definition with trust leads.			
	What is the data telling us and key actions in place			
	Currently the data reflects approximately 140 medics and 240 psychologists. While variation exists across staff groups, the baseline provides a valuable starting point for understanding clinical productivity and identifying opportunities for improvement. There are some concerns over the activity recording and therefore its subsequent impact onto data quality so we have an in-depth review on an initial subset of consultant and psychology activity over the next month to identify barriers to strengthen this metric. This will also provide an opportunity to identify opportunities to improve performance. Key Actions and Next Steps: • Strengthen data integration between ESR and RiO to improve confidence in the measure. • Refine the denominator to better account for individual leave and sickness, moving beyond generic uplift assumptions. • Engage clinical leads to validate contact recording practices and ensure consistency across services. • Use this metric to inform workforce planning, service redesign, and targeted support for teams with lower contact ratios.			

Watch Metrics

Measure Name	Target	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
4.1.04: In Month Budget (£000)	0	(13,767)	(13,735)	(14,233)	(19,323)	(14,814)	(15,042)	(14,756)	(14,708)	(14,742)	(15,122)	(15,315)	(15,413)
4.1.05: In Month Actual (£000)		(13,900)	(14,555)	(13,822)	(18,717)	(14,756)	(14,960)	(15,863)	(15,637)	(15,488)	(16,169)	(16,064)	(15,684)
4.1.06: In Month Variance (£000)		(133)	(820)	411	606	58	82	(1,107)	(930)	(746)	(1,047)	(749)	(271)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	3.5%	3.8%	3.5%	2.9%	3.2%	2.8%	2.6%	2.5%	1.9%	2.7%	2.5%	2.6%

5. Appendices

NHS Oversight Framework

NHS England » NHS Oversight Framework 2025/26

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

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

Overall Segment and Domain Scores

Headlines	Data period	Provider value
Oversight framework segment (latest distribution)	Q1 2025/26	1 NOF Score
Average metric score	Q1 2025/26	2 NOF Score
Pre-adjusted segment	Q1 2025/26	1 NOF Score
Is the segment downgraded due to financial deficit?	Q1 2025/26	No
Is the organisation in the Provider Improvement Programme	Q1 2025/26	No

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

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

Report Guide

True North

The guiding direction of the organisation

Timeframe: 3-5 years

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

Breakthrough Objectives

The improvement focus of the organisation

Timeframe: 0-12 months

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

Watch Metrics

Important metrics to understand department performance

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

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31 July 2025
Title of Paper:	Memory Assessment System Delivery Plan
Author:	Victoria Nystrom-Marshall, Improvement Team
Executive Director:	Adrian Richardson, Director of Transformation and Partnerships

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The breakthrough objective as part of the Trust strategy is to diagnose 95% of patients within 6 weeks.

This paper outlines the improvement work that has been undertaken for the memory assessment service and the ongoing plan for improvement.

This paper then provides an update on core areas of focus including, eliminating patients waiting 52+ weeks, optimising service efficiency, Trust wide improvement activities and work with system partners.

Issues to bring to the Board's attention

As of the 14th of July 2025, there are 2,573 people awaiting a diagnosis. In June 2025, 26.5% of patients were diagnosed within six-week.
The average time to diagnosis has reduced from 27.1 weeks in July 2024 to 17 weeks on the 14th July 2025
The number of patients waiting over 52 weeks has reduced from 260 in February 2025 to 115, with work continuing to eliminate all non-clinically relevant waits by September 2025.

Governance

Implications/Impact:	KMPT Trust Strategy Risk ID 00580 – Organisational Inability to meet Memory Assessment Service Demand
Assurance:	Reasonable
Oversight:	Trust Board and Provider Collaborative Board

1 Vision for Dementia Services

Working together with our system partners and the people who access our services, we have developed a vision for the memory assessment service (MAS):

Kent and Medway will have the most efficient MAS service that provides patients with timely and appropriate diagnosis, enabling them to access the best future pathways that promote living and dying well with dementia.

The Dementia Care Pathway 2018 set out three benchmarks:

a) ensuring that at least two-thirds of the estimated number of people with dementia have a formal diagnosis
b) increasing the number of people being diagnosed with dementia, and starting treatment, within 6 weeks of referral
c) providing post diagnostic support.

As part of the Trust Strategy, a breakthrough objective for the organisation is that 95% of people will receive a dementia diagnosis within six-weeks.

The Dementia Programme is being completed in three phases:

1. The first phase rolled out stand alone memory assessment services in six areas across Kent and Medway, optimisation of these services continues.
2. The second phase focuses on reducing variation and developing a sustainable workforce model using multi-disciplinary teams to assess and diagnose.
3. In the third phase, we are working as a system to address the gap between estimated prevalence and the number of people with a diagnosis on the dementia register by delivering diagnosis where appropriate in the community.

This paper provides an overview of our current performance against the six-week wait. It then provides an update on core areas of focus including, eliminating patients waiting 52+ weeks unless clinically necessary, optimising service efficiency, Trust wide improvement activities and work with system partners as part of the programmes plan.

2 Trust Wide Performance

The waiting time to diagnosis and the percentage diagnosed within six-weeks has improved at Trust level.

There is unwarranted variation across the six teams within KMPT, driven by a range of differing factors that teams are working to address.

Whilst some teams are prioritising efforts to reduce the number of patients waiting longest, others are directing their focus toward tackling the underlying efficiency issues.

2.1 Percentage of people referred for a memory assessment diagnosed within six-weeks

The mean performance in April 2024 of patients diagnosed within six-weeks was 9.43%. A number of substantial changes have been delivered to reduce variation, improve quality, and enhance performance. Six standalone memory assessment services were rolled out between June and September 2024. There was an shift in performance in October 2024. In January 2025, new dashboards were rolled out to teams, front line improvement huddles commenced, and team managers brought together to share best practice and inform change. This was marked by a

further shift in performance. A new standard operating procedure was developed during this period and finalised in May 2025.

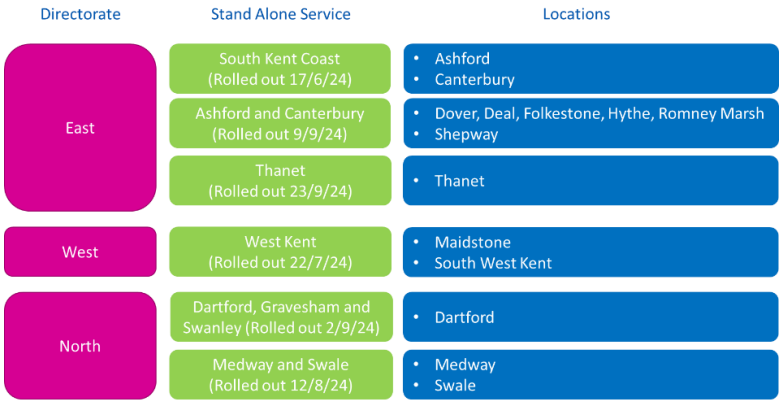


Figure 1: Rollout of the stand-alone Memory Assessment Services

Since these measures have been put in place there has been an increase in six-week diagnosis performance from 9.4% in April 2024 to 26.5% in June 2025

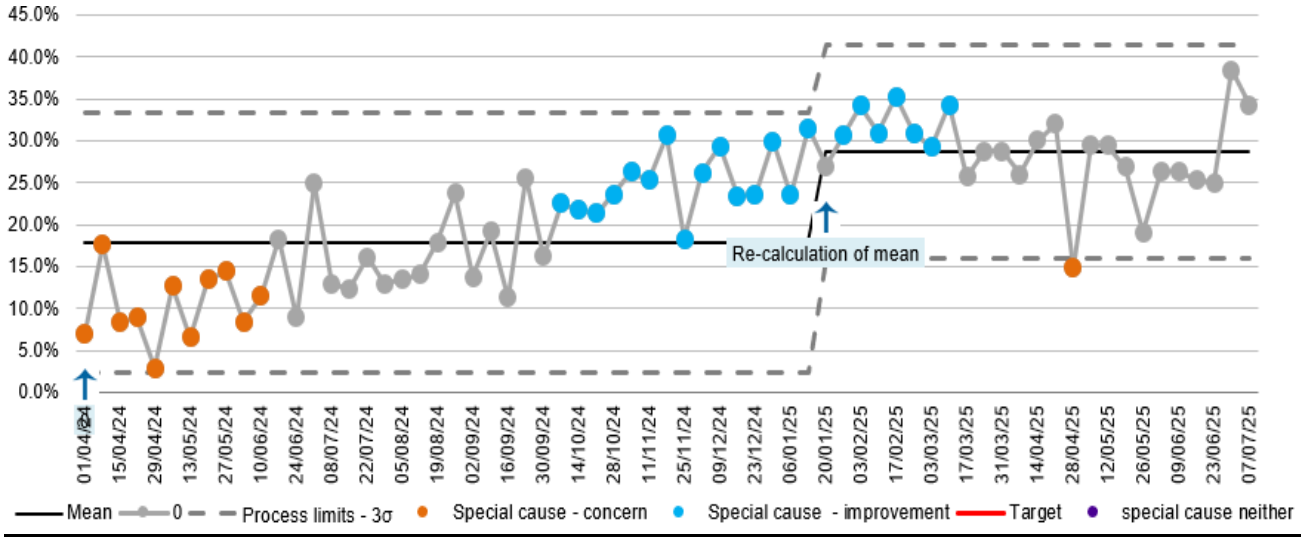


Figure 3: Percentage of patients diagnosed within 6 weeks (7/7/25)

2.2 Waiting List Composition

There are currently 2,573 people awaiting a diagnosis.

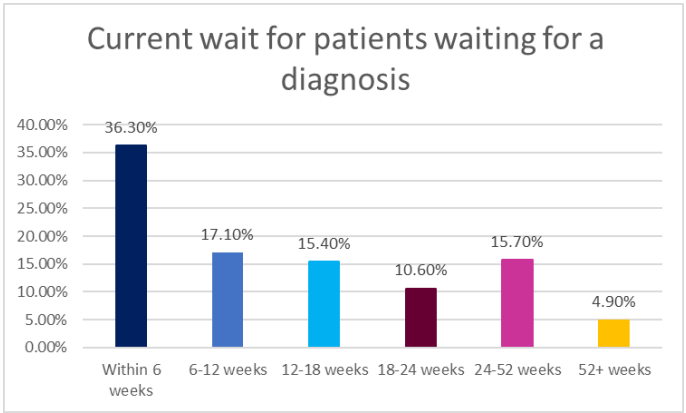


Figure 2: Current wait for patients waiting for a diagnosis (14Jul2025)

2.3 Average waiting time to Dementia Diagnosis

From February 2025, teams with patients waiting 52+ weeks (five of the six MAS) focused on identifying the contributing factors to those waiting longest. It resulted in appointment slots being prioritised for people in that waiting time bracket which has had an effect on six-week performance. As the factors associated with those waiting longest are addressed, the focus will shift to addressing the contributing factors to achieving a six-week wait.

The focussed piece of work since February has contributed to a further improvement in our average waiting times. The average waiting time has reduced from 27.1 weeks in July 2024 to 16.5 weeks (115.5 days) as of 18th July 2025. The national average waiting time reported in the national dementia audit was 21.6 weeks (151 days).

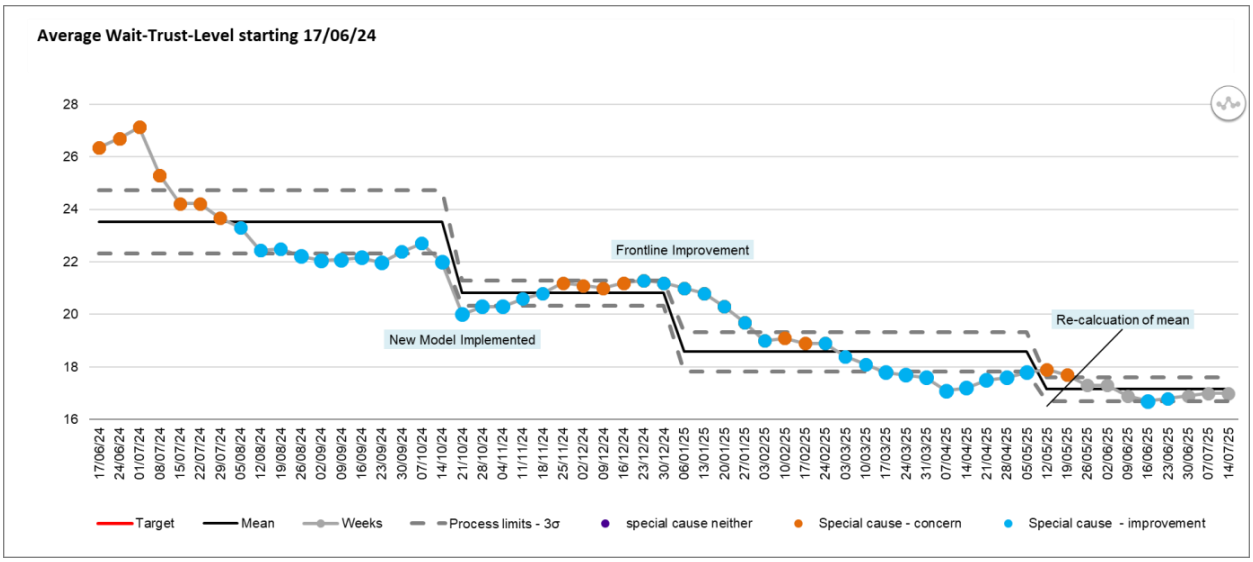


Figure 4: Average wait in weeks for Dementia Diagnosis (14Jul25)

2.4 Diagnosing people waiting 52+ weeks

In February 2025, there were 260 patients who were on the waiting list for over 52 weeks. This number has reduced to 114 (18th July 2025). Teams are working through improvement huddles and with locality management to address the waits, with a goal to address the backlog by September 2025.

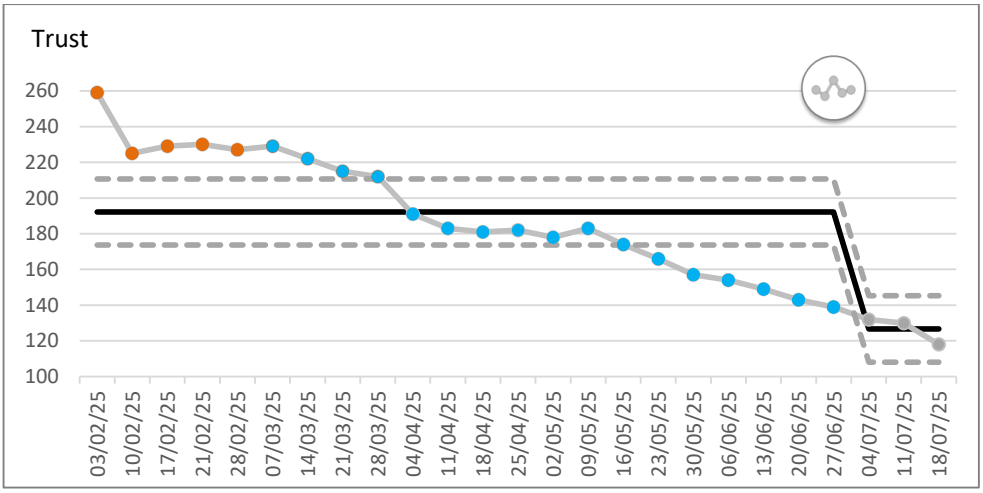


Figure 6: Trust wide memory assessment service – patients waiting over 52 weeks for a diagnosis

The performance of each memory assessment service and the trajectories for the patients waiting 52+ weeks are detailed in Appendix 1.

West Kent has seen notable improvements in reducing the number of people waiting 52+ weeks from 186 people in February 2025 to 51 people (18th July 2025). 42 patients currently waiting 52+ weeks have a scheduled appointment and the remaining 12 need to be scheduled. We continue to monitor those people currently under 52 weeks who will tip into this category to ensure mitigations are in place.

South Kent Coast remains challenged with a caseload of 54 people waiting over 52 weeks (18th July 2025). 45 have a scheduled appointment before the end of September. Waiting list initiatives are being explored to ensure that all patients including those tipping into 52 weeks have appointments in place.

The performance of both the number of 52 week waits and the six-week diagnosis rate are reviewed weekly by the Executive Sponsor and Senior Responsible Officer to ensure that the percentage of patients diagnosed within six-weeks does not fall outside of the lower control limits whilst the number of 52+week waits reduces. 52+week waits are reviewed weekly at the Trust Safety Huddle.

2.5 National Benchmarking

The National Audit for Dementia 2023/24 identified that only 10% of patients were diagnosed within six-weeks.[1] Memory assessment service waiting times are monitored nationally via the Mental Health Services Data Set (MHSDS) Memory Assessment Service (MAS) Dashboard. In May 2025, 3.4% in the South East and 16.8% in England were diagnoses within six-weeks. The percentage diagnosed in KMPT within six-weeks currently sits at 26.5% (Jun25).

