HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 4th February, 2026

10.00 am

Council Chamber, Sessions House, County Hall, Maidstone

Kent County Council
kent.gov.uk

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Wednesday, 4th February, 2026, at 10.00 am
Council Chamber, Sessions House, County Hall, Maidstone

Ask for: **Gaetano Romagnuolo**
Telephone: **03000 416624**

Membership

Reform UK (7):	Mr R Mayall (Chair), Mr T Mole (Vice-Chair), Mr J Baker, Mrs B Porter, Mrs S Roots, Mr T L Shonk and Dr G Sturley
Liberal Democrat (2):	Mr M Brice and Mr A Ricketts
Conservative (1):	Ms C Russell
Green (1):	Mr S Jeffery
Independent (1):	Mr O Bradshaw
Independent Reformers (1):	Miss I Kemp
District/Borough Representatives (4):	Councillor K Tanner, Councillor H Keen and Councillor K Moses

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item

1. Apologies and Substitutes

2. Declarations of Interests by Members in items on the Agenda for this meeting.

3. Minutes of the meeting held on 4 December 2025 (Pages 1 - 8)

4. South East Coast Ambulance Service NHS Foundation Trust - Update on Group Model Collaboration (Pages 9 - 12)

5. Kent and Medway Mental Health NHS Trust CQC Response Update

(Pages 13 - 84)

6. Proposed Integration between the Kent Community Health NHS Foundation Trust and Medway Community Healthcare (Pages 85 - 104)

7. Work Programme (Pages 105 - 108)

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Benjamin Watts
General Counsel
03000 416814

27 January 2026

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Thursday, 4th December 2025 at 10:00am.

PRESENT: Mr R Mayall (Vice-Chair), Mr J Baker, Mr A Kibble, Mt T Mallon, Mr T Mole, Mrs B Porter, Mr A Ricketts, Mrs S Roots, Mrs C Russell, Mr T Shonk and Dr G Sturley.

IN ATTENDANCE: Mr A Doyle (Chief Executive, NHS Kent and Medway), Mr M Atkinson (Director of Strategic Commissioning and Operational Planning, NHS Kent and Medway Integrated Care Board), Dr A Richardson (Director of Partnerships and Transformation, Kent and Medway Mental Health NHS Trust), Dr A Qazi (Chief Medical Officer, Kent and Medway Mental Health NHS Trust), Mr R Goatham (Healthwatch Manager), Dr C Rickard (Medical Director, Kent Local Medical Committee) and Mr G Romagnuolo (Research Officer, Overview and Scrutiny, KCC).

UNRESTRICTED ITEMS

1. Election of Chair and Vice-Chair
(Item 1)

1. Mr Mole proposed, and Mr Kibble seconded, that Mr Robert Mayall be elected Chair of the Health Overview and Scrutiny Committee.
2. As Mr Mayall was the Committee's Vice-Chair, the election of HOSC Vice-Chair had also to be carried out.
3. Mr Shonk proposed, and Mr Kibble seconded, that Mr Terry Mole be elected Vice-Chair of the Health Overview and Scrutiny Committee.

RESOLVED that Mr Robert Mayall be elected Chair of the Health Overview and Scrutiny Committee, and Mr Terry Mole be elected Vice-Chair of the Health Overview and Scrutiny Committee.

3. Apologies and Substitutes
(Item 2)

4. Apologies were received from Mr M Brice, Mr S Jeffery, Cllr H Keen and Cllr K Tanner. There were no substitutions.

5. Cllr Keji Moses joined the meeting virtually.

4. Declarations of Interests by Members in items on the Agenda for this meeting.
(Item 3)

1. Mr A Ricketts declared that he was a Public Governor of the East Kent Hospitals University NHS Foundation Trust.

5. Minutes of the meeting held on 9 October 2025
(Item 4)

RESOLVED that the minutes of the meeting held on 9 October 2025 were a correct record and that they be signed by the Chair.

6. NHS Kent and Medway Chief Executive Update
(Item 5)

1. Mr Doyle (Chief Executive, NHS Kent and Medway) introduced himself as the newly appointed Chief Executive of NHS Kent and Medway. He said that the report provided an outline of the current challenges and opportunities facing the local health and care system.

2. Kent and Medway faced significant operational and financial pressures, including a large system deficit, long waiting lists and marked health inequalities. In response, the ICB had launched a comprehensive Reset, Recovery and Transformation Programme which was underpinned by a System Improvement Plan focused on neighbourhood transformation, acute service reconfiguration, strategic commissioning, leadership and culture, digital innovation, and financial recovery.

3. The NHS 10-Year Plan was a national document which set out the government's vision for the future of health and care in England. Its aim was to respond to rising demand, widening health inequalities and financial pressures by committing to a fundamental transformation of how services were delivered. The Plan also set the context in which all ICBs and other health bodies had to operate.

4. The Plan included three main shifts.

    a) Care would move out of hospitals and into communities. Instead of relying on large acute centres for most services, the future model provided for neighbourhood health hubs to become the focal point for care.

b) A greater use of digital technology by the NHS as a core part of everyday care. NHS App would become the main gateway for patients, offering everything from appointment booking to prescription management.
c) A shift in focus from treating sickness to prevention.

5. The NHS 10-Year Plan and other national reforms also prescribed that Integrated Care Boards (ICBs) developed into strategic commissioners, with a focus on improving population health, reducing inequalities and ensuring high-quality, sustainable services. The new commissioning framework embodied a model that was more outcome-focused and embedded in partnership working across health, social care and the wider public sector.

6. The Kent and Medway ICB would undergo a substantial transformation. It was required to halve its operating budget—from £73.5 million to £38.3 million—to meet national targets. This would be achieved through the Reset, Recovery and Transformation programme and would result in significant reductions in its workforce.

7. In terms of community services procurement, Mr Doyle said that, over the past two years, the ICB briefed the Committee on the rationale and ambitions for the re-procurement of these services. The new procurement followed the Provider Selection Regime Regulations (2023), with contracts awarded for five years, plus up to three years of extensions. This arrangement allowed alignment to national priorities, such as the Darzi Report's call to move care closer to home, and the NHS 10-Year Plan.

8. In reply to a question about the role of pharmacies in this new model, Mr Doyle explained that in primary care there were four main professional groups: GP services, pharmacy, dentistry and optometry. One of the key challenges for public health teams in the future was to better analyse and understand population growth and demographic patterns in order to allocate the right pharmacies in the right places to best respond to local need.

9. In reply to a question about preventative measures to reduce the consumption of processed foods which led to increased obesity, anxiety and diabetes Type 2 in the population, Mr Doyle said that the current number of children who were obese (in Year 6) in Kent and Medway was above the national average. In order to respond to this issue, it was important to develop a robust local strategy. Also, given that very little could be done at a local level to change the regulation of food industry, the ICB lobbied the relevant parliamentary groups.

10. A Member asked whether Mr Doyle could expand on the neighbourhood care model.

d) Mr Doyle explained that it was important to develop a standardised model for Kent and Medway in terms of opening times. The model also advocated that general practises be well resourced and well-funded.

e) A key aim was to move a proportion of diagnostic tests and first appointments away from hospital and into the community. When appropriate, a number of visits would be provided virtually.

RESOLVED that the Committee note the report.

7. Prosthetic Limb Service relocation
(Item 6)

1. The Chair welcomed Mr Atkinson (Director of Strategic Commissioning and Operational Planning, NHS Kent and Medway Integrated Care Board) to the meeting. Mr Atkinson explained that the Prosthetic Limb Service for Medway, Kent and Southeast London was currently provided by the Kent and Medway Mental Health NHS Trust (KMMH) at Medway Maritime Hospital. The service supported about 1,100 people of all ages with limb loss and congenital limb deficiencies. Approximately 70% of people supported by the service lived in Kent, 20% in Medway and the remainder in southeast London.

2. In 2023, KMMH served notice on their contract. A procurement process was carried out which included extensive engagement with patients, carers and staff and involved national charities.

3. The company Hugh Steeper Limited was awarded the contract with plans to commence delivery by the end of 2025. The service would be relocated from Medway Maritime Hospital to Maidstone town centre. The provision of the service would therefore remain within Kent.

4. Patient, carer, and staff engagement would continue as part of the mobilisation plan. All partner organisations had committed to minimising disruption and maintaining high-quality care during the transition.

RESOLVED:

a. that the Committee deems that the proposal relating to the relocation of the Prosthetic Limb Service is not a substantial variation of service.

b. that NHS representatives be invited to attend this Committee and present an update at an appropriate time.

8. Kent and Medway Mental Health NHS Trust CQC Response Update
(Item 7)

1. Dr Richardson (Director of Partnerships and Transformation, Kent and Medway Mental Health NHS Trust) explained that, following an inspection in March 2025, the CQC published two reports into services delivered by Kent and Medway Mental Health NHS Trust. These included:

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

2. The report provided an overall re-rating as 'Requires Improvement' for both services.

3. He said that Kent and Medway Mental Health NHS Trust fully accepted the findings of the CQC in both of those reports and was already working to address some of the concerns that were raised, particularly on safety.

4. The organisation was confident that progress was made in this area and that there were now mechanisms in place that regularly reviewed it.

5. In reply to a question asking to expand on the safety concerns, Dr Qazi (Chief Medical Officer, Kent and Medway Mental Health NHS Trust) said that these were around the risk assessment framework that the organisation was using at the time. The national risk assessment around mental health changed and a new more robust framework for mental health was implemented. This was a dynamic document where risks could be updated as patients' needs changed.

6. Dr Qazi explained that, when the CQC visited the Trust, the organisation was in the very initial stages of rolling this new model out. In the several months that had elapsed since the visit, the rolling out of the new risk assessment had progressed and was monitored by several audits.

7. In reply to a question, Dr Qazi said that there was a point of contact for people who experienced a mental health crisis and needed an immediate emergency response. In addition to rapid response teams, there was a dedicated telephone line. Also, members of the public could receive mental health treatment through emergency departments in acute care sites.

8. In response to a question, Dr Richardson said that there had been a number of recent changes in the organisation's leadership, including a new chief executive who took up her post around two years ago. He added that the Trust aimed at strengthening its collaboration with scrutiny committees and service users, and at bringing about a cultural change that entailed more engagement with stakeholders when designing services that best met their needs.

RESOLVED: that the Committee note the update from the Kent and Medway Mental Health NHS Trust.

9. Healthwatch Kent Annual Report 2024-25 and Update
(Item 8)

1. Mr Goatham (Healthwatch Manager) explained that Healthwatch was a national organisation which included Healthwatch England and over 150

local Healthwatch services. The key, statutory role of Healthwatch was to gather the views and experiences of the public on health and social care service provision, and to produce reports with recommendations based on the public's feedback.

2. Healthwatch was funded by the Department of Health and Social Care (DHSC). KCC was allocated a portion of this funding which then assigned to the local Healthwatch Kent.Mr Goatham expressed his gratitude to all the volunteers for their invaluable support, including school and university students who had student placements.

3. Some of the key issues identified by the Healthwatch Kent Annual Report included:

    a. Addressing any inequalities in mental health service provision, which impacted on people of Black or Asian ethnicities in particular.
    b. Making sure that people who were affected by both mental health and substance misuse issues would not get 'stuck' between services.
    c. Offering support to those less proficient in IT, for example when using digital appointment systems.

4. The paper also reported that Healthwatch Kent hosted the annual Healthwatch Recognition Awards. This celebrated the work of organisations and individuals contributing to positive change in Health and Care. There were over 100 nominations from professionals and residents.

5. Mr Goatham then discussed the future of Healthwatch. He said that the Dash Review, which was commissioned by the DHSC, recommended the disbanding of Healthwatch in its current form and the creation of a stronger National Quality Board to lead a strategic, evidence-based approach.

6. The Government had accepted the recommendations of the Dash Review and, as a result, planned to legislate to end the statutory provision of local Healthwatch and Healthwatch England and transfer the functions of the former to local authorities and ICBs and the latter to a new Directorate of Patient Experience in the Department of Health and Social Care. This process was expected to commence in 2026/27.

RESOLVED: that the Committee note the Healthwatch Kent Annual Report 24/25 and the update on the future of Healthwatch.

10. Work Programme
(Item 9)

7. A Member suggested that the Committee further engaged with Healthwatch Kent in order identify and scrutinise local health and care services that, according to the views and experiences of the public, required particular attention.

RESOLVED that the Committee note the Work Programme.

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Item 4: SECAmb Group Model Collaboration Update

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 4 February 2026

Subject: SECAmb Group Model Collaboration Update

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by the South East Coast Ambulance Service NHS Foundation Trust (SECAmb).

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1) Introduction

a) In November 2024, the boards of South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South Central Ambulance Service NHS Foundation Trust (SCAS) started exploring options for closer collaboration.

b) At a Joint Board meeting in October 2025, the two Trusts agreed to progress to a formal collaboration through the creation of a group model. A public announcement confirming the intention to form the South Central and South East Ambulance Group was made shortly afterwards - the first of its kind in England.

c) The transition to the South Central and South East Ambulance Group is scheduled to take place in phases from late 2025 through to 2027.

2) Recommendation

a) RECOMMENDED that the Committee note and comment on the update.

Background Documents

None.

Contact Details

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Kent County Council
Health Overview and Scrutiny Committee

4 February 2026

South East Coast Ambulance Service NHS Foundation Trust: Update on Group Model Collaboration

Report From: Daryl Devlia, Strategic Partnerships Manager
David Ruiz-Celada, Chief Strategy Officer

1. Summary

1.1 The purpose of this report is to provide an update on the group model collaboration with South Central Ambulance Service (SCAS).

2. Recommendations

2.1 The committee is asked to note and comment on the update provided.

3. Budget and policy framework

3.1 Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Council may review and scrutinise any matter relating to the planning, provision and operation of the health services in Kent.

4. South Central and South East Ambulance Group Collaboration

4.1. In November 2024, the boards of South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South Central Ambulance Service NHS Foundation Trust (SCAS) endorsed the appointment of a joint strategic lead to develop a Case for Change and Joint Roadmap, exploring options for closer collaboration and making recommendations to both boards.

4.2. At a Joint Board meeting in October 2025, the two Trusts agreed to progress to a formal collaboration through the creation of a group model. A public announcement confirming the intention to form the South Central and South East Ambulance Group was made shortly afterwards - the first of its kind in England.

4.3. The new group model is a proactive move to strengthen patient care, ensure sustainable services, and build a more resilient ambulance system across the region.

4.4. By working together more closely, the two services will be better placed to share expertise and resources, harness innovation, and invest in improvements that directly benefit patients.

4.5. Through the group model, both Trusts will continue to operate independently, retaining the flexibility to meet the specific needs of their local communities, while collaborating on key priorities such as digital innovation, clinical best practice, and workforce development.

4.6. To strengthen alignment and ensure shared priorities are delivered effectively, the Group will introduce a shared leadership model, with a single Chief Executive and Chair supporting both Trusts. This will enable greater strategic coordination while maintaining each organisation's local accountability and identity.

4.7. The move is fully supported by NHS England (South East) and aligns with the NHS 10 Year Plan, helping to ensure ambulance services across the region remain safe, equitable, and financially sustainable.

4.8. Stakeholder engagement is a priority for both Trusts. A microsite for the South Central and South East Ambulance Group has been launched (Appendix I), providing information, such as the Case for Change.

4.8.1. The first internal joint engagement session was held on 3 November 2025 and was attended by more than 700 staff.

4.9. The transition to the South Central and South East Ambulance Group will take place in phases from late 2025 through to 2027.

Lead officer contact

Daryl Devlia, Strategic Partnerships Manager (Kent and Medway)
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Appendix I

Home - South Central and South East Ambulance Group

https://scseamb.info/

Item 5 - Kent and Medway Mental Health NHS Trust CQC Response Update

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 4 February 2026

Subject: Kent and Medway Mental Health NHS Trust CQC Response Update

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Summary: This report invites the Health Overview and Scrutiny Committee to consider the update and response provided by the Kent and Medway Mental Health NHS Trust.

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1) Introduction

a) Following an inspection in March 2025, the CQC published two reports into services delivered by the Kent and Medway Mental Health NHS Trust. The reports covered the following areas:

i) Community Mental Health Services for All-Age Adults and Working People, and;
ii) Crisis Mental Health Care and Place-Based Places of Safety (HBPOS).

b) The CQC gave an overall rating as 'Requires Improvement' for these services.

c) In addition to the CQC inspection, a more recent report by Healthwatch Kent provided feedback from service users about their experiences of using mental health services in Kent and Medway.

d) The Healthwatch report covered a number of services. A large proportion of the feedback focused on community mental health teams and Mental Health Together, which were provided by the Trust. 93% of feedback about community mental health teams and Mental Health Together was negative. However, the report also acknowledged some positive comments about these teams' effective coordination and continuity of care.

2) Recommendation

a) RECOMMENDED that the Committee note and comment on the update and the response to the report.

Background Documents

Healthwatch Kent (October 2025) Mental health crisis support: What are we hearing in Kent and Medway? The report can be accessed via this link

Contact Details

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Kent County Council
Health Overview and Scrutiny Committee

4th February 2026

Kent and Medway Mental Health NHS Trust CQC Response Update

Report from: Dr Adrian Richardson Director of Transformation and Partnerships, Kent and Medway Mental Health NHS Trust

Author: Sarah Atkinson Deputy Director of Transformation and Partnerships, Kent and Medway Mental Health NHS Trust

Summary

The purpose of the paper is to provide further update to the Health Overview and Scrutiny Committee (HOSC) on the work that is underway in response to the Care Quality Commission (CQC) review and the Healthwatch report which was issued in October 2025.

1. Background

1.1 In addition to the CQC inspections last year and the subsequent reports, we also received a report from Healthwatch detailing feedback collated from services users about their experience of using mental health services in Kent and Medway.

1.2 The Healthwatch reports highlights feedback on a number of services across the county, with a large proportion (22%) of the feedback focused on community mental health teams (CMHTs) or Mental Health Together, which are provided by KMMH. The report states that 93% of feedback had a negative sentiment, however, it also acknowledges some positive comments and these are quoted in the report.

1.3 Whilst we fully accept the feedback in the report we also want to acknowledge the hard work and dedication of our members of staff who work tirelessly to provide the very best care that they can in a challenging environment of rising demand.

1.4 The negative feedback within the Healthwatch report centred on a number of themes:

- Impact on lifestyle and wellbeing
- Co-ordination and continuity of care
- Communication between staff and patients
- Care given by staff
- Medication, prescriptions and dispensing

- Discharge
- Triage, assessment and admission

1.5 This feedback does not reflect where we want to be as a trust and is not the experience that we want for our service users, their carers and loved ones. The feedback in the Healthwatch report further confirms what we knew as a trust but also what was highlighted by the CQC and by our own internal review. 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 acting to work through these challenges. The CQC feedback, independent review findings and the Healthwatch report have been incorporated into our quality plan which is on-going, continuous improvement work, which is outlined below.

1.6 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.

1.7 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.

1.8 Whilst some challenges remain, the feedback we have received from Healthwatch closely aligns with the CQC, 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.

1.9 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. Quality Plan Update

2.1 We have a robust quality plan in place to address the finding from both the CQC and Healthwatch. The plan is structured around four domains:

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

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

Safety & Risk

2.3 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 will enable us to more effectively manage risk for those within our services but also those who are waiting for interventions. 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.

2.4 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.

Access & waiting times

1.3 Waiting times and contact with those on the waiting list was highlighted in the Healthwatch report as well as triage and assessment.
For context, community mental health services in Kent and Medway have been undergoing the largest transformation for 30 years. This has involved implementing a new model of care, Mental Health Together. Whilst necessary, this has been a significant change in ways of working for staff but also in the way that patients access community mental health services.

1.4 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.

1.5 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.

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

1.7 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 more complex 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.

1.8 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.

1.9 For non-urgent referral the average wait to first contact is under 4 weeks across the county. This allows us 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.

1.10 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.

1.11 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.

1.12 For Mental Health Together in Medway & Swale specifically as this was an area where feedback on wait times was noted in the Healthwatch report. 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.

1.13 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 those who do not attend their appointments (DNA's), 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. However, unutilised appointments from DNA's remains a challenge for us and a focus for the coming year.

1.14 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. This will be ready late in December 2025.

1.15 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.

Environment, experience & equity

1.16 Whilst not highlighted in the Healthwatch report specifically, the environment in some of our buildings was highlighted by the CQC and forms part of our quality plan. Therefore, a brief undated on progress is provided in this report.

1.17 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.

1.18 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 and work to install improvements more widely gets underway in early 2026.

1.19 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. 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. This will support the feedback in the

Healthwatch report that patients have not also had inclusive and accessible information and signposting.

Leadership, culture & governance

1.20 Again, whilst leadership, culture & governance wasn't explicitly highlighted by the Healthwatch report, it does form part of our quality plan and we are mindful of the impact leadership and culture specifically on the care we deliver to our patients. Therefore, we have included a brief update for Members.

1.21 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.

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%

3. Summary

3.1 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 Kent and Medway. This does not provide any justification for unsatisfactory care but demonstrates the scale of the challenge we are addressing.

3.2 The Trust is committed to continually improving building upon the positive changes we have begun to see in services in the last 9-12 months. As part of these improvements, we are also committed to listening to feedback from our patients and their loved ones and involving them in how we evolve services going forward.

3.3 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.

3.4 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 improvements are achieved and sustained.

Mental health crisis support

What are we hearing in Kent and Medway?

healthwatch Kent

Mental Health Voice

healthwatch Medway

Contents

About us

Healthwatch Kent, Healthwatch Medway and Mental Health Voice are your local independent champions for health and social care. Our aim is to improve services by ensuring local voices are heard – we want to hear about health and social care experiences to influence positive change for communities across Kent and Medway. We have the power to make sure NHS leaders and other decision makers listen to your feedback and improve standards of care.

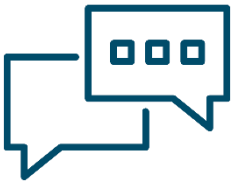
We use your feedback to better understand the challenges facing the NHS and other care providers, to make sure your experiences improve health and care services for everyone. It is really important that you share your experiences – whether good or bad, happy or sad. If you've had a negative experience, it's easy to think there's no point in complaining and that 'nothing ever changes'. Or, if you've had a great experience, that you 'wish you could say thank you'. Your feedback is helping to improve people's lives, so if you need advice or are ready to tell your story, we're here to listen.

