Kent County Council
Health Overview and Scrutiny Committee

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Kent and Medway Mental Health NHS Trust CQC Response Update

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Summary

The purpose of this paper is to provide Members with an overview of the CQC inspections into services delivered by Kent and Medway Mental Health NHS Trust, and offer assurance that progress is being made to improve services.

Following an inspection in March 2025, the CQC has published two reports into services delivered by Kent and Medway Mental Health NHS Trust. These include:

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

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

While this is not the outcome we had hoped for, it sadly reflects where the trust was earlier this year, following a significant period of change and transformation.

To provide assurance to Members, many of the areas identified for improvement by the CQC were known to us. During the transformation of the community services we decided to undertake an independent review into the transformation and this highlighted a number of areas for us to improve on. This sadly aligned with CQC findings when they visited our services in March.

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.

1. Introduction

1.1. In March 2025 the CQC undertook an inspection of our community mental health and crisis care/Health Based Place of Safety services. Kent and Medway Mental Health NHS Trust accepts the inspection report. Whilst challenging, the areas of improvement identified were already known to us and plans were in place or are now in place to address as part of our ongoing transformation.

1.2. The trust priority remains to provide high quality care and support our people in the delivery of this care. The quality plan underpins our journey of improvement, placing patients first and ensuring that the plan supports rather than hinders high quality care.

1.3. The plan is a whole-organisation strategy using both the CQC findings and our own independent review to drive improvement. It aims to:

- Simplify our approach
- Link our strategic improvement programmes to daily management and front-line staff;
- Share transparently what the CQC found, what we have already done and what we will do next;
- Deliver the improvements necessary in a collaborative manner with staff, patients, families and our partners.

2. CQC Findings

2.1. The CQC inspection rates services in five key areas which then contribute to an overall rating. The ratings from the inspection are:

Domain	Community Mental Health services rating	Crisis/Health Based Places of Safety rating
Overall	Requires improvement	Requires improvement
Safe	Inadequate	Requires improvement
Effective	Requires improvement	Requires improvement
Caring	Requires improvement	Good
Responsive	Requires improvement	Requires improvement
Well-led	Requires improvement	Requires improvement

2.2. The inspection found a number of positive regarding our services including:

- A strong learning culture;
- Delivery of evidence-based care;
- Effective partnership working;
- Kindness, compassion and dignity in care;
- Promotion of equality and supporting healthy lives;
- A culture of openness and speaking up;
- Support for patient wellbeing and independence.

2.3. There were four thematic issues identified for improvement:

- Safety and risk management including physical health checks, care records, infection control and medicine optimisation;
- Assess and waiting times including demand and capacity and waiting list management

- Environmental, experience and equity including building standards, tailoring interventions and addressing health inequalities;
- Leadership, culture and governance including embedding new models and improving oversight.

3. Response Principles

3.1. The trust response to the findings follow four principles in order to deliver the high-quality care and support together through continuous improvement;
3.2. Our response is anchored in our new values of caring, inclusive, curious and confident;
3.3. We will create a transparent and psychologically safe response with ownership and full transparency on where we must improve;
3.4. We will ensure the response is co-created involving our staff, patients, partners and communities in the solutions;
3.5. We will ensure sustained changes and not just quick wins, we will address immediate risks but also recognise some of these areas require long term culture change and service improvement.

4. Phasing

4.1. Our response is being managed in three phases to ensure improvement is embedded and owned across the organisation.
4.2. Phase 1 began in April 2025 and continued into November 2025, where the trust has undertaken a listening and learning approach, while also acting on immediate safety concerns.
4.3. Phase 2 runs through October 2025 to January 2026 where improvements will be co-created and implemented.
4.4. Phase 3 runs through January 2026 to April 2026 where the improvements will be embedded and the impact of these improvements will be demonstrated.

