AGENDA

NHS Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 26th May 2022
Time 9.30 to 12.00
Venue Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/22-23/1	1.	Welcome, Introductions & Apologies		Verbal	Chair	9.30
TB/22-23/2	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/22-23/3	3.	Personal Story – Recover and Resettlement Team		Verbal	SS	9.35
TB/22-23/4	4.	Quality Improvement – Safety Pods Project		Verbal	AQ	9.45
STANDING ITEMS						
TB/22-23/5	5.	Minutes of the previous meeting – 31/03/22	FA	Paper	Chair	9.55
TB/22-23/6	6.	Action Log & Matters Arising	FN	Paper	Chair	10.00
TB/22-23/7	7.	Chair's Report	FN	Paper	JC	10.05
TB/22-23/8	8.	Chief Executive's Report	FN	Paper	HG	10.10
TB/22-23/9	9.	Board Assurance Framework	FA	Paper	AC	10.20
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/22-23/10	10.	Low and Medium Secure Provider Collaborative – Year End performance summary 2021 – 22	FD	Paper	SS	10.30
TB/22-23/11	11.	Strategic Delivery Plan Priorities 2021/22 Review	FD	Paper	VB2	10.35
TB/22-23/12	12.	Research Strategy	FD	Paper	AQ	10.45
OPERATIONAL ASSURANCE						
TB/22-23/13	13.	Integrated Quality and Performance Report – Month 1	FD	Paper	HG	10.55
TB/22-23/14	14.	Finance Report: Month 1	FD	Paper	SS	11.15
TB/22-23/15	15.	Workforce Deep Dive – Equality, Diversity & Inclusion	FD	Paper	SG	11.25
TB/22-23/16	16.	Staff Survey	FD	Paper	SG	11.35
TB/22-23/17	17.	Safer Staffing Report	FD	Paper	AC	11.45
CONSENT ITEMS						
TB/22-23/18	18.	Quality Committee Chair Report (incl Mortality Report Q4)	FN	Paper	FC	11.50
TB/22-23/19	19.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/22-23/20	20.	Audit and Risk Committee Chair Report	FN	Paper	PC	
TB/22-23/21	21.	Finance and Performance Committee Chair Report	FN	Paper	MW	
TB/22-23/22	22.	Mental Health Act Committee Chair Report	FN	Paper	KL	
CLOSING ITEMS						
TB/22-23/23	23.	Any Other Business			Chair	11.55
TB/22-23/24	24.	Questions from Public			Chair	

	Date of Next Meeting: 28th July 2022

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Sean Bone-Knell	SB-K	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Martin Carpenter	MC	NExT Director Scheme
Helen Greatorex	CE	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Organisational Development
In attendance:		
Sheila Wilkinson	SW	Trust Secretariat Locum (minute taker)
Kindra Hyttner	KH	Director of Communications and Engagement
Geoffrey Lawrence	GL	Financial Planning Manager (item TB/22-23/3)
Alice Sigfrid	AS	Senior Nurse (item TB/22-23/3)
Apologies:		
Fiona Carragher	FC	Non-Executive Director
Tony Saroy	TS	Trust Secretary
Hannah Puttock	HP	Deputy Trust Secretary

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Board Meeting held at 0930 to 1215hrs on Thursday 31st March 2022
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Fiona Carragher	FC	Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Martin Carpenter	MC	NExT Director Scheme
	Helen Greatorex	HG	Chief Executive
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Sandra Goatley	SG	Director of Workforce and Organisational Development
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
	Kindra Hyttner	KH	Director of Communications
	Dan Lagadu	DL	Head of Quality Improvement
	Chelsey Wahoviak	CWa	Peer Support Worker
	Tom John	TJ	Deputy Head of Nursing (RGN/RMN)
	Dr Kirsten Lawson	KLa	Deputy Medical Director/Clinical Director - CMHTs
	Dr Efiong Ephraim	EE	Consultant Older Adult Psychiatrist/Clinical Director– Older Adult Care Group
Apologies:			
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Sean Bone-Knell	SBK	Non-Executive Director
	Andy Cruickshank	AC	Chief Nurse
Observers:			
	Dr Mo Eyeoyibo	ME	Clinical Director

Item	Subject	Action
TB/21-22/112	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, noting the apologies of CW, SBK and AC.	
TB/21-22/113	**Declarations of Interest** There were no declarations of interest.	
TB/21-22/114	**Personal Story: Veteran's Story**	

Item	Subject	Action
	The Board was joined by James Macdonald-Smith, an army veteran and a service user with the Trust's Ashford Community Mental Health Team (CMHT). James described his army career, during which he experienced harrowing situations. Although he left the army in the 1990s and maintained a successful career, his mental health deteriorated after being triggered by the Manchester Arena bombing in 2017. He contacted Combat Stress – a charity that provides mental health services for veterans – with whom he received a course of residential treatment. However, James suffered a further episode of deteriorating mental health and came under the care of Ashford CMHT. James described the care he received in very positive terms, including support provided and the ease in which he was able to access services. The Board reflected on the story and discussed the joint work between the NHS and veteran charities and between KMPT and local veterans. The Board **noted** the Veteran's story.	
TB/21-22/115	**Quality Improvement Story** The Board was joined by TJ and CWa who both set out the quality improvement project of reducing violence and aggression on acute wards. The project was created to support the delivery of the Trust's Promoting Safe Services policy. CWa set out how the quality improvement project was implemented across three of the Trust's wards and described how obstacles in rolling out the project were overcome. The project was co-produced with patients regarding sensory equipment, and CWa engaged with a charity receiving £500 for the purchase of sensory equipment such as ear defenders, light projectors, DVD players and weighted blankets. The project also ensured that there was a multi-disciplinary approach to the de-escalation processes. The project achieved a 56% decrease in violence and aggression on the wards. This work has led to a national ward for the positive impact on staff wellbeing. The Board **noted** the Quality Improvement story.	
TB/21-22/116	**Minutes of the previous meeting – 25/11/2021** The Board **approved** the previous minutes save for the following changes: • "mca" to be capitalised and "best interest conversations" to be "best interest decisions"	
TB/21-22/117	**Action Log & Matters Arising** The Board received the Action Log, commenting: • On behalf of the Board, MW & PC are assured by the Estates Prioritisation Plan • VB will support JC, HG & SG on the production of the Equality and Diversity Seminar, which is to be held in July	

Item	Subject	Action
	• From 1st April, the Trust will collate the necessary data so that the IQPR presented at the May Board meeting will contain actions and benchmarking regarding memory assessments. The Board **approved** the Action Log.	
TB/21-22/118	**Chair's Report** The Board received and **noted** the Chair's Report.	
TB/21-22/119	**Chief Executive's Report** The Chief Executive's Report was received by the Board. The Chief Executive highlighted: • Following the mass redundancy at P&O ferries, the Trust is reaching out to former P&O employees with employment opportunities, • The Trust has launched its hybrid working policy, with the Trust closing Farm Villa, which was the Trust's headquarters. There has been positive feedback from staff regarding the hybrid working policy, which works to the benefit of staff as well as patients, • The Trust won seven Healthwatch awards in the evening of 30th March 2022 – including a gold award for the consultation regarding the Trust's Ruby ward. The Board **noted** the Chief Executive's report.	

TB/21-22/120	**Board Assurance Framework**
	
	The Board received the Board Assurance Framework (BAF), with SS highlighting that since the last iteration:
	• One new risk has been added to the BAF since January
	  ○ Risk ID 6966 – 2022/23 Financial Planning
	• No risks have increased in risk score
	• Two risks have reduced in risk score
	  ○ Risk ID 5345 – Participation in Research and Innovation (reduced to rating of 4 (moderate) from 6 (Moderate))
	  ○ Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services (Reduced to rating of 4 (Moderate) from 8 (High))
	• Three risks were recommended for removal
	  ○ Risk ID 6626 – Development of a Crisis Line
	  ○ Risk ID 6880 – Impact of mandatory COVID vaccinations on staffing levels
	  ○ Risk ID 6850 – H2 Planning
	
	The Board recommended that some of the risks on the BAF could be rewritten and that there could be further risks removed. SS confirmed that other risks might be removed once the executive management team has reflected further on the BAF.
	
	The Board **approved** the Board Assurance Framework.	

Item	Subject	Action
TB/21-22/121	**Care Quality Commission (CQC) Well-Led Inspection Update** The Board received the CQC Well-Led Inspection Update, which included a copy of the CQC's well-led inspection report and various quality improvement plans. Formal thanks were given to Rachel Town for the production of the paper. In November 2021, the CQC carried out a well-led inspection of KMPT. The Trust achieved a 'Good' rating overall, with lots of positives found. Two CQC domains were 'outstanding', two further domains were 'good' and one domain was a 'requires improvement'. The issues that the CQC picked up were matters linked to estates, which were known to the Trust. The Trust had already begun to address the other issues found and had created quality improvement plans that have been shared with the CQC. The Board noted: • There is significant value in NED visits and the outcomes of those visits are captured by the trust secretariat and actioned by the executive management team. Updates are provided biannually to the public Board meeting. • The new Estates Director is now with the Trust and is looking at the structure of the estates department. The Trust will be buying-in expertise regarding its capital programme and there is also now a catering compliance officer in place. The Board will receive assurance on estates matters through the Finance and Performance Committee (FPC), and the Audit and Risk Committee (ARC). • The Trust is determined to resolve issues that staff from ethnic minority backgrounds face and the Trust is learning from the experience of East London Foundation Trust, which became an early adopter of the anti-racist organisation work. • The Trust's workforce department is working on the culture within Jasmine Ward. The Board **noted** the CQC well-led inspection update and thanked staff for their work in helping the Trust achieve a 'good' rating.	
TB/21-22/122	**Workforce Deep Dive – Agency staff strategy** The Board received the inaugural Workforce Deep Dive, which focussed on agency staff strategy. The Board noted in particular: • There has been an improved financial position regarding agency spend as the Trust reduces its staff turnover rate and ensures better rostering of staff. Improvements to the Trust's agency booking procedures have also occurred. • There may be an issue regarding junior doctors due to a number going on maternity leave whilst with the Trust. A number of junior doctors also leave the Trust quite quickly. The Board reflected on the following items:	

Item	Subject	Action
	• Acute hospitals within the system control the rota for junior doctors and the Trust will need to investigate whether there is a pattern of rotas being created whereby junior doctors come to KMPT when they are likely to go on maternity leave, • The Trust will also investigate any underlying reasons for why junior doctors are leaving the Trust. To date, junior doctor feedback to the General Medical Council has been predominantly positive. • The Trust's Communications and Engagement Team will be promoting the Trust's research work, its quality improvement work, and its links with local universities to junior doctors so that they can see that their career aspirations can be met whilst at KMPT, • The Trust's financial position regarding agency spend is not an outlier when benchmarked against other local trusts, • The Board emphasised that in order to have sufficient control on agency spend, the Trust needs to be clear that agency use will only occur when patient safety could be compromised. This would mean that agency spend is a clinically-led discussion rather than an operational discussion. The Board **noted** the Workforce Deep Dive – Agency staff strategy paper.	
TB/21-22/123	**Strategic Delivery Plan Priorities for 2022/23** The Board received the Strategic Delivery Plan Priorities for 2022/23, with the Board noting that it was an easy-to-read and focussed document. The priorities are focussed on three matters: 1) quality improvement, 2) people and 3) partnerships. Although simplified, there is a lot of work that underpins the SMART goals as detailed in the document. The Board complimented the document and recommended that a communications campaign occurs to ensure staff are aware of the new priorities. The Board **approved** the Strategic Delivery Plan Priorities for 2022/23.	
TB/21-22/124	**Mental Health, Learning Disability and Autism Improvement Board update** The Board received the Mental Health, Learning Disability and Autism Improvement Board update. The Board noted that the improvement board will be a newly constituted provider collaborative, with JC to be the chair of the provider collaborative. John Goulston, chair of Kent Community Health Foundation Trust, will be the deputy chair of the provider collaborative. The Board noted that there was an error in one of the key performance indicators. Acute general out of area (OOA) placement data had been included rather than specialist OOA data. This will be corrected in future iterations. The target will be moving from 73 OOA placements to 50 OOA placements, which will lead to a reduced annual spend of £2.4million. The Board reflected on the new provider collaborative model and assurances were received that this work will continue to be a priority for us going forward.	

Item	Subject	Action
	Discussions centred on partnership working, both with partners within the system and the third-sector. There has been joint working between the Trust and Alzheimer's Society, with the Board noting the forthcoming working in Dementia Action week. In the lead up to that week, there has been significant progress in the primary care dementia special interest groups, with there now being ten dementia coordinators. Following a request from the Trust Chair, TS advised that FC's remunerated work with the Alzheimer's Society has been previously declared and the matters that are being discussed do not amount to a pecuniary or non-pecuniary advantage for FC. The Board **noted** the Mental Health, Learning Disability and Autism Improvement Board update.	
TB/21-22/125	**Integrated Quality and Performance Report (IQPR) – Month 11** The Board received the IQPR for month 11. The Board's discussion focussed on delayed transfers of care (DTOC), and demand and capacity issues: • Work is ongoing with statutory partners to deal with DTOC as this is predominantly caused by delays in accessing social care, • There is a need to embed the demand and capacity model across the teams to ensure that the Trust can effectively tackle its waiting lists. Once embedded, the Trust believes that waiting lists will be positively impacted, • The demand and capacity model must be matched with the workforce issues being tackled. Many of the referrals that are being received can in fact be dealt with by partner organisations within the system. The Board noted the partnership work that had already occurred in the Medway area regarding the triaging of patients. Although, that appeared to be a qualitative success, there was a need to see the metrics. The Board expressed its disappointment that the Trust had not yet assured itself of the outcomes of that Medway pilot and that the successes learned had not yet been rolled out. The **Board** noted the IQPR.	
TB/21-22/126	**Finance Report: Month 11** The Board received the Finance Report (Month 11), with the following matters highlighted: • **Income and Expenditure:** Within the breakeven position reported, there are several key factors. There are continued high use of temporary staffing due to vacancies and staff absence. Year to date agency spend at the end of February was £6.8m, £1.1m lower than the same period last financial year. • **Capital Programme:** The year to date position is underspent by £7.2m, £3.6m on estates and £3.8m on strategic schemes and the Improving Mental Health Services programme. The forecast of £9.6m has been updated to reflect changes in timelines for commencement of estates	

Item	Subject	Action
	schemes. No organisations within the Kent and Medway system were able to utilise the additional slippage, as a result we will not receive this back in 2022/23 which will put pressure on the future capital programme. • **Cash:** The cash position increased by £0.9m in month to £22m mainly due to additional cash received from CCG related to Integrated care team, Dementia crisis and MAS recovery. The forecast for year-end has been increased by £1.5m to £20m reflecting the change in the capital expenditure forecast. • **Cost improvement programme:** The Trust will deliver most of its cost savings this year, with there being just a £422k gap to target. However, much of the savings have been made on a non-recurrent basis. Future iterations of the finance report will include a one-page briefing on the Trust's work to deal with the financial deficit. The Board **noted** the finance report for month 11.	
TB/21-22/127	**'The Year of the Community Team' update** The Board received the Year of the Community Team update paper and was joined by KLa and EE, who both spoke to this item. The Board noted that there had been progress across younger adults and older adults' services respectively. The improvements have been through the staffing, streamlining and specialism work that has occurred. With there being greater skill mixing and development of staff, they are able to express their specialisms more consistently. Staff members have also benefited from a reduction in the need to enter data multiple times, as systems have been amended. The Community Mental Health Framework will be rolled out, which will impact both services. It will be a big cultural shift and will therefore be a risk and challenge for the Trust. Outcomes for patients have improved and where performance has not matched ambition, such as within dementia pathways, patients are being kept safe. A task-and-finish group is addressing the issues within dementia services. The Board reflected on the above and noted: • Progress had been made but further work is still required to deliver sustained improvements in performance. This includes work on reducing bureaucracy and informing staff how impactful their work is for patients. More ambition and energy are required to deliver positive changes quicker. • The Board can support the community teams by having the system reinforce the process of dementia diagnosis, and by supporting the messaging that with the Community Mental Health Framework, risks will be shared across the system. • Communicating the changes will be a key factor in the success of embedding the Community Mental Health Framework changes. This will help change the culture within the community teams.	

Item	Subject	Action
TB/21-22/128	**Register of Interests** The Board received and **noted** the Register of Interests.	
TB/21-22/129	**Managing Conflicts – gifts and hospitality policy** The Board received and **approved** the Managing Conflicts – gifts and hospitality policy.	
TB/21-22/130	**Standing Financial Instructions** Following assurances from the Chair of ARC, the Board received and **approved** the Standing Financial Instructions.	
TB/21-22/131	**Quality Committee Terms of Reference** The Board received and **approved** the Quality Committee Terms of Reference.	
TB/21-22/132	**Quality Committee Chair Report** The Board **received** and **noted** the Quality Committee Chair Report. The Committee will be receiving a deep dive into the Trust's compliance with Duty of Candour regulations.	
TB/21-22/133	**Workforce and Organisational Development Committee Chair Report** The Board **received** and **noted** the Workforce and Organisational Development Committee Chair Report. **Action: By July 2022, TS to support the Trust Chair in advising NEDs about the different assurance levels contained within the Committee Chair Reports.**	
TB/21-22/134	**Audit and Risk Committee Chair Report** The Board **received** and **noted** the Audit and Risk Committee Chair Report	
TB/21-22/135	**Finance and Performance Committee Chair Report** The Board **received** and **noted** the Finance and Performance Committee Chair Report.	
TB/21-22/136	**Any Other Business** SG raised two matters: 1) The Trust received an overall staff survey response rate of 68% against an average national response rate of 48.3% 2) Quality Improvement –The Trust has achieved a 9% reduction in the number of patient attacks on staff members. This was against a target reduction of 10%. AQ raised one matter:	

Item	Subject	Action
	1) The KMPT-KCHFT Adult Autism Spectrum Disorder service will be going live on 1st April 2022.	
TB/21-22/137	**Questions from Public** There were no questions received from the Public.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 26th May 2022	

Signed …….. (Chair)

Date ……..

NHS
Kent and Medway
NHS and Social Care Partnership Trust

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/05/22

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN MAY 2022								
25.11.2021	TB/21-22/74	Mental Health, Learning Disability and Autism (MHLDA) Improvement Board Update	In May 2022, HG to produce a year-end MHLDA Improvement Board report detailing what the position was last year, what the position is now, what are the future trajectories and how is learning shared.	HG	May 2022		This action has now been superseded by events, with the MHLDA Improvement Board moving to the next stage in its development. It will work as a provider collaborative, and the improvement board will become more strategic in its remit, providing vision as well as assurance to the system. KMPT Trust Board last received an update on the MHLDA Improvement Board's work in March 2022.	**Complete**
25.11.2021	TB/21-22/76	Kent, Surrey and Sussex Provider Collaborative Update	SS to provide further update on the Kent, Surrey and Sussex Provider Collaborative by May 2022.	SS	May 2022		This is on the agenda for discussion.	**Complete**
ACTIONS NOT DUE OR IN PROGRESS								
25.11.2021	TB/21-22/75	Strategic Delivery Plan Priorities Update	HG to give a year-end progress report on Operation Cavell in May 2022.	HG	May 2022	July 2022	The Trust now has in post a new Local Security Manager and the adjustment in the date will allow an opportunity to establish themselves in post before reporting to the Board on this matter.	
31.03.2022	TB/21-22/133	Workforce and Organisational Development Committee Chair Report	By July 2022, TS to support the Trust Chair in advising NEDs about the different assurance levels contained within the Committee Chair Reports.	TS	July 2022			
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.11.2021	TB/21-22/72	Chief Executive's Report	By January 2022, Dr Kirsten Lawson to provide progress report on CMHT work concerning increasing staffing, streamlining processes and developing the service as a speciality.	Dr Kirsten Lawson	January 2022	March 2022	Item is on the Board agenda	**Complete**
27.01.2022	TB/21-22/95	Action Log & Matters Arising	By March 2022, TS to arrange for the estates prioritisation plan to be discussed at the next Board meeting.	TS	March 2022		Since the last Board meeting, the Chair of the Audit and Risk Committee and the Chair of Finance and Performance Committee have considered the Trust's estates prioritisation plan. On behalf of	**Complete**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/05/22

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
							the Board, both have been assured regarding the Trust's estates prioritisation plan.	
27.01.2022	TB/21-22/99	Progress on Turning the Ride; Tackling Racism	By March 2022, JC, HG, SG and VB are to meet to discuss how the tackling racism updates are reported up to Board to ensure that all statutory requirements are met as well as avoiding a duplication in reporting.	JC	March 2022		The Trust will arrange an externally facilitated board seminar on the subject of the board approach to diversity and racism. Seminar scheduled to take place in July 2022	Complete
27.01.2022	TB/21-22/101	Integrated Quality and Performance Report – Memory assessment service	By March 2022, the IQPR to be adjusted so as to include a regular update on actions and benchmarking for memory assessments.	HG/SS	March 2022		Verbal update was provided at the March Board.	Complete

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 26th May 2022**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

In my role as Trust Chair, I present this report focusing on six matters:

- Kent & Medway system
- Board Seminar Day
- Governance Matters
- Advisory Appointment Committee
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

Work across the Integrated Care System continues to be busy. I attended the Dartford, Gravesham & Swanley Health & Care Partnership board in March with a view to chairing the meeting going forwards. I am also delighted to say that we have had our first Mental Health, Learning Disability & Autism provider collaborative board meeting in May, with partners coming together from health, social care and the third sector to focus on our ambition for mental health in the system.

3. Board Seminar Day

On 28th April, the Board met together for one of its programmed Board Seminar Days, which was a really productive event. The Board was joined by a number of speakers and received presentations on KMPT's sustainability plans, public health nequalities in Kent & Medway, and anchor institutions. The Chief Executive and I anticipate producing a paper on anchor institutions and our approach to health inequalities for a public board meeting later this year.

4. Governance Matters

KMPT continuously reviews its governance arrangements to ensure that they are fit for purpose. Sometimes the adjustments needed are of a minor nature and do not require a full paper. This month, through the Trust's Chair report, the Trust Secretary wishes to make two minor amendments to the governance arrangements. These are:

1) A change in the name of 'Executive Assurance Group' to 'the Transformation Board' – reflecting the merger of two different groups within KMPT, and
2) An adjustment within the 'Development, Approval and Management of Formal Trust Documents - Policy and Procedures' document. The Trust Board approved the document in November 2021, and additional wording is required to inform policy owners that an amendment to an appendix triggers a review of the policy so as to ensure there is no conflict.

5. Advisory Appointment Committee

I would like to thank Non-Executive Directors for making themselves available for the chairing of Advisory Appointment Committees. These interview panels for the recruitment of consultants are really important, particularly in supporting the Trust to reduce medical agency spend through the recruitment of consultants on a substantive basis.

6. Trust Chair and NED visits

Since the last Board meeting, in-person visits have begun again with the following visits having taken place.

Where	Who
March 2022	
Ashford Community Mental Health Team & Community Mental Health Service for Older People	Kim Lowe
Medway Crisis & Home Treatment team	Jackie Craissati
Newhaven Lodge, Medway	Jackie Craissati
Disablement service	Jackie Craissati
April 2022	
Maidstone Criminal Justice Liaison and Diversion Service and Sevenoaks Community Mental Health Service for Older People	Peter Conway
Vocational Rehabilitation Service and West Kent Mental Health Learning Disability Team	Peter Conway
May 2022	
Upnor Ward	Catherine Walker
Support and Signposting	Catherine Walker
Brenchley Unit (psychological therapies service)	Jackie Craissati
Peer support workers	Jackie Craissati

Kim Lowe - Ashford Community Mental Health Team (CMHT) & Community Mental Health Service for Older People (CMSHOP)

There were a number of positives from my visit to the two teams. These included a lovely team atmosphere and a modern working environment, although with a number of different services sharing the same building, there is an impact on when and where they could see patients. There was a very good open relationship between the CMHT and Invicta health, who joined the Red Board meeting. The teams felt they were empowered to do the right thing for their patients and they all valued the flexibility hybrid working gave them.

A few issues were raised during my visit. The team felt under pressure through the combination of staff absences due to COVID-19 and the need for staff to use their annual leave allowance before the end of March. There were some anxieties regarding future working models for primary and secondary care joint working. Although they were aware that the Trust is developing a plan, there were also some anxieties about having to pay for COVID-19 testing themselves.

Peter Conway – Maidstone Criminal Justice Liaison and Diversion Service and Sevenoaks Community Mental Health Service for Older People

Visiting Maidstone Criminal Justice Liaison and Diversion Service was a positive and encouraging experience: low vacancies, good service, morale, financials, organic growth, reputation and atmosphere. There were a few suggestions for improvements such as mileage reimbursement, and small spend on staff facilities.

The Sevenoaks Community Mental Health Service for Older People service was in business continuity plan mode because of demand (referral volumes and complexity) and supply factors (vacancies, staff turnover and retention), difficulties which are well known to the Board.

Peter Conway – Learning and Disability Team and Vocational Rehabilitation Service

The Learning Disability (LD) Team were a positive, enthusiastic and lively team. At the moment, there are no vacancies and minimal waiting times. Two trainees were very positive about the Trust's Induction programme and the team liked Helen's Bloggs. How could things be improved? The amount of time liaison and co-ordination takes, seeing patient records of GPs and the Community Trust, more resource to handle the increased referrals following the decommissioning of Forensic LD, care home support and the suggestion that Lifesize be replaced by Teams.

The Vocational Rehabilitation Service are a small but valued service adopting the relatively new IPS (Individual Placement Support) model. There are positive and friendly staff with minimal waiting times for service users. The team raised the issue of car travel reimbursement rate.

Catherine Walker – Upnor Ward

I visited the above ward almost a year from my last visit in June 2021. It was such an uplifting way to spend a morning and I was really proud of this ward. The new outside sports Deck is now in place, the Gym is open and running as is the therapy kitchen both giving opportunities for service users to engage in activities. A well-attended art therapy class was in progress and a social group was gathered talking and cleaning/maintaining their iPod ear pieces. The ward was calm and the lunch was being got ready. Much better range of fruit and positive feedback from patients apart from a newly joined vegan whom the OT team were going to support. I had positive comments from patients about how safe they felt and how kind the staff were.

Catherine Walker – Support and Signposting

I paid a brief and impromptu visit to Support and Signposting. The unit had no patients whereas last week it was full with a waiting list. Plans are afoot to ensure all possible points of entry are refreshed as to what this service can offer. Staff made time to update me on current staffing issues. There are plans afoot from the new service lead to look outside KMPT and the NHS for further links that may help our patients. A number of people return regularly to the service where they receive time and one to one personal care with the intent to avoid admission during short periods of crisis.

Jackie Craissati visits

I spent a rewarding day with three teams on the Medway Hospital site: the crisis and home treatment team, the disablement service and the rehabilitation service at Newhaven Lodge. All three services took time and effort to provide me with an enjoyable and interesting experience, and as always, I was impressed with the dedication of staff and the pride in their team's service. I took aways a few points to raise with the Executive:

- The crisis team have noted the uneven service delivered by their local community mental health team and felt in particular that there could be an improved approach to working with individuals with emotionally complex needs.
- We need to prioritise the need for the disablement service to find new premises and support them to ensure their finances are in order.
- There seemed to be untapped opportunities to think creatively about new staffing models for our rehabilitation services

In May I visited the Brenchley Unit which provides a highly specialist and well-regarded psychological therapies service. I was pleased to see that the skilled and dedicated staff team are reaching out into community mental health teams and have plans to enhancing their training and support offer.

My virtual visit with a group of newly appointed peer support workers was as uplifting as the last time I visited the team. They provide a unique and important service for KMPT, and I am delighted to see the team continuing to expand, with additional opportunities emerging for career progression.

Chief Executive's Board Report

Date of Meeting: 26th May 2022

Introduction

Since the last board meeting, every member of KMPT staff as well as our exceptional volunteers were sent a thank you card for all that they have done, and all that they do. A hamper of treats was also sent out on behalf of the board along with a note in the card to say that everyone has been given an additional days Annual Leave to celebrate their Birthday.

There was an extremely high level of positive feedback from colleagues who welcomed the surprise delivery with many of them commenting that it had given them a real boost and felt a sincere gesture of thanks and recognition from the board.

Hybrid Working Launch

We launched our hybrid working programme across the whole organisation on April 1st supported by a series of briefings and checklists. Designed to ensure that we retain our learning from working in different ways during the pandemic, KMPT's approach has at its heart, the aim of working as effectively and efficiently as we can whilst reducing our carbon footprint and becoming a more sustainable organisation.

The board has made its own commitment to working differently and earlier in the year agreed that we would not need the planned replacement Headquarters which before the pandemic had been included as part of the building programme on our Maidstone site. The old Farm Villa building has been decommissioned as trust headquarters and the Chair and Chief Executive along with their respective teams are now working from hot desks and shared spaces across KMPT.

Hybrid working and its impact will be evaluated later in the year and the findings shared with the board.

Integrated Care System / Board

The Accountable Officer continues to appoint his executive team. KMPT has agreed with Kent Community Health Foundation Trust that the one place allocated to a representative for mental health and community trusts will be allocated to KMPT's Chief Executive for an initial period of eighteen months. A formal process including an interview with members of the Integrated Care System is to take place in June.

Strategic Priorities and Videos for Staff

The trust's three overarching strategic priorities (Quality Improvement, Workforce and Partnerships) have been shared widely and in different formats since the board last met. A series of short films in which a range of staff share their thoughts about the priorities and why they matter has been well received with colleagues noting that this format was much easier to digest than written material.

The board will receive as requested, regular updates on performance against the detailed work that sits behind the overarching priorities.

Mental Health Learning Disability and Autism Provider Collaborative

The inaugural meeting was held on Friday 20th May, chaired by KMPT Chair, Dr Jackie Craissati. John Goulston, Chair of Kent Community Health Foundation Trust is Vice Chair.

Kent and Medway Dementia Diagnosis and Showcase Conference

For the first time, KMPT in partnership with Alzheimer's Society hosted a Kent and Medway Dementia Diagnosis and Showcase conference on 20th May. Bringing together expert speakers and practitioners from Kent and beyond, its aim was to showcase best practice and restate KMPT's ambition to drive up the quality of service for those who need memory assessment.

Project Wingman Bus – Health and Wellbeing

Talking wellness is the newly named Kent and Medway staff mental health and wellbeing service led by KMPT.

It is a county-wide service funded by NHSE whose aim is to provide mental health support to all NHS and social care staff across Kent and Medway.

Keen to work in partnership with a non-NHS organisation, KMPT contacted Project Wingman and submitted a bid to NHSE for £50k to take the staff mental health and wellbeing service on the road in a Project Wingman double decker bus.

The bid was successful and the Project Wingman Bus started a fourteen-week tour of the seven acute hospital sites and three community hospitals. Project Wingman was started by members of flight and cabin crew during the pandemic. Unable to work, they wanted to support the NHS and created luxury spaces for frontline NHS staff to relax and recuperate in. the KMPT and Project Wingman project builds on that model and offers not only a lovely environment to those who drop in, but an opportunity to talk about mental and physical wellbeing.

Electronic Prescribing Go Live

We have committed to putting in place electronic prescribing across all wards by March 2023.

Our first ward to go live was Rivendell, one of our rehabilitation houses.

Electronic prescribing is modern, efficient, safe and contributes to our continuous improvement of services. It also supports to our aim to be a more sustainable organisation through reducing our use of paper.

Leading the Way Celebration

Our first cohort of the KMPT developed leadership course concluded with a celebration and reflection event on May 16th. Along with Non-Executive Director Kim Lowe and Human Resources Director Sandra Goatley, I joined the event to mark the achievement and listen to the experience of those who had completed the course. It was a very positive afternoon which will help shape and inform the further development of the course.

NVQ Training for service users

In November 2021, the Board asked me to check if NVQ training is provided for service users, particularly in the areas of catering and gardening. I am pleased to let the Board know that KMPT supports service users obtain a range of vocational and educational qualifications – including catering and gardening - although not necessarily NVQs for all subject areas.

The Trust is always looking at how we can expand provision and opportunities for patients within our services within our current resources and funding.

Helen Greatorex
Chief Executive

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26 May 2022
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

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

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in March 2022. It was then updated and presented to the Audit and Risk Committee at on 16 May.

- No new risks have been added to the BAF since March
- No risks have changed their risk score since March
- 4 risks are recommended for removal
  - Risk ID 6420 – COVID 19 Personal Protective Equipment (Rating of 4 (Moderate))
  - Risk ID 5989 - Emerging Infectious Diseases (including response to covid-19 and subsequent variants) (Rating of 8 (High))
  - Risk ID 6623 - Easing of Lockdown National Roadmap - Hybrid working (Rating of 8 (High))
  - Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services (Rating of 4 (Moderate))

Governance

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

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The Board Assurance Framework

The BAF was last presented to the Board on 31 March 2022. It was updated and presented to the Audit and Risk Committee on 16 May.

The Top Risks are

- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 6857 – Maintenance Services Funding Availability (Rating of 20 – Extreme)
- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6628 - Financial Sustainability (Rating of 16 - Extreme)
- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6861 – Estates and Facilities Resources (Rating of 16 – Extreme)
- Risk ID 6881 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)

Risk Movement

There have been no changes to risk scores since the Board Assurance Framework presented to Board on 31 March

The Audit and Risk Committee discussed the risk scores of the following risks:

- Risk ID 6848 – Staff Turnover
- Risk ID 6849 – Retention of Employees
- Risk ID 6847 – Sickness
  The target risk scores for each of these risks are currently sitting at the same level as the current risk scores. This is now under review and any changes will be reflected in the next BAF report. Consideration is being given to the actions being taken for each of these risks and when the impact of this work will be seen.

Risks Recommended for Removal

Four risks are recommended for removal

- **Risk ID 6420 – COVID 19 Personal Protective Equipment (Rating of 4 (Moderate))**
  This risk is being recommended for removal to the Board. PPE stocks are being managed within current Business as usual arrangements, the majority of Covid restrictions are being eased, and there has been a recent change to the wearing of face masks in non-clinical areas further reducing the use of PPE. However, the Covid response is still being managed as a level 4 incident, retaining co-ordination and control at a national level.
  The recent Trust Wide EPRR meeting considered if this risk should remain a BAF level risk, and it was agreed to recommend this risk for removal from the BAF.
  It will remain open on the EPRR risk register to ensure oversight remains while the pandemic response is ongoing and to ensure consideration of PPE requirements at an early stage with any future emerging infectious disease.

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- **Risk ID 5989 - Emerging Infectious Diseases (including response to covid-19 and subsequent variants)**
  This risk is also being recommended for removal from the BAF. The Trust is moving to business as usual following the acute response to the covid-19 pandemic. While nationally the pandemic is still being managed at a level 4 incident, we are seeing little direct viral infection impact of Covid on trust services. The Tactical Co-ordination group is looking to stand down the regular tactical meetings whilst retaining high level oversight of demand and capacity in patient flow. This risk will remain open on the EPRR risk register to ensure there is still oversight of any new variants of concern and to ensure any learning is fed back into Trust plans.

- **Risk ID 6623 - Easing of Lockdown National Roadmap - Hybrid working**
  This risk is recommended for closure. The new hybrid working arrangements are being managed as business as usual. A plan is in development so we complete all sites during 22/23, which a strong focus on rationalising our estates.

- **Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services**
  This risk is recommended for closure. A paper is being presented to the Board regarding the collaborative which provides an update on performance and the financial position. The collaborative is in surplus at the end of its first financial year. Consideration will be given as to whether there is any other risk that needs to be articulated regarding the collaborative.

The following risks were also discussed for removal at the Audit and Risk Committee, but were not supported at this time:

- **Risk ID 4083 – Management of Environmental Ligatures**
  This risk was discussed with a view for removal from the BAF as its risk score is at 8 (high) and has remained quite static. This is not supported due to the ongoing risk of existing and newly identified ligatures across KMPT sites. The risk score is at 8 as the likelihood score is at 2 – Unlikely, but the consequence score remains at 4 – Major. Inclusion of this risk as part of the BAF ensures ongoing focus and assurance that the controls and assurances remain robust.
- **Risk ID 6485 – Clinical Engagement for the Strategy**
  This risk was discussed with a view for removal from the BAF as it is a low rated risk. However, clinical engagement for the clinical technology strategy remains challenged and needs improving to ensure the full benefits of the projects are realised.
- **Risk ID 5345 – Participation in Research and Innovation**
  This risk was discussed with a view for removal from the BAF as it is a moderate rated risk. Progress has been made against this risk, with the appointment to the Research and Innovation Director post, and the development of the Research and Innovation strategy, which is due to be presented to the May Board. It is considered that this risk should remain on the BAF at this time, but may be recommended for removal in the coming months.

New Risks

No new risks have been added to the BAF this time.

One new risk is being written to be added to the BAF:

- **Delayed Transfers of Care**
  A risk regarding the high number of Delayed Transfers of Care is currently being drafted to reflect the impact on patients and trust services and recognise the work that is currently being undertake to address this.

Emerging Risks

One emerging risk is currently being considered

- **Community Transformation**
  This programme was discussed at the Quality Committee and consideration is being given as to if there is a risk that needs to be recognised around the delivery of this programme, and the impact on trust services and community teams until this work is in place.

Recommendations

The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.
The Board are requested to note that work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

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Updated: 18 May 2022

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Board Assurance Framework

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

Definitions:

Initial Rating = The risk rating at the time of identification

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

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

Action status key:

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

1 - Consistently deliver an outstanding quality of care

17/11/2020 — Risk Opened — 04/06/2021: The top 5 assurances need to be identified for this risk

15/11/2021: Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered.

14/01/2022: Risk score has reduced slightly. Demand and capacity reamins an issue for the CMHTs, but this risk feels like it is at a steady state. Actions continue to reduce the risk, but there is good oversight at CPR and there does not seem to be any increase in S's or complaints.

22/02/2022: A review is needed as this relates to Covid. MAS which was one of the highest areas of risk now has its own system risk in BAF and delivery of the CMHF is a 3 year programme due to fully deliver at the end of 2024. Therefore the risk for demand and capacity has mitigations for CMHTs and Older Adult CMHT which will take another two years

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs compared to pre pandemic levels** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	3	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Refocussed Community Transformation Programme (led by KMPT) / Chief Operating Officer / 30/04/2023 / A Integration of provider workforce to aid skill mix and new ways of working / Chief Operating Officer / 30/04/2023 / A Skill Mix of Workforce (CMHSOPs) / Head of Service / 28/02/2022 / A Dementia Strategy Development / Deputy COO / 31/03/2022 / A	Chief Operating Officer	To be confirmed	3	3	9	30/04/2024

12/01/2022 — BAF Risk Opened

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

10/03/2022: The Dementia SIG have identified key actions for delivery by year end.

21/04/2022: Since the last report, part year funding has been agreed for extra clinics for dametia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st Septmber.

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6881	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by October 2022. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG.	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Identification of additional funding for increased MAS assessment appointments into the 22/23 financial year. / Executive Director of Finance / 31/05/2022 / G MHLDA IB to escalate to ICB for addition to system risk register / Chief Executive / 18/03/2022 / G Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment / Chief Medical Officer / 31/12/2022 / A Dementia Strategy Development / Chair of K&M Dementia Service Improvement Group / 31/12/2022 / A	Chief Medical Officer	To be confirmed	3	3	9	27/03/2023

				Initial rating					Current rating					Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
6052	Mar 2019	Chief Nurse	**Improving and sustaining quality and safety** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice.	3	4	12	CMHT 'day in the life of' guidance CQC Insight Report Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Membership of quality networks and national accreditation schemes Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CQC Mental Health Act Reviews System wide Quality Surveillance Reports Feedback from Healthwatch and Mental Health Action group Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock inspections)	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Cliq checks and Deep dives — Executive Director of Nursing, AHPs and Quality — Ongoing — A Quality Summits — Executive Director of Nursing, AHPs and Quality — Ongoing — A Learning from each other - Peer reviews — Executive Director of Nursing, AHPs and Quality — Ongoing — A	Chief Nurse		1	3	3	31/03/2022
4083	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Refreshed Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool. — Deputy Director of Nursing — 01/11/2022 — A Annual Ligature Audit (Undertaken in November) — Deputy Director of Nursing — 28/01/2022 — G	Chief Nurse		1	4	4	31/03/2023
6420	Apr 2020	Chief Nurse	**COVID 19 Personal Protective Equipment** IF there are not adequate national stocks of COVID-19 PPE provided through the National Supply chain to NHS organisations THEN there is a risk that Trust Staff (including contractors, partners and volunteers on trust sites) will not have access to appropriate PPE RESULTING IN a failure of the Trust to comply with Health and Safety regulations which may lead to increased staff sickness and unions instructing staff to withdraw from the working environment which in turn will impact on the health and safety of patients.	3	4	12	National: National Stockpile of PPE National Daily Situation Reporting from Trusts to DoH National Exception reporting for PPE National/Regional Mutual Aid Agreement Regional: Kent and Medway Strategic Co-ordinating Group Kent and Medway Tactical Incident Control Centre Regional Distribution centre within Kent and Medway for COVID-19 PPE Mutual Aid between Partners in Kent and Medway Trust: Central Procurement strategy for COVID-19 related PPE, Managed by a Trust Director Link between Business intelligence and procurement to identify new suspected and confirmed cases by location Dedicated procurement contact email address Centralised stock and buffer store Trust tactical control meetings held weekly (and assessment prior to any bank holiday period) Dedicated drivers for PPE logistics (department of Transport contact details should further logistical support be required) Policies, procedures, real time circulation of new/updated guidance via tactical control Product reviews prior to acceptance of product into the organisation to include assessment of any revised Fit testing required. Dedicated tactical control contact details with ICC open 08:00-20:00 daily. Fit testing, Donning and Doffing and Hand Hygiene Training Hybrid working arrangements support a reduction in demand for PPE.	Stock management system that is reported nationally. Local review of buffer stock annually from October 2021 with stock rotation as appropriate	1	4	4	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** No further actions identified	Chief Nurse		1	4	4	29/07/2023

2 - Recruit, retain and develop the best staff making KMPT a great place to work

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6847	Nov 2021	Director of Workforce and Organisational Development	**Sickness** IF we fail to support the health and wellbeing of our staff THEN this will impact on the sickness absence rate RESULTING IN reliance on agency staff, increased cost and potentially lower quality service to patients	5	4	20	Health & Wellbeing Group [2a] Range of targeted support and leadership Musculosketal health and screening Mental wellbeing and stress support Tobacco control Physical activity and active travel Healthy eating and healthy weight Alcohol and substance misuse support Winter wellbeing messaging Health and Wellbeing Conversations [1a]	Monitoring locally, reporting to IQPR Report to WF&OD Committee	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Targeting communications / H&WB lead / 31/03/2022 / G Supporting managers through absence management cases / Deputy Director of Workforce and OD / 31/03/2022 / G Flu vaccination programme / Director of Workforce and OD / 28/02/2022 / G Covid vaccination programme / Deputy Director of Workforce and OD / 31/03/2022 / G	Director of Workforce and Organisational Development	To be confirmed	4	4	16	31/03/2023

17/11/2021 — Risk Opened — 22/02/2022: Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff.

21/03/2022: Sickness levels remain consistent. A Health and Wellbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year.