Notice on Healthwatch England changes announcement:

As part of the Dash Review published in July 2025, Healthwatch England and the local Healthwatch network were recognised for their work in listening to and raising the voice of the people who use health and social care services across the country. The review highlighted the government's desire to streamline bodies contributing to patient safety and consequently local Healthwatch responsibilities will be transferred to NHS integrated care boards and local authorities. This transformation will take time and therefore, here in Kent and Medway, we will continue to work with the public and stakeholders to achieve change for local people. We also recognise that since the announcement, while the current body Healthwatch will cease to exist, there has been an acknowledgement of the need for high-quality, independent voice to remain.

Healthwatch Kent, Healthwatch Medway and Mental Health Voice are hosted by EK360.

Get in touch



If you or a loved one would like to share your experiences of health or care services, please get in touch – Have your say | Healthwatch Kent or Have your say | Healthwatch Medway.

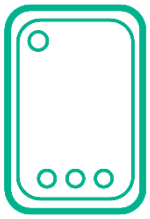
Or call our freephone number on 0808 801 0102.
Text 'Need BSL' to 07525 861 639 for our British Sign Language communicator to contact you.

If you work in or alongside health or social care and would like to discuss how you might use the insights in this report, we would love to speak to you – please get in touch via info@healthwatchkent.co.uk.

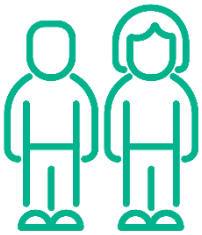
Support information

In need of support now?

- Mental Health Wellbeing Information Hub – Help and support if you are feeling anxious or stressed, down or low.
- Children and young people – specific services to support you are just a text, call, or click on a website or app away.
- Kent and Medway Mental Health Crisis Line – Anyone experiencing an urgent mental health crisis can call 111 and select the option for mental health to speak to a specially-trained mental health practitioner. If there is a risk to your life or someone else's, please do not call 111. Dial 999 instead.



- Release the Pressure have a highly trained and experienced team available 24/7 to provide expert support no matter what you are going through. Don't suffer in silence. You can call the helpline on 0800 1070 160, text the word SHOUT to 85258, or use Rethink's webchat service.
- Kent and Medway Safe Havens offer people aged 18+ free mental health and crisis support in a welcoming, comfortable, non-judgmental, and non-clinical environment. This is a drop-in service, with no referral or appointment required, via face-to-face or virtual support.



- Samaritans – Call us any time, day or night. Whatever you're going through, from any phone for free on 116 123.

Summary

From September 2024, we started to receive more feedback on people's experiences of support in a mental health crisis. We heard some positive feedback where people had accessed support that had helped them prevent or recover from a mental health crisis. We did, however, also hear from some people sharing experiences in which individuals had tragically died.

In December 2024 and February 2025, we presented summary reports to key stakeholders in the Kent and Medway mental health system (see Appendix 1) on what people had told us about support in mental health crises. They took action to improve awareness of and access to crisis care (see Responses section). We also called for the improvement of care coordination and continuity within and between services, particularly for people reaching out in a mental health crisis.

To understand in more depth what people were telling us, we analysed 489 related experiences from January 2024 to February 2025. These emerged from what people had told us through Mental Health Voice, Healthwatch Kent and Healthwatch Medway without any targeted prompts for mental health crisis. People told us about understanding, supportive and helpful care and how positive interactions had enabled them to manage their mental health, keep them safe and help them to recover. When people had less positive experiences, key issues included waiting times for crisis support, ineffective crisis response, and unsuccessful coordination or continuity of care between services.

> I had been feeling very depressed and I rang 111 to get some support as I did not know where to turn, although I waited a long time for them to get back to me. I spoke to [a doctor, who] was very reassuring and listened to me and suggested some ideas to calm me down, I would like to say thank you as it makes such a difference when somebody takes the time to listen to you.

This report provides further detail on people's experiences of crisis support, analysis of the underlying themes and trends for key services (see Findings section) and recommends next steps (see Recommendations section).

In June 2025, we shared a draft version of this report with the mental health team at the NHS Kent and Medway Integrated Care Board, who initiated positive changes (see Responses section). From October 2025, we shared this end report with them and the executive team, plus the Kent and Medway suicide prevention programme team, senior and operational leaders at Kent and Medway Mental Health NHS Trust, Public Health teams, key members of adult social care in Kent and Medway, all four health and care partnership leaders, safe havens, and general practice leadership, with a call to action for further positive change.

Methods

Engagement

Mental Health Voice and the Healthwatch Kent and Healthwatch Medway signposting, information and research services receive a continuous and ongoing flow of insights from people sharing their experiences of health and social care. We invite feedback from anyone living in Kent or Medway. Mental Health Voice is a forum for people with lived experience of mental health issues.

Engagement in Mental Health Voice and the Healthwatch signposting, information and research service was both solicited and unsolicited and was conducted by online webform, email, social media, text message, telephone and in-person methods. As much of the feedback was unsolicited, there was a bias towards negative sentiment.

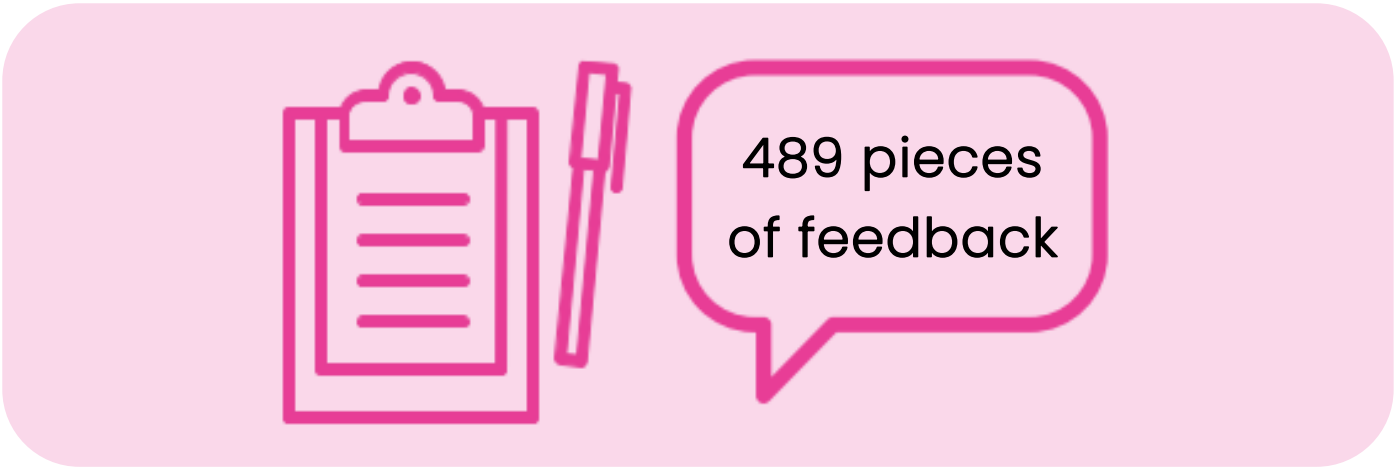
Wherever possible, a member of staff contacted the individuals providing feedback to support them to tell their story and to ensure high quality engagement and data capture. Feedback received from January 2024 to February 2025 via these engagement methods was considered in this report.

Measures

The survey questions were open and invited people to tell us about their or their loved one's health or social care experience, providing detail on what happened, where it happened and when. There were no targeted prompts for feedback about mental health crisis support.

Sample selection

Within all of the feedback shared with Mental Health Voice and Healthwatch Kent and Healthwatch Medway signposting, information and research services between January 2024 and February 2025, we identified 489 pieces of feedback about mental health crisis support.



All feedback received had been assigned a service type and organisation. Feedback on crisis support was identified by filtering for items relating to mental health care from urgent, emergency or crisis services including A&E, ambulances, home treatment and rapid response, the police, liaison psychiatry, crisis lines, safe havens and urgent treatment centres, and other organisations relevant to crisis care. Word searches were also used on the feedback itself to identify pieces outside of these services that contained terms related to mental health crisis, which were then checked manually for relevance.

Analysis

All feedback was assigned topics from our topic bank (see Appendix 2). Feedback relevant to crisis support was then grouped by service and topic before being analysed further thematically. Demographics were also explored to identify any trends or patterns.

Demographics

Demographics were captured in all engagement methods by using closed question sets (see Appendix 3). The amount of feedback from the demographic groups of the people who gave the feedback is shown in Figure 1. For feedback about crisis support, 74% was about the person who gave the feedback and 26% was about someone else.

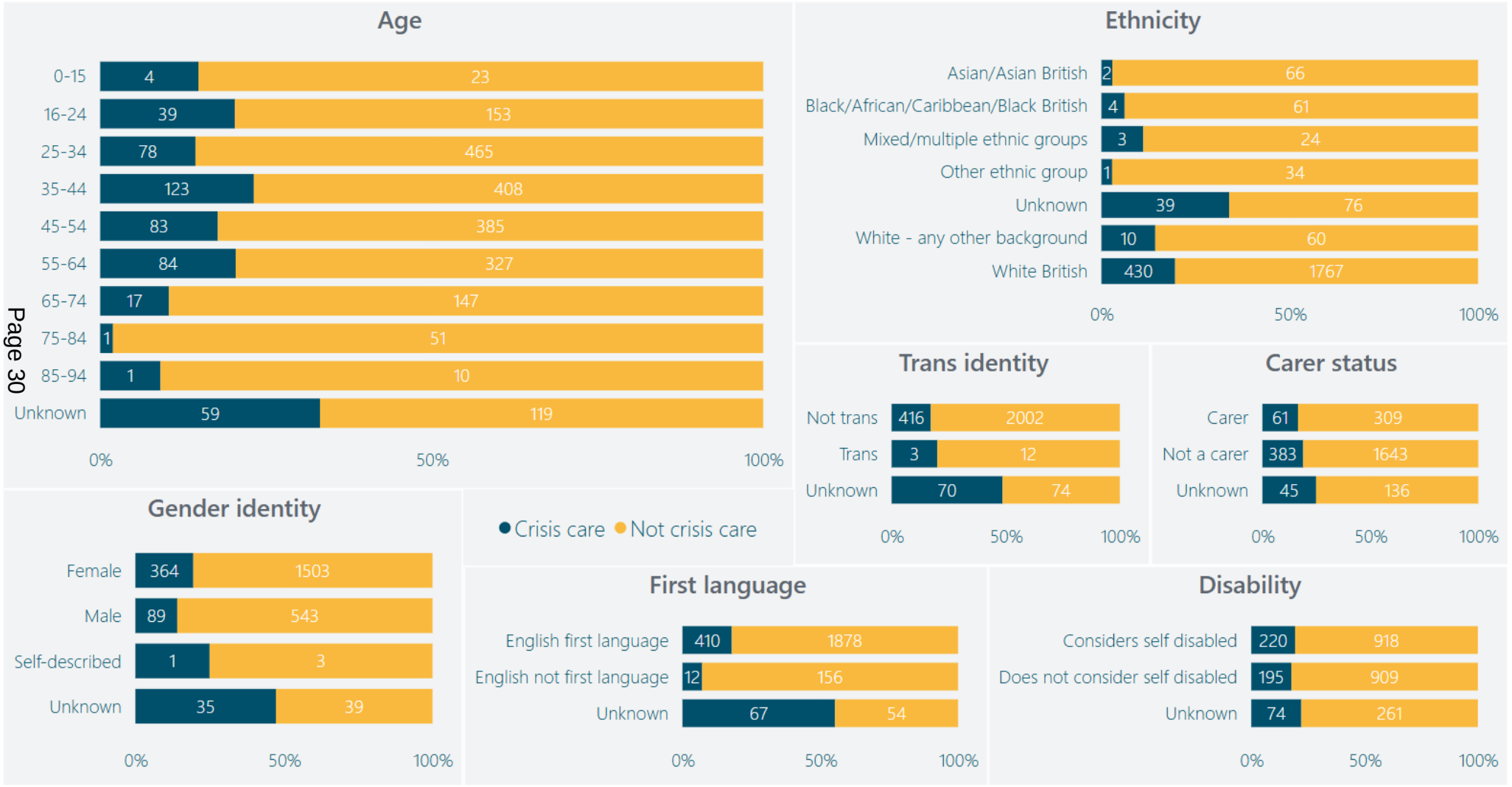


Figure 1. Demographics of people who gave feedback by the amount and percentage of feedback about crisis care vs. any other care.

Findings

Were there any changes over time?

To identify if there were key periods for feedback on crisis support, the amount of feedback on crisis support over time is shown in Figure 2, in both number and as a percentage of the total amount of all feedback about any care or service.

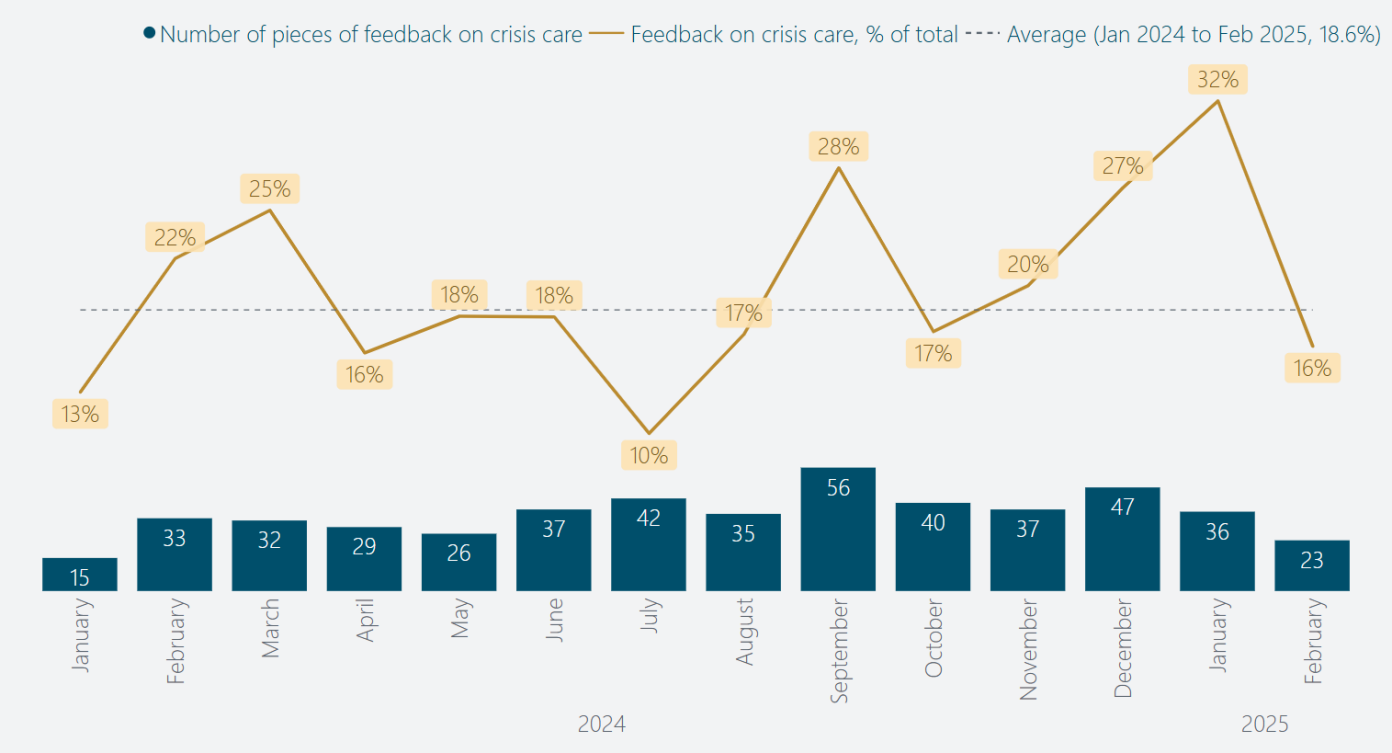


Figure 2. Amount of feedback on crisis support over time, in number of pieces and as a percentage of the total amount of all feedback about any care or service.

The percentage of feedback on crisis support was above the average of 18.6% in February, March and September 2024 (22%, 25% and 28%, respectively), showing that a greater proportion of the people we spoke to were telling us about crisis support at these times. Between October and December 2024, this percentage increased three times in a row (from 17% in October to 32% in December), showing an escalation in how much people were telling us about crisis support during these months. These observations underline recent findings that indicate the importance of considering time of year, as well as time of day and day of the week, in the planning and provision of services for mental health (Bu, Bone and Fancourt 2025).

Was age a factor?

To understand if we heard more about crisis support for people of certain ages, the age of the person the feedback was about is examined as a factor in Figure 3. In terms of the percentage of feedback that was about crisis support, we heard the most about people aged 16 to 25, 35 to 44 and 55 to 64 (23%, 22% and 20%, respectively), compared to the average of 18.6%.

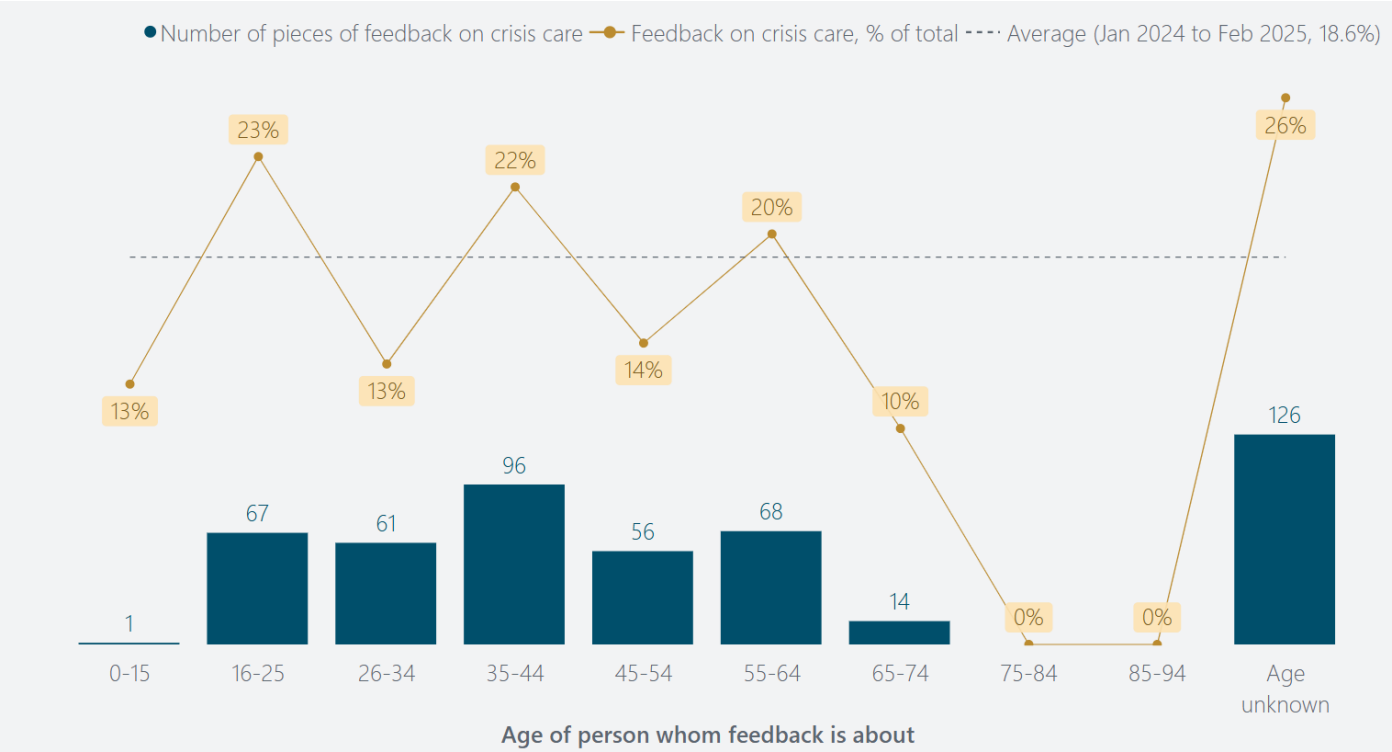


Figure 3. Amount of feedback on crisis support by the age of the person it was about, in number of pieces and as a percentage of the total amount of all feedback about any care or service.[1]

Were there times when we heard more about crisis support for key ages?

As we heard the most about crisis support for those aged 16 to 25, 35 to 44 and 55 to 64, we looked for any variability over time for these groups (see Figure 4).

For people aged 16 to 25, the percentage of feedback that was on crisis support peaked in February, April and May 2024 (39%, 50% and 31%, respectively, see Figure 4) to levels higher than for all other age groups or those of unknown age. Levels rose again in October 2024 (39%), staying high until January 2025 (33%), a peak that was both higher and started a month earlier than for feedback not filtered for age (33–39%, Figure 4 vs. 20–32%, Figure 2, respectively). These observations echo recent evidence that time of year, particularly the autumn season, can be linked to trends in young people's mental health (Jack, et al. 2023).

1. Figure 3 and Figure 4 are limited to the feedback for which we were told the age group of the person the feedback was about, which made up 19% of all feedback and 26% of feedback about crisis support.

For people aged 35 to 44, the percentage of feedback that was on crisis support peaked around February, March and April (29%, 56% and 25%, respectively, see Figure 4), then September and December 2024 (48% and 26%, respectively). The February and April 2024 peaks were most notable in the 35 to 44 (29% and 25%, respectively) and 16 to 25 (39% and 50%, respectively) age groups, although did not repeat in February 2025. The March peak, at a high level of 56%, was most notable in the 35 to 44 age group. The September 2025 peak was most significant in the 35 to 44 and 55 to 64 age groups (48% and 39%, respectively).