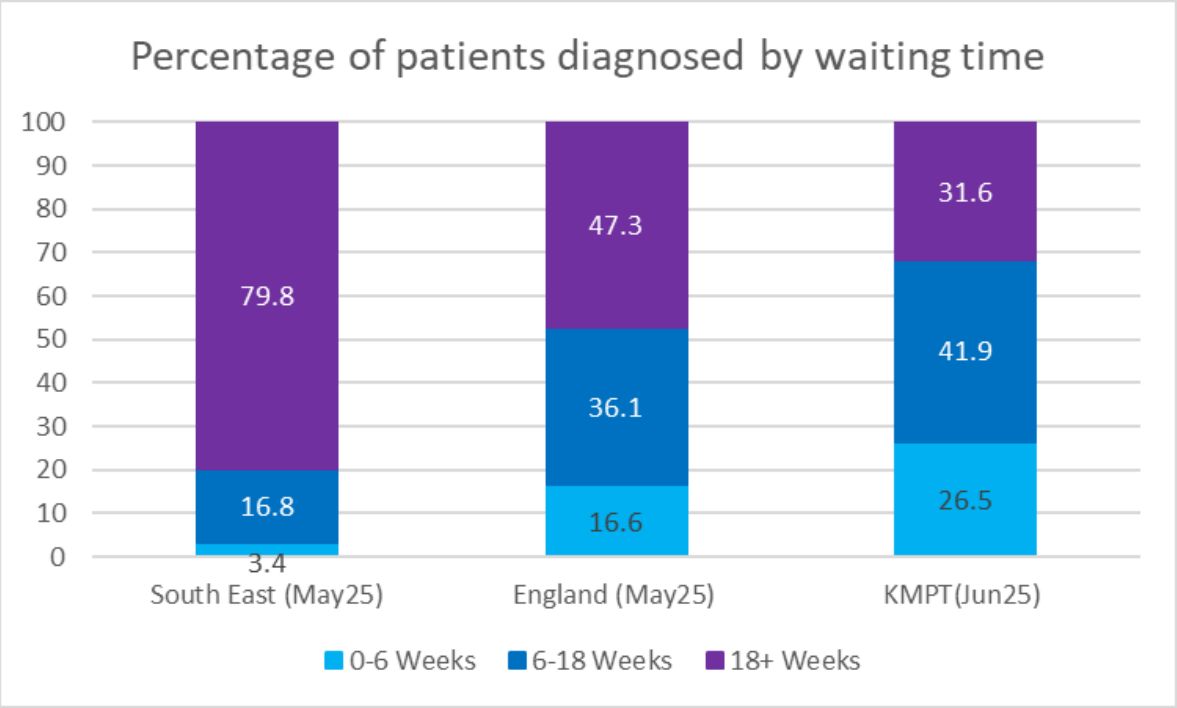


Figure 5: MHSDS Memory Service Dashboard (extracted 11Jul25) compared to current KMPT performance (Jun2025) Memory Assessment Services – Areas of Focus

[1] National Audit of Dementia accessed 14Jul25

2.6 Optimising Services to Diagnose within 6 weeks

A series of audits have been carried out by resident and senior clinicians to identify opportunities to optimise services. Details of these audits can be found in Appendix 2. Teams are utilising their improvement huddles to focus on the next immediate challenges with the aim of improving flow and reducing process waste. These are shown in Appendix 3. The findings from the Resident doctor audits will feed into frontline improvement as well.

2.7 System Delivery Plan (Phase 3 of internal KMPT plan)

We are working together with our partners to develop a three-level community clinical model to provide this additional capacity to enable the system to meet and sustain the dementia diagnosis rate (DDR) at 66.7%.[2] The model has been shared in previous board reports and the delivery plan referenced in the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Update submitted separately on this agenda. Our governance is integrated to enable transparent collaborative working.

3 Next Steps

Conditions for Change: Ensuring teams have the right tools to improve their services:

- Review and learn from the first seven months of frontline improvement huddles to ensure that they are sustainable and meaningful for teams moving forward. Frontline improvement huddles have been found to be a powerful improvement tool that stimulate whole team engagement in continuous improvement. Here they have primarily focused on supporting teams to reduce waiting times.
- Bring teams together to use other improvement methodologies to address Trust-wide memory assessment issues. For example, ensuring that patients are thoroughly informed and comprehend the purpose of a memory assessment, especially where an assessment has been requested. This will help prevent patient disengagement during the memory assessment process.

Phase 1: Stand Alone Memory Assessment Services - Reducing Variation

- The rollout of six stand-alone services has identified a degree of unwarranted clinical variation. This includes non-standardised clinic templates, variation against job plans, variation against agreed KMPT guidance on imaging, variation against diagnostic threshold, and variation in the time that patients are open to the memory assessment service after diagnosis. A dashboard is being developed to assist in the discussions with clinicians and the Chief Medical Officer and Director of Transformation and Partnerships are working closely to address these issues during the summer. A summary of this will be reported to board in September 2025.
- Cancellations and DNAs are also a significant contributor to waste where both time and staff are allocated but not utilised for the intended purpose. Accurately documenting cancellations and addressing preventable cancellation reasons will release time back for direct patient care. Utilising the findings of Resident doctor audits initiatives are being put in place during Q2 and Q3 2025.
- Recording a diagnosis and interventions is crucial for managing a memory assessment caseload effectively. It ensures proper tracking, helps us to better understand the constraints associated with service interdependencies, and enables follow up in line with

[2] DDR is based on prevalence rates calculated from the Cognitive Function and Ageing Study (CFAS II) scaled up to give the estimated rate for England. This is then compared to recorded dementia diagnosis recorded on primary care systems.

the standard operating procedure. Work has been undertaken on this and continues to be reinforced. It will also form a specific part of the dashboard above.
- Waiting times to diagnosis remain a key focus in the National Dementia Teams workplan. All KMPT patients to be diagnosed within 52 weeks from September 2025 unless clinically necessary. A trajectory for reducing the waiting time further to be delivered in September 2025.

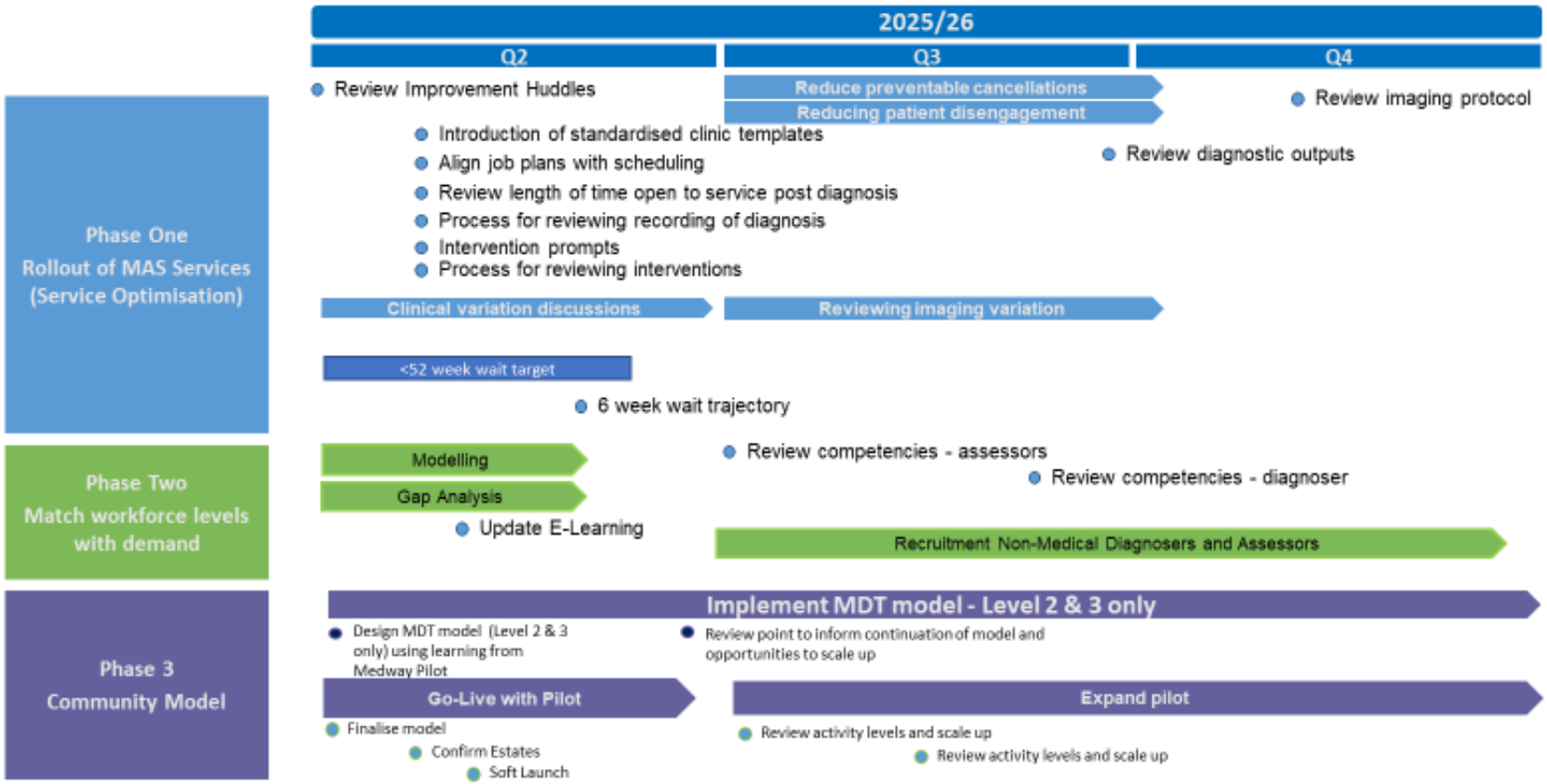
Phase 2: Match workforce levels to demand

- One of the most significant contributors to our waiting times is variation in the workforce model in teams to complete assessments and deliver diagnosis. KMPT has developed a competency-based framework to enable the Trust to diversify the workforce by focusing on the skills and abilities needed to deliver each component of the assessment pathway. By September 2025, the workforce model will be completed and costed to inform discussions around future recruitment and training exercises. In the interim, new role descriptions have been generated. We will initiate recruitment to broaden our workforce pool, coupled with providing the necessary training and supervision. This will deliver our commitment to providing high quality assessment services.
- Recruitment and implementation will begin in Q3 and continue alongside the work being undertaken in the community model.

Phase 3: Work with System Partners to build capacity to meet future demand

- Collaborate with the system to implement the new community model ensuring that DiADeM is utilised in care homes and establishing MDTs to support local clinicians to diagnose dementia where appropriate within general practice. KMPT is significantly contributing to this work and reviewing the impact this will have on our trajectory and resources.

Next Steps

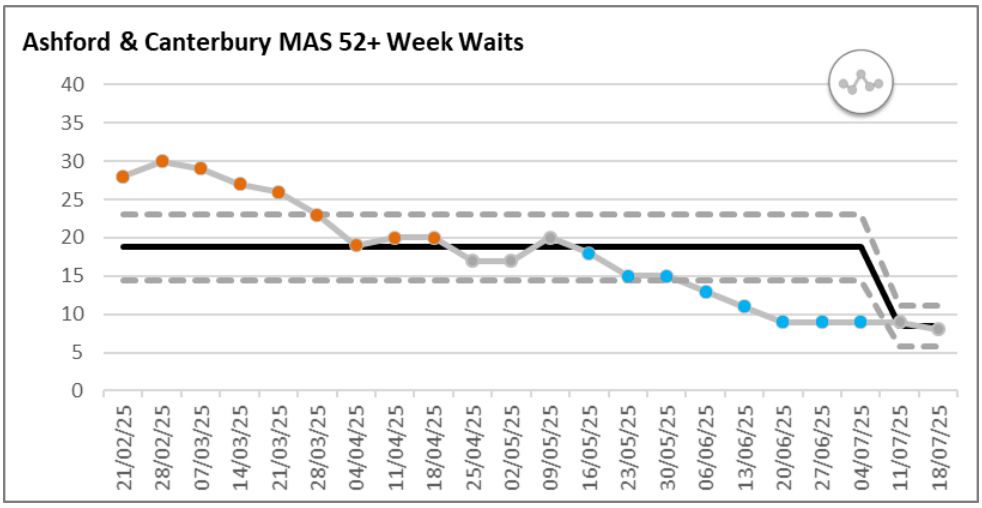

2025/26
Q2
Q3
Q4
Phase One
Rollout of MAS Services
(Service Optimisation)
Review Improvement Huddles
Reduce preventable cancellations
Reducing patient disengagement
Review imaging protocol
Introduction of standardised clinic templates
Align job plans with scheduling
Review diagnostic outputs
Review length of time open to service post diagnosis
Process for reviewing recording of diagnosis
Intervention prompts
Process for reviewing interventions
Clinical variation discussions
Reviewing imaging variation
<52 week wait target
6 week wait trajectory
Phase Two
Match workforce levels
with demand
Modelling
Review competencies - assessors
Gap Analysis
Review competencies - diagnoser
Update E-Learning
Recruitment Non-Medical Diagnosers and Assessors
Phase 3
Community Model
Implement MDT model - Level 2 & 3 only
Design MDT model (Level 2 & 3 only) using learning from Medway Pilot
Review point to inform continuation of model and opportunities to scale up
Go-Live with Pilot
Expand pilot
Finalise model
Review activity levels and scale up
Confirm Estates
Review activity levels and scale up
Soft Launch

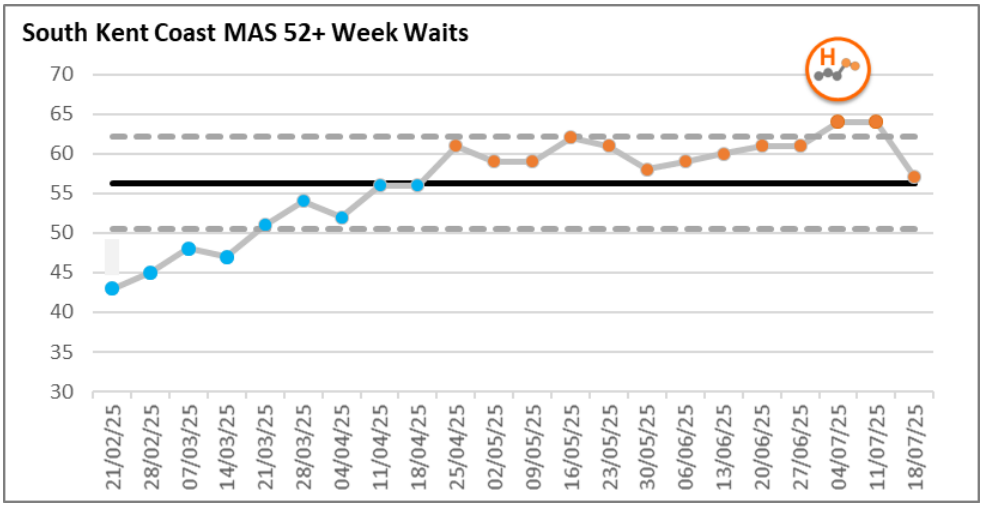
4 Recommendations

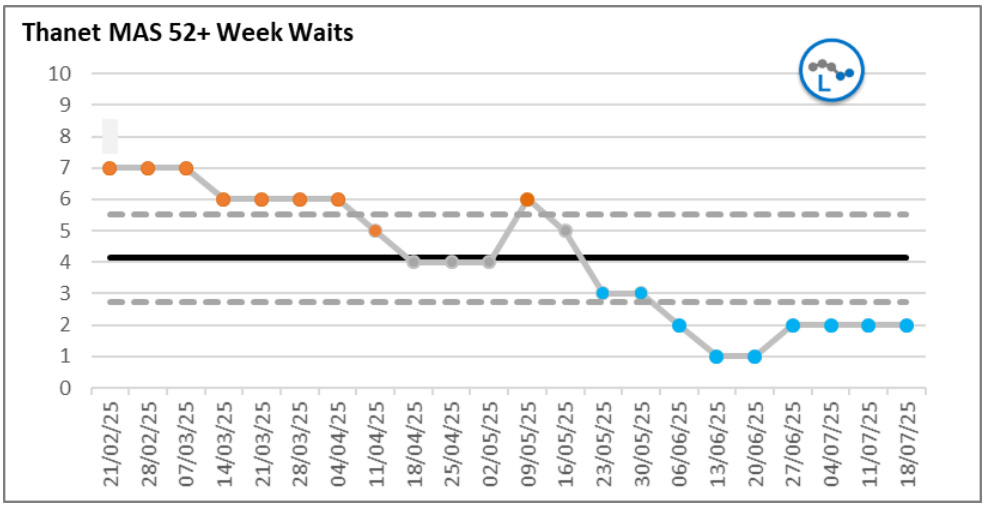
It is recommended that the Board note the content of this report and:

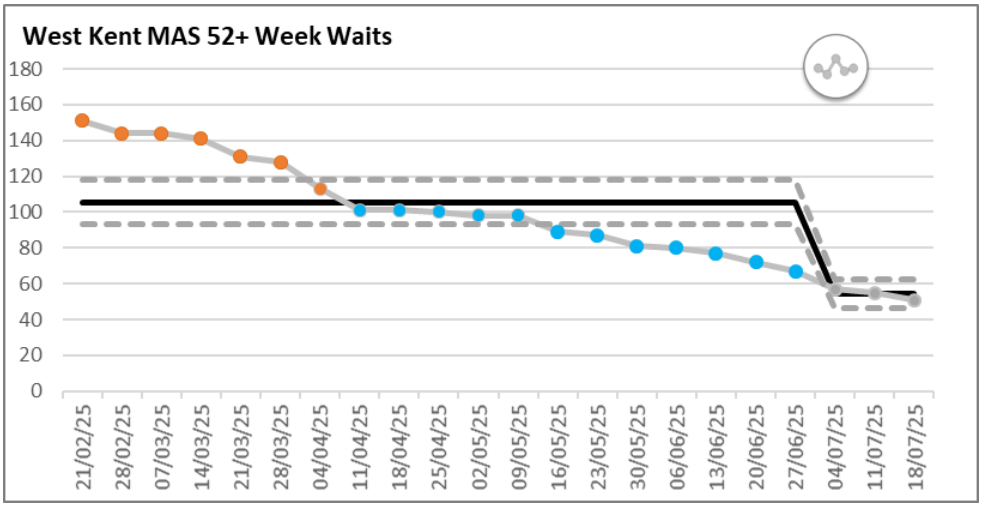
1) **SUPPORT** the continued reduction in long waiting times
2) **SUPPORT** the development of strategies to broaden the pool of staff able to provide assessments and diagnosis with the aim of increasing appointment availability and delivering a consistent capacity offer that matches future demand.
3) **SUPPORT** frontline improvement huddles as a structured approach to address issues within the immediate control of teams
4) **SUPPORT** the development of the community-based diagnostic with the aim of reducing unnecessary referrals to KMPT, enabling services to focus on higher levels of acuity and to meeting future demand needs.

Appendix One: Performance of Ashford and Canterbury, South Kent Coast, Thanet, and West Kent memory assessment services in respect of those waiting 52+ weeks and the trajectories for the patients waiting 52+ weeks in West Kent and South Kent Coast MAS as of 14th July 2025.