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6848	Nov 2021	Director of Workforce and Organisational Development	**Staff Turnover** IF we have high turnover in Additional Clinical Services and Allied Health Professionals THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways / OD Specialist / 31/03/2023 / A Quarterly People Pulse / Director of Workforce and OD / 31/03/2022 / G National Staff Survey / Director of Workforce and OD / 31/01/2022 / G Recruitment and Retention group to deliver on identified workstreams to support retention / HR Business Partners / 31/03/2023 / A	Director of Workforce and Organisational Development	To be confirmed	4	5	20	31/03/2023

17/11/2021 — Risk Opened — 22/02/2022: Turnover rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.

21/03/2022: Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6849	Nov 2021	Director of Workforce and Organisational Development	**Retention of Employees** IF we do not retain our employees in additional professional scientific and technical group and allied health professionals group THEN this would impact on staff morale, recruitment, turnover, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1e] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways / OD Specialist / 31/03/2023 / A Quarterly People Pulse / Director of Workforce and OD / 31/03/2022 / G National Staff Survey / Director of Workforce and OD / 31/01/2022 / G Recruitment and Retention group to deliver on identified workstreams to support retention / HR Business Partners / 31/03/2023 / A	Director of Workforce and Organisational Development	To be confirmed	4	5	20	31/03/2023

17/11/2021 — Risk Opened — 22/02/2022: Retention rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.

21/03/2022: Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23

				Initial rating					Current rating					Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
3 - Put continuous improvement at the heart of what we do																			
25/01/2019 Risk Opened 04/06/2021			This risk is required as part of the EPRR assurance process. Risk actions require development to evidence the ongoing monitoring and update of response plans and will reflect any learning from the covid-19 pandemic. Surge testing is in place to track spread in areas seeing increasing rate of infection				06/09/2021 Rolling tactical control rota for the Trust is being maintained aligned to NHS command and control arrangements for monitoring and response functions.	15/11/2021 NHS command and control arrangements continue, Trust monitoring and response functions continue to align. Staff encouraged to have their Covid booster vaccinations in addition to seasonal Flu vaccination, and uptake is monitored.				17/01/2022	There is a commitment to central funding for PPE for the 2022/23 financial year. In light of this the target date for this risk remains appropriate to cover any extended period of uncertainty in relation to the current pandemic response and allow for the learning outcomes from it to be identified.	17/01/2022 This risk is recommended for Removal from the BAF. It remains well controlled, but the Trust is moving to Business as usual with regard to the Pandemic. This risk will remain open and be managed via the EPRR risk register.					
5989	Jan 2019	Chief Nurse	**Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK and national command and control arrangements THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical and mental health of clients	3	4	12	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Significant Incident Plan [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g] Timely Trust adoption of new centrally provided guidance relating to the specific disease [3b] Engagement with Vaccination Programme Engagement with Surge testing requirements	Significant incident plan which provides Trust Command and Control linking into the system Command and Control, regional and national Physical Health Nurses in place Access to Cloud now widely available to staff Business Continuity Plans in place Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance	3	3	9		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Continued compliance with national IPC guidance — Infection prevention and control — ongoing — A Screening Programmes (lateral flow testing and PCR testing for both staff and patients) — Infection prevention and control — ongoing — A Fit testing and use of PPE — Infection prevention and control — ongoing — A Maintain a rolling tactical rota aligned to NHSE response — EPRR Lead — ongoing — A	Chief Nurse		2	3	6	29/07/2023
02/03/2021 Risk Opened 04/06/2021			Actions to reduce risk and top 5 Assurances need development				06/09/2021 The risk description has been updated to reflect where the government roadmap is with relation to easing of lockdown. The Trust continues to have work from home direction in place and infection prevention and control measures in place on all trust sites.	17/01/2022 A draft policy for hybrid working is under development and is due to be presented at the next Agile working group meeting in February. The work from home where possible direction for Trust staff remains in place.				14/03/2022	Hybrid working will be launched in the Trust formally in April 2022. A Standard Operating Procedure (SOP) has been developed, with tool kits for staff and managers. This will allow the Trust to deliver on its Estates Strategy to use our buildings more efficiently and effectively.	18/05/2022 This risk is recommended for Closure. The Hybrid Working Standard Operating Procedure is now in place and the arrangements have moved to business as usual.					
6623	Mar 2021	Executive Director of Finance	**Easing of Lockdown National Roadmap - Hybrid working** IF the national removal of restrictions leads to staff returning to pre pandemic working practices THEN staff may conclude that they can return to work in Trust buildings RESULTING IN the Trust not maintaining the new ways of working. Hybrid working will be launched in the Trust formally in April 2022. A Standard Operating Procedure (SOP) has been developed, with tool kits for staff and managers. This will allow the Trust to deliver on its Estates Strategy to use our buildings more efficiently and effectively.	3	4	12	Agile working group Communications re continuation of work from home Covid secure SOP Restriction on number of staff in rooms against risk assessment Use of face masks on trust sites	Reporting through Hybrid Working Group EAC oversight	2	4	8		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop Hybrid Working Policy — Executive Director of Finance — 11/02/2022 — G Launch Hybrid Working Standard Operating Procedure — Executive Director of Finance — 30/04/2022 — G	Executive Director of Finance	To be confirmed	2	2	4	30/04/2022
23/11/2021 Risk Opened																			
6862	Nov 2021	Executive Director of Finance	**Contract Management of Outsourced Services** IF the outsourced services contracts are not robustly managed THEN services as required and contracted are at risk of not being delivered at all or compliantly RESULTING in complaints, accidents/incidents, statutory non-compliances, over-expenditure, poor value for money, KPIs not achieved, quality of care for patients and property compromised and adversely impacted	5	4	20	Estates and Facilities Review 1a Management controls are in place Management of Key Performance Indicators 1b Contract Management Procedures 1f Project Board Policies and procedures in place with robust Standing Orders / SFI's		4	3	12		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Management training on client side contract management — Acting Lead for Estates — 28/03/2022 — A Recruitment to interim resource — Acting Lead for Estates — 24/11/2021 — G High level Improvement plan in place — Acting Lead for Estates — 31/12/2021 — A	Executive Director of Finance	To be confirmed	2	3	6	01/04/2022
02/03/2021 Risk Opened																			
6861	Nov 2021	Executive Director of Finance	**Estates and Facilities Resources** IF adequate resources are not available to deliver the required services THEN non-delivery of all or some contracted services would occur RESULTING in backlogs, complaints, reputational damage, statutory non-compliances including CDM Regulations, potential harm to life and property, inability to respond to or avoid emergencies	5	4	20	Adequate staffing levels to carry out critical tasks to ensure compliance. Regular updates from Contractors regarding availability of staff / resources. Possible restructure of Estates and Facilities. Interim appointments of staff where required use of external specialist advisors	Project management support and reporting Interim recruitment to posts Vacancy reporting and recruitment	4	4	16		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Interim Appointmentsbeing made to support operations and the capital programme — Acting Lead for Estates — 20/06/2022 — G Monitor staff workloads — Acting Lead for Estates — 20/06/2022 — A New structure being drafted and approved at EMT w/c 21st March — Strategic Director of Estates and Facilities — 31/03/2022 — A Full review of JDs and Person Specifications underway to draft develoment programmes where required for staff — Strategic Director of Estates and Facilities — 20/06/2022 — A	Executive Director of Finance	To be confirmed	3	3	9	27/06/2022
4 - Develop and extend our research and innovation work																			
10/08/2017 Risk Opened 04/06/2021			Recruitment to Research and Innovation Director post was successful. Candidate due to start in September. Further sources of assurance need to be identified.				06/09/2021 Research and Innovation Director due to start mid October. Actions identified are currently on hold and will be picked up under their leadership. Some research activity/ participation in drug trials has been paused due to team capacity.	15/11/2021 Research and Innovation Director is now in post. The research and Innovation strategy is on track for ratification ahead of March 2022				10/03/2022	This has reduced in current risk score due to the Research and Innovation Director being in post. There has been progress on the other two key actions with the R&I Strategy due for ratification in May 2022.	21/04/2022 The Research and Innovation Strategy, and increase in funding are due to be presented to Board in May 2022.					
5345	Aug 2017	Chief Medical Officer	**Participation in research & innovation** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment and tendering and patient choice.	3	2	6	R&D links across the organisation in line with the Research & Development Strategy [2e] Research & Development SoP [2e] Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b] Annual report to the Board [3a] Report CRN clinical research network [3e]	National Clinical Research governanace arrangements Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee minutes	2	2	4		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recruitment to Research and Innovation Director post — Chief Medical Officer — 29/10/2021 — G Increase in funding for research and innovation team — Research and Innovation Director — 29/06/2022 — A Ratification of research and Innovation Strategy — Chief Medical Officer — 31/05/2022 — A	Chief Medical Officer	To be confirmed	1	1	1	17/10/2022

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5 - Maximise the use of digital technology																			
23/07/2020 Risk Opened 04/06/2021 — Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 — Digital Business partners are attedning clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this. 15/11/2021 — Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy.																			
6485	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	3	2	6	Trust board commitment and approval (3a) Digital business partners allocated (1g) reviewed at ICTSMT monthly (1a)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	2	1	2	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Digital Business Partners to attend clinical meetings — Head of ICT — 29/03/2024 — G Recruitment of Change Leads — Head of ICT — 31/01/2022 — A	Executive Director of Finance	To be confirmed	1	1	1	31/03/2023
6 - Meet or exceed requirements set out in the Five Year Forward View																			
			No Risks Identified against this Strategic Objective																
7 - Deliver financial balance and organisational sustainability																			
01/04/2020 Risk Opened 04/06/2021 — Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. 06/09/2021 — This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway 17/01/2022 — The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.																			
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose and a potential for an increasing backlog.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Ensure Capital Plan reflects backlog maintenance and services priorities, as well as implementing standing orders and SFI's for robust financial management — Director of Estates and Facilities — 31/03/2022 — A Provide comprehesive report to Trust Capital Group. — Director of Estates and Facilities — 31/03/2022 — A	Executive Director of Finance	To be confirmed	2	3	6	31/03/2024
10/03/2021 Risk Opened 06/09/2021 — As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.																			
6628	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. A 4 % efficiency target has ben set to start to tackle the underlying deficit.	4	4	16	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of underlying defecit — Deputy Director of Finance — 31/01/2022 — G Delivery of multiyear efficiency programme — Deputy Director of Finance — 31/06/2022 — A Deep dive of Acute and Forensics financial position — Deputy Director of Finance — 28/02/2022 — G Complete financial planning (Subject to national timetable being confirmed) — Deputy Director of Finance — 31/03/2022 — G	Executive Director of Finance	To be confirmed	3	3	9	31/03/2023
23/11/2021 Risk Opened																			
6858	Nov 2021	Executive Director of Finance	**External Market Forces** IF external market forces that have arisen from Brexit and the Coronavirus pandemic are not built into the Trust plans sufficiently this could lead to inadequate planning for building projects and contracts THEN additional expenditure and delays to projects might arise RESULTING in RESULTING in poorly set budgets and contract management.	4	4	16	Robust supply chain and procurement process in place. Clear Route to Market. Pre-Tender Estimates. Complete and comprehensive invitation to tender packages. Use of competent external project managers.	Sense checking against other providers	4	3	12	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Clear route to Market — Wilson, Craig — 25/07/2022 — A Pre tender estimates — Wilson, Craig — 25/07/2022 — A Complete and comprehensive Invitation to Tender packages — Wilson, Craig — 25/07/2022 — A Use of competent external project managers — Wilson, Craig — 25/07/2022 — A	Executive Director of Finance		2	3	6	29/08/2022

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
17/11/2021 Risk Opened																						
6857	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Existing approved and in date contracts in place with external maintenance contractor Maintenance process in place for reporting required maintenance Maintenance KPIs in place Issue reactive maintenance Procedures to services.	Reporting to FPC TiAA Audit and follow up Audit due to limited Assurance	5	4	20	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance	To be confirmed	3	4	12	**26/09/2022**
													Implement 5-year Planned Maintenance Programme	Acting Lead for Estates	20/06/2022	A						
													Issue Reactive Maintenance Procedures to Services	Acting Lead for Estates	20/06/2022	A						
													Invest in SFG 20 for statutory Planned Preventative Maintence	Acting Lead for Estates	20/06/2022	A						
22/03/2022 Risk Opened																						
6966	Mar 2022	Executive Director of Finance	**2022/23 Financial Planning** IF the Trust fails to deliver on the 2022/23 financial Plan THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance	3	4	12	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Monthly Finance Report [1h] Finance position and CIP update [1h]	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance	To be confirmed	3	4	12	**31/03/2023**
													Deliver efficiency programme - fully identified 29th April 2022 (as per CIP delivery plan led by the deputies)	Deputy Director of Finance	31/03/2023	A						
													Ensure appropriate cost controls are in place, with particular focus on agency	Deputy Director of Finance	22/06/2022	A						
													Full Review of Vacancies	Deputy Director of Finance	22/09/2022	A						
													Signed Commissioner Contracts	Deputy Director of Finance	30/04/2022	A						
8 - Develop our core business and enter new markets through increased partnership working																						
01/10/2017 Risk Opened 04/06/2021 Actions to reduce risk need development 06/09/2021 The Trust continues to work with Sussex Partnership Trust to ensure that the five workstreams are effective and allow the provider collaborative to be sustainable on a long term basis. 17/01/2022 This risk and actions will be fully reviewed on completion of the planning round at the end of March 2022. it may be at this time this risk is reframed to reflect the development in the provider collaborative since this risk was opened. the objectives set via the planning round will inform the BAF risk actions. 18/05/2022 **This risk is recommended for closure. A paper is being presented to Board regarding the Provider Collaborative which provides an update on performance and the financial position. The collaborative is in surplus at the end of its first financial year**																					
5456	Oct 2017	Executive Director of Finance	**Provider Collaborative (New Care Models) - Secure Services** If we do not deliver on the objectives of the Provider Collaborative for KSS, for example achieving repatriation and reducing Length of Stay THEN the forensic services may not be able to sustain the investment in the community services and the overall provider collaborative may not be sustainable on a longer term basis. RESULTING in a risk to the sustainablity of the Provider Collaborative	3	5	15	Clear governance process established for the New Care Models (NCM) [1f] The DoF is the Executive Lead and attends the NCM Board and sub group [2f] The Trust are also part of the activity modelling group [2f] Financial governance (1g) Quality assurance processes (1f) Strategic Partnership with Surrey/Sussex Partnership (2f) Partnership working with 3rd party providers (2f) On-going service evaluation & audits (2d) Board oversight (3a) Peer network and other 3rd party assurance (3e)	Numerous quality audits are carried out within the service Regular inspections by CQC take place NHSE evaluation of performance	1	4	4	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance	To be confirmed	1	4	4	**31/09/2022**
													Deliver care pathway within financial envelope and to required quality standards	Head of Forensic Psychological Services	31/03/2022	G						
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																						
10/03/2021 Risk Opened 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide suppport for the delivery of identified priorities. 17/01/2022 **Quarter 3 review is currently underway to inform the Q4 delivery. A further review will be undertaken in March and this BAF risk will be reviewed.**																					
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2023** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2023 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	9	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	3	2	6	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	**25/04/2022**
													Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans	Lead Executive Director and Trust Secretariate	Completed	G						
													Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021	Executive Director Partnerships and Strategy	Completed	G						
													Review of strategy delivery plan trajectories to final quarter 2021/22	Executive Director Partnerships and Strategy	March 2022	A						

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 26th May 2022
Title of Paper:	Low and Medium Secure Provider Collaborative – Year End performance summary 2021 – 22
Author:	Phil Lawrence – Director of Contracting, Information Governance and Business Development
Executive Director:	Sheila Stenson – Executive Director of Finance

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Committee Requested

Overview of Paper

The paper provides an update on the 2021/22 activity and financial performance of the Kent Surrey and Sussex Provider Collaborative. Included in the paper are the following:

- In year performance all three NHS Risk share partners
- Financial performance of the collaborative
- Next steps

Issues to bring to the Committee's attention

- Overall the collaborative reduced the inpatient cohort by 22 patients, 1 more then planned, Kent's inpatient activity reduced by 10 against a target reduction of 13,
- The collaborative reported an in year surplus of £1.6m. Discussions continue on how this income will be reinvested back into front line KSS collaborative services.

Governance

Implications/Impact:	Potential impact on Trust finances if aims of collaborative are not met.
Risk recorded on:	Currently recorded on BAF, with recommendation in May 2022 for the removal of risk from BAF as collaborative aims are being met.
Risk IDs:	BAF Number 5456
Assurance/Oversight:	Trust Board

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1. Executive Summary

This update paper is presented to the Trust Board to provide a summary of the performance of the Kent, Surrey and Sussex (KSS) Provider Collaborative for the financial year ending March 2022. The Trust is one of three NHS partners, (alongside Surrey and Borders Partnership NHS Foundation Trust and the Sussex Partnership NHS Foundation Trust (Sussex are the host) as well as 6 private providers who formed the provider collaborative formally in April 2021. The collaborative is commissioned to provide low and medium secure forensic care for the patients of Kent Surrey and Sussex with responsibility for patients within this geographic footprint as well as patients placed in low and medium secure locations throughout the country.

The paper will provide an update on the following: -

- Activity performance against the collaborative plan for 2021-22
- Financial performance against the collaborative plan for 2021-22
- Next steps for the new financial year (2022-23)

2. Activity Performance 2021-22

The KSS Collaborative set itself a target of reducing the net inpatient numbers by 21 overall across the three localities, this equated to the following:

	Inpatient position	KSS Target 2021/22	Anticpated Reduction
Locality	**Mar-21**		
Kent	140	127	-13
Surrey	50	45	-5
Sussex	127	124	-3
Total	**317**	**296**	**-21**

NOTE – Surrey's target was adjusted in year, a change in ICS boundaries saw Surrey take on Surrey Heath CCG activity in year.

The targets were set reviewing the available information in relation to planned discharge dates for each patient, the targets set were challenging and assumed that any increases in referrals would be managed within the collaborative.

The collaborative has performed well during the year, there has been an increase to referrals in the year with demand increasing noticeably from November 2021, there has been additional pressure on seclusion room availability towards the end of the financial year.

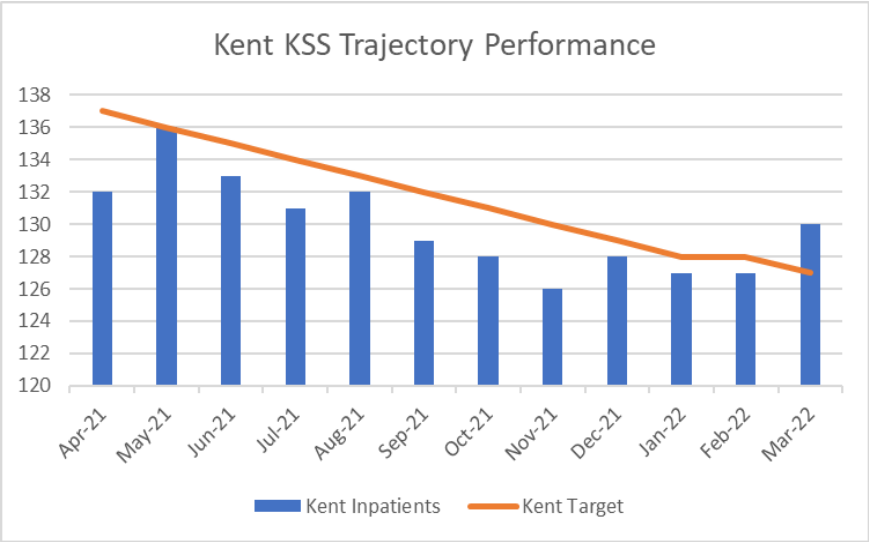
The three localities final position is illustrated below: -

	Inpatient position	KSS Target 2021/22	Anticipated Reduction	Outturn	Performance against target
Locality	**Mar-21**			**Mar-22**	
Kent	140	127	-13	130	3
Surrey	50	45	-5	47	2
Sussex	127	124	-3	118	-6
Total	**317**	**296**	**-21**	**295**	**-1**

Kent (KMPT) performed well throughout the financial year, we were set the largest reduction and remained below this throughout the year, however in the last month of the financial year there was a spike in referrals and a drop in discharges which meant we did not deliver the year end target.

Towards the end of the year discharges slowed down mainly due to pressure finding suitable placements for inpatients and Delayed Transfers of Care (DTOC) remained high within the collaborative.

There have been specific pressures with the availability of male inpatient capacity (this is a known pressure across the country), therefore the collaborative has had to place some patients outside of the KSS footprint into both low and medium secure private placements. This has mainly been due to the increased acuity of the referrals being received alongside the reduction in seclusion room availability. Seclusion room capacity issues locally has now been resolved which will help support the Collaborative aims in the new financial year.



	Kent Inpatients	Kent Target	Performance
Apr-21	132	137	5
May-21	136	136	0
Jun-21	133	135	2
Jul-21	131	134	3
Aug-21	132	133	1
Sep-21	129	132	3
Oct-21	128	131	3
Nov-21	126	130	4
Dec-21	128	129	1
Jan-22	127	128	1
Feb-22	127	128	1
Mar-22	130	127	-3

As is being seen within other parts of the service/sector, DTOC remain a challenge. Within the KSS Collaborative there are currently 19 patients (6% of the overall inpatient cohort), who meet the criteria of a DTOC, the locality split is below, Kent 3 patients, Surrey 3 patients and Sussex 13 patients.

The collaborative plans a detailed review of the reasons behind these delays early in the new financial year.

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3. Financial performance 21-22

The KSS Collaborative reported a surplus for 21/22 of £1.6m which is a combination of savings delivered through the repatriation and discharge of patents during the year.

The surplus position is set out below;

	Q1	Q2	Q3	Jan-22	Feb-22	Mar-22	Q4	YTD
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
KSS Financial Baseline 21-22	14,863	14,863	14,863	4,954	4,954	4,954	14,863	**59,451**
Surrey Heath Reconfiguration	381	381	381	127	127	127	381	**1,523**
OOA Activity - Other Provider Collaboratives	414	414	414	138	138	138	414	**1,656**
Total Budget	**15,658**	**15,658**	**15,658**	**5,219**	**5,219**	**5,219**	**15,658**	**62,630**
KSS Bed expenditure costs	13,956	14,097	13,840	4,654	4,495	4,686	13,836	**55,728**
KSS Other Expenditure Commitments	1,254	1,380	1,328	430	444	441	1,316	**5,277**
Total KSS Expenditure	15,209	15,477	15,167	5,084	4,940	5,128	15,152	**61,005**
Surplus / (Deficit)	**448**	**181**	**490**	**135**	**280**	**92**	**506**	**1,625**

The three NHS partners of the KSS Collaborative have signed a risk and gain share agreement as part of joining the collaborative agreement, any gains are managed thorough the governance processes of this agreement.

The collaborative is now in a strong position financially. Discussions are underway regarding how to re-invest the surplus into front line services. It should be noted that when the collaborative was set up a loan was received from NHSE (£2m in total) to pump prime the establishment of community services. Part of the loan (£1m) is due for repayment in 22/23. The collaborative is in a position to fulfil this agreement.

4. Next steps

The Trust leads are working with Sussex as the host to finalise the sub contract for 2022-23. This is the first year following the pandemic that contracts will be signed. The main areas being finalised are;

- **Inpatient targets** – The Collaborative have proposed a further reduction of 8 inpatients for KMPT (Kent). Discussions are taking place to understand the proposal and the data to support this target.
- **Extraordinary packages of care** - **patient acuity** – An urgent discussion with the collaborative is required to understand the change in patient acuity levels and the impact this is having on performance and the potential financial implications.
- **Forensic Outreach Liaison Service (FOLs)** – A full review is underway across the collaborative to ensure that the community services are consistent in each patch. The Trust is also reviewing the financial performance of this service as part of the structural deficit work that is on-going.

In addition to the above the Collaborative are focusing on three main areas in 2022/23:

- **FOLS Transformation** – a review of the FOLS service has been undertaken by the host over the past few months, designed to specify the shape, size and

expectations of the FOLS services with Kent, Surrey and Sussex, (currently the three teams work differently). The Trust is engaging with this work and a final plan will be agreed before the end of Quarter 1.

- **Woman's pathway** – The collaborative has noted a reduction over the past couple of years of inpatient referrals into the woman's pathways of the three NHS risk share partners. This reduction has led to an under occupancy of female beds across KSS. The collaborative has commenced a review and a KSS strategy will be drafted for all partners to review, participate in and comment on. This work is in its infancy and will continue through tithe year.

- **DTOCs -** as mentioned above, a review of the delayed transfers of care is planned for 2022-23 to reduce the position from the current 19 patients identified and sustain a reduction moving forward.

Activity and financial progress against the 2022-23 KSS targets alongside updates on the work programmes for this financial year can be provided quarterly on request.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31 March 2022
Title of Paper:	KMPT Strategy Delivery Plan 2021/22- end of year report
Author:	Martine Mccahon (Assistant Director Transformation and Improvement)
Executive Director:	Vincent Badu (Executive Director of Partnership and Strategy)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This Board report provides an end of year position summary on the delivery of the Trust's 2021/22 Strategic Delivery Plan Priorities.

Issues to bring to the Board's attention

Items of excellence – first prize in best presentation on Doctor wellbeing at the Cambridge Quality Improvement online conference; KMPT achieved our highest ever response at 67.8% to the staff survey; KMPT is reporting a breakeven even position in line with forecast and expectation for the second half of the financial year, before the Prior Period Adjustment that will be made; inpatient services exceeded the target for CROM

Items of concern and hot spots - there is negative variance to trajectory for staff turnover, retention and sickness. Although there is variance to trajectory for sickness this is an improvement year-on-year with the exception of last year. Turnover is an improving picture year-on-year and turnover performance has improved compared to last year. Oversight and monitoring of risks and performance is undertaken by Workforce and Organisational Development Committee

To make it easier to assess progress against agreed goals and objectives, traffic colour coding has been used against the overall goal.

- Red – Not met. Work ongoing to achieve target and action remains overseen by committee
- Amber – Substantially met, with positive outcomes on the delivery of strategic aims being achieved
- Green – Met, with learning cascaded where appropriate

Of the 44 objectives set, 31 were either met or substantially met.

Governance

Implications/Impact:	Ability to deliver Trust Strategy.
Assurance:	Reasonable
Oversight:	Oversight by Quality Committee, Finance and Performance Committee, Workforce and Organisational Development Committee and Board

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

STRATEGIC DELIVERY PLAN (END OF YEAR POSIITON 2021/22)

Goal	RAG	Board agreed target outcomes by 31 March 2022	Outcomes achieved
1a. Embedding quality improvement		• 25 QI projects completed with learning shared across the organisation • 350 staff trained in bitesize QI modules • 800 staff attended QI awareness events	• 7 QI projects completed • 115 multi professional staff trained • 1396 staff attended QI awareness events
1b. Successfully deliver our 3 Quality Account priorities		• Patient Safety; 95 % of ward staff trained in Broset Checklist tool • Patient Experience; 95% of patients have a copy of their crisis plan and care plan; Patient Recorded Experience Measure (PREM) score 8/10 and above • Clinical Effectiveness; Improved clinical outcomes across care groups from 41% to 75% CROM (HONOS) from 2.7% to 50% PROM REQOL	• 60% of staff across identified inpatient wards • 89.3% of Care Programme Approach (CPA) patients had received a care plan and 8.2 PREM score • CROM: inpatients services exceeded the target at 78.8% whilst Community services achieved 38.2%. PROM: Inpatients services achieved 38.4% while community services achieved 9.3%
2a. Collaborate to deliver sustainable services and improved care for service users, carers and families		Alignment of pathways to reduce disjointedness and reduce health inequalities in line with NHS Long Term Plan • 65% Physical health check completed for people with SMI improved • 75% Annual health checks for people with Learning Disability & Autism • 66.7% Dementia memory assessment/ diagnosis rates improved • Improved access to mental health crisis support for adults and older people embedded in NHS111	• 35.6% achieved • 48% achieved • 57.5% achieved • alignment with NHS 111 agreed across all partners for October 2022
2b. Delivering improvements to population health and outcomes through innovation and transformation		Strong community engagement on Prevention Concordat for public health and mental wellbeing • 5000 people across Kent & Medway engaged in listening events • Community Mental Health Framework redesign milestones delivered • 43 Primary Mental Health Care Practitioners new roles developed in partnership with PCNs	• 4,829 people • established programme management office • 20 mental health practitioners recruited
3a. Looking After Our People by creating the Perfect Day and delivering the People Recovery Plan		• Reduced sickness absence from 4.22% to 4% • Reduce turnover from 10.5% to 9% overall	• sickness – year end 4.4% without Covid and 4.5% with COVID-19 • turnover year end 11.9% - additional clinical services (ACS) 14.6% against 10% target; nursing 10% against target of 9%, and medical 12.1% against target of 8%.

Goal	RAG	Board agreed target outcomes by 31 March 2022	Outcomes achieved
		• Improved rate from 86% to 90% retention overall	• retention rate overall year to date, 83.7% -ACS 81.4% against 90% target; nursing 82% against target of 91%, and medical 85.6% against target of 92%.
		• 20 more Mental Health First Aiders (currently we have 30)	• 44 staff trained
		• Improved staff survey result on health & wellbeing question by at least 5%	• this question has changed year on year and the scoring criteria was also changed year on year – we are not able to show a year on year picture
		• Improved staff survey result on engagement score to 7.2	• 7.0 achieved
		• Improved staff survey response rate to 68%	• 67.8 % achieved
		• Improved staff result on Organisation acts fairly: career progression improves from 86% to 88%	• 85.3% achieved
3b. Encourage Belonging by becoming a fully diverse and inclusive organisation with anti-discriminatory behaviour		• Workforce race equality standards (WRES) performance improved overall ○ Indicator 5: Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months: from 44.3% to 34.4%	• 35.4% achieved
		○ Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months: From 25.5% to 17.5%	• 18% achieved
		• Workforce disability standards (WDES) performance improved Metric 3: Relative likelihood of disabled staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation: From 4.27 times more likely to 2.27	• 0 staff with a disability went through the disciplinary process
3c. New ways of Working and Delivering Care by creating innovative Workforce Modelling for the future, delivering Brilliant Care		Leadership and implementation of structured plan for workforce remodelling • New workforce model	• New roles: Advanced Clinical Practitioners (ACP) 4; ACP trainees 9, peer support workers (PSW) confirmed Care Groups position is 61. Clinical Assistant Psychologists (CAPS) 23. We have also skill mixed other roles
		• Expenditure on use of locum/agency staff reduced by £2M	• agency spend: in-year reduction of £1.2m
		• Test for change extended hours in Community Mental Health Teams	• to be discussed as part of Community Mental Health Framework
		• Tests for change peripatetic model at Priority House and Band 7 within Community Teams	• central Team for Priority House to be established
4a. Continue to implement the		Improved delivery of digitally enabled care • Video consultations	

Goal	RAG	Board agreed target outcomes by 31 March 2022	Outcomes achieved
Clinical Technology Strategy		• Roll out of E Meds (Interface between Civica and RIO (paper processes ceased) • Real time bed management information (FLOW) • Mobilising RIO	• ICS Procurement for Replacement of (Centrally Funded for Two Years) Attend Anywhere complete, currently configuring and planning roll out TPRO e-clinic manager • live on Rivendell ward, awaiting bug fixes and interface work to progress roll out across the Trust resulting in reducing errors and freeing up valuable staff time by moving away from out dated paper-based systems • phase 2 is awaiting RIO master release 22 which is due in July. Once implemented KMPT will progress • currently being tested in CRHT, trialling ipads and hybrid devices
4b. Simpler and lighter expectations for patient recording, focusing on the core issues with exception report around performance		Increased focus on clinical outcomes and engagement on clinically lead measures • Agreed KPIs for focused exception reporting at Care Group Level • Reduction in time spent inputting to RiO up to a maximum of 10%	• exception reporting introduced September 2021, further development underway to establish an overall scoring mechanism for each care group against selected KPIs • project being scoped
4c. Improved data ensuring ability to quickly identify and correct performance		• Relaunch of Performance Framework for 21/22 • Care Group IQPR indicators agreed including exception reporting • Board triangulation of QPR data (workforce, performance, quality and finance)	• formally reviewed for adoption at QPRs in April • see above • exception reporting template launched September 2021 includes all areas of trust data enhancing the ability to triangulate data
5a. Support the delivery of breakeven and an organisational and system trajectory		• KMPT to achieve break even position during H1 • Deliver year end position as per the control total set for KMPT by NHS I/E • Deliver 4% efficiency programme	• met • KMPT is reporting a breakeven even position before prior period adjustments • efficiencies delivered in year total £6.6m, £0.4m lower than the target set

Goal	RAG	Board agreed target outcomes by 31 March 2022	Outcomes achieved
5b. Lead the Kent and Medway one public estate initiative		• Optimised estate running costs and occupancy levels (aim to reduce running costs by a maximum of 4%) • Reduce backlog maintenance costs by up to a maximum of 10% (this will be within a reduced capital allocation)	• not delivered. Aim as part of hybrid working this year • not delivered
5c. Deliver specialised services as part of the NHS-led Provider Collaborative		• 4 % reduction in Occupied Bed day of patients within the Provider Collaborative Baseline • Net reduction of 6 patients (1,816 bed days)	• met • Kent reduced its position by 13 (requested at the start of the year 6)

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th May 2022
Title of Paper:	KMPT Research Strategy 2022-2027
Author:	Professor Sukhi Shergill, Director of Research and Innovation (R&I)
Executive Director:	Dr Afifa Qazi, Executive Medical Director

Purpose of Paper

Purpose:	Approval
Submission to Board:	Board requested

Overview of Paper

A paper setting out the proposed KMPT Research Strategy for 2022-2027.

Issues to bring to the Board's attention

In 2020, the Board recognised research as a key enabler of the Trust Strategy. Within the Trust Strategy's Quality aim, the sixth objective is 'to build on the current quality of our services, and drive further improvements' by driving 'a coherent approach to research and development and evidence-based decisions to promote an improvement culture and maximise our impact on the quality of care and people's outcomes'.

The attached Research Strategy builds upon that premise and sets out three main pillars: people, systems and structures, and external collaboration. The combination of those three pillars will, by 2027, lead to:

- An increase the number of National Institute for Health and Care Research (NIHR)-supported studies to which the Trust recruits;
- The establishment of a portfolio of 'home-grown' studies;
- A boost in research income and
- Obtaining a teaching trust status which will further maximise all of the above.

In its pre-formative stage, the Trust has shared the drafted Research Strategy with local and national partners. Where appropriate, adjustments have been made to reflect best practice and partnership working.

The Research Strategy helps the Trust's ambition of leading its own research, co-producing with patients and partners, embedding research for the improvement of care and services to patients, and evidencing the impact of KMPT-led research on the health and care of service users.

In line with the Trust's ambition to eliminate its underlying deficit in this financial year, careful consideration has been given to funding the required additional capacity in the directorate. A business case setting out the proposed (cost neutral) changes required, will be submitted to the Finance and Performance Committee following approval of the strategy by the board.

Governance

Implications/Impact:	Positive impact on Trust Strategy through the delivery of its sixth objective
Assurance:	Reasonable
Oversight:	Oversight by Quality Committee

Kent and Medway NHS and Social Care Partnership Trust Research Strategy 2022-2027

1. OUR GOALS

This Strategy aims to increase the number of research studies carried out within Kent and Medway NHS and Social Care Partnership Trust (KMPT).

Over the next five years (2022-2027), we want to:

• **increase the number of NIHR-supported studies to which we recruit**.

• **establish a portfolio of 'home-grown' studies** investigating ideas that come from our own staff, service users, patients and carers, or from local academics keen to collaborate with us. We want to support projects that address local needs and priorities as well as studies of national and international relevance.

• **boost research income** from local, national and international funders in the statutory, voluntary and private sectors.

• **host and initiate a wide range of research** – for example: trialling new therapies and/or medication; developing and testing interventions that use innovative technologies; evaluating novel ways of delivering services in a digital age; investigating factors that contribute to mental health problems.

We want to make research part of KMPT's everyday business by investing in people, systems and structures, and in external collaborations.

People

We want to:

• **encourage more people who work in, and more people who use, KMPT services to get involved in research.** 'Involved' here covers a range of activities – for example: being a participant in research; helping recruit participants to studies; acting as an advisor; leading a project.

• **foster a research environment in which co-production is the norm to ensure we focus on questions and outcomes that are most important to our patients, service users and carers**. Co-production is when clinicians, academics, service users, patients and carers 'work together, sharing power and responsibility from the start to the end of the project, including the generation of knowledge' (NIHR INVOLVE, 2018/2021[(1)]).

• **increase the diversity of KMPT service users, patients and carers who are involved in research** as participants or co-producers. We want to increase the numbers of people from groups that are currently under-represented in research activities: people from black and ethnic minority backgrounds, care leavers and refugees, for example.

Systems and structures

We want to:

• **work with KMPT internal teams to make sure the best available systems are in place to support research activity**, and that overlapping and complementary activity is co-ordinated.

• develop a **high quality, easily accessible programme of training, mentorship and other initiatives** that can equip staff, patients, service users and carers with the skills they need to get involved in research.

• ensure the **results of our research are publicised** within KMPT and to other health and social care organisations.

• **increase the number of academic publications** produced by staff at KMPT**.**

• support the **implementation of evidence-based improvements within KMPT** to ensure the best possible services are offered. The implementation process should be routinely evaluated using research methods.

• apply for **university hospital status** (or equivalent) by 2027.

External collaboration

We want to:

• broker relationships between mental health professionals, service users, patients and carers and academics by **bolstering collaborative relationships with the University of Kent, Canterbury Christ Church University, Kent and Medway Medical School (KMMS),** and with KMMS' mentor institution, Brighton and Sussex Medical School.

• **increase collaborative work with NIHR organisations,** particularly the Clinical Research Network (CRN) Kent, Surrey and Sussex and the Applied Research Collaboration (ARC) Kent, Surrey and Sussex.

• **build good working relationships** with other NHS organisations (including the Kent Surrey Sussex Academic Health Science Network and Kent and Medway Clinical Commissioning Group/Integrated Care System), charities, voluntary and community organisations, private sector organisations and local authorities.

2. WHY ADOPT THIS STRATEGY?

NHS organisations that routinely carry out research, and implement its findings, offer better care, and greater choice, to patients and service users. Research activity means patients and service users have improved access to the latest, innovative treatments. Staff benefit too – they learn new skills that give them better career opportunities and promotion prospects, and they can apply for funding to test their own ideas for new methods of care and new ways of organising services.

The Department of Health and Social Care report *Saving and improving Lives: The future of UK Clinical Research Delivery* (March 2021)[(2)], urges research to be 'embedded at the heart of patient care across the NHS, making participation as easy as possible and ensuring all health and care staff feel empowered to support research.'

The report says: 'NHS staff are not always able to deliver research as part of their day to day activities. Research can also be seen as "someone else's business" reserved only for clinical academics and specialist research teams. This has to change. Delivering research is everyone's business across the NHS.'

Patients and service users 'must also be routinely involved in the design of clinical research, to ensure outcomes match their needs, and studies are designed with real participants, and the realities of their daily lives in mind.'

This Research Strategy sets out the first steps towards achieving an environment where research is part and parcel of everyday work at KMPT, where clinicians, other NHS staff, patients, service users, carers and academics work together to improve services.

Kent and Medway NHS and Social Care Partnership Trust Research Strategy 2022-2027

We plan to create and update a delivery plan on an annual basis, and hope to be able to apply for university hospital status (or equivalent) by 2027. In order to qualify as a university hospital, NHS Trusts must demonstrate they are ‘research active’, and work collaboratively with one or more university/ies.

Kent and Medway NHS
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**26th May 2022**
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

A paper setting out the Trust's performance across the Care Quality Commission (CQC)'s five domains.

Issues to bring to the Board's attention

Whilst this report (which presents April's activity) includes targets met and some areas of improvement, it also clearly sets out areas of challenge where targets have been missed, helping to inform future priorities.

This report reflects the first reporting period of 2022/23 and contains a number of changes following an engagement exercise carried out with key stakeholders to refine the report. Full details of these changes can be found in the change tracker at the end of the report. Additionally, the Trusts Data Quality Group is overseeing ongoing development of the report's contents with further amendments under consideration during 2022/23.

The Board's attention will naturally focus on those areas below target, seeking assurance that measures are in place to rectify the situation. The report shows continued pressure in some of our key workforce metrics along with examples of the work in train to improve the situation. Sickness Absence, Turnover and Vacancy rates all continue to exceed the targets the trust aspires to. Recruitment and retention remain a strong focus and is a priority area included in the trust's strategic priorities for 2022-23.

Bed pressures is an area of focus for the Executive Team, this is partially driven by high levels of Delayed Transfers of Care. It is positive to note a reduction in month in Bed days lost to delayed

transfers of care to 10.9% following three months in excess of 12.4%. The Chief Operating Officer continues to oversee a detailed review of this area, actions in place include twice-weekly escalation calls with Social Care and planning a Multi-Agency Discharge Event involving internal and external partners. The largest proportion of delayed bed days are attributable to Social Care (>50%) with patients requiring residential/nursing home placements being the prominent reason for delays.

There was an increase in bed days used in Out of Area placement which exceed contracted beds, the majority of these bed days were used as a result of the challenges at Willow Suite limiting capacity.

Within our community teams' areas requiring an increased focus include; care planning and waiting times for assessment and treatment. These are being managed at a team level supported by exception reporting, the impact of factors such as vacancy rates, sickness and referral rates have led to increased variation across teams.

The Trust will need to focus on the delivery of recurrent efficiencies as we move into the new financial year to ensure deliver of a break-even position. KMPT's spend on temporary staffing has reduced slightly in month 1, this is mainly due to medical agency. This will continue to be an area of focus during the year and it is likely we will see national agency caps/controls introduced shortly. Proposals for developing a locum bank and sharing the learning from opportunities to use existing resource and locum resource more effectively are underway.

Governance

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

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Domain	Safe
Trust Strategic Objective & Board Assurance Framework	• **Achieving our Quality Account Priorities** • **Developing and delivering a new KMPT Clinical Strategy**

Executive Lead(s): Chief Nurse
Lead Board Committee: Quality Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

The Trust's approach to the use of restraint is carefully monitored and reviewed in line with national best practice. The use of restraint is always a last resort and staff are trained in de-escalation techniques which are always considered before restraint is implemented.

There were 82 reported incidents of restraint needing to be used in April 2022, a decrease of 23 from the previous month. The Acute Care Group (ACG) reflected a decrease of 33 incidents, with both the Forensic and Specialist care group (FSCG) and the Older Adult care group (OACG) showing a slight increase of nine and one incidents respectively. The majority of restraints occurred in the Acute Care Group (ACG) with 61 reported in April. The data indicates that Fern Ward had the highest rate of restraints with 15 incidents; 80% (12) of these were attributable to three patients. Unusually the next highest number of restraints occurred in the Older Adult Care Group (ACG) with Woodchurch Ward reporting fifteen incidents. It is worth noting that ten of these restraints involved just three patients and the majority of the restraints were to prevent harm to others. All use of restrictive interventions are monitored in line with Trust policy with strategic oversight by the Promoting Safe Care group which has membership from all care groups and subject matter experts. Prone restraints increased slightly from last month from two to four reported incidents in April 2022.

The use of seclusion continues to follow a downward trajectory; from eleven instances in March to nine in April 2022. The majority of these occurred in the Acute Care Group (6) with the remaining three in the Forensic & Specialist Care Group. All nine seclusions involved eight patients with one patient being secluded twice. All instances of seclusion are reviewed and an overview retained in order to identify outliers or patterns.