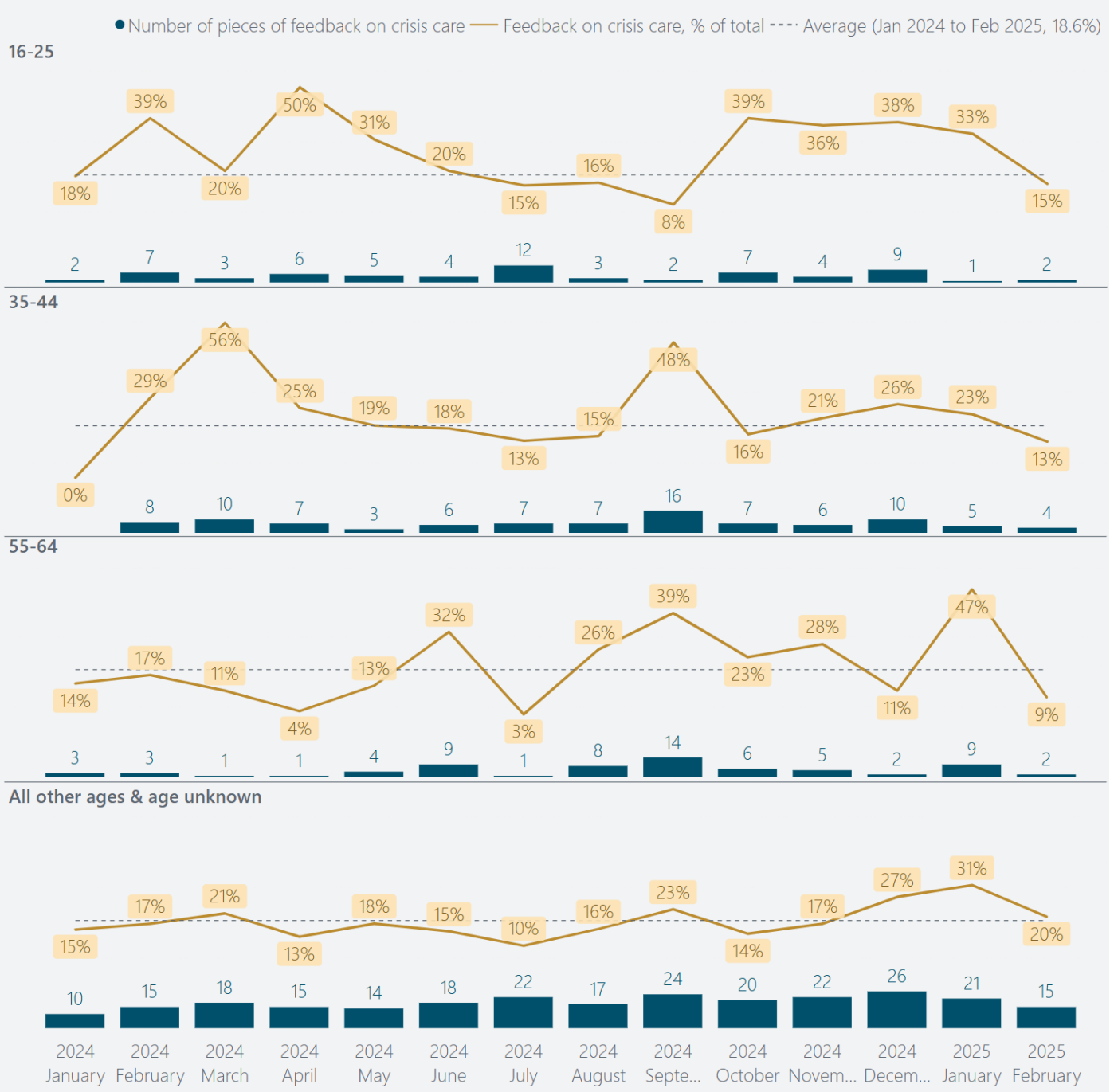


Figure 4. Amount of feedback on crisis support over time for the key age groups of the person it was about, in number of pieces and as a percentage of the total amount of all feedback about any care or service.[1]

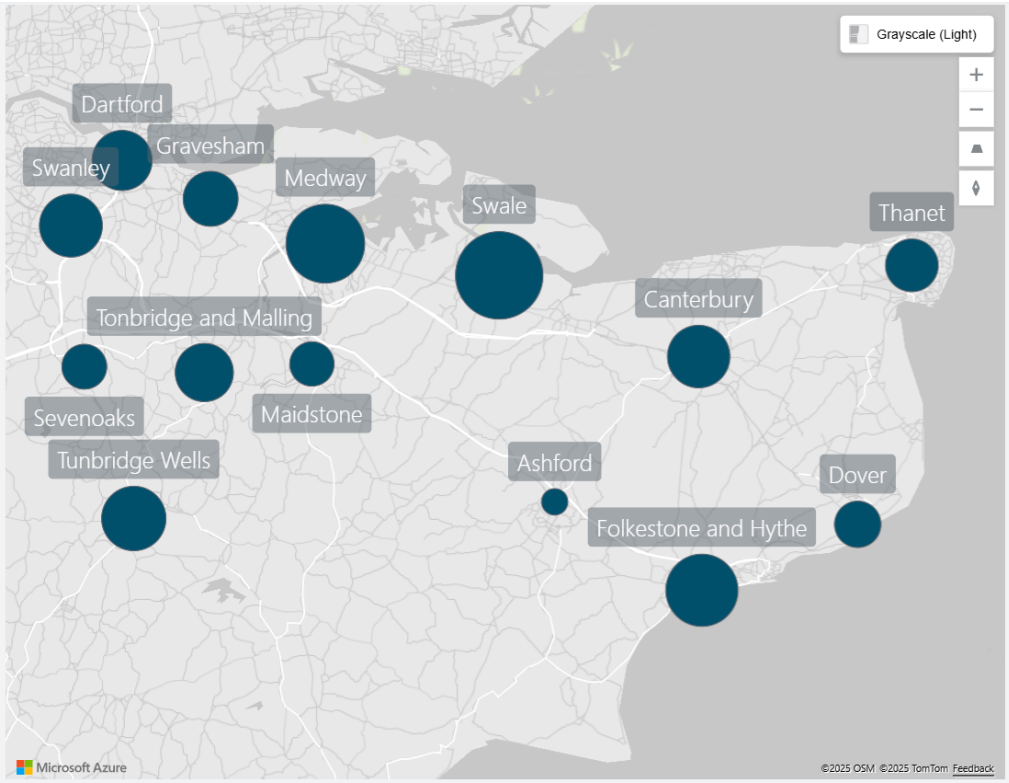
For people in the 55 to 64 age group, the percentage of feedback on crisis support peaked in June, August, September and November 2024 and January 2025 (32%, 26%, 39%, 28% and 47%, respectively). The June and August 2024 peaks were most notable for the 55 to 64 age group. The September 2024 peak was shared with the 35 to 44 age group and the November 2024 peak with the 16 to 25 group. The January 2025 peak, whilst common across age groups, was most pronounced for the 55 to 64 age group.

Whilst the percentage of feedback on crisis support for people in the 45 to 54 group was overall below average (14% compared to the average of 18.6%, see Figure 3), it also peaked in January 2025 at 32%.[2] Notably, the 45 to 54 and 55 to 64 age groups represent many people in Generation X, aged roughly 45 to 60, who have been identified in research as the generation most likely to die by suicide and drug poisoning (Office for National Statistics 2019).

2. Based on seven pieces of feedback on crisis support.

What were people's experiences in different districts?

The proportion of people's feedback that was about crisis support and the sentiment of the feedback by district are shown in Figure 5 and Figure 6.

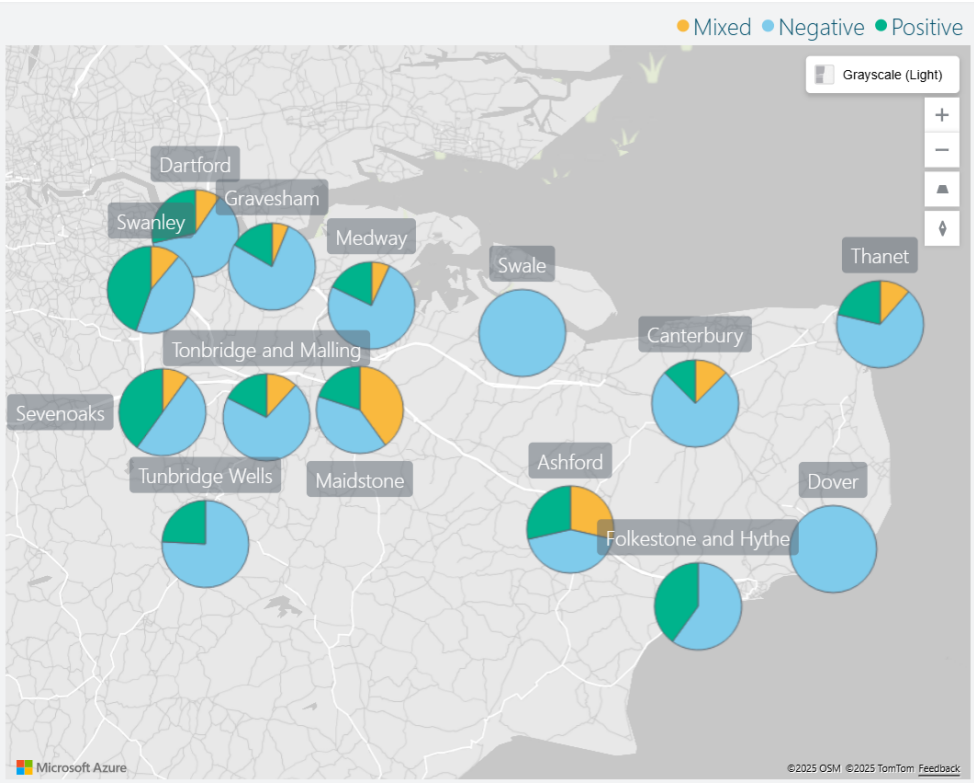


District	Percentage
Swale	42%
Medway	33%
Folkestone and Hythe	26%
Tunbridge Wells	20%
Swanley	19%
Canterbury	19%
Dartford	17%
Tonbridge and Malling	16%
Gravesham	14%
Thanet	13%
Dover	10%
Sevenoaks	10%
Maidstone	10%
Ashford	6%

468 pieces of feedback on crisis care

2553 pieces of feedback in total

Figure 5. Percentage of feedback that was about crisis support in each district. Feedback from people who did not specify which district they lived in was excluded.



District	Positive	Negative	Mixed
Ashford	4	6	4
Canterbury	2	12	2
Dartford	6	13	2
Dover	0	12	0
Folkestone and Hythe	2	3	0
Gravesham	8	37	3
Maidstone	2	4	4
Medway	34	143	13
Sevenoaks	4	5	1
Swale	0	14	0
Swanley	4	4	1
Thanet	13	41	7
Tonbridge and Malling	3	12	2
Tunbridge Wells	7	22	0

457 pieces of feedback

Figure 6. Proportion of positive, negative and mixed feedback by district. Feedback about our engagement partners' services was excluded to avoid bias.

Swale, Medway, and Folkestone and Hythe districts had the highest proportion of feedback about crisis support (42%, 33% and 26%, respectively) compared to the average of 18.6% (see Figure 5). Within Swale, all 14 pieces of feedback were negative; in Medway, 143 of 190 were negative (75%), 34 positive (18%) and 13 mixed (7%); and in Folkestone and Hythe, three of five were negative (60%) and two positive (40%), however, the latter is based on a limited sample size (see Figure 6).

Whilst the proportion of feedback from people living in the Dover district that was about crisis support, at 10%, was less than the average for Kent and Medway (see Figure 5), all of this feedback was negative (12 pieces, see Figure 6). Whereas in Sevenoaks, the same proportion of feedback was about crisis support (10%), but four of these ten pieces of feedback were positive (40%) and five negative (50%). In Swanley, the proportion of feedback that was about crisis support was average (19%), with four out of nine pieces positive and four out of nine negative (each 44%).

Of the eight pieces of positive feedback in the Sevenoaks and Swanley districts, four were about Samaritans. There was one piece each about private therapy, NHS 111, West Kent Mind and the Kent and Medway Mental Health Crisis Line.

In the Dover district, five of the 12 pieces of negative feedback were about a community mental health team or Mental Health Together, two were about acute hospitals and two about safe havens. In Swale, two of the 14 pieces of negative feedback were about a community mental health team or Mental Health Together and two about Kent Police.

This variation in sentiment by district, when broken down by service, is relatively consistent with the overall sentiment of feedback about services (see Figure 7). For example, voluntary, community and social enterprise services received more positive feedback than community mental health teams. An exception to this was the lack of positive feedback about safe havens from people living in the Dover district, with one negative feedback linked to the lack of a safe haven in Dover. Notably, in Swale, the two pieces of negative feedback for Kent Police were about a lack of support for children experiencing suicidal ideation or intent.

What did we hear about different services?

Sentiment of feedback about services

The key service types we heard about regarding crisis support were community mental health teams (CMHTs) or Mental Health Together (22% of feedback), Kent and Medway Safe Havens (13%), voluntary, community and social enterprise (VCSE) services (10%), general practice (10%), home treatment and rapid response (8%), Kent and Medway Mental Health Crisis Line (6%), A&E (6%), children and young people's mental health services (5%), counselling, psychotherapy and talking therapies (5%), liaison psychiatry (4%), and mental health hospitals (3%).

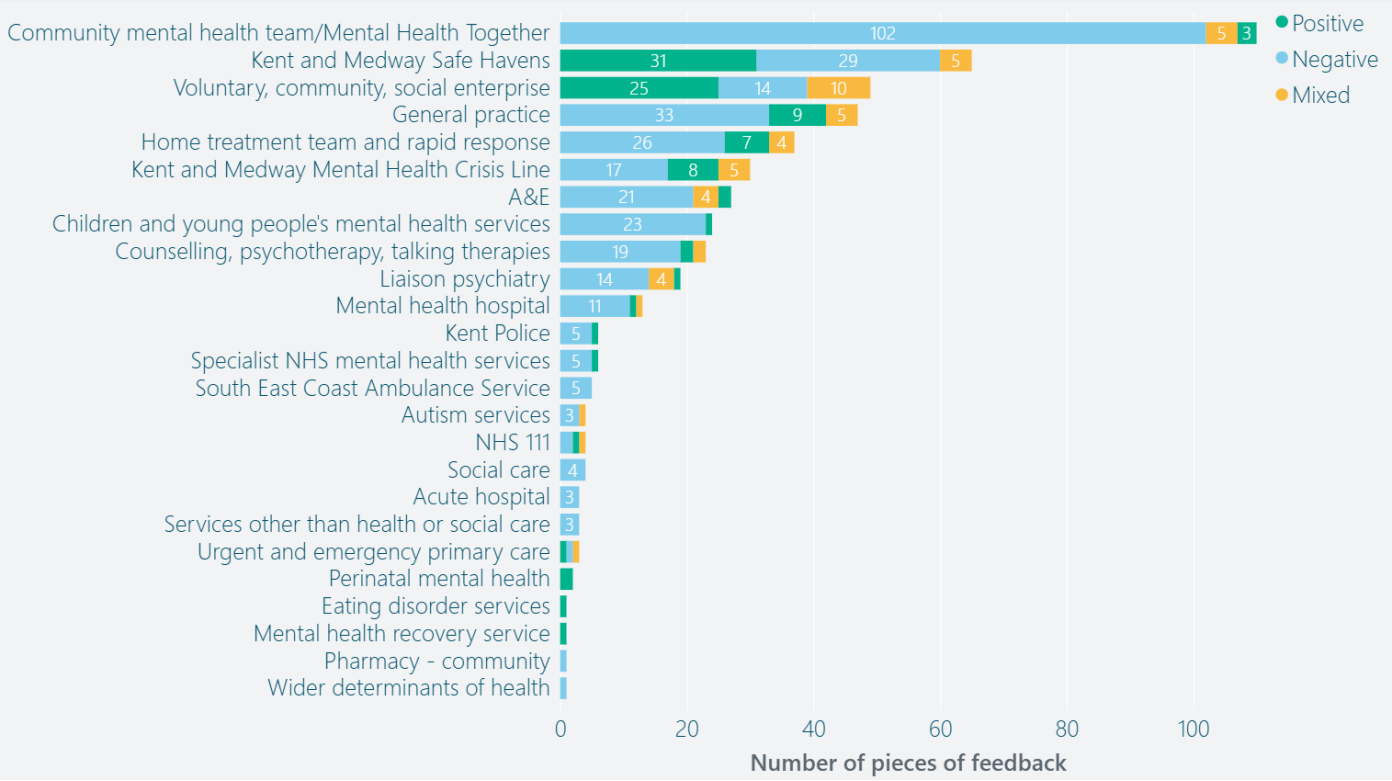


Figure 7. Number of pieces of feedback by service type and sentiment.

The service types with the most positive feedback were VCSE services (51%) and Kent and Medway Safe Havens (48%), suggesting that we can learn from what is going well in these services.

Case study involving multiple services

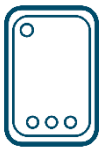
We heard about Nat's experiences with crisis services.[3] Nat's story involves multiple services and highlights issues of access, coordination and continuity of care, and response to crisis situations.

3. Pseudonyms and they/them pronouns are used to protect identity.

Nat

The experience I had … and the way I was treated … made me feel so much worse at a time in my life when I already felt at my lowest. Since then, I have not engaged with any mental health services or accepted any help from my GP practice and if I were to experience another crisis in the future, I would be extremely reluctant to reach out for help.

‘ [In early] 2024, I had a mental health crisis. A family member called 111 and was advised to take me to hospital, where I was given a number for a crisis line and sent home. At home, I called this number to discover it was no longer in use.



I ended up calling [an out-of-county] home treatment team, which I had been receiving treatment from before this. They gave me the number for [my local] home treatment team, who told me they could not help me and to call 111 again.

This time, 111 told me to attend [the] hospital. I ended up staying there for six days. During this time, I stayed in a room with at least five other patients at once, having to sleep on a chair. I didn’t leave this room for six days, except from the attached bathroom and assessment rooms, and I was told I couldn’t shower because there was not enough staff. This room and the attached bathroom were not cleaned during the time I was there.

There were many issues with medication, causing me and other patients to experience withdrawal symptoms. One evening, I was given the wrong medication but when I tried to explain this, I was dismissed and I took the medication. … I was put into one of the assessment rooms attached because I was upset. This room had faeces smeared on the walls from another patient the day before and it had not been cleaned. When I tried to leave the room, I was told I wasn’t allowed and that I needed to calm down. I was eventually allowed to leave after other patients argued with the staff and advocated for me.

I was later transferred to [a mental health inpatient unit] and then discharged to [the home treatment team]. Throughout this process, I felt very ignored and dismissed, like I was wasting time. [In the mental health inpatient unit], a doctor told me they were treating people who were ‘actually sick’, which felt very invalidating. **I want to share my story to highlight that mental health services are not only underfunded but lacking empathy and compassion. ’**

Community mental health teams and Mental Health Together

93% of feedback about CMHTs and Mental Health Together was negative, 3% positive and 5% mixed.[4] People giving positive feedback about CMHTs or Mental Health Together described effective coordination and continuity of care.

> I have recently been in crisis and … expressed my need to just get away, which I did. During this time [the CMHT] liaised with the [CMHT in another part of the country] where I was staying to ensure continuation of care.

> I phoned the [CMHT]. I was having really dark thoughts and feeling suicidal. I asked to speak to my worker, and I was told that someone has signed me off from their mental health service. [The CMHT] said no problem and that they will refer me back in right now. She transferred me to a [member of staff] who did all the forms, and it was all easy. It was one phone call, and I was back on there. I am very happy about this. I would just like to say thank you to how quickly they sorted this out for me.

The most frequent topics in negative feedback were impact on lifestyle and wellbeing, coordination and continuity of care, and communication between staff and patients (see Figure 8). Care given by staff, medication, discharge, and triage, assessment and admission were also frequently mentioned. These issues were identified in CMHTs in all four health and care partnership areas.

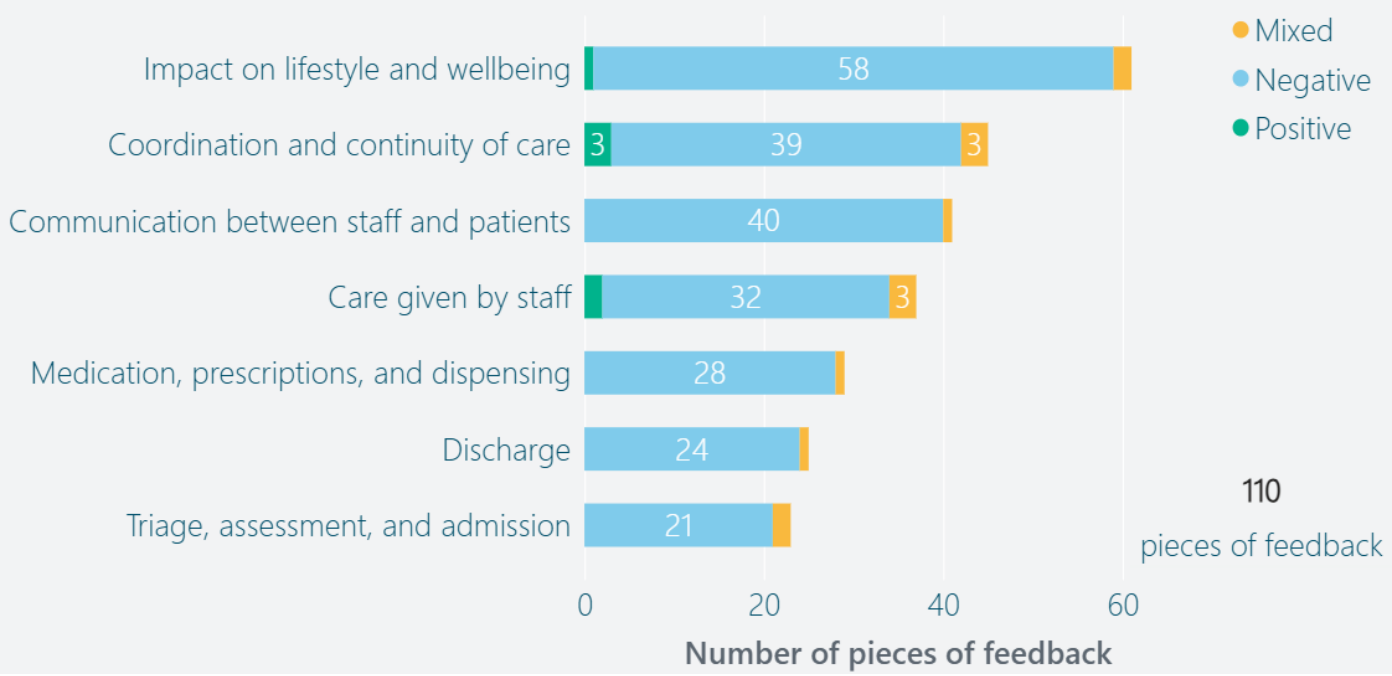


Figure 8. Top seven topics in 109 pieces of feedback about CMHTs.