West Kent MAS 52+ Week Waits
180
160
140
120
100
80
60
40
20
0
21/02/25
28/02/25
07/03/25
14/03/25
21/03/25
28/03/25
04/04/25
11/04/25
18/04/25
25/04/25
02/05/25
09/05/25
16/05/25
23/05/25
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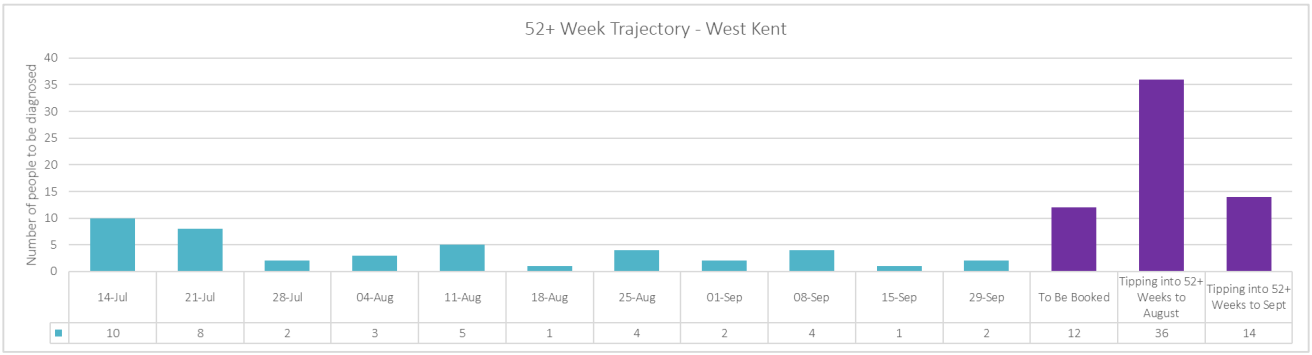
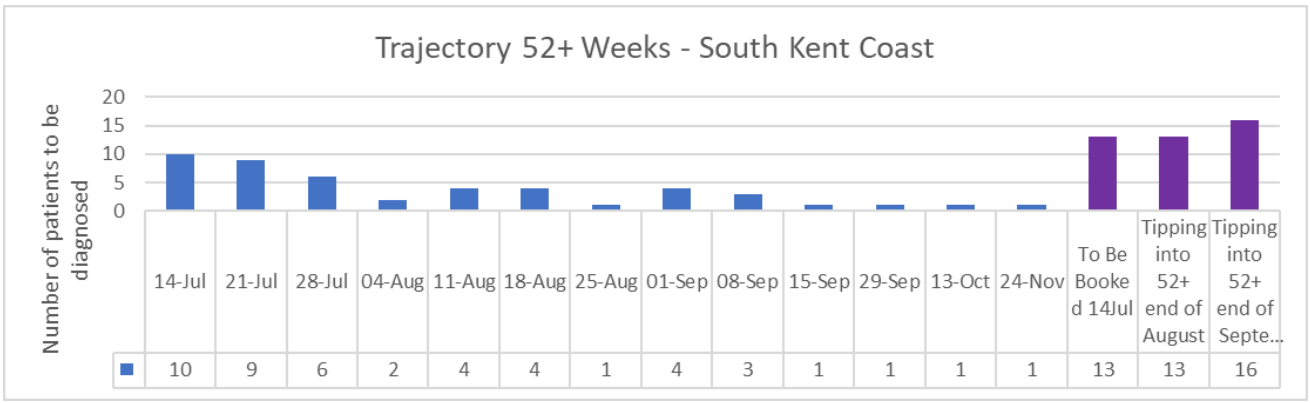
27/06/25
04/07/25
11/07/25
18/07/25


52+ Week Trajectory - West Kent
Number of people to be diagnosed
40
35
30
25
20
15
10
5
0
14-Jul
21-Jul
28-Jul
04-Aug
11-Aug
18-Aug
25-Aug
01-Sep
08-Sep
15-Sep
29-Sep
To Be Booked
Tipping into 52+ Weeks to August
Tipping into 52+ Weeks to Sept
10
8
2
3
5
1
4
2
4
1
2
12
36
14


Trajectory 52+ Weeks - South Kent Coast
Number of patients to be diagnosed
20
15
10
5
0
14-Jul
21-Jul
28-Jul
04-Aug
11-Aug
18-Aug
25-Aug
01-Sep
08-Sep
15-Sep
29-Sep
13-Oct
24-Nov
To Be Booked 14Jul
Tipping into 52+ end of August
Tipping into 52+ end of Septe...
10
9
6
2
4
4
1
4
3
1
1
1
1
13
13
16

Appendix 2 – Resident Doctor Audit findings and recommendations

Audit Focus	Best Practice	Recommendations
Time to diagnosis being recorded on RiO	65% cases had the diagnosis recorded in three areas on RiO Once the diagnostic appointment is complete; the majority of patients have a clear plan and experience no further delays.	Match staff capacity and appointment availability to demand for services Train appropriate staff in assessing and diagnosing dementia to reduce delays 25% of cases audited did not have the diagnosis recorded on the relevant section of RiO. Senior clinicians and Doctors should record a confirmed diagnosis has been made in the appropriate section of RiO. Teams should have systems in place to regularly audit diagnosis to improve compliance. 14% of referrals were deemed inappropriate leading to delays.
Cancelled by Trust	84% of appointments cancelled by Trust were re-booked with 53% rebooked within 1-2 weeks. Only 10% took more than six-weeks to rebook. 20% of these were awaiting further investigations.	Noted that miscoding of cancellations by patients as cancelled by Trust accounted for 17% of cancellations. Clearer documentation and categorisation of cancellations recommended. Wrong time entered/double booking accounted for 15-20% of cancellations – process waste. Unavailability of staff contributed to 15%. Match staff capacity.
Cancelled by Patient	83% of appointments were rebooked and 32% were rebooked within 1-2 weeks. Only 24% took more than 6 weeks to rebook. 9% of these were awaiting investigation. 54% of cancelled appointments had a recordable reason.	18% of patients declined to engage with the Memory Assessment Services. Patients should therefore be informed of the reason for the referral and what to expect. 48% were the first appointment. 58% of the cancellations were for a diagnostic appointment. Reasons for cancellations included 18% not fit for review (sickness or decline), 10% logistics and support, and 5% appointment clashes. Recommendation is to review cancellation data to put in place targeted interventions to reduce cancellations.

Appendix 3 – MAS Countermeasures

	Number of people waiting 52+ weeks	Average Wait	Percentage seen within Six-weeks 14Jul25	Contributors (Our Focus)	Countermeasures (What we are doing differently)
Medway and Swale	**0**	**10.6**	**57.1%**	18-24 and 24-52 weeks	1. Having reduced the waiting list below 52 weeks, currently auditing contributing factors in lower waiting time brackets. 2. Determine whether assessment measures are being uploaded at the appropriate time.
Dartford, Gravesham and Swanley	**0**	**9.4**	**68.4%**	No appointments booked	1. Review identified that roughly 50% were awaiting a diagnostic intervention within another service (see 3.3.2), Review factors delaying the other 50%.
West Kent	**54**	**21.1**	**19.0%**	52+ Weeks	1. Care Home Residents - Care homes have been grouped for assessment purposes. 2. Patients are then able to have a virtual diagnostic appointment. 3. Appointment reminders being sent via letter and SMS (if there is consent) to reduce DNAs.
Thanet	**2**	**14**	**15.4%**	52+ Weeks	1. Appointment booked by September with an interpreter. 2. Other to be reviewed as currently an inpatient and out of area. Under review.
				90+ awaiting imaging	1. Review rationale for imaging in these circumstances
South Kent Coast	**60**	**22.8**	**17.6%**	52+ Weeks	1. Additional clinics to be run using overtime to achieve target. Patients to be booked into these spaces. 2. Recruitment of new locum underway.
Ashford and Canterbury	**9**	**12.5**	**26.70%**	52+ Weeks	1. 7/9 people have appointments booked by 1st September. 2/9 need an outcome.
				Diagnosed but open on caseload	2. Review people who are diagnosed but who have not been discharged to ensure that they transition to appropriate services.
				People aged 90+ awaiting imaging	3. Rationale for imaging in these circumstances being reviewed.
				6wk Target	4. Opportunities to utilised Junior Doctors to support diagnostic process.

Figure 7: Frontline Improvement Focus by Memory Assessment Service – 14th July 2025

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 2025
Title of Paper:	Finance Report for Month 3 (June 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 3 (June 2025).

Items of focus

For the period ending 30th June 2025, the Trust has reported a pre-technical adjustments surplus of £0.19m and a surplus of £0.55m 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 8 PICU beds used in month resulting in a year to date budgetary pressure of £2.41m. This pressure was anticipated during financial planning due to the operational constraints created by clinically ready for discharge patients. The Trust therefore held a reserve to mitigate the impact during quarter 1.
- Year to date agency spend is £1.47m with action required to deliver the forecast for agency of £4.27m as per plan.
- Inpatient Nursing remains a pressure, however additional controls have been put in place, and staffing levels have reduced 24 wte in month. This position is being closely monitored by the operational teams.

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
June 2025

Trust Board

Brilliant care through brilliant people

RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Contents

Brilliant care through brilliant people

Executive Summary

Key Messages

For the period ending 30th June 2025, the Trust has reported a pre technical adjustments surplus of £0.19m and a surplus of £0.55m post technical adjustments, this is in line with the financial plan.

Key pressures for the Trust are:

External beds

- The Acute beds usage increased over May levels, with an average of 17 beds utilised costing £0.56m. The Trust doesn't hold a budget for external acute beds.
- June saw an improved position on external PICU bed usage with a reduction of 3 beds used with an average of 6 external Female PICU beds, and an average of 2 external Male PICU beds being utilised at a cost of £0.33m. The Trust holds a budget for 7 PICU beds.
- The Trust has put in place stepdown capacity, which will facilitate the repatriation of patients from external Acute beds to KMPT beds.

Acute Inpatient staffing

- The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels.
- On average usage over and above establishment equates to 99 additional WTEs, £0.35m per month.
- Additional controls have been implemented in June where we have seen a reduction of 24 WTEs being utilised.
- Work is on-going in this regard and further reductions are anticipated in future months.

Agency spend

- In month spend increased by 3.3% in month (£0.02m). Year to date agency spend is £1.47m, with East Kent medical agency and West Kent nursing agency being key areas of pressure.
- In month spend levels were highest in East Kent, with 39.4% of overall agency spend, due to medical vacancies, but also West Kent due to pressures within Liaison services, CMHTs and Crisis teams.
- For 2025/26 an agency spend limit has been set for the Trust of £4.27m. Based on current forecasts, the Trust would spend £5.19m, £0.92m over the cap. Actions are in place to reduce current run rates..

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

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

Capital Programme

- As at 30th June the overall capital position is £0.10m ahead of plan. This is due to Estates and IT projects being ahead of the delivery plan and is offset by IFRS 16 lease remeasurements which have not yet taken place.
- The forecast spend position is £17.30m which recognises the outcomes of the Public Sector Decarbonisation and Estates Safety Fund bids.

Cash

- The closing cash position for June was £9.15m which was an increase in month of £0.77m and is £1.68m higher than the May forecast. This is the result of VAT receipts being higher than expected as well as a lower level of trade payable payments.

Brilliant care through brilliant people

Finance KPIs

I&E YTD position

M3 YTD actual	**£0.55m surplus**
Forecast outturn	£2.20m surplus

Year to date position on plan with a reported £0.55m surplus. Key pressures include Acute Inpatient staffing and External beds and are mitigated with non-recurrent benefits and pay slippage.
The Trust is forecasting an outturn position of a £2.20 surplus as per plan.

Efficiency delivery

M3 YTD actual	**£2.27m**
Forecast outturn	£17.64m

The CIP programme is currently on plan. Work is underway on the CIP programme for 2025/26 to ensure delivery and any slippages in planned delivery mitigated.
In month progress has been made on the Community Services schemes.
The Trust is forecasting full achievement od the annual target of £17.64m.

Capital spend

M3 YTD actual	**£1.37m**
Forecast outturn	£17.30m

The Capital position is £0.10m ahead of plan. This is due to Estates and IT projects being ahead of the delivery plan and is offset by IFRS 16 lease remeasurements which have not yet taken place. The forecast spend position is £17.30m which recognises the outcomes of the Public Sector Decarbonisation and Estates Safety Fund bids.

Bank spend

M3 actual	**£1.54m**
Planned Run Rate	£1.52m

Bank spend decreased in month by 8.8%. Acute saw the largest reduction with 19.54 less WTEs being used in month within the Nursing and HCA staff groups. This is due to substantive new starters completing their induction and the bank bakfill no longer being required. The Acute Directorate has implemented further controls for temporary staffing sign off.

Agency spend

M3 actual	**£0.49m**
Planned Run Rate	£0.36m

Agency spend in June represents a 3.3% increase on spend in May. The current forecast pre mitigations for agency is £5.19m, which against a cap of £4.27m results in the annual cap being exceeded by £0.92m.

WTEs utilised

M3 actual	**4,012**
Planned Staffing	4,071

WTEs utilised are monitored by NHSE against the Trust's workforce plan and are monitored to ensure there is no workforce growth. A decrease of 12.35 WTE is reported in month, and 32.70 WTE reduction since April 25.

External beds spend

Year to date overspend	**£2.41m**
Average Beds in Month	25

External bed utilised decreased as the month progressed but remains a key area of financial pressure for the Trust. Mitigations are in place including step down beds to relieve the pressure from CRFD patients.

Cash position

M3 cash balance	**£9.15m**
Operating Expenditue Days	11.5

The closing cash position for June was £9.15m which was an increase in month of £0.77m and is £1.68m higher than the May forecast. Predominantly due to less credit payments and a higher VAT rebate than planned.

Principles

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

Indicate a favourable or adverse movement against the previous month

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

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Financial statements

Statement of Comprehensive Income

	Current Month			Year to date		
	Budget	Actual	Variance	Plan	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	24,317	25,368	1,052	72,947	74,891	1,944
Employee Expenses	(18,837)	(18,608)	229	(56,507)	(56,047)	460
Operating Expenses	(4,958)	(6,181)	(1,223)	(14,987)	(17,317)	(2,330)
Operating (Surplus) / Deficit	**521**	**579**	**58**	**1,453**	**1,527**	**74**
Finance Costs	(338)	(396)	(58)	(904)	(978)	(74)
System control Surplus / (Deficit)	**183**	**183**	**(0)**	**549**	**549**	**0**
Excluded from System control (Surplus) / Deficit:						
Technical adjustments	(10)	78	88	(496)	(355)	141
Surplus / (deficit) for the period	**173**	**261**	**88**	**53**	**194**	**141**

Commentary

The Trust is reporting a surplus of £0.55m at the end of June. This is in line with plan.

Employee expenses

The Trust is reporting a year to date underspend on employee expenses of £0.46m. This consists of an underspend on substantive pay of £5.42m, offset by overspends on temporary staffing which total £4.96m; £3.49m on bank staff and £1.47m of agency spend.

The Trust spent £0.49m 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 48.5% and 43.6% of overall agency spend, respectively.

Operating expenses

In month operating expenses are over budget by £1.22m which is heavily driven by external bed spend. The Trust utilised 9 external PICU beds (7 PICU beds funded) and 17 external Acute beds, all of which are unfunded, and this presents a financial pressure to the end of June of £2.30m.

Small overspends were also seen with maintenance and utilities.

Statement of Financial Position

	30/04/2025	31/05/2025	30/06/2025
	Actual	Actual	Actual
	£000	£000	£000
Non-current assets	174,192	173,543	173,528
Current assets	20,105	16,807	18,820
Current liabilities	(30,182)	(26,139)	(28,051)
Non current liabilities	(39,058)	(38,917)	(38,743)
Net Assets Employed	**125,057**	**125,294**	**125,555**
Total Taxpayers Equity	**125,057**	**125,294**	**125,555**

Commentary

Total assets

Overall total assets increased by £2.00m in month primarily driven by current assets. This was due to an increase in accrued income (£1.22m) relating to the Kent, Surrey and Sussex provider collaborative, NHS England cost per case activity and funding from Kent and Medway ICB due to a complex package of care. Additionally, cash increased by £0.79m the result of VAT receipts being higher than expected as well as a lower level of trade payable payments.

Total liabilities

Overall total liabilities increased by £1.74m in month.

Current Liabilities increased by £1.91m due to outstanding invoices with Mears ltd, £0.93m, in relation to capital programme spend; and Hampshire and Isle of Wight NHS FT, £0.34m for Peri Natal contractual charges.

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Appendices

Cost Improvement plans 2025/26

Savings plans

Commentary

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

Schemes underway:

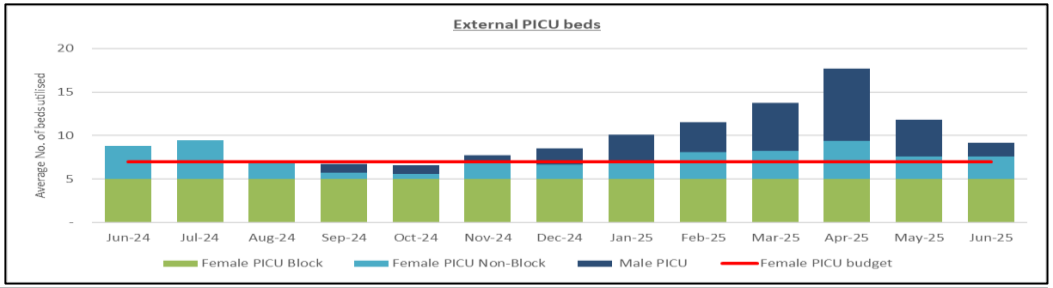
- Support Services – a 10% reduction in costs, reflecting NHS England benchmarking and growth analysis . Further plans continue to be developed with system partners. Fully developed plans are now progressing with consultations being launched from June 2025 to ensure savings are realised.
- Provider Collaborative Risk Share – Working with KSS PC to reduce out of area placements with funding secured through risk share arrangements, as per prior financial years. Discussions are progressing with the Provider Collaborative to confirm in year arrangements.
- Perinatal service review – underspends delivered, service review required to identify opportunities for recurrent reductions. Review of benchmarked costs and productivity metrics is underway.
- Community review – Service review for Early Intervention & At Risk Mental State services underway with Consultation paper taken to Joint Negotiating Forum at the end of July and savings recognised from September. Proposed establishments for MHT+ were shared with Directorate teams in early June with final amendments to be agreed.
- Budget management – 1% non-recurrent savings identified from slippages.
- Estates – a 10% reduction in costs. Following the decision to permanently remove administration estate, the whole estate is being reviewed for consolidation opportunities.