KMPT's Promoting Safe Services have been awarded the national accreditation for meeting the standards for its Physical Interventions training. This provides assurances to the CQC and stakeholders that KMPT adheres to best practice within this area of staff training. Along with the implementation of

the Broset Violence Checklist (a risk prediction tool) and safety pods within all our inpatient wards, we hope to continue to see a reduction in the use of restrictive practices.

Kent and Medway NHS and Social Care Partnership Trust

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	1	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	94.7%	94.5%	94.2%	93.2%	92.8%	92.3%	92.9%	93.0%	93.2%	93.5%	93.8%	93.4%
006.S	Serious Incidents Declared To STEIS		-	-	17	13	11	13	21	20	23	20	18	26	27	24
011.S	Restrictive Practice - All Restraints		-	-	145	88	151	96	82	62	72	71	88	83	105	82
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	8	4	6	5	11	4	2	2	2	4	2	4
013.S	Restrictive Practice - No. Of Seclusions		-	-	21	21	26	19	17	12	17	19	17	8	11	9
017.S	RIDDOR Incidents		-	-	6	0	2	2	3	3	2	5	3	1	4	3
020.S	Unplanned Readmissions within 30 days		8.8%	L	4.2%	3.8%	7.8%	11.0%	5.6%	8.5%	5.8%	7.2%	5.3%	4.5%	7.7%	6.7%

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Domain	Effective
Trust Strategic Objective & Board Assurance Framework	• **Implementing programmes that improve Care Pathways** • **Strengthening our approach to Research and Development and delivering evidence-based care.** • **Testing and evaluating models for integrating care and systems with our partners**

Executive Lead(s): Executive Medical Director
Lead Board Committee: Finance and Performance Committee

Issues of Concern
Increased use of Out of Area Placements due to pressures on Willow Suite

Executive Commentary

	005.E: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			0.0	0.0	-50.5	121.9	35.7
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			253.0	0.0	15.8	270.8	143.3
4	**Trust Total**			253.0	0.0	-0.4	358.3	178.9

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

April 2022 saw an increase in the use of out of area beds not procured in advance by KMPT, 253 bed days were used (all PICU), the highest reported monthly figure since June 2021. Ongoing restrictions on capacity on the Trust's PICU ward, Willow Suite, due to the admission of a patient with complex needs. 193 of the 253 beds days used have been as a direct result of the capacity challenges on Willow Suite requiring male patients to be placed externally. There have now been ten admissions for male PICU placements since February with seven patients remaining placed externally as at 13th May.

The Chief Operating Officer continues to review closely with patient flow services, noting the national requirement to aim for zero out of area non-contracted bed use by the 1st of April 2022.

Kent and Medway NHS
NHS and Social Care Partnership Trust

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			68.0%	95.0%	49.6%	92.8%	71.2%
2	CRCG			85.9%	95.0%	85.9%	92.2%	89.0%
3	FSS			95.3%	95.0%	90.8%	98.0%	94.4%
4	OPMH			94.7%	95.0%	93.7%	99.6%	96.7%
5	Trust Total			87.9%	95.0%	87.7%	93.0%	90.3%

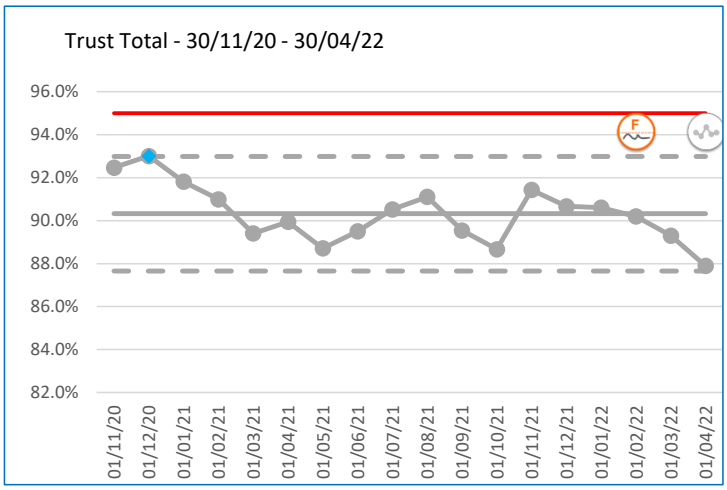
	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			67.3%	95.0%	65.3%	71.4%	68.3%
2	FSS			71.9%	95.0%	69.4%	81.8%	75.6%
3	OPMH			64.3%	95.0%	66.7%	76.5%	71.6%
4	Trust Total			69.2%	95.0%	69.0%	74.5%	71.7%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Common Cause - no significant change *Non CPA PSP & Care Plans:* Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

CPA Care Planning

Whilst not statistically significant the percentage of patients on CPA with a valid Care Plan has reduced further, for the sixth successive month as shown by the graph below.



FSCG continue to exceed target and the Acute Care Group Figure reflects a low number of patients (25). The greatest scope for further improvement remains in CRCG, being responsible for 75% of the CPA caseload within this indicator. The CRCG care group plans a deep dive in the coming month to understand the dip in compliance and agree actions to improve the position.

Non CPA Care Plans and Personal Support Plans (PSP):

Having previously shown special cause variation of an improving nature there has been a reduction for the third successive month, the reduction was across all care groups.

Whilst both CMHTs and CMHSOPs continue to fall short of the target, CMHSOPs are additionally showing special cause variation of a concerning nature. The picture is varied across teams with 4 CMHTs and 7 CMHSOPs showing special cause variation as shown.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHT			73.7%	95.0%	73.8%	81.6%	77.7%
2	Canterbury & Coastal CMHT			79.4%	95.0%	64.5%	76.9%	70.7%
3	DGS CMHT			79.7%	95.0%	52.1%	68.5%	60.3%
4	Dover & Deal CMHT			66.8%	95.0%	68.5%	87.8%	78.1%
5	Maidstone CMHT			49.3%	95.0%	46.6%	67.5%	57.0%
6	Medway CMHT			62.5%	95.0%	61.1%	76.6%	68.8%
7	Shepway CMHT			72.5%	95.0%	74.5%	92.6%	83.6%
8	Swale CMHT			72.2%	95.0%	60.1%	74.1%	67.1%
9	SWK CMHT			57.9%	95.0%	40.1%	65.9%	53.0%
10	Thanet CMHT			64.9%	95.0%	75.3%	92.1%	83.7%
11	**CMHT Total**			68.0%	95.0%	65.8%	71.0%	68.4%

South Kent Coast CMHT: Action has already been taken and an improvement in month has already been seen.

Ashford CMHT: training is in place for staff to support and ensure this is met.

Thanet CMHT: compliance relates to a process issue post initial assessment. This is being addressed within the team and compliance will improve in month.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			85.1%	95.0%	69.5%	87.3%	78.4%
2	Canterbury CMHSOP			63.7%	95.0%	65.2%	83.2%	74.2%
3	DGS CMHSOP			68.8%	95.0%	73.7%	89.1%	81.4%
4	Dover & Deal CMHSOP			80.3%	95.0%	81.2%	88.6%	84.9%
5	Maidstone CMHSOP			62.7%	95.0%	71.3%	92.9%	82.1%
6	Medway CMHSOP			70.3%	95.0%	70.9%	83.0%	77.0%
7	Sevenoaks CMHSOP			63.7%	95.0%	66.1%	86.3%	76.2%
8	Shepway CMHSOP			84.5%	95.0%	81.0%	89.1%	85.1%
9	Swale CMHSOP			68.2%	95.0%	66.1%	79.9%	73.0%
10	Thanet CMHSOP			82.5%	95.0%	71.5%	87.4%	79.4%
11	Tunbridge Wells CMHSOP			59.1%	95.0%	60.5%	74.3%	67.4%
12	**CMHSOP Total**			71.9%	95.0%	74.7%	82.8%	78.8%

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The Personal Support Plan is a new concept to CMHSOPs within the last 3 months and continues to be embedded in practice. Locality Managers are prioritising supporting Team Leaders and staff in using PSP. This is being addressed and monitored through the SMT governance structure and has been added to the CLIQ check audit process.

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NHS and Social Care Partnership Trust

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	97.3%	97.8%	97.8%	96.4%	96.3%	95.2%	95.3%	96.2%	98.5%	98.6%	93.8%	95.6%
001b.E	CPA patients receiving follow-up within 72hours of discharge				84.0%	82.7%	86.5%	86.6%	81.7%	87.5%	88.0%	80.0%	78.6%	85.0%	84.4%	84.1%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.9%	95.9%	95.7%	95.7%	95.9%	96.2%	96.1%	96.1%	96.1%	95.9%	95.7%	95.3%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	192	351	201	103	205	175	142	108	120	69	168	253
006.E	Delayed Transfers Of Care		7.5%	L	8.6%	8.4%	8.8%	9.0%	10.6%	11.9%	9.6%	10.6%	13.1%	12.8%	12.4%	10.9%
012.E	Average Length Of Stay(Younger Adults)		25	L	26.42	33.92	28.23	27.68	29.78	36.63	33.96	26.85	35.99	33.63	36.23	38.84
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	61.63	65.75	53.24	56.90	72.25	80.22	85.18	85.90	53.88	57.41	72.63	81.88
015.E	%Patients with a CPA Care Plan		95%	L	89.0%	89.9%	90.7%	91.3%	89.5%	88.7%	91.4%	90.7%	90.6%	90.2%	89.3%	87.9%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	58.9%	60.9%	63.5%	64.4%	65.4%	66.3%	67.9%	71.7%	74.2%	73.3%	72.5%	71.5%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	73.4%	74.1%	74.4%	74.2%	73.2%	74.0%	73.7%	72.6%	73.5%	73.4%	70.9%	69.2%
018.E	'YA and OPMH Acute Bed Occupancy (Net)				96.3%	96.5%	91.1%	94.9%	96.8%	96.1%	95.5%	90.7%	95.0%	93.7%	94.4%	94.4%

CQC Domain	Well led – Workforce
Trust Strategic Objective & Board Assurance Framework	• **Building a resilient, healthy and happy workforce** • **Evolving our culture and leadership**

Executive Lead(s): Director of Workforce and OD
Lead Board Committee: Workforce Committee

Issues of Concern
Staff Sickness & **Staff Turnover** continue to exceed target, breakdown detailed within narrative below.

Executive Commentary

Staff Sickness (001.W-W)

April 2022 is 0.44% above the set target. If we remove the Covid sickness which is 0.14%, the sickness for the month is 4.30%.
April 2022 - Short term sickness is 1.64%, compared to 1.92% last month. Long term sickness is 2.40%, compared to 2.82% the previous month.

Activities in place to reduce sickness absence include:

- Successfully closed 21 long term sickness absence cases.
    - 19 employees are returning to same post
    - 2 employees are no longer employed at KMPT
    - We are currently actively supporting managers with 47 cases of sickness absence.
- Part of NHS Health and Wellbeing Framework Trailblazer Project
- Schwartz Rounds now in place
- Wellbeing Conversation Cafés - looking after our people
- Health and Wellbeing sessions and managers training
- Stop smoking practitioner training
- Healthy Workplace Allies eLearning programme
- Health and Wellbeing Conversations
- NatureWell Training for healthcare practitioners
- Health and Wellbeing Project Wingman bus
- All employees received a wellbeing hamper and 1 additional days annual leave

Staff Turnover (019.W-W)

April 2022 - turnover is 13% for rolling 12 months. This is an increase of 0.3% since previous month.
The biggest increase is in Forensics and Specialist services, from 14.7% to 15.2%.

Activities to reduce turnover:

- Getting recruitment right first time
- Onboarding and first 2 years in service
- Enhancing flexible working
- Staff feedback from Staff Survey and quarterly People Pulse
- Staff wellbeing
- Development, internal opportunities and career pathways
- Understanding why people are leaving- improvements to Exit surveys and new system to be implemented
- A recruitment and retention group is also supporting strategies to address turnover.

Staff Retention (015.W-W)

April 2022 - retention rate is 83.4% The April position for the reported staff groups is as below:

- Additional Clinical services: 81%
- Nursing: 82%
- Medical: 85%

Activities to support retention are reflected in the same actions detailed above to address turnover:

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IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
001.W-W	Staff Sickness - Overall	✓	4.00%	L	4.0%	4.6%	4.6%	4.2%	4.6%	5.0%	4.9%	4.7%	4.3%	4.3%	4.3%	4.3%
005.W-W	Appraisals And Personal Development Plans		95%	L							98.8%	99.0%	99.0%	99.0%	99.0%	99.0%
006.W-W	Vacancy Gap - Overall		10.00%	L	15.5%					15.0%	14.9%	14.9%	15.1%	15.2%	15.7%	15.1%
007.W-W	Vacancy Gap - Medical			-	29.8%					28.5%	31.3%	31.4%	15.1%	30.4%	30.9%	27.9%
008.W-W	Vacancy Gap - Nursing			-	16.5%					12.6%	13.7%	13.9%	14.6%	14.9%	17.1%	14.5%
009.W-W	Vacancy Gap - Other			-	13.5%					13.1%	13.1%	13.6%	12.1%	13.9%	13.5%	13.2%
012.W-W	Essential Training For Role		90%	L	92.4%	92.4%	90.4%	90.5%	92.6%	91.5%	92.7%	93.1%	92.5%	93.0%	92.0%	91.9%
014.W-W	Consultant Job Planning Completion			-												
015.W-W	Staff Retention (overall)		87%			87.3%	82.7%	84.3%	81.8%	81.8%	81.0%	83.2%	85.9%	85.4%	83.2%	83.4%
016.W-W	Staff Retention (Additional Clinical Services)		90%			85.1%	82.3%	83.9%	77.6%	78.8%	81.5%	80.8%	81.4%	82.1%	80.4%	80.8%
017.W-W	Staff Retention (Nursing)		90%			87.0%	80.5%	82.1%	78.9%	79.3%	81.6%	81.6%	81.6%	85.9%	81.5%	81.9%
018.W-W	Staff Retention (Medical)		90%			89.2%	86.8%	88.4%	82.2%	82.6%	85.8%	85.8%	85.8%	85.3%	84.6%	85.0%
019.W-W	Staff Turnover (Overall)		9.00%		10.5%	9.5%	10.9%	11.3%	12.2%	12.6%	12.8%	13.6%	13.1%	13.4%	12.7%	13.0%
020.W-W	Staff Turnover (Additional Clinical Services)		10.00%			11.9%	13.1%	12.7%	13.1%	15.1%	16.2%	15.6%	15.3%	17.8%	15.1%	15.8%
021.W-W	Staff Turnover (Nursing)		10.00%			9.1%	10.8%	9.7%	10.6%	9.9%	9.1%	10.1%	9.9%	10.6%	10.0%	9.9%
022.W-W	Staff Turnover (Medical)		10.00%			8.1%	10.4%	12.2%	12.5%	12.4%	13.2%	13.2%	13.6%	12.9%	12.9%	13.0%
023.W-W	Safer staffing fill rates		80.00%	L	110.1%	110.7%	110.5%	110.5%	110.5%	110.3%	110.2%	100.6%	102.5%	101.3%	101.5%	103.5%

- *New targets were introduced April 2022; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

CQC Domain	Well led – Finance
Trust Strategic Objective & Board Assurance Framework	• **Partnering beyond Kent and Medway, where it benefits our population** • **Optimising the use of resources** • **Investing in system leadership.**

Executive Lead(s): Executive Director of Finance
Lead Board Committee: Finance and Performance Committee

Issues of Concern
The Trust has a challenging efficiency target for this financial year (£7m). Plans are in place for 50% of this target. The gap is to be identified, there are clear areas of focus for all care groups and support services, final delivery plans are now required.

Executive Commentary

Please see the financial performance report included as a separate agenda item for the detailed financial performance narrative.

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Kent and Medway

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
004.W-F	In Month Budget (£000)		0.0	N	0	(0)	(0)	(0)	(0)	0	0	0	0	0	0	0
005.W-F	In Month Actual (£000)		-	-	(0)	(0)	0	0	(0)	0	0	0	0	0	0	0
006.W-F	In Month Variance (£000)		-	-	(0)	0	0	0	(0)	0	0		0		0	(0)
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.32%
007.W-F	Agency - In Month Budget (£000)		-	N	427	427	427	427	427	427	427	427	427	427	427	427
008.W-F	Agency - In Month Actual (£000)		-	-	661	520	664	658	687	562	536	741	595	516	698	533
009.W-F	Agency - In Month Variance from budget (£000)		-	-	234	93	237	231	260	135	109	314	168	89	271	106
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	73.02%	69.04%	60.85%	59.31%	51.76%	48.88%	45.97%	49.04%	48.08%	45.60%	47.08%	43.84%

- *Some targets are variable in year; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

CQC Domain	Caring
Trust Strategic Objective & Board Assurance Framework	• **Embedding Quality Improvement in everything that we do** • **Build active partnerships with Kent and Medway health and care organisations** • **Strengthening partnerships with people who use our services and their loved ones**

Executive Lead(s): Chief Nurse & Chief Operating Officer
Lead Board Committee: Quality Committee

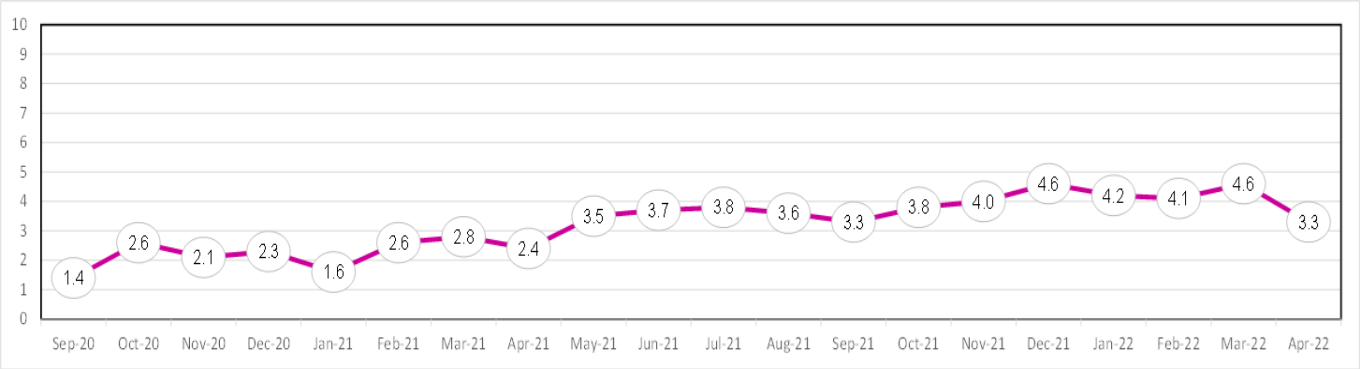
Issues of Concern
No areas of concern to raise this month.

Executive Commentary

Patient Reported Experience Measures (PREM) (013-015.C)
The Trust target is to receive 10% of unique patient numbers which would be over 1500 PREM collected each month. There has been gradual improvement over time, however there was a reduction in April due to an issue with the Royal Mail Freepost that impacted on the response rate in.

Graph 1 below shows the trust PREM response rate going back to October 2020. The acute care group had a 15.4% response rate in March 2022 and a 14% response rate in April 2022 therefore are exceeding the target. The response rate variation is due to the lower uptake in the community and recovery, the older adult and the forensic and specialist care groups.

Graph 1 PREM response rate month on month tracking



Improving the PREM response rate is being driven by the team and ward leads with the support of the care group leadership and the Allied Health Professional (AHP) leads who have responsibility for leading on patient and carer experience. The AHP leads are constantly driving improvements and

providing support at a service and team level. The community and recovery care group lead meet regularly with services and teams about PREM matters.

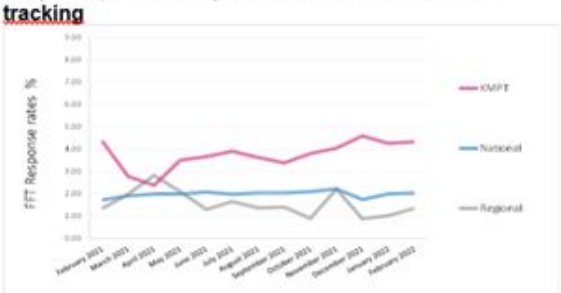
Patient Reported Experience Measures (PREM) (002.C)

The NHS Patient Friends and Family Test (NHS FFT) question is “Overall, how was your experience of our service?” and it is included on the PREM survey. The latest mental health national NHS FFT data was released in February 2022.

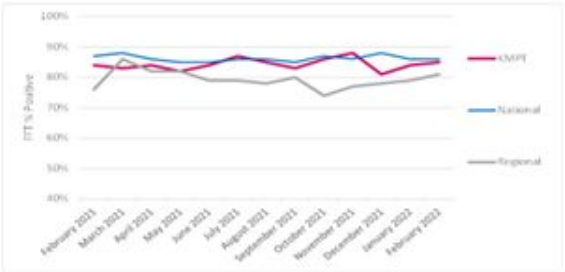
In terms of how we compare nationally and regionally for the quantity of NHS FFT submitted, the analysis is positive. We are exceeding the national response rate (note: there is no formal national target). KMPT submitted 4.3% (this has improved on the 4% in the previous reporting period) compared with all mental health trusts who submitted 2%. We are exceeding a regional response rate comparison with Sussex Partnership NHS Foundation Trust who submitted 1.3%. The NHS FFT tracking in Graph 3 below shows the month on month tracking of the NHS FFT response rate.

In terms of how we compare nationally and regionally for performance, analysis observes a rise in performance since December 2021. We were 1% below the national ‘positive percentage’ in February 2022. Nationally patients were 86% positive about their experience. For KMPT, patients were 85% positive about their experience. This is in the range where overall, the experience of our service is ‘very good’. We are exceeding a regional comparison as Sussex Partnership NHS Foundation Trust patients were 81% positive. The NHS FFT tracking in Graph 4 below shows the month on month tracking of the NHS FFT ‘positive percentage’.

Graph 3 NHS FFT response rate month on month tracking



Graph 4 NHS FFT positive percentage month on month tracking



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IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	82.4%	84.4%	87.2%	85.1%	82.5%	85.6%	87.8%	81.3%	84.5%	84.9%	84.5%	84.5%
003.C	Complaints - actuals		-	-	48	45	28	47	36	46	34	33	26	37	36	35
004.C	Complaints - per 10,000 contacts		-	-	12.84	11.27	7.19	13.36	9.83	12.94	8.78	10.15	7.25	10.99	9.71	10.81
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	98.0%	98.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	95.0%	98.0%	98.0%	98.0%	100.0%	96.0%	98.0%	100.0%	98.0%	98.0%	97.0%	98.0%
007.C	Compliments - actuals		-	-	100	120	141	121	106	106	195	148	187	131	162	113
008.C	Compliments - per 10,000 contacts		-	-	26.74	30.06	36.20	34.39	28.93	29.83	50.38	45.53	52.16	38.93	43.68	34.90
010.C	PALS acknowledged within 3 days (or agreed timeframe)		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	99%
011.C	PALS responded to within 25 days (or agreed timeframe)		-	-	100%	99%	100%	100%	100%	100%	100%	99%	99%	98%	97%	98%
012.C	PALS - actuals		-	-	75	94	83	62	70	85	95	57	78	70	88	79
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	550	591	611	541	526	585	641	653	651	634	698	511
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	3.5	3.7	3.8	3.6	3.3	3.8	4.0	4.6	4.2	4.1	4.6	3.6
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.2	8.3	8.4	8.3	8.2	8.2	8.4	8.0	8.1	8.2	8.3	8.2

CQC Domain	Responsive
Trust Strategic Objective & Board Assurance Framework	• **Partnering beyond Kent and Medway, where it benefits our population** • **Driving integration to become business as usual for the system and for KMPT.**

Executive Lead(s): Chief Operating Officer
Lead Board Committee: Finance and Performance Committee

Issues of Concern

Memory Assessment Services, demand continues to outstrip capacity. Actions include the role out of a new model *(see below)*

CMHT waiting times for assessment and treatment impacted by staff sickness levels leading to high levels of variability across teams.

Executive Commentary

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			66.5%	95.0%	54.3%	85.5%	69.9%
2	OPMH			67.7%	95.0%	44.5%	84.6%	64.5%
3	Trust Total			67.0%	95.0%	53.1%	82.4%	67.7%

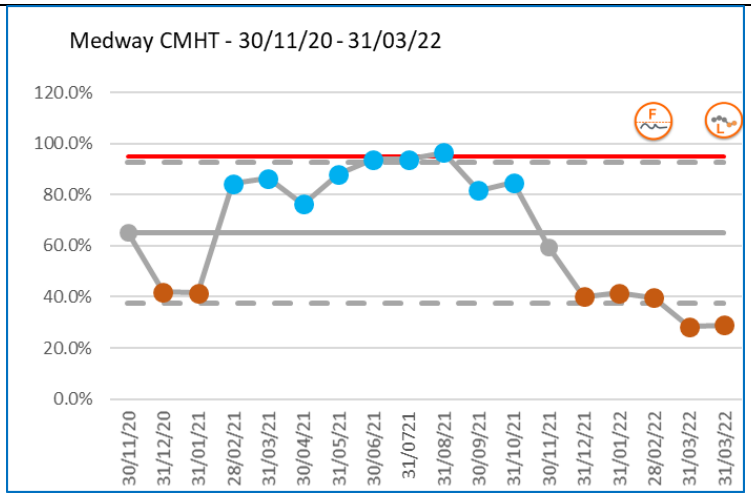
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	Variation indicates consistently **failing short of target**

Narrative

This indicator has been amended for 2022/23: Older activity related to Routine Memory Assessments is now reported within a separate measure against a 6-week target. The activity reported against CMHSOPs now reflects Functional and Complex Dementia presentations. The intention is to split this category on RiO, following which referrals triaged as complex dementia will also be reported against the 6-week target combined with Routine Memory Assessments. SPC analysis of the new metric will commence once sufficient history is established. The reporting methodology for CRCG activity remains unchanged.

The challenges concerning this measure are generally an issue of demand outstripping capacity. Referral rates to CMHTs and CMHSOPS had shown special cause variation in late 2021 but are now subject to common cause variation.

CMHTs continue to show common cause variation overall, however Medway CMHT continues to show special cause variation of a concerning nature with a significant reduction in performance in 2022 to date.



Staff sickness within the Medway CMHT continues to cause a decline in performance. Two full time clinicians continued to be job planned to complete assessments until the backlog of assessments are cleared. The care group are monitoring this weekly.

Older Adult performance against the 4 week wait for functional and complex dementia referrals remains stable as does the newly introduced 6 week wait target for routine memory assessment. Additional memory assessment clinics which had been delivering 50 additional assessments per month since mid-September 2021 ceased to operate at the end of March 2022 as per plan. The service is using vacancy slippage monies to operate additional diagnostic appointments. Additional funding has been secured (non-recurrent) funding to continue backlog clearance.

Demand continues to outstrip capacity; three key actions are underway to address this:

- GP's with extended roles to commence independent memory assessments in KMPT services from September 2022
- DiADeM (Diagnosing Advanced Dementia Mandate) being introduced for care home diagnosis to reduce referrals for dementia diagnosis from care homes to KMPT
- Implementation of a new memory assessment operating model that reduces time to diagnosis

The new operating model is named the Enhanced Memory Assessment & Intervention Service. This aims to see people in a combined initial assessment and diagnosis clinic as part of an aspirational system wide 6 week wait from referral to diagnosis KPI. This service is gradually being rolled out across the Older Adult Care Group to release capacity and improve timeliness of assessments. Additionally, the Chief Operating Officer is working with the Head of Service on a backlog clearance approach to allow the new service capacity to focus on the new model, aiming to match capacity to demand.

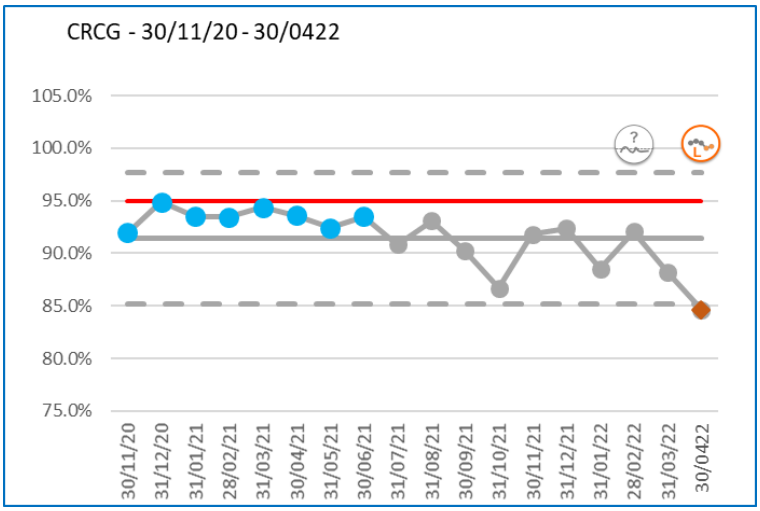
Kent and Medway NHS
NHS and Social Care Partnership Trust

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			84.6%	95.0%	85.2%	97.7%	91.5%
2	OPMH			71.0%	95.0%	63.0%	82.8%	72.9%
3	Trust Total			77.5%	95.0%	74.3%	87.3%	80.8%

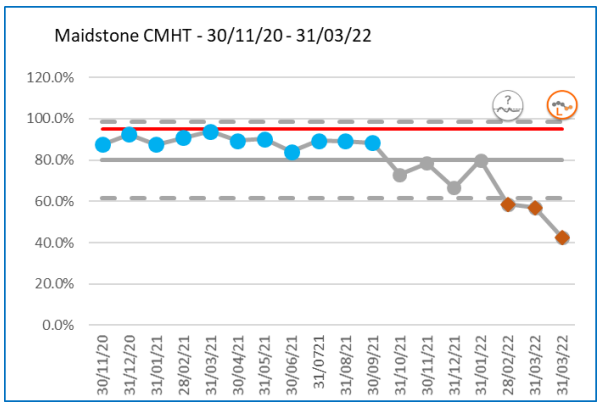
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	Variation indicates consistently **failing short of target**

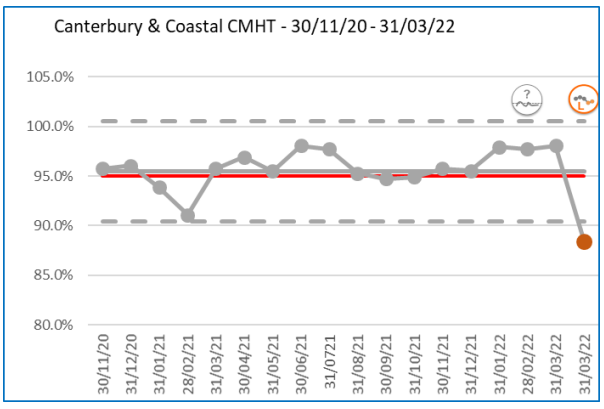
Narrative

Overall performance (77.5%) decreased by 0.5% in month following a 3.4% reduction the previous month. As recently as August 2021 performance was in excess of 89% and increasing monthly. Whilst overall the position remain common cause variation, CRCG is now showing special cause variation of a concerning nature as shown:



This reduction is driven by two teams, Maidstone and Canterbury & Coastal. As shown Maidstone has been experiencing a gradual reduction whereas Canterbury has experienced a significant drop in month.





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Within Maidstone CMHT sickness in the medical workforce has had a short-term impact. Additionally the team have identified an improved process of allocation to appointment or active review now following initial assessment.
There have been medical recruitment issues in Ashford, Canterbury have been providing additional short-term support which has impacted their capacity. In order to keep the service safe Canterbury consultants have helped to cover the gaps in service in the Ashford area. Part of the process has seen a review of the caseload which has resulted in a reduction of about 80 people being moved off of the waiting list.

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IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	69.2%	75.0%	87.5%	78.6%	85.2%	82.8%	75.0%	89.5%	81.3%	86.4%	75.0%	76.5%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	88.3%	87.5%	85.7%	85.6%	83.9%	80.0%	89.3%	87.3%	79.8%	78.9%	79.8%	90.0%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	93.9%	89.1%	90.2%	96.0%	91.3%	93.8%	95.3%	92.1%	91.6%	93.0%	90.3%	90.0%
007.R	DNAs - 1st Appointments		-	-	8.7%	9.8%	11.0%	11.2%	11.5%	11.2%	10.3%	9.6%	10.0%	10.7%	10.7%	11.0%
008.R	DNAs - Follow Up Appointments		-	-	8.2%	10.7%	12.4%	9.8%	8.7%	8.5%	8.4%	7.8%	8.5%	7.8%	7.9%	8.4%
009.R	Patient cancellations- 1st Appointments		-	-	1.4%	2.0%	1.9%	2.0%	2.5%	1.9%	2.1%	2.7%	2.2%	1.9%	2.7%	2.3%
010.R	Patient cancellations- Follow Up Appointments		-	-	3.9%	3.9%	4.2%	4.5%	4.5%	4.5%	4.9%	5.0%	4.7%	4.9%	5.2%	5.4%
011.R	Trust cancellations- 1st Appointments		-	-	3.5%	3.9%	4.3%	3.9%	4.6%	4.9%	5.2%	5.4%	4.0%	3.9%	4.5%	4.9%
012.R	Trust cancellations- Follow Up Appointments		-	-	8.8%	8.9%	8.5%	9.7%	10.2%	10.4%	10.0%	10.8%	10.4%	11.4%	12.0%	11.6%
013.R	Referrals Received (ave per calendar day)		-	-	95.5	104.2	106.0	92.9	97.8	97.2	102.2	88.1	90.5	103.0	105.9	94.3
016a.R	% Assessed in 4 weeks (Care Spells) (Excl. MAS)		95%	-	68.2%	70.0%	75.0%	68.7%	60.8%	68.9%	70.0%	68.1%	57.2%	70.8%	68.3%	67.0%
016b.R	% Assessed in 6 weeks (Care Spells) (MAS only)		95%	-	85.7%	77.0%	72.1%	62.2%	35.5%	49.4%	54.3%	58.0%	53.1%	59.9%	55.6%	58.2%
017.R	Referral to Treatment within 18 weeks Care Spell		95%	-	87.7%	90.0%	88.8%	89.1%	83.3%	83.5%	83.4%	80.2%	76.8%	81.7%	78.3%	77.5%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)		-	-	31.8%	30.1%	32.5%	37.7%	36.7%	34.4%	31.4%	39.1%	37.2%	30.3%	32.2%	36.5%
019.R	Urgent referrals seen within 72 Hours		95%	-	62.3%	62.4%	59.2%	62.6%	59.8%	60.4%	61.3%	65.1%	62.3%	60.2%	58.4%	62.6%

016a.R reports functional and complex dementia, a further change is required on RiO to allow the separating of these patient groups for reporting purposes, once complete the complex dementia cohort will be amalgamated with Routine Memory assessment in 016b.R against a 6 week referral to assessment timescale.

Appendix A: Single Oversight Framework

Overview

The Single Oversight Framework (SOF) sets out how NHS Improvement (NHSI) oversees NHS trusts and NHS foundation trusts, using one consistent approach. It helps to determine the type and level of support needed. The first version of the SOF was published in September 2016 with small amendments made in 2017. The Framework aims to help NHSI to identify NHS providers' support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

NHSI monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs. KMPT's current segmentation is 1 as highlighted below

Segment/ category	Description of support needs
1 (Maximum autonomy)	No actual support needs identified across the five themes described in the provider annex. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider supports providers in other segments.
2 (Targeted support)	Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not considered needed.
3 (Mandated support)	The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts) but is not in special measures.
4 (Special measures for providers; legal directions for CCGs)	The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.

NHSI segment providers based on information collected under the SOF, existing relationship knowledge, information from system partners (e.g. CQC, NHS England, clinical commissioning groups) and evidence from formal or informal investigations. The process is not one-off or annual. NHSI will monitor and engage with providers on an ongoing basis and, where in-year, annual or exceptional monitoring flags a potential support need a provider's situation will be reviewed.

A breakdown of measures reported against the Single Oversight Framework is shown below. This shows that currently the trusts biggest challenge is achievement of the agency cap against the national target. It also reports staff turnover as non compliant. This is against a target that is set by the Trust as no target has been set in the SoF.

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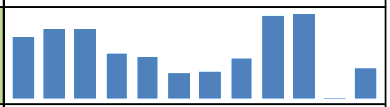
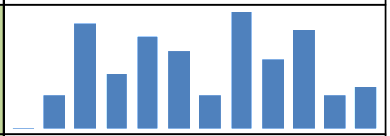
IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Mar-22	Apr-22	Trend *(Last 12 months where available, left to right)*
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	93.8%	95.6%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		84.4%	84.1%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		168	253	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	75.0%	76.5%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.7%	95.3%	
001.S	Occurrence Of Any Never Event	0	1	0	
001.W-W	Staff Sickness - Overall	4.0%	4.3%	4.3%	
002.C	Mental Health Scores From Friends And Family Test – % Positive		84.5%	84.5%	

**The above tables includes those SoF measures that are reportable and supported by clear national guidance but is not inclusive of all indicators within the SoF. Full details available*

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Appendix B: IQPR Overview and Guides

The Integrated Quality and Performance Report (IQPR) is a key document in ensuring that the Board is sighted on key areas of concern in relation to a range of internally and externally set Key Performance Indicators (KPIs).

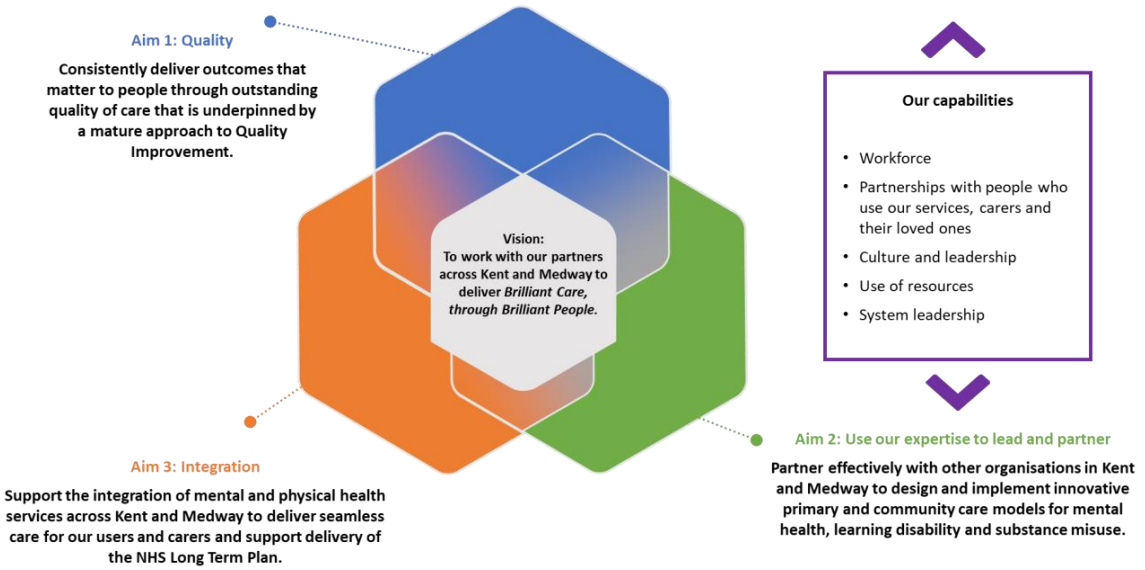
Good examples of IQPRs from high performing organisations change and improve over time. KMPT's is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the rationale for any change.

The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally embedded in executive led Care Group Quality Performance Meetings (QPR).

Each member of the Chief Executive's team provides the narrative to support the exceptions identified via SPC commentary along with wider commentary for the area for which they are the lead. This adds a further strengthening to the actions outlined, and ownership and accountability where improvements are required.

Because this report brings together in one place, all the key work streams that the Chief Executive's team lead, the overarching paper is presented to the Board by the Chief Executive.

Our Strategic Objectives (for 2020-23) are set out at the start of the report under our aim of Brilliant Care Through Brilliant People. The detail within these are mapped to the Care Quality Commission's five Domains (Safe, Caring, Effective, Responsive and Well Led) helping focus the report on both the national and local context.


Aim 1: Quality
Consistently deliver outcomes that matter to people through outstanding quality of care that is underpinned by a mature approach to Quality Improvement.
Vision:
To work with our partners across Kent and Medway to deliver Brilliant Care, through Brilliant People.
Our capabilities
Workforce
Partnerships with people who use our services, carers and their loved ones
Culture and leadership
Use of resources
System leadership
Aim 2: Use our expertise to lead and partner
Partner effectively with other organisations in Kent and Medway to design and implement innovative primary and community care models for mental health, learning disability and substance misuse.
Aim 3: Integration
Support the integration of mental and physical health services across Kent and Medway to deliver seamless care for our users and carers and support delivery of the NHS Long Term Plan.

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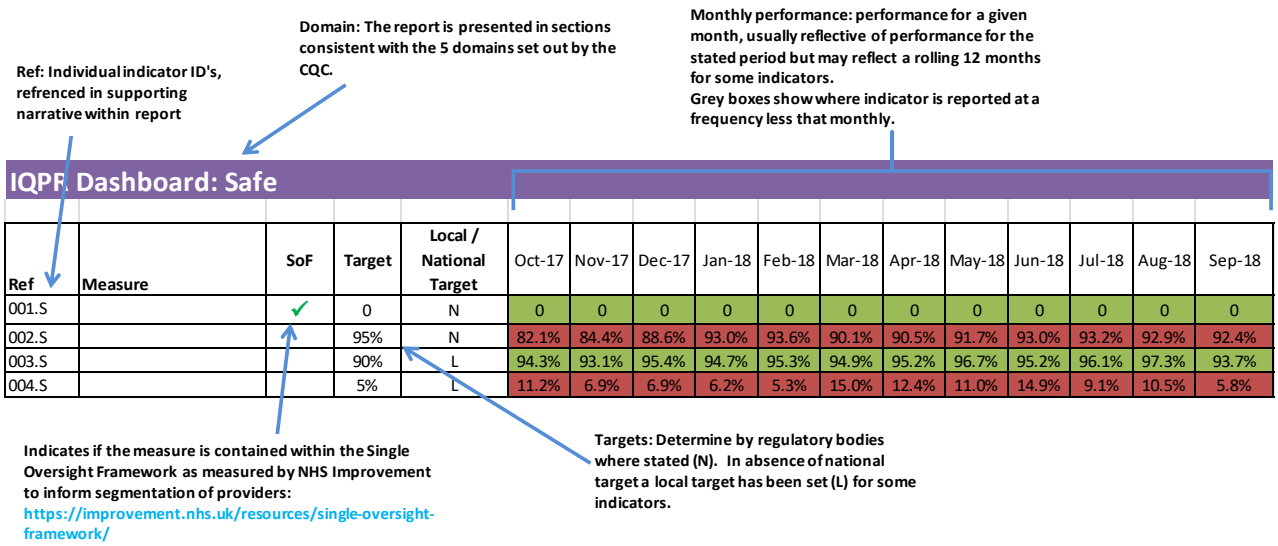
IQPR Dashboard Guide

The IQPR is structured by domains with executive commentary followed by the domains dashboard and a page in which up to three indicators are brought into focus with additional information on current actions in place.

The diagram below provides a guide for each of the columns with the domain dashboards; this is followed by further information on the application of Statistical Process Control charts which are applied within the 'Domain Indicators in Focus' sections.