4. These percentages total more than 100% because they have been rounded to the nearest whole number.

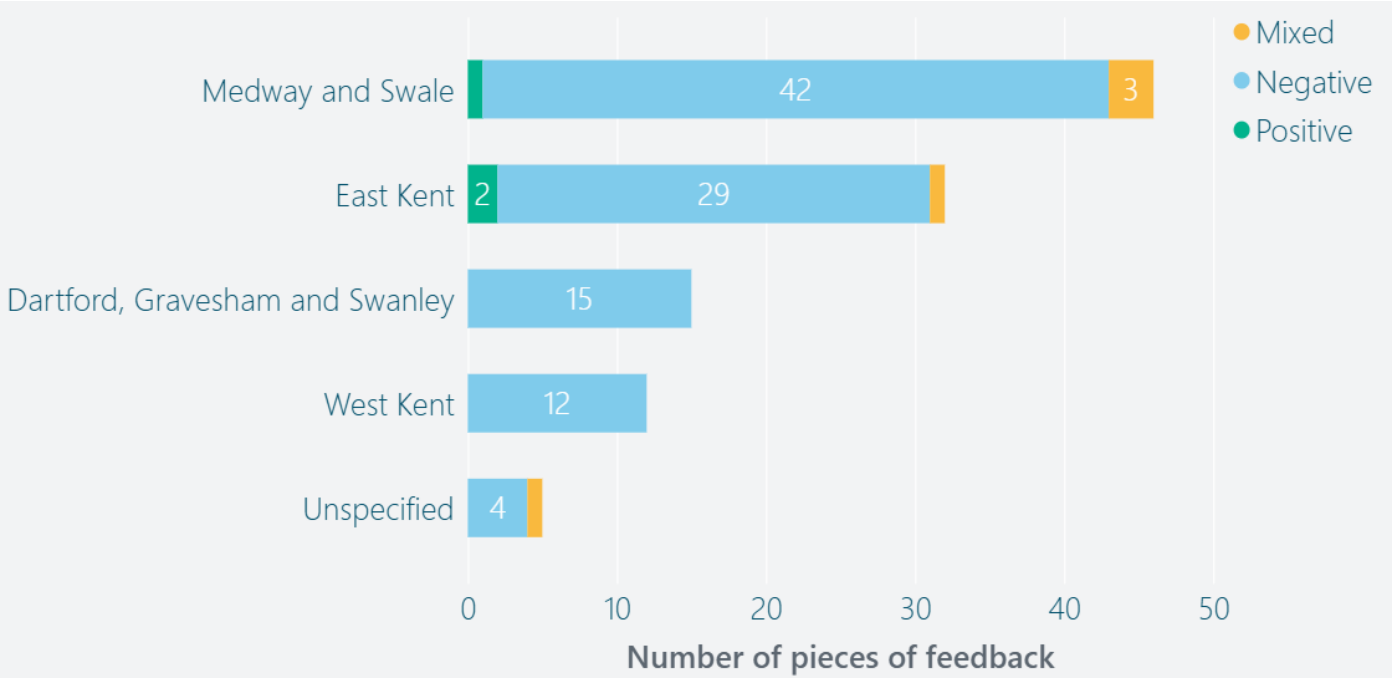


Figure 9. Sentiment of feedback about CMHTs in each health and care partnership area.

Impact on lifestyle and wellbeing: Of the 61 pieces of feedback on this topic, the most common theme was people describing how their interactions with CMHTs had left then feeling more unwell or had tipped them into crisis.

> I became a lot more anxious, depressed and suicidal after my dealings with them.

Coordination and continuity of care: The most common theme in the 45 pieces of feedback on this topic was from people with ongoing mental health conditions that caused them to occasionally reach crisis point. They shared how they felt unsafe with a lack of oversight or ongoing check-in support from the CMHT. They were instead in a cycle of referral, assessment, discharge and re-referral, during which we heard cases of people not receiving effective support.

> As a result of the wait times to be referred back in and receive an appointment for a medication review, it has resulted in two admissions to [the mental health] hospital, which could have been prevented had [Mental Health Together] kept me under their service.

Communication between staff and patients: Within the 41 pieces of feedback on this topic, people most commonly told us they had been unable to access timely or effective support when they contacted their CMHT. People also told us of instances where they did not receive planned or promised phone calls from the CMHT, including for follow-ups and remote appointments.

> I originally contacted the CMHT [a few months ago] as I was in crisis and felt very unstable. … I waited ten weeks before anyone contacted me. … I went on to self-harm after a week. … I have now been signposted on to a [mental health] course and informed of a few more things that may be of help – this shouldn't have taken ten weeks.

Care given by staff: Within the 37 pieces of feedback that mentioned this topic, whilst we heard about responsive and understanding care, people also described feeling dismissed or that they were not being listened to.

> I found [them] unsympathetic and felt like [they weren't] listening or understanding.

Medication, prescriptions and dispensing: The most common theme in the 29 pieces of feedback on this topic was of people having difficulties getting medication reviews or changes.

> I recently contacted [the] CMHT and asked them for their help and to review my [mental health medication]. This was completely ignored and I was told basically I'm going to get discharged from their service. This is despite basically saying I'm planning to [die by] suicide.

Discharge: Within the 25 pieces of feedback that related to discharge, people referred most often to being discharged without follow-ups or support.

> I was referred by 111 to the CMHT during crisis as I was actively suicidal. I had a one-hour consultation and then was discharged back to the care of GP without any follow up. This has had a detrimental effect as they acknowledged how bad things were during my assessment and then did nothing to support me.

Triage, assessment and admission: Within 23 pieces of feedback on this topic, the most common theme was that people who had reached crisis point or had identified that they were approaching it described not being accepted into the CMHT for support because they were not unwell enough.

> I was told by [the CMHT] that I wasn't suicidal enough to have their support and was turned away.

A professional also told us of the exclusion of people with a dual diagnosis, an issue we have reported on previously (Healthwatch Kent and Healthwatch Medway 2024).

> The CMHT refuse to work with anyone who is self-medicating with substances despite this being an area covered extensively within the dual diagnosis and co-occurring conditions act.

Next steps for community mental health teams and Mental Health Together

We recommend community mental health teams and Mental Health Together to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Maintain systems and plans to ensure that if people contact their CMHT in crisis, they access timely and personalised support.
- Ensure that callbacks, follow-ups and appointments take place. If there is an unavoidable need for cancellation, ensure that these are rebooked at the point of cancellation and communicated clearly to the individual.

Breaking the cycle of referral, assessment, discharge and re-referral

- Review re-referral rates to understand opportunities for more effective support systems.
- Review why people referred into the CMHT due to mental health crisis are not being accepted for support, including people with co-occurring conditions, and communicate this back to the referrers.
- Facilitate regular check-ins with people diagnosed with mental health conditions, those on mental health medication and/or those at greater risk of mental health crisis.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Support for people on waiting lists

- For those on waiting lists, put in place signposting and updates for all, and check-ins or support plans for those at higher risk.

Discharge practices

- Ensure that people are discharged with coproduced and personalised support plans and receive follow-up check-ins for a tapered discharge.

Kent and Medway Safe Havens

48% of feedback about Kent and Medway Safe Havens was positive, 45% negative and 8% mixed.[4] The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 10). Communication between staff and patients was the third most common theme and the one with the most negative feedback. Other common topics included quality of treatment, service change or closure, coordination and continuity of care, and health inequalities.

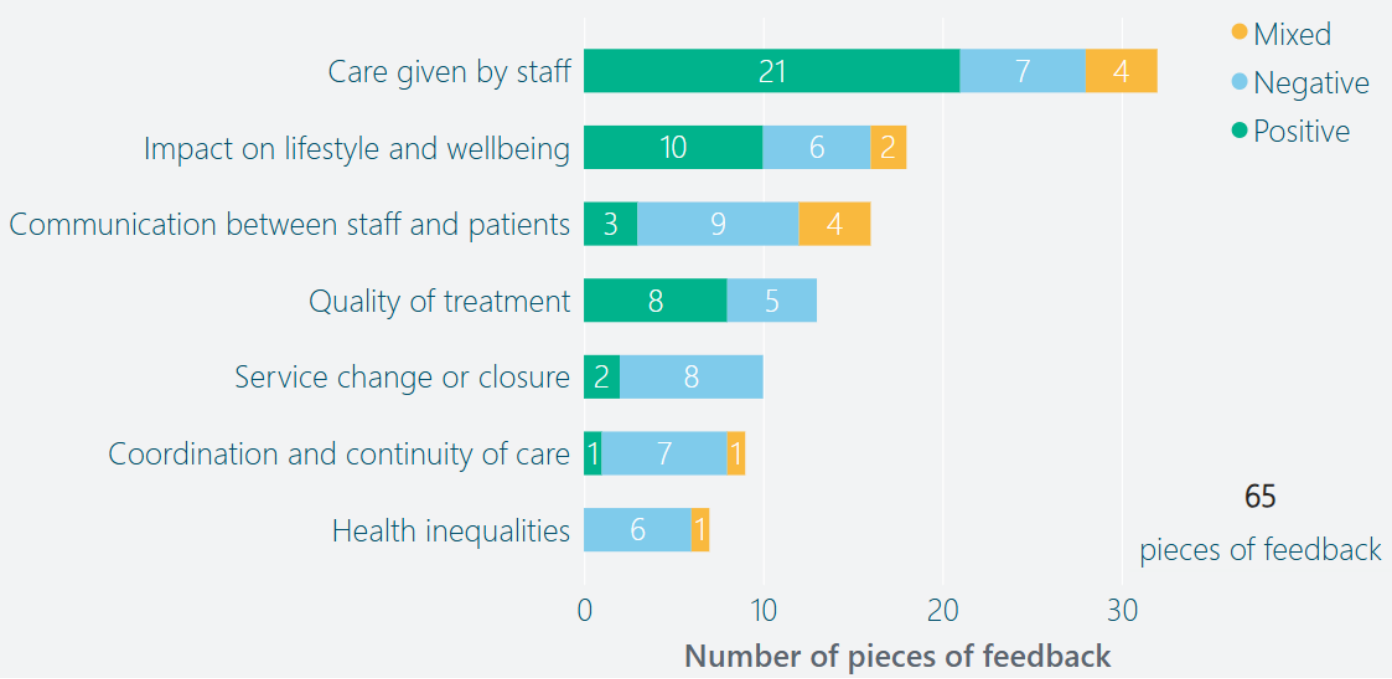


Figure 10. Top seven topics in 65 pieces of feedback about Kent and Medway Save Havens.

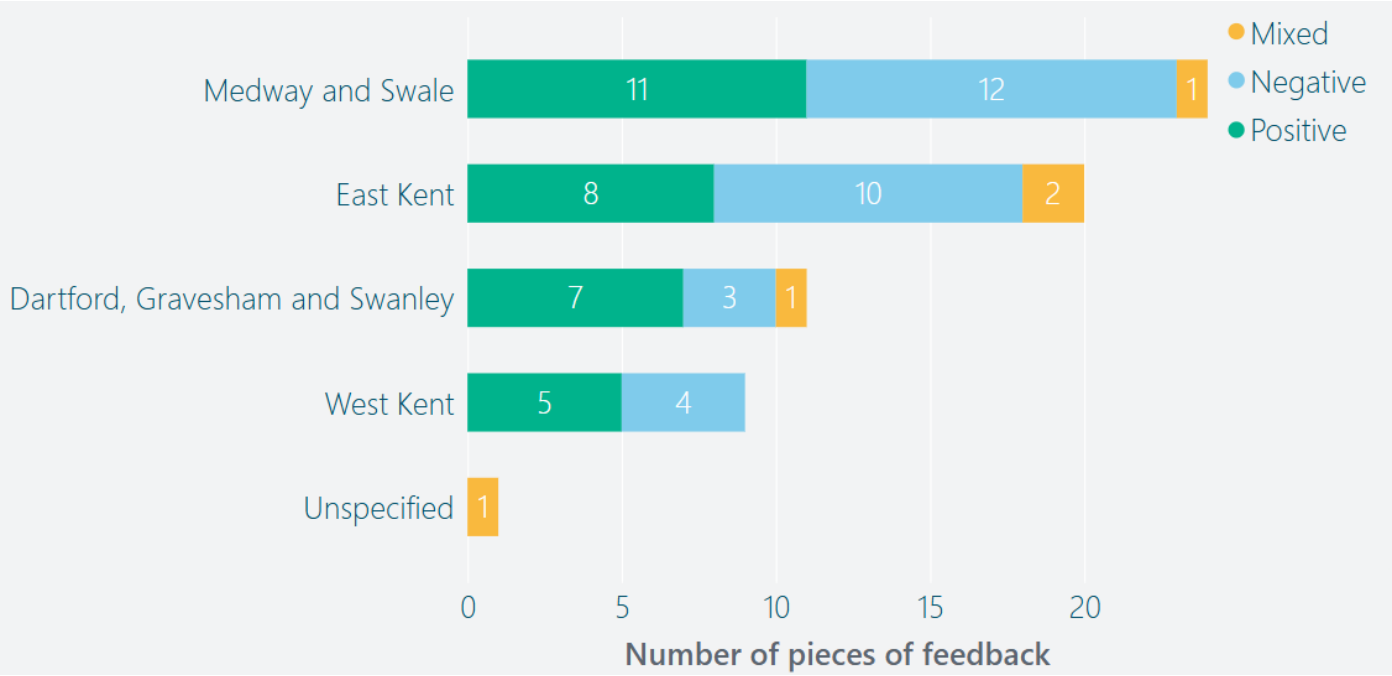


Figure 11. Sentiment of feedback about Kent and Medway Safe Havens in each health and care partnership area.

Care given by staff: Within 21 pieces of positive feedback on this topic, the most common theme was of people experiencing a welcoming and safe atmosphere and feeling listened to without pressure or judgement.

> The safe haven[s] … are great. They will listen. I was in crisis back in November and they gave me the time to just be.

However, ten people relayed that they ended up feeling they had been wrong to attend the safe haven or that the interactions with staff had not helped.

> The first time, I didn't feel like the [member of staff] I spoke with was taking me seriously. … The second time I spoke with [another member of staff] who seemed to listen more and took me seriously.

Impact on lifestyle and wellbeing: Ten people told us how their attendance at the safe haven had had a positive effect on them. In eight cases, this was tied in with the care given by staff theme, suggesting that positive interactions had a direct impact on people's wellbeing.

> Everyone was really helpful to get me through the nursing baby phase. I am okay now.

One person reported how a chaotic atmosphere at a safe haven had a negative impact on their wellbeing.

> It was chaotic up there. There were all these people wanting help, some of them were under the influence of drugs or alcohol, and it was loud. … I came away feeling more traumatised than when I arrived.

Communication between staff and patients: People described accessing safe haven support via email, phone and text, which they found helpful. Others mentioned that useful information had been given to them at the safe haven.

> The [member of staff] who got in touch with me said I could text, which we did for a bit, and it helped having someone there on the other end when I couldn't speak.

Some people were concerned that there was not enough public awareness of the support offered at safe havens, including the peer support groups, or of the fact that locations had changed.

> I am concerned that so few people in Thanet know about the safe havens here. … If they knew sooner, they could have benefitted from this support service.

Quality of treatment: People felt that the support offered, including the groups, were good quality and helpful.

> The safe havens is a brilliant service and I don't know what I would do without it.
>
> Safe havens are really good. I use them all the time.

Others felt the support they received at the safe haven was not as thorough as they needed it to be. For example, two people stated that a 20-minute time limit on phone calls was not long enough.

> It was an activity evening, but I wanted something less informal where I could meet people and gain peer support.

Service change or closure: Whilst one person cited the longer opening hours of the Tunbridge Wells Safe Haven as helpful when compared to the previous crisis café offer, others mentioned issues with the change to the service offer in Thanet, Tonbridge, Ashford and Medway. Two people felt the support at the Thanet Safe Haven was not as good as in its previous location and two others experienced confusion around its move, with one arriving during the advertised opening hours only to find it closed. Two others expressed concern at the lack of service in Ashford. People who had attended the former crisis café in Tonbridge were disappointed that the service was only being replaced in Tunbridge Wells and one person described staffing issues at the Medway Safe Haven.

> I rang 111 option 2 and they suggested that I go to the safe haven instead of A&E. I got a taxi and found out it had closed, I had no knowledge of this at all.

Coordination and continuity of care: People described challenges when it came to coordination of their care between safe havens and CMHTs. People also identified continuity of care issues as they had been offered welfare checks that then did not take place.

> [After being referred by the CMHT], I attended the safe haven. … I went there in a high level of crisis … but it was not what I had hoped for at all. … The support I received was minimal, and it was explained to me that the safe haven was actually more of a social community place, offering weekly group classes.

Health inequalities: People described issues with the location of some safe havens, especially due to limited transport links. For example, people in Tonbridge and Swale were unable to access their nearest safe haven as public transport stopped at 8pm. Others shared issues linked to Ashford, Sandwich and Dover, with one identifying it was unsafe to drive if in a mental health crisis.

> We don't even have a safe haven in Dover, so I can't even use this service.

A person with a disability felt that their needs had been accommodated well.

> They made me feel comfortable by adapting the environment to my needs.

However, others with disabilities or neurodiversities shared mixed experiences in accessing the safe havens. For example, one person with autism and communication difficulties said she would be unable to access safe havens without support. Another benefitted from the sensory room but felt misunderstood as an autistic person, as did an individual with mutism.

> Autistic individuals can be more sensitive to rejection, have a strong sense of right and wrong, and dislike breaking rules or making mistakes. It's important to choose words carefully to avoid making them feel they've done something wrong.

Next steps for Kent and Medway Safe Havens

We recommend Kent and Medway Safe Havens to consider the following.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.
- Ensure that planned welfare checks reliably take place.

Effective signposting and awareness of service

- Share good practice in providing appropriate signposting information.
- Engage in public and community outreach to raise awareness of the support offered at safe havens, including peer support groups.

Accessibility and reasonable adjustments

- Share and develop good practice in meeting diverse needs, including for people with disabilities, neurodiversities and communication differences.

Locations

- Pursue facilities for communities in underserved locations, for example, Tonbridge, Swale, Sandwich and Dover.

Support offer

- Continue to offer a broad range of engagement options, including email, phone, text, walk-ins and support groups.

Integrated care

- Work with community mental health teams and home treatment and rapid response teams to develop good coordination of care between services, for example signposting and referral processes.

Voluntary, community and social enterprise services

51% of feedback about VCSE services was positive, 29% negative and 20% mixed. The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 12). Other common topics were quality of treatment, communication between staff and patients, and service change or closure. Access to services was the sixth most common theme and the one with the most negative feedback.

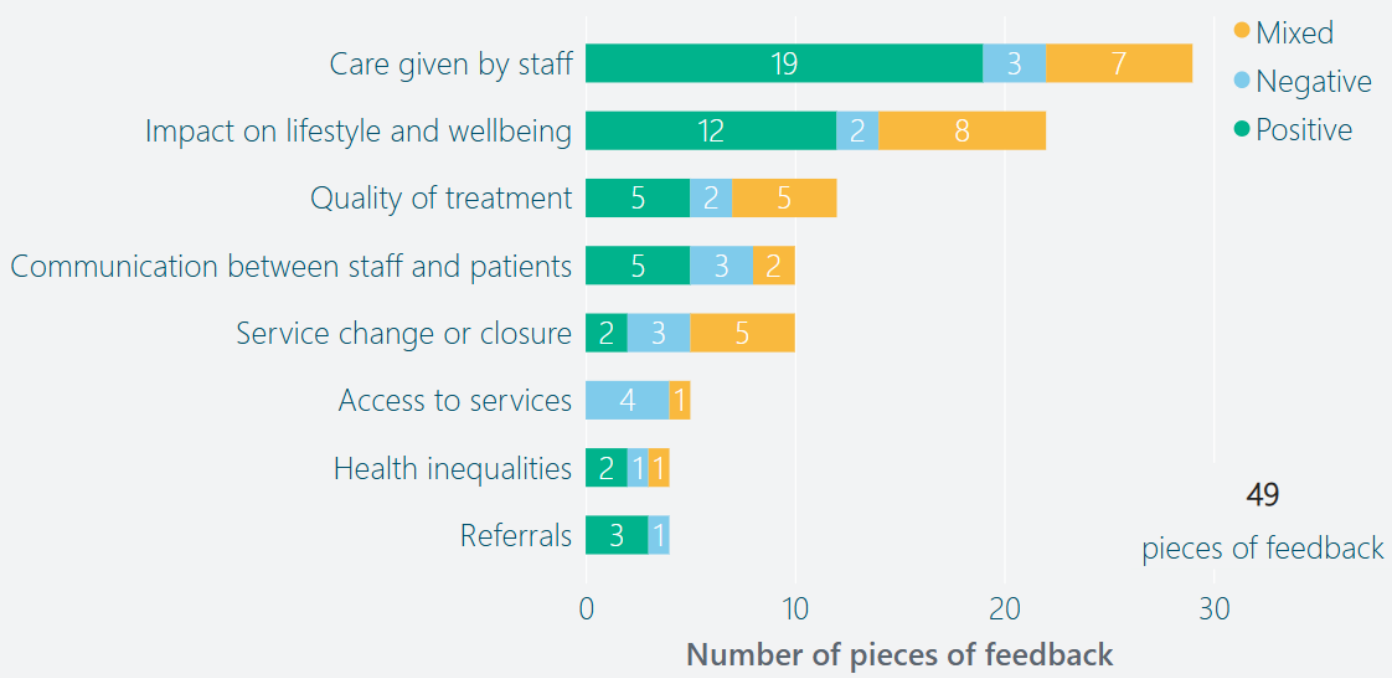


Figure 12. Top seven topics in 49 pieces of feedback about VCSE services.