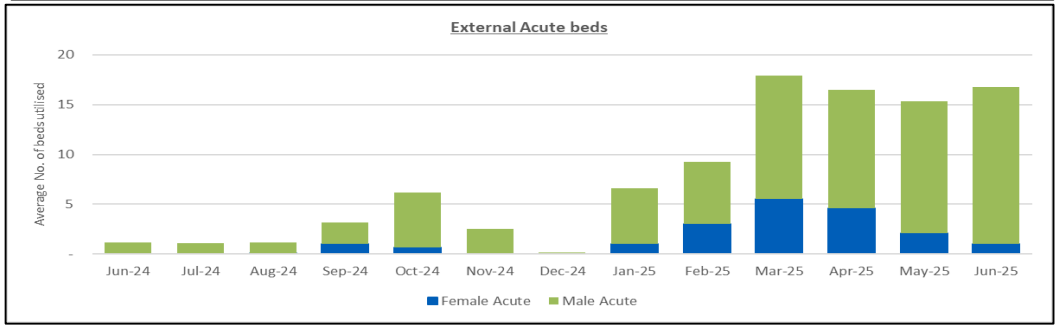
Plans under development:

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

Scheme	Planned CIP	Identified to Date	Expected completion date
Support Service	£3.7m	£2.2m	30th September 2025
Estates	£1.6m	£1.2m	30th June 2025
Forensic Inpatient	£1.0m	£1.5m	31st July 2025
Provider Collaborative Risk Share	£1.0m	£0.8m	On-going
Perinatal	£0.5m	£0.5m	30th September 2025
Community Review	£2.4m	£2.4m	31st July 2025
Rota Management	£1.7m	£0.0m	On-going
Budget Management	£1.8m	£1.8m	On-going
Non-Pay Review	£1.0m	£0.2m	On-going
Unidentified	£0.7m	£0.0m	31st July 2025
System stretch	£2.2m	£0.0m	Work on-going
Total	**£17.6m**	**£10.6m**	

Exception report – External beds





Commentary

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

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

In June, the Trust saw a reduction in external PICU bed usage (a reduction of 3), although external bed usage increased. This equated to 25 beds being used in month, a cost pressure of £0.89m.

The Trust has undertaken a number of steps to reduce this pressure, including the implementation of step down beds, with the expectation that this would improve patient flow. This work was beginning to lead to some improvement in the position towards the end of the month. With an expectation that spend will reduce further in Month 4.

Exception report – Inpatient Staffing

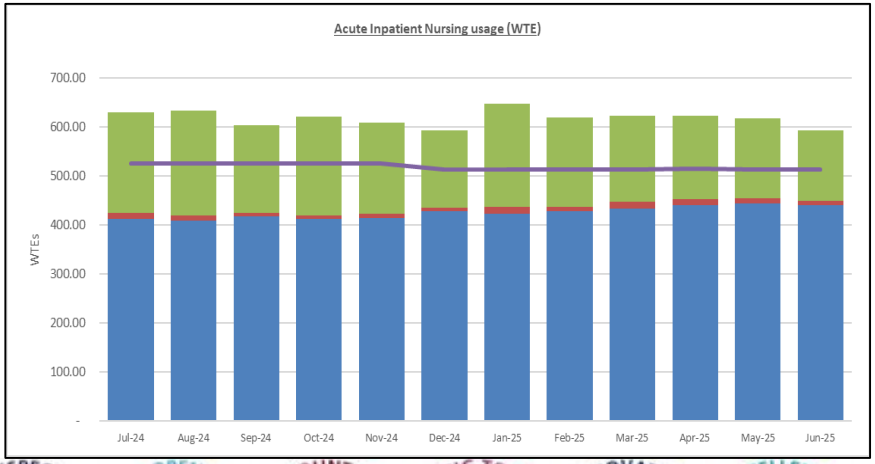
Commentary

The Trust's Acute Inpatient wards have consistently utilised additional Nursing staff (both registered and unregistered) over and above established levels. On average usage over and above establishment equates to 99 additional WTEs and £0.35m per month.

A review has been undertaken in month which has identified the various cost drivers; these identified the following steps to mitigate the pressure,

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

These actions were implemented in June and the Trust saw a reduction of 24 WTEs in month. Work remains on-going with further improvements to be made.



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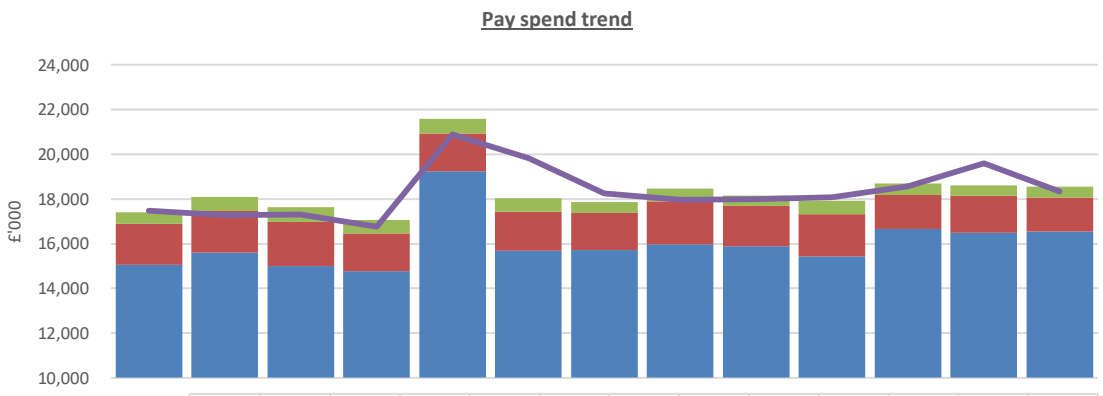
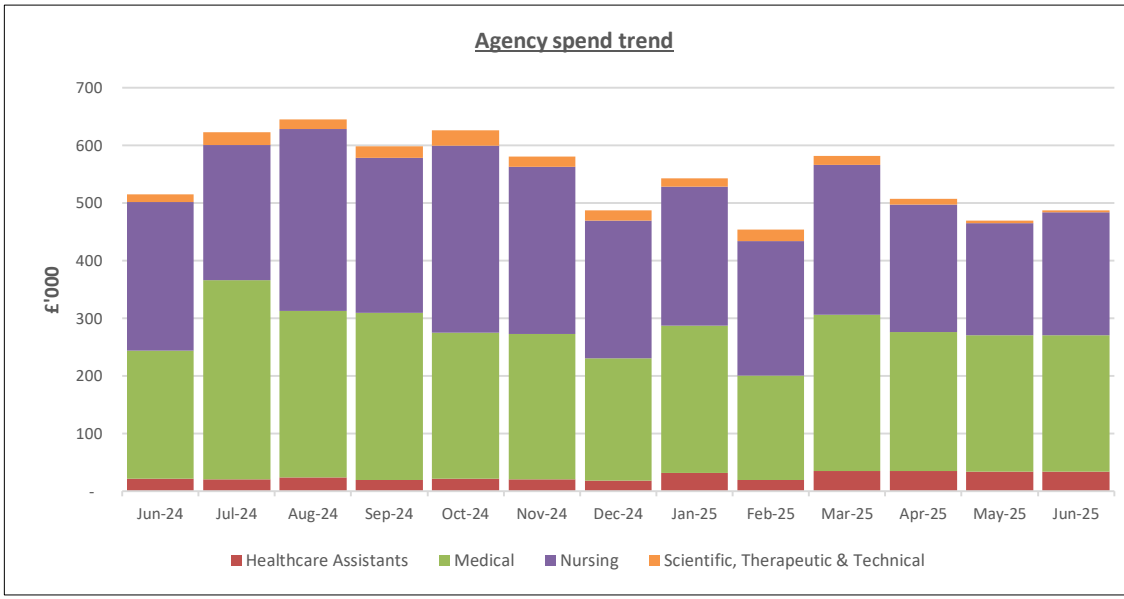
Exception report – Pay trend



	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
Agency	515	631	672	600	635	585	493	551	463	591	510	472	488
Bank	1,835	1,861	1,974	1,670	1,699	1,740	1,645	1,927	1,804	1,880	1,502	1,671	1,524
Substantive	15,066	15,612	15,004	14,780	19,244	15,699	15,721	15,980	15,891	15,442	16,672	16,476	16,543
Budget	17,490	17,288	17,310	16,764	20,897	19,821	18,247	17,959	17,990	18,088	18,561	19,599	18,347



Commentary:

As at the end of June the Trust reported a year to date underspend on pay of £0.46m.

The unadjusted current forecast for agency spend is £5.19m, £0.92m against a cap of £4.27m; with further work planned to bring spend back in line with CAP.

There is a high level of focus from the system and NHS England to ensure pay run rates and WTEs are not increasing in year. The Trust is presently 59 wte below plan, and 70 wte down on March 2025.

Bank spend decreased in month by 8.8%. Rosewood MBU has decreased their temporary staffing usage as bed occupancy was lower in month, and Bridge House has also reduced bank usage as staff sickness reduced.

On Acute wards, levels of supernumerary staff have reduced, supporting a reduction in bank usage.

Agency spend in May totalled £0.49m which represents a 5.2% reduction on spend seen for the same period in 2024/25; and a 3.3% increase on spend in June.

- Medical agency WTE was 11.5 WTE in June, 8.0 WTE of which are in East Kent.
- Nursing agency increased 2.9 WTE in month. Of the Nursing agency utilised, approximately two thirds is supporting community teams covered by CMHF.
- HCA agency increased by 0.1 WTE to 10.4 WTE, the majority of theses relate to Acute Inpatient wards to cover additional observations. Golden key controls have now been implemented to NHS bookings to reduce, then eliminate, HCA agency usage.

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Capital Position

	Annual			In month			Year to Date		
	Plan	*Forecast*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
System Capital expenditure									
Capital Maintenance and Minor Schemes	4,164	4,364	200	337	797	460	764	984	220
Information Management and Technology	1,299	1,299	0	0	0	0	0	102	102
Section 136 development	3,462	3,462	0	0	17	17	0	137	137
Public Decarbonisation	200	0	(200)	0	0	0	0	0	0
IFRS 16 Leases	3,375	3,375	0	0	(16)	(16)	384	22	(362)
Total system expenditure	**12,500**	**12,500**	**0**	**337**	**798**	**461**	**1,148**	**1,245**	**97**
External expenditure									
Out of Area Placement (Female PICU)	3,940	3,940	0	0	5	5	0	5	5
PFI 2025/26	461	461	0	38	96	58	114	115	1
Public Decarbonisation	629	0	(629)	0	0	0	0	0	0
Estates Safety Fund	0	400	400	0	0	0	0	0	0
Total external expenditure	**5,030**	**4,801**	**(229)**	**38**	**101**	**63**	**114**	**120**	**6**
Total Capital Expenditure	**17,530**	**17,301**	**(229)**	**375**	**899**	**524**	**1,262**	**1,365**	**103**

As at 30th June the overall capital position is £0.10m ahead of plan. This is due to Estates and IT projects spend being higher than plan driven predominantly by Anti-ligature works on Acute and Forensic offset by IFRS 16 lease remeasurements which have not yet taken place.

A new lease for the pharmacy unit at Albion Place was planned for from April 2025 however it is not yet finalised, this is now anticipated to be completed later this year.

- A remeasurement in relation to the Disablement Service Centre (DSC) lease was also expected to take place but discussions regarding leasing arrangements are ongoing.

The forecast spend position is £17.30m which recognises the outcomes for the Public Sector Decarbonisation Funding of £0.63m and the Estates Safety Fund £0.40m bids.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 31st July 2025
Title of Paper:	Freedom to Speak Up Annual Report
Author:	Rebecca Crosbie, the Guardian Service
	(Cover sheet authored by Sheila Stenson, Chief Executive)
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

A paper updating the Board on the annual performance of the Freedom to Speak Up (FTSU) Guardian Service.

The appendix to this paper also sets out the recommendations from the guardian service and the actions that the Trust are taking in response to these recommendations.

Issues to bring to the Board's attention

During the period of 1st April 2024 to 31st March 2025, a total of 111 concerns were raised with the FTSU Guardian (FTSUG). There is no noticeable increase from the previous period. Of these 111, 93 have closed, 18 remain open and under regular review

The most prevalent themes were

- Management Issues 47%
- System and Process 59%

Cases relating to these two themes have increased year on year since 2022 within KMPT.

With regards to concerns raised within directorates, West Kent saw the highest percentage of staff raising concerns (5.17%), followed by East Kent (2.79%). The directorate with the most concerns raised was West Kent with 25.

The main reason for staff contacting GSL was because they felt they had raised matters internally, but feel that they have not been heard.

We are pleased to report that during this period there were no cases report to the Guardian relating to violent and aggression from patients towards staff, this is a positive reflection on the work being carried out within the trust on this. Another positive to note is that nationally 10% of cases were reported anonymously, in KMPT this is 3.6% showing that staff are more willing to share their identity with the Guardian Service or the Trust when raising their concerns.

Version Control: 01

Governance

Implications/Impact:	Trust Strategy: Growing our capability to deliver
Assurance:	Reasonable
Oversight:	Oversight by People Committee/Trust Board

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual Report
1st April 2024 to 31st March 2025

The Guardian Service
Here to listen

Circulation: Public Board

Main point of contact
Sheila Stenson
CEO and Exec Lead for FTSU

Prepared by:
Rebecca Crosbie
Guardian
The Guardian Service Ltd.

Date: 29th May 2025

The Guardian Service
Here to listen

Contents

1. Executive summary

During the 2024/25 reporting period 111 concerns were raised via the FTSU Guardian.

Of these 111 cases 82 (73%) were rated as green, general workplace concerns. 20 (18%) were rated as amber and 8 (7%) red. Red cases contain an element of patient safety or quality of care.

All cases that had been carried over from the previous reporting period (2023/24) have now closed. Of the 111 cases opened within this period 93 have closed and 18 remained open under regular review.

79% of cases had a verbal or written outcome. The remainder of cases either chose not to pursue or ceased contact with the Guardian.

57% of cases were escalated to the trust in some capacity. 43% of cases used the service for confidential, impartial support only.

The leading themes for this period were Management Issue and Systems and Process. 47% of cases had an element of Management Issue and 59% had an element of System and Process. Cases relating to these two top themes have increased year on year since 2022 within KMPT.

Nationally 20% of cases contain an element of other inappropriate behaviours or attitudes in the workplace. Within KMPT for this period it has been 47% of cases.

One in three cases nationally contain an element of worker safter/wellbeing. KMPT figures run at slightly less than one in three with 33 out of 111 cases having an element of worker safety/wellbeing and only 6 out of 111 having this as a primary theme. We have seen a year-on-year reduction in this as a primary theme since 2022.

During this period there were no cases reported to the Guardian relating to violence and aggression from patients towards staff. This is a positive reflection on the work being carried out within this space trust wide.

Nationally 10% of cases were reported anonymously but within KMPT this figure is only 3.6% showing that staff are more willing to share their identity with the Guardian or the trust when raising their concerns.

44% of staff raised concerns with the Guardian due to feeling they had not been listened to internally. 40% used the service due to its independence from the trust.

15% of staff raised concerns through fear of reprisal. This figure increased from 5% to 15% in the latter half of the period.

Recommendations for this period include consideration on whether the leadership and management training programmes will be mandatory for both new and current managers. In addition to explore a ‘you spoke up, we listened’ piece of communication using the action plan and lessons learned over the last three years using The Guardian Service. This should help reassure staff that speaking up impacts organisational change.

2. Purpose of the paper

The purpose of this paper is to give an overview of the cases raised at Kent and Medway NHS and Social Care Partnership Trust (KMPT) to the Freedom to Speak Up Guardian employed by The Guardian Service Limited (GSL) during the reporting year of 2024/25. This reporting period begins on 1st April 2024 and ends on 31st March 2025.

This paper does not include any data relating to cases raised internally and only those raised with the Guardian. This paper will not contain any identifiable information to ensure that confidentiality of those raising concerns is respected within national guidelines.