Ref	Measure	SoF	Target	Local / National Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
001.S		✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S			95%	N	82.1%	84.4%	88.6%	93.0%	93.6%	90.1%	90.5%	91.7%	93.0%	93.2%	92.9%	92.4%
003.S			90%	L	94.3%	93.1%	95.4%	94.7%	95.3%	94.9%	95.2%	96.7%	95.2%	96.1%	97.3%	93.7%
004.S			5%	L	11.2%	6.9%	6.9%	6.2%	5.3%	15.0%	12.4%	11.0%	14.9%	9.1%	10.5%	5.8%

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IQPR Exception Reporting

The report identifies exceptions against a selection of key trust measures using Statistical Process Control (SPC) Charts. SPC charts are used to study how a process changes over time. Data is plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data, usually over 12 months within this report. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).

SPC Key:

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Full details on SPC charts can be found at: https://improvement.nhs.uk/resources/making-data-count/

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IQPR Change Tracker

Date	Change	Report Reference
April 2022	Removals: • 003.S % Inpatients With A Physical Health Check Within 72 Hours • 007.S % Serious Incidents Declared To STEIS within 48 hours • 008.S Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days • 010.S All Deaths Reported On Datix And Suspected Suicide • 015.S Ligature Incidents - Ligature With Fixed Points (moderate to severe harm) • 016.S Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm) • 018.Sa Infection Control - MRSA bacteraemia • 018.Sb Infection Control - Clostridium difficile • 011.E Number Of Home Treatment Episodes • 005.R % of Liaison (urgent) referrals seen within 1 hour • 006.R % of Liaison (urgent) referrals seen within 2 hours • 013.R. 014.R, 015.R Referral counts *All removals are subject to appropriate internal governance despite no longer being reported in the IQPR with routes of escalation if required.* Amendments and Additions: • 019.S. Safer staffing fill rates – moved to workforce section with new reference • Acute bed occupancy introduced • Amendments to inclusions for 4 week wait and additional 6 week wait metric for Dementia waits introduced	023.W-W 018.E 016.R (a,b)

Changes made prior to 2022/23 reports removed from table, these can be viewed in earlier IQPRs

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th May 2022
Title of Paper:	Finance Report for month 1 (April 2022)
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director of Finance

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for Month 1 (April 2022). As at the end of April 2022, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with the annual plan. No formal report has been required by NHSE/I for this month, external reporting will commence from month 2 (May).

Items of focus

The 2022/23 final plan was submitted on 28 April and due to the financial pressures within the wider Kent and Medway system as well as nationally it is anticipated that a further planning submission will be required in June.

Focus needs to continue on ensuring a breakeven position is delivered for this financial year.

1. The 22/23 efficiency target has an unidentified balance and it is essential that focus must be on identifying recurrent and sustainable efficiencies for the forthcoming financial year.

2. Focus needs to remain on minimalising agency spend as much as possible. It is anticipated that Agency caps will be reintroduced at some point in the future so the Trust's agency spend will be under external scrutiny as per the pre-Covid regime. Currently no caps are in place.

3. Substantive pay continues to underspend and the Trust has introduced a Vacancy control process to ensure that historical vacancies included within establishments are required going forward. This work is expected to reduce the underlying deficit.

The Trust Capital year to date position is overspent by £0.1m to the end of month 1. The overspend in month was largely as a result of schemes brought forward from 2021/22 proceeding quicker than anticipated and progress being made on the Improving Mental Health Services Programme.
The cash position remains strong at £22.2m at the end of April.

Governance

Implications/Impact:	Risk to capital programme due to restraints on capital funding in year. Further risk of non-delivery of efficiencies, impacting on financial sustainability.
Assurance:	Reasonable
Oversight:	Oversight by Finance and Performance Committee

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Finance Report

Trust Board

April 2022

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Contents

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Executive Summary

Key Messages for April 2022

This is the first month of the new financial year, and at the end of the April the Trust has reported a breakeven position which is in line with the annual plan submitted on 28th April.

The business planning process for 2022/23 resulted in a breakeven plan for KMPT, delivered as a result of system support funding and just under £1m of COVID funding. The financial position for the wider Kent and Medway system is still a large deficit, mirroring many other systems nationally. Further planning exercises are anticipated, requiring refreshed plans to be submitted in late June. For KMPT the only change to our plan required is to reflect national support for inflation pressures for areas above the planning guidance assumptions (energy and private placements), but our overall plan will remain breakeven.

The Long Term Sustainability Programme (CIPs) for 22/23 has commenced and plans already identified need to start delivering as expected. Where progress is interrupted alternative initiatives need to be identified to mitigate any gaps in delivery. Further work is being undertaken to identify CIP schemes for the unidentified CIP balance - this work is imperative to support the eradication of the underlying deficit by March 2023.

Income and Expenditure

Within the breakeven position reported, there are several key factors. There is continued use of temporary staffing due to vacancies and staff absence, but the spend on agency in April was lower than that seen in 2021/22 - £533k in April 2022 compared to £699k in April 2021, a 24% reduction. Most of the continued reduction is due the on-going medical agency reviews being undertaken by the Executive Director of Finance, the Executive Director of Workforce and OD and Medical Director.

In other expenditure areas, there are high levels of spend in Estates maintenance as we address backlog issues across the Trust. External placements for PICU patients remain high due to complexities regarding how the Trust's PICU can be utilised.

	Year to date		
	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(19,355)	(19,303)	53
Employee Expenses	15,013	14,570	(443)
Operating Expenses	3,861	4,264	403
Operating (Surplus) / Deficit	**(481)**	**(469)**	**13**
Finance Costs	481	469	(13)
(Surplus) / Deficit	**0**	**(0)**	**(0)**

At a Glance - Year to Date

Income and Expenditure
Efficiency Programme
Agency Spend
Capital Programme
Cash

Key

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

Capital Programme

In April, the Trust spent £0.6m against the plan of £0.5m. The overspend in month was largely as a result of schemes brought forward from 2021/22 proceeding quicker than anticipated and progress being made on the Improving Mental Health Services Programme.

The Estates team are focusing on completing schemes brought forward from 2021/22 whilst preparing for tenders to be issued for the 2022/23 agreed schemes.

The capital plan for the year is £22.1m. This includes £10.5m relating to the Improving Mental Health Services programme for which national funding and system support are being received. The overall programme will need to be carefully monitored and managed in year to ensure all resources are used to the maximum benefit.

Cash

The cash position has increased by £2.1m to £22.2m in comparison to March and is £1.8m higher than plan This is mainly due to funds received for prior year invoices.

The high level cash plan for March 2023 has been reported at £10.6m. Key assumptions include achieving a breakeven position, completing the capital programme in full and drawing down the PDC funding for Eradicating Mental Health Dormitories.

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Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to date		
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(19,355)	(19,303)	53	(19,355)	(19,303)	53
Employee Expenses	15,013	14,570	(443)	15,013	14,570	(443)
Operating Expenses	3,861	4,264	403	3,861	4,264	403
Operating (Surplus) / Deficit	**(481)**	**(469)**	**13**	**(481)**	**(469)**	**13**
Finance Costs	481	469	(13)	481	469	(13)
(Surplus) / Deficit	**0**	**(0)**	**(0)**	**0**	**(0)**	**(0)**

Commentary

Pay is underspent at the end of April by £443k. Within this, substantive pay is £570k underspent against plan, partially offset by bank and agency spend. This is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives. For these areas, corresponding income has also been deferred to match and performance is being closely monitored between the Trust and ICS colleagues.

Other non pay at year end includes a high level of spend on external placements when compared to previous months. The average number of patients in April increased to 17 per day including 4 acute beds and 13 female PICU. Most of these have been commissioned with an external provider under a managed contract.

Estates costs remain high as backlog maintenance work is undertaken to improve the condition of our buildings and sites.

Long Term Sustainability Programme (Efficiency Programme)

	Annual	Current Month			Year to Date		
	Plan	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
Pillar	£000	£000	£000	£000	£000	£000	£000
Back Office	(816)	(29)	(64)	(36)	(29)	(64)	(36)
Workforce	(938)	(24)	(7)	17	(24)	(7)	17
Service Line Reporting	(2,905)	(101)	(103)	(1)	(101)	(103)	(1)
Patient Pathways	(905)	(33)	(86)	(53)	(33)	(86)	(53)
Procurement and Purchasing	(300)	(15)	0	15	(15)	0	15
Commercial Development	(1,130)	(53)	(36)	17	(53)	(36)	17
Non-recurrent slippage	0	0	0	0	0	0	0
Total	**(6,995)**	**(255)**	**(296)**	**(41)**	**(255)**	**(296)**	**(41)**

Commentary

The Long Term Sustainability Programme (CIPs) for 22/23 has commenced and plans have been identified and phased throughout the year.

Further work is being undertaken to identify CIP schemes for the unidentified CIP balance - this work is imperative to support the eradication of the underlying deficit by March 2023.
Where progress is interrupted alternative initiatives need to be identified to mitigate any gaps in delivery.

Agency spend will be closely monitored throughout the financial year and it is anticipated that Agency caps will return to be monitored against.

The SLR pillar has seen deep dive information being shared with Care Groups and these packs continue to be a key driver for savings in 22/23.

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Exception Report

Top Variances

	Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last report
Agency	620	533	(87)	(14%)	13%
Bank	1,387	1,601	214	15%	N/A
External Placements	319	532	213	67%	20%

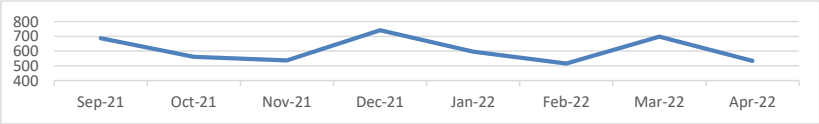
1. Temporary Staffing Spend: Agency (£87k)

Agency spend remains high however in month 1 is reported below the expected level of spend by £87k. The largest reduction was within the medical staff group. There have been several medical agency placements that have concluded recently and this has been since the deep dive was undertaken in Qtr 4 of 21/22. There were also reductions seen in Nursing and Admin and Clerical.

There will be continued focus and scrutiny on all agency spend as the new financial year progresses to ensure spend remains within budget. No agency caps have been set nationally this year.

ANNUAL	2018/19	2019/20	2020/21	2021/22	2021/22
Agency	6,459	6,395	8,740	7,537	533

MONTHLY TREND



2. Temporary Staffing Spend: Bank £214k

The financial plan for Bank has been based on trend analysis from previous financial years, and is predominantly planned to cover annual leave and short term sickness.

Month 1 spend was higher than the trend and will be predominatly due to covering vacancies and higher sickness across the Trust.

The Acute care group has needed to use higher levels of bank due to the clincial requirements and the high level of obersavations of a specialist patient. These addtional costs will be recharged to Kent & Medway CCG.

MONTHLY TREND	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Nursing	508	586	567	548	643	577
Healthcare Assistants	733	984	813	752	889	884
Other	123	135	122	129	143	140
Total	**1,364**	**1,705**	**1,502**	**1,430**	**1,676**	**1,601**

3. External placements £213k

For month 1 of the new financial year the Trust has seen an increase in spend on external placements. The average number of patients in April increased to 17 per day which consisted of 4 acute beds and 13 female PICU. Most of these have been commissioned with an external provider under a managed contract.

The Acute Care Group has seen an increase in spend compared to previous months, particularly due to restrictions in place on existing bed base to reflect patient needs. The financial risk is being closely monitored and where necessary costs are being recharged to the Commissioner for this increase. A plan to address the situation long term is underway.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Structural Deficit

Current Annual Underlying Deficit **£7.7m**

Key Drivers

Forensic Community Service	£0.8m
Forensic Inpatients	£1.4m
External placements	£1.2m
Brookfield	£0.8m
Mental Health Learning Disability Services	£1.1m
Neurology Services	£0.3m
Bridge House Detox Service	£0.3m
Agency Spend (premium element)	£1.8m

Total	**£7.7m**
Last reported deficit	**£7.7m**
Movement	***£0m***

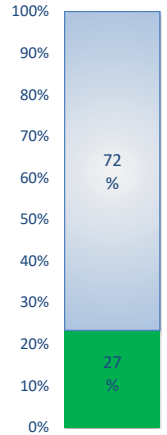
Key Actions currently being implemented

These schemes have been reviewed with Care Groups. Any schemes still in development are not included in this section but mapped out in the "Bridging the Gap" section below. As schemes are signed off they will transfer to this section.

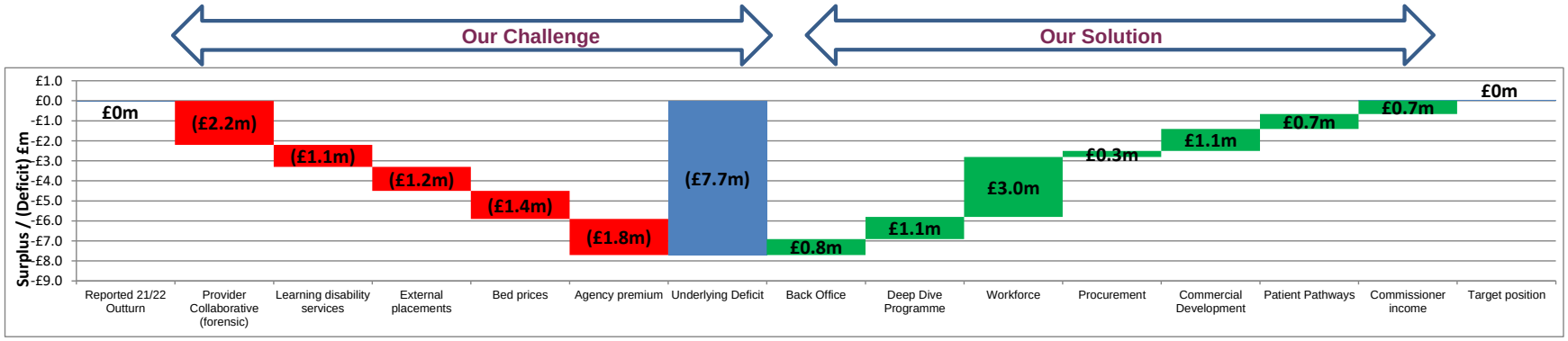
Psychology review*	£0.4m
Medical agency controls	£0.3m
Bridge House price increases	£0.3m
Forensic service establishment review	£0.7m
MHOST (Mental Health Optimal Staffing Tool) and ward establishment reviews	£0.3m
Brookfield price increase	£0.1m

*this is the recurrent value, £0.7m will be realised in 22/23, of which £0.3m is non recurrent

Total	**£2.1m**
Residual Annual Underlying Deficit	**£5.6m**
Target position for 31st March 2023	**£0m**
Remaining Gap	**£5.6m**



Bridging the Gap

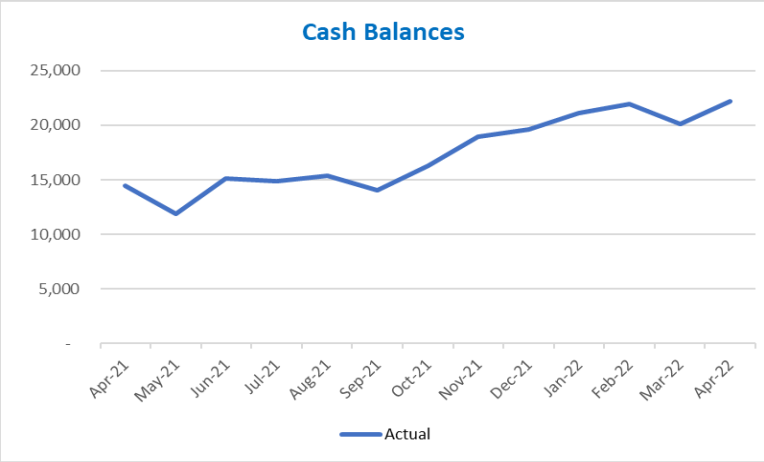


Kent and Medway
NHS and Social Care Partnership Trust

Appendices

Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2022	Current Month 30th April 2022
	Actual	*Actual*
	£000	£000
Non-current assets	139,701	157,811
Current assets	26,599	27,705
Current liabilities	(25,907)	(28,927)
Non current liabilities	(17,502)	(33,698)
Net Assets Employed	**122,891**	**122,891**
Total Taxpayers Equity	**122,891**	**122,891**



Commentary

Non-current assets

Non current assets has increased by £18.1m, this is as a result of leased properties transitioning onto the balance sheet following the introduction of the new accounting standard, IFRS16.

Current Assets

The cash position has increased by £2.1m with funds received from NHSE of £1m for 21/22 baseline funding, £0.6m from Oxleas FT for Tarentfort patients and £0.3m from Sussex Partnership Trust for the prior year's provider collaborative.

Receivables have decreased by £1m, mainly due to a decrease in trade receivables in line with the cash movement. There have been smaller reductions for the VAT and PDC receivables. These decreases have been partially offset by an increase in accrued income of £0.9m (related to NHSE, Kent and Medway CCG and Sussex Partnership FT) and prepayments of £0.6m.

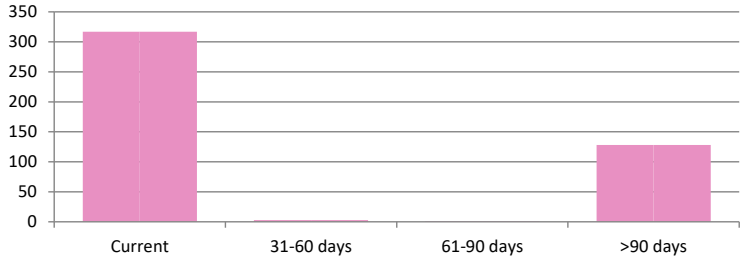
Current Liabilities

Trade and other payables have increased by £1.2m mainly due to an increase in deferred income of £1.1m (related to HEE and CCG). Whilst trade creditors, general accruals and the monthly PDC accrual have increased by a total of c. £1.3m, this has been largely offset by a decrease in capital creditors of £1.2m.

In total borrowings have increased by £18m with the recognition of liabilities associated with the impact of IFRS16 transition.

Aged Debt

Our total invoiced debt is £0.5m, of which £0.3m is within 30 days. Debt over 90 days stands at £0.1m.

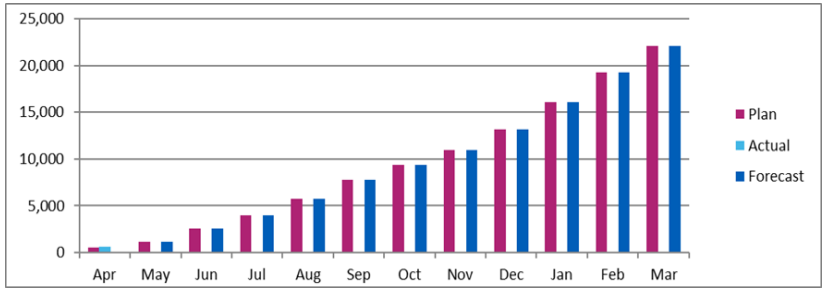


NHS
Kent and Medway
NHS and Social Care Partnership Trust

Capital Expenditure

	Current Month			Full Year
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000
Information Management and Technology	85	96	11	2,350
Capital Maintenance & Minor Schemes 2021/22	2	0	(2)	3,742
Capital Maintenance & Minor Schemes from 2020/21	177	211	34	3,412
Capital Maintenance & Minor Schemes Prior Year Adj	0	0	0	0
Strategic Schemes - Ward Refurbishment	0	0	0	2,000
Improving Mental Health Services (Maidstone)	258	290	32	10,545
PFI 2020/21	3	3	0	41
Total Capital Expenditure	**525**	**601**	**76**	**22,090**

Cumulative Performance against Plan



Commentary

In April, the Trust spent £0.6m against the plan of £0.5m.

The overspend in month was largely as a result of schemes brought forward from 2021/22 proceeding quicker than anticipated and progress being made on the Improving Mental Health Services Programme. This is not expected to cause an issue for future months as it relates to the timing of schemes completing rather than additional schemes added to the programme.

The Estates team are focusing on completing schemes brought forward from 2021/22 whilst preparing for tenders to be issued for the 2022/23 agreed schemes. The IT team are commencing recruitment to key posts to support delivery of the Clinical Technology Strategy priorities this year.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th May 2022
Title of Paper:	Equality, diversity and inclusion update
Author:	Sarah Feather Diversity and Inclusion Manager
Executive Director:	Sandra Goatley Director of Workforce and Organisational Development

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper gives a high-level overview of the WRES results 2020/2021 for KMPT at a local level and a comparison against NHS Trusts nationally. This includes job applications, disciplinaries, bullying and harassment and areas for noting success and concerns. KMPT has been compared nationally to all NHS Trusts and the breakdown of data to a comparator group will become available at a later stage.

This paper also includes the learning from the recently completed reverse mentoring programme and the current position of the black, Asian and minority ethnic staff network.

Issues to bring to the Committee's attention

Items of excellence

- Our representation of black, Asian and minority ethnic staff continues to above that of the South East and nationally, this is also demonstrated within the make-up of our Board.

Significant improvements in matters that were previously an area of concern

- National data shows that white staff continue to be shortlisted for interview over black, Asian and minority ethnic staff – we have improved our overall position year on year, to above the national average
- There have been some significant improvements in the areas of bullying and harassment faced by black, Asian and minority ethnic staff taken from scores within the most recent NHS staff survey.

Items of concern and hot spots

- The key concern for our most recent data is that there is an increase in the likelihood of black, Asian and minority ethnic staff being taken through a formal disciplinary process. We are one of the ten poorest performing Trust's in the country.
- We need to continue to develop career pathways and the talent pool to ensure black, Asian and minority ethnic staff have opportunities for progression from band 3 and band 7.

Governance

Implications/Impact:	Equality and diversity is key factor of employee retention, motivation and advocacy of the organisation. The retention and motivation of employees links directly to patient experience.
Risk recorded on:	NA
Risk IDs:	NA
Assurance/Oversight:	Limited assurance. Oversight by Workforce and Organisational Development Committee

1. Background and context

1.1 This report sets out the Trust's commitment to developing and maintaining a diverse workforce; a workforce that experiences equality of experience and in job satisfaction. KMPT is striving to be an outstanding provider of care. Research has proven that there is a clear link between the satisfaction levels of the workforce and the quality of care.

1.2 The Workforce Race Equality Standard (WRES) and staff survey tell us that black, Asian and minority ethnic staff, LGBTQ+ staff and Disabled staff regularly experience and report lower levels of satisfaction, equal opportunity and more discrimination, abuse and harassment. The report outlines some of the most recent WRES data, staff survey results and reports on the conclusion of KMPT's first reverse mentoring programme and highlights the work of the staff networks.

2. Workforce Race Equality Standard (WRES)

2.1 This diverse population needs an NHS organisation providing services that reflects its make-up. A diverse workforce delivers services that are appropriate and responsive to community needs. NHS England and the NHS Equality and Diversity Council introduced the Workforce Race Equality Standard (WRES) in 2015.

2.2 Since then, NHS organisations have been compelled to review their workforce race equality performance and develop action plans to make continuous improvement on the challenges within this agenda. The WRES is made up of nine indicators; the first four measure staff experience over a 12-month period for harassment, bullying, or abuse from patients, relatives or the public. Another four measure workforce data, in relation to fellow colleagues, managers or team leaders and progression opportunities. Indicator nine considers BME representation on executive boards, in relation to the workforce.

2.3 WRES dashboard

The following table sets out the data at Trust, national and south east region levels across the nine indicators for the reporting period 2020/2021. The local KMPT data formed part of the annual equality report in September 2021 but the comparison with other Trusts is new. The percentile ranks the Trust from 0% the (best in the country) to 100% (worst in the country) on each indicator.

Summary for the 2020/21 reporting year

RXY

Indicator number and description			Trust	South East	National	Percentile rank*
Indicator 1: BME representation in the workforce by pay band						
BME representation in the workforce overall			23.0%	22.1%	22.4%	
Pay band at which BME under-representation first occurs	Non-clinical	Band 4 and under	Band 3	Band 3	Band 3	
		Band 5 and over	Proportional	Band 8B	Band 8B	
	Clinical	Band 4 and under	Band 3	Band 3	Band 3	
		Band 5 and over	Band 7	Band 6	Band 6	
	Medical		Proportional	Consultant	Consultant	
Race disparity ratios	Non-clinical	Lower to middle	1.42	1.07	0.91	45%
		Middle to upper	0.65	1.28	1.39	42%
		Lower to upper	0.93	1.38	1.27	4%
	Clinical	Lower to middle	1.29	1.98	1.59	11%
		Middle to upper	2.12	1.64	1.36	76%
		Lower to upper	2.73	3.26	2.16	45%
Indicator 2: likelihood of appointment from shortlisting						
likelihood ratio White / BME			1.19	1.48	1.61	13%
Indicator 3: likelihood of entering formal disciplinary proceedings						
likelihood ratio BME / White			4.94	1.01	1.14	96%
Indicator 4: likelihood of undertaking non-mandatory training						
likelihood ratio White / BME			1.13	0.93	1.14	31%
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months						
BME			42.9%	30.3%	28.9%	95%
White			28.7%	26.9%	25.9%	76%
Indicator 6: harassment, bullying or abuse from staff in last 12 months						
BME			23.4%	26.7%	28.8%	16%
White			21.1%	23.0%	23.2%	36%
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion						
BME			74.3%	75.7%	69.2%	37%
White			89.3%	88.4%	87.3%	37%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months						
BME			15.0%	15.3%	16.7%	35%
White			6.4%	6.1%	6.2%	64%
Indicator 9: BME representation on the board minus BME representation in the workforce						
Overall			-3.0%.	-8.8%.	-9.8%.	12%
Voting members			+5.6%.	-9.2%.	-10.0%.	27%
Executive members			+19.9%.	-12.8%.	-13.5%.	73%

* ranks the Trust from 0% (best in the country) to 100% (worst in the country) on each indicator.

2.4 Workforce Indicators 1 and 9

Across the whole of the NHS there was a 33,000 increase in black, Asian and minority ethnic staff making up 22.4% of the overall workforce. For KMPT black, Asian and minority ethnic staff are 24.7% of the workforce a 5% increase over the last three years.

Nationally 12.6% of trust board members are from black Asian and minority ethnic backgrounds. For KMPT there has been an improvement in black Asian and minority ethnic representation at Board level of 6% since 2019 making the KMPT percentage 20% and putting KMPT within the 12th percentile of Trusts nationally in this indicator.

The disparity ratio reflects staff progression in terms of representation through the pay bands, comparing. Black, Asian and minority ethnic staff with white staff. Nationally, black Asian and minority ethnic representation falls at band 6 for clinical staff; for KMPT this is at Band 7.

To counter this impact, our Workforce information team provide regular data to our HR Business Partners to allow Care Groups to identify their areas for improvement and the Organisational

Development team are working on developing career pathways and talent management. KMPT have also introduced Recruitment Inclusion Ambassadors to ensure diversity on interview panels.

2.5 Applications Indicator 2

In 71% of Trusts white applicants were significantly more likely than black Asian and minority ethnic applicants to be appointed from shortlisting. For KMPT this is just over 1 time more likely (1.19 times) compared with 1.6 times nationally. This puts the KMPT within the 13th percentile of Trusts nationally in this indicator.

2.6 Disciplinary process Indicator 3

In 50% of NHS Trusts black Asian and minority ethnic staff were more than 1.25 times more likely than white staff to enter the formal disciplinary process. For KMPT this was 4.9 times more likely and this figure means that KMPT are one of the ten poorest performing trusts on this indicator. The numbers of any staff going through the disciplinary process is relatively low (less than 1% of the total workforce) but this will need further examination. The just and learning culture work and early resolution policy are designed to help counter this figure. The very latest figures for KMPT show that this has reduced to 2.1 times more likely. The numbers of any staff going through the disciplinary process remains low (less than 0.5% of the total workforce) but the reasons behind the figures this will be explored further.

2.7 Bullying and Harassment Indicators 5 & 6

These figures are taken from the national staff survey that is run every year.

KMPT aimed to reduce the percentage of black Asian and minority ethnic staff experiencing harassment, bullying or abuse **from patients / service users, relatives** or the public in the WRES action plan 2020-2022 from 44.3% - 34.3%. The data presented shows the staff survey result for last year and shows a modest reduction to 42.9% as shown in the Equality Annual report 2020-2021. The latest staff survey figures show that this ambitious target was nearly met reducing to 35.4%.

KMPT aimed to reduce the percentage of black Asian and minority ethnic staff experiencing harassment, bullying or abuse **from staff** in the last 12 months from 25.5% - 17.5%. The data presented shows the staff survey result for last year and shows a modest reduction to 23.4% as shown in the Equality Annual report 2020-2021. The latest staff survey figures show that this ambitious target was nearly met reducing to 18% meaning KMPT are nearly 5% lower than benchmark organisations who have an average of 22.9%

2.8 Staff engagement

From this year's staff survey, KMPT has an overall engagement score of 7 out of 10 based on the answers to several questions within the staff survey (appendix 1). When that score is broken down black, Asian and minority ethnic staff have scored higher on the engagement score which is up again this year to 7.6 from 7.4 last year.

2.9 Next steps

The newly created Colleague Harassment Task and Finish Group will work with Communications team to produce a Trust wide zero tolerance campaign and this will link with a new Quality Improvement project to reduce racism in KMPT. The organisational development culture work will continue to roll out the just and learning approach as well as the introduction of the early resolution policy designed to reduce staff being taken through a formal disciplinary process.

Although these steps have already been taken to address our results in our poorer performing areas KMPT will be producing a new action plan for the WRES to address all indicators. The action

plan will be coproduced with our black, Asian and ethnic minority staff network and will come to the Board later in the year for sign off.

3. Reverse mentoring

3.1 As part of the WRES action plan KMPT committed to providing staff development for black Asian and minority ethnic staff. KMPT commissioned TPC Health to run a reverse mentoring course.

3.2 The purpose of the reverse mentoring for senior members of staff was to gain insight into the experiences of staff from diverse ethnic backgrounds, with the intention of supporting senior leaders to:

- understand the lived experience of staff
- identify some of the challenges that staff experience
- form connections and develop positive relationships
- widen organisational knowledge and develop strategic insight
- gain experience to inform their leadership roles and support a culture of continuous improvement

For more junior members of staff from diverse ethnic backgrounds to develop personally and professionally through:

- Developing mentoring and coaching skills to enable them to support colleagues
- Gaining an accredited professional qualification
- Developing their senior network and leadership experience through mentoring a senior leader
- Feeling listened to and valued

3.3 Outcomes

Of the 16 mentors that began the programme, nine have now completed and gained their mentoring qualification. Three mentors have an extension and four did not complete the course either for personal reasons or because they left KMPT.

3.4 Learning

The evaluation of the programme and closing event showed that the reverse mentoring programme was successful and beneficial to mentors/mentees and the organisation.

A key point of learning for KMPT included the impact on black, Asian and minority ethnic staff who are required to apply and re-apply for the right to remain in the UK. As a result, KMPT's own letters reminding staff of their visa status are more compassionate and KMPT has raised a concern nationally to simplify and support staff through this process.

Moving forward, KMPT would like to introduce further mentoring opportunities for a broader range of staff. KMPT would encourage staff to uptake learning on mentoring before taking part in such a programme, this will allow both mentor and mentee to gain the most of the programme as understanding the time commitment and work load was not anticipated.

KMPT would also utilise iLearn to offer mentors a space to find the paperwork that was required.

3.5 Next steps

The Leadership and Big Conversation events in July will showcase the reverse mentoring programme and the learning by inviting some pairings to talk about their experiences.
Kent and Medway Integrated Care System is looking into a reciprocal mentoring offer but this may not be for another 12-18 months.

4. Staff network update

4.1 The black, Asian and minority ethnic staff network has over 150 members and is the most well attended network with a number of allies joining this network over the last two years to understand the experiences of staff.

4.2 The network receives executive support from the Deputy Chief Executive and currently has an allocated budget of £5k per annum. The network has an active membership who are willing and able to provide support in terms of communications and meeting planning, although they offer this support alongside their full-time role. The network recently held an away day to discuss their intentions for the next 12 months and a will present their plan at their next meeting to be held in June 2022.

4.3 All of KMPT's staff networks contribute to improving the work environment and service delivery and we will be increasing each network budget and providing dedicated administration support. We will be linking the networks into the Workforce and OD Committee this year and each network will submit a paper twice yearly to the Committee detailing their planned actions and progress.

5. Recommendations

5.1 The Board is asked to note:

- the improved WRES results and agree to receive the new action plan that will address the areas for concern for consideration and sign off in September 2022.
- the reverse mentoring outcomes and proposed approach to further mentoring.
- the consideration to increase staff network budgets and administrative support.

Appendix 1

Staff engagement score is based on the following nine questions in the staff survey

Q2a - “I look forward to going to work.”

Q2b - “I am enthusiastic about my job.”

Q2c - “Time passes quickly when I am working.”

Q4a - “There are frequent opportunities for me to show initiative in my role.”

Q4b - “I am able to make suggestions to improve the work of my team / department.”

Q4d - “I am able to make improvements happen in my area of work.”

Q18a - “Care of patients / service users is my organisation's top priority.”

Q18c - “I would recommend my organisation as a place to work.”

Q18d - “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.”

Kent and Medway NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26/05/2022
Title of Paper:	National Staff Survey 2021 Highlight Report
Author:	Natalie Adams, Organisational Development Specialist
Executive Director:	Sandra Goatley, Director of Workforce and Organisational Development

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper gives a high-level overview of the NHS Staff Survey 2021 results for KMPT. This includes organisational scores on participation, employee engagement, areas for noting success and concerns.

Issues to bring to the Board's attention

Items of excellence

- Our line managers continue to be a brilliant asset to our staff satisfaction, experience and engagement – national data shows that our line managers garner the highest staff satisfaction in comparison to other Mental Health Trusts across the country when it comes to encouraging colleagues and providing clear feedback on work their work.
- Learning and Development, KMPT scores well against comparators for questions relating to their development.

Significant improvements in matters that were previously an area of concern

- National data shows that engagement has reduced in comparison to 2020. KMPT has improved our overall position year on year, to the national average
- National data shows that morale has reduced in comparison to 2020 – KMPT has improved our overall position year on year, to above the national average
- There have been some significant improvements in the areas of Equality and Diversity and Health and Wellbeing.

Items of concern and hot spots

- KMPT is Compassionate and Inclusive: we are below average in terms of colleagues feeling able to advocate for the Trust as a care provider and employer
- KMPT Colleague recognition: we are below average in terms of colleague satisfaction about their level of pay.
- KMPT Colleague Voice: we are below average in terms of colleagues feeling they are involved in deciding changes that affect work and having choice in deciding how to do work.

Version Control: 01

- KMPT Colleague Safe and Healthy: like previous years we have poor colleague satisfaction around negative experiences at work such as physical violence from patients and colleagues and harassment, bullying and abuse from patients in comparison to other NHS providers who work in the same field as us – supporting our intentions to make difference through our task and finish group this year.
- KMPT Colleague Morale: we are below average in terms of colleagues thinking about leaving the Trust and colleagues agreeing that they are involved in changes introduced in relation to their work or department.

Governance

Implications/Impact:	Employee engagement is one of the biggest predictors of the level of quality of care and patient safety. Employee Engagement is a key predictor of employee retention, motivation and advocacy of the organisation.
Assurance:	Reasonable
Oversight:	Workforce and Organisational Development Committee

Version Control: 01

1. Staff Survey 2021 – National - Slide Pack at a Glance

To view alongside the below paper a slide pack has also been provided.

KMPT National Picture – Comparison against 50 comparators	Slide 3
NHS Culture and People Promise Focus – KMPT Highs and Lows	Slide 4
People Promise 1- 'We are compassionate and inclusive' - KMPT Picture	Slide 5
People Promise 2- 'We are recognised and rewarded' - KMPT Picture (presented to show disparity in question responses)	Slide 6
People Promise 3- 'We have a voice that counts' - KMPT Picture	Slide 7
People Promise 4- 'We are safe and healthy' - KMPT Picture	Slide 8
People Promise 5- 'We are always learning ' - KMPT Picture	Slide 9
People Promise 6- 'We work flexibly ' - KMPT Picture	Slide 10
People Promise 7- 'We are a team ' - KMPT Picture	Slide 11
KMPT Colleague Engagement – National Comparison Picture	Slide 12
KMPT Colleague Morale – National Comparison Picture	Slide 13
KMPT Staff Survey Retention Picture – National Comparison	Slide 14
KMPT Staff Survey Brand Management Picture – National Comparison	Slide 15
KMPT focus areas for Making A Difference in 2022/3	Slide16

2. Background and context

The National NHS Staff Survey provides an annual opportunity to measure staff satisfaction, experience and engagement over time. It highlights what we do as an employer that impacts positively on staff and where we need to improve.

The paper summarises the Staff Survey 2021 national key findings which facilitates comparisons across KMPT and benchmarking with 50 other Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts. It is this formal national report that is referenced by the Care Quality Commission (CQC).

The staff survey has been redeveloped in line with the NHS People Promise which sets out what NHS staff can expect from their leaders and colleagues. From this point, the staff survey will track our progress towards the seven elements of the People Promise plus colleague engagement and morale, this will also align with the new quarterly People Pulse survey (replacing quarterly Friends and Family test).

Version Control: 01

The national picture does suggest colleagues across the NHS are feeling bruised after two years of working in a pandemic, with national colleague engagement and morale indicators down year on year.

3. Results

Response Rate

The national results further reflect the success KMPT achieved in its response rates this year, out of 50 comparable Trusts the highest was 67.9% KMPT's was 67.8%

National Comparison - What Matters to our KMPT Colleagues

KMPT – best

The national data confirms that in terms of our line managers encouraging colleagues and providing clear feedback on work – we are the best in our sector.

KMPT – above average

The slide pack summarises the national data which outlines that our colleague satisfaction is above average in the following areas:

- Compassionate leadership: supportive, caring and interested line management
- Recognition and reward: again, immediate line managers do great work valuing colleagues work and there is some marginal distinction around recognition for good work and colleagues showing appreciation to each other
- Colleague voice: we are getting somethings right in terms of involving colleagues – colleagues report knowing what their work responsibilities are, feel able to make suggestions and improvements to the work of their team
- Safe and Healthy: whilst sometimes marginal, our colleague feedback shows we are above average in a number of important areas including; around work pressure, having the right resources and feeling above to report incidents. Burnout factors across the board are marginally better than our average comparator and we have come out above average in regards to colleagues experiencing MSK problems or work-related stress.
- Learning Environment: how we support our colleagues across KMPT in terms of career, skills and knowledge development is one area we really do well, alongside how we ensure our colleagues get good quality appraisals and have the potential to be 'best' in.
- Flexibility and Work-Life Balance: KMPT has a healthy approach to providing the opportunity of flexible working.
- Team Cohesiveness: Clearly we have great line management across the Trust but we also are above average in terms of team cohesiveness with regards to teams having shared objectives, meeting to discuss effectiveness and team dynamics.
- Engagement: Colleague feedback put us above average in the areas of colleagues looking forward to going to work and being able to make suggestions/improvements in their area of work
- Morale: KMPT has a number of morale factors that are above average. Colleagues report being able to meet all the conflicting demands of their work, having adequate resources both staff and materials and equipment to enable them to do their job, clarity about their work appropriate encouragement from their line manager.

Equality and Diversity

Like last year, colleagues who identify as non-white have a very high overall engagement score of 7.6, which is both significantly more positive than KMPT's average outcome of 7.0 and also colleagues who identify as white, who's average engagement was 6.9.

Understanding the detail behind this shows an incredibly positive picture is replicated in 'colleague advocacy' which increased year on year, 'colleague involvement' had a highly improved year on year outcome and 'colleague motivation' whilst maintained year on year, stands our markedly more positive than Trust-wide outcomes or our colleagues who identify as white.

Health and Wellbeing

This year there have been some slight changes to the wording of questions relating to health and wellbeing.
In 2020 the question "Does your organisation take positive action on health and wellbeing" scored 35%.
In 2021 the question was changed to "My organisation takes positive action on health and wellbeing. KMPT scored 62%.
Whilst we still remain marginally lower than the average competitor, we have reduced the gap from 3.5% to 1%.

KMPT – below average

- KMPT is compassionate and Inclusive: we are below average in terms of colleagues feeling able to advocate for the Trust as a care provider and employer. In terms of diversity and equality – our average comparators have greater staff satisfaction in terms of colleagues experiencing discrimination from service users and colleagues and whether we are a culture that accepts differences
- KMPT Colleague recognition: we are below average in terms of colleague satisfaction about their level of pay. Colleague satisfaction around pay was part of our staff survey action plan last year with no improvements made, in fact it has further declined year on year.
- KMPT Colleague Voice: we are below average in terms of colleagues feeling they are involved in deciding changes that affect work and having choice in deciding how to do work. In addition, we are below average in colleagues feeling able to voice concerns which reiterates that we still have cultural work to do to support colleagues to speak up.
- KMPT Colleague Safe and Healthy: we are marginally below average in terms of colleague satisfaction around KMPT taking positive action around health and wellbeing and like previous years we have poor colleague satisfaction around their negative experiences as work such as physical violence from patients and colleagues and harassment, bullying and abuse from patients etc in comparison to other NHS providers who work in the same field as us – supporting our intentions to make difference through our task and finish group this year.
- KMPT Colleague Engagement: we are below average in terms of colleagues getting job satisfaction in their roles and colleagues feeling able to recommend us (advocacy) as a care provider and an employer. Engagement of our colleagues is becoming critically important to us in our attempt to attract and retain staff.
- KMPT Colleague Morale: we are below average in terms of colleagues thinking about leaving the Trust and colleagues agreeing that they are involved in changes introduced in relation to their work or department.

What matters to our KMPT People?

The national data helps crystallise what we really need to focus on in terms of improving staff satisfaction, experience and engagement – this paper works on the assumption that staff feedback that is below average should attract our attention and reflecting the Trust strategic aims, cultural aspirations and operational challenges, the priorities below are suggested as key focuses for KMPT during 2022/2023 and beyond.

NHS People Promise 1
- Colleagues feeling able to advocate for the Trust as a care provider and employer

NHS People Promise 2
- Colleague satisfaction around pay

NHS People Promise 3
- Colleague involvement in deciding changes that affect work
- Colleagues feeling able to voice concerns

NHS People Promise 4
- Colleague satisfaction around their negative experiences as work such as physical violence, bullying, harassment and abuse from patients

KMPT Colleague Engagement
- Colleague advocacy about KMPT as a care provider and as an employer

KMPT Colleague Morale
- Colleague retention
- Colleague involvement in changes at work

Further challenge and scrutiny from the Workforce and Organisational Development Committee has led to 4 key areas from the NHS People Promise being agreed by the Executive Management Team as a focus for action this year.

Area of Focus	What will be different?	What will we do?	How do we measure impact? Links to Strategy
We are compassionate and inclusive	**Our people feel able to advocate for KMPT as a care provider and employer**	Employee Voice-**New**-Why people do/don't advocate for KMPT as an employer and a care provider Communications research with non desk based teams	Q 21 a, b, c, d Recruitment and Retention Communications Equality & Diversity
	Our people feel that their work is valued by the organisation	Living Our Values-**New**-staff recognition programme in line with the KMPT Values	Q4 c, Q21 c Recruitment and Retention Culture Communications

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		Development of Internal' Careers Hub'	
	**Our people feel safe to speak up and involved in decision making affecting their work**	Just and Learning Approach- Psychological Safety development with teams and leaders, HR Early resolution framework Introduction of external organisation to provide the freedom to speak up service	Q 3c, Q17a & B, Q21 e Culture Recruitment & Retention Quality Improvement
	**Our people feel safe at work and that their wellbeing is a priority**	Reporting of harassment and violence project in line with NHS Civility & Respect programme Wellbeing spaces created for staff	Q 13a, 14 a, 21a&c plus local questions Recruitment and Retention Partnerships Health & Wellbeing Equality & Diversity Estates

Conclusion

The KMPT Board is asked to note the results of the National Staff Survey 2021 and areas of focus for 2022/23.