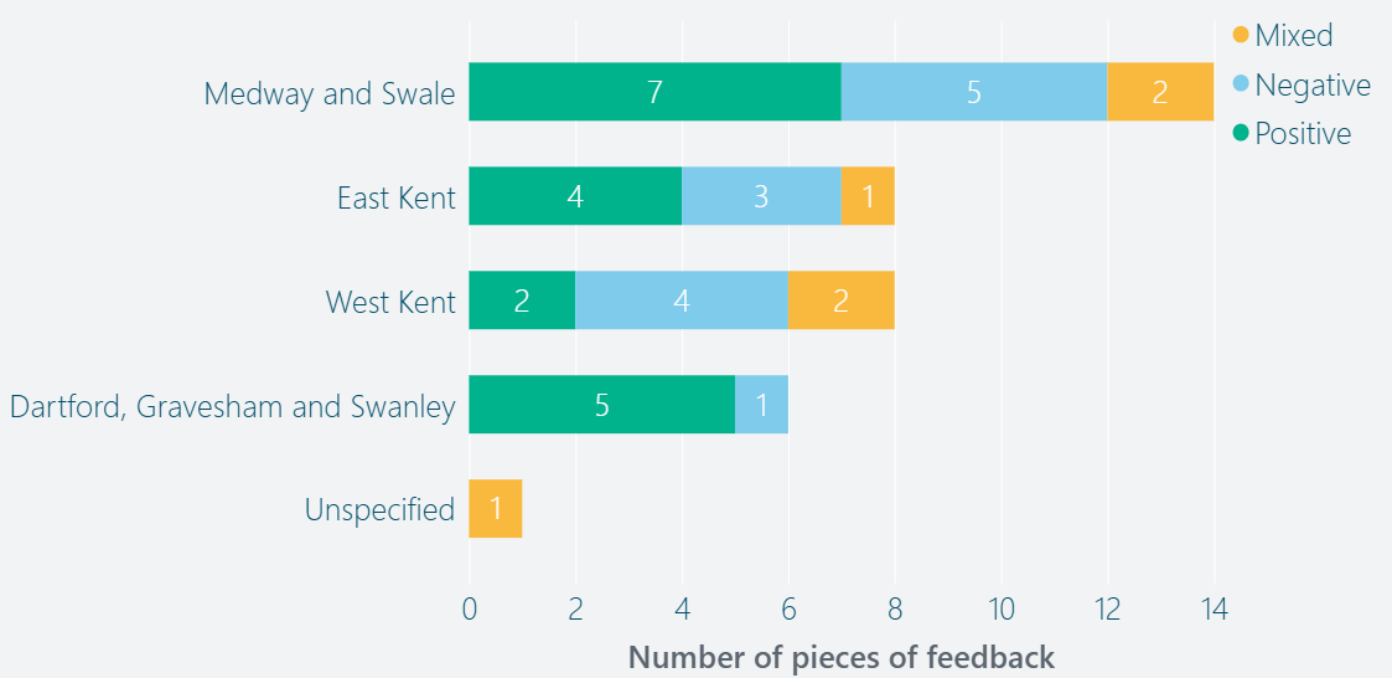


Figure 13. Sentiment of feedback about VCSE services in each health and care partnership area. Feedback about our engagement partners' services was excluded to avoid bias.

Care given by staff: Staff who treated people with understanding and compassion were mentioned, particularly on the Samaritans helpline. As were a range of other VCSEs, including peer support organisations, charities and a church.

> Each time I've spoken with [Samaritans], they have been absolutely incredible in helping me gain clarity and perspective. I called them after self-harming on a few occasions, and they responded with such understanding and compassion. They made me feel supported and ensured my safety, guiding me to seek the care I needed at A&E, who also treated me with respect and understanding.

Impact on lifestyle and wellbeing: People reported being able to manage their mental health or navigate further support as a result of the support provided.

> In three weeks, I've started accessing the church and other things alongside [the peer support organisation] and no longer feel in crisis.

Two people, however, told us of the danger of not receiving timely or effective support when in crisis.

> [A] telephone assessment [with Live Well Kent] took place [nine days after my GP referred me to the crisis team], but there was nothing they could offer me other than going back to [a mental health support service] and paying for one-to-one counselling. … This constant rejection makes me feel completely inadequate and worthless.

Quality of treatment: People felt that the support available in the voluntary sector was good quality. Two people compared this to NHS services.

> The voluntary sector is far more underfunded than the mental health teams but will do more to support.
>
> Services such as the [crisis café] take pressure off the NHS and work to prevent crisis, rather than responding to it.

Communication between staff and patients: People described effective signposting practices that helped with crisis treatment and recovery.

> Fortunately, via [a peer support organisation], I have been given details about the Kent Enablement [and Recovery] Service and I am going to contact them in the hope that they can accept and support my [loved one].

However, two people described being given advice they did not find helpful.

> They told me to talk to family and friends. I had no family or friends at the time.

Service change or closure: People who were accessing support from personality disorder peer support groups were concerned about the potential impact of these services being replaced by the Service User Network, particularly for people in crisis.

> This has the potential for suicidal thoughts to overrun.
>
> I worry I'll end up in psychosis through the ending of the group.

Access to services: Four people reported issues with accessing support via the Samaritans phoneline and one via the Release the Pressure helpline.

> I wouldn't try to call any helplines again for support after trying to call Samaritans on a few different occasions and not getting an answer.

Health inequalities: One person identified good practice in supporting an autistic young person.

> My [loved one] has been really happy to engage with the [member of staff] supporting her, which is rare for my [loved one], as she is autistic and finds engaging with support agencies really hard.

Next steps for voluntary, community and social enterprise services

We recommend that voluntary, community and social enterprise services consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Identify and share good practice in the provision of timely, targeted care.
- Review and address why some helpline calls are not answered.
- Fast-track people at risk of mental health crisis on waiting lists.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Effective signposting

- Share good practice in providing appropriate signposting information.

Accessibility and reasonable adjustments

- Share and develop good practice in meeting diverse needs, including for people with disabilities, neurodiversities and communication differences.

General practice

70% of feedback about general practice was negative, 19% positive and 11% mixed. The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the highest proportion of positive feedback (see Figure 14). Other common topics were medication, prescriptions and dispensing, communication between staff and patients, coordination and continuity of care, booking appointments and referrals.

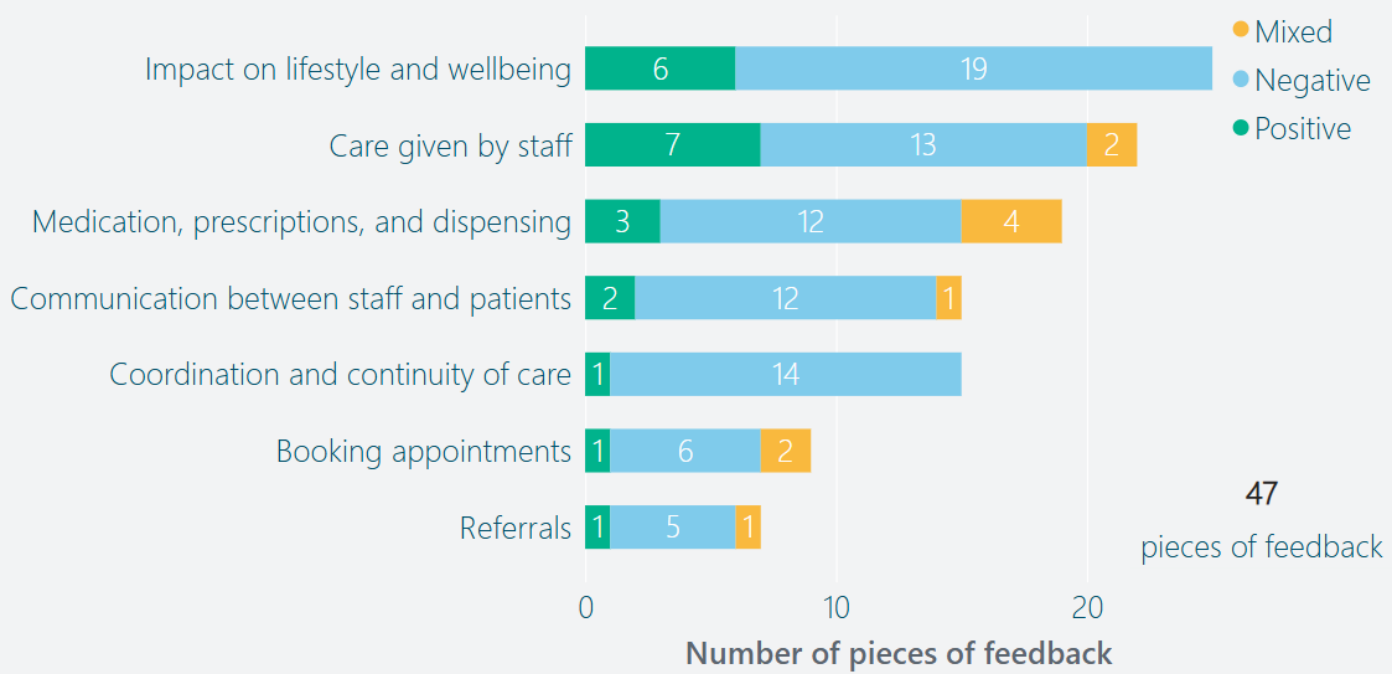


Figure 14. Top seven topics in 47 pieces of feedback about general practice.

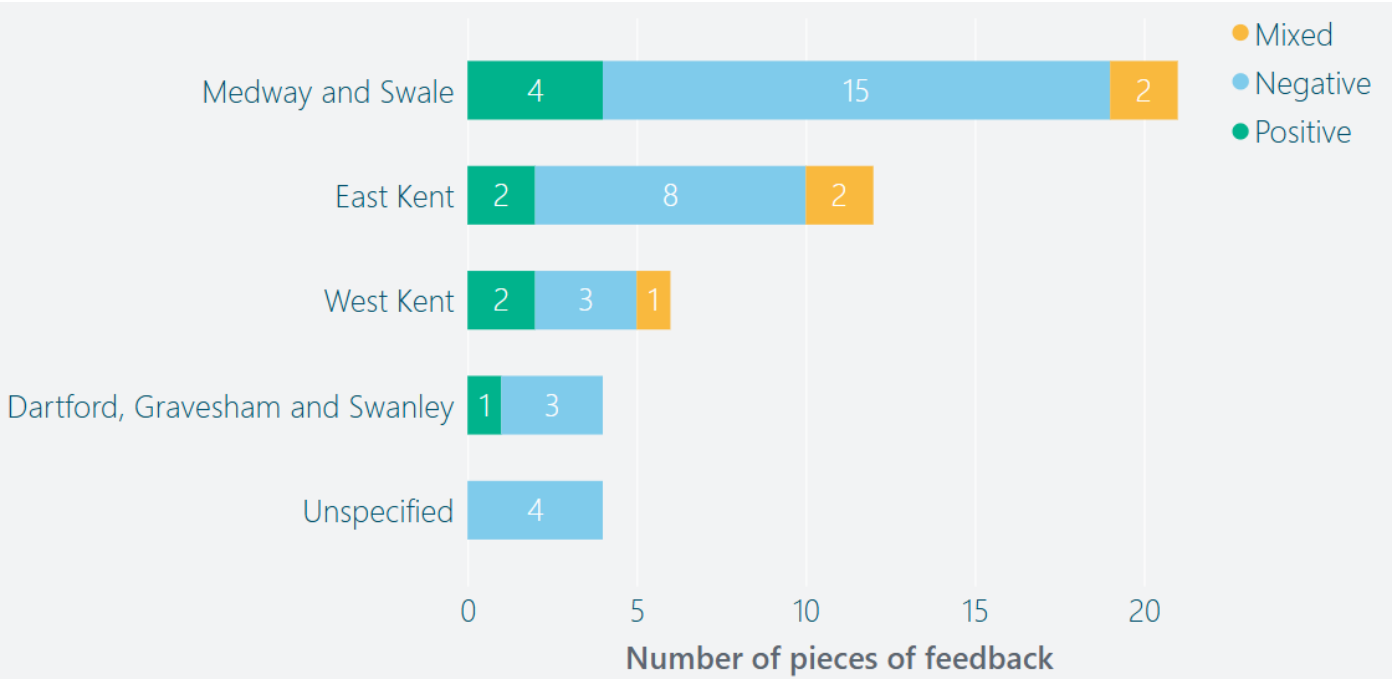


Figure 15. Sentiment of feedback about general practice in each health and care partnership area.

Impact on lifestyle and wellbeing: People described how effective and timely care from GPs or mental health nurses had kept them safe and helped them to recover. One young person was able to return to work as a result.

> I have been very suicidal at times and [my mental health nurse] has literally kept me going.

However, general practice professionals telling people they could not help them or no help was available, making ineffective referrals, forgetting to refer, not supporting with medication, cancelled appointments and being dismissed directly contributed to people's mental health becoming worse.

> He has appointments [at the GP surgery] that get cancelled and rebooked, which impacts him even more because he mentally prepares for these appointments to then be let down.

Care given by staff: People described understanding and supportive care from their GP or mental health nurse.

> The doctor she saw … was very understanding.

> We had been doing a lot at home with our amazing GP. The GP had managed to get my [child] into a better place mentally.

However, people also described dismissive attitudes from professionals when they disclosed how they were feeling.

> The doctor I last saw laughed when I said I was feeling suicidal.

> In the end, I tried going into the surgery and explaining, but the receptionist tutted and laughed at me.

Medication, prescriptions and dispensing: Four people received a prescription for medication within two days of contacting the GP. This was after two of these had been let down by children's or adults' mental health services.

> I got an appointment with a doctor that same day who was stunned at my [loved one's] presentation and immediately prescribed her antidepressants and talking therapies.

We heard of two people struggling with crises who were not having medication reviews from their CMHT and were finding their GP support insufficient. People also told us of GPs not following their CMHT's prescription recommendations.

> I'm not under the care of a psychiatrist, no one checks if my medication is still suitable, and the only way I get to see someone is if I get referred back into the CMHT by my GP because I have gone to him in crisis.

Others described medication being changed without enough support.

> I brought in some of my medications from my home country, registered with the GP when I arrived, went in for medical review where the medical team cancelled my medications without any proper review.

Communication between staff and patients: One person said it had been helpful to receive fortnightly follow up calls, which reliably took place on the scheduled date, although it would have been better to know what time the calls would be.

> [The GP] offered me follow-up consultations every two weeks, which they kept to. It was a little annoying not to know what time they were going to call me – they told me what day, but they didn't say a time – so sometimes I had to leave a meeting or worry about going to the loo and missing the call, but they always did call on the day they said they would and that was reassuring and I felt heard and taken care of.

Two people told us that their GP had told them they could not or did not know how to help them. Two others mentioned ineffective signposting, where out of date or incorrect information had been provided.

> When I again said I wasn't coping, [the GP] said, 'I can't help you.'

> I was given a telephone appointment where I was told they had no idea how to help and that they would refer me to another organisation.

Coordination and continuity of care: Two people described the positive impact of having consistent support from their mental health nurse.

> I have [the mental health nurse's] direct email and so when I need help/support, I am able to contact her rather than having to go through the GP surgery. To be able to speak with the same person and have that consistency means the world.

However, one person had the opposite experience when a cognitive behavioural therapy course at their GP surgery was run by three different practitioners. Three others described how they or their child had been passed between their GP surgery and other services without receiving effective care.

> What would a good service look like? A single person responsible for my care. Let me know who they are and what to do if I don't hear from anyone. Joined up care across services, without me having to make dozens of GP appointments.

Booking appointments: Two people mentioned the positive difference easy appointment booking experiences had made. Two others were satisfied with the appointment booking procedure.

> An individual phoned his GP at 9:30am because he was feeling "very low and depressed". His GP made an appointment for him at 11am that day. On another occasion, this individual was feeling suicidal and the GP phoned him that evening. He felt the service he received was very good and felt very supported by his GP.

However, people also told us of struggles to book an appointment for a mental health crisis: two could not get an appointment for two weeks, another was given a telephone appointment for their child only after visiting the practice 13 times, and another was asked to download an app to book an appointment, but the triage system deemed they did not need one. Two people in mental health crisis due to physical health issues also described issues obtaining appointments.

> Mental health crisis, police involved, completely unable to get a face-to-face GP appointment. Initially offered nothing, then an appointment in two weeks. Eventually got a phone call and meds prescribed.
>
> When I eventually got through, they told me to download an app. Not what you want to hear when you're feeling this way.

Referrals: One person was referred promptly to the crisis team by their GP, only to then not hear from the crisis team. Two others told us of a referral being forgotten and delayed or of struggling to be considered for a referral at all.

> I had a very strong urge to take my own life. … My GP was supportive and did an urgent referral to the crisis team and said that someone would call me within the next 24 hours. It was totally ignored.
>
> His GP took weeks and weeks to get a mental health referral sorted and nothing happened. The GP actually forgot to do it twice.

Next steps for general practice

We recommend that general practice considers the following.

Timely and effective support for people in or at risk of mental health crisis

- Ensure that urgent mental health appointments are easy to book and that all staff including receptionists recognise their importance.
- Make it possible for people to make contact throughout the day for booking urgent mental health appointments.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.
- Promote delivery of care by the same professional to people experiencing mental health issues wherever possible.

Mental health medication

- Facilitate prompt care for issues involving mental health medication.
- Promote face-to-face appointments for medication changes and reviews.

Holistic approach for people experiencing mental health issues

- Consider how physical health issues such as chronic pain, weight and mobility may increase mental health risk factors.

Integrated care

- Work with community mental health teams to develop good coordination of care between services, for example, referrals and medication plans.
- Ensure mental health referrals are dealt with promptly and patients are updated when they are completed and provided further contact details.

Signposting and awareness of mental health services

- Promote accessible and up-to-date mental health signposting information, for example, the Kent and Medway Mental Wellbeing Information Hub[5] and local community and peer support groups.

5. https://www.kmhealthandcare.uk/mental-wellbeing-information-hub

Home treatment and rapid response

70% of feedback about home treatment and rapid response was negative, 19% positive and 11% mixed. The topics of care given by staff, impact on lifestyle and wellbeing, medication, prescriptions and dispensing, and quality of treatment had the most positive feedback at two pieces each. The impact on lifestyle and wellbeing theme had the most negative feedback (see Figure 16). Other common topics were care given by staff, coordination and continuity of care, and quality of treatment.

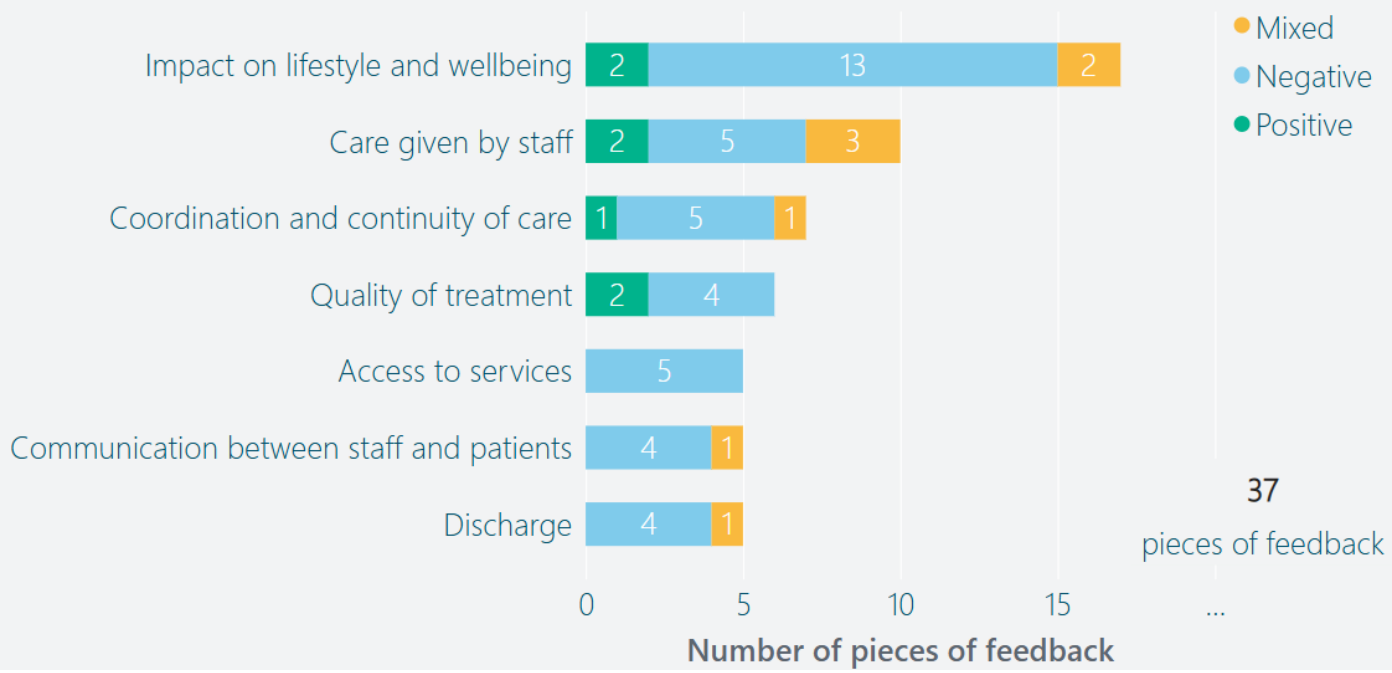


Figure 16. Top seven topics in 37 pieces of feedback about home treatment and rapid response.