The main purpose of the annual report is to give an insight into the data arising from cases, themes and issues raised through the FTSUGs from 1st April 2024 to 31st March 2025. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include: Assessment of cases, Action taken to improve speaking-up culture, Recommendations.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Kent and Medway NHS and Social Care Partnership Trust (KMPT) on 6th June 2022.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

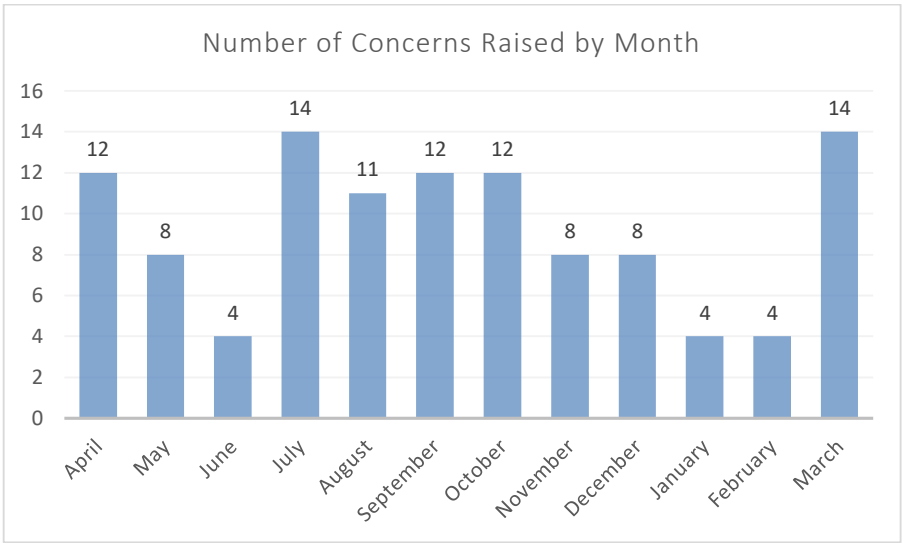
Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved, or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

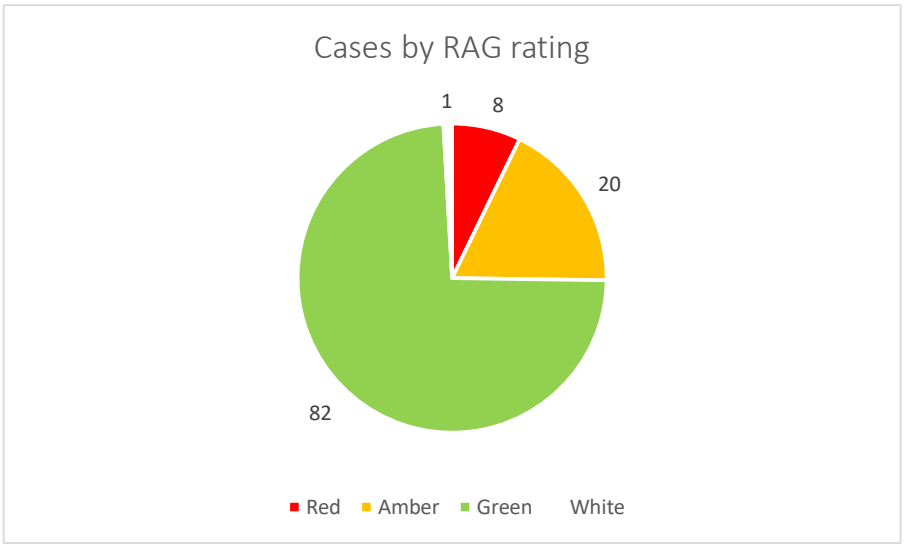
Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated later by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

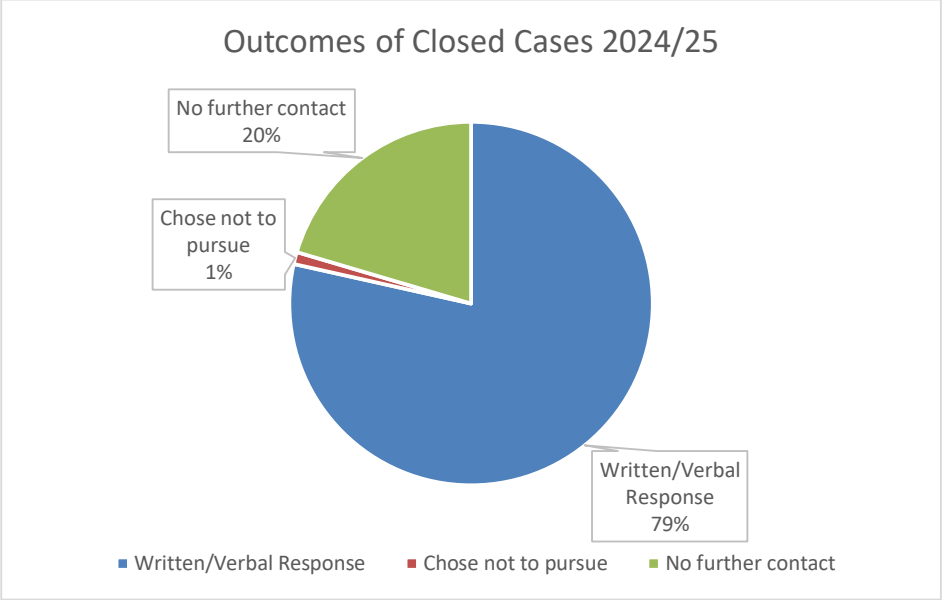
The reporting period for FTSU runs from 1st April to 31st March. For the 2024-25 period 111 cases were raised through The Guardian Service Ltd. This figure does not include any concerns raised internally, only those raised directly to the FTSU Guardian.

Of these 111 cases 82 (73%) were rated as green, general workplace grievances. 20 (18%) we rated as amber and 8 (7%) red. Red cases contain an element of patient safety or quality of care.





All cases that had been carried over from the previous reporting period (2023/24) have now closed. Of the 111 cases opened within this period 93 have closed and 18 remained open under regular review.



In cases where there is no further contact the Guardian will prompt a staff member at least twice and if no response they will close the case. In cases where the Guardian has escalated a case and a staff member ceases communicating with the Guardian, the Guardian will follow through on any remaining actions with the trust and record outcomes appropriately. Feedback will always be shared where possible.

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	48	43.24%
Permission to escalate with names	37	33.33%
Permission to escalate anonymously	4	3.60%
Permission to escalation without name	22	19.82%
Total	**111**	

Of the 111 cases raised with GSL 57% of them were escalated to the organisation either with or without disclosure of identity. 43% remained within the remit of the Guardian. In these cases, the Guardian often uses coaching and communication skills to empower an individual to manage their concern independently without escalation by the Guardian.

In some cases, staff may not wish to escalate due to fears or barriers. The themes or soft intelligence from these cases are shared with the organisation or directorate within monthly or quarterly meetings, working towards reassuring staff and removing barriers. This information is shared without breaking confidentiality.

9. Themes

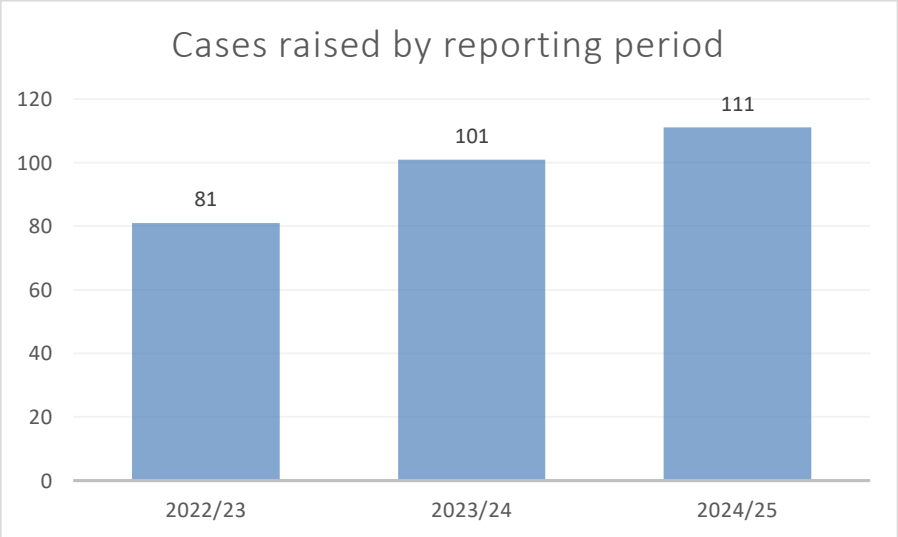
Concerns raised are broken down into the following categories;

Primary Theme	Total
A Patient Safety / Quality of Care	6
B Management Issue	**37**
C System Process	**36**

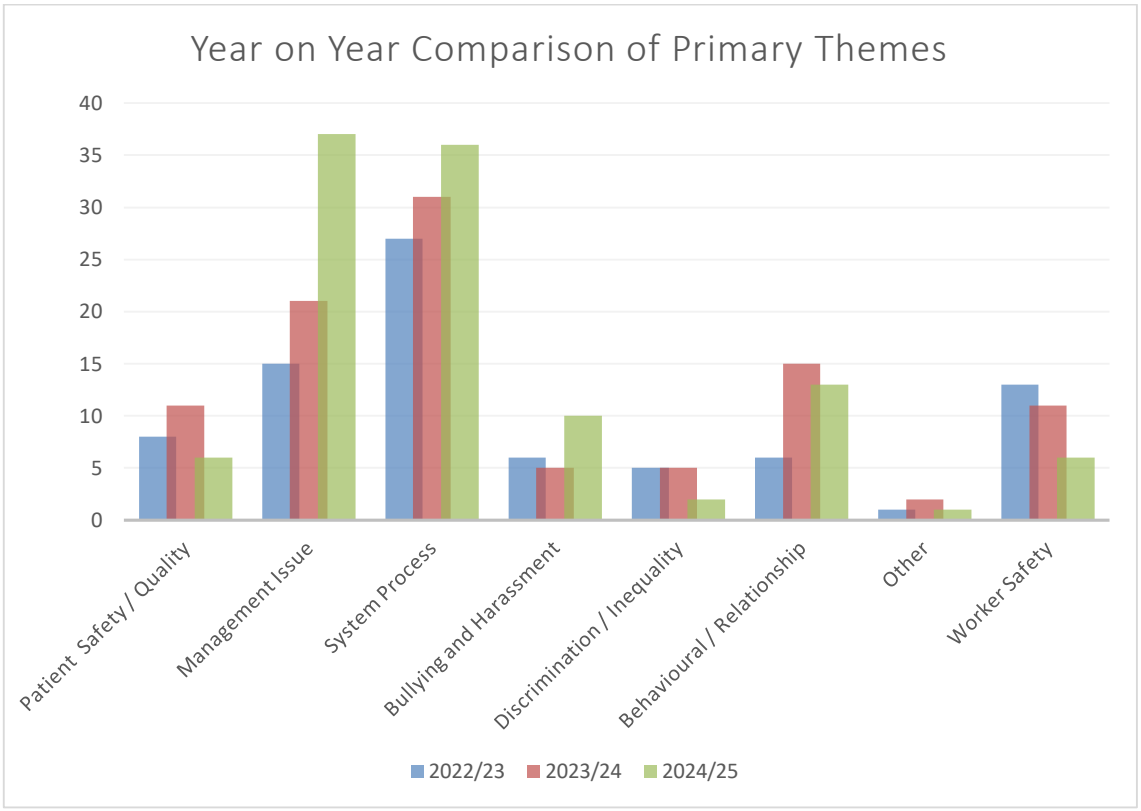
D Bullying and Harassment	10
E Discrimination / Inequality	2
F Behavioural / Relationship	13
G Other (Describe)	1
H Worker Safety	6
Grand Total	111

Multi Theme Occurrence	Total
A Patient Safety / Quality of Care	12
B Management Issue	**53**
C System Process	**66**
D Bullying and Harassment	19
E Discrimination / Inequality	8
F Behavioural / Relationship	**49**
G Other (Describe)	1
H Worker Safety	33

10. Trends in Cases



Please note that for the 2022/23 reporting period the service went live on 6th June, and this data does not include cases raised prior to that date making it slightly shorter than a full year reporting period. There has been a 10% increase in cases since the last reporting period. This increase is not to be seen as a negative and in addition to other factors can be due to a more open culture developing where more people feel able to speak up and share their concerns.



When comparing themes year on year we can see a sharp increase in cases relating to management issues within the last 12 months. We also see an increase year-on-year with cases relating to systems and processes in the workplace.

There is a year-on-year reduction in cases relating to a primary theme of worker safety or wellbeing, but it is important to note that this remains in the top four themes for multi theme occurrences. These cases usually relate to the impact of the concern on someone's overall wellbeing inclusive of work-related stress.

11. Benchmarking

The National Guardians Office (NGO) has determined that there is no direct correlation between the size of an organisation and the number of concerns raised. Data is now based on staff numbers per 1000. The comparisons below are based on the most recent available national data report from the NGO published in 2024.

When we look at national data we can see the following:

- One in three cases nationally contain an element of worker safter/wellbeing. KMPT figures run at slightly less than one in three with 33 out of 111 cases having an element of worker safety/wellbeing and only 6 out of 111 having this as a primary theme. This is a reduction on previous years.
- 19.8% of cases nationally have an element of bullying or harassment and within KMPT this figure is 21% with an increase in cases from the previous.
- Nationally 20% of cases contain an element of other inappropriate behaviours or attitudes in the workplace. Within KMPT for this period it has been 47% of cases.

- Nationally 10% of cases were reported anonymously but within KMPT this figure is 3.6% showing that staff are more will to share their identity with the Guardian or the trust when raising their concerns.

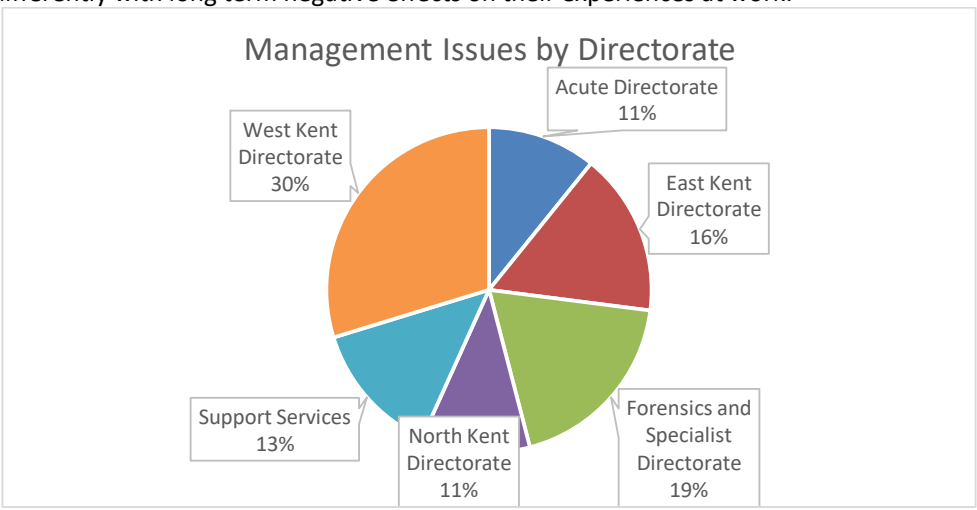
12. Assessment of Cases

Management Issue

When looking at multi theme occurrences 53 out of 111 concerns had an element of management issue.

The key perceptions and sub themes from concerns raised within the theme of 'Management Issues' are as follows with all cases reporting several of these sub themes to make up their concern.

- Inexperienced management – a perception that a manager hasn't been trained appropriately to effectively carry out their role and that this is having a negative impact on their ability to lead a team and/or service
- Poor leadership or communication styles – including micromanagement, a lack of compassionate leadership, unprofessional communication. Staff feeling that managers leadership and communication is not reflective of trust values
- Lack of effective communication – staff not receiving clear or regular messaging leading to a lack of clarity or stress in the workplace
- Abuse of power – a perception that managers can get away with certain behaviours or inaction due to their stature in the organisation
- Misuse of 1-1s or appraisals - staff not feeling these have been recorded accurately and that they are being used against them
- Management minimising or invalidating staff concerns – staff reporting that when they raise concerns directly to management that they are faced with a response which downplays their concerns. A feeling that it is put back on them rather than accountability at management level.
- Leading with a culture of blame or shame
- Poor visibility or a lack of capacity to lead due to work pressures
- Lack of objectivity – staff feeling that judgements are being made without due consideration for wider context or perspectives and that managers could be more objective
- Repercussions – staff feeling that if they speak up or challenge management that they are treated differently with long term negative effects on their experiences at work.



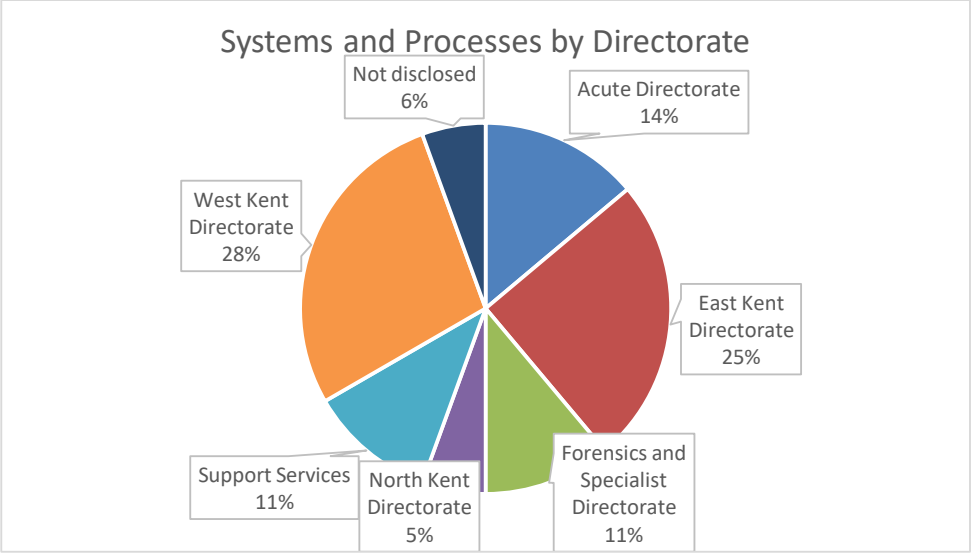
Systems/Processes

When looking at multi theme occurrences 66 out of 111 concerns had an element of System/process related concerns. When breaking this down into sub themes we see the following:

- The most prominent concern within this theme was staff experience of consultation processes, in particular relating to community-based services. Staff felt that pre-engagement was lacking and reported feeling that changes were being made to services and roles which was having negative impact on staff and patients/service users.

