AGENDA

NHS Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 28th September 2023
Time 10.00 to 12.00
Venue The Orchards, East Malling

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/23-24/59	1.	Welcome, Introductions & Apologies		Verbal	Chair	10.00
TB/23-24/60	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/23-24/61	3.	Personal Story – Open Dialogue	FN	Verbal	DHS	10.05
TB/23-24/62	4.	Quality Improvement - Long term/work related sickness reduction project in Thanet OACMHT	FN	Verbal	AQ	10.15
STANDING ITEMS						
TB/23-24/63	5.	Minutes of the previous meeting	FA	Paper	Chair	10.25
TB/23-24/64	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/23-24/65	7.	Chair's Report • Board Self-Assessment 2023	FN FA	Paper	JC	10.30
TB/23-24/66	8.	Chief Executive's Report	FN	Paper	HG	10.35
TB/23-24/67	9.	Board Assurance Framework	FA	Paper	AC	10.40
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/23-24/68	10.	Strategy Delivery Plan Priorities Progress Report	FD	Paper	HG	10.50
TB/23-24/69	11.	MHLDA Provider Collaborative Board Progress Report	FD	Paper	AR	11.00
OPERATIONAL ASSURANCE						
TB/23-24/70	12.	Integrated Quality and Performance Review	FD	Paper	HG	11.05
TB/23-24/71	13.	Finance Report	FD	Paper	SS	11.20
TB/23-24/72	14.	Workforce Deep Dive: Anti-Racism Plan	FD	Paper	SG	11.25
TB/23-24/73	15.	Community Mental Health Framework Transformation Progress Report	FD	Paper	DHS	11.35
TB/23-24/74	16.	Business Continuity and Emergency planning report	FD	Paper	AC	11.40
TB/23-24/75	17.	Standing Orders	FA	Paper	TS	11.45
CONSENT ITEMS						
TB/23-24/76	18.	Register of interests	FN	Paper	TS	11.50
TB/23-24/77	19.	Use of Trust Seal	FN	Paper	TS	
TB/23-24/78	20.	Report from Quality Committee	FN	Paper	SW	
TB/23-24/79	21.	Report from Audit and Risk Committee	FN	Paper	PC	
TB/23-24/80	22.	Report from Workforce and Organisational Development Committee	FN	Paper	VB	
TB/23-24/81	23.	Report from Finance and Performance Committee	FN	Paper	MW	
CLOSING ITEMS						
TB/23-24/82	24.	Any Other Business			Chair	11.55

TB/23-24/83	25.	Questions from Public			Chair	
	Date of Next Meeting: 30th November 2023					

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
Stephen Waring	SW	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Associate Non-Executive Director
Dr Asif Bachlani	AB	Associate Non-Executive Director
Helen Greatorex	CE	Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sheila Stenson	SS	Chief Finance and Resources Officer/ Deputy Chief Executive
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnership and Transformation
In attendance:		
Tony Saroy	TS	Trust Secretary
Hannah Puttock	HP	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications and Engagement
Apologies:		

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 11.55hrs on Thursday 27th July 2023
Via videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director
	Dr Asif Bachlani	AB	Associate Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Associate Non-Executive Director
	Helen Greatorex	HG	Chief Executive
	Sheila Stenson	SS	Chief Finance and Resources Officer/Deputy Chief Executive
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	Chief People Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
	Stephanie Archer	SA	Peer Support Worker (Mother and Baby Unit)
	Rose Waters	RW	Deputy Service Director (Specialist Services)
	Alan Dunlop	AD	Community Mental Health Nurse
	Dr Verity Williams	VW	ST5 doctor (Higher Trainee) in General Adult Psychiatry
Apologies:			
	Kindra Hyttner	KH	Director of Communications and Engagement
Observers:			

Item	Subject	Action
TB/23-24/34	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/23-24/35	**Declarations of Interest** There was a declaration of interest from AB regarding the Bed Strategy item. The Board was informed that TS had advised AB and the Trust Chair that AB does not need to recuse himself from that item as the Bed Strategy was for discussion and not approval of any commissioning or financing.	