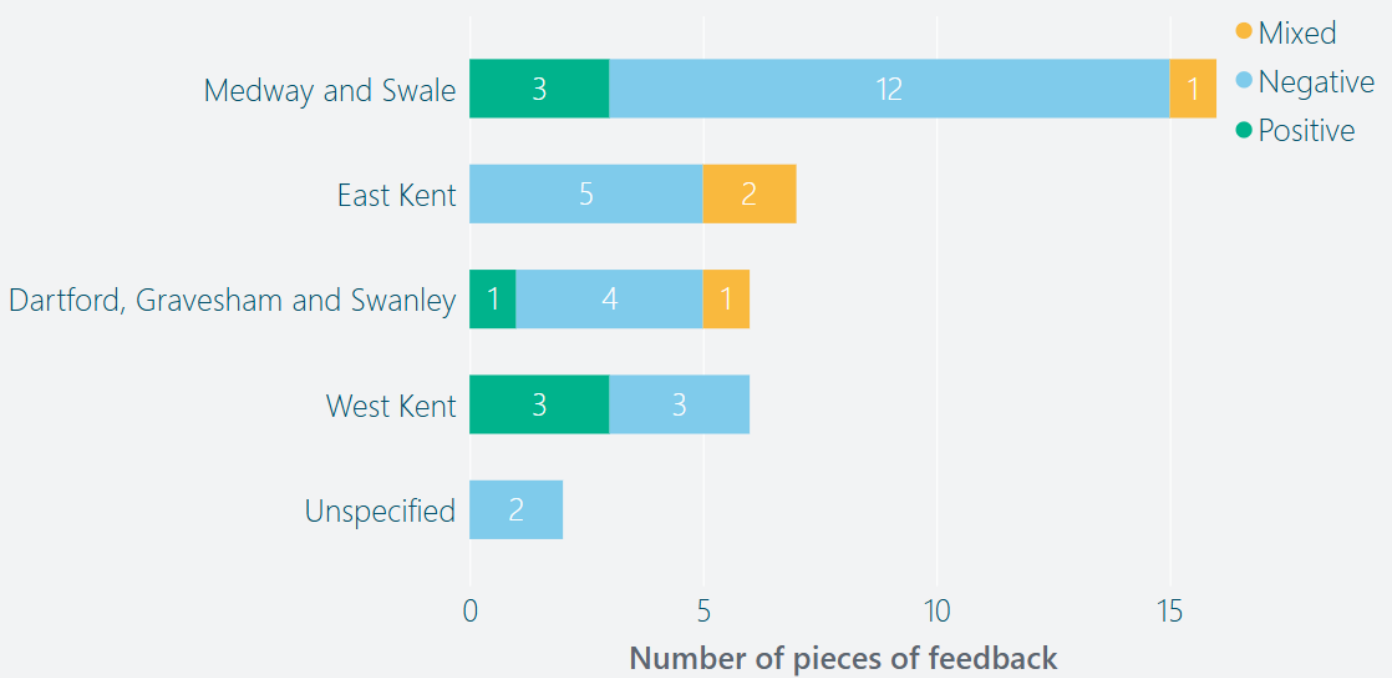


Figure 17. Sentiment of feedback about home treatment and rapid response in each health and care partnership area.

Impact on lifestyle and wellbeing: One person said that the home treatment and rapid response team had helped them to avoid a mental health crisis.

> The rapid response team were really good with me when I needed them in hospital. They helped me avoid a mental health crisis, which I'm very grateful for.

Two people told us of the home treatment and rapid response team not offering direct support to their loved one, which had a detrimental effect on their loved ones' mental health, with one nearly losing their life and being placed under section 136. Others described losing their trust in the service.

> So, through their lack of support, although they tell me I'm not a burden, their actions show otherwise and there just isn't any help and why people end up ending their life. … It's made my mental health worse as I said I won't reach out to anyone when in crisis, which is daily.

Five people told us of the impact of being discharged from the service, with people left feeling worse, unable to cope with their mental health or back in a crisis. One of these had experienced multiple prompt discharges without treatment plans being followed and three were discharged without a plan.

Care given by staff: Positive feedback was about people feeling helped and supported by the home treatment and rapid response team.

> I recently received support from the crisis resolution home treatment team, which was very good. I found the support to be very helpful.

However, others felt described indifference or rudeness. Two people had mixed experiences, depending on which staff they were being supported by.

> Some of the crisis nurses are fantastic. Others shouldn't have a job like this.
>
> The [other team] were much kinder and better at the job in general. They asked questions and seem like they care.

Coordination and continuity of care: An individual whose loved one was admitted to hospital praised the service for their support in his transition.

> I can only praise the team who eventually came with police support as they managed to get him to leave the house calmly and be taken by ambulance for the help he so clearly needs.

However, three people described ineffective referrals or care transfers from the GP or hospitals to the home treatment and rapid response team, resulting in them not receiving sufficient support.

> Each time she has been referred to the home treatment team … this team has ignored the hospital instructions and discharged her after one visit.

Access to services: Five people told us that their calls to the home treatment and rapid response team were not answered or they did not get a callback as promised. Another was referred by their GP but did not hear from the team.

> The phone just kept ringing and ringing, and nobody answered; I was holding on for nearly an hour and finally gave up.

Next steps for home treatment and rapid response

We recommend home treatment and rapid response teams to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Ensure that people are provided direct support.
- Ensure that callbacks take place within the timeframes stated.

Integrated care

- Work with GPs, A&E, liaison psychiatry and mental health inpatient services to improve referral processes into home treatment and rapid response.
- Review and address why mental health treatment plans from other services may not have been followed.

Discharge practices

- Review and address the negative impact of discharge practices on people's mental health and make improvements.
- Ensure that people are not discharged too soon and have robust, personalised and coproduced support plans in place.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Kent and Medway Mental Health Crisis Line

57% of feedback about the Kent and Medway Mental Health Crisis Line was negative, 27% positive and 17% mixed.[4] The two most common topics of care given by staff and impact on lifestyle and wellbeing were also the topics with the most positive feedback (see Figure 18). Other common topics were access to services, coordination and continuity of care, and communication between staff and patients.

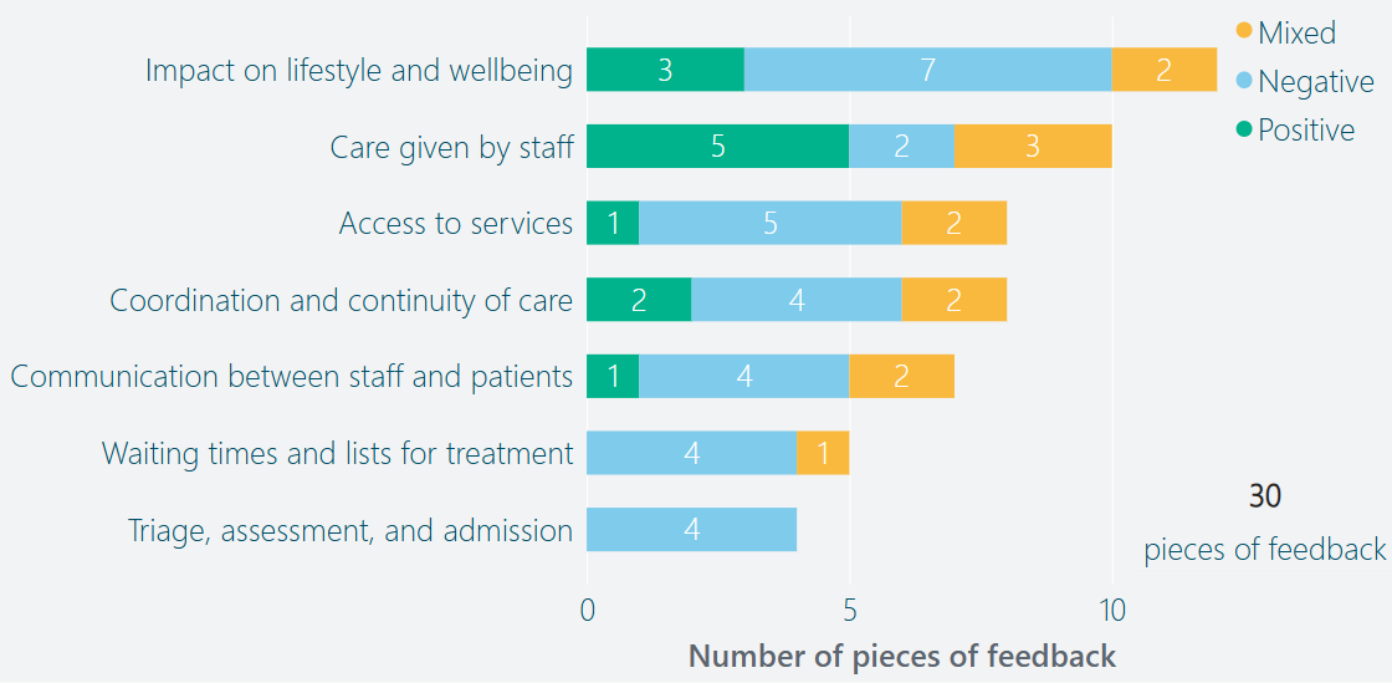


Figure 18. Top seven topics in 30 pieces of feedback about the Kent and Medway Mental Health Crisis Line.

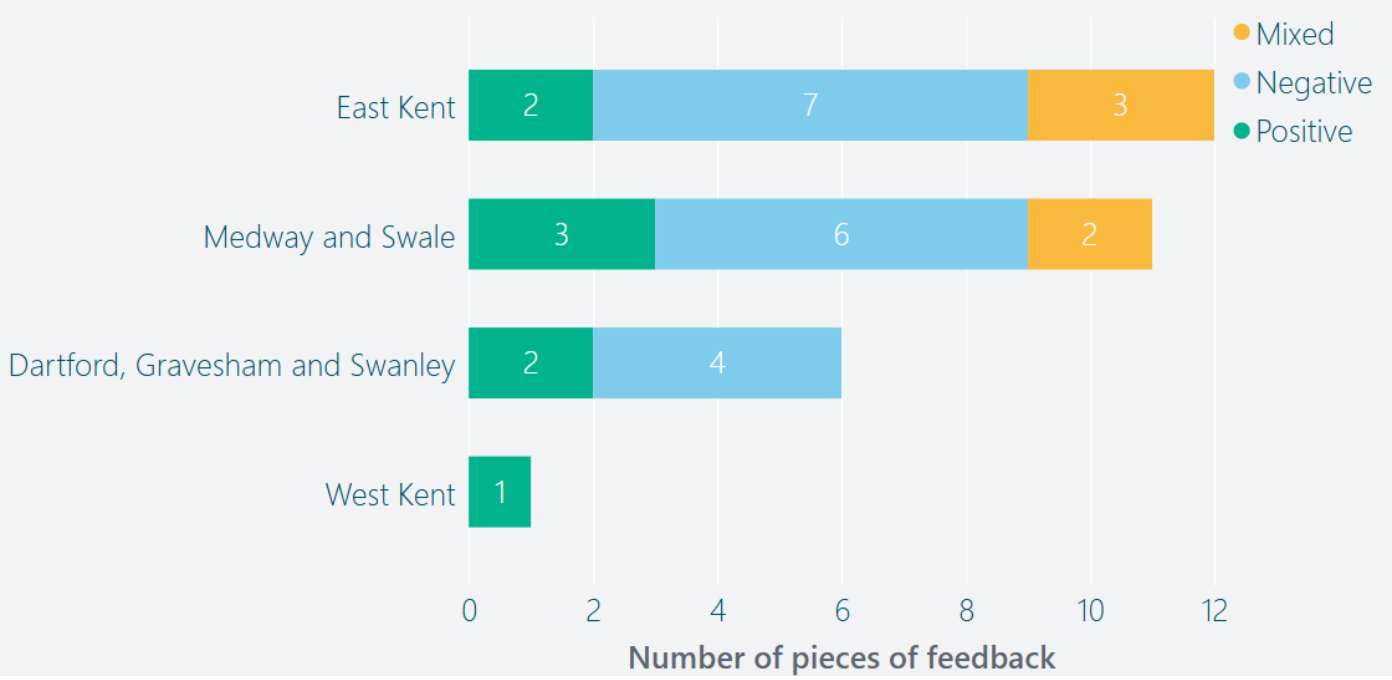


Figure 19. Sentiment of feedback about the Kent and Medway Mental Health Crisis Line in each health and care partnership area.

Impact on lifestyle and wellbeing: Two people told us about the positive impact of the support from the crisis line.

> They spoke to me like I was human and I could tell they genuinely cared. It really helped to calm me down and pick me back up again.

> It was decided that [a person I was supporting] would be contacted by [the crisis line] within the next 72 hours. I informed [the individual]. … It was immediately apparent [they] felt instant relief because of this.

However, four people told us they had become more distressed or had self-harmed as a result of their call to the crisis line. One of these people had waited for a 72-hour callback that did not happen, two were waiting for their call to be answered and one person felt dismissed by the call handler.

> I was placed in a queue. Unable to wait any longer, I self-harmed as a result.

Care given by staff: Six people described call handlers as helpful, understanding and caring. They also described how this contributed to effective support.

> I dialled 111 option 2 and spoke to a really understanding woman. She totally got what I told her.

However, two people felt judged, dismissed or that the call handler was reading from a script.

> She kept interrupting like she was following a script. At point[s] of the conversation, it felt like she was judging me and trying to get me off the phone.

Access to services: Three people told us they had received the care they needed from the crisis line after being unable to access GP support. Five others reported positive experiences accessing the crisis line, including two professionals raising safeguarding concerns. Two people told us of effective support for their urgent medication needs.

> I decided to call 111 option 2 and ask for an emergency prescription. They helped me a huge amount to get it done.

However, four people waited a long time for an answer from the crisis line, ranging from 15 minutes to over two hours, which aligns with known challenges in the delivery of the service in Kent and Medway (NHS England 2025). Three people did not receive the callbacks they had been told to expect.

> I contacted 111 option 2 last week and they told me somebody would call me back within two hours. 24 hours later and nobody had called. I rang them again and they had no record of my previous call, but said I would get a callback within the next hour. Still never got called back, so I just gave up and went to A&E for some help.

Two people who got through to the crisis line felt they did not access direct support, being told instead to attend A&E or await their planned CMHT appointment in two to three weeks. Another was told there was no help available for a person in crisis on the street as they were too distressed for A&E and there were not enough staff at the crisis line to handle the situation.

Coordination and continuity of care: Two people also felt that 72 hours was too long for an urgent callback. One of these people also told us that, whilst the crisis line had coordinated police and paramedic home visits, they did not get to speak to a mental health nurse, which is what they felt they needed most. Two others had referrals made to adult social care by the crisis line, however were then left waiting for that support.

Next steps for Kent and Medway Mental Health Crisis Line

We recommend the Kent and Medway Mental Health Crisis Line to consider the following.

Timely and effective support for people in or at risk of mental health crisis

- Improve call answer times.
- Ensure that callbacks take place by the planned timescale, if not sooner.
- Facilitate more direct support by mental health professionals for people in crisis rather than signposting to A&E.

Responsive and understanding care

- Celebrate and promote responsive and understanding care where people feel listened to by all staff, with ongoing training as required.

Integrated care

- Maintain a clear pathway for professionals to raise safeguarding concerns at the first point of contact, whether an individual is known to services or not.
- Work with adult social care to ensure people referred into their service by the crisis line are clear on timelines and details for further contact.

Recommendations

Recommendations are based on the feedback people gave about the services they accessed for mental health crisis support and any suggestions they made for improvements to these services.

Next steps for Kent and Medway Integrated Care System

We recommend the Kent and Medway Integrated Care System to consider the following.

Continuity of care

- Provide a consistent professional for the care of individuals at risk of mental health crisis, based on a caring and understanding relationship.
- Support families and loved ones who care for people at risk of mental health crisis, seeking their input and including them in care plans.

Preventative support for people in or at risk of mental health crisis

- Support access to local and accessible daytime, evening and weekend support groups and wellbeing activities, both online and in person.
- Improve access to preventative support that does not require people to book a GP appointment first.
- Reinforce the mental health support offer for periods of high demand, with consideration of time of year, time of day and day of the week.

Integrated care

- Facilitate joined-up care across services that does not rely on people making GP appointments.
- Support a simple means of inter-trust digital patient record sharing.
- Progress community care centres that enable holistic health support.
- Support services, including prison and probation, to provide up-to-date and accurate information on the mental health support available.
- Facilitate means for patients and professionals to track the progress of referrals, both into and out of mental health services.

Wider determinants of health

- Improve access to supported housing for people with severe mental illness.
- Improve transport to safe havens and community centres.
- Subsidise access to wellbeing facilities such as sports centres.
- Improve access to counsellors and support networks in schools.

Conclusions

We analysed 489 experiences related to mental health crisis that people had told us about from January 2024 to February 2025. We found that:

- People told us about understanding, supportive and helpful care from professionals and how positive interactions had enabled them to manage their mental health, keep them safe and help them to recover.

> It makes such a difference when you're supported by people who understand and treat you as a person and things are explained to you.

- We heard the most positive feedback about voluntary, community and social enterprise services and Kent and Medway Safe Havens.
- Other key service types were: community mental health teams, general practice, home treatment and rapid response, the Kent and Medway Mental Health Crisis Line, A&E, children and young people's mental health services, talking therapies, liaison psychiatry and mental health hospitals.
- Key issues were waiting times for crisis support, ineffective responses and unsuccessful coordination or continuity of care between services.

> There needs to be room to deviate from a script in order to fully understand a person.
>
> It was better when you could call the crisis team and speak to people who know you who can help calm you.

- We heard the most about crisis support for people aged 16 to 25, 35 to 44, and 55 to 64.
- Time of year was an important factor for consideration in the provision of services that support mental health.

We have made a range of recommendations throughout this report (see Recommendations section), both for key services and the wider integrated care system. These align with the draft Kent and Medway suicide and self-harm prevention strategy for 2026 to 2030, in terms of the priorities of supporting efforts to improve support for those in crisis and maximising our collective impact (NHS Kent and Medway, Kent County Council, Medway Council 2025).

Responses

In December 2024 and February 2025, we presented summary reports on what people had been telling us about mental health crisis support to key stakeholders in the Kent and Medway mental health system. NHS Kent and Medway Integrated Care Board took swift action to ensure that:

- Clear messaging and signposting on the different ways of accessing crisis support was issued via their public newsletter in time for the winter season.

Kent and Medway Safe Havens engaged proactively, implementing the following.

- Working with staff teams on the management of and messaging around telephone support.
- Improving the pathway for people accessing Thanet Safe Haven who need a full mental health assessment, managing this in the haven wherever possible and working with the hospital liaison psychiatry service to improve coordination and continuity of care for those who need to be assessed by them.
- Ensuring clear and prominent messaging about safe haven opening times over the festive period and increasing social media visibility.
- Increasing local promotion of safe havens to the public and professionals, including in primary care.
- A marketing campaign for community crisis alternative services based on the Stop Think Choose campaign.

A draft version of this report was shared with the mental health leads at the NHS Kent and Medway Integrated Care Board in June 2025. NHS Kent and Medway have made the following changes so far, which include:

- Working with Mental Health Matters to develop information videos about Kent and Medway Safe Havens to promote awareness of the services with both public and professionals, including police and ambulance staff.
- Improvements to the triaging of the mental health advice line to ensure that safe havens are offered as an option.
- With regards to providing a consistent professional for the care of individuals at risk of mental health crisis based on a caring and understanding relationship, the integrated care board is supporting providers to deliver services in alignment with NHS England's recently drafted Personalised Care Framework: The Modern Care Programme.

- Preventative support for people in or at risk of mental health crisis: The ICB is expanding the safe haven model to a third operating 24/7, with all 11 interoperable, ensuring a 24/7 community crisis alternative, and is also expanding community crisis recovery beds.
- To improve access so GP appointments are not required: Safe havens and the urgent crisis line are open access and both services can help service users access more help if required, signposting or referring where appropriate to other clinical commissioned services.
- Plan to incorporate Healthwatch feedback into future commissioning intention.

A further response and next steps from NHS Kent and Medway is detailed in Appendix 4.

Kent and Medway Safe Havens also responded:

- They will review people's feedback about underserved locations with the integrated care board. They also promote to these areas, offering virtual and telephone support.
- Regarding welfare checks, these are done on a needs basis and if consented to by the individual where there is a threat to life or the individual has requested this as part of their safety plan. Safe havens will endeavour to ensure that these reliably take place.

In October 2025, a draft version of this report was shared with the Kent and Medway suicide prevention programme team. They felt the report aligned with the priorities of the draft Kent and Medway suicide and self-harm prevention strategy for 2026 to 2030 (NHS Kent and Medway, Kent County Council, Medway Council 2025) in terms of maximising collective impact and supporting efforts to improve crisis support, and are interested in joining next-step discussions.

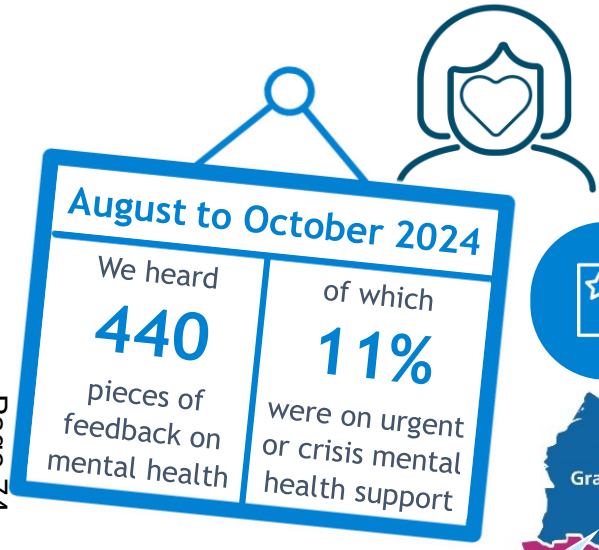
Kent and Medway Mental Health NHS Trust received this report in October 2025 and responded with details of the improvements they are making, which include:

- Addressing waiting times and crisis support.
- Enhancing coordination and continuity of care.
- Fostering compassionate care.
- Bridging service gaps and inequalities.
- Improving crisis line performance and integrated care.

Full details can be found in the response from Kent and Medway Mental Health NHS Trust in Appendix 4.

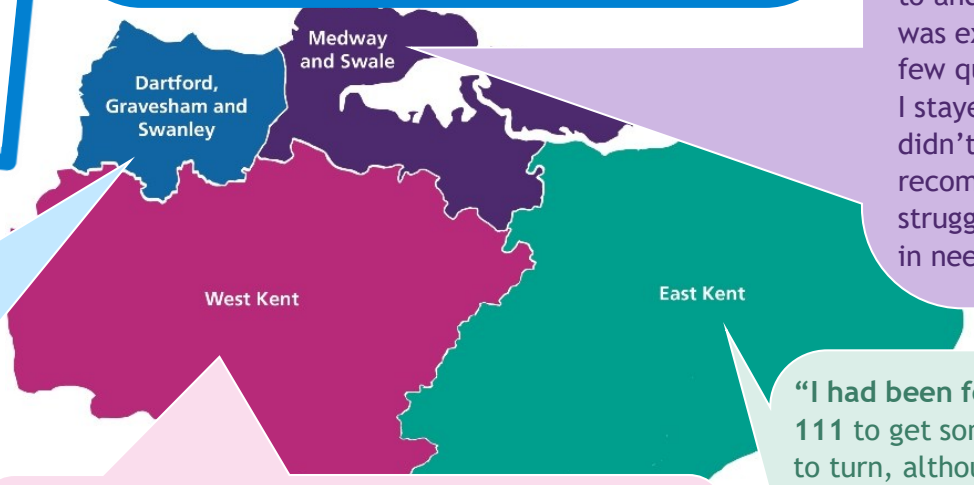
Appendices

Appendix 1: Excerpt from November 2024 summary report – positive experiences



Mental Health Voice

What positive experiences did people have of crisis support?