In addition to these we saw concerns relating to:

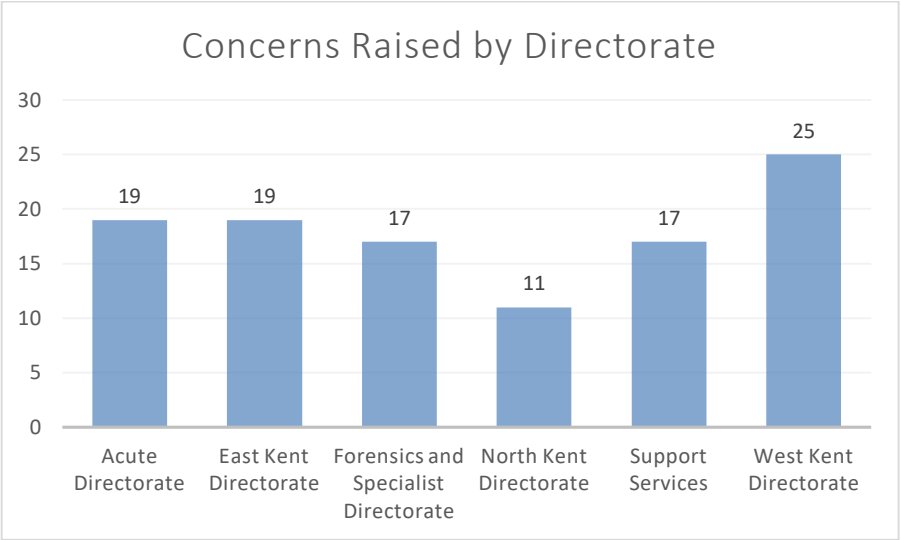
- Staff experience of the sickness review process or work-related stress risk assessment
- Staff reporting that they feel processes relating to investigations including grievances lacked dignity, compassion and insufficient ongoing communication and/or feedback.
- Staff reporting that managers are not following internal processes relating to reasonable adjustments or flexible working and managers reporting a lack of clarity around using these processes.
- Staff experience of probationary review processes including how things have been recorded, or a lack of information being recorded.



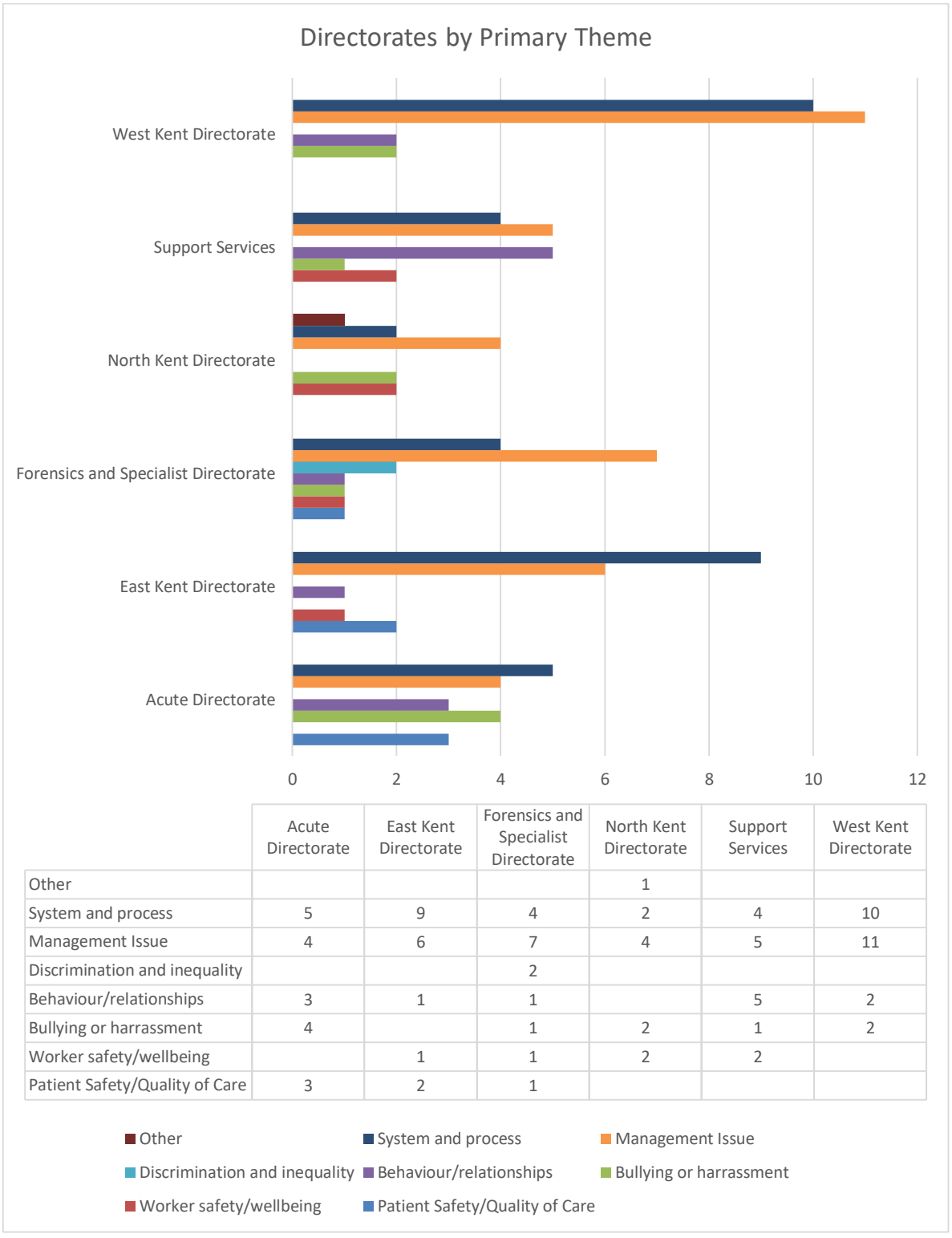
13. Statistical Graphs

Concerns raised by Directorate

When looking at concerns raised by directorate for the year the largest number of concerns raised in one area was within the West Kent Directorate. This also remains the highest when compared to the head count within that area. Having a higher number of concerns raised in one area can been seen as a sign of having a more open culture as people feel able to speak up and share their concerns. Lower numbers can often be seen in areas where people feel less comfortable speaking up or are part of a closed culture.



Directorate	Head Count	Concerns	
Acute Directorate	706	19	2.69%
East Kent Directorate	679	19	2.79%
Forensics and Specialist Directorate	748	17	2.27%
North Kent Directorate	507	11	2.16%
Support Services	900	17	1.88%
West Kent Directorate	483	25	5.17%



	Acute Directorate	East Kent Directorate	Forensics and Specialist Directorate	North Kent Directorate	Support Services	West Kent Directorate
Other				1		
System and process	5	9	4	2	4	10
Management Issue	4	6	7	4	5	11
Discrimination and inequality			2			
Behaviour/relationships	3	1	1		5	2
Bullying or harrassment	4		1	2	1	2
Worker safety/wellbeing		1	1	2	2	
Patient Safety/Quality of Care	3	2	1			

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Concerns raised by Location

Location	Head Count	Concerns	%
Dartford & Gravesham	777	12	1.54%
Sevenoaks **	23	8	34.78%
Tonbridge and Malling	27	1	3.70%
Maidstone	1201	31	2.58%
Tunbridge Wells	128	2	1.56%
Swale	124	0	0.00%
Ashford	115	4	3.47%
Canterbury	770	7	0.90%
Folkstone and Hythe	97	2	2.06%
Dover *	93	12	12.90%
Thanet	292	12	4.10%
Medway	336	10	2.97%
Unspecified	42		
Not disclosed		10	
Grand Total	**4025**	111	

*Work has been carried out within the location of Dover and there has now been a reduction in cases within this area. The East Kent directorate have had an open dialogue with the Guardian to ensure appropriate support and leadership is in place for staff throughout this period.

**There has been changes in leadership within services in this area of West Kent which has seen a reduction of concerns being raised. Some reflection has been suggested in this area around early resolution in supporting leadership behaviour/communication.

Concerns raised by Job Group

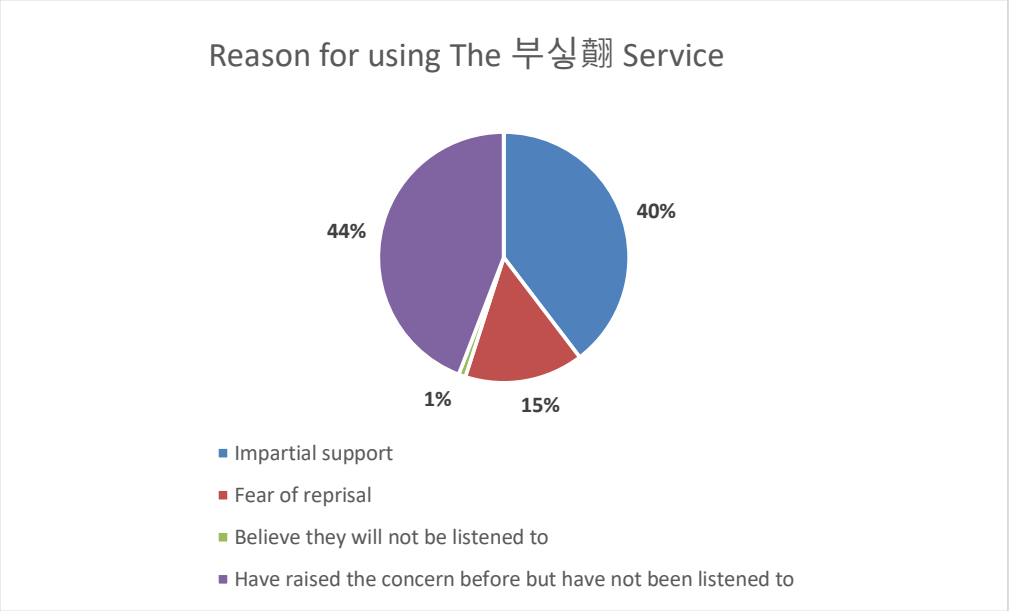
Job group	Head Count	Concerns	% of staff group
Add Prof Scientific and Technic	383	5	1.30%
Additional Clinical Services	975	26	2.66%
Administrative and Clerical	948	23	2.42%
Allied Health Professionals	247	10	4.04%
Estates and Ancillary	167	2	1.19%
Medical and Dental	242	8	3.30%
Nursing and Midwifery Registered	1062	29	2.73%
Students	unknown	2	
Not disclosed		6	
Misc	1		
Total	**4025**	**111**	

There has been in an increase in concerns from medical staffing who were previously a group less likely to speak up. This could be seen as confidence building towards a more open culture within this area. The Guardian has been trying to increase engagement in this area with attendance at medical education sessions.

14. Why do staff use The Guardian Service?

We continue to see the main reason for staff using The Guardian Service being that they feel they have already raised their concerns internally but do not feel heard. The second most popular reason for using the service is to receive impartial support due to the service being independent. Staff often use this to gain insight into the options and ways they may be able to address their concern independently and use the Guardian to support them to develop the confidence in doing so.

It is worth noting that in the latter part of this year there has been an increase from 5% to 15% in cases where the staff member has used the service due to fear of reprisal.



15. Detriment

In addition to the cases of detriment reported in the six-month report there has been a further two cases of perceived detriment in the latter part of the reporting period. Both cases came from the same service and both staff members resigned from post due to their experiences in the workplace.

As the staff are no longer with the organisation it has not been possible to investigate their claims of detriment in full, but the trust has carried out several formal investigations into the concerns raised and commissioned an independent review of the culture in this area. There have been several areas raised as learning and improvement and a plan is in place to support staff in this team going forward.

There is room for reflection around how earlier intervention can potentially reduce the likelihood of someone feeling that they have suffered a detriment and preventing their resignation.

16. Action taken to improve the Freedom to Speak Up Culture

The trust is engaging well with the FTSU Guardian to ensure feedback and learning is in place using the themes, data and recommendations provided by the Guardian. There is a live action plan in place which is being reviewed and added to based on the comments and recommendations within the FTSU six monthly and annual report.

In response to the data showing us that over 40% of cases raised with The Guardian Service are because of staff not feeling listened to internally the trust is now hosting regular HR drop-in sessions across all areas of the organisation. In addition to that some directorates have also hosted their own drop-in sessions or

listening events in areas which have become a hot spot for the Guardian. The CEO continues to host 'Speak to Sheila' listening events.

The FTSU Guardian ensures that they are up to date with all national training requirements and current affairs relating to the area of Speaking Up and organisational culture.

The trust has updated their values which now include being 'curious'. This hopes to empower colleagues and managers to be more curious to hear each other's perspectives and listen to staff concerns without judgement or recrimination.

17. Learning and Improvements

The Guardian and Deputy Chief People Officer have identified learning and improvements which relate to staff experience and feedback from concerns raised as follows:

There has been a reduction in worker safety/wellbeing cases year on year since service live date. Those cases within this theme are currently predominantly relating to work related stress. There have been no new cases relating to staff safety on the wards or due to abuse from patients within this period. This falls in line with the trust wide initiative around violence and aggression towards staff from patients.

Although cases relating to Management Issues are high and have increased year on year the trust has a robust plan in place for improvements in the next year. The launch of the new Leading Well Together programme for the senior leadership teams is due to commence and in addition to that there is the Management Foundations Programme. This should lead to improvements in leadership and management skills and culture over the next 3 years.

The trust has worked with the Trust Wide Health and Safety Committee to build a new stress risk assessment. The trust is requesting that once this is signed off that all consultation papers that go to JNF will include not only the equality impact assessment but also the risk assessment.

The trust is working hard to ensure that they are more empathic in their approach when taking colleagues through processes. KMPT have increased their Early Resolution cases over the last year so 45% of all cases are dealt with through this process. KMPT have also signed off a panel who will stand over suspension in the trust, this is to ensure that the trust only suspend when necessary and have considered all options before doing so. For instances where colleagues are suspended, the suspension checklist has been updated to include more welfare points that need to be considered to support people whilst concerns are investigated. This year coming KMPT will be launching Restorative Just Learning into the Trust, so they approach concerns from learning in the first.

As part of the Restorative Just Learning process KMPT are looking at the introduction of informal notes and impact statements, in addition gathering feedback following cases that have been investigated formally by the Investigation Team. The trust review lessons learnt every quarter and hold reflective sessions for managers involved in a process to understand what it is that could be done differently in certain cases where harm has been caused to a colleague at the request of the manager.

18. Comments & Recommendations

1. There is proactive work being undertaken to develop leadership and management within KMPT. With the new training due to commence consideration is urged to ensure that it is compulsory for new and current managers. If all those within a leadership or management role are enabled to engage in this training, it will improve the chances of this having a successful impact and create consistency across the organisation.
2. With the action plan now in place for recommendations relating to FTSU and the service having been live for three years in June 2025, there have been many learning and improvements

because of staff speaking up. The trust could benefit building confidence in staff speaking up by spending some time with the communications team to develop a *'you spoke up, we listened'* piece in response to some of the completed or ongoing actions within the action plan. This helps staff to see more tangible evidence to the positives of speaking up.

3. Review the NGO Board Reflection Tool in preparation for this to be completed again in early 2026.
4. To share formal confirmation with The Guardian Service communications lead around the trust change of name in order for service collateral to be updated.

Additional comments:

The Guardian will be updating the pre recorded FTSU section of the managers induction this summer with a more detailed presentation.

19. Staff Feedback

Q6. Given your experience would you speak up again?

- Rebecca was amazing and kept me fully updated throughout the whole process.
- The assistance and support I received at an extremely difficult time for me was invaluable, and that someone was prepared to listen was of major importance.
- Without hesitation. I feel this is a valuable service the Trust offers.
- Yes, although I feel the longer a Guardian is in place there is a possibility of COIs forming due to continued contact with management and relationships forming
- Approachable, prompt, professional, empathetic and all round lovely person to speak to
- Although guardian was very helpful and sympathetic my concerns weren't resolved.
- I would speak up again as Rebecca made me feel valued and heard.
- I couldn't have felt more supported and heard during a stressful situation. Rebecca was sensitive and professional.
- It was so helpful to know that I had support and my sessions with the Guardian encouraged feel happier within my work place

Q8. Any additional comments:

- I woudl like to thank Rebecca for her time, compassion and professionalism.
- In times of difficulty and feeling alone in tackling issues, the importance of this service cannot be stressed highly enough.
- Rebecca has been a great help and support during the whole process. I was able to talk through my concerns and the process. Guidance and feedback was given in a professional and confidential manner.
- The Guardian I spoke to was great.rnI know some colleagues will not raise concerns this way as they don't feel its totally confidential.rnThe Green Button was.
- I would like to thank Rebecca for being such a great help in my time of need. She made me feel valued and showed genuine concern. She is a credit to the service
- I'm pregnant and the issue addressed was related to pregnancy. It was dealt with so sensitively from the guardians end with intentions to reduce my stress.
- The Guardian that I spoke to has be so supportive and helped me with a difficult time that I was experiencing. I would highly recommend the service to everyone.