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Kent and Medway NHS and Social Care Partnership Trust

KMPT Staff Survey 2021

‘What Matters to our KMPT Colleagues’

Key Organisational Highlights

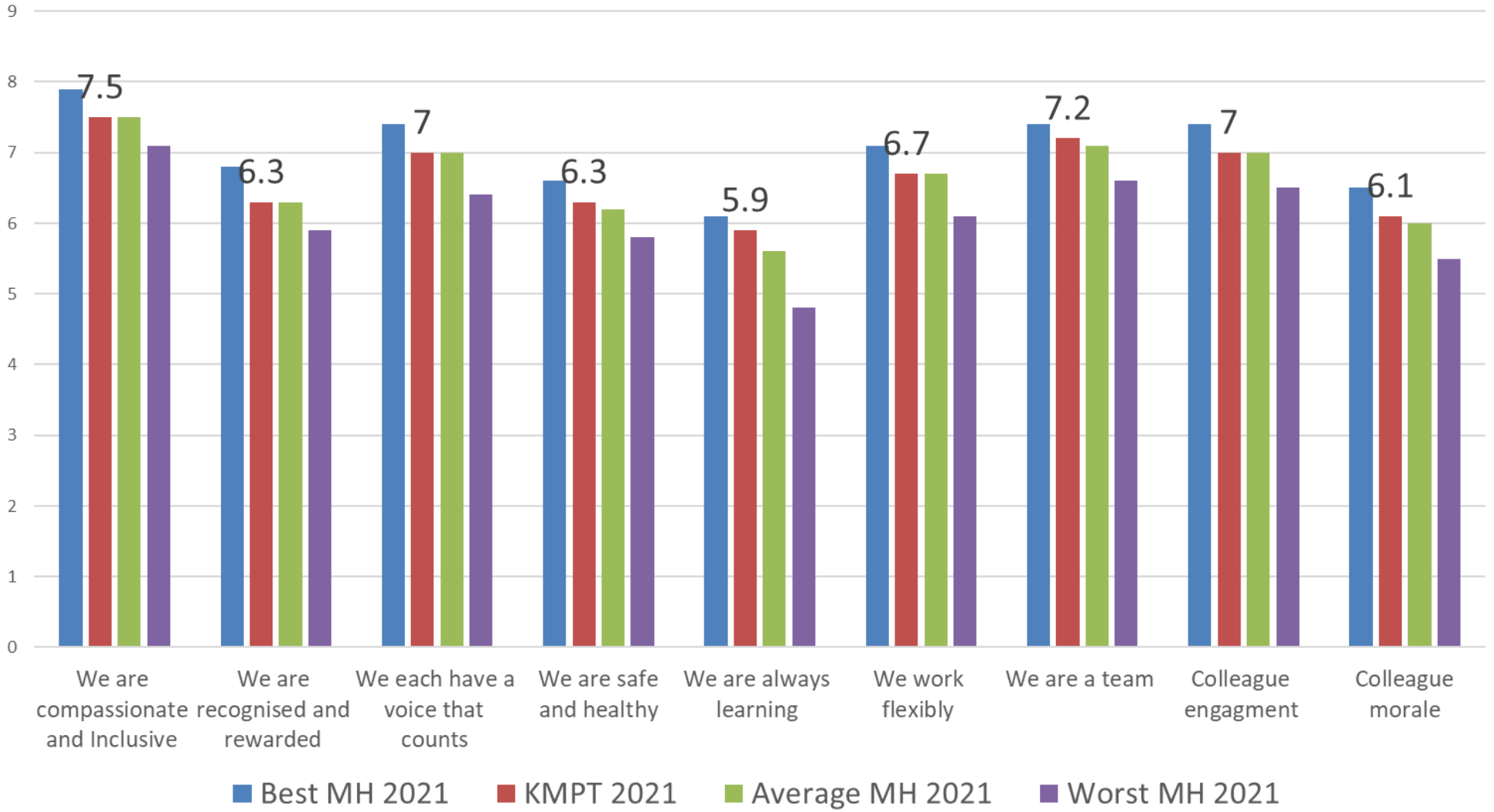
Brilliant care through brilliant people

RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Slide Contents at a Glance

Brilliant care through brilliant people

KMPT Staff Survey 2021 National Picture



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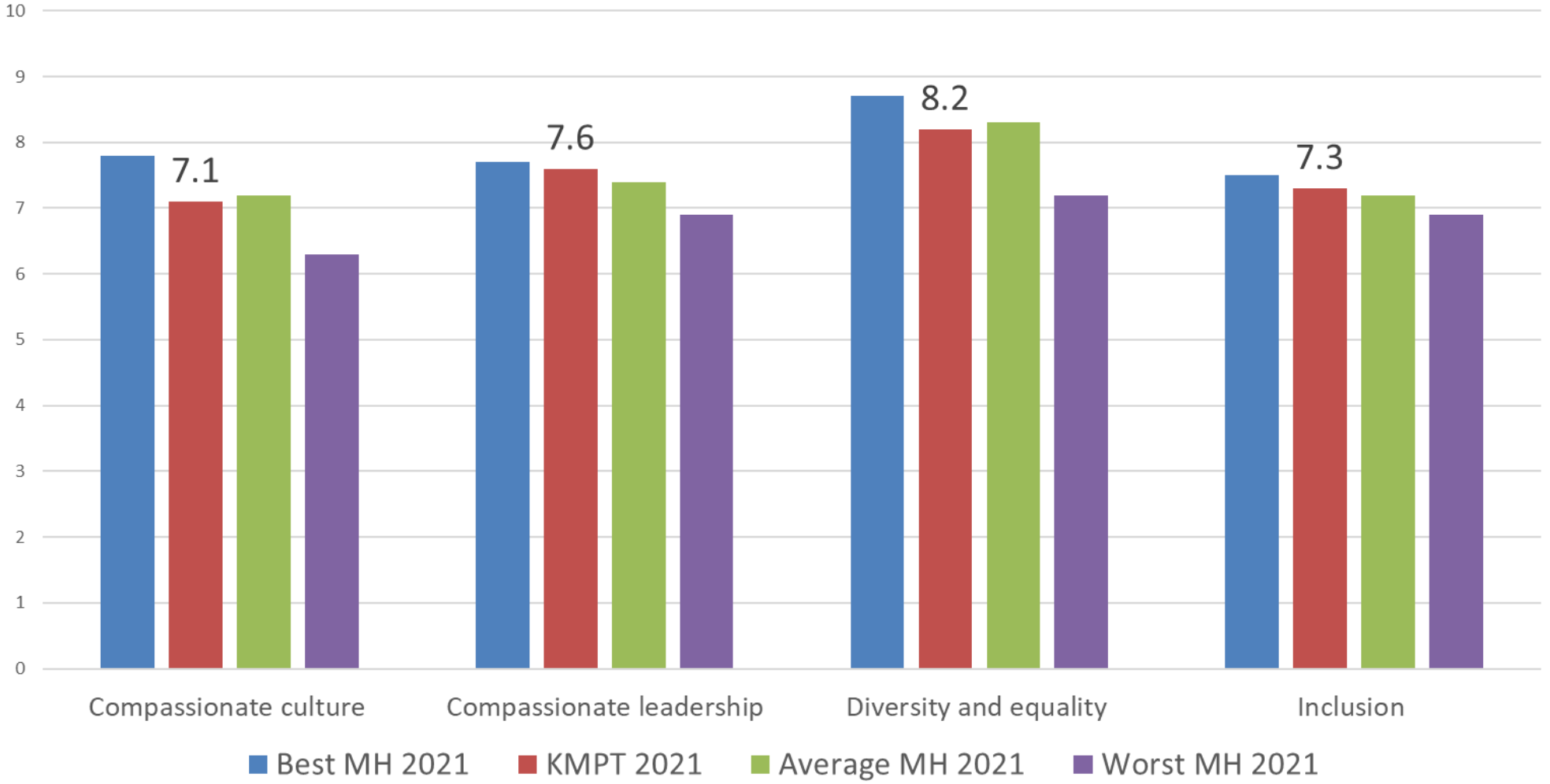
Cultural barometer	KMPT above average (better than)	KMPT below average (worse than) ** urgent action needed: text shaded yellow
We are compassionate and inclusive	• Compassionate leadership *(see also PP7 below)* • Inclusion	• Compassionate culture – colleague advocacy of KMPT as care provider and employer • Diversity and Equality – colleague experience of discrimination
We are recognised and rewarded	• Recognition for colleagues work (marginally above average) • The people I work with show appreciation to one another(marginally above average) • My immediate manager values my work	• Colleague level of pay
We each have a voice that counts	• Knowing what work responsibilities are • able to make suggestions to improve the work team • Able to make improvements happen in area of work	• Raising concerns – colleagues feeling able to speak up and confidence that KMPT would address concerns • Colleagues involved in decisions around change that affect work • Choice in deciding how to do work
We are safe and healthy	• Health and safety climate • Burnout (sometimes marginally better than average) • Reporting negative experiences ie physical violence/B&H • Experiencing MSK problems/work-related stress due to work • Coming to work despite feeling unwell • Bullying and harassment from KMPT colleagues	• My organisation takes positive action on health and well-being • Negative experiences ie Physical violence from patients and other colleagues etc – also harassment & bullying from patients etc
We are always learning	• Career, Skills and Knowledge Development • Appraisals	• This organisation offers challenging work
We work flexibly	• Opportunities to discuss and implement flexible working	• Achieving good balance between work life and home life
We are a team	• Line management**** best performer** • Team cohesiveness	• My team has enough freedom in how to do its work
Engagement	• Colleagues look forward to going to work • Colleagues able to make suggestions to improve the work of team • Colleagues able to make improvements happen in area of work	• Enthusiastic about job • Time passes quickly when working • Care of patients is KMPT's top priority • Happy with the standard of care provided by KMPT • Recommend KMPT as an employer

People Promise 1 2021:National Picture

We are compassionate and inclusive



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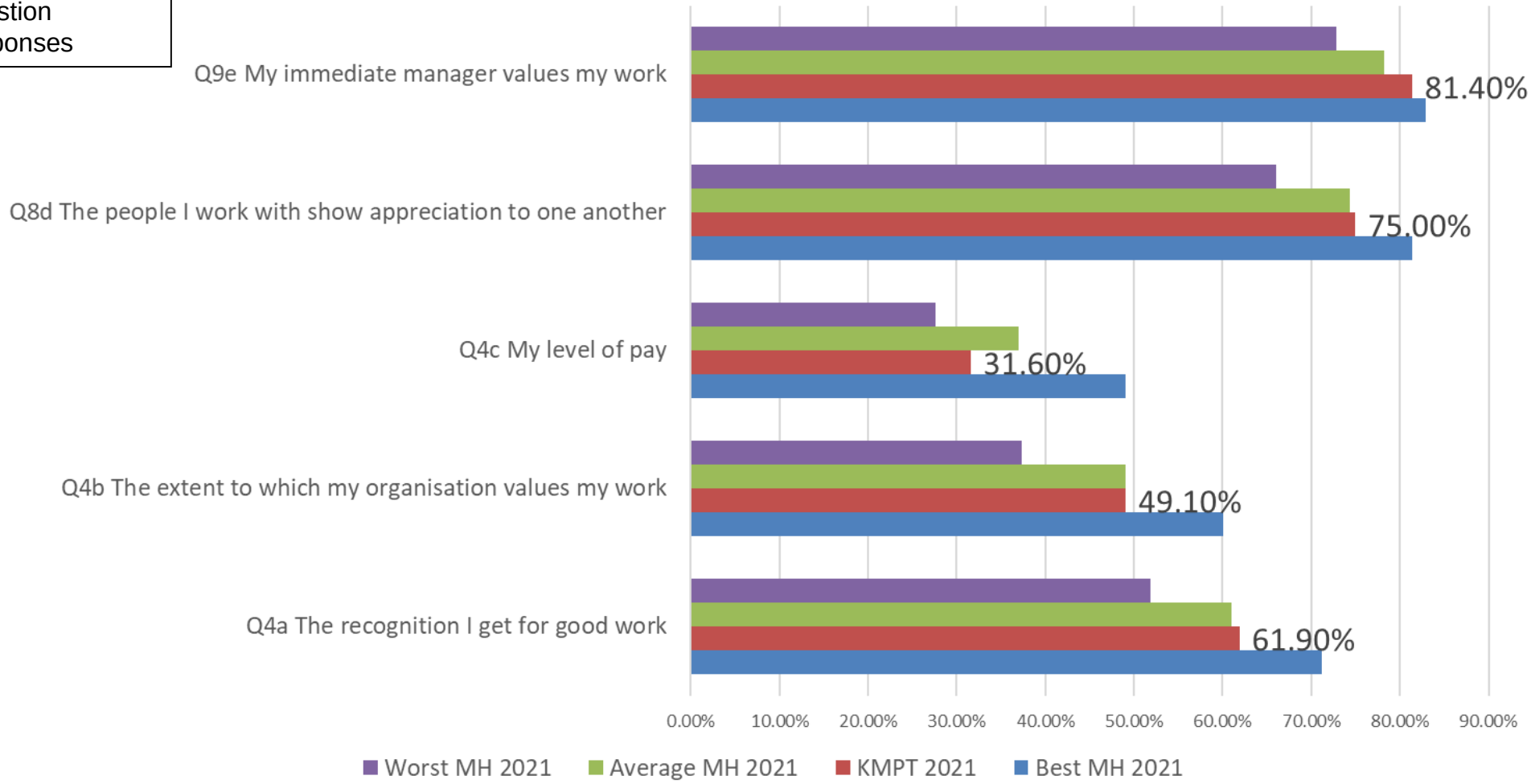
People Promise 2 2021:National Picture

We are recognised and rewarded

Presented differently to show disparity in question responses



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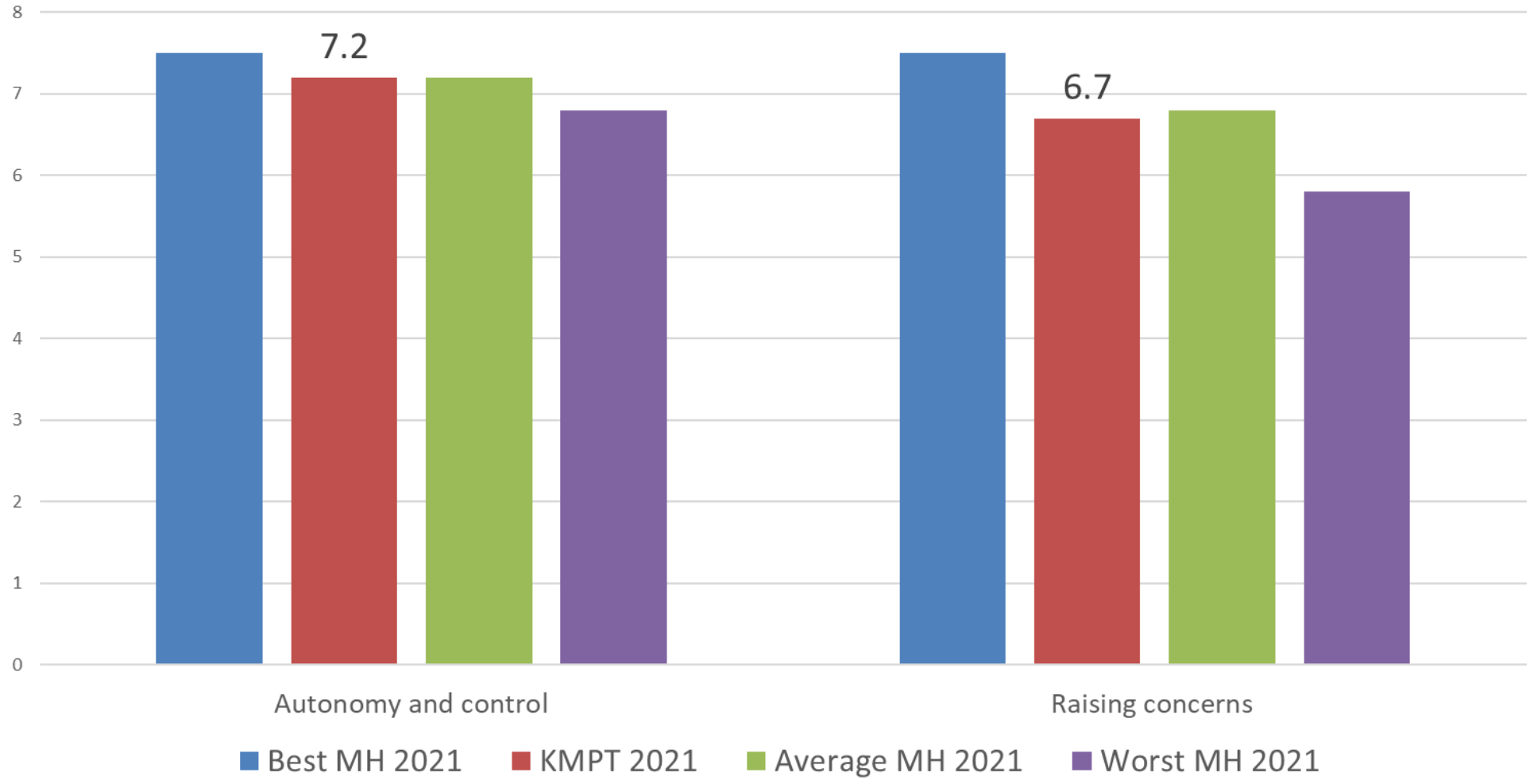
People Promise 3 2021:National Picture

We each have a voice that counts



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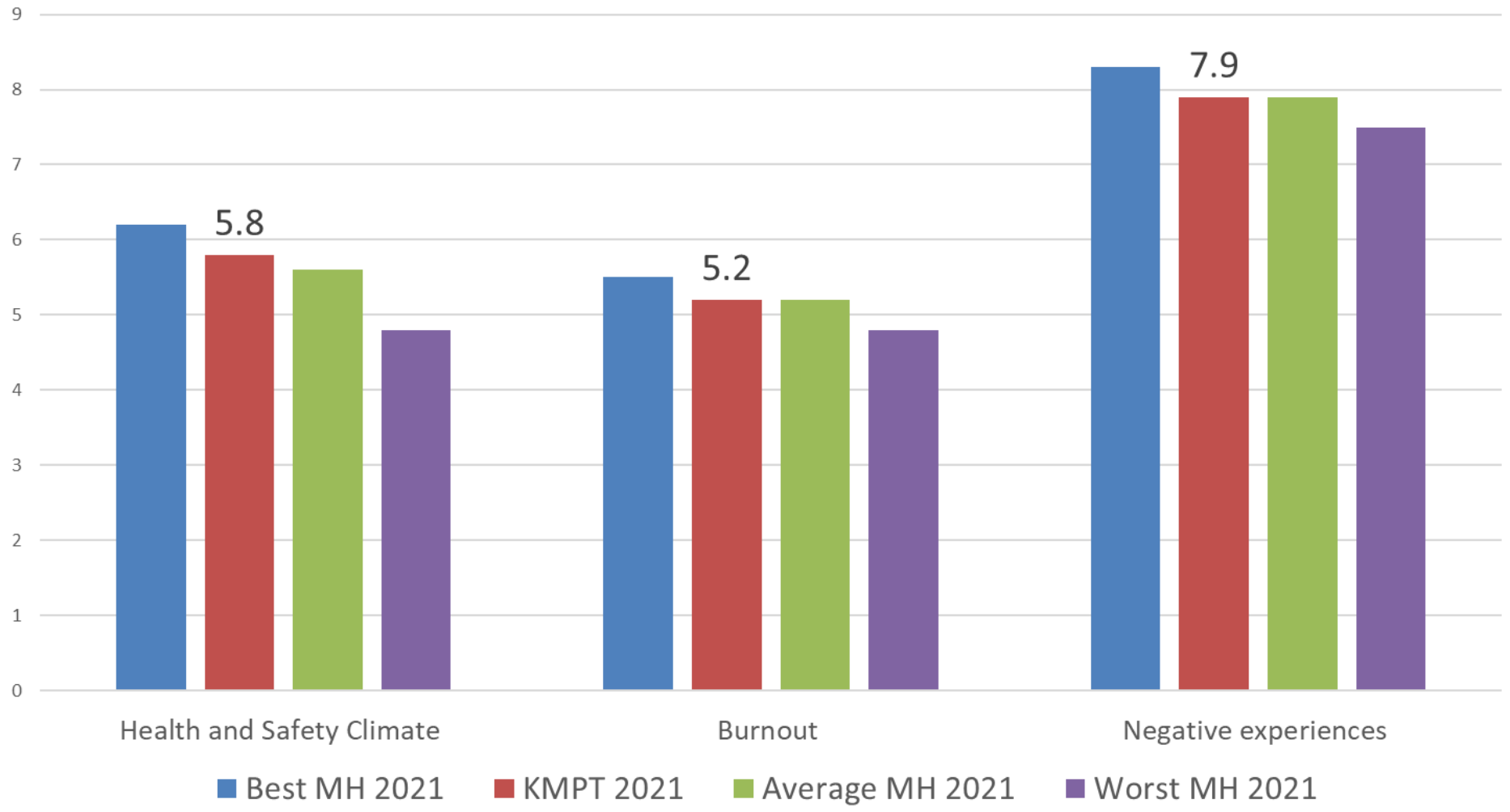
People Promise 4 2021:National Picture

We are safe and healthy



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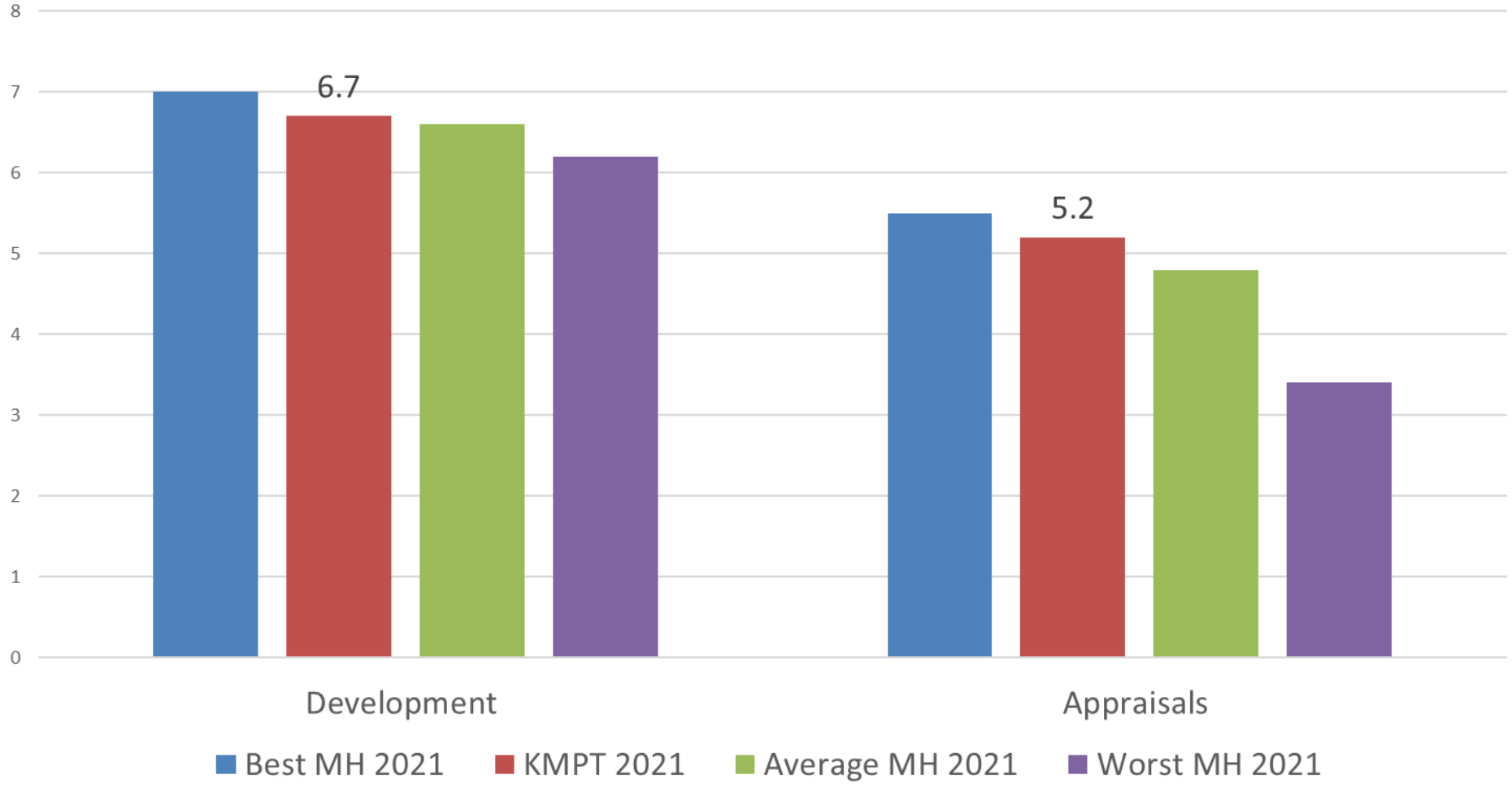
People Promise 5 2021:National Picture

We are always learning



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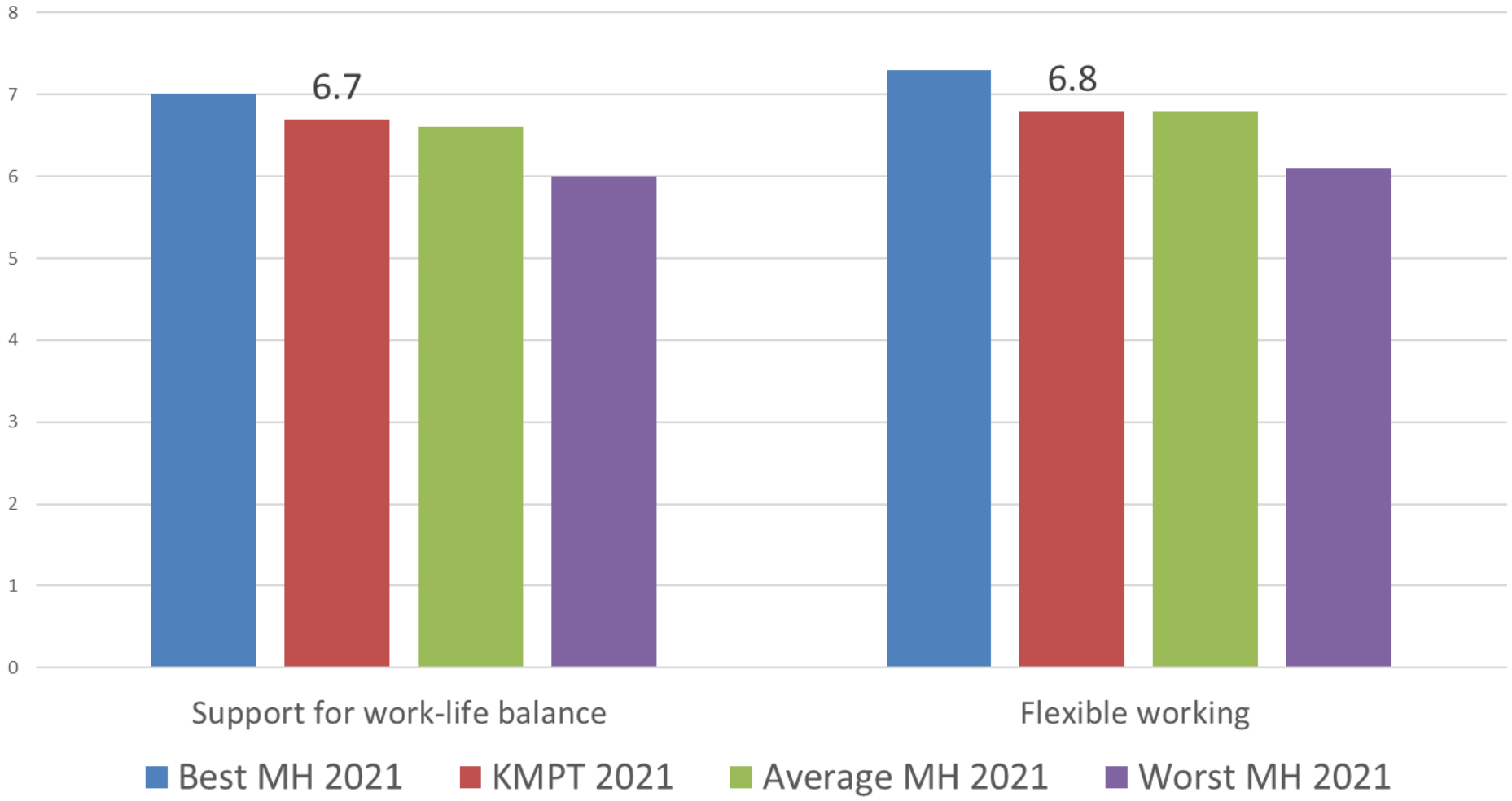
People Promise 6 2021:National Picture

We work flexibly



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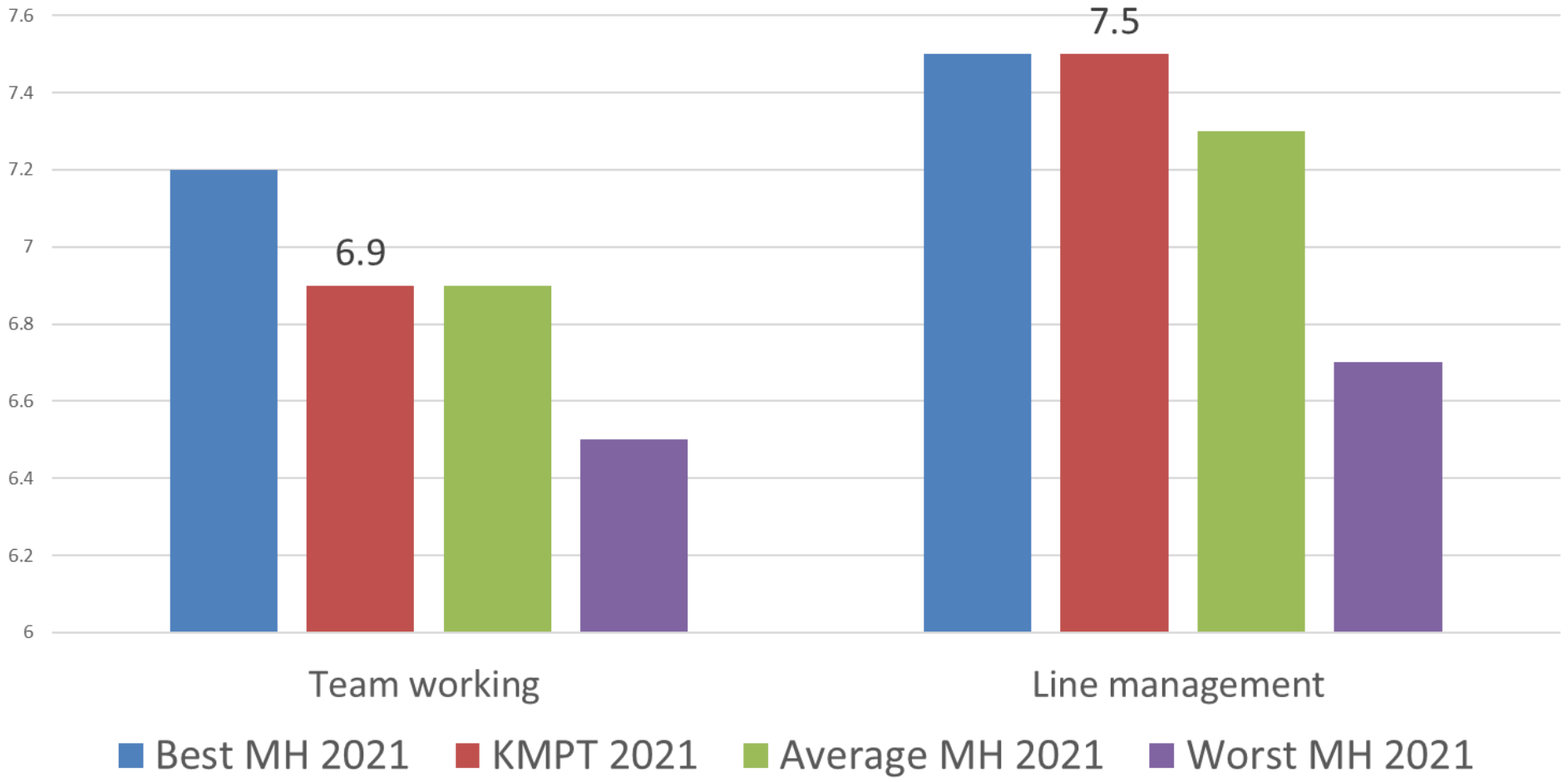
People Promise 7 2021:National Picture

We are a team



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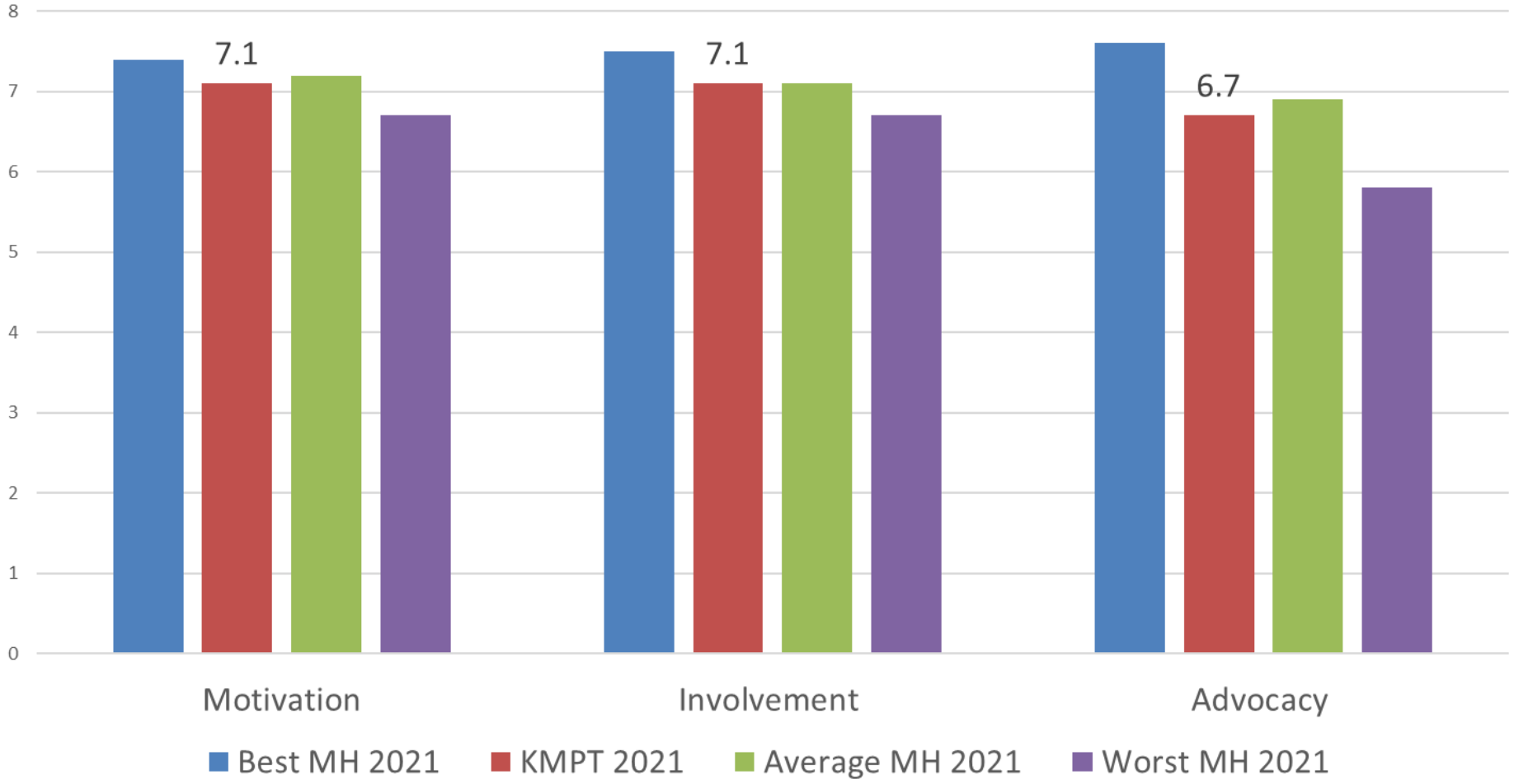
KMPT Colleague Engagement 2021 – National Picture



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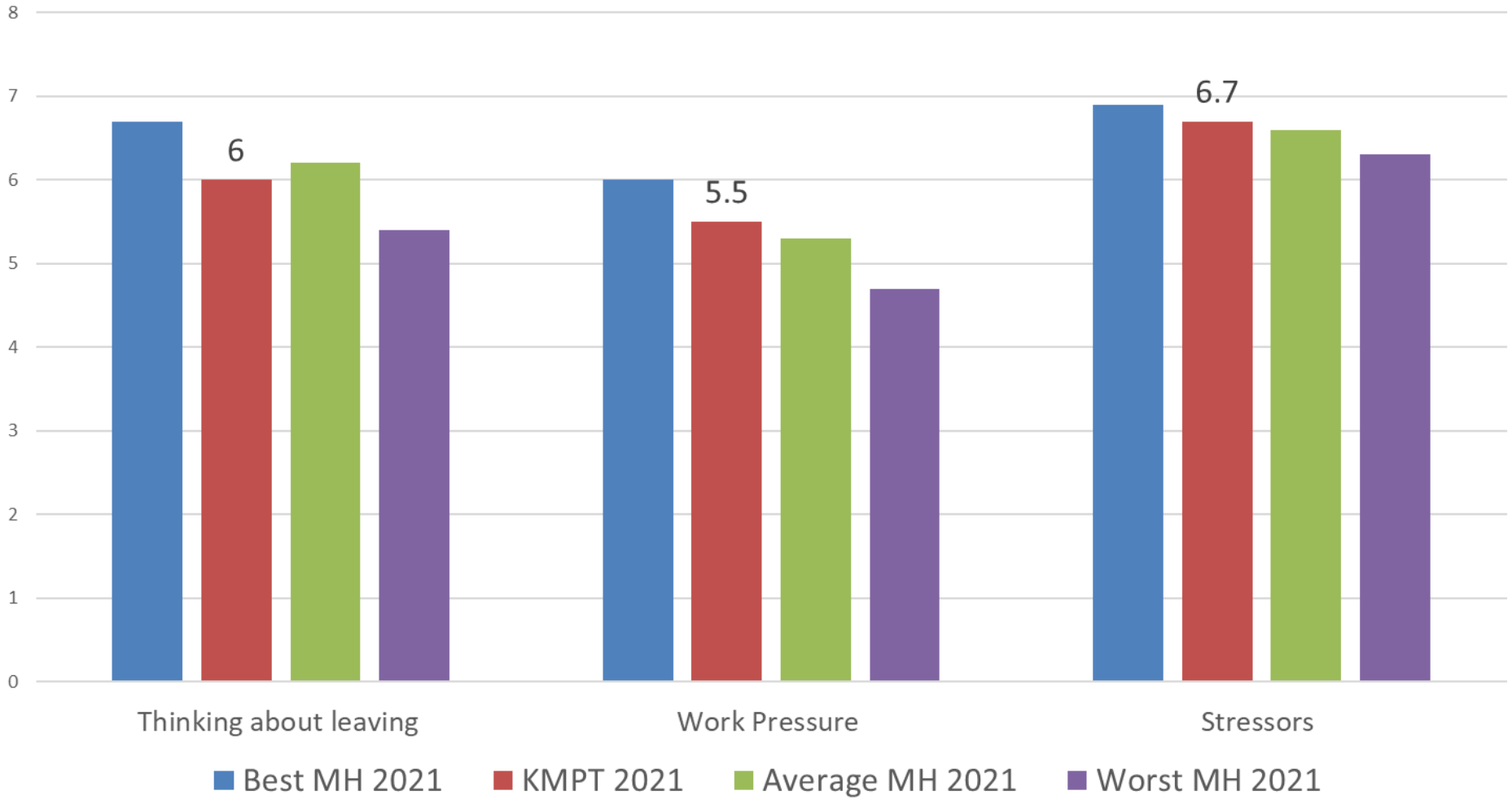
KMPT Colleague Morale 2021 – National Picture



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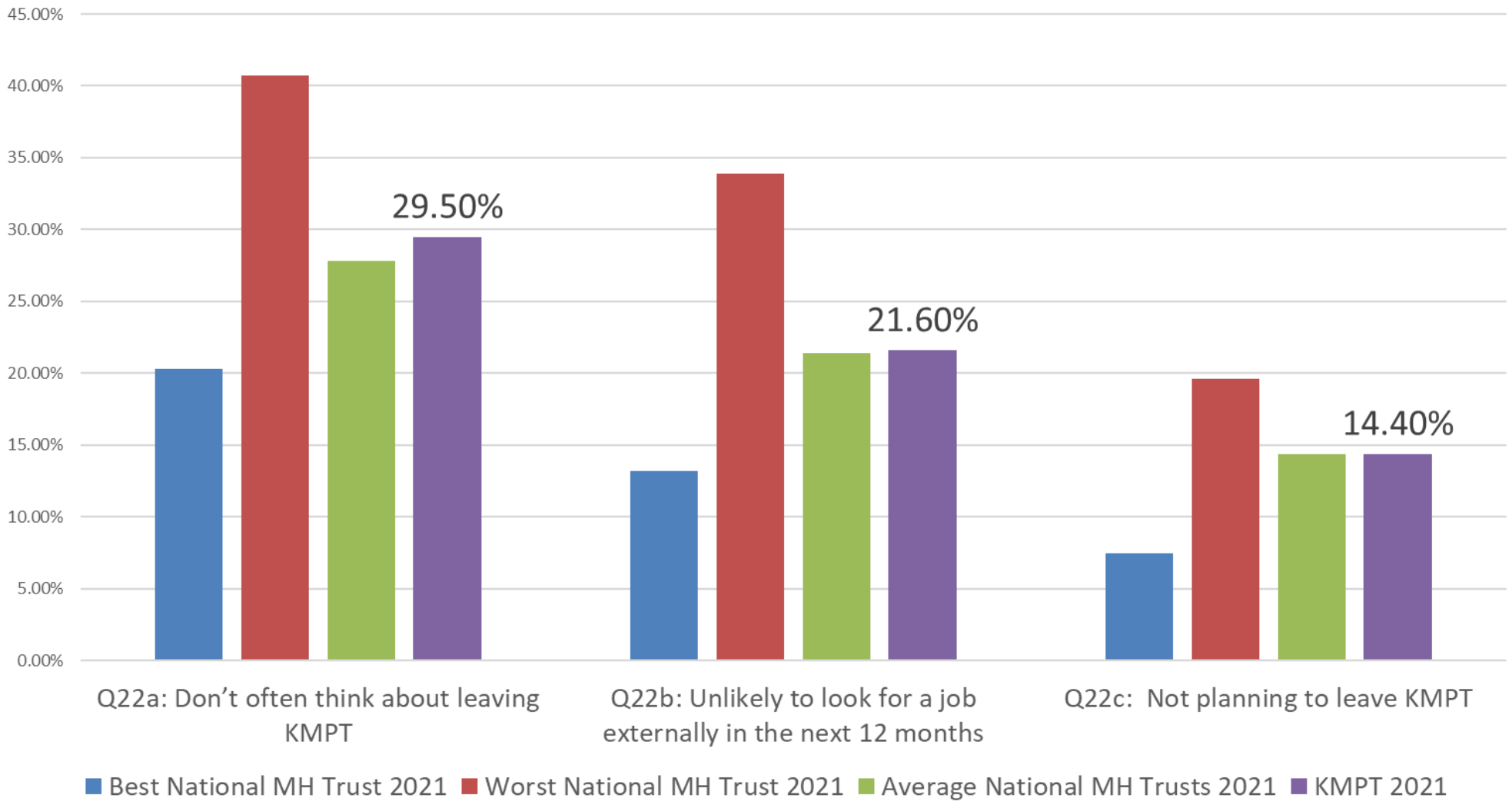
KMPT Staff Survey Retention Picture – National



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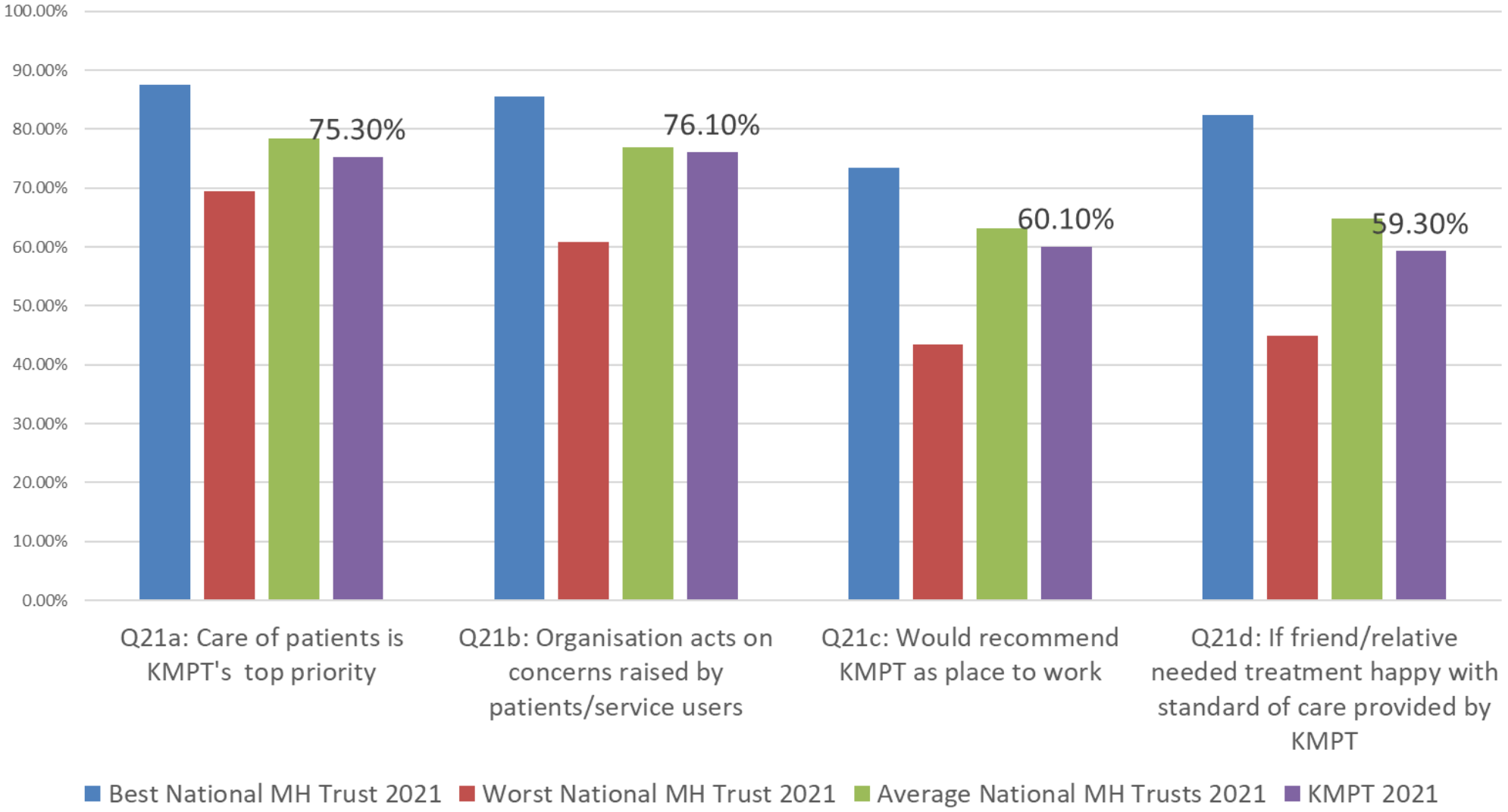
KMPT Brand management – National Picture



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KMPT Focus Areas-Making a Difference in 2022/3

We are compassionate and inclusive **Our people feel able to advocate for KMPT as a care provider and employer**	We are recognised and rewarded **Our people feel that their work is valued by the organisation**
We each have a voice that counts **Our people feel safe to speak up and involved in decision making affecting their work**	We are safe and healthy **Our people feel safe at work and that their wellbeing is a priority**

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Kent and Medway
NHS and Social Care Partnership Trust

COMMITTEE MEETING

Meeting details

Committee:	Trust Board
Date of Meeting:	May 2022
Title of Paper:	Establishment Review
Author:	Tumi Banda: Deputy Director of Nursing and Practice
Executive Director:	Andy Cruickshank: Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Committee:	Statutory

Overview of Paper

A paper setting out an establishment review, using the Mental Health Optimal Staffing Tool (MHOST).