"I am so thankful to [the peer support organisation] for informing me of the Medway Safe Haven. I went to the Safe Haven the other night … . The Safe Haven was warm and clean. The [member of staff] I saw was welcoming and understanding. I felt safe, listened to and most importantly heard. Nothing was expected from me, I was asked a few questions for clarification purposes. I stayed in for about two hours and didn't feel rushed to leave. I really do recommend this service to anyone struggling with their mental health and in need of someone to listen."

"I had to take my [loved one] to the minor injuries unit at [the hospital] after he had self-harmed. It wasn't bad enough for A&E and the staff were so good with us both. They were helpful and advised he goes back to his GP and discuss his mental health so that's our next step."

"We contacted Kent Police last week as a client [communicated suicidal intent] …. We notified the police … and they acted immediately - they found the person in time and stopped the plan. An amazing outcome. They also phoned us back with the update."

"I had been feeling very depressed and I rang 111 to get some support as I did not know where to turn, although I waited a long time for them to get back to me. I spoke to [a doctor, who] was very reassuring and listened to me and suggested some ideas to calm me down, I would like to say thank you as it makes such a difference when somebody takes the time to listen to you."

Appendix 2: Topic bank

Topics	How to use them
Access to services	Use for access to services, e.g. NHS dentistry, as well as registering or deregistering with a GP; and services picking up the phone. Include positive experiences of access.
Accessibility and reasonable adjustments	Feedback regarding if and how people's additional needs are met, e.g. no email options for deaf people. Includes physical access.
Administration	Use for administration or letters, including the length of time it takes for letters to be sent, fit notes (sick notes) and results communicated. Not including referral administration and patient records.
Booking appointments	Use for the ease or means of booking appointments, including changing the date and time.
Buildings and facilities	Use for issues about the building the service is situated in, e.g. suitability for purpose, facilities and access to toilets. Not relating to physical access. Includes issues regarding health and safety.
Cancellation	Use for cancelled meetings, appointments, procedures or operations.
Care given by staff	How staff interacted with people when delivering care or treatment or in general interactions, e.g. giving respect or dignity, being friendly or helpful.
Cleanliness, hygiene and infection control	Use for all issues related to general hygiene and cleanliness, including for Covid, e.g. keeping venues covid-secure, social distancing, hand sanitiser, mask wearing.
Communication between staff and patients	Use for feedback regarding communication: both the content that is communicated, and the timeliness of communications, including a lack of communication. Does not include administration processes.
Complaints procedure	Use for feedback regarding the process of complaining or when the organisational complaints process is not being followed.
Consent to care and treatment	Use for all issues about consent, including do not resuscitate orders (DNACPR, DNAR, DNR).
Coordination and continuity of care	Use for issues where people do or do not get the same professional every time or must explain themselves afresh every time they have an appointment with a different professional on an issue. Also use for someone being passed from service to service and lack of communication between services.
Cost and funding of services	Cost and provision of funding to the individual; e.g. social care; NHS charges, e.g. dental; or having to pay for private care.
Diagnosis	Feedback received regarding diagnosis or lack of diagnosis.
Discharge	Use for all issues about being discharged from a service, including support put or not put in place as part of the discharge.
Food, drink and nutrition	Use for all issues about food, hydration and catering, e.g. quality of food served in hospitals or care homes, and whether people's preferences and special dietary needs are met.

Health inequalities	Experiences regarding disadvantages or advantages relating to: socio-economic factors, e.g. income; geography, e.g. region or whether urban or rural; specific characteristics, including those protected in law, such as sex, ethnicity or disability; socially excluded groups, e.g. people experiencing homelessness.
Impact on lifestyle and wellbeing	Use when an individual states their lifestyle or wellbeing has been impacted.
Medication, prescriptions and dispensing	Use for issues around medication, prescriptions or vaccinations, including efficacy. Use this for healthcare professionals being willing to prescribe and pharmacies being able to dispense it.
Parking and transport	Use for availability and location of car parking spaces. Use for the cost of parking, including penalty charges for contravening parking rules. Includes public transport and patient transport.
Patient records	Use for issues about accuracy of information on patient records and data protection issues.
Quality of treatment	Use for issues about people's perceptions of the efficacy of treatment they have received that does not include detail allowing it to be themed into the other categories.
Referrals	Use for all issues about referrals, including administration and making the case for a referral.
Service change or closure	Use for all closure issues, whether temporary or permanent. Use when there is change in the way in which a service is delivered, e.g. location.
Triage, assessment and admission	Relating to the process required to access a service or treatment, e.g. the assessment to become an inpatient within a hospital setting, including mental health, or resident within a care home or short stay bed.
Waiting time to be seen once arrived at appointment	Use for length of waiting time on arrival to the service before being seen or treated by a healthcare professional. Not including transport.
Waiting times and lists for treatment	Use for waiting times and lists to get treatment, e.g. for elective care or NHS dental care, waiting time for a residential bed.

Appendix 3: Demographics

1st box: About You □□ **2nd box:** About person receiving care, or information is for, if not you

Relationship to person receiving care/info:
□ **Individual** □ **Family** □ **Friend** □ **Carer** □ **Professional**

Postcode:

What district do you live in?:

□□ Ashford
□□ Canterbury
□□ Dartford
□□ Dover
□□ Folkestone and Hythe
□□ Gravesham
□□ Maidstone
□□ Medway
□□ Sevenoaks
□□ Swale
□□ Swanley
□□ Thanet
□□ Tonbridge and Malling
□□ Tunbridge Wells
□□ Out of county
□□ Prefer not to say

Ethnicity

White

□□ English/Welsh/Scottish/Northern Irish/British
□□ Irish
□□ Gypsy, Roma or Irish Traveller
□□ Any other White background - please describe:

Mixed/multiple ethnic groups

□□ White & Black Caribbean
□□ White & Black African
□□ White & Asian
□□ Any other mixed/multiple ethnic background - please describe:

Black/African/Caribbean/Black British

□□ Caribbean
□□ African
□□ Any other Black/Black British background please describe:

Asian/Asian British

□□ Indian
□□ Pakistani
□□ Bangladeshi
□□ Chinese
□□ Any other Asian/Asian British background - Please describe:

Other ethnic group

□□ Arab
□□ Any other ethnic groups - please describe:

□□ Prefer not to say

Gender

□□ Male
□□ Female
□□ Prefer not to say
□□ Prefer to self-describe

Sexual Orientation

□□ Heterosexual/straight
□□ Bisexual
□□ Gay/lesbian
□□ Prefer not to say
□□ Other (please describe)

Do you identify as trans?

□□ Yes □□ No
□□ Prefer not to say

Age

□□ 0- 15
□□ 16-24
□□ 25
□□ 26-34
□□ 35-44
□□ 45-54
□□ 55-64
□□ 65-74
□□ 75-84
□□ 85-94
□□ 95-99
□□ 100+
□□ Prefer not to say

Disability

□□ No
□□ Prefer not to say
□□ Yes

Disability Type

□□ Physical disability
□□ Learning disability
□□ Mental health condition
□□ Long-term health condition
(Please specify below if you wish)

Are you a carer?

□□ carer
□□ Young carer
□□ No
□□ Prefer not to say

Appendix 4: Responses

Further response from NHS Kent and Medway

NHS Kent and Medway Integrated Care Board (ICB) will use the insights from the crisis care report to better understand the experiences and needs of people across Kent and Medway. The ICB is committed to working in partnership with Healthwatch, service users, and carers to coproduce solutions that are informed by lived experience and local priorities, ensuring meaningful improvements to mental health services.

The ICB is committed to sharing timelines and progress updates through the Local Mental Health Networks, where appropriate. This approach will ensure that partner organisations remain informed about changes, have an opportunity to provide feedback, and work collaboratively towards more integrated care.

NHS England has now published a Strategic Commissioning Framework;[6] Strategic commissioning is now the central purpose of ICBs, focusing on long-term, evidence-based planning, purchasing, monitoring, and evaluation of services to improve population health, reduce inequalities, and ensure equitable access to high-quality care.

This involves ICBs being more data-driven and focused on long-term strategic planning based on population health and strong contract management. ICBs will use joined-up, person-level data and intelligence (including user feedback, such as this report) partner insight, outcomes data, public health resource and insight to understand the local population of Kent and Medway.

The ICB will look to align with the Lived Experience Engagement and Employment Framework (LEEEF). Aligning with the content of the framework will help with the inclusion of lived experience and removal of barriers. The ICB recognise the importance of working with people who live in local communities and/or use services.

Full response from Kent and Medway Mental Health NHS Trust

Sheila Stenson, Chief Executive of Kent and Medway Mental Health NHS Trust responded to this report with the following letter.

6. https://www.england.nhs.uk/publication/nhs-strategic-commissioning-framework/

Kent and Medway Mental Health NHS Trust

Robbie Goatham
Manager | Healthwatch Kent
Leanne Trotter
Manager | Healthwatch Medway
By email

Sheila Stenson
Chief Executive
Priority House| Hermitage Lane
Maidstone | PE16 9NZ
sheilastenson@nhs.net
www.kentmedwaymentalhealth.nhs.uk

10 December 2025

Dear Robbie and Leanne,

Healthwatch Kent and Medway Mental Health crisis care report

On behalf of the Trust Board and all our staff, I want to write to acknowledge and confirm receipt of your detailed report into crisis mental health care in Kent and Medway.

I would like to thank you and your team for the thorough work involved in compiling this report and I am grateful for the inclusion of direct patient views and lived experiences within the report. Understanding the reality of care from a patient's perspective is essential for us to drive meaningful, patient-centred improvements.

We value our partnership with Healthwatch and appreciate the vital role you play in giving voice to the patients and service users within our community.

The findings presented, while challenging and certainly not what we aspire to hear have been reviewed carefully by our clinical and operational leadership teams. I want to acknowledge your findings and be transparent. The findings were consistent with what we have heard from the Care Quality Commission (CQC) inspection, which was published in October and our own independent report, which we undertook earlier this year.

Please be assured that we are committed to listening to feedback, and addressing systemic challenges. We have a robust quality plan in place, and while we recognise there is much to do, we have started to see some improvements. It is imperative we take forward these improvements with our partners, which includes Healthwatch.

I have set out some of the headlines below:

Addressing waiting times and crisis support

- **Rapid response:** Our Rapid Response service attends to those in crisis within 4 hours, achieving this benchmark for over 90% of referrals over the past year.
- **Waiting times:** We have successfully implemented reductions in waiting times by 10% for Mental Health Together (MHT) services. We have also improved our memory assessment waiting times. People are receiving a first contact following referral within four weeks and the average wait for an intervention is just over 11 weeks - up to two months faster than the national average.
- **Crisis line monitoring:** Ongoing, concentrated work is focused on monitoring and reducing call abandonment rates on the crisis line to ensure timely access to support.
- **Long wait reviews:** We conduct weekly reviews for patients waiting over 52 weeks, providing regular contact and ensuring they receive appropriate, stepped-down support where clinically indicated.

Enhancing co-ordination and continuity of care

- **Standardised planning:** All people referred to our service receive a DIALOG Plus intervention that underpins care planning and we are soon to launch this being completed within 4 four weeks of referral as part of the first contact proceed - early in the calendar year.
- **System collaboration:** In addition, we continue to build relationships with our VCSE providers to meet the holistic needs of people. As part of our Mental Health Together developments we will roll out ‘Better Understanding’ sessions to support effective care navigation. This is following a successful pilot in Medway.
- **Community Mental Health services transformation:** Through the second phase of our Community Mental Health Framework (CMHF) and as part of our quality plan, we are revising our model of care to ensure a partnership approach, getting people to the right support, with the right agency/partner, more quickly. We aim to launch this early in the new calendar year with a phased approach.

Fostering compassionate care

- **Culture and values:** We recognise that we have some work to do to improve our culture, and in March 2025, we introduced our new identity and values – to help us strengthen our culture and live our values. We are embedding our values through staff engagement initiatives, the Doing Well Together programme, and the Value in Practice Awards.

Bridging service gaps and inequalities

- **Safe havens and access:** We work in partnership to deliver the safe havens, and have contributed significantly to expanding Safe Haven hours and locations, and we are actively reviewing underserved areas for targeted support.
- **Dual diagnosis support:** We are working with our partners including the local authority to role a group-based intervention further.

Improving crisis line performance and integrated care

- **Crisis line improvements:** We have set clear improvement targets for our crisis line, refining triage processes and improving signposting to ensure direct support from mental health professionals where needed. In the last two months we have seen a 50% improvement in abandonment rates.
- **Digital integration:** We are improving outcomes through enhanced digital record sharing and referral tracking for community services.

While not an exhaustive list of the improvements we're making, I hope this provides an overview of the work we have already done to respond to the findings in your report. We are committed to complete transparency, and over the coming weeks we will be sharing information about ongoing improvements that are making a difference to the people we care for.

I am delighted that in July this year, our Board agreed to recruit a team of Co-Creation Facilitators, who are working with our Patient Experience team and partners, to listen to the views of our patients. Their work will be invaluable so we can make future improvements to our services through a lived experience lens.

I am confident that their work, together with the continued insights from Healthwatch will help us to monitor the impact of the progress we're making – and guide us as we continue to improve the services we deliver.

Should you wish to discuss our improvement work in further detail, please do contact my Executive Assistant, Sharon Tree and we will arrange for you to get an in person briefing from clinical and operational leaders.

Yours faithfully,

S. Stenson.

Sheila Stenson
Chief Executive

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Item 6 - Proposed integration between KCHFT and MCH

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 4 February 2026

Subject: Proposed integration between the Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH)

Summary: This report invites the Health Overview and Scrutiny Committee to consider the information provided by representatives of KCHFT and MCH about the proposed integration between the two organisations.

---

1) Introduction

a) This paper provides an update on the proposal for Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare CIC (MCH) to integrate as one organisation.

b) In July 2025, the two organisations announced they were at an early stage of developing a strategic case to explore the potential benefits and implications of working more closely. The strategic outline case was submitted to NHS England - with the preferred option of coming together as one organisation and with MCH's staff and services transferring to KCHFT.

c) After receiving feedback from NHS England in November 2025, KCHFT and MCH are now progressing with a full business case which they plan to submit in April 2026. If agreed, integration is expected to be completed on 1 October 2026. A summary of the strategic outline case is included in Appendix 1 and can be read at www.kentcht.nhs.uk/strongertogether

2) Recommendation

a) RECOMMENDED that the Committee note and comment on the proposal.

Background Documents

Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH) *Stronger Together: Why we believe our two organisations should unite for stronger community care and what this means for you – our patients, staff and our communities*. www.kentcht.nhs.uk/strongertogether

Contact Details

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Proposed integration between Kent Community Health NHS Foundation Trust and Medway Community Healthcare Community Interest Company

1 Overview

1.1. This paper provides an update on the proposal for Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare CIC (MCH) to come together as one organisation.

1.2. In July 2025, the trust and CIC announced they were at an early stage of developing a strategic case to explore the potential benefits and implications of working more closely. The strategic outline case was submitted to NHS England in July – with the preferred option of coming together as one organisation, with MCH's staff and services transferring to KCHFT.

1.3. In November 2025, feedback was received from NHS England and we are now progressing with a full business case, which we expect to be submitted in April 2026. If agreed, integration is expected to be completed on 1 October 2026. A summary of the strategic outline case is included as appendix 1 and can be read at www.kentcht.nhs.uk/strongertogether.

1.4. We are keen to continue engaging with system partners to understand perspectives, ensure alignment with wider system plans and identify opportunities or concerns.

2. Background and strategic rationale

2.1 As part of the strategic case for increased collaboration of community services, we have considered a range of options open to us in terms of organisational form and the pros and cons of each.

2.2 These options ranged from a "do minimum" option, increased collaboration in a number of different forms, exploring coming together with acute partners, to our preferred option that is bringing KCHFT and MCH together as one NHS foundation trust organisation. This would involve MCH's staff and services transferring to KCHFT.

2.3 There are four primary reasons why the two organisations are looking to increase collaboration:

- **We have rapidly increasing demand and complexity** – our populations are growing with increasingly complex conditions and we have long waiting lists for some services.

- **Our communities face significant health inequalities** – and differences in service provision across our geography

- **We have small specialist teams with recruitment and retention challenges** – national workforce shortages are seen across the country and both organisations have varying high vacancy factors, with a rising risk of retirements from community healthcare staff, which make some services fragile.

- **We face significant financial challenges –** the Kent and Medway system as a whole, faces a significant financial challenge. It is the responsible approach to maximise our resources for direct patient care.

3. Benefits and risks:

3.1 As part of the development of the full business case, we will further define the benefits and risks of increased collaboration. At a high level, the expected benefits are set out in the table below:

Benefit grouping	Key themes
1. Better care and outcomes	• Addressing health inequalities • Strengthening community-based care models • Improved care pathways and access to services • Expanding intermediate care • Targeting resources to priority areas • Reducing unwarranted variation
2. Resilient, highly-skilled and stable workforce	• Expanded carer development opportunities • Increase workforce stability and staff retention • Equity in pay award funding
3. Innovation, improvement and service resilience	• Enable digital innovation • Improved integration of digital platforms • Streamline governance for data sharing • Enabling cross-organisation patient pathways • Service resilience • Reduced duplication • Access to education and investment funding
4. Financial and operational efficiencies	• Corporate synergies • Rationalisation of estate • Stronger purchasing power • Strategic investment planning • Synergy with Kent and Medway Mental Health Trust footprint.

3.2 As part of the strategic case, we have also considered identified a number of potential risks associated with closer working, as set out below, and are considering appropriate mitigations.

- **Cultural integration**: Differences in organisational culture, governance, and operating models could impact the success of the integration and the attainment of expected benefits.

- **Service disruption**: Potential for short-term instability if service transformation or workforce alignment is not carefully planned and resourced.

- **Workforce retention**: Risk of losing key staff during the transition if clear communication and support are not provided.
- **Impact on BAU performance**: Risk that performance and ultimately quality of care suffers due to the demands and distractions of the integration/transformational change; potentially linked to leadership burnout due to the pressures of the integration requirements.
- **Digital and data alignment**: Challenges in aligning IT systems, data governance, and analytics across two different infrastructures.

4. What we have heard so far about our plans

4.1 We know that any change of this scale must be shaped by the people it affects, and we continue to engage as we move towards developing a full business case.

4.2 To ensure that staff, patients and public, and our wider partners understand our rationale and can feedback on our proposal, we have:

- published a summary of our strategic outline case – www.kmstrongertogether and an easy read version is also available
- summarised our plans and rationale in KCHFT's Community Health magazine and extended distribution for our next edition to Medway residents
- shared a simple animation, which describes the challenges we face and why we think we can improve the quality of care we provide by coming together
- launched a survey for patients, which is currently live, with more than 200 responses
- surveyed staff and wider stakeholders
- engaged with impacted staff across staff events and discussions
- engaged with patients, public and seldom heard groups
- responded to questions and concerns by publishing frequently asked questions on our intranets and public website
- provided briefings to key stakeholders through e-bulletins and meetings where appropriate
- planned a public event as part of our conversations about neighbourhood care at Pilkington Building, University of Greenwich, Gillingham from 1 until 4pm on 4 February.

4.3 So far, the majority of partners we have spoken to are broadly supportive of our proposals in principle and they believe this aligns with the current strategic objectives and the priorities of the Kent and Medway integrated care system.

4.4 Many patients and public groups understand the rationale – however often need more understanding of what services the community trust provides. There were some concerns that people will have to travel further for care, however this is not the intention.

4.5 Many staff support the idea of collaboration to reduce duplication and improve quality; however, we have heard concerns from staff about the need for clarity of job

security alongside assurance that patient care standards will not decline during the transition and the importance of retaining funding for Medway.

4.6 Together, we have also explained to staff our intention that if it is agreed that MCH's staff and services transfer, we do not plan on changing the name from Kent Community Health NHS Foundation Trust at this time. Our rationale for this is that KCHFT also provides care in East Sussex and London, so KCHFT's name isn't a description of everywhere it provides care, but it is recognised and trusted. Council boundaries are also under review nationally, so aligning to 'Kent and Medway' could quickly become outdated. A name change would cost a significant amount of public money, at a time of significant financial challenge, without improving care. Keeping KCHFT's name ensures stability and clarity during this transition.

4.7 More detail about what we have heard can be found in our summary strategic outline case.

5. Next steps:

5.1 We are continuing to engage with our staff, patients and wider stakeholders. The full business case is due to be submitted in April 2026, with a view to MCH staff and services joining KCHFT as an NHS foundation trust in October 2026.

5.2 The final decision will need the approval of both our Boards, KCHFT's Council of Governors, NHS England and NHS Kent and Medway Integrated Care Board.

Mairead McCormick
Chief Executive
Kent Community Health NHS Foundation Trust

Martin Riley
Managing Director
Medway Community Healthcare CIC

Appendix 1: *Summary strategic outline case for the integration of Kent Community Health NHS Foundation Trust and Medway Community Healthcare.*

MCH
medway community healthcare

NHS
Kent Community Health
NHS Foundation Trust

Why we believe our two organisations should unite for stronger community care and what this means for you – **our patients, staff and our communities**

Stronger together

A new chapter for community health in Kent and Medway

Helping people in Kent and Medway to lead their best and healthiest lives is at the heart of everything we do.

It's this shared purpose — and the shared challenges we face — that have led Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH), to explore becoming one organisation.

Our communities are changing. People are living longer, often with more complex health needs. Yet access to care can vary depending on where you live, and long waits for some services persist. At the same time, we face growing pressures from financial constraints and workforce shortages.