Item	Subject	Action
TB/23-24/36	**Personal Story – Rosewood Mother and Baby Unit** The Board received RW and SA, who both highlighted the positive effect that peer support work has had on the outcomes of the 300 women and children who have been in the Mother and Baby Unit. The Board reflected on the positive work and noted that despite only being a eight-bed unit, there are rarely delays in admitting mothers and babies. Those who do wait are looked after in the community by the Home Treatment Team until a bed becomes available. The Board thanked RW and SA for attending and **noted** the Personal Story – Rosewood Mother and Baby Unit.	
TB/23-24/37	**Quality Improvement – Using Digital Inclusion in Enhancing Service Responsiveness Neuropsychiatry team** The Board received AD and VW, who informed the Board about the embedding of digital tools within the treatment pathway for patients open to their service. The team developed a step care model which includes multidisciplinary team input for those patients with functional neurological disorders (FND). The embedded digital solutions have reduced psychology waiting lists from 365 days (in Jan 2022) to 78 days (today). For non-urgent medical appointments, it has reduced from 180 days (Jan 2022) to just over 60 days (today). A symptom self-management booklet was created last year, and there is now a revised version following feedback from patients. This booklet has informed the production of five videos psychoeducation regarding FND, which will be available to patients on a prescription basis. This self-management work has meant that 2000 appointments were no longer required, leading to savings of approximately £200,000. The Board thanked AD and VW, and **noted** the Quality Improvement – Using Digital Inclusion in Enhancing Service Responsiveness Neuropsychiatry team.	
TB/23-24/38	**Minutes of the previous meeting** The Board **approved** the minutes of the previous meeting without amendment.	
TB/23-24/39	**Action Log & Matters Arising** The Board **approved** the Action Log without amendment. There were no matters arising.	
TB/23-24/40	**Chair's Report** The Board received and **noted** the Chair's Report.	

Item	Subject	Action
TB/23-24/41	**Chief Executive's Report** HG formally thanked SS for her work whilst acting as the Chief Executive. HG highlighted the following matters: 1) The discovery of an effective drug for Alzheimer's Disease is likely to lead to an increase in demand for the Memory Assessment Service (MAS). As early intervention is key for the drug to be effective, it is likely that referrals to MAS will occur at an earlier stage. The Trust is reviewing its MAS model with KMPT psychiatry working closely with brain imaging teams from the acute hospitals. AQ is leading that work, with AD supporting that work. 2) There has been media coverage regarding 'Right Care, Right Person'. The Trust has met with Kent Police and the partnership remains strong. There is no pressure at this stage to rollout the 'Right Care, Right Person' at a local level. 3) Prior to the pandemic, all KMPT patients were provided with a bed by the organisation. However, during the pandemic, there was an increase in demand and led to the use of private care beds. There has been a reduction more recently and the Trust's Bed Management Strategy will bring the Trust to the first principle of having KMPT patients in KMPT beds. The Board **noted** the Chief Executive's Report.	
TB/23-24/42	**Board Assurance Framework (BAF)** The Board received the BAF and was informed regarding the new risk relating to the Management of Environmental Ligatures. The Executive Management Team is continuously sighted on risks, with early discussions regarding risk controls taking place. The Board reflected on the following matters: • The effect of industrial action by doctors on the morale of staff is variable, with different teams feeling different levels of pressure. AQ is working to mitigate the effect of the industrial action. Staff commitment to patient has remained resilient. • The MAS work is occurring now, with HG expecting some improvements before she leaves the organisation in November. • In terms of delayed transfers of care (DTOCs), the Trust is working with the Kent and Medway System, but there is a need to recognise that Kent County Council has significant financial pressure, which is impacting having patients being in the right placements. The Board **approved** the Board Assurance Framework.	
TB/23-24/43	**MHLDA Provider Collaborative Report** The Board was informed that there had not been a MHLDA Provider Collaborative Board (PCB) meeting since May 2023 and therefore the Trust will receive the PCB's risk register once it has been approved.	

Item	Subject	Action
	There shall be a Provider Collaborative workshop in October which is focussed on dementia, and lived experience. The Board **noted** the MHLDA Provider Collaborative Report.	
TB/23-24/44	**Operation Cavell Annual Progress Report** The Board received the Operation Cavell Annual Progress Report with discussions focussed on the limited impact it has had for staff. The Board noted that Operation Cavell is an element of the wider Trust Strategy work regarding the reduction of violence and aggression. The most impactful work has been staff engagement with patients, which has led to a reduction of violence and aggression by patients. The Board expressed its lack of confidence regarding Operation Cavell being able to deliver its desired outcomes and noted that there are data challenges which reduces Board confidence. **Action: AR to bring an Operation Cavell Progress Report to the Board in January 2024.** The Board **noted** the Operation Cavell Annual Progress Report.	**AR**
TB/23-24/45	**Progress against the Research and Innovation Strategy** The Board received the paper detailing progress against the Research and Innovation Strategy. The Board was pleased with the progress, noting that the Trust has won research bids of £465k against a target of £50k. This has been done with the backdrop of spending just 50% of the approved funding budget of £60k. The Board highlighted that the Trust has not approved any further funding for the service. The Trust's research is focussed on suicide prevention, cognitive disorders, and a mobile MRI scanner. The Board delegated the oversight of delivery of the Research and Innovation Strategy to the Quality Committee. The Board **noted** the progress against the Research and Innovation Strategy.	
TB/23-24/46	**Bed Strategy** The Board received the Bed Strategy paper. The Bed Strategy has considered the Kent and Medway population growth for the next three years, which has then been projected over the next ten years. The Board was pleased to receive the Bed Strategy, with the Board noting that not all NHS trusts have set out their Board strategy. However, the Board expressed its concern with Kent County Council's ability to deliver under the service level agreement (SLA). A similar SLA is in place with Medway Council.	