Issues to bring to the Committee's attention

- There was adequate staffing for the acuity on the wards during review period
- The staffing levels have been adversely affected by increased number of delays of transfers of care
- The services are accepting patients outside the care pathways which is contributing to high usage of observations and posing challenges meeting the needs of those patients not on the appropriate pathway
- The PICU data from this review has been advisedly affected by the need to respond to a county wide challenge and it is not reflective of the care pathway
- The care groups since the last establishment review report to board in 2021 have worked on various initiatives that have seen reduction in acuity across all the care groups.
- The Care Groups have submitted plans to meet the financial efficiencies for the year 2022/23

Governance

Implications/Impact:	Vacancies and use of temporary staff can impact on quality of care, financial viability and quality of care.
Assurance	Reasonable
Oversight:	Oversight by Workforce and OD Committee

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1. Background and context

The annual inpatient establishment review is a statutory responsibility for the Chief Nursing Officer to complete on behalf of the Board.

The review complies with requirements set within the National Quality Board report (NQB) (2016); Supporting NHS providers to deliver right staff, with the right skills in the right place at the right time, set out the guidance focusing on the following principles right staff, right skills, right place and time.

Demonstrating sufficient staffing is one of the fundamental qualities and safety standards required to comply with the Care Quality Commission (CQC) regulation. CQC Regulation 18; “To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times”.

The Board was last presented with an establishment review in May 2021 using the Mental Health Optimal Staffing Tool (MHOST). The review has fully considered multi professional contributions to inpatient care settings across all care groups.

The review provides assurance to the Board that the staffing establishments utilised in inpatient settings are safe and adequate. Using the MHOST the review is a continuation of the review by the Chief Nurse and Deputy Director of Nursing and Practice to ensure that resources are optimised and comparing to MHOST benchmark wards and data collected in May 2021. The Covid19 pandemic had an effect on establishments in both collection periods therefore the two data collection periods are safely comparable. Opportunities for financial efficiencies have been identified and agreed with the care groups. The efficiencies identified will be led by the Deputy Executives in the pillar approach. Efficiency from the MHOST are set at £2m for 2022/23 and various strands of initiatives are underway to deliver with the care groups.

2. Methodology

Overview of the evidence-based establishment review tool

The establishments were reviewed using the MHOST this is the second time the tool has been used in the Trust. In 2021 the data was collected over 21 days in March and April 2021. In 2022 the data was collected over a 21-day period from 24 January and 13 February 2022.

The MHOST provides a view into the establishments over the collection period in this case 21 days. This does not consider overnight leave, and long periods of patient leave, variations in environment that may need to be mitigated by extra staff. Each Trust and care setting can set its own base of establishments, in KMPT the establishments are guided by the In-patient Establishment Review Guiding Principles set out by the Chief Nurse. The clinicians can exercise clinical judgement to mitigate any potential risk.

3. Deployment of tool and data collection

The collection of the data was supervised by the ward manager of each unit/ward. Wards were provided with the guidance and the data collection tool. There was sufficient knowledge in the teams on how to collect the data. The Heads of Nursing and Matrons monitored the collection of the data. The review was led by the Deputy Director of Nursing and Practice.

The guidance sets out the criteria for acuity levels 1-5 specifically designated for their service, with 1 being the lowest level of dependency and 5 the highest. The staff could use professional judgment in deciding the most appropriate level of acuity. Staff collecting acuity and dependency data must have had an insight

into the patient's current care needs and clinical presentation within the last 24 hours and not just how the patient presented at the point of collection at 3pm.

Data was collected over a period of 21 days from 24 January to 13 February 2022. The data was collected at 3pm on each unit/ward. Patients on extended leave more than 4 hours were not included. If they were on overnight leave, they were discounted. Long periods of escorted leave are already included in MHOST tool, they were not added separately.

The headroom in the Trust varies, in Acute Care Group is 23% and the other groups have 21%. The recommended headroom in the MHOST tool is not less than 22%. The head room remained unchanged from 2021.

The Ready for Action (RfA) time is the percentage of time allocated to a staff member for their breaks. Time is set in the MHOST for the particular ward type, ranges between 8.6%-9.1% depending on the type of ward being analysed. This has been set at 8.3% for this review.

The data processing was done by the Head of Nursing from Acute Care Group and Deputy Director of Nursing. The initial results were shared with the Senior Management Teams (SMT) of the care groups. The Deputy Chief Operating Officers also joined the meetings. The SMTs of the care groups are multidisciplinary teams. The findings were shared in the care groups and discussions were had on the interpretation of the results and next steps agreed per care group which will be discussed in the report. The care groups have been using the feedback from the MHOST to input into budget setting meetings to ensure financial viability and financial efficiencies for the year 2022/23.

4. Results

Community Recovery Care Group (CRCG)

The data was received from all 6 rehab units. There was reported low acuity in this data collection period similar to the last collection period in March-April 2021. Rosebud and the Grove had marginally higher acuity with patient recorded in acuity Level 3, Rosebud 2.29 and The Grove at 1.71 only the Grove had acuity Level recorded at 0.14 during the 21-day collection period. The acuity remains low compared to the MHOST control wards.

The low acuity in the rehabilitation units may have been affected by delayed discharges which would have been rated as Level 1 or 2. Delays that were reported in the first year of the pandemic continues to affect discharges and there were 4 Delay Transfer of Care (DTOC) at the time of the data collection. There is monitoring of the delays in the care group and escalations have been made in the Trust and across the Kent and Medway System.

Although the acuity was low compared to the MHOST control wards, the rehab units in the trust utilised mores staffing resources. Each unit used at least double the recommended care hours per patient per day (CHPPD), Rivendell utilised 4.7 times over the recommended CHPPD, New Haven Lodge utilised 3.2 time over and 11 Ethelbert Road used 3.3 times over.

One of the contributing factors is that all of the units were operating under their bed capacity during the data collection period. There are 53 beds in the 6 units, 40 beds were occupied during the collection period. The SMT acknowledges that this was not dissimilar to times outside the data collection period. Whilst the bed occupancy was reduced staffing levels were not varied to reflect the reduction in occupancy. Some of the limitations are the requirements to maintain minimum safe staffing levels.

5 Forensics and Specialist Care Group

5.1 Rosewood Mother and Baby Unit (MBU)

Mother and Baby Unit staffing levels are predetermined by Royal College of Psychiatry: Service Standards for Mother and Baby Units (2014) and NHSE/I. The multi-disciplinary team (MDT) staffing levels are not varied according to acuity, there set in the standards. Other needs such as enhanced observations are met by increased staffing level. Rosewood is operating within this guidance and is compliant with the standards.

Acuity remains a lower than that of MHOST wards. There were no patients assessed to be at Level 4 or 5. Services has seen disruptions to discharges similar to 2021 due to the on-going pandemic. The ward had a Covid19 outbreak during the collection period that started on 06 February 2022, there were restrictions on transfers and discharges till 14 February, which affected the rest of the collection period.

The increased FTE also includes support for the babies in the unit, staffing may be increased to look after the babies even though the mother is on level 1 acuity. Care for the mother and baby are individually assessed and support is put in accordingly. On the unit the MDT was aware of the Trust staffing and Royal College of Psychiatry guidance and followed both.

5.2 Medium Secure Unit (MSU)

The Acuity on the MSU was reduced during this period of data collection compared to the 2021 data collection. The data from all the wards showed reduced acuity levels and majority of the patients were in acuity level 3. The establishments of the wards were safe and adequate. The wards are yet to be refurbished and professional judgement is required to mitigate some of the challenges posed by the environment.

It is notable that although there has been a reduction in acuity in the wards the staffing levels which include additional staff booked remain unchanged. Penshurst had 70.9 FTE in 2021 and 70.5 in 2022 despite a significant reduction in acuity. On Walmer although acuity reduced FTE in 2022 was 56 compared to 56.4 in 2021. There were no significant changes in FTE on Groombridge 30 FTE in 2022 compared to 30.3 in 2021, Emmetts had no significant reduction in staffing used despite reduction in acuity 2022 FTE was 49.3 compared to 50.1 in 2021.

MHOST recommends that staffing should respond to acuity. The staffing levels do not seem to be reducing when acuity reduces which points at culture and practice of staff booking rather than response to patients needs and acuity levels.

The care group is utilising advanced practitioners and has two Multi-professional Responsible Clinicians in post and 1 Advanced Clinical Practitioner in training and Trainee Advanced Clinical Practitioner. These roles are adding to the broad expertise in the teams**.**

5.3 Forensic Rehabilitation: Low Secure Units

All wards in the Care group apart from Bridge House submitted their data. Bridge House as a substance misuse rehabilitation specialist unit was not included in the MHOST data collection because the tool is not validated to be used in this setting.

In 2022 the acuity was notably reduced on Brookfield with all the patients in acuity 1, in 2021 data collection there were patients in acuity levels 1, 2 and 3. Allington had no patients in level 4 compared to 4.05 in 2021. There was reduction in acuity in the low secure services recorded, compared to 2021, however the service is still adversely affected by a number of patients that are being cared for in the services that should be on a different care pathway. This has affected Allington mainly in this data collection, the patients have been admitted outside the service criteria and they have to be nursed on enhanced observations. At the time of the data collection 3 patients were deemed to be outside the service criteria but admitted to Allington because of unavailability of Autism and specialist services in the region and nationally. One of the patients was being nursed on 3:1 and the other on 2:1.

The Low Secure Services working with Kent, Surrey and Sussex Collaborative need to work with the admission criteria to ensure that care is safe and delivered within the allocated resources. There are challenges that the services and collaborative need to consider which are high number of staff from enhanced observations and patients in a limited space adversely affects recovery in this care setting

Although Brookfield had reduced acuity the staffing levels remained unchanged and it was 3.8 times over the recommended staffing.

Tarentfort used the same amount of staff 75.2 from 2021. The staffing levels were still above the recommended levels by 2.8 times.

The care group is affected by admitting patients not appropriate for their pathway which affect the staffing levels. There is also a need for the staffing levels to correspond to acuity levels.

6. Admin support Service in Forensic and Specialist Service

The Admin staff are not included in the MHOST establishments review as they are not clinical staff. However, the review can extend to hear from clinicians how they can be supported to deliver safe and effective care. Clinical staff have raised concerns that whilst they are working on their clinical duties they have limited or no admin support on the wards. The establishment review has found that all the wards in Forensic and Specialists Care Group have resources allocated for admin support. The support varies in the hours and time allocated, on average each ward is allocated

Clinical staff note some of the tasks taking them away from clinical duties, include ordering and chasing ward supplies, reporting and chasing faults and repairs, arranging meetings and sending invites some of which take considerable time to do.

These findings have been shared with Forensic SMT and it has been recommended that SMT review the resources and function of the admin staff in the care group.

7. Older Adults Care Group (OACG)

Acuity

Acuity in the Older Adult care group remains high compare to the MHOST wards. The Older Adult wards have a mixed model of organic and none organic illnesses. There are no specialist dementia wards. The acuity fell from 2021. All though each ward had patients in level 5 acuity the number of patients in this acuity group reduced. Sevenscore had 6.52 in 2021 compared to 3.67 in 2022. At the time of data collection Orchards was transitioning and was not using all the capacity after a period of

refurbishment. Jasmine also saw a reduction in acuity from 4.33 to 1.86 in level 5 acuity. Heather Ward had 0 level 5 in 2021 which increased to 2.05 in 2022.

The care group has been adversely affected by delays in transfers of care with 19 cases on average during the period of data collection. The DTOC cases were of different levels of acuity, due to the needs of the patients some needed enhanced observations whilst awaiting appropriate placement. The delays ranged from 56 to 210 days most of which were social care. Work is underway to improve on this as care system in the county.

The staff establishments are adequate and safe. Staff is higher than recommended levels this due to the need for professional judgment were the wards are standalone units, increased staffing levels are required to be able to respond to medical emergencies and there are no opportunities to cross cover with other wards. Only Orchards and Heather have the opportunity to share responses with other wards that they are on the same unit with.

The staffing levels have been distorted by high levels of DToC cases, the care group needs this reduced to set effective establishments. The staffing levels are also affected by the number of patients on enhanced observations at any given time, this intervention required extra staff to be booked. Reducing observations may reduce the amount of staff required.

8. Acute Care Group

8.1 Psychiatric Intensive Care Unit (PICU): Willow Suite

Acuity

Willow Suite collected data using the MHOST tool during the same period as the other wards however from 01 February 2022 the ward had to take an admission of a patient on the Autism and Learning Disability pathway as part of the Kent and Medway System response. The patient has been on 5:1 being nursed in the seclusion area. A placement is still being sort at the time of writing this report. When Willow Suite admitted the patient, it was agreed that PICU admissions will be diverted to the private sector with agreement of the CCG and the bed capacity has been reduced to not more than 8 at the time of the data collection.

The male PICU pathway has been distorted from its usual flow and the data for the PICU does not reflect the usual function and use of staffing in the service. Patients that need seclusion cannot be admitted to Willow at present, the facility is not available. Covid19 Outbreak from 31 January 2022, restrictions were in place on admissions and transfers as part of infection control outbreak management plan for the rest of the data collection period.

When an appropriate placement has been found for the patient and the pathway is restored to its usual function, it is recommended that the MHOST data to be repeated on the ward separately before the next trust wide review.

8.2 Acute wards

All the nine acute wards had high acuity levels compared to the MHOST benchmark wards. Foxglove had high number of patients on level 1 acuity (10.3), this was similar trend to 2021 when the ward had 6.67 in acuity level 1. There was a reduction in acuity from 2021 in acuity level 5 across the service. Boughton had the highest level with 1.6 in 2022 compared to Cherrywood in 2021 which had 3.43. Upnor recorded

high acuity in acuity level 4 with 7.8. The care group has been working on various initiatives using QI methodology to reduce violence and aggression, menu of interventions and actively recruiting to vacancies which has contributing to reduction in acuity.

It has been highlighted by the care group that it has been affected by the limitation of the PICU beds to accommodate the patient admitted there in February on the Learning Disability and Autism pathway. There have been delays in getting male PICU as beds have to be sort out of the Trust and take more time or may not be found. This may have given rise to acuity on the wards with a marked impact on Boughton ward which is a male ward. Boughton had increased acuity in level 5 compared to the previous data collection period, 1 in 2021 to 1.6 in 2022.

The DTOC report from 10 February 2022 noted 28 DTOC patients on the wards at the time of data collection. 24 were on the acute wards, 4 were on Older Adult wards. Fern ward had the highest number of DTOC cases with 7 and Pinewood ward had 4.

There are 5 vacancies in psychology in the care group, 4 of these have been recruited awaiting to start subject to pre-employment checks. The remaining vacancy is actively being recruited to.

The care group is utilising advanced clinical practitioners (ACPs) as well as developing new ones in training programmes. There are 5 Trainee Advanced clinical Practitioners in the wards that provide clinical care, 3 ACPs and 1 consultant nurse. The care group now has a multi-professional Responsible Clinician at Priority House and the care group is skill mixing to meet the recruitment challenges across all the disciplines.

Staffing levels in ACG remains higher than the MHOST benchmark wards. The changes to operational arrangements in the PICU have had an impact on observations and delays in PICU for male patients that would have been admitted to a PICU, some of these patients have been directed to Boughton ward, whilst awaiting a PICU bed.

9. Covid19 Pandemic

The Covid19 pandemic continues to impact on the services in various ways such as delaying transfers and discharges, conflict and delay in recovery.

An outbreak is declared when there are two or more people that have tested positive to an infectious disease in this case Covid19. The ward works with Infection Control and Prevention Team to reduce the risk of spread with an outbreak plan. This includes limiting transfers and admission in and out of that ward. There are restrictions on visiting, off ward activities, leave and engagement programmes have to be adjusted accordingly. To ensure that the outbreak plan is implemented extra staff may be required, there were instances were patients refused to isolate which brought about conflict on those wards which needed extra staff to be booked. These restrictions were similar to those implemented in the last collection period in 2021.

At the time of the data collection there were 9 active Covid19 Outbreaks in the inpatient settings. In Older Adults there was an outbreak on Woodchurch, Forensic and Specialists there were outbreaks on Tarentfort and MBU. In Acute there were outbreaks on Willow, Cherrywood, Pinewood and Chartwell. All the wards were supported by Infection Prevention and Control Team and other support services to minimise restrictive practices. Outbreak were monitored by Silver Command and Tactical and concerns were addressed or escalated to minimise disruptions to services.

10. Roster Review

The Deputy Director of Human Resources and Organisational Development and Deputy Director of Nursing and Practice conduct a monthly check and challenge roster review that focuses on roster optimisation, rosters to be constructed on time and available to staff. The care groups have a bi-monthly check and challenge with the Deputy Director of Nursing and Practice in the Safe Care Steering Group. 12 weeks leading time on rosters is posing challenges to the staff and care groups, the target is being reached but the rosters are being changed considerably by the time they are utilised and this approach is no longer efficient. The Chief Nurse is now reviewing the lead time against national standards.

The rosters in the care groups when constructed on e-roster, do not include all members of the multi-disciplinary team. The rosters tend to only reflect the nursing complement. It is recommended that rosters include all disciplines that input on the wards going forward.

It has been identified that roster efficiencies need to deliver £0.3m in 2022/23. To deliver this the roster check and challenge is being strengthened. The following process will be in place. The ward managers, matrons/service managers in rehab led by the head of nursing will have a monthly check and challenge roster review each month reviewing 4 weeks worked, and 6 weeks ahead. The Heads of Nursing will report to the Deputy Director of Human Resource and Organisational Development, Deputy Director of Nursing and Practice and Head of Service of the care group. The Safe Care Steering Group chaired by the Deputy Director of Nursing and Practice will continue to meet bi-monthly and report to the Chief Nurse.

11. Financial Viability

The MHOST tool has been utilised in the Trust for two years for two establishment reviews. In both reviews it has been established that the services within the Trust operate above the recommended establishments which cannot be accounted for by professional judgement or accounting for environmental differences and challenges.

For NHS providers to deliver right staff, with the right skills in the right place at the right time, financial prudence is required. For this standard to be met and safeguard services and quality of care, financial viability must be achieved. To achieve this efficiency the following areas of cost reduction have been identified.

Area of Efficiency	Comments	Targeted Value for 2022/23 £000	Lead
Service Line Reporting: ➢Rota and MHOST review	Following the MHOST establishment review, opportunities have been highlighted in terms of reducing the staff resource in line with clinical need and acuity. This continues to be worked through ward by ward.	£1.2 m	Deputy Director of Nursing
Workforce: ➢Agency controls	Following the Medical review and reduction of agency locum placements this will be continued and extended to the Nursing staff group.	£1.15m	Deputy Chief Operation Officer

Version control: 1

Patient Pathways: ➢Psychology review	Full review of psychology posts particularly within the Forensic Care Group	£0.7m	Deputy Chief Operation Officer
Therapeutic Observations QI	This is a trust wide QI initiative that is looking at improving practice to reduce high usage of enhanced observations.	£0.5m	Deputy Director of Nursing
Roster Check and Challenge:	The rosters are being reviewed to ensure that staffing resources are optimised and minimise the usage of temporary staffing bank or agency	£0.3m	Deputy Director of Nursing

The care groups also have submitted plans that meet set of efficiencies as detailed below are achieved. There is support from The Deputy Exec's Group using the Pillar approach and there is periodic reporting to Executive Assurance Group on the delivery of the efficiencies.

12. Recommendations and Next Steps.

- The Chief Nurse will continue to use the MHOST for the annual establishment review, this will bring about consistency in the reviews and allow benchmarking in the review.
- Community Recovery Care Group Rehab units to review use of their establishments to reflect bed occupancy in the service and engage with other care group to promote the service and utilise the under-utilised bed capacity.
- The Trust to review gate keeping across the services to ensure that patients are cared for in the appropriate care pathway as required in National Quality Board report (NQB) (2016); Supporting NHS providers to deliver right staff, with the right skills in the right place at the right time.
- The Trust to main initiatives to reduce delayed transfers of care across all the care groups.
- The Roster Check and Challenge process of Rosters to be strengthened to ensure that staffing resources are optimised and respond to patient and service needs and not unit cultures.
- All staff disciplines to be included on ward or unit rosters by the end of 2022/23 fiscal year.
- There is a continued need to respond to the Covid19 pandemic as services strive to return to pre-pandemic operations, staff and the services to be supported with adequate staffing to respond to the challenges of the on going pandemic.
- The care groups and Deputy Executives to work to the agreed efficiency plans to realise the set financial efficiencies.
- It is that recommended that SMT in forensic services review the resources and function of the admin staff in the care group
- When an appropriate placement has been found for the patient on PICU and the pathway is restored to its usual function, the MHOST review to be repeated.

13. Conclusion

The MHOST review and quality data evidences that the staff have been able to deliver safer staffing, meeting the required standards across all care groups, despite the challenges posed by the Covid-19 Pandemic**.**

The care groups have worked on various initiatives to reduce acuity on the wards. Although this has been successful there is still high usage of staffing above the recommended levels. This needs to be addressed and there are financial efficiencies targets that have been set out to be achieved by the end of the fiscal year 2022/2023.

Version control: 1

13. Recommendation

The board to note that the statutory requirements for establishment reviews are being met in the Trust and endorse the direction of travel with MHOST review and efficiencies required in the fiscal year ahead.

Version control: 1

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26 May 2022**
Title	**Quality Committee Report**
Author	**Siobhan Shardlow-Wrest, Executive Assistant**
Presenter	**Catherine Walker, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- CMHT Skills Mix – the Committee noted concerns around progress and timeframes of the CMHT skill mix review. Assurance was provided that a demand and capacity planning exercise is underway, with a mapping focus over the next year. Oversight will be provided from the programme board ahead of reporting to Committees once item is more mature. Assurance was provided that this item has been discussed at Exec level, with agreement that verbal escalation to trust board is required to ensure board is sighted.
- DTOC remains an area of concern as does increasing referrals/wait for treatment across services. Caseloads in Community are rising. The COO will give a verbal update to May Board.
- E-Meds - The Committee noted E-Meds is now live on Rivendell, with further Rehab and Acute services to be rolled out in due course, with positive progress noted.
- It was reported that medication incident reporting is back to the pre-pandemic level, however some concerns were discussed around fridge temperatures for medications having occasionally exceeded the maximum temperature. Assurance was provided that this is being monitored, and air conditioning will be implemented in remaining areas (Swale and The Grove).
- The Committee discussed the Research Strategy, and associated benefits of achieving a university teaching status, with assurance that this is a realistic aim and a great opportunity for KMPT. The Committee briefly discussed workforce implications with agreement to refer the Strategy to Workforce Committee. The Chair advised that the ambition of the trust will be to use existing funds to make this cost neutral in year with the additional forward expectation of being fully self-funding by 2027. A business case will come in due course to FPC. The Committee agreed to recommend for approval by trust board.

Items referred to other Committees (incl. reasons why)

- The Committee noted that Autism Awareness training work is progressing, under a delivery agreement with SLAM. Committee agreed to ask George Matuska to give an update at the July Committee, cross referenced to the Workforce Committee for oversight of implementation.
- The Committee discussed workforce issues implicit in the Research Strategy, with agreement to refer that Strategy in due course to Workforce Committee.

The Quality Committee was held on 18 May 2022. The following items were discussed and scrutinised as part of the meeting:

1. Quality Impact Assessments
2. Quality Risk Register
3. Quality Digest
4. Quality Account

5. Strategic Delivery Plan Priorities 2021/22 Review
6. Operational Hot Spots
7. Serious Incidents Report
8. Mortality Report – Q4
9. Research Strategy
10. Trustwide Patient Safety and Mortality Review Group Terms of Reference and Work Plan

The Board is asked to:

1) Note the content of this report.

Mortality Report – Q4 2021/22

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

2.1 The Trust Wide Serious Incident and Mortality Review Panel (TWSIMRP) continues to meet twice a week to review all mortality incidents reported on Datix. The membership has been consistent and includes Care Group SI leads, Information Governance, medical input and subject matter experts as necessary.

2.2 Mortality incidents are further scrutinised by the Mortality Review manager, to allow analysis across the Trust and identification of themes and trends.

3 ANALYSIS OF INFORMATION

3.1 In Q4, a total of 470 mortality incidents were reported on Datix. The graph (1) below shows the figures relating to mortality that have been reported since January 2021. This includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality have noticeably increased in Q4. When data is compared to the Q3 Mortality Report, there has been a 52% increase in mortality reported incidents (308 reported in Q3 2021/22). The explanation for this could be due to the number of Datix Death Notifications reported in Q4, which totalled at 167. This is part of the data reconciliation work, carried out by the Datix team.

3.2 The number of COVID–19 deaths has again remained low in Q4, with a total of ten reported. The number of STEIS reported mortality incidents in Q4 2021/22 was 14. This compares to 13 in Q3 2021/22. Older Adult Services have seen a slight increase in STEIS reported mortality incidents, with a total of four, compared to two in Q3. Acute and Community Recovery Services have seen no change in the number of STEIS reported mortality incidents, when compared to the previous quarter, as detailed in graphs three and four.

3.3 As previously highlighted to the Board, the figures will continue to fluctuate depending on the timing of updating patients' records on the national spine by General Practitioners. The vast majority of these incidents were reported by Older Adults' community teams and would have been people who had previous contact with community teams and from areas in the county with a high proportion of older people and also with more nursing or residential homes. As shown in graph 5, the number of mortalities in older adult patients is consistently higher than any other service.

3.4 Whilst the cases are reported as a death of the patient, it does not mean that the death was attributable to the organisation or that there were care or service delivery concerns. They are reported to enable a review by the Serious Incident and Mortality Panel to assure the organisation and external bodies, including families as necessary, that there were no contributory factors relating to the death of the patient. In the event that any additional learning points are identified, the individual incidents are reviewed and action

is taken to prevent reoccurrence. This can include further review in the form of a Structured Judgement Review or a Root Cause Analysis/Learning Review.

Graph 1 Mortality reported cases

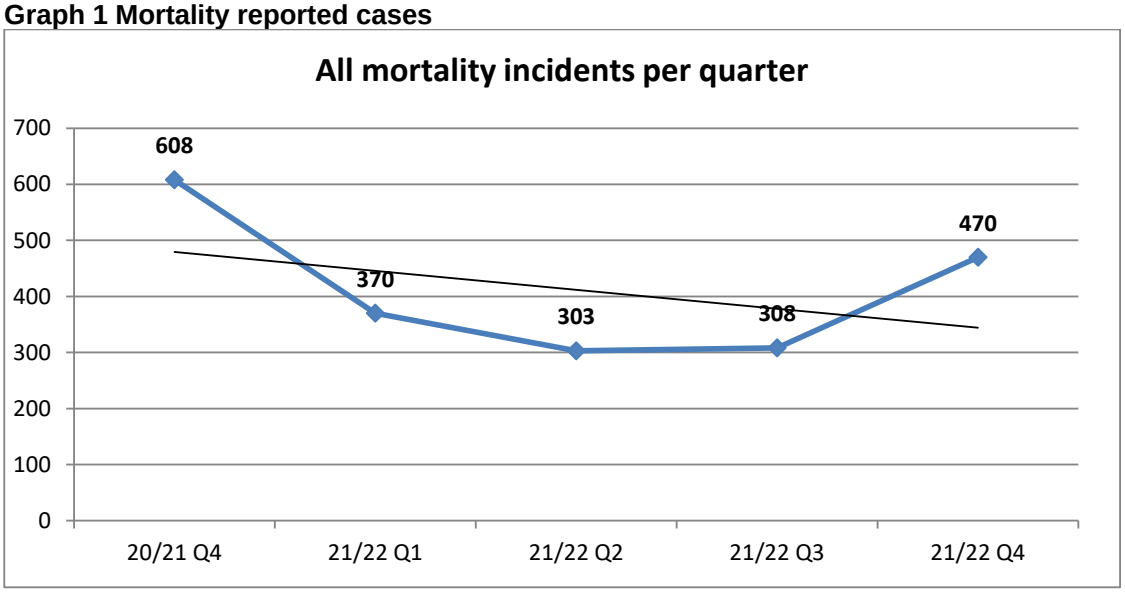


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Mar-21	Apr-21	May -21	Jun-21	Jul-21	Aug -21	Sep -21	Oct-21	Nov -21	Dec -21	Jan-22	Feb -22	Mar -22	Total
Suicide (actual)	1	2	5	5	2	3	2	2	3	0	1	3	2	31
All Deaths reported on Datix	155	150	75	146	75	122	107	91	97	120	174	152	144	1609

3.5 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q4, 1.8% of deaths of patients are suicide or suspected suicide related. This compares to 1.6% reported in the previous quarter. The average number of deaths for the 13 months above was 124 per month. For this quarter (Q4), there was an average of 157 per month. This is an increase of 55 compared to the previous quarter, where there was an average of 102 per month in Q3 2021/22.

3.6 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services were the highest reporters. In Q4 2021/22, the number of suspected suicide incidents marginally increased, with a total of six compared to five in Q3 2021/22. Table 1 shows that the number of suspected/confirmed suicides was at its highest in Q1 2021/22, with a total of 12 suspected suicides reported. There were no suspected suicides reported by Forensic and Specialist Services over the course of the financial year.

3.7 Of the six suspected or confirmed suicide incidents reported in Q4 2021/22, three were for patients under Community Recovery services at the time of their death, two patients under Older Adult Services, and one patient under Acute Services (the Crisis Team). The three suspected/confirmed suicides reported within the Community Recovery Care Group relate to different teams, whereas the two suspected/confirmed suicides reported

within the Older Adult Care Group, relate to the same team. Only one of the Older Adult suspected suicide cases has been STEIS reported as a serious incident. The case that was not STEIS reported was reviewed in the Trust wide SI and Mortality Panel where no gaps in care were identified. The incident was however initially linked to a domestic incident involving a younger adult KMPT patient, where violence occurred. As the incident relating to the younger patient is not a mortality, it has not been included in this part of the report, however has been included in a separate review of homicide and violent incidents (Appendix one)

3.8 Analysis by age and gender

Table 2 and 3, below, show all deaths recorded on Datix by age and gender

Age Band	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
100+	1	5	2	1	1	**10**
90-99	97	61	47	42	72	**319**
80-89	255	121	102	103	179	**760**
70 to 79	124	74	58	62	101	**419**
60 to 69	49	33	28	26	30	**166**
50 to 59	31	31	28	30	28	**148**
40 to 49	24	20	21	23	31	**119**
30 to 39	18	17	8	13	15	**71**
20 to 29	5	8	9	5	12	**40**
10 to 19	1	0	0	3	1	**5**
Unknown	3	0	0	0	0	**3**
Total	**608**	**370**	**303**	**308**	**470**	**2059**

Table 3 Deaths reported on Datix by gender and age

	100+	90-99	80-89	70-79	60-69	50-59	40-49	30-39	20-29	10-19	Total
Male	0	25	76	59	19	15	21	9	7	1	232
Female	1	47	103	42	11	13	10	6	5	0	238

Table 4 COVID-19 deaths by gender

	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Total
Female	5	0	0	1	0	0	0	2	2	2	4	2	0	181
Male	5	1	2	0	0	2	3	3	1	1	1	1	2	204
Total	10	1	2	1	0	2	3	5	3	3	5	3	2	385

3.8.1 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age, residing in residential or nursing homes and presenting with co-morbidities. In Q4 there have been six older adult incidents where the criteria for Structured Judgement Review was met. Five incidents met the criteria due to their diagnosis and one incident was due to family concerns raised about the care provided, prior to the patient's death. These are currently in the process of a review.

3.8.2 We continue to see low numbers of mortality from COVID-19. A total of 10 COVID-19 deaths occurred in Q4 2021/22. The figures will continue to be monitored over the coming months.

3.8.3 When data is analysed for reported deaths within KMPT according to gender, indications are that figures of all mortality in men are usually higher than in women. The number of deaths of females in Q4 was slightly higher than males. The Q4 2021/22 data shows that the vast majority of patient deaths was due to natural causes, including deaths of patients living in a care home or nursing home, and of patients who died in an acute hospital, unrelated to their mental health condition. The overall figures of mortality are higher in older adults, with 78% of the total mortality incidents reported in Q4 2021/22 relating to patients over the age of 65.

3.8.4 There is one mortality incident that relates to a patient under the age of 20 years old. This is a decrease of two compared to Q3. From a brief review of the incident, the case related to a 19 year old male, with a diagnosis of autism and complex PTSD. The incident was reviewed in the Trust-wide Serious Incident and Mortality Panel with expert advice from the executive team and Learning Disability leads, where no care or service delivery issues were identified. A separate STEIS reported themed review is currently underway, which will include this incident, to look at the commissioning of services for patients with a learning disability and autism. The review will include three separate cases, involving patients who had a diagnosis of a learning disability or autism.

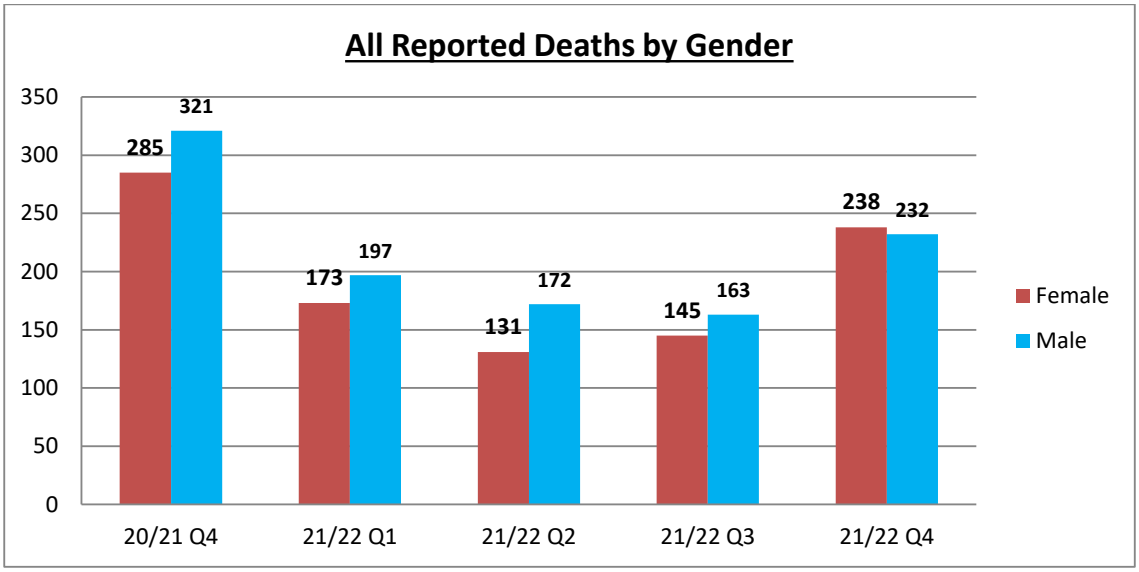
3.8.5 As the overall figures of mortality have increased in Q4, it is to be expected that the mortality figures for each age category would have also increased, particularly for patients under the care of the Older Adult Services, as demonstrated in Table 2. As mentioned previously, this is likely to be as a result of the retrospective reporting of mortality. It is worth recognising that in Q4, there has been an increase in younger adult mortality, specifically age categories, 40-49, 30-39 and 29-29, (As highlighted in Table 2). Of the 59 mortality incidents relating to patients between the ages of 20 to 49, eight have been STEIS reported as a serious incident. Seven incidents have been reported as retrospective deaths, as part of the data reconciliation work. 32 cases were reported to KMPT legal services by HM Coroner. Overall, a large proportion of mortality incidents within these age categories are unexpected deaths.

3.8.6 Death of females aged 20-29 has fluctuated over the financial year, but indicates that there has been an increase in Q4 2021/22:

Q1 2021/22	1
Q2 2021/22	2
Q3 2021/22	1
Q4 2021/22	5

3.8.7 It would be useful monitor this over the coming months, and to consider exploring the increase in more detail, by way of a themed review to understand if there are any emerging themes or areas of concern to consider.

Graph 2 All reported mortality incidents within KMPT by gender of patients



3.8.8 In Q4, the six cases of suspected suicide by age and gender were as follows in table 5.

Table 5 Suspected suicides by age and gender

Age	Male	Female
10 – 19 years	-	-
20 – 29 years	2	-
30 – 39 years	-	-
40 – 49 years	-	2
50 – 59 years	-	-
60 – 69 years	2	-
70 – 79 years	-	-
80 – 89 years	-	-
90 – 99 years	-	-

3.8.9 National data has previously stated that middle-aged males (between the ages of 40 to 54 years) are at a higher risk of death by suicide, although recognised that suicide occurs in all ages and genders (NCiSH data). In Q4 2021/22, a total of six suspected/confirmed suicides were reported, four male patients and two females. Over the course of the financial year, there were no suicides reported for males aged 40-49. The Q4 mortality report represents a different picture to that of the national data, as shown in Table 5. From a brief review of the two suicide incidents for females in their forties, one patient is believed to have died from hanging and another believed to have died from an overdose, although this is unconfirmed at this stage. There were no male patients between the ages of 40 and 54 who died from suicide in Q4, contradictory to the picture as presented by NCiSH.

3.8.10 The number of suspected suicides reported in Q4 2021/22 has slightly increased, with a total of six reported, compared to five in Q3 2021/22.

3.8.11 KMPT is continuing to participate in a study for The National Confidential Inquiry into Suicide and Homicide (NCiSH), by providing real time data for patients who have died from suspected or confirmed suicide. The information provided is in the form of a questionnaire and will help to understand the rates of suicide nationally during the COVID-19 pandemic. NCiSH have recently notified KMPT that the study has been extended until 2024 and KMPT will continue to participate in this.