Rather than face these challenges alone, KCHFT and MCH, which is a community interest company (CIC), are choosing to unite — not as a takeover, but as a partnership of equals. Together, we believe we can build a stronger, more resilient organisation that delivers better care, closer to home.

What does this mean for you?

For patients and communities:

- **better access** to care, especially in areas with limited access to services
- **more consistent services** across Kent and Medway
- **stronger neighbourhood teams** delivering care closer to home.
- **improved health outcomes** through better use of data and joined-up care.

For staff:

- **more career opportunities** and training
- **fairer pay and conditions,** especially for MCH staff, who would have the stability and funding of an NHS trust, which isn't always guaranteed as part of a CIC
- **stronger support** for wellbeing and inclusion
- **a shared culture** that values both NHS and CIC strengths.

For all:

- **more efficient use of resources**
- **a stronger voice** for community services in system planning
- **better digital systems** and estates planning
- **improved financial sustainability.**

We're still in the early stages of discussion and are committed to working with our staff, patients, communities and partners to explore all options. Our preferred approach is for MCH to join KCHFT as part of the NHS family, through a transfer of services and staff.

Together — in whatever form we take — we will continue working with our health and care partners to deliver the best possible services for our communities.

Let's build something better and stronger for our communities together.

Mairead McCormick

Chief Executive,
Kent Community Health NHS Foundation Trust

Martin Riley

Managing Director,
Medway Community Healthcare

About this document

This document sets out why we believe Kent Community Health NHS Foundation Trust and Medway Community Healthcare should come together as one organisation.

It's a summary version of a larger technical strategic outline case, which sets out why we think we need to do things differently and what we think the benefits are.

Contents

Your voice matters

Let us know what you think

Whether you're a member of staff, a patient, or one of our valued partners — we want to hear from you. Your feedback will help shape how services are delivered and how we work together. Find out how on page11.

Who are we?

Both organisations are deeply rooted in their communities and share a commitment to high-quality, compassionate care.

Category	Medway Community Healthcare (MCH)	Kent Community Health NHS Foundation Trust (KCHFT)
Organisation type	Community interest company (CIC) 99% of staff are shareholders in the organisation and an elected members forum ensures that the voices of staff and shareholders are heard at meetings of the Board and its committees.	NHS trust All staff are members of the Foundation Trust with elected public and staff governors acting as ambassadors for the organisation and providing a public and staff voice.
Established	2011	2011
Mission	Lead the way in excellent healthcare	Empower adults and children to live well, be the best employer, and work with our partners as one
Values	Caring and compassionate, deliver quality and value, work in partnership	Compassionate, aspirational, responsive, excellence
Funding	£80million	£325 million
Workforce (WTE)	1,500 staff	5,300 staff
CQC Rating	Good	Outstanding
Strategy	- Deliver care closer to home - Provide flexible, efficient services - Respect dignity and privacy	- Putting communities first - Better patient experience - Great place to work - Sustainable care
Services	More than 40 community services in Medway and surrounding areas	More than 70 services in Kent, Medway, East Sussex, London
Governance	Independent Board with CIC accountability	NHS Trust Board with public accountability

Why do we need to do things differently?

Like many parts of the NHS, we are under pressure:

More people need care

The population is growing and ageing. By 2040, the number of people aged 65+ in Kent and Medway is expected to rise by more than 40 per cent.

Workforce pressures

Recruiting and retaining staff is increasingly difficult, especially in community nursing.

Financial constraints

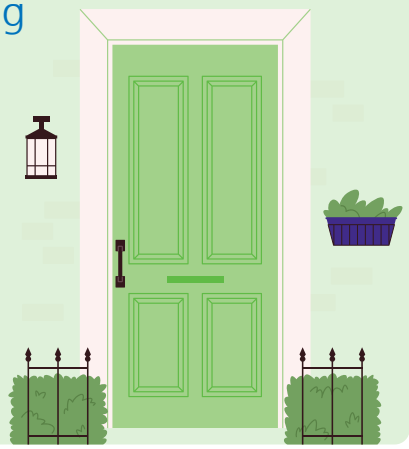
Both organisations are operating at breakeven, but face ongoing savings targets of 3 to 6 per cent of turnover.

Services are fragmented

Different providers, systems and standards can lead to delays, duplication, and confusion for patients.

Health inequalities are widening

People in deprived areas live more than a decade less in good health than those in more affluent areas.



The NHS nationally is also shifting towards neighbourhood-based care, where services are more local, joined-up, and focused on prevention. This merger supports that direction.

We believe this integration will help make care more joined-up, easier to access and better suited to the needs of local people.

Our two organisations believe uniting will make us stronger to face these challenges and build services fit for the future.

What are the benefits?

This integration is about building a stronger, more joined-up community health service for everyone in Kent and Medway. It will bring real benefits for patients, staff, and the wider health and care system.

For patients and communities:

We know that where you live can affect the care you receive. Our goal is to change that — so everyone can access high-quality care, no matter their postcode.

Here's what the integration will help us deliver:

Better access to care:
Especially in underserved areas like coastal and rural communities, where health needs are often greatest.

More consistent services:
We'll reduce variation in how services are delivered across Kent and Medway, so patients get the same high standard of care wherever they live.

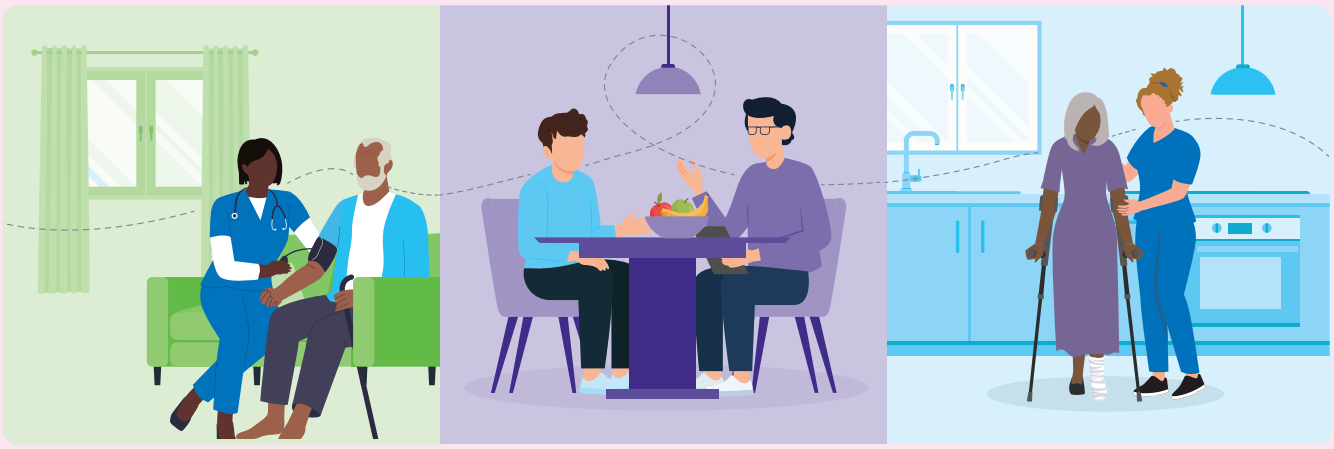
Stronger neighbourhood teams:
Services will be more local, more joined-up, and better tailored to the needs of each community.

Improved health outcomes:
By using data more effectively, we can target support where it's needed most and help people stay well for longer.

Less repetition:
Patients won't have to repeat their story multiple times — services will be better connected and easier to navigate.

Focus on prevention:
We'll invest more in keeping people well, not just treating illness.

We'll still deliver care in the same places, with the same dedicated teams — but over time, services will become more integrated and responsive.



For staff:

We know change can bring uncertainty, especially for those in corporate or support roles. But this integration is also a chance to create a better, more supportive working environment for everyone.

Here's what it means for you:

More career opportunities:

A larger organisation means more roles, more training, and more chances to grow.

Fairer pay and conditions:

Especially for MCH staff, who would have the stability and funding of an NHS trust, which isn't always guaranteed as part of a CIC. TUPE protections apply — your terms and conditions will be honoured.

Stronger support for wellbeing and inclusion:

You'll be part of a wider network with more resources and a shared commitment to staff wellbeing.

A shared culture:

We're bringing together the best of both organisations — the innovation and agility of a CIC, and the stability and scale of the NHS. Together, we'll build a shared culture that captures the best of both organisations.

More resilient teams:

By pooling resources, we can reduce pressure on individuals and improve work-life balance.

We're committed to open communication, early clarity on roles, and involving you in shaping the future.

For the wider system:

This integration supports the ambitions of the Kent and Medway Integrated Care System and national NHS priorities.

It will help us:

Use resources more efficiently:
Reducing duplication and making every penny of public money count.

Plan better:
With a single organisation, we can take a more strategic approach to estates, digital systems, and workforce planning.

Strengthen our voice:
A unified community provider will have more influence in system-wide decisions and planning.

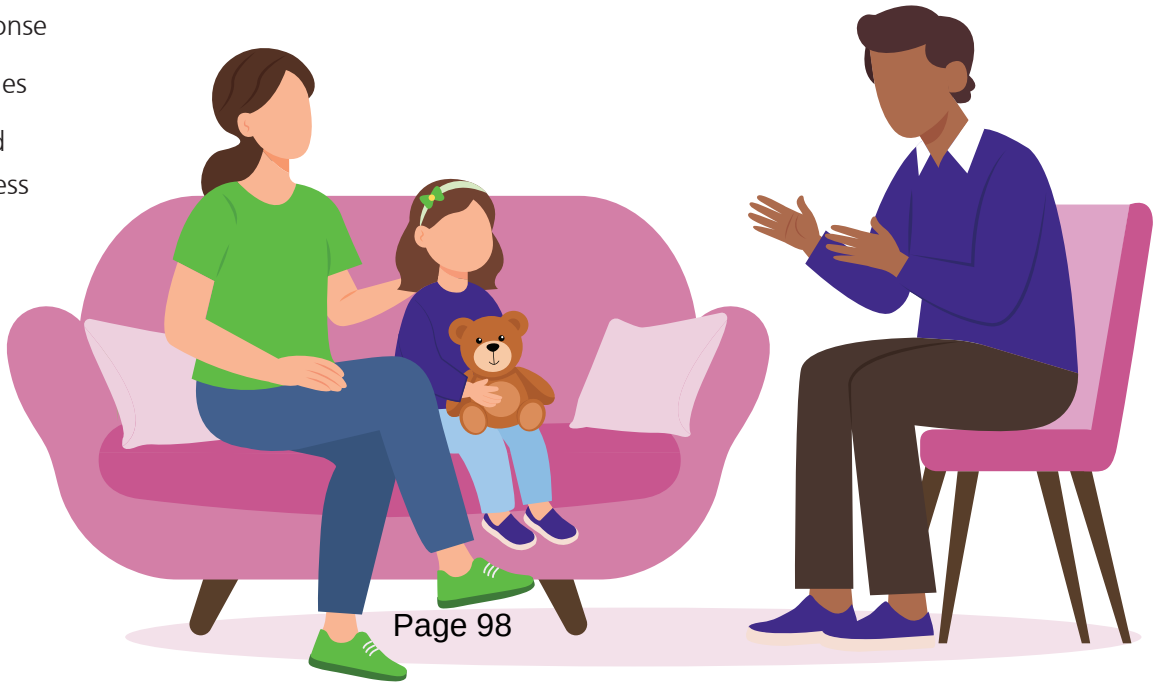
Improve financial sustainability:
By streamlining services and sharing infrastructure, we can deliver better care within our means.

What will change?

Patients will still see the same teams in the same places — but behind the scenes, we'll be working more closely together. Over time, services will become more joined-up, with early focus on:

- integrated frailty pathways and urgent community response
- children's therapies
- virtual wards and discharge-to-assess
- rehabilitation, end-of-life care, and long-term condition management.

We'll also invest in digital tools and automation to improve patient experience and free up staff time for care.



What have we heard so far about our plans?

We know that any change of this scale must be shaped by the people it affects most — our patients, staff, partners, and local communities. That's why we've made listening a priority from the very beginning.

How are we engaging?

We want to make sure voices are heard and feedback is acted on. So far, this has included:

- staff webinars and briefings
- stakeholder letters to local authorities, MPs, NHS partners, and voluntary organisations
- media statements and updates on our websites and social media
- meetings with councillors and scrutiny committees
- drop-in sessions and FAQs for staff.

This is just the start — and we'll continue to listen and involve people throughout the process.

What people are telling us

Our commissioner for adult and children's community services, NHS Kent and Medway Integrated Care Board, has expressed strong support for the merger. They highlighted the importance of: Equitable access to care, simplified governance and a more resilient and capable community provider.

Our partners have been supportive, recognising the potential benefits for local people. However, they've been clear that local services and funding must be protected.

Transparency and accountability are essential. We've committed to maintaining a strong local presence and continuing to report to local scrutiny bodies.

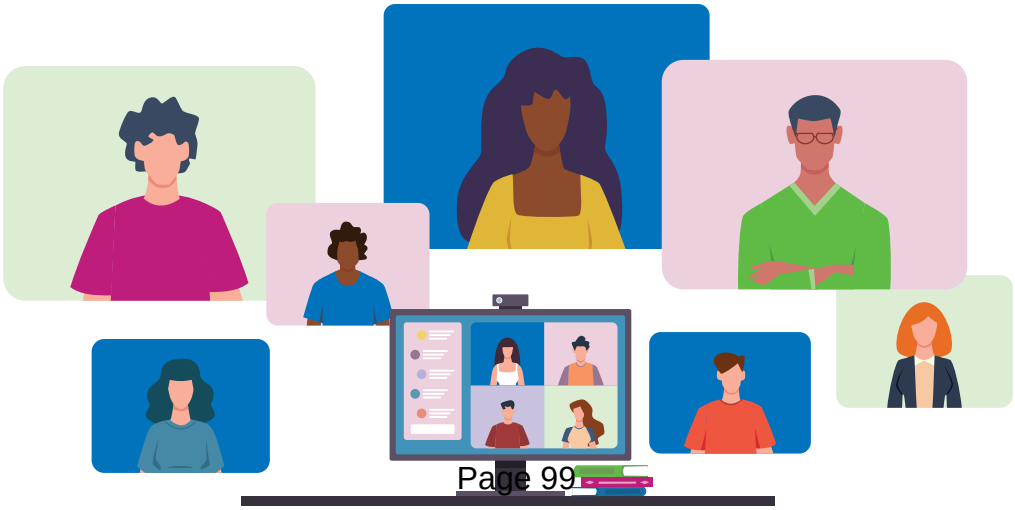
Feedback from staff has been generally positive, with many seeing the merger as a natural next step.

- MCH staff welcomed the opportunity for greater career stability, access to NHS benefits.
- KCHFT staff valued the potential for improved patient experience, shared learning, and stronger collaboration.

At the same time, we've heard concerns — particularly around:

- job security, especially in corporate and support roles
- cultural integration between an NHS trust and a community interest company.

In response, we've created a dedicated people and culture workstream and tailored engagement plans to support staff through the transition.



"It makes complete sense that as Medway is in Kent, we have one organisation serving the whole of the region."
- **MCH staff member**

"From a patient's perspective this would be good news for the sharing of good practice and resource."
- **KCHFT staff member**

"It makes sense to join the communities — we have such close borders and yet are subject to a 'postcode lottery' by remaining separated."
- **KCHFT staff member**

"It would be much more seamless and less confusing for our patients. Being joined up would allow ideas and ways of working to be better shared."
- **MCH staff member**

So, what next?

July 2025

In July 2025 a more detailed strategic case for change was approved by both organisations' boards. This outlines the rationale and high-level benefits of the merger.

March 2026

As MCH is a community interest company (CIC), there will be an advisory vote of MCH shareholders.

September 2026

Integration is officially approved by MCH and KCHFT's Boards. NHS England formally approve.

Now until April 2026

Continued planning and engagement with staff, patients, and local communities. A full business case is being developed and is due for submission in April 2026

July 2026

NHS challenge meeting with both Boards' organisations.

By October 2026

The transfer of services is planned to be completed, with the goal of ensuring the new organisation is ready to deliver safe, effective care from day one.

Your voice matters

Our communities and colleagues will be involved throughout this process. Your feedback will help shape how services are delivered. There will be opportunities to ask questions, share concerns and help make the new organisation work for everyone.

How you can give your views:

There are many ways in which you can give us your views. You can:

find out more information on our website
www.kmstrongertogether.nhs.uk

give your views through a survey
https://surveys.kentcht.nhs.uk/s/HXRKK7

email us at
kchft.comms@nhs.net

write to us at
Communications and Engagement Team
Kent Community Health
NHS Foundation Trust
Trinity House
110-120 Upper Pemberton
Eureka Park, Ashford
Kent, TN25 4AZ

Frequently asked questions

What other options were considered?

We didn't jump straight to a integration. A full options appraisal was carried out, including:

- a strategic partnership
- integration of corporate and support services
- a full merger (the preferred option)
- a merger with local acute trusts.

Each option was assessed for its impact on patients, staff, and financial sustainability. The full integration scored highest across all areas — offering the greatest benefits with manageable risks.

How will it affect my care?

You should see very little change to your care. You'll continue to see the same professionals in your community or at home. Over time, we hope you'll benefit from:

- even better-quality care
- more advanced technology
- shorter waits and more support between appointments.

Will it reduce waiting times?

Yes, that's the aim. Currently, waiting times vary across Kent and Medway due to different local contracts. As part of the new community services contract and integration, we're reviewing care pathways to:

- standardise services
- learn from teams who've successfully reduced waits
- improve access and consistency across the county.

Is this a merger or a takeover?

While MCH staff and services will transfer to KCHFT, this is not a takeover. It's officially referred to as a 'transaction', with MCH's staff and services joining KCHFT as one NHS Foundation Trust. Our approach is to combine the best of both organisations to tackle shared challenges and improve care.

Who decided on this change?

The choice to work together has been made independently by the two Boards at KCHFT and MCH.

This decision is supported by our commissioning partners and local authorities and will need to be agreed by NHS England.

Is this just to save money?

No. While financial sustainability is important, the primary driver is improving care.

This integration will:

- strengthen services
- make us more resilient
- help us deliver better care for patients.

What will a single, larger organisation offer that the existing separate trusts cannot?

A larger organisation brings:

- greater buying power
- easier recruitment and retention
- more efficient service delivery
- a stronger voice for community services
- faster learning and innovation across teams.

What happens to my data?

Your data remains secure and confidential. Initially, both organisations will keep separate systems, but over time we'll bring them together.

Will this integration mean I will have to reapply for my job if I am a Medway member of staff?

TUPE protections apply and we will be transferring colleagues to KCHFT on their current terms and conditions. There is no blanket requirement to reapply for roles.

I am worried our culture and identity will be lost when we integrate

Preserving the strengths of both organisations is a priority. We'll be looking at the best of both cultures to shape a new identity for our colleagues. The transformation required to deliver sustainable services for our communities means change is inevitable and we must adapt and shape our organisation together so it is fit for purpose.

What would happen if the two organisations stayed as they are?

We'd miss the opportunity to combine resources, strengthen services and avoid future financial challenges.

For MCH, remaining a small organisation would make it harder to meet rising demand and financial pressures without affecting services. This integration is a proactive step to protect and grow community care.

Will all the policies, procedures and digital systems change overnight?

No. We'll continue using current systems and policies. Any changes will be carefully planned and only made where they benefit staff and patients.

Will there be a disruption to care?

Maintaining high-quality care is our top priority. The integration work will happen behind the scenes while services continue as usual.

Alternative formats

If you need communication support or would like this in an alternative format, please contact the KCHFT Communications and Engagement Team.

Phone:
0300 790 0506

Email:
kchft.comms@nhs.net

Web:
www.kentcht.nhs.uk

Write:
Communications and Engagement Team
Kent Community Health NHS Foundation Trust,
Trinity House
110-120 Upper Pemberton
Eureka Park
Ashford
Kent, TN25 4AZ

Stronger together

MCH
medway community healthcare

NHS
Kent Community Health
NHS Foundation Trust

Item 7: Work Programme 2026

By: Gaetano Romagnuolo, Research Officer - Overview and Scrutiny

To: Health Overview and Scrutiny Committee, 4 February 2026

Subject: Work Programme 2026

Summary: This report gives details of the proposed work programme for the Health Overview and Scrutiny Committee.

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1) Introduction

a) The proposed work programme has been compiled from actions arising from previous meetings and from topics identified by Committee Members and the NHS.

b) HOSC is responsible for setting its own work programme, giving due regard to the requests of commissioners and providers of health services, as well as the referral of issues by Healthwatch and other third parties.

c) HOSC will not consider individual complaints relating to health services. All individual complaints about a service provided by the NHS should be directed to the NHS body concerned.

d) HOSC is requested to consider and note the items within the proposed work programme and to suggest any additional topics to be considered for inclusion on the agenda of future meetings.

2) Recommendation

The Health Overview and Scrutiny Committee is asked to consider and note the work programme.

Background Documents

None.

Contact Details

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Research Officer - Overview and Scrutiny
Email: gaetano.romagnuolo@kent.gov.uk
03000 416624

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Kent County Council

Health Overview and Scrutiny Committee

Work Programme

4 February 2026

1. Items proposed for upcoming meetings

2 April 2026		
Item	**Item background**	**Substantial Variation?**
Proposed reconfiguration of stroke services in East Kent.	To receive an update about the reconfiguration.	-
Proposed establishment of a Group between Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust.	To receive information about the proposal.	-
Neighbourhood Health – with a focus on provision and access.	To receive an update on Neighbourhood Health, with a focus on provision and access.	-

2. Items yet to be scheduled

Item	Item Background	Substantial Variation?
South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and South Central Ambulance Service NHS Foundation Trust (SCAS) Group Model Collaboration Update.	To receive an update on the Group Model collaboration between SECAmb and SCAS.	-
Proposed integration between the Kent Community Health NHS Foundation Trust (KCHFT) and Medway Community Healthcare (MCH).	To receive an update on the proposed integration between KCHFT and MCH.	-
Kent and Medway Mental Health NHS Trust CQC Response Update.	To receive an update on the work that is underway in response to the Care Quality Commission (CQC) review and the Healthwatch report.	-

3. Items that have been declared a substantial variation of service and are under consideration by a joint committee

No proposals are currently under scrutiny by the Kent and Medway Joint Health Overview and Scrutiny Committee (JHOSC).