FTSU Action Plan 25/26 (July 2025 Update)

Area of Focus:	What has been highlighted:	Action Points:	Who:	Progress: On Track Yes/No	Date of Review:	Commentary
Management Leadership – Leading Well Together	There has been a number of concerns raised to the Guardian over the last year that had an element of 'management issues' such as poor communication; inexperienced managers; poor leadership style; visibility	• Our Leading Well Together Programme for senior leaders was launched in April 2025 and will run into Spring 2026. 33 delegates in total made up of our Trust Leadership Team.	OD/ TLT	Yes	End of 25/26	RAG – Program has started: (33 Cohort) • May Day 1 attendance: 30 complete • July Day 2 attendance: 30 booked • TBC Day 3 attendance:
Support for Managers Workplace incivility	To build on existing management programmes with consideration for focus on upskilling managers in compassionate leadership, communication skills and awareness, management style and impact, consistency and listening up. Support and training for middle managers to empower them to be able to inform and support teams through change, manage complex interpersonal relationships within teams and engage in difficult conversations. These are essential leadership skills which will support development of a positive workplace culture. Management and behavioural issues continue to be key themes within cases including incivility in the workplace. Consideration for a trust wide initiative into compassionate communication and respect. Inclusive of communication towards both patients, colleagues, and compassionate leadership skills.	• 6 new online workshops are being created for all to access at KMPT. ○ Acting with Compassion ○ Living the KMPT values ○ Professional Impact ○ Developing Self ○ Understanding myself & others ○ Managing myself through Change • A new behavioural framework has been developed for managers and leaders. Further Support:	OD	Yes	On-going review	RAG – AMBER All workshops are live now Work here needs to be re-focused on operational leaders to really maximise the results and drive improved culture and grow capability as this is where a proportion of issues are manifesting. The framework we were planning to release is now under review due to the announcement in early 2025 of a new NHS shared management and leadership competency framework. As of 15/7/25 (latest update by Gill Rooke) the framework is in the final stages of being finalised and planned to launch Autumn 2025. We continue to run in-person induction and have launched 2 new

		• New manager Induction – in person and online • Manager Foundations – will include workshops such as; Creating healthy Teams, Handling difficult conversations, Management skills and Performance management. Online and self-guided learning are also included. These will help give managers the skills needed and set the standard of best practice in line with our trust values and behaviour framework. • Mary Seacole Programme – we are currently training 6 facilitators to deliver this programme for KMPT				course – Creating Healthy Teams - Performance, Creating Healthy Teams – Culture. Work on a Performance Management course is due to start and be co-delivered between OD and ER. 2 X Mary Seacole cohorts have been launched and will run up until late Autumn. The leadership Academy local licensing is under review so we are not yet clear as to the future provision of the programme. Our Leading Well Together Programme for senior leaders was launched in April 2025 and will run into Spring 2026. 33 delegates in total made up of our Trust Leadership Team.
Whistleblowing and detriment	To review how the trust records and supports those who have made a protected disclosure and to investigate reports of detriment.	• Review of cases that claim to suffer detriment	Employee Relations/ Patient Safety/ Safe guarding/ IG	Yes	On-going when cases are reported.	RAG – AMBER
Consistency of formal processes	A recurrent theme within cases has been a lack of consistency across formal processes – this includes timeframes, practice, and feedback delivery. Although there is the new central investigations team in post there will still be processes which fall outside of this team. Consideration to explore how consistency can be achieved and maintained across internal processes is recommended.	• All cases have a process to follow, start of case meeting; investigation; end of case meeting; outcome meeting	Employee Relations	Yes	September 2024	RAG – AMBER Still need to set process up in medical, all other cases are managed the same way since March 24

Stress Risk Assessment	**Colleagues find this meaningful and managers have the tools to understand how to use it**	• **Review of current stress risk assessment** • **Update process within the absence management process** • **Build stress toolkit for organisational change**	**HR Advisors, HR Officers, H&S Committee**	**Yes**	**Sept 2025**	**RAG – AMBER** **Absence policy being reviewed as part of EDI focus area 4 which will include a manager guide.** **Trust H&S committee are working on a stress health check broken down by directorate to be completed with any organisational change, this is now complete.**
Communication	**Raising the profile of FTSU to improve confidence in the service and promote actions taken by Trust from listening and learning from feedback**	• **Build a communication plan with the comms team** • **Utilise Staffroom**	**Guardian/ Comms Team**	**NA – Added Jul 2025**	**Sept 2025**	**RAG – NA**
Board Reflection Tool	**Complete Board reflection tool before January 2026**	• **Reflection planned for October 2025**	**Sheila**	**NA – Added Jul 2025**	**Nov 2025**	**RAG - NA**

Area of Focus:	What we are doing:	Outputs:
Handling concerns relating to Medical Staffing	• Training for 21 people on 3rd 4th Feb • Post Survey around training and confidence in process • Fortnightly DMU making a difference on decision making	• Post Training survey to ascertain confidence of the process • New cases to be supported by the investigation team
Communication around Organisational Change and transformation	• KOTTER Model • In Time Training • Post Change Surveys	• Feedback surveys completed already for Transformation, Nursing, Digital Changes and consultation process updated as a result • New consultation template put in place • KOTTER model to be included in leadership training • Continue to gather feedback post further organisational change • Introduce a Stress Risk assessment
Support for Managers Workplace incivility	• 4 out of 6 on-line workshops launched Sept 2024 • Acting with compassion being written • Living the values (post values launch) • Managers Induction launched Sept 2024 • Senior Leadership Programme procurement • Mary Seacole training	• 16 sessions already taken place – 135 delegates attended • Review post course feedback • Managers induction running once a month on-going, 40 managers attended so far • ICB have approved the external leadership program • 6 trainers trained on Mary Seacole. March 2025 2 Cohorts will run (15 per cohort)
Whistleblowing and detriment	• Feedback from Whistle Blowers – concerns handled etc • Is it covered in policy	• Where person is known then seek feedback after allegations have been investigated as well as giving outcomes of allegations • Update policy to include process for whistleblowing, how to raise concerns, what will happen signpost from FTSU policy
Early Resolution Policy	• Merseycare Restorative Just Learning Culture • Number of Early Res cases Vs Formal process	• Deputy Chief People Officer and Senior Investigator trained on Merseycare Restorative Just Learning Culture (Nov 2024) • Build plan to launch process into KMPT by end of 25/26 • Sept 2023 – March 2024 26% (18) cases resolved through Early Resolution • April 2024 – December 2024 50% (57) cases resolved through Early Resolution
Work related stress and Pastoral Support	• Updated stress risk assessment • FTSU Check-ins with her cases and feeds back	• Complete updated Trust Risk assessment and agree at Trust Wide Health & Safety committee (Jan 25) • FTSU to feedback any concerns to help reduce stress regarding processes
Consistency of formal processes	• FTSU to report back	• FTSU to feedback regarding processes so that these can be addressed and added to lessons learnt
Follow Up training for senior leaders	• Review of mandatory training to take place	• Waiting for Nursing to complete review of mandatory training • New NHSE guidelines have been issued on Mandatory training this will need to be reviewed
Board reflection and planning tool	• Planned for Board in October 2025	
Addressing Concerns	• When are the HR Drop-In Sessions	• Colleagues raising concerns: ○ 3 Jasmine Ward around Culture

		• Virtual drop-in sessions running in all directorates • Face to face drop-in sessions detailed in additional calendar below ○ Support services/ East/ North Directorates to arrange Face to Face Sessions

Board reflection and action planning tool high level actions to be completed again in October 2025

High Level Action:	Actions:	Progress:
Principle 1: Value speaking up **For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.**		
Formalise a regular review of FTSU arrangements	Current procurement process has started, will need to embed regular review	Amber
The ability for managers to move faster with communication and action when a member of staff speaks up to our Guardian.	Regular meetings with each Service Director and HR Business Partner in Place Regular meetings with Senior Leaders such as CEO; CPO are in place Dialogue open outside of this process Infographic designed and shared with Directorate leadership teams	Green
Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture **Role-modelling by leaders is essential to set the cultural tone of the organisation.**		
Embedding greater consistency around senior leaders addressing rather than delegating concerns	Feedback from FTSU Guardian will say we still have work to do in certain directorates with repeat issues/concerns being raised and not dealt with. On-going concerns with managers ability to deal with concerns when they are raised	Amber
More explicit messaging around not accepting detriment, including in language used in policies	All policies have been updated	Amber
Deliver joint plans around improvement culture and addressing concerns (ensuring these plans contain sufficient detail)	FTSU Guardian is working with Deputy Chief People Officer to embed learnings and address concerns/themes FTSU Guardian to be involved in the launch of restorative just learning	Amber
Define and deliver plan around just and learning culture	Training has been attended, plan needs to be built	Red
Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so **Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.**		
Communications plan to be developed to support Freedom to Speak Up and Just and Learning plan	FTSU Guardian has a communication plan, this has been impacted this year (24/25) with capacity in comms and the launch of Staffroom	Amber

Principle 4: When someone speaks up, thank them, listen and follow up **Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.**		
Add into local induction handbook	Local handbook not updated to include, FTSU guardian joins induction	Green
Sharing positive stories and case studies of improvements which have started with speaking up	Work to be done on this	Red
Summary of expectations around responses from managers, expectations in terms of timeframes, and guidance to be circulated alongside request for response	New Terms of reference for cases in place FTSU Guardian to be clear on what she needs when raising concerns (i.e. feedback to close down cases instead of having to chase)	Green
Principle 5: Use speaking up as an opportunity to learn and improve **The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.**		
Regularly bring together multidisciplinary group to reflect on concerns raised and lessons learned	This has not been put in place	Amber
Identify specific areas where freedom to speak up is of concern, and follow up on these	These are raised with Directorates however seeing repeat concerns still being raised	Amber
Build learning from this self-assessment into KMPT's FTSU workplan for next year	FTSU Action plan is a live working document taken from the Board report in July 2024	Green
Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements		
Guidance and expectations of managers in speaking up cases to be circulated alongside requests, including in relation to timeframes, content of responses and managing confidentiality	Discuss with FTSU Guardian and look at introducing a template for FTSU Guardian to use to ensure concerns are addressed and appropriate action taken	Red
Improvement/Freedom to Speak Up work to focus on local teams	FTSU Guardian regular visits across the Trust and specific hot spots	Green
Principle 7: Identify and tackle barriers to speaking up **However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.**		
Re-engage FTSU champions	Was discussed and not pursued, needs to be re-energised	Red
As part of 2024-25 FTSU work plan, establish a process for seeking feedback from individuals who have spoken up upon closure of their case, and three months subsequently	Feedback surveys are in place as well as case reviews / lessons learnt	Green
Principle 8: Continually improve our speaking up culture **Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.**		
Plan around Freedom to Speak Up to be developed (including communications plan)	New plan needs to be developed	Red
Ensure PDSA cycle is overtly captured in evaluation plans	As above	Red

Items closed from previous Plans continue to be reviewed: (24/25)

Area of Focus:	What has been highlighted:	Action Points:	Who:	Progress: On Track Yes/No	Date of Review:	Commentary
Handling concerns relating to Medical Staffing	Consideration to review processes and responsiveness for the handling of concerns relating to medical staffing. To ensure that action is taken within reasonable timeframes and that there is no disparity between the handling of medical and non-medical staffing concerns.	• Full review of the DMU Process • Additional colleagues trained to undertake investigations in MHPS • Continually learnings to be shared as part of the CD and HoP CPD days	Afifa; Mohan; Marne; Jacqui	Yes	On-going	RAG – Green Review of DMU has taken place, fortnightly DMU put in place from January; MHPS Policy re-written to include flowcharts going to LNC in Dec 24; Training completed in Feb 25 for 21 people now trained in MHPS.
Addressing Concerns	Colleagues feel that when they raise concerns with managers they are not heard or dealt with properly.	• Hold monthly HR Clinics for colleagues to come and address concerns that they have, ask questions and give feedback	HRBP's, HR Advisors, HR Officers	Yes	To be in place by Sept 2024	RAG – GREEN All HR Clinics set up in place across all directorates including Support Services
Work related stress and Pastoral Support	Feedback from cases has been that individuals don't feel supported when they experience work related stress, with their perception being that the trust does not fully explore what led to the stress to mitigate any future experience. Recommendation to review processes for supporting staff with work related stress including monitoring of situations leading to work related stress to mitigate sickness absence and resignation. Pastoral support has been raised as a recurring theme within cases. It is a recommendation to ensure sufficient resources and clear expectations for pastoral support for those	• New Pastoral support guide has been built • Pastoral support and line management support to be separate people • Review the Staff Support policy	Employee Relations	Yes	August 2024	RAG – GREEN All actions completed Pastoral support guide in place, Staff Support Policy has been reworked an due at TLT on 4th Dec

	undergoing a formal process or those on long term sickness absence due to work related stress.					
Early Resolution Policy	Since being published it has been reported that there has been a lack of communication and training around the new policy. For this policy to become effective and for those who engage it to have a positive experience it is a recommendation that the trust prioritise a communication and training initiative around this to ensure consistent use of the policy and best practice.	• Relaunch Policy in July 2024 • Include Just learning Culture into Early Resolution Policy • Manager Training in: ○ Investigations ○ Disciplinary & Grievance ○ Absence Management	Marne/ Employee Relations	Yes	August 2024	RAG – GREEN Policy relaunched and just learning now taking place to assess if case needs to progress formally or we can learn from situations. Training is now taking place across the trust since July: Investigation & Disciplinary – 24 Grievance – 14 Absence - 14
Whistleblowing and detriment	To review how the trust records and supports those who have made a protected disclosure and to investigate reports of detriment.	• Case management system to be used to record Whistleblowing • Better joined up approach to investigate and follow up on concerns raised and closed down accordingly	Employee Relations/ Patient Safety/ Safe guarding/ IG	Yes	September 2024	RAG – GREEN Case calls now taking place with all concerned parties when needed to discuss and agree how to handle cases
Communication around Organisational Change and transformation	Consideration to review the communication around organisational change and the support offered to teams going through transformation. Feedback from teams and managers has been that they don't feel informed and when asking for further information report not feeling heard.	• Feedback from Organisational Change to be gathered • Review feedback and ensure builds are implemented into Future plans	Marne/ HRBPs	Yes	As required As identified	RAG – GREEN • Surveys completed post organisational restructures • Consultation Pack updated and being reviewed by Staff Side. • Working on HSE Stress Toolkit survey to implement, will test post CMHT+ launch August 25 HRBPs to take this forward A toolkit for managers to use with staff ahead of change has been developed and is available on iLearn

The following has been removed due to the continuing review of Statutory and Mandatory Training commissioned by NHSE will re-address possibility of introducing when this work has been completed:

Area of Focus:	What has been highlighted:	Action Points:	Who:	Progress: On Track Yes/No	Date of Review:	Commentary
Follow Up training for senior leaders	To consider making the NHSE Follow Up FTSU training for senior leaders mandatory to promote all elements of the speaking up experience and process within KMPT.	• Launch module 3 of the FTSU training incorporating Follow Up • Ensure that all Top 100 leaders complete the course	FTSU Guardian/ L&D	No	To be actioned when a full review of mandatory training has taken place this year (2024). To be signed off by CEO.	RAG – RED Not been actioned as still waiting for mandatory training review, sitting with nursing currently however also had a NHSE review so will also need to be considered. Do feel we should launch this it is only 20mins and we already do speak up and listen up

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 2025
Title of Paper:	Refreshed KMPT Net Zero Green Plan 2025-2028
Author:	Sirina Blankson, Head of Sustainability, Environment & EFM Compliance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Approval
Submission to Committee:	Statutory

Overview of Paper

This paper has been produced in response to a statutory requirement for all Trusts to produce a refreshed Green Plan 2025-2028 by August 2025.

It sets out key actions the Trust will take to deliver emissions reductions and support resilience to climate impacts over the next three years.

The Green Plan also prioritises interventions that support the improvement of patient care and population health.

The report focuses on the current position, intended changes and the impact of the changes across the four themes; covering, embedding sustainability, direct emissions, travel and partnership working.

Issues to bring to the Committee's attention

The Green Plan continues to deliver the following benefits;

- Ensuring Compliance with all relevant statutory regulation on Climate Change
- Deliver on NHS Long Term Plan
- Expected efficiency and Carbon savings over the years.
- Improving the health of the local community
- Sustaining and improving patient care

Governance

Implications/Impact:	The implementation of the Green Plan will ensure compliance in meeting our Net zero targets
Risk recorded on:	Inphase
Risk IDs:	Climate Change Risk 00002097
Assurance/Oversight:	Oversight by Finance & Performance Committee

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KMPT Green Plan 2025-2028: Board Summary

1.0 Overview of the Refreshed Green Plan

The Refreshed KMPT Net Zero Green Plan 2025-2028 builds on the Trust's commitment to achieving Net Zero by 2040 aligning with NHS statutory requirements and the Long-Term Plan. The updated plan expands from ten to fifteen focus areas (as per NHS England Guidance) across four themes:

- **Theme 1: Embedding Sustainability** - (Net Zero Clinical Transformation, Workforce and Leadership, Digital Transformation)
- **Theme 2: Direct Emissions** - (Waste, Carbon Emissions, Estates & Facilities, Medicines)
- **Theme 3: Travel** (Fleet, Business Travel and patient Travel)
- **Theme 4: Partnership Working** (Procurement, Adaptation, Green Space, Food, Capital Projects)

2.0 Key Changes

The key changes introduce the new focus areas such as Net Zero Clinical Transformation and Climate Adaptation which will help to address emerging risks and opportunities within these areas through our operations and services.

It also provides clearer targets and alignment with the Trust's Strategic Ambitions as well as enhanced collaboration across departments and and external partners.

3.0 Year 1 Priorities: What This Means on the Ground

Table below shows the 5 agreed Year 1 priorities translate into tangible actions and deliverables.

Priority	On-the-Ground Actions	Deliverables & Link to Impact
1. Waste Management	Improve waste segregation (20:20:60 targets by 2026). Reduce single-use plastics	70% clinical waste diverted from incineration by 2026 Cost savings and reduced Scope 3 emissions
2. Climate Adaptation	Assess climate risks to estates/services Update business continuity plans	Resilient services amid extreme weather Reduced financial risks from climate disruptions
3. Net Zero Clinical Transformation	Review care models (e.g. telehealth / Patient Portal). Optimize clinical pathways	Lower patient travel emissions Aligns with NHS Net Zero Clinical Care targets
4. Estates & Facilities	Replace fossil fuel heating. Install additional solar panels	60% energy emissions reduction by 2028 Compliance with NHS decarbonization mandates

5. Green Spaces & Biodiversity	Create accessible green spaces Plant native species	Improved staff/patient wellbeing Enhanced biodiversity and community health

4.0 Impact of Changes: Strategies for the Next Three Years

The refreshed plan's fifteen focus areas will drive measurable progress through:

Environmental Impact
- Energy: Phase out fossil fuels and expand renewables (e.g. solar).
- Waste: Achieve 70% clinical waste diversion by 2026.
- Water: Reduce usage by 30% by 2028.

Operational & Financial Benefits
- Cost savings: From energy efficiency and waste reduction.
- Compliance: Meet NHS ERIC reporting and TCFD disclosure requirements.

Health & Community Benefits
- Health inequalities: Target emissions reductions in deprived areas e.g. Clean air campaigns / Green Spaces
- Staff engagement: Green Ambassadors program and training to foster ownership.

5.0 Key Strategies for 2025-2028

The key strategies adopted to ensure compliance and proper implementation of the Green Plan include the following:
- **Funding**: Secure finance for low-carbon estate upgrades.
- **Governance**: Quarterly progress reports to the Board.
- **Partnerships**: Collaborate with ICS, system partners and local authorities on sustainability projects.

6.0 Next Steps

- Board approval required for implementation by 31 July 2025
  - Adoption of the Green Plan 2025-2028 as the Trusts roadmap to Net Zero
  - Endorsement of 15 focus areas (grouped under 4 themes)
  - Annual prioritisation (e.g. 5 focus areas in 2025/26).

- **Immediate Actions**: Roadshows, staff training and Green Plan integration into departmental objectives.

- **Mid - Long-Term**: Align capital projects (e.g. estate upgrades) with Net Zero targets.