3.9 Mortality review by ethnicity
Table 6 Deaths by ethnicity

	20/21 Q4	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	Total
Bangladeshi	1	0	0	0	0	1
Black African	1	2	0	0	1	4
Black Caribbean	0	0	0	0	1	1
Chinese	0	1	0	0	0	1
Indian	3	1	0	1	2	7
Mixed white and Asian	1	0	1	1	1	4
Mixed white and black African	1	0	0	0	0	1
Mixed white and black Caribbean	1	2	0	0	1	4
Not stated	49	33	24	42	50	198
Other Asian	3	1	1	4	1	10
Other Mixed	2	0	1	0	1	4
Other ethnic category	2	0	1	2	1	6
Pakistani	0	0	0	0	0	0
White - British	528	324	269	248	403	1773
White - Irish	4	1	1	0	2	8
White - other white	10	5	5	10	6	36
Unknown	2	0	0	0	0	2
Total	608	370	303	308	470	2059

3.9.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British. On reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were seven in Q4 2021/22, compared to six in Q4 2021/22. Of the BAME deaths in Q4 2021/22, two incidents were reported to KMPT legal services by the Coroner. Two incidents were retrospectively reported as part of the data reconciliation work. Five of the seven incidents have been downgraded in the Serious Incident and Mortality Panel, following a review of the care provided. One incident remains in panel, awaiting a cause of death.

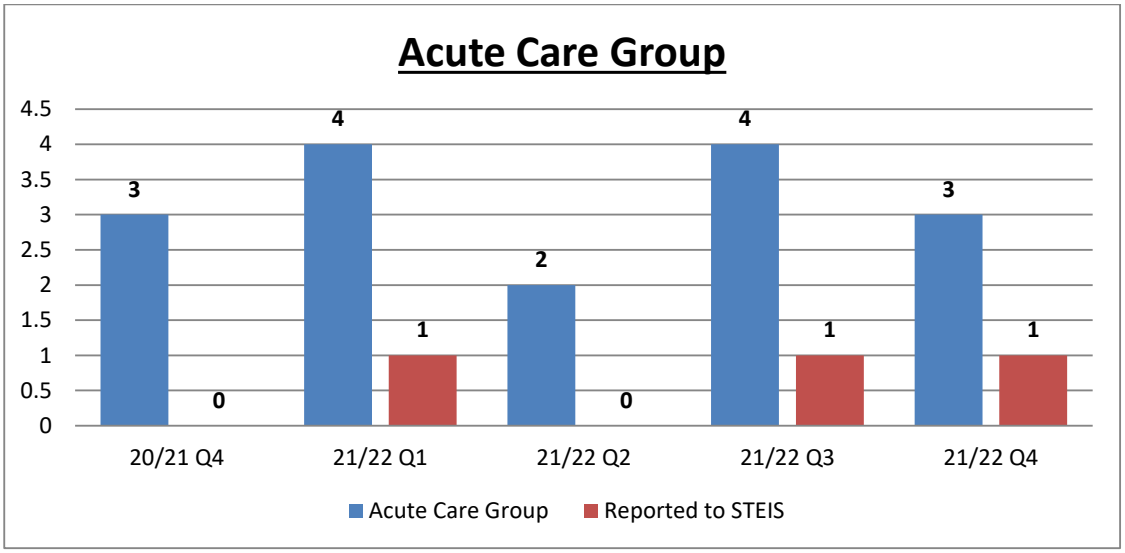
3.9.2 One of the BAME deaths, relating to a female of Black Caribbean ethnicity has been STEIS reported, due to gaps in care relating to 72-hour follow up and physical health management.

3.9.3 Of the 470 incidents reported on Datix during Q4, 10.6% had no ethnicity recorded compared to 13.6% in Q3. This appears to be a slight improvement. There are a number of reasons why ethnicity may not be not recorded; this could be due to some patients declining to provide their ethnicity, or where there are gaps in the administrative processes for recording ethnicity.

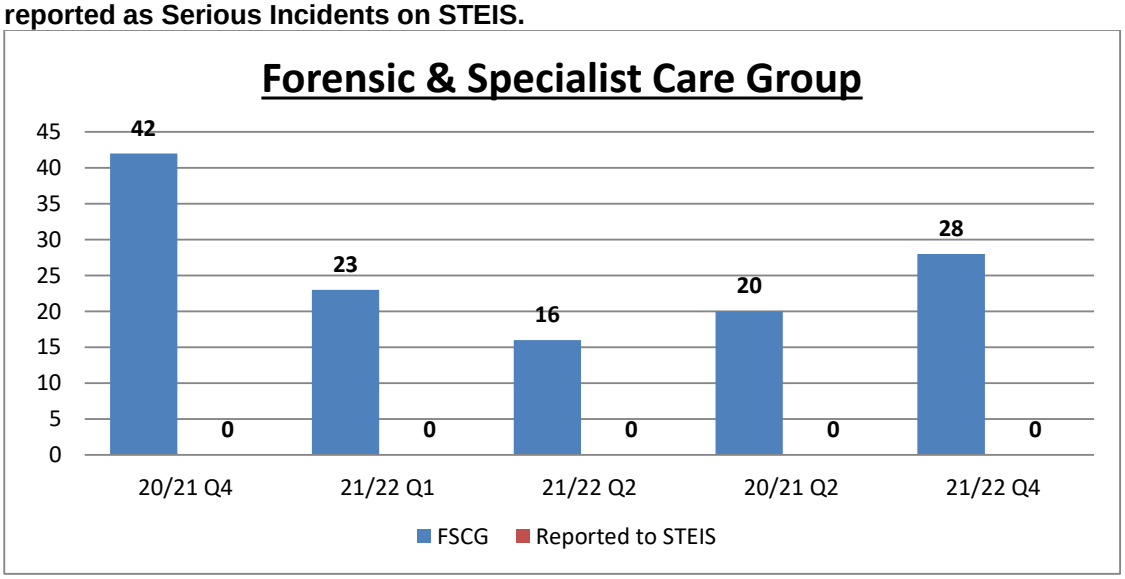
4 Serious Incidents and LeDeR cases

4.1 The following graphs (3 to 6) show the mortality incidents reported for the period 01/01/2021 to 31/03/2022 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

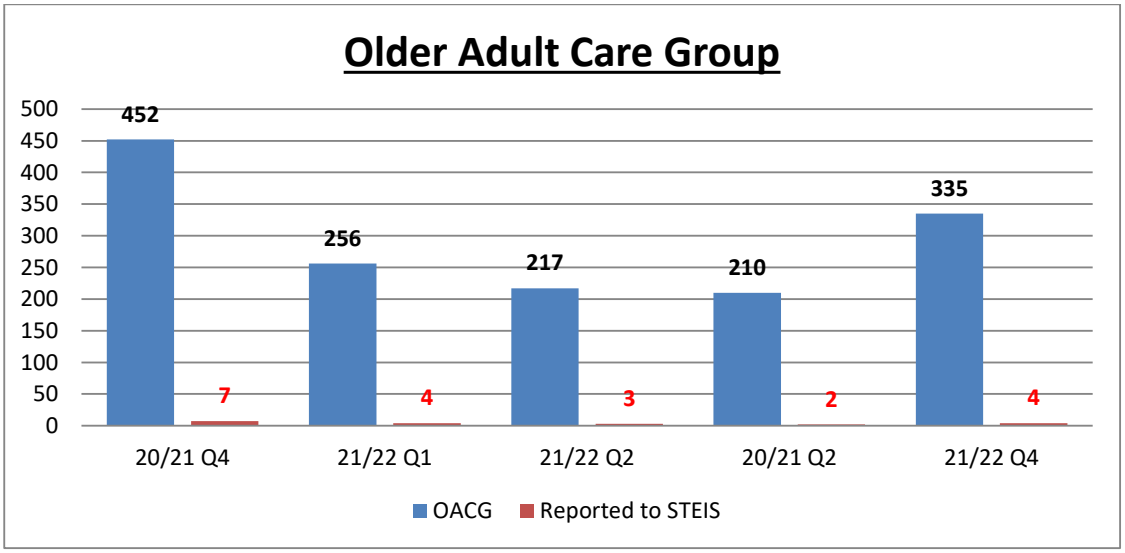
Graph 3 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.



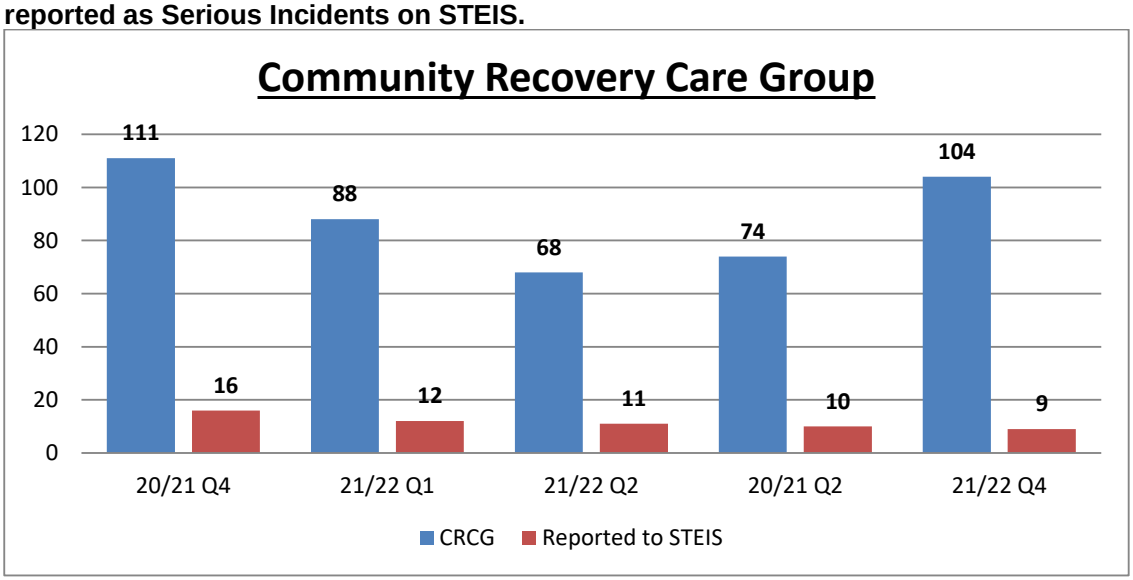
Graph 4 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.



Graph 5 Mortality by Older Adult Care Group and numbers of those reported as Serious Incidents on STEIS.



Graph 6 Mortality by Community Recovery Care Group and numbers of those reported as Serious Incidents on STEIS.



4.2 A total of 14 mortality serious incidents were reported in Q4, whereas there were 13 in Q3. The percentage of serious incidents compared to overall mortality in Q4 is 3%, this compares to 4.2% in Q3. Although the number of STEIS reported incidents has slightly risen in Q4, the ratio of overall incidents to STEIS referral has reduced. Older adults STEIS reported incidents increased in Q4 with a total of four, compared to two in the previous quarter. Two of the older adult serious incidents relate to the same team, but highlight different gaps in care.

4.3 Community Recovery Services saw a slight reduction in the number of STEIS reported mortality incidents between Q3 and Q4, and has reported similar numbers throughout the financial year, with the exception of Q4 2020/21. It is however important to note that Community Recovery Services did report a domestic homicide in February 2022. This incident has not been included in the mortality figures as the patient is the alleged perpetrator and the victim was not known to mental health services. Forensic and Specialist Care Group has reported no mortality serious incidents throughout the financial year, as shown in Graph 4.

4.4 On review of the 14 Serious Incidents relating to mortality that were reported on STEIS in Q4, five relate to suspected suicide and are in the stages of investigation. Some of the remaining serious incidents relate to mortality where cause of death may not be known but where care and service delivery problems have been identified that may have contributed to the patient's death.

4.5 Two of the STEIS reported mortality incidents are for patients who were detained under the Mental Health Act at the time of their death (Section 3). One patient died on an older adult ward following a rapid decline in their physical health, another younger adult female patient died in the acute hospital following transfer from a KMPT ward, still under Section. A separate serious incident relating to the physical health care for the patient, prior to admission to the acute hospital, has also been reported.

4.6 Two STEIS reported mortality incidents relate to homicides, and are unrelated to one another. One homicide incident was STEIS reported due to the gap in contact with the patient, before he was attacked in public. Another incident relates to an older adult patient who was a victim of homicide. More detail of each is included in Appendix one.

4.7 In Q4, there were seven mortality incidents where the patient had a diagnosis of a learning disability or autism, all of which have been reported to LeDeR, as per national guidance. All patients were of white-British background. Four patients were male and three were female. Six incidents have been downgraded to an incident, following review in the SI and Mortality Panel, with one pending a cause of death before a decision is made. Two patients were in their sixties and two patients were in their seventies at the time of death. There were two patients who died young; one patient was 29 and one was 19 years old. Both identified no care or service delivery issues through review. As mentioned earlier in the report, the death of the 19 year old patient will be included in the thematic STEIS review, looking into commissioning of services for learning disability and Autistic patients.

4.8 KMPT are continuing to work with LeDeR to improve engagement with families. This is working well so far and compliance is monitored via the Duty of Candour panel, held weekly.

5. STRUCTURED JUDGEMENT REVIEW LEARNING

5.1 Work is ongoing to further implement and improve the Structured Judgement Review Process, including organising training for medics and patient safety colleagues. This will allow reviews to be completed in a timely manner and will contribute to a more robust system approach for learning from SJRs to be put in place.

5.2 There have been no Serious incidents to come from SJRs in Q4 2021/22. However some learning, not previously highlighted during initial review has been identified. This has been further discussed in the SI and Mortality Panel and shared with the care groups.

5.3 A themed review will be completed in 2022. The focus at this time is to strengthen the SJR process and to spread awareness of what SJR is to acute and community teams within the trust. The mortality Review Manager and Head of Patient Safety have worked with Datix in developing learning sections within the Mortality module for Datix Cloud. Pulling themes from SJRs will be an easier process with the implementation of this module.

5.3 The most common “red flag” criteria that prompted the SJRs is:

- Diagnosis of psychosis during the patient’s last episode of care.

6. THE MEDICAL EXAMINER

6.1 The Mortality Reviewer Manager met with the lead Medical Examiner (ME) for East Kent in February 2022, and plans to meet with other medical examiner leads across the county. This is in preparation for the anticipated introduction of the ME role for Mental Health Trusts. A separate paper has been produced to explain the role of the Medical Examiner in more detail as well as the projection for KMPT. A summary has been included in this report:

- For KMPT, the medical examiner is interested in non-coronial deaths and only when a KMPT doctor is responsible for completing the Medical Certificate Cause of Death (MCCD).

- The vast majority of deaths within KMPT are those that have died in the community, under the care of our community based services. This will mean that in most cases, a doctor, independent to KMPT will be the responsible professional for completing the MCCD.

- With the understanding that all non-acute and community services will be engaging in the ME process (including GP’s, hospices, and care facilities). there will only be a small number of KMPT patients where a KMPT doctor will be completing the MCCD.

- It is therefore likely that the only deaths that will need to be referred to the ME, will be patients who have died on a mental health ward, and/or where the KMPT doctor is completing the MCCD. We understand that these numbers are small, as typically, it is uncommon for a patient to die on a mental health ward.

- In addition to this, there will be an exclusion in that any death reported to the Coroner will not need to be referred to the medical examiner, even if a KMPT doctor was the responsible professional for the MCCD.

- The Mortality Review Manager will work with the ME offices in Kent to devise a joint working protocol. This will include creating an information sharing agreement and working on a way for the Medical examiners to access to have access to RiO.

- Another Medical Examiner paper will be completed at the end of Q1 2022/23 to provide information on developments of implementation.

7. CONCLUSION AND NEXT STEPS

7.1 Mortality incidents recorded on Datix have largely increased in Q4, compared to Q3. STEIS reported incidents have marginally increased, with a total of 14 compared to 13 in Q3.

7.2 The types of STEIS reported incidents have shifted this quarter, with two homicides being reported, as well as two deaths of patients detained under Section 3 of the Mental Health Act. A separate older adult incident where it is believed the patient died from suicide, was also initially related to a violence and aggression incident that was STEIS reported (included in Appendix one).

7.3 It appears as though there has been an increase in mortality for patients between the ages of 20 to 29, 30 to 39 and 40,49 in Q4. It would be worth considering conducting an in depth review into this, to understand if there any trends or emerging themes.

7.2 The Mortality Review Manager will continue to work with the Medical Examiners in Kent to support implementation of the process within Mental Health Trusts

7.2 The Trust will continue to review mortality incidents through the Structured Judgement review process and relevant thematic reports and share the learning as necessary.

Appendix one

COMMITTEE MEETING

Meeting details

Committee:	Quality Committee
Date of Meeting:	April 2022
Title of Paper:	Homicide/Violent incidents themed review
Author:	Frances Lowrey, Mortality Review Manager
Executive Director:	

Purpose of Paper

Purpose:	Discussion
Submission to Committee:	Ad hoc report

Overview of Paper

This is a thematic report into the review of incidents relating to homicide and violence, and was requested, following a possible increase in violent incidents, in the early part of 2022 (January to March).

Data will be compared to the Office of National Statistics (ONS) report into homicide.

The report has looked at KMPT serious incidents, reported on STEIS relating to violence and homicide, between January 2020 and March 2022.

Issues to bring to the Committee's attention

- Middle age appears to account for the majority of patient victims. As shown in the graph above, there were no patient victims younger than 40 years old. This differs to the national data

- The data indicates that patients in their twenties was the most common age for perpetrator of the incident. This is fitting with the national data
- The data suggests that homicide incidents has increased in 2022, compared to 2020 and 2021.
- The data suggests that there has been a rise in serious incidents relating to violence (not including death) for the Acute Care Group, although so far, incidents relating to violence were at their highest in 2021.
- There were more patients that were the perpetrators of violence
- There were three serious incidents relating to violence where learning had been identified relating to discharge from a KMPT ward.
- Common areas of learning from a review of completed Root cause analysis investigations relate to safeguarding, communication with patients, staff and other service providers and discharge processes.

Governance

Implications/Impact: Patient safety

Risk recorded on: Not applicable

Risk IDs: Not applicable

Assurance/Oversight: Mortality Review panels and Trust Wide Patient Safety and Mortality Review Group

Homicide/violence thematic review 2022

1. Introduction

1.1 A report into homicide and violent incidents was requested, following what seemed to be an increase in Q4 2021/22. A similar report, focussing on homicide incidents between 2015 and 2019 was presented in 2020, where learning from incidents was themed, where possible.

1.2 In February 2022, the Office of National Statistics released a report into Homicide in England and Wales, year ending March 2021.[1] The report findings will be compared to KMPT data, where applicable.

1.3 Due to way in which incidents are reported on Datix, the review has focussed on homicide and violent incidents that have been declared as a serious incident and therefore STEIS reported. When pulling a report relating to violence, there was an excess of 400 incidents to review, these incidents included incidents on the wards (staff on patient/ patient on staff/ patient on patient) and therefore was not feasible to review each individual incident.

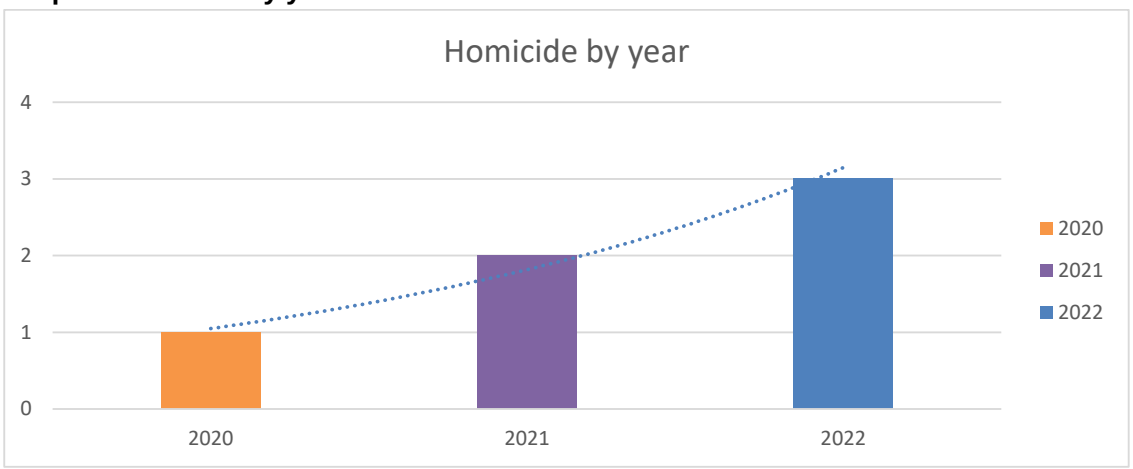
1.4 The scope for this review is for incidents that have occurred between January 2020 and March 2022.

[1] Homicide in England and Wales - Office for National Statistics (ons.gov.uk)

2. Analysis

2.1 The graph below shows the numbers of homicide related incidents that have been reported between 2020 and 2022.

Graph 1 Homicide by year



2.2 The data has been pulled from the Trust's incident reporting system, Datix. A total of six homicide serious incidents have occurred between January 2020 and March 2022. As shown in the above graph, there has been an upward trend in homicide over the years, particularly in 2022. This is of initial concern, given that the data covers just three months, compared to the 12 month scope in 2020 and 2021. It is however important to note that as Datix is a live reporting system, the incident categories may change over time following conclusion of criminal proceedings and or internal investigation.

2.3 The Office of National Statistics report, for data ending in March 2021, states that there were 594 victims of homicide in the year ending March 2021, 79 fewer (12% decrease) than the previous year and the lowest since the year ending March 2016. Included in the national figures are the 39 victims of human trafficking whose bodies were found in a lorry in Grays, Essex, in October 2019. Excluding this single incident, the number of homicides decreased by 40 (a 6% decrease).

2.4 More recent data from the main police recorded crime return, shows that the level of homicides increased following the removal of COVID-19 restrictions on 11 April 2021. For KMPT, there was a total of two homicides in 2021. One occurring in January, and one in April, days after the restrictions had eased. There isn't sufficient data to compare our local data to that of the national statistics. It could however be compared to the local data recorded in 2020. The ONS report states that the impact of COVID-19 restrictions appeared to differ by the nature of homicide. For example, the number of victims who were killed in a public place in the year ending March 2021, fell by 27%. This could explain why 2020 saw lower numbers, compared to 2021 and 2022, although cannot be confirmed with any certainty.

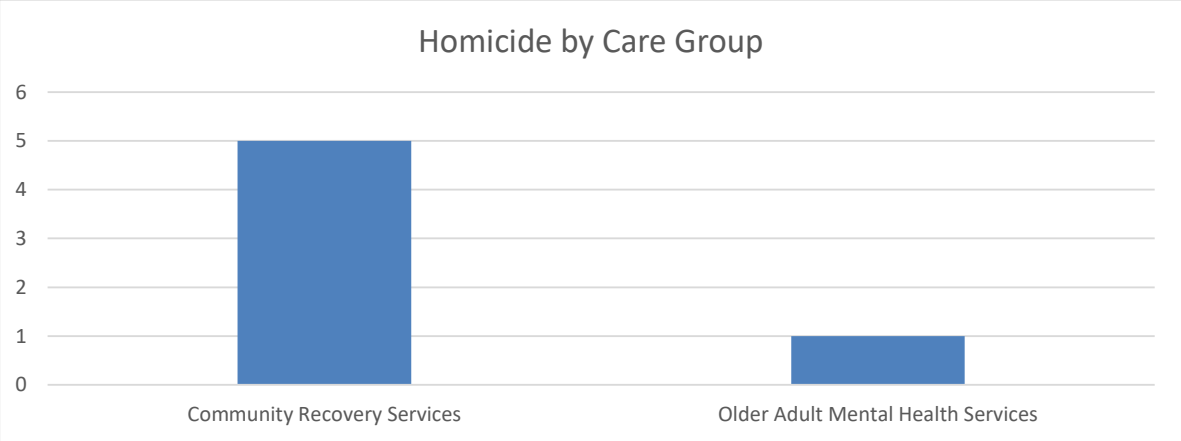
2.5 To understand where Kent sits in the overall figures for homicide within the South East of England, the following data has been extracted from the Office of National Statistics report:

Table 1 Homicide in South East England

	Apr 2012 to Mar 2013	Apr 2013 to Mar 2014	Apr 2014 to Mar 2015	Apr 2015 to Mar 2016	Apr 2016 to Mar 2017	Apr 2017 to Mar 2018	Apr 2018 to Mar 2019	Apr 2019 to Mar 2020	Apr 2020 to Mar 2021	Rate of offences per million population Apr 2018 to Mar 2021
South East	**53**	**53**	**43**	**60**	**55**	**86**	**63**	**76**	**48**	**6.8**
Hampshire	9	13	15	6	12	17	10	21	10	6.9
Kent	11	13	8	16	8	12	18	10	11	7.0
Surrey	5	6	6	8	5	6	5	3	4	3.3
Sussex	13	6	8	13	12	30	16	24	8	9.3
Thames Valley	15	15	6	17	18	21	14	18	15	6.5

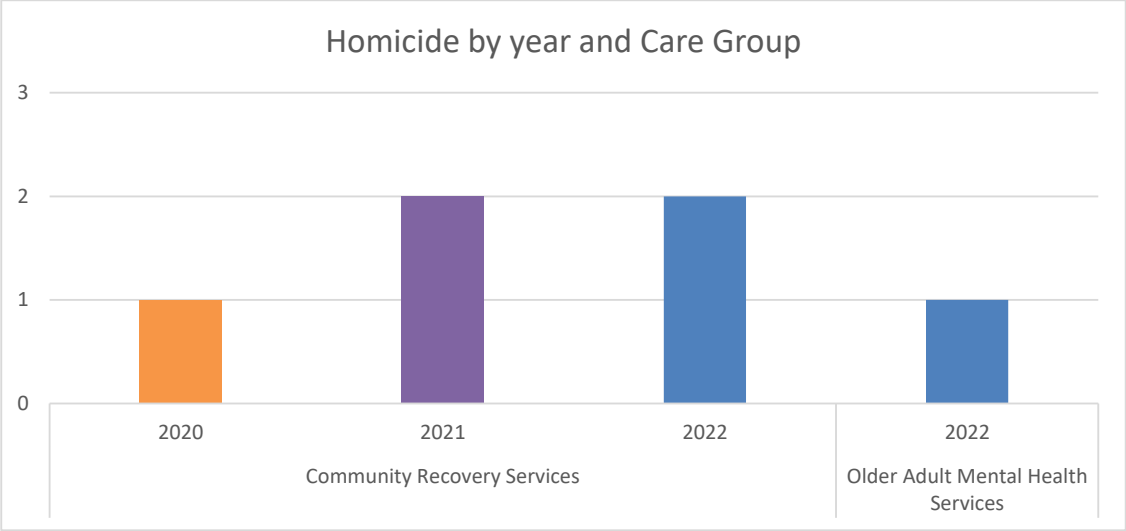
2.6 As shown in the table above, Kent were the second highest reporters of homicides in April 2020 to March 2021.

Graph 2 Homicide by care group



2.7 As expected, Community Recovery Services were the highest reporters of serious incidents relating to homicide. This is fitting with the National data in that most victims and perpetrators of homicide are of younger, working age adults. Acute and Forensic Services reported no incidents related to homicide within this report scope.

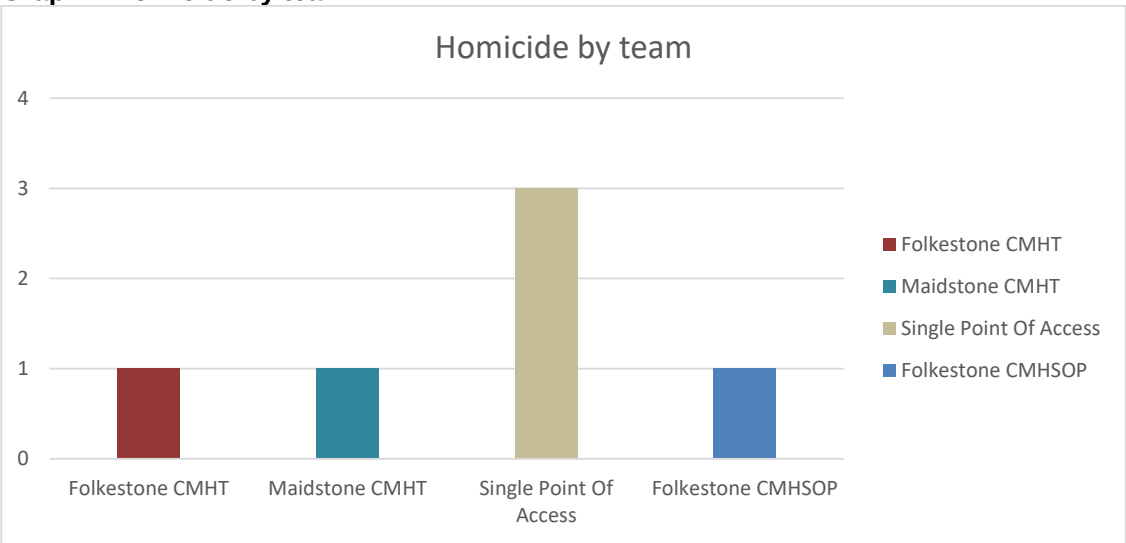
Graph 3 Homicide by year and Care Group



2.8 As shown in the above graph, the data indicates that the number of homicides over the years has remained unchanged for the community recovery care group in 2021 and 2022 with a total of two homicides reported as serious incidents. As previously mentioned, the similar numbers that have occurred this year so far, could mean that there has been an increase in homicide in 2022, due this year only representing three months of data, compared to the 12 months in 2020 and 2021. It would be worth revisiting the figures at the end of 2022 to fully understand the numbers.

2.9 There was one homicide that occurred within the older adult care group in 2022. This compares to zero in 2020 and 2021.

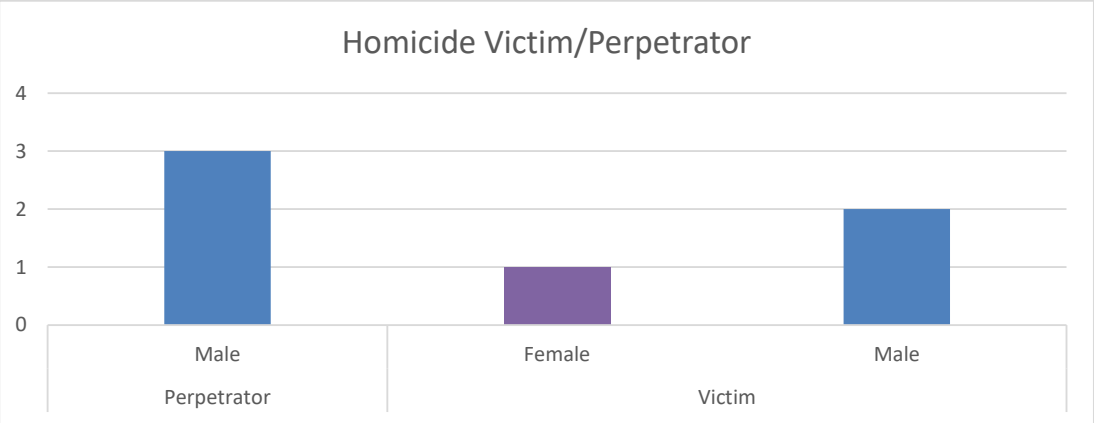
Graph 4 Homicide by team



2.10 Three homicide incidents were for patients under the care of Single Point of Access (SPoA) at the time of the incident, but may have had contact with community services prior to their SPoA referral. Two of these incidents relate to the perpetrator.

2.11 There were two homicides that occurred in the Folkestone area in 2022 (January and February). One patient was under the older adult services at the time of his death and one patient was discharged from the Folkestone CMHT at the time of the offence.

Graph 5 Victim/perpetrator in Homicide



2.12 As shown in the graph above, males accounted for the majority of victims and perpetrators. Of the six homicide serious incidents that have occurred between 2020 and 2022, three male patients were the alleged perpetrator (suspect) of the incident. Four patients were the victims of homicide between January 2020 and March 2022. Three patients were male and one female. The data shows that there have been more serious incidents that relate to the victim of homicide over the perpetrators.

2.13 Three investigations are subject to a Domestic Homicide Review (DHR).

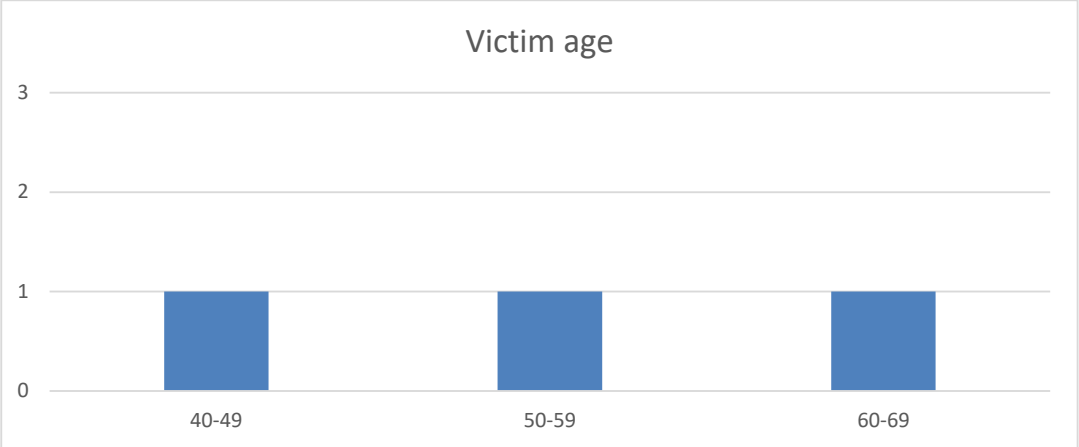
2.14 When reviewing the homicide incidents over the years, the numbers of victim and perpetrator are as follows:

2020- 1 victim
2021- 2 perpetrators
2022- 2 victims and 1 perpetrator

2.15 The Office of National Statistics latest report states that the homicide rates were 9.9 per million population, with a rate for males (14 per million population) more than twice that for females (6 per million population). The number of male victims decreased by 16% (495 to 416), whereas the number of female victims was the same as 2020 (177 victims).

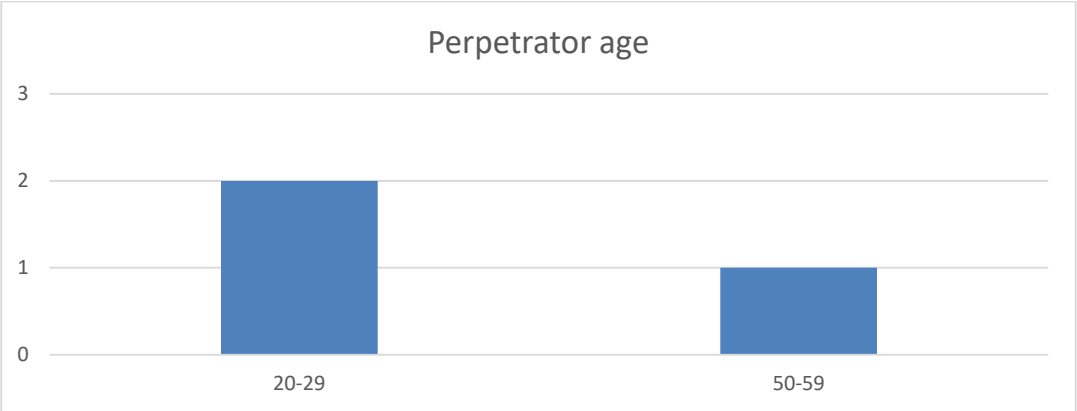
2.16 The Office of National Statistics report also stated that although there was a substantial fall in the number of victims who were killed in public places compared the previous year, 2020 (a 27% decrease), there was a 5% increase in victims who were killed in a residential setting, which may explain the different trends between males and females in the national data.

Graph 6 Homicide victim age



2.17 Middle age appears to account for the majority of patient victim. As shown in the graph above, there were no patient victims younger than 40 years old. This differs from the Office of National Statistics report, where the most common age group for victims of homicide recorded in the year ending March 2021, was those aged 25 to 34 years. We do however have small proportion of numbers in comparison to the national data.

Graph 7 Homicide perpetrator age

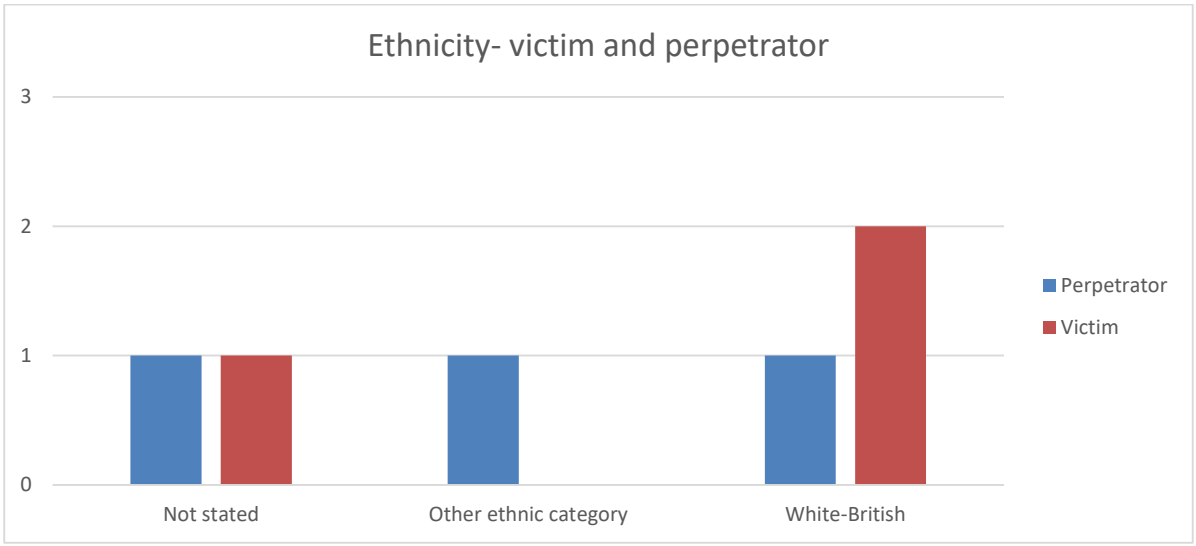


2.18 The above graph indicates that patients in their twenties was the most common age for perpetrator of the incident, with one patient in their fifties at the time of the incident. This is a different picture to the information we have for victims of homicide, where there were no victims of homicide between the ages of 20 to 29.

2.19 In addition to the figures we have for patients who were a victim of homicide, the alleged perpetrators were also known to mental health services. Of the three incidents relating to the victim of homicide, all three alleged perpetrators were either open to or previously known to mental health services at the time of the incident. *It is however worth noting that for some cases, these are subject to investigation and therefore some perpetrators may not yet have been formally charged or sentenced with the alleged offence.*

2.20 The Office of National Statistics report shows that convicted suspects of homicide show a younger age profile than female suspects. The most common age group for male suspects being between the ages of 16 to 24 years old. This is fitting with the KMPT data (two patients in their early twenties)

Graph 8 Ethnicity- Homicide



2.21 Of the six homicide incidents that have occurred between January 2020 and March 2022, ethnicity has been reviewed for both perpetrator and victim. As shown in the graph above, the majority of victims were of white-British ethnicity. This is fitting with the national data, as shown in the Office of National Statistics report. There were two patients where ethnicity was not stated, and therefore unknown.

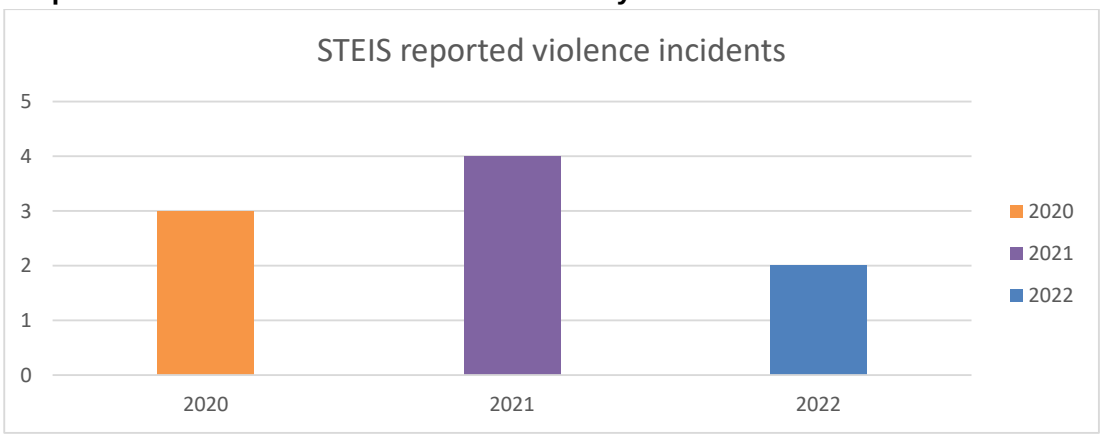
2.3 Method of killing

2.3.1 According to the Office of National Statistics report, the most common method of killing for both male and female victims was by a sharp instrument (including knives; 40%). There were 235 homicides committed using a knife or other sharp instrument recorded nationally in the year ending March 2021.

2.3.2 When comparing this to the data for KMPT, it was confirmed that sharp instrument was used for three of the six homicides that occurred between January 2020 and March 2022.

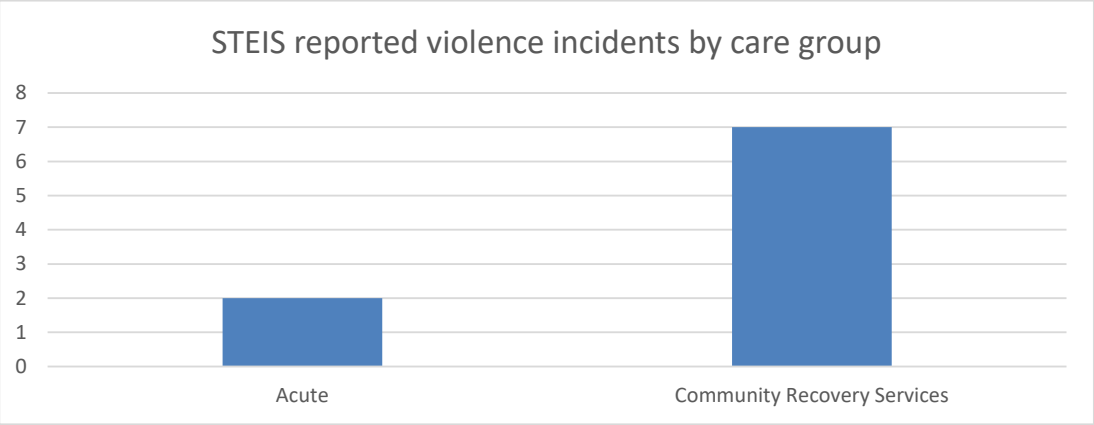
2.3.3 Nationally, there were 35 homicide victims killed by shooting in the year ending March 2021 (6% of all homicides). As far as we are aware, a firearm was not used in any of the homicide offences reported within this reporting scope.

