KMMH SUBMISSION

Kent and Medway Mental Health NHS Trust CQC Response and All Age Mental Health Services and All Aged Eating Disorders Service Transition Update

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Summary

The purpose of the paper is to provide an update to the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) on the work that is underway in response to the Care Quality Commission (CQC) review. Following an inspection in March 2025, the CQC published two reports into services delivered by Kent and Medway Mental Health NHS Trust. These include:

1. Community mental health services for all age adults and working people, and;
2. Crisis mental health care and Place Based Places of Safety (HBPOS).

The report provides an overall re-rating as Requires Improvement for these services.

The paper also provides an update to HASC on the work that is underway within the Trust to ensure a safe transition of the Children and Young People Mental Health Services (CYPMHS) and All Age Eating Disorders (AAEDS).

1. Background

1.1 In October, the CQC published a report into our community based mental health services for adults and working age people. The report follows an inspection that was undertaken in March 2025, and provides an overall re-rating as Requires Improvement for these services.

1.2 The CQC rated our community based mental health services in five areas:

Safe was downgraded to Inadequate

Effective was rated as Requires Improvement

Caring was rated as Requires Improvement

Responsive was rated as Requires Improvement

Well-led was rated as Requires Improvement

1.3 This outcome does not reflect where we want to be yet, but we are clear about what hasn't worked, why we changed course, and how we are now

embedding improvement with stronger accountability and evidence of delivery. To provide assurance to Members, the issues identified by the CQC and in our independent review are long-standing systemic challenges and the trust is taking action to work through these challenges. The CQC feedback and the independent review findings have been incorporated into our on-going continuous improvement work, which is outlined below.

1.4 In addition to the aforementioned internal review, Chief Executive, Sheila Stenson has also commissioned an independent review into our quality and safety governance/assurance processes. This review will conclude at the end of January and be reviewed by our Trust Board in January.

1.5 Further to these inspections in Spring 2025, the CQC revisited and re-inspected community services in Ashford, Thanet, Canterbury, South Kent Coast. In December 2025 the East and West Kent Health Based Place of Safety along with South Kent Coast had a further review.

1.6 Whilst some challenges remain, the feedback we have received from the CQC aligns closely with the finding from the rapid review, reinforcing the need to focus on embedding improvement. The reports have allowed the Trust Board to see more clearly the ongoing historical systemic challenges faced and support the executive in taking a thematic and systemic approach across the organisation.

1.7 Further inspections of our in-patient services have recently been undertaken by CQC. The report is currently being drafted but the Trust has been given high level feedback. The majority of areas identified were already know to the organisation for example our care planning and medication optimisation and were part of our ongoing improvement work. An area of improvement was highlighted by the CQC on the knowledge of our temporary staff and when they should use restraint. The CQC before Christmas informed the organisation that following their inspection they are satisfied that no enforcement action is necessary.

1.8 As a trust, we are confident that we are well-positioned to make the necessary improvements and we are pleased to provide an overview of the progress being made to date. Our focus is on creating conditions where improvement is expected, supported and sustained.

2. Leadership & Organisational Changes

2.1 In 2026, there will be a number of changes to the Kent and Medway Mental Health NHS Trust Board, as the chair and a number of non-executive directors reach the end of their tenure.

2.2 The Trust, with its partners of Kent Community Health NHS Foundation Trust and NHS England have advertised the role of Joint Chair. A recruitment agency is being used to support us with our search. The advert for this role is out now with interviews planned for March.

2.3 Our trust has strong and stable clinical leadership. In October 2025, Dr Afifa Qazi was appointed as Interim Chief Medical Officer for Kent Community Health Foundation Trust, alongside her role with KMMH. This decision has been taken to strengthen our partnership working and ensures mental health leadership is central to the neighbourhood model. Dr Qazi has two deputy medical officers currently who support her at KMMH and she is working on a proposal to create a medical director role that provides robust oversight to organisational performance and safety internally at KMMH. This support will ensure strong clinical leadership within the organisation. Each directorate has a Clinical Director lead, and they are supported by a Head of Psychiatry. Her joint role will support improved delivery and efficiency in joint functions across both organisations such as medical education, research and medical revalidation.