7.0 Conclusion

The refreshed Green Plan ensures KMPT remains a leader in sustainable healthcare, delivering environmental, financial and health benefits while mitigating climate-related risks.

The full green plan is provided in the meeting reading room, and if approved will be published on the Trust's website.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st July 2025
Title of Paper:	Review of Committee Terms of Reference
Author:	Tony Saroy, Trust Secretary
Executive Director:	N/A

Purpose of Paper

Purpose:	Approval
Submission to Board:	Standing Order/Regulatory Requirement

Overview of Paper

The Board is asked to approve the changes to Committee Terms of Reference proposed by the Committees.

Issues to bring to the Board's attention

The Board Committees have completed reviews of their respective adjusted Terms of References and as a result of these reviews are proposing some changes to their Terms of Reference for Board approval. Where Committees have requested changes, these are highlighted in the attached paper.

Copies of the Committee Terms of Reference are available on the Board Reading Room on Diligent for Board members.

Governance

Implications/Impact:	Maintenance of sound governance systems
Assurance:	Significant
Oversight:	Trust Board

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Committee Terms of Reference

1 Context

In order to fulfil its statutory duties and responsibilities, the Trust Board has established Committees. The Board Committees are an essential part of the overall governance structure and provide the Board with assurance and scrutiny in the areas delegated to them by the Board. These responsibilities are defined in the Committees' Terms of Reference and only the Trust Board can approve any changes to these.

In accordance with best practice, and to ensure the Board Committees continued to deliver the assurance and scrutiny required by the Board in response to internal and external changes within the Trust's operating environment, the Terms of Reference are reviewed on an annual basis, or sooner if required.

To maintain efficient use of the Board's time, a *de minimis* clause be proposed for each of the Committee's Terms of Reference, to enable minor non-material / 'housekeeping' changes to be adopted (e.g. changes in job titles), without the requiring formal approval by the Board.

Clean copies of the new Terms of References have been uploaded to the Diligent Reading Room.

2 Proposed Changes for Approval

1 Quality Committee

The Quality Committee Terms of Reference were amended to reflect changes within the Quality Improvement Function and ensure alignment of the terminology utilised with the Patient Safety and Incident Response Framework. The use of language related to social care was removed, to better reflect the services delivered by the Trust. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

2 People Committee

The People Committee seeks to change its membership to include the Chief Medical Officer, to ensure there is sufficient input from all staffing groups. The Committee also seeks to amend its quorum requirements to enable these to remain balanced and achievable. The language within the People Committee's Terms of Reference has been aligned with the People agenda and the reporting requirements have been expanded to reflect statutory requirements. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

3 Mental Health Act Committee

The Mental Health Act Committee Terms of Reference received a number of minor 'housekeeping' adjustments to the language within the terms of reference to reflect changes in terminology and functions at the Trust.

4 Finance and Performance Committee

The Finance and Performance Committee Terms of Reference were adjusted to more explicitly outline the Committee's role in relation to the annual 'going concern' assurance process and to amend the roles and responsibilities related to Clinical Technology and Informatics to ensure oversight of the Trust's Digital Plan. The Committee's focus in relation to assurance and risk was enhanced. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

5 Conclusion and Recommendation

It is recommended that the Board approve the changes proposed by the individual committees following their annual reviews.

The annual reviews of the Audit and Risk Committee and Charitable Funds Committee Terms of Reference are scheduled for Quarter 3 of 2025/26, and any proposed amendments will subsequently be submitted to the Board, for approval.

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31st July 2025**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Andy Cruickshank, Chief Nurse**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
	• Quality Digest • Violence and Aggression / Restrictive Practice Report • Annual Controlled Drug Report • Quality Impact Assessments • Mortality Report • Complaints Report • Safeguarding Annual Report	• Chief Nurse's Report • Quality Risk Register • CQC Report • Review of Terms of Reference

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse Report:	Following the CQC inspection, the Committee received a further update on the progress which had been made to address the recommendations and the discussions which had been held with the CQC regarding the short, medium and long-term programmes of work. The Committee noted the impact of health inequalities on the use of detention and restriction, with assurance provided that a holistic approach to addressing health inequalities had been commissioned.	**Reasonable Assurance**	The Committee requested that discussions be held with Sussex Partnership NHS Foundation Trust (SPFT) to explore the lessons learned regarding the adjustment which had been made to improve patient outcomes for patients with suspected, or confirmed, diagnosis of autism. The committee asked that work on health inequalities be linked up with other related work.
Quality Risk Register	The Committee received assurance regarding the measures aimed at risks connected to: a) High demand and waiting lists for Memory and Dementia assessment b) The boundary fence within the Trevor Gibbons Unit The Committee noted the further assurance which was required in relation to long-standing risks and the importance of ensuring the risk register reflected a 'live' position.	**Limited Assurance**	The Committee commended the reduction in the number of poorly controlled risks; however, requested the addition of a new risk associated with the impact of health inequalities on patient outcomes be considered.
Safeguarding Annual Report	The Committee commended the quality of the report and the candour of the recommendations which had been provided. The Committee emphasised the importance of future-proofing the Safeguarding Team, whilst	**Reasonable assurance**	Concerns were expressed regarding the continuation of external funding for the Independent Domestic Abuse Advocates; however, the importance of the role was recognised and if indications were received

	acknowledging the need to explore what, if any, efficiencies could be found, including any administrative aspects that could be streamlined or automated via Artificial Intelligence.		that funding would be withdrawn the matter would be considered further.
Complaints Report	The Committee noted the further work which was required to achieve 95% performance against the 20-day response time target; and recommended that benchmarking be conducted against an equivalent Trust to provide more comprehensive understanding of the Trust's performance.	**Reasonable Assurance**	The Committee emphasised the importance of acknowledging the compliments which had been received from patients as well as the opportunities for learning, and renaming the report to reflect this.
Terms of Reference	The Committee reviewed and recommended amendments to its Terms of Reference as part of the annual review process.	**Reasonable Assurance**	The proposed amendments have been submitted to the Board, under a separate item, for approval
The chair noted that the Committee had been heavily focused on safety, particularly during the implementation of the Patient Safety Incident Response Framework (PSIRF). It was important going forward to ensure equal balance of focus on healthcare outcomes (including physical health) and patient experience. The chair was also considering how best to ensure the clinical voice from directorates was fully represented in Committee discussions.			

Title of Meeting	**Public Board Meeting**
Meeting Date	**31st July 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 • Deep Dive – Health and Wellbeing • Statutory and Mandatory Training Streamline work • Medical Recruitment and Pipeline • Freedom to Speak Up • Guardian of Safe Working Hours Report	• Female Psychiatric Intensive Care Unit Workforce Model and Recruitment Plan	• HR Policies and Procedures

Agenda Items by Exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
People Risk Register	The Committee reviewed the Trust's People risks and noted that further work is underway to embed risk appetite at board level. The register remains a live document, and updates continue to be made as the organisation refines its approach to risk evaluation. The Committee emphasised the importance of clear ownership for all corporate risks and projects.	**Reasonable Assurance**	Advise Next steps: Oversight committees are asked to review risks within their areas and ensure robust accountability is in place for all key programmes and mitigations.
Female Psychiatric Intensive Care Unit (FPICU) Workforce Model and Recruitment Plan	The Committee received an update on the development of the FPICU. A clinically led and co-produced workforce model has been agreed, with recruitment planned to ensure all staff are in post by January 2026 ahead of the service opening in April 2026. A comprehensive recruitment plan is in place, supported by a dedicated Task & Finish Group, with staggered advertising and onboarding schedule beginning from August 2025.	**Limited Assurance**	Alert Key points for assurance and action: • The Committee noted a potential financial risk if recruitment targets are not met, which could lead to agency usage or delays in service mobilisation. • The Board is asked to note the current assurance level and tight delivery timeline. • Any escalated or emerging risks will be brought back to the September 2025 meeting for review.

Deep Dive – Health and Wellbeing	The Committee received an update on a new pilot offering up to four clinical psychology sessions for staff impacted by trauma, stress, or workplace assault. The aim is to provide early, targeted support, reduce sickness absence, and improve staff experience, recovery and retention.	**Reasonable Assurance**	Advise The Committee fully supported the pilot, noting its alignment with national priorities and potential benefit if adapted by other providers across the system.
Guardian of Safe Working Hours	The Committee received assurance from the quarterly Guardian of Safe Working Hours report covering February–April 2025.	**Reasonable Assurance**	Assure The Guardian continues to work with Medical Staffing to prepare for the implementation of national exception reporting reforms, due by 12th September 2025.
Freedom to Speak Up Independent guardian report	During 2024/25, 111 concerns were raised via the service, with 57% escalated to the Trust. The main themes were Management Issues and Systems and Processes, both of which have shown year-on-year increases. The report highlights positively that no cases involved violence or aggression from patients toward staff and that the trust rate of anonymous reports remains low (3.6%), suggesting greater staff trust in KMPT.	**Reasonable Assurance**	Advise The Committee was assured by the ongoing efforts to foster a culture of safety and responsiveness. It recommends to the Board that the conclusions in the paper are progressed. In particular sharing the themes and actions.
The Committee reviewed and recommended amendments to its Terms of Reference as part of the annual review process. The proposed amendments, which incorporate additional feedback from the Committee, have been submitted to the Board, under a separate item, for approval.			

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31st July 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**
	• Mental Health Act Bill and Legislative Changes • Chief Medical Officer's Report • Report from MHLOG & MHLOG Attendance List • Serious incidents with a Mental Health Act Element • Mental Health Act Activity Data Quarterly Report • CQC Mental Health Act Reviews • Bi-annual CTO Lapses report • Bi-Annual DoLs Audit Report • Section 136 practices and breaches • Health Inequalities • MHA/MCA training	

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	The Committee received an update on Mental Health Act developments, including the appointment of a Clinical Lead for the Place of Safety and actions taken to address CQC concerns around 24-hour detentions. Training on the draft Mental Health Act bill was well attended, with clinicians expressing both interest and concern regarding the potential impact on clinical time.	**Reasonable assurance**	An awareness session on the New Mental Health Act Developments at a future Board Seminar is to be arranged for all Board Members.
Chief Medical Officer's Report	Staffing within the MHA Administration team has improved following recruitment; however, some vacancies are still open, and the department remains under pressure due to reduced expertise. Community Treatment Orders continue to be well managed, with low lapse rates assuring appropriate oversight.	**Limited assurance**	
Mental Health Act Activity Data Quarterly Report	The Mental Health Legislation Operational Group (MHLOG) continues to provide assurance against its terms of reference. A new Standing Operating Procedure (SOP) for Section 136 has been implemented to enhance the legal frameworks for holding service users.	**Reasonable assurance**	The Section 136 Report is to be referred to the Quality Committee for information and discussion as required.

	Mental Health Act (MHA) dashboard data remains stable, with positive trends in Community Treatment Order (CTO) compliance. However, concerns persist regarding the consistent completion of Section 132 rights, with targeted support to be provided. The Committee acknowledged the ongoing pressures on the Mental Health Act Team due to staffing gaps but noted continued efforts to maintain performance standards.		
Bi-Annual DoLs & MCA Audit Report	The Committee received an update on the recent Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) audits. The DoLS audit achieved substantial assurance, though challenges remained nationally around local authority follow-up processes. In contrast, the MCA audit received reasonable assurance, with the overall aim to progress to substantial assurance, requiring full compliance. While training compliance across the Trust is strong, this has not yet translated into consistent, high-quality documentation. Key areas for improvement include ensuring sufficient detail in capacity assessments, clear documentation of best interest decisions, the involvement of families and advocates, and the accurate recording of patients' views, and the rationale for decisions made on their behalf.	**Reasonable assurance**	Next steps include: • Ongoing delivery of MCA training sessions with a focus on both foundational knowledge and complex decision-making. • Continued engagement of MCA leads with staff to promote best practice. • Review and improvement of electronic documentation templates and prompts to support consistency and completeness in recording. • Emphasis on leadership support to reinforce the importance of MCA documentation as an essential part of care.

Health Inequalities in the use of the Mental Health Act Detentions and use of Force.	From the data supplied to date, there appear to be inequalities amongst BAME groups and males in the use of force and restraint under the Mental Health Act. Data cleansing is still taking place, and regular monitoring will now come into MHAC at every meeting. A thematic analysis will now take place to understand the data and identify trends involving wards, staff and justifications for use of force.	**Limited assurance**	

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31st July 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 • Research and Innovation (R&I) Business Case	• Finance Report and Forecast • BAF Risk Updates • Cost Improvement Plan (CIP) Update • Trust Digital Plan • Commissioning Committee • Review of Terms of Reference

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
IQPR	The Committee received assurance on the continued progress in addressing long waits, particularly within dementia services. There has been a 43% reduction in patients waiting over 52 weeks since February, with further work underway to eliminate these waits entirely by the end of summer. The Memory Assessment Service is embedding well, and waiting times are steadily improving. Efforts to improve patient flow continue, including collaboration with three voluntary sector organisations to provide step-down facilities and reduce out-of-area placements. Population growth and demand pressures are acknowledged, and potential solutions such as day hospitals, are being explored.	**Reasonable Assurance**	The Trust is working to strengthen communication around pathways back to primary care for those with less complex needs. The committee was assured by the clear focus on performance improvement, system collaboration, and patient-centred care delivery. Progress is being closely monitored and demonstrates the Trust's commitment to quality and access.
Dementia Diagnosis Update	There is continued progress in improving access to Memory Assessment Services across the Trust. The percentage of patients diagnosed within six weeks is now above the national average. There is assurance that services are focused on directing patients to the right pathway, ensuring community teams manage lower-acuity cases appropriately, and avoiding over-reliance on GPs or high-performing areas. The current strategy is helping to stabilise and improve overall performance.	**Reasonable Assurance**	Targeted work is underway to address the 52-week wait cohort, with plans to eliminate these waits by the end of August 2025. This has required temporary prioritisation, but performance is being closely monitored weekly by the Executive Senior Responsible Officer to ensure balance is maintained. The long-term target is to have 100% of patients diagnosed within 6 weeks. A milestone is 70%-80% by June 2026

Finance Report and Forecast	The Committee received the financial position for the period ending 31st May 2025. The Trust remains broadly on track with its financial plan, reporting a surplus position post-technical adjustment. Key pressures continue, particularly around the use of external beds and agency staffing.	**Reasonable Assurance**	Committee members were assured that although the agency usage and external bed spend have breached the gross target, the month-on-month breakdown demonstrates a clear plan to recover and bring spending back in line with controls in place. The Committee received a paper giving an update on CIP targets, which was commended
Trust Digital Plan	An early draft of the Digital and Data Strategic Plan was shared with the Committee. The plan sets out how digital priorities will support the delivery of the wider Trust strategy and corporate programmes. While it provides a clear direction of travel, further work is needed to align the plan with broader organisational priorities and to develop a robust approach for project prioritisation, particularly in light of emerging technologies such as AI. The Committee noted that risks remain and will need further review.	**Limited Assurance**	The paper will be taken to the Board in July for further consideration.
Research and Innovation Business Plan	An active R&I function has the following benefits • Improves patient care • Supports recruitment of top-quality staff • Creates opportunities for working in collaboration with other top-flight organisations] • Improves KMPT's reputation • It was noted that the R&I team had brought in approx. £1m of research funding, and there were further opportunities for grants for specific projects	**Reasonable Assurance**	The Committee received a paper from Prof Sukhi Shergill supporting a proposal to support the programme of Research and Innovation with a budget for 5 years totalling £1.4m. This reverses the previous Board requirement that the Research programme aims to be self-financing. The Committee accepted that the benefits to KMPT of a strong research base justified the annual expenditure and recommended that the proposal is accepted

Terms of Reference	The Committee reviewed and recommended amendments to its Terms of Reference as part of the annual review process.	**Reasonable Assurance**	The proposed amendments have been submitted to the Board, under a separate item, for approval

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31st July 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	The Charity continues to make strong progress despite a 60% vacancy rate, which has impacted capacity but is being mitigated through interim support and active recruitment. Assurance is given that all roles are expected to be filled by the end of Q3. Significant fundraising success has been achieved, notably a corporate donation worth approximately £30k from Barratt	**Reasonable assurance**	Next steps include: • Completing recruitment to ensure full staffing by end of Q3 • Submitting the next phase of the Greenspaces Grant application by 8th September 2025

	Homes for the development of a therapeutic summer house at Webb's Garden, St Martin's Hospital. The charity has also advanced to the next stage of a major NHS Charities Together Greenspaces Grant and submitted multiple additional funding bids, indicating a robust pipeline. Corporate volunteering has delivered over £15k in pro bono support this quarter, enhancing green spaces and strengthening community partnerships. Internal visibility has increased through NHS Birthday events, a new Facebook page, and promotion via internal communications. Governance arrangements remain on track, with the Annual Report submitted and preparatory work underway for year-end accounts and the new charity dashboard. Overall, the Committee can be assured of the charity's ongoing impact and strategic progress, with clear plans in place to support further growth in income, delivery, and visibility.		• Developing impact metrics to supplement financial reporting • Progressing corporate partnerships and fundraising pipeline • Finalising the database solution for volunteer and charity functions • Enhancing internal and external communications to raise visibility and engagement
Finance Report	The Committee reviewed the charity's financial position as at the end of May 2025. The charity holds a carried forward fund balance of £22,995, comprising £9,334 in restricted funds and £13,661 in unrestricted funds. Although the charity is currently reporting net outgoings of £2,778 for the year to date, this reflects the early stage of the financial year. Income received so far totals £1,186, primarily through donations and interest, while expenditure of £3,964 relates to salary recharges, professional fees, bank charges, and administration. The charity's cash position remains healthy at £54,500, which includes a £10,000 payment received from the first tranche of Barratt Homes funding. Current creditors relate mainly to salary recharges due to the Trust, with sufficient funds in place to meet this obligation. Gift Aid remains at	**Reasonable assurance**	Next steps: A financial forecast will be developed and presented at the next Committee meeting to assess progress against the annual plan and provide further assurance on the charity's financial trajectory. Monitoring of salary recharges will continue to ensure appropriateness and alignment with the charity's financial capacity.

	zero but is expected to increase as income activity builds through the year.		