Graph 9 Serious incidents of violence over the years



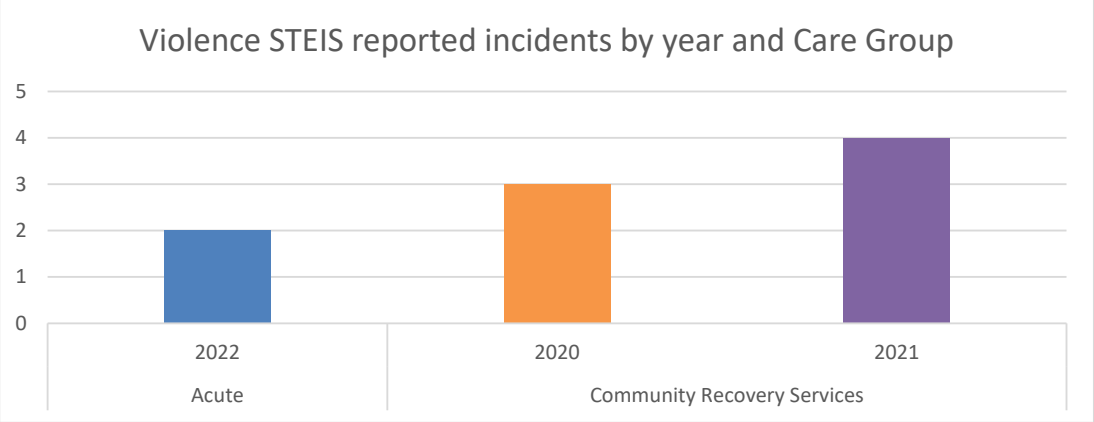
2.3.4 The above graph shows the number of STEIS reported incidents where violence has been inflicted towards or from a KMPT patient. The data indicates that the figures were at their highest in 2021.

Graph 10 Violence by care group



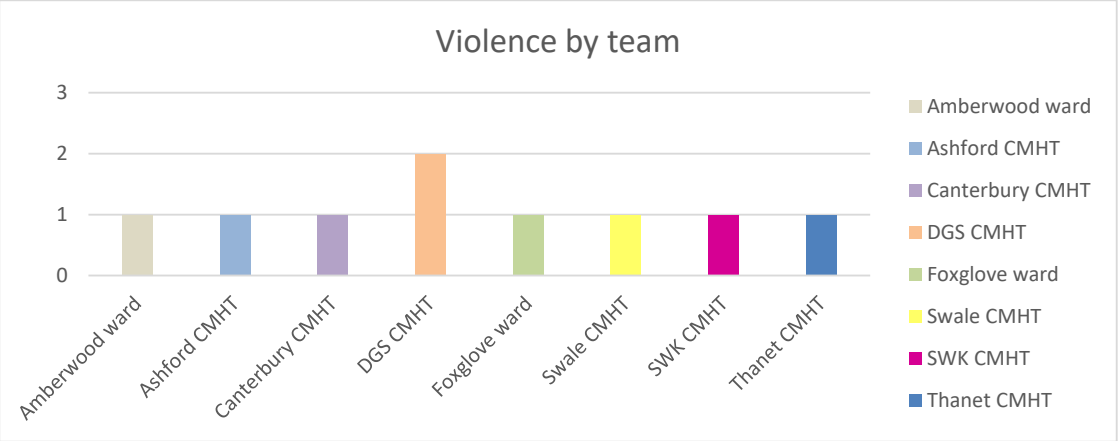
2.3.5 As shown in the above graph, Community Recovery Services were the highest reporters, with a total of seven incidents reported between January 2020 to March 2022. There were no incidents relating to violence for patients under older adult or forensic services.

Graph 11 Violence by year and care group



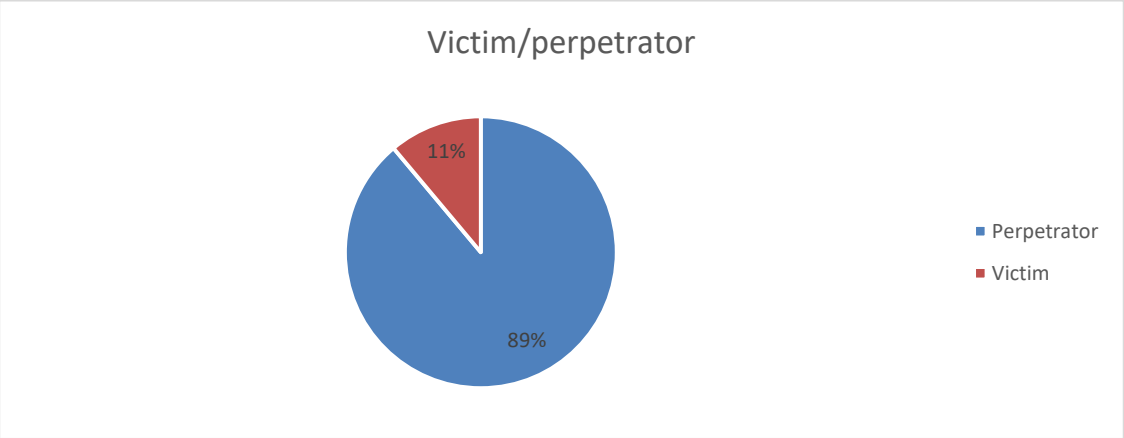
2.3.6 The initial data indicates that there has been a rise in incidents relating to violence for patients under the Acute Care Group, with zero serious incidents relating to violence in 2020 and 2021. Both of the Acute incidents in 2022 related to patients who were either on an inpatient ward or who had been recently discharged from a ward at the time of the incident. One patient was detained under Section 3 of the Mental Health Act (MHA) at the time of the incident, on Section 17 leave, and one patient was recently discharged from an inpatient ward. Both incidents related to two separate wards.

Graph 12 Violence by team



2.3.7 DGS CMHT were the highest reporters of violence incidents, with a total of two reported. The incidents occurred in different years (2020 and 2021). The remaining incidents were split across different teams, as shown above.

Graph 13 Victim/perpetrator violence incidents

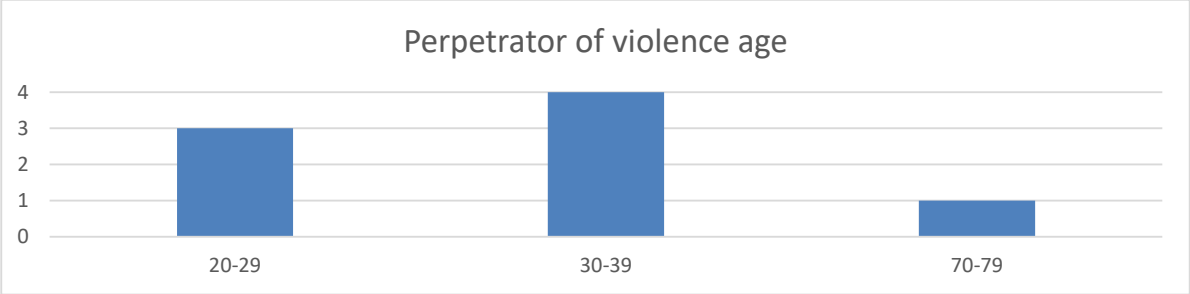


2.3.8 As shown in the chart above, 89% (8) patients were the perpetrator of violence and 11% (1) was the victim. This is a slightly different picture to that of the homicide incidents, where there was an even number of victim and perpetrator.

2.4 Victim of violence age

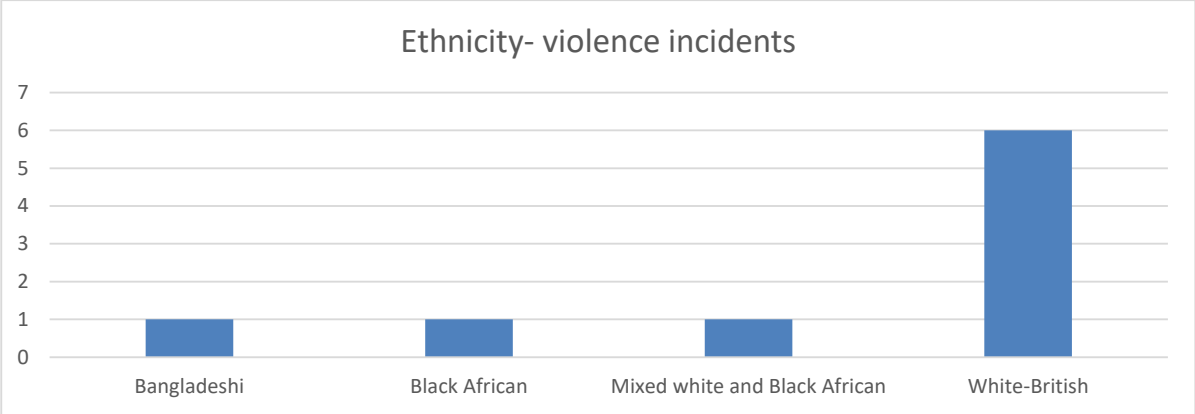
2.4.1 The one female victim of violence incident was 49 years old.

Graph 14 Perpetrator of violence age



2.4.2 Much like the homicide data, the perpetrator fits a younger profile, with three perpetrators being in their twenties at the time of the offence. The most common age category for perpetrator of violence was 30 to 39 years.

Graph 15 Violence- ethnicity



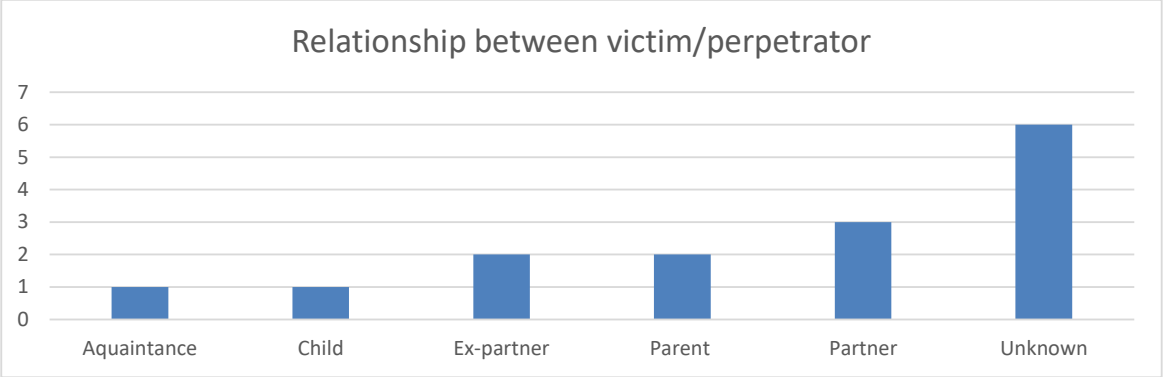
2.4.3 Ethnicity was recorded for all perpetrators and victims of violence, as shown in the graph above. The majority of patients were of white-British ethnicity. This is consistent with the local population profile being predominantly white-British. There were three patients of ethnic minority- all are recorded as the perpetrator of the incident, in their twenties and thirties.

2.4.4 Two patients within the BAME community had diagnoses of mental and behavioural disorders due to the use of drugs and alcohol and one patient had a diagnosis of schizoaffective disorder. Two patients within the BAME community were under the care of community mental health teams at the time of the incident, and one patient had recently been discharged from an acute inpatient ward.

2.5 Relationship between victim and perpetrator

2.5.1 The relationship between the victim and perpetrator has been reviewed for all violence and homicide STEIS reported incidents.

Graph 16 Relationship between victim and perpetrator



2.5.2 Of the 15 cases relating to homicide and violence incidents included in this review, the majority of the incidents (8) were domestic related. This includes partners, ex-partners, parents and children. This is fitting with the national data in that most victims and perpetrators of violence and homicide are known to each other. There were five cases where the relationship between the victim/perpetrator is either unconfirmed or unknown, although is believed that the majority of these patients were unknown to the perpetrator/victim.

2.5.3 Of the nine patients who knew the victim/perpetrator, six were known to reside at the same address, the relationship between both parties being of a domestic nature (parent, child and partner).

2.5.4 The relationship between perpetrator and victim has been reviewed, as shown below:

Table 2 Relationship between perpetrator and victim

Homicide	
Female victim 1	The perpetrator was her partner (male), who was also known to mental health services
Male perpetrator 1	The victim was his mother, who was not known to mental health services
Male victim 1	It is unclear what the victims relationship was between the perpetrators (male and female). Both were known to mental health services
Male perpetrator 2	It is believed that the victim was unknown to him. The victim was not known to mental health services
Male victim 2	Perpetrator is not confirmed for this case. A suspect has been identified, who we understand was known to mental health services. It cannot be confirmed at this time if he was involved, or what their relationship was
Male perpetrator 3	The victim was his ex- partner, who was not known to mental health services.

2.5.5 The Office of National Statistics report states that there were 114 domestic homicides in the year ending March 2021, a similar number to the average over the last five years. For those homicide victims where a suspect had been charged, 92% (380) of victims had suspects who were male. For the data within KMPT, this is confirmed for three cases, (with an additional one case relating to two perpetrators, male and female), and unconfirmed for one case.

2.5.6 The national report also states that there were large differences in the profile of victim-suspect relationships between male and female victims. In the year ending March 2021, female victims were more commonly killed by a partner or ex-partner or a family member.

The female victim included in this report, was killed by her partner, which fits with the national data, although it is recognised that females are underrepresented in this report to gain a true picture.

Table 3 Violence incidents

Violence incidents	
Male perpetrator 1	It is not clear what the relationship was between victim and perpetrator. The victim was not known to mental health services
Male perpetrator 2	The victim(s) was the patient's parents. The father was known to mental health services and has subsequently died. It is believed that his death was suicide related. The police are not treating both incidents as linked
Male perpetrator 3	The victim was the perpetrators ex-partner (female) who was known to mental health services
Male perpetrator 4	The victim was the perpetrators infant child
Male perpetrator 5	It is unclear of the relationship between victim and perpetrator, although appears as though they knew each other
Male perpetrator 6	The victim was unknown to the perpetrator and was not open to mental health services
Male perpetrator 7	The perpetrator was the patient's partner (male), who was also known to mental health services
Male perpetrator 8	It is unknown if the victim was known to the perpetrator, but was not believed to have been known to mental health services
Female victim 1	The perpetrator is the patients partner. This was a complex domestic violence case, where both parties were the victim and perpetrator. The male partner was also known to mental health services

Table 4 Diagnosis- violence and homicide incidents

Alcohol dependence syndrome. Abnormal complex grief reaction. Moderate-severe depressive disorder. Alcohol Hallucinosis.	1
Depressive illness	1
EUPD	1
Frontal lobe dementia	1
Mental and behavioural disorder due to alcohol use	1
Mental and behavioural disorder due to alcohol use with anti-social personality disorder	1
Mental and behavioural disorder due to cannabinoids	2
No formal diagnosis	5
Schizoaffective disorder	2
Total	**15**

2.5.7 Patient diagnosis is listed as above. As shown, five patients that had no formal diagnosis at the time of the incident. Four patients had a diagnosis in the form of drug or alcohol use (three patients were the perpetrator and two the victim). One patient had a diagnosis of an organic mental health disorder, in the form of frontal lobe dementia. Two patients had a diagnosis of a type of psychosis at the time of the incident, where both patients were the perpetrator.

2.5.8 It is believed that one patient, who was the perpetrator of homicide, had a diagnosis of Autism Spectrum Disorder (ASD).

2.5.9 The types of diagnosis are very different to patients who die from suicide or who self harm. Usually we see more patients with diagnoses of depressive disorders.

2.5.10 When reviewing the types of diagnosis for patients who were a victim of homicide or violence, two patients were diagnosed with a form of depression. This is slightly different to patients who are listed as the perpetrator of the offence, as no patients listed as the perpetrator had a diagnosis of a depressive disorder at the time of the incident.

Table 5 Drug and alcohol use

Alcohol	3
Drugs	4
Drugs and alcohol	3
No/Unknown	5
Total	15

2.5.11 Of the 15 incidents reviewed, 10 patients were known to have used drugs and or alcohol. Two patients were the victim and eight were the perpetrator. Upon reviewing this further, five of the incidents involving patients with alcohol and drug use were for patients known to one another, their relationship being partner, or child.

2.5.12 According to the homicide index , in the last three years, almost a third (32%) of homicide victims were thought to be under the influence of alcohol or illicit drugs at the time of the homicide. The Office of National Statistics report states the following:

- 18% had been drinking alcohol
- 6% had been taking an illicit drug
- 8% were under the influence of both

2.5.13 When we compare the national data to that of KMPT, three patients involved in homicide had reported issues with drugs or alcohol. Two patients were the victim (alcohol use) and one perpetrator (drug use). It is unknown if drugs or alcohol were involved at the time the homicide occurred.

2.5.14 The use of drug and alcohol was more common in males nationally, with 37% compared to 22% of females.

2.6 Conclusion of criminal investigation

2.6.1 Where possible the outcome of the criminal investigations has been gained. From the available information, three perpetrators were not charged with the offence, all relate to incidents of violence, graded as moderate harm.
The outcome is unknown for three cases.

2.6.2 Five perpetrators were charged with the offence. Three relate to homicide and two relate to violence incidents, graded as severe harm.

3. Root cause analysis outcomes

3.1 Learning has been reviewed separately for both homicide and violence incidents. Any themes from the different incident categories will be reviewed and analysed as part of this review.

3.2 Homicide RCA's

3.2.1 Three of the six homicide investigations are complete and therefore have been included in this part of the review. Some context around the incident has been provided.

Table 6 Patients

Patient A

Patient A was a 50 year old female who was the victim of homicide, who was stabbed to death by her partner. Her partner was also known to mental health services and the care provided to him was included in the review. There were several gaps in care identified around risk management, safeguarding and understanding of the function of another team. The root causes were determined to be the misunderstanding of the roles and function of the CJLDs services and lack of knowledge regarding the difference between their vulnerabilities screening and a mental health assessment. It was also noted that the team's misunderstanding of their safeguarding responsibilities, resulted in the absence of any safeguarding consultation or safeguarding alert being raised.
Patient B
Patient B is a 20 year old male who was charged with the murder of a member of the public. It is believed the victim died from a head injury. The victim was not known to mental health services. Some areas of learning were identified through investigation, relating to safeguarding and referral processes, however there was no identified root cause.
Patient C
Patient C is a 57 year old male who was arrested on suspicion of the murder of his ex-wife. The perpetrator was believed to have been a victim of domestic abuse from his ex-wife. The victim was not known to mental health services. Several areas of learning were identified for this case, particularly around domestic abuse and safeguarding. The patient was a victim of domestic abuse and this does not appear to have been considered The investigation was unable to confirm a root cause, however identified that action should have been taken to safeguard and signpost the patient for appropriate support when he disclosed that he was a victim of domestic abuse. The patient should have been accepted back into services to understand if the perceived domestic abuse was real or a facet of his illness.

3.2.2 Learning from the three homicide investigations has been grouped, where possible to identify any possible themes.

Table 7 Themes

Safeguarding	- There is no evidence that a safeguarding consultation or alert was considered in response to the arrest of the perpetrator or in response to the urgent police crime report referral - No safeguarding alert was raised following the disclosure of potential domestic abuse - The patient was no signposted to domestic abuse services for support - Lack of consideration for the use of safe routine enquiry - No evidence of a full assessment taking place with consideration for risk and safeguarding
Documentation	- When the patient was seen by CJLDS, it was not always clear to the worker making decisions or from RiO records who the perpetrator has assaulted or when.

Risk rating	- Perpetrator was RAG rated as AMBER by SPoA despite the risk information held within the referral by the police.
Unclear of team processes	- There was a lack of understanding of the types of assessments, carried out by CJLDS. SPoA and the CMHT were unaware that a vulnerabilities screening was not an assessment of mental health.
Incorrect process followed	- A telephone call received into SPoA was treated as a referral when it did not meet the criteria - A referral to EIP was not completed - A letter was sent to the patient advising of discharge following a self-referral, when the patient had not self referred - Patient was not accepted into services from SPoA following a self-referral to see his psychiatrist
Timeframes for assessment	- SpOA were not able to carry out a telephone triage screening within the planned 72 hours
Management of appointments	- A planned call did not go ahead - It is not clear from RiO when or how some appointments with the CMHT were scheduled, moved or cancelled in 2020
Collateral information/information sharing	- Limited collateral information was obtained by KMPT teams, partly due to the restrictions presented by COVID. - Unclear if information was shared with the GP following KMPT contact with the patient. - Concerns raised from the school were not shared with the police by SPoA and advice was not provided for the school to contact the police
Contact with the patient	- Patient was discharged from the CMHT with missed opportunities to speak directly to the patient. - Patient had not been reviewed since December 2019
Ways of working	- Staff were working off site making communication more challenging when escalating concerns - Limited capacity for a clinician to take over the call given how busy the service was at the time
External factors	- A contrast MRI was not completed

3.2.3 As shown in the table above, there were missed opportunities to consider safeguarding, which was identified in all three investigations. For two of the cases, it was found it was either missed or unclear that information had been shared with other care providers such as GP and the police. COVID-19 was noted to have had an impact on the ways of operating for some cases. This included limited capacity of a clinician, the lack of opportunity to gain collateral information and barriers to communication due to home working. It is clear from investigations that robust actions, post incident have been put in place to mitigate the possibility of such issues occurring again. These include:

- Development of a bitesize domestic abuse training package
- Recruitment of an Urgent Access Lead in SPoA
- Improvements to attendance at the safeguarding champions forum
- Adult safeguarding referrals flowchart to be relaunched by the safeguarding team
- Training session to be held surrounding the completion of the DASH risk indicator checklist

- CJLDS to provide training sessions to CMHTs and SPoA detailing the function, role and responsibility of the CJLDS service
- Review and re-design of SPoA to include identified learning from this serious incident.
- Multiagency pathway to be developed for co- occurring conditions
- Joint working with substance misuse services to develop a county wide protocol
- Embed and strengthen the arrangements for SPoAs performance and governance
- All SPoA staff to complete PREVENT training
- SPoA to produce a set of voice standard (trigger words) for monitoring voice analytics software
- For CMHTs to have an identified carers champion to support the implantation of triangle of care
- Include a section on collateral history within the carers awareness training elearning.
- Spread awareness of EIP service and referral process to all teams
- CRHT to add prompt on the first visit checklist and again on the discharge checklist
- For an older adult consultant psychiatrist to provide training on older adult risk factors to SPoA staff
- To review the SPoA workforce model to ensure there is sufficient staffing capacity to meet demand
- Manual review of under 65 year old patients with a dementia diagnosis to gain assurance that risk factors have been identified appropriately and management plans put in place.
- The SPoA call handler script will be modified to include a yes/no question relating to domestic violence

3.3 Initial concerns from remaining homicide incidents

3.3.1 For the three homicide incidents where the investigations are still in progress, the initial learning has been reviewed to gain an understanding of the areas of learning identified. Learning is subject to change throughout investigation and analysis of the problem.

Table 8 Patients

Patient D
Patient D is a 24 year old male who was arrested on suspicion of murdering his mother and setting fire to the family home. The concerns identified during the initial investigation were: • No consideration to refer the patient to EIP • No evidence of safeguarding discussion or alerts raised in relation to the patient mother • No exploration of who lived in the property such as younger siblings.
Patient E
Patient E was a 66 year old male who was victim of homicide by two perpetrators who were also known to mental health services. Initial concerns were identified for all patients: **For patient E (victim) concerns identified were as follows:** • No evidence of a safeguarding referral being considered or actioned when the patient's property was noticed to be in a neglected state and concerns were raised around self neglect • Additional safeguarding concerns relating to a 'friend' staying in the patient's property were not explored • Limited evidence of any contact from social care or Forward Trust • The patient was not contacted weekly as pre expectations of patients on the RED board

- No documented evidence that physical health checks were offered to the patient

For the female perpetrator, concerns identified were as follows:
Following discharge from the service, the patient was not formally discharged from services, which led to another appointment being offered
No evidence that that the dual diagnosis policy/ joint working protocol for co-occurring mental health and substance misuse disorders was considered

For the male patient, concerns identified were as follows:

- A screenshot of the referral made to the council was not uploaded to the RiO record.
- The referral made to Forward Trust and uploaded to the patients RiO record is for a different person.

Patient F
Patient F was a 43 year old male who was victim to an assault, which subsequently led to his death. The alleged perpetrator is believed to have been a KMPT patient, however due to their being insufficient evidence at this time, and no confirmed conviction it would not be beneficial to include their details within this report. Concerns identified from initial review were as follows: • SPoA, did not attempt to contact the patient within the expected 72-hour time frame • After the initial attempt by CMHT Duty staff to contact the patient, the follow up plan was to book another appointment to try to contact the patient, however this does not appear to have been carried out. • On 13/01/2022, it was recognised that no contact had not been made with the patient. There was then a further 13 days until contact was attempted on 26/01/2022.

3.4 Learning from incidents of violence
3.4.1 Seven investigations relating to incidents of violence are complete, and have been included in this part of the review. An additional one incident has been downgraded by the CCG, as the investigation identified that the incident was not linked to the suicide death of the patient's father. The incident has been included in this review as learning was identified with regards to discharge processes from a KMPT ward.

3.4.2 Some context around each incident has been provided.

Table 9 Patients

Patient G
Patient G was 34 years old at the time of the offence and was arrested for attempted murder of his ex-partner, who was also known to mental health services. A root cause was not identified for this case but there was learning around documentation and MARAC.
Patient H
Patient H was 20 years old at the time of the offence. He was arrested for a Section 18 GBH offence, for child cruelty with life threatening injuries to his five week old daughter. Some pertinent areas of learning were identified through investigation of this case, that related to safeguarding and assessment/communication with the patient.

The root cause was felt to be the lack of child safeguarding and false assurances that the patient's baby was a protective factor when the patients mental health presentation required an urgent assessment.
Patient I
Patient I relates to a male who was 33 years old at the time of the offence. He was arrested following an allegation that he stabbed a member of the public in their garden. The victim was not known to mental health services. Several points of learning were identified in this case, relating to the assessment of the patient, poor discharge from services, non-adherence to DNA policy and a lack of discussion in the RED Board. The root cause was that the patient was discharged without a clear assessment of his mental health or risk, with COVID-19 having an impact on this. The patient was discharged from services following telephone calls only, with assurances from the patient that he was well.
Patient J
Patient J was female and was 49 year old at the time of the incident. The perpetrator was also known to mental health services and the couple were both the perpetrators and victims of domestic abuse. Several gaps in care were identified, for both the male and female in this case, which related to cross care group working (male patient was under Older Adult Services and the female patient under younger adult services). Issues related to safeguarding, follow up of patients and consideration of risk. The root cause was determined to be the missed opportunities to complete safeguarding referrals, largely due to the assumption that other NHS colleagues (internal and external) had completed these.
Patient K
Patient K relates to a male who was 24 years old at the time of the offence. The patient was arrested for assaulting a member of the public with a carving fork. Issues identified in the investigation related to the discharge processes from an inpatient setting. The CMHT was not involved in the discharge from the ward and family input was not provided. The root cause had not been fully confirmed, however stated that it was likely that the patient's mental health could have declined with poor engagement and possible non-compliance with medication.
Patient L
Patient L was male and was 26 years old at the time of the offence. He was arrested following an assault on his partner which left her with life threatening injuries. The victim was 49 years old at the time of the incident and also known to mental health services. Learning identified was around monitoring of patients following recent medication changes, lack of consideration to raise a safeguarding, a lack of consideration of the patient's living arrangements and HCP advising of medication changes, rather than the consultant psychiatrist. The root cause could not be confirmed; however it was noted that there was a missed opportunity to fully consider follow up arrangements for the patient having made a recommendation to reduce his medication.
Patient M

Patient M is male and was 31 years old at the time of the offence. He was arrested for allegations of sexual assault on a female aged 13 and over, rape of a female aged 16 and over and ABH. The victims of the sexual assault are not believed to have been patients of KMPT. It has been confirmed through investigation that the victim of ABH was his ex-partner. A root cause could not be determined in the investigation; however several points of learning were identified. These related to the CMHT and CRHT not being involved in the KMPT ward MDT discharge meeting, a lack of evidence of MARAC or safeguarding being discussed with the patient's ex- partner and a lack of communication with children and family social services, with regards to the patient's discharge from the inpatient setting.
Patient N
Patient N is a 40 year old male who was arrested for allegations of harassment, using violence to secure entry, threats to kill and a public order offence. All alleged crimes were directed towards his parents in the family home. Shortly after this event, the patient's father, who was known to mental health services, died from what was believed to be suicide. The incident was initially STEIS reported as a serious incident as it was considered that the impact of the family not being informed of the patient's discharge from the ward and his subsequent presentation at the family home had caused the patient's father to commit suicide. When investigators reviewed this incident, there was a missed opportunity to inform the family of the patient's discharge from the ward, however following confirmation from the police that they were not linking the patient's offences to his father's suicide, a downgrade request was submitted to the CCG and agreed. This incident has been included in this review for the purpose of capturing the learning around discharge, as this appears to be a common area of concern for some cases.

3.4.3 Learning from the eight investigations has been grouped, where possible to identify any possible themes.

Table 10 Themes

Documentation	- Records were not always contemporaneous, due to staff shortages - A note regarding MARAC was concealed by Safeguarding in clinical records - Lack of documentation around decision making - Retrospective progress note added - Core assessment was not completed by CJLDS
Team communication	- The consultant was not contacted by the KMPT safeguarding team in regard to the MARAC until the morning of the MARAC. - The patient was not discussed in the MDT or RED board meeting. - The patient was not discussed and placed on the red board meeting - There is no evidence of the CMHSOP receiving correspondence from CJLDS following the patient's arrest - No feedback provided to the wider team following assessment by two agency nurses

Communication with another provider	- No clear documented evidence in the patient's healthcare records that Children and Family Social Service were informed specifically of the patient's discharge - There was no attempt made to contact the relevant mental health service in London - Inadequate communication between KCC Children and Family Social worker and KMPT about MARAC referral made
Patient care/ communication	- The patient had not been informed of the location of his appointment - The patient was not offered a more urgent face to face assessment. - The patient was not advised of his care coordinator's departure from the CMHT - No follow up with the patient as planned - Lack of contact with the patient when memory assessment was paused for 7 months - The CMHT clinician had not sufficiently researched the patient's referral information prior to his assessment and was unaware of the reason for his urgent referral. - Lack of consideration of the patient's living arrangements when appointment planning - No evidence that Substance misuse services were discussed with the patient.
Risk management	- Patient's risk to others was incorrectly rated as low, following arrest for domestic assault - Risk assessment was not updated
Safeguarding/MARAC	- Missed opportunities to raise a child safeguarding - Missed opportunities by several teams to raise a safeguarding - Lack of consideration given to raising safeguarding concerns that the patient had moved back in with his partner. - No evidence that a MARAC referral or safeguarding was discussed with patient's ex-girlfriend during her discussion with ward doctor.
Software errors	- ICOM telephony system was not recording calls from and to SPoA on for a period of two days -
Referral processes	- The patient was not referred to EIP by SPoA
Follow up	- No evidence of a further follow up being arranged after 72 hour follow up - The patient was not seen in a face to face follow-up within 72 hours by the CMHT - Planned CPA appointment was delayed
Adherence to policy	- The CMHT did not follow the DNA policy on three occasions
Team issues/process/induction	- Limited induction provided to a new care coordinator - Limited supervision provided to a clinician - Lack of process for following up allocated actions at the MDT meeting.

Discharge processes	- Patient was discharged without being seen face to face for several months following discharge from hospital - The CMHT were not in attendance at the ward discharge CPA - The patient's discharge from a KMPT ward had taken place without involvement from the CMHT. - No evidence of CMHT discussions surrounding the complexities and risks of the patients prior to decision to discharge - The patient had been discharged from the ward without input from the patient's family - The patient was discharged following a medication change without consideration for follow up. - KMPT ward MDT discharge review occurred without the presence of CMHT Healthcare professional and CRHT team.
Engagement with carers and families	- The CMHT did not involve or engage the patient's mother in the last episode of his care.
Other providers	- Missed opportunity by SECAMB to raise a safeguarding - No safeguarding issues raised by the patient's GP

3.5 Action plans from violence incidents

3.5.1 It is clear that robust actions have been put in place following investigation of each incident. Actions have been reviewed for the common issues that have been identified in the table above.

- The recruitment of a safeguarding clinician to focus on MARAC
- Safeguarding team to develop immediate learning notes for the organisation reminding staff children can be both a protective and stress factor and to consider safeguarding in line with policy
- Safeguarding team to produce a short story relating to a domestic abuse/safeguarding incident that will be shared with care groups.
- For the care group patient safety leads to provide the safeguarding team with an up to date list of each care groups designated safeguarding leads.
- For the adult safeguarding referrals flowchart to be relaunched by the safeguarding team.
- Complete an audit against the Trust Patient discharge Policy for patients directly discharged from PICU
- All PICU staff to complete DASH Training staff.
- Continue to progress the development plan of the recruitment and retention of staff in the CMHT (DGS)
- Joint review (task & finish group) to include SPoA, CMHT and CRHTT, and OACG representation to agree amended wording of the: CMHT SOP CMHSOP SOP, in relation to responding to urgent referrals from SPoA and Liaison Psychiatry Services being carried out within 72 hours to read 3 working days.
- Explore an efficient and simple way of reporting KASAF to KCC
- Audit to be completed to evidence compliance in the team of the RED board process.
- For safeguarding considerations to be added to the CJLDS CLIQ checks.
- For historical arrests/risks to be added to the CJLDS CLIQ checks.
- For an induction package to be provided to temporary staff

- MHA co-ordinator to liaise with ward manager and attend ward staff meeting and deliver any bespoke training required
- Add the point re medication changes to the agenda at the trust wide Team Managers Forum.

3.6 Recommendations

3.6.1 It is recommended that a review is completed for assurances that compliance with discharge processes and planning has improved as a result of the findings from investigations.

3.6.2 A review a of homicide and incidents relating to violence to be completed at the end of 2022 to fully understand the numbers. For care group leads and patient safety leads to monitor this regularly in the interim and escalate any concerns that may arise.

3.6.3 A review of safeguarding compliance within the Trust would also be useful, considering all safeguarding elements, including domestic abuse/MARAC, self neglect and children.

Title of Meeting	Public Trust Board Meeting
Meeting Date	26th May 2022
Title	Workforce & OD Committee (WFODC) Report
Author	Venu Branch, Chair of WFODC
Presenter	Venu Branch, Chair of WFODC
Executive Director Sponsor	Sandra Goatley, Director of Workforce & OD
Purpose	Assurance

The Workforce and Organisational Development Committee met on 17th May 2022.

Matters to be brought to the Board's attention

Positive Assurance:

- Older Adult Care Group Presentation: Presented a good report on their challenges and achievements. In the high-level summary provided from the Staff Survey Results, it was reported the Community Older Adults Service scored above the Trust's advantage, whilst there is work is still needed on Inpatient Services.
- The Allied Health Professionals (AHP) & Nursing Placement Expansion Project: The target for placements has been exceeded with 45 Nursing Students placements and 27 AHP placements with a capacity increase of 72 new placements from June 2021 to April 2022. Placements overall compared to 2019-2022 have increased by 37.5%. and an offer of 452 weeks of placements secured. Income from placements has increased by 54.7% compared to the financial year of 2019-2020, with an increase of £179,850 compared to 2019-2020.
- With up and coming innovations and support systems in place, the project was awarded with the Service of Improvement Award in 2021.
- The new Guardian Service: The new service will be launched the 1st June 2022. Communications are being prepared and a soft video launch is being filmed with our Director of Workforce and Organisational Development.

Issues of Concerns:

- Older Adults Care Group Presentation: The care group reported a number of significant Green Button concerns over a period of 2 weeks, whereby staff are feeling tired and overwhelmed. We need to acknowledge this and challenge it so that it does not become embedded in KMPT. All the concerns raised have been addressed.
- HR Risk Register: there are ongoing challenges with workforce and the risks remain red and scoring 20, so extreme. We recognise there are ongoing issues and this is also a national issue. The risks will be reviewed and linked to the strategic delivery plan for this year and will be more focused on gaining traction in specific areas, then observing if there are corresponding impacts.

Approvals

- The items detailed below were approved by the Committee:
  - Policy Handbook
  - Management of Nursing Students and Placement Policy
  - Equality and Diversity Steering Group

Items referred to other Committees (incl. reasons why)
• None

	Title of Meeting	**Board of Directors**
	Meeting Date	**26 May 2022**
	Title	**Audit and Risk Committee (ARC) Report**
	Author	**Peter Conway, Chair of ARC**
	Presenter	**Peter Conway, Chair of ARC**
	Executive Director Sponsor	**N/A**
	Purpose	**Assurance**

ARC met on 16.5.2022 to consider:

- BAF and Trust Risk Registers
- Annual Report and Accounts 21-22
- Auditors' Annual Reports and latest Progress Reports
- Finance Matters
- NHS Audit Committee Handbook Compliance

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Management	*Limited Assurance*	6 risks recommended for removal. A number of reporting improvements needed eg. confidence assessments, risk scoring, target risk assessments and dates. New Estates risk (15) reflecting the poor state of Coleman House, Dover and at least £250k capital spend needed to bring it up to H&S standard. ARC has requested assurance at next meeting that Coleman House is a one-off
Annual Report and Accounts 21-22	*Reasonable Assurance*	On track for ARC to finalise the Accounts, Annual Governance Statement and Remuneration Report on 7 June and make a recommendation to the Board in time for its 15 June extraordinary meeting. The draft Annual Report should be ready by the end of May to allow Board members early sight before distribution of Board papers on 8 June.
Auditors' Annual Reports	*Reasonable Assurance*	Internal Audit overall opinion is likely to be ''reasonable assurance'' provided nothing substantive arises in the meantime (unlikely). Anti-Crime Service annual report confirmed no frauds meeting reporting materiality levels, no control weaknesses, counter-fraud well embedded in the Trust and a likely green rating for the Fraud National Functional Standards
Auditors' Progress Reports	*Reasonable Assurance*	Board to be updated on the Estates Investigation following receipt of an ACS Interim Report expected in the next 2 weeks
Finance Matters	*Limited Assurance*	Verbal update on 2022-23 Financials - NHS as a whole under considerable financial pressure, Budgets not yet concluded and further ''stretch'' anticipated. This will create even more pressure on KMPT's structural deficit challenge and unfunded capital projects such as data centres.

NHS Audit Committee Handbook Compliance	*Reasonable Assurance*	ARC self-assessed to be compliant in all areas.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

	Title of Meeting	**Board of Directors**
	Meeting Date	**26 May 2022**
	Title	**Finance and Performance Committee (FPC) Report**
	Author	**Peter Conway (in Mickola's absence)**
	Presenter	**Peter Conway, Non-Executive Director**
	Executive Director Sponsor	**N/A**
	Purpose	**Assurance**

FPC (quorate with 1xNED and 2xED present) met on 26.4.2022 to consider:

- IQPR
- 72 Hour (Crisis) Performance
- Financials (month 12)
- Annual Plan 2022-23 (final)
- Structural Deficit and CIPs
- Risk Register
- Operational Maintenance Contract
- Business Cases x 2
- Terms of Reference

Area	Assurance	Items for Board's Consideration and/or Next Steps
IQPR	*Limited Assurance*	Several concerning/deteriorating areas plus 1 never event - DTOC, Out of area placements, CPAs, LoS, RTTs, CMHT(OP)s. Various actions in train which will partially mitigate but there are no quick fixes. Performance will remain well below target for some time.
72 Hour (Crisis) Performance	*Limited Assurance*	SPoA/Crisis care needs to be aligned with the (still in development) ICS Urgent and Crisis Pathways then rebadged and relaunched which will take 3 month of planning then up to 3 months for implementation. Current data being reported (58% of urgent referrals seen within 72 hours vs target of 95%) is inaccurate with the service performing better than headlined. Metrics to be sorted ASAP and assurance provided to FPC/Board of the true levels of performance
Financials (month 12)	*Reasonable Assurance*	Month 12 outcome in line with expectations (excluding the adjustments that will need to be made for Littlebrook).
Annual Plan 2022-23	*Limited Assurance*	Plan submission agreed. The key risks and assumptions will be set out for Board members out of Committee. These include unfunded inflationary pressures, the amount of CIPs still needing detailed plans, £2m for funding of the data centre and capital spend gaps in the medium term (£4.7m). Limited assurance assessment reflects the extreme risk ratings per the Risk Register

Structural Deficit and CIPs	*Limited Assurance*	The limited assurance reflects the size of the task (£7m), where we are in the year, £4m of savings still to be worked through and the Trust's track record of delivery.
Risk Register	*Reasonable Assurance*	3 x extreme risks: -capital availability, financial sustainability of the Trust (£7m structural deficit), maintenance funding 1 x high risk: -CIP programme
Operational Maintenance Contract	*Reasonable Assurance*	Approach and financial envelope for 2022-23 endorsed. Quarterly assurance requested evidencing that plans are being achieved and spend within the £1.028m budget
Business Cases	*n/a*	1)Band 2/3 FTEs (increasing number of band 3s and reducing band 2s in order to improve retention) - declined on the basis that payroll would increase by £513k pa but no sources of funding identified so the additional spend would merely add to the £7m structural deficit 2)Maternal Mental Health - agreed (fully funded by NHSI/ICS)
Terms of Reference	*n/a*	ToR to be redrafted (delegated authorities and responsibilities for Estates, IT and Procurement). Committee Forward Plan then to be updated and aligned

Title of Meeting	Board of Directors (Public)
Meeting Date	28th April 2022
Title	Mental Health Act Committee (MHAC) Report
Author	Kim Lowe, Chair of MHAC
Presenter	Kim Lowe, Chair of MHAC
Executive Director Sponsor	Dr Afifa Qazi, Chief Medical Officer
Purpose	Assurance

Matters to be brought to the Board's attention

- The risk of unlawful detention following section 136
- Liberty Protection Safeguards (LPS) transition

Items referred to other Committees (incl. reasons why)

- None

MHAC met on 11th April 2022 to consider:

Significant assurance:

- Chief Medical Officer's Report
- MHLOG Report
- Report from Associate Hospital Managers
- Governance of Hospital Managers

Reasonable assurance:

- Mental Health Act Monitoring Report

Limited assurance:

- Liberty Protection Safeguards
- Detention under Section 136

Detention under Section 136

There are complications when the 24 hours runs out following a section 136, where the assessment has been formally completed but no bed can be identified. The section paperwork cannot be completed with the name of the detaining hospital, leaving the patient unlawfully

detained in a cell or hospital, which is seen as an operational risk to both the Trust and to the Police.

There are two risks relating to this, firstly is the risk of serious harm to a patient or member of public if the patient is released from the place of safety, as the detention under the section 136 has expired and although medical recommendations are in place, no bed has been identified and the patient harms themselves or others. This can lead to a breach of Article 2 of the Human Rights Act, as it is likely a patient would meet the test of a vulnerable person with real and immediate risk to life. The second risk is by not allowing the patient to leave there could be a challenge for de facto or unlawful detention. It is acknowledged that the Trust have not been legally challenged around this area, but identified that this could be challenged in the future and leaves our frontline staff with often difficult decisions. This is not a new issue for KMPT or other Mental Health Trusts in the UK.

The Committee noted and support that the Mental Health Act Legalisation Operational Group (MHLOG) have recognised this problem and have agreed that a multiagency working group will to be formed to update legal guidance to sit alongside the Standard Operating Policy for staff faced with this difficult situation and there being no legal framework to support this problem.

Liberty Protection Safeguards

The opening of the consultation period has commenced which is a major change programme which will touch all areas of the organisation. The Trust are already seeing a decline in mandatory training compliance for DoLS, which is inevitable, but this leaves the Trust vulnerable without a plan or approach to manage the gap period.

There is a requirement for the creation of a robust transition plan to move the Trust from DoLS to LPS safely, which needs clear ownership and Executive accountability.