2.4 In January 2025 our Chief Nurse Andy Cruickshank is starting a secondment as the Chief Nurse for Integrated Neighbourhood Health in the Kent and Medway system. This is an exciting and excellent opportunity for us to have a mental health nurse shaping the future of community and neighbourhood care across Kent and Medway. Andy will bring his clinical leadership and improvement expertise to shaping the future of our services. To ensure continuity, Julie Kirby will act up as Chief Nursing Officer while we backfill her role as Deputy Chief Nursing Officer through a formal recruitment process that has already commenced.

Changes in the leadership team are aligned to where we are heading as a trust and a local system. Together, they strengthen the trusts influence, our partnerships and our ability to help people not just live with mental health challenges, but to live well.

2.5 The Care Quality Commission has confirmed it will be undertaking a well-led inspection of the trust in March. This is a planned inspection, focused specifically on leadership, culture, governance and how we effectively identify risk, learn and improve. It is not a re-inspection of individual clinical services. We welcome the inspection and see it as an important opportunity to demonstrate how far we have come in the past year, for independent challenge on the progress we are making, as well as any feedback on where we need to go further. We will keep elected members informed and share the outcomes and learning once the inspection has concluded.

3. Quality Plan Update

3.1 We have previously advised the committee that we have a robust quality plan in place. The plan is structured around four domains:

- Safety and Risk
- Access and waiting times
- Environment, experience and equity
- Leadership, culture and governance

3.2 The next section of this report provides an update on each domain.

Safety and Risk

3.3 A key focus of this domain has been to implement a new nationally mandated risk assessment approach for our patients. Its aim is to provide a formulative approach to risk assessment that is co-produced with our patients. This is a completely new approach for our staff and will take time to embed across our organisation. As part of the re-inspection the CQC inspector shared they can see what our intention is and how this new approach to managing risk will work but recognised that we are mid-way through implementation. They also commented that they could see a good standard of note taking on risk in a number of the cases they looked at. This will remain a priority for us in the coming months. Updates on the progress of this implementation are reported to our Quality Committee.

3.4 As part of the assurance and governance processes we have in place to monitor our implementation of the quality plan we have undertaken an audit of several risk assessments completed to review progress. We have agreed with local governance teams that we will build a trajectory for improvement and set up a broader coalition around this. A digital solution as part of our electronic patient record is being designed and implemented. Additional staff training is being provided. We recognise this will take time to implement to the required clinical standard. The CQC also supported this at the re-inspection.

3.5 The inspection highlighted a number of health and safety issues. These included ensuring cleaning records were being kept up to date, maintaining equipment checks at the Beacon Centre. Processes have now been put in place to ensure these checks and the associated records are being maintained.

3.6 The inspection highlighted a number of health and safety issues in Medway. The majority of these issues have been addressed and measures put in place to prevent these from recurring. Measures include reviewing standard work for individuals within the teams and is reinforced with ongoing audits to ensure compliance.

Access and waiting times

3.7 Throughout Quarter 3 2025/26, we have been making further refinements to our model of care, working through our multi-disciplinary and multi-agency workstream structure to ensure meaningful engagement across the partnership. As part of the refinement process, we have reviewed: the clinical interventions available through the model, the key operational functions and processes required to deliver the model, and the partnership structures which underpin it. We are assessing these different options to ensure that they address the drivers for change we have identified through extensive staff and user feedback, and align with our core programme goals to improve access to safe, high quality effective services that are tailored to enabling our communities to live well. This work has been completed in partnerships with our partners, through extensive engagement.

3.8 A critical test and learn piece, is the Medway Approach, which has been an impressive pilot to support improved access, planning next steps in care and optimising care navigation and is integral to the revised model delivered across the county. From this approach, which is underpinned by mental health care navigation, we have seen significant improvement in our responsiveness and reduced wait times.

3.9 In North Kent you can be seen for your first or initial contact with in under 23 days and following this will wait an average of 7 weeks for an intervention - against a target of 4 week for initial contact and 18 weeks for an intervention (data as of November 2025).