5. Action plan and delivery

5.1. In response to the four themes, a trust executive is providing oversight and work with teams to ensure the three phases are implemented timely.
5.2. Sandra Goatley, the Chief People Officer is overseeing Safety and Risk. This work focuses on two key areas from the report including the process and use of care planning and risk assessments, as well as clinical effectiveness and monitoring.
5.3. Dr Adrian Richardson, the Director of Transformation and Partnerships is responsible for delivering improvements in access and waiting times. The two areas of focus in this theme are caseload and access management and the trust digital, communication and engagement approaches.
5.4. Dr Afifa Qazi, the Chief Medical Officer is leading work on environmental, experience and equity. This is focusing on two areas of estates and environment and the trust patient information and engagement

5.5. Nick Brown, the Chief Finance and Resource Officer is overseeing the leadership, culture and governance theme - focusing on three areas of staff support and supervision, safeguarding audit and training and governance and policy review.
5.6. Oversight of the plan is being managed through a series of regular quality meetings and huddles which reports to the Regulation, Compliance and Quality Group and the Trust Quality Committee. Andy Cruickshank Chief Nursing Officer is the Senior Responsible Officer for the plan, and reports to the Executive Management Team.
5.7. As a trust, we are committed to continuous improvement and existing programmes of work that were already underway have incorporated aspects of the findings from the CQC and are tasked with delivery. This ensures that our governance is aligned and that the response is not an isolated one – and supports the sustainability of the improvements.

6. Access

6.1. Teams have clear oversight on their waiting lists through a Business Intelligence (BI) dashboard. This has had a positive impact and is discussed at regular review meetings including the regular directorate and trust performance meetings.
6.2. A caseload management tool is being built to further support the management of caseloads and high-risk patients.
6.3. We are reviewing the past 12 months complaint data alongside patient reported experience measures to exclusively look for references to lack of access and lack of inclusivity. This will allow us to focus on specific services and pathways.
6.4. There is a complex piece of work being undertaken on demand and capacity within Mental Health Together and Mental Health Together+ (our approach to delivering the Community Mental Health Framework), which is due to completed by December. Additional refinement of the original model has already been undertaken with our partners and the demand and capacity work will allow for further refinement of the model.

7. Estates

7.1. We are working with our staff Disability Network in reviewing an audit tool to be used across sites to identify and improve accessibility.
7.2. Consultation for the closure of Laurel House, in Canterbury has commenced. The proposal is to move the services from Laurel House to our main Canterbury site. The proposal was already being drafted prior to the CQC inspection.
7.3. Soundproofing improvements have taken place at Britton House and are in the process of being assessed.
7.4. Site visits are being undertaken to address IT connectivity issues and partner access. This is due to conclude by the end of November.

8. Leadership

8.1. The Board Assurance Framework (BAF) and Trust Risk Register are in the process of being updated to include strengthened risk descriptions. This is due to be completed by the end of November and will allow close oversight by the Trust Board.
8.2. The senior group of deputies have reviewed the list of all trust policies to ensure accurate and relevant guidance is available, with some policies removed as no longer required.
8.3. The work refining the service model includes monitoring outcomes and staffing.
8.4. Local induction packages are being strengthened and due to be completed by the end of this month.
8.5. In April the Trust embarked on a leadership development program using external facilitation from an experienced provider for our leadership team, leaders are due to complete the second of four modules this month and it is anticipated the program will be complete in March 2026. It is split into four modules around leading self, team, organisation and system. Feedback to date has been positive and delegates report it is helping in their leadership within the organisation.

9. Quality

9.1. We have completed a quality audit on the recent changes to risk assessments and plan to implement further support to staff regarding risk formulations.
9.2. Commencing in December, we will implement a new policy on care planning, introducing Dialog+ as the main care planning tool (with some exceptions due to team functions i.e liaison, rough sleepers team). This is a proven method of care planning that is shown to improve outcomes for patients.
9.3. Do Not Attend (DNA) rates are reviewed weekly within each team in a productivity meeting. It is noted some online treatments have a higher DNA rate which is being monitored through the CQC response as well as existing programs of work we will work with service users to implement measures to reduce DNA rates .

10. Impact to transition of Children and Young People and All Age Eating Disorders Service

10.1. To provide assurance to Members, we are preparing for services for children and young people to transfer to the trust in April 2026. We recently held a Board to Board oversight meeting with NELFT to ensure the smooth transition of services.
10.2. Strengthened oversight with NELFT and ICB ensures transition readiness is monitored at system level with a series of assurance meetings receiving the necessary level of assurance.
10.3. We are committed to ensuring voices of patients, carers and staff are included in our work – and Lived Experience Practitioners and youth engagement forums are being used to co-design improvements and build trust.

10.4. Tracked alongside CQC compliance metrics, a series of performance metrics are already monitored for the services that will transition.

10.5. Our approach ensures early planning, co-production, and continuity of care. Despite the challenges highlighted by the inspection, the Trust remains committed to delivering a safe and effective transition.

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