3.10 The revised model proposes development of a Partnership Delivery Model which would more clearly delineate the role of provider partners across the service to enable delivery of services as close to local communities as possible. Under this proposed way of working, people with lower/medium needs would access services through local access points, managed and delivered by provider partner(s). While people with higher needs would step-up and/or be directly referred to Kent and Medway Mental Health Trust. The model was approved by the partnership oversight group in November 2025.

3.11 In tandem with the reviewing the care model, we have been prioritising the reduction in waiting times across the county, with success from our previous position nine months ago.

3.12 For non-urgent referral the average wait to first contact is under 4 weeks across the County. This allows to understand any risk we are not aware of at referral and provide a brief intervention where required. People who are identified as urgent on the day of the referral with receive intervention sooner. Either on that day through rapid response or from Mental Health Together within 2 days, depending on the level of safety concerns identified at triage.

3.13 The overall waiting list for Mental Health Together is on average 6000 patients, county wide, which is balanced against receiving on average 3741 referrals per month. In March 2025, the waiting list was c.7000 people, therefore a reduction in 1000 patients in the past nine months. As referenced earlier in this report, while people will be waiting for their formulated intervention, they will have had a first contact within four weeks.

3.14 Following first contact, people waiting for an intervention is approximately 12 to 16 weeks, against a national target of 18 weeks and this remains an area of focus for all our teams. Of the total people waiting 20% have been waiting over 18 weeks. The biggest areas attributing to waiting over 18 weeks are for people who need help regulating emotional difficulties and formal psychological therapy, which is a result of the current capacity challenges and is a priority to resolve. This is also being addressed through the community mental health review we have undertaken.

3.15 For Mental Health Together in Medway & Swale specifically, there has been a marked improvement in waiting times for community services in the last 12 months. The services have received an average of 194 referrals each week, with their total case load rising from 1252 in January 2025 to 1492 in December 2025, peaking at 1699 in November. Despite the increase in caseload the table below shows how waiting times have decreased in the last year.

Measure	Jan 2025	December 2025
Number of patients waiting ***under*** 4 weeks for first contact	60	257
Number of patients waiting ***over*** 4 weeks for first contact	438	60

This shows a 66% reduction in the number of patients waiting over 4 weeks in Medway and Swale. The average time from referral to first contact is currently (data from 28/12/25) 22.8 days against a 4 week/ 28-day target, down from 87.1 days in Feb 2025.

3.16 An improvement plan has been in place earlier this calendar year (2025) and was reviewed in November 2025, which has increased measure in reviewing caseload, effective management of DNA, increasing first contact capacity and focusing on reducing the number of people waiting over 18 weeks where feasible. All patients who DNA are discussed at a daily clinical huddle to determine next steps and weekly reporting around DNA's are issued to services. We have also been encouraging patients to sign up to our text message reminder service. In January 2025, 321 and 305 text message reminders were sent from Mental health Together and Mental Health Together

Plus, respectively, in Medway. In December, this had increased to 1068 and 661, respectively. This has shown a small improvement in the number of DNA's.

3.17 Further engagement and co-design activities are underway to develop this delivery model further and ensure alignment with our enabling workstreams: communications and engagement, data and assurance, workforce and contracting. In Quarter 4 we will focus on the technical aspect of the model to ensure it is operationally underpinned and data driven. This also includes establishing effective structures that enable partnership delivery. We are planning a partnership event in early January. The communications and engagement group are working up the plan for wider stakeholder engagement, including General Practice. We are benefiting from 2 primary care clinical directors supporting this workstream.

3.18 Going forward, as part of the work being undertaken as part of the Community Mental Health Framework. And in line with other providers we are about to launch the DIALOG plus to be undertaken at the first contact. This will be a meaningful way to agree care and the next steps. This approach has been piloted in Medway and proven to be successful at first contact rather than waiting further into treatment for this to be undertaken. Imminently, DIALOG plus will be completed within four weeks for routine cases and we will continue to work towards 18 weeks of commencement of formal treatment.

4. Environment, experience and equity

4.1 The main focus of this domain is ensuring our estates strategy is continually refreshed and reflects the needs of our patients and staff. The Trust has several community buildings that are not fit for purpose and has clear plans for addressing these. We will also be undertaking an accessibility audit from January to June 2026 of all our buildings.

4.2 Work is being undertaken at Britton House in Gillingham. A package of acoustic improvements in six consultation rooms to address sound transfer between rooms has been trialled. While these works were successful in reducing noise leakage, they inadvertently increased echoing and reverberation within the rooms due to the lack of absorbent surfaces.

4.3 A follow-up acoustic survey has now been completed to assess this issue and recommend solutions. A number of recommendations were made and we are currently sourcing appropriate products to fit acoustic absorbent panels which will mitigate the echo and improve sound quality. It is anticipated that these works will be completed in early 2026.

4.4 Upon completion of the above works, acoustics will be retested to ensure they comply with the necessary regulations.

4.5 In addition, the CQC fed back that the trust needed to ensure that it had up to date patient communication and literature that was accessible and inclusive. As part of the work the trust undertook to launch our new identity in October 2025, we will be refreshing all of our patient literature and ensuring it reflects our new tone of voice. This work was already in hand ahead of the CQC inspection. So far, we have identified 180 patient information leaflets/ literature which will be updated to ensure they are accessible for our patient population. These are being prioritised and work to create new literature will start in early 2026.

5. Leadership, culture and governance

5.1 This area of our plan focuses on staff support and supervision, safeguarding, audit and training and governance and policy review. The CQC highlighted 30 mandatory training programmes where compliance was below the statutory requirements. A number of actions have been taken to improve mandatory training compliance, this has improved. However, the trust remains below the 90% compliance target for 3 training programmes at this time. We are putting in place an urgent trajectory for improvement for paediatric basic life support training. Compliance for this has improved since the CQC inspection with monitoring of staff who are not compliant and are nearing becoming out of date to ensure they are booked onto the closest available training sessions.

5.2 Immediate Life support training compliance has continued to increase each month and we anticipate achieving the 90% compliance target by February 2026. Freedom to speak up training was introduced in 2022 as a 3 yearly training package. A number of managers training had expired prior to the CQC inspection and our Learning and Development team are working to ensure all managers complete this training. We will also be undertaking more targeted training for managers in the coming months.

Training programme	**Compliance Target**	**Current Trust Compliance (Dec 2025)**
Basic Life Support Paediatric	90%	72%
Immediate Life Support	90%	89%
Freedom to Speak Up – Managers training	90%	87%

5.3 For the North Kent directorate, there are 4 mandatory training programmes which are showing as non-compliant. These are being addressed now but are close to acceptable compliance levels.

Training Programme	Compliance Target	Current NK directorate compliance
Anaphylaxis	90%	89%
Basic Life Support (practical)	90%	89%
Immediate Life Support	90%	86%
Safeguarding Children Level 2	90%	89%

5.4 The trust recognises the importance of safeguarding training and a number of measures have been taken to increase compliance against safeguarding training across the trust. In North Kent/ Medway specifically, the below table shows compliance rates, as of 17/12/25, against specialist safeguarding training programmes. Kent & Medway ICB sets a target of 85% compliance against safeguarding training, however, KMMH has an internal target of 90%

Programme	**Compliance (17/12/25)**	**Compliance against target**
Prevention	98.2%	Green
Mental Capacity Act	94.5%	Green
Consent to Treatment	94.7%	Green
Adult Safeguarding Induction	99%	Green
Safeguarding Adults Level 3	94.5%	Green
Safeguarding Adults Level 2	96%	Green
Safeguarding Children Induction	99%	Green
Safeguarding Children Level 3	94%	Green
Safeguarding Children Level 2	90.5%	Green

5.5 Whilst there are individual teams where compliance needs to be improved, this is managed through regular reporting to line managers and this remains a focus for the trust. This has been led by the Trust safeguarding lead and their team.

5.6 The review of Trust policies continues with direct oversight by the Director of Quality ensuring the policies are relevant and all necessary impact assessments have been completed. A trajectory of completion has been

established with regular reporting of progress to the trust executive. All polices will be updated by the end of February 2026.

5.7 The Trust leadership development programme is continuing with the first cohort of delegates due to complete the yearlong bespoke course in Spring 2026. The programme aims to develop senior leaders around 4 modules; Leading Self, leading team, leading the organisation and system leadership.

5.8 Staff Supervision continues to be monitored by our directorate leadership teams. There has been a 15% improvement within the North Kent directorate between March 2025 and November 2025 to 82% compliant. It continues to be a focus for our senior management teams and the general managers who are working with service managers to ensure compliance.

6. Children and Young Persons (CYP) and All Age Eating Disorder Services (AAED)

6.1 The trust has a robust transition plan in place with North East London Foundation Trust (NELFT) overseen by the Integrated Care Board (ICB). Significant progress has been achieved against the key milestones since this work commenced last summer. We have a robust plan in place to that has identified, is monitoring, and delivering the essential Day One activities that will ensure the safe transfer of CYP and AAED services between NELFT to KMMH on the 1st April 2026 and assure continuity of care for service users, families and carers

6.2 Plans to safely transfer all current staff and ensure recruitment to critical roles are underway. There is a schedule to induct all staff and ensure they receive all essential training in March. All safeguarding roles are currently (Dec ’25) live and out to recruitment with appointments planned in January, Medical recruitment will be live in early January. Medical vacancies are the highest vacancy levels in the services transferring, this has been a longstanding issue. KMMH is implementing several initiatives we have worked on in the last 18 months to improve our medical recruitment. All other remaining vacancies are now out to recruitment following agreement with NELFT to commence recruitment.

6.3 Additionally, all equipment and estate will transfer to KMMH on Day 1. Key contracts that underpin the service have been identified and a plan is in place to ensure continuity after 1 April 2026.

6.4 Policies and plans are in place to ensure the safe transfer of the case load and waiting lists, colleagues from KMMH and NELFT are working together every day to ensure the safe transition of services on Day 1.

6.5 Digital has been the most complicated workstream when planning for the transition. It has been agreed with NELFT that NELFT will continue to host all the clinical systems for the next 12 months. For all non-clinical systems KMMH systems will be used, for example ESR, finance system etc. A robust

Service Level Agreement (SLA) is currently being drafted for the clinical systems management, this will also include all clinical data reporting that will be provided by NELFT. This approach will ensure a smooth transition of services and will not impact clinically or operationally on staff from day 1. KMMH will continue to work with NELFT post 1st April to have a clear plan to transition to KMMH within 12 months. This also provides KMMH an opportunity to learn from NELFT with regards to how they have developed their systems to enhance and support patient care.

6.6 The programme's communication plan is actively managing communications to staff, patients, families and carers and partner organisations – including GPs, schools and the local authorities.

6.7 All Day One milestones are RAG-rated, with mitigation actions actively managed through programme governance. In parallel, Day 1–30 milestones and Success Measure KPIs have been defined to evaluate achievement against intended objectives.

7. Summary

7.1 The Trust has been operating in an environment of rising demand and workforce pressure. Alongside the need to modernise models of care that were no longer meeting the need of the populations of Medway and Kent. This does not provide any justification for unsatisfactory care but demonstrates the scale of the challenge we are addressing.

7.2 The CQC have identified positive foundations during their inspections in March 2025 and follow-up inspections throughout the rest of the year which as an organisation we must continue to build upon.

7.3 The Trusts recognises the importance of working with partners as part of the ongoing improvements we have set out within this paper. The Trust will continue to explore current and new ways of working with partners and the wider system to ensure the improvement is achieved and sustained.

7.4 The integration of Children and Young People and All Ages Eating Disorder services into the KMMH provides a unique opportunity to improve the continuity of services and accountability across mental health pathways to allow younger people a smoother and safe transition into adult services. This will also be the first time ever that children and adults (all-aged) mental health services have been provided by one provider within Kent and Medway.