Item	Subject	Action
	The Board requested an opportunity for further discussion on the paper, noting that the Bed Strategy will impact the Trust's estates strategy. There is however no request for additional clinicians or nursing. The Board determined that the Bed Strategy needed to have each option risk assessed, with oversight to be carried out by the Quality Committee. The Board requested that a further Bed Strategy paper be brought to the Board meeting in July 2024. **Action: AQ to present a Bed Strategy progress report in July 2024.** The Board **noted** the Bed Strategy paper.	**AQ**
TB/23-24/47	**Integrated Quality and Performance Report (IQPR)** The Board received the IQPR with the Board discussion focussed on: • Nearly 1 in 7 appointments in the patient not attending the appointment. The Trust has noted that a number of patients are inappropriately referred to services, which is impacting attendance. The Trust is reviewing compliance with the 'Did Not Attend' Policy. • There has been a decline in the Friends and Family metrics which have been affected by the change in the care group structure to PLACE based, and also a need for complaint responses to be signed off by the Chief Nurse. • Care planning metrics continue to be below target. Elements of this is due to the Trust but other elements are due to the Kent and Medway System. The Trust is rolling out Dialogue+ training, which should increase the rate of care planning. The Board sought further assurance in future IQPRs. **Action: Future iterations of the IQPR should address any concerns raised by the CQC regarding restrictive practices.** The Board **noted** the IQPR.	**HG**
TB/23-24/48	**Finance Report** The Board received the Finance Report and highlighted the following: • Although the Board is positive with the breakeven position, it is still quite early in the financial year to be able to give positive assurance. There is a risk that there will be a breach in the agency cap and the Trust may receive a sanction that puts the breakeven position at risk. • Any savings that have been identified are connected to the operational changes that have taken place. There is a possibility that the Trust Board will need to establish its tolerance level regarding savings achieved. The Board **noted** the Finance Report.	
TB/23-24/49	**Workforce Deep Dive – Leadership** The Board received the Workforce Deep Dive paper regarding Leadership. Board discussions focussed on:	

Item	Subject	Action
	• The Leadership programme felt fragmented, with the Trust recommended to make clear that the programme is mandatory. • The staff induction programme reinforces and supports the culture of leadership within the Trust, with there being very good engagement opportunities. • The Leadership programme needs to be integrated with the Trust's work regarding Equality, Diversity, and Inclusion ('EDI'). The Board **noted** the Workforce Deep Dive paper regarding Leadership.	
TB/23-24/50	**Freedom to Speak Up Annual Report** The Board received and welcomed JP to the Board who highlighted progress over the year and the successful implementation of the in-year recommendations. The Trust was pleased to see that 43% of staff who raised a concern had given permission for their name to be used, which is evidence they have confidence in the system. The Board **noted** the Freedom to Speak Annual report.	
TB/23-24/51	**Community Mental Health Framework Progress Report** The Board received the Community Mental Health Framework Progress Report with discussions focussed on the Triage system being an effective way of managing referrals, with the clinical decision maker within the triage system. The model of triage is known as Mental Health Together and the key element is engagement of the clinical leadership. The Board **noted** the Community Mental Health Framework Progress Report.	
TB/23-24/52	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/23-24/53	**Report from Workforce and Organizational Development Committee** The Board received and **noted** the Workforce and Organisational Development Committee Chair's report.	
TB/23-24/54	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/23-24/55	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/23-24/56	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report for both June 2023 and July 2023.	

Item	Subject	Action
TB/23-24/57	**Any Other Business** None.	
TB/23-24/58	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 28th September 2023.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 08/09/2023

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2023								
25.05.2023	TB/23-24/10	MHLDA Provider Collaborative Report	AR to include a Risk Register in future iterations of MHLDA Provider Collaborative updates.	AR	July 2023	September 2023	This is included within the MHLDA Report.	**Closed**
27.07.2023	TB/23-24/47	Integrated Quality and Performance Report (IQPR)	Future iterations of the IQPR should address any concerns raised by the CQC regarding restrictive practices.	HG	September 2023		This is included within the IQPR	**Closed**
ACTIONS NOT DUE OR IN PROGRESS								
27.07.2023	TB/23-24/44	Operation Cavell Annual Progress Report	AR to bring an Operation Cavell Progress Report to the Board in January 2024.	AR	January 2024			**NOT DUE**
27.07.2023	TB/23-24/46	Bed Strategy	AQ to present a Bed Strategy progress report in July 2024.	AQ	July 2024			**NOT DUE**
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29.07.2022	TB/22-23/46	Operation Cavell Annual Progress Report	VB2 to provide an Operation Cavell update report to the Board in January 2023.	HG	January 2023	July 2023	On agenda	**COMPLETE**
26.01.2023	TB/22-23/126	Freedom to Speak Up Report – six monthly report	The next Freedom to Speak Up Report, due in July 2023, shall have a high-level progress chart against the recommended actions.	SG	July 2023		On agenda	**COMPLETE**
25.05.2023	TB/23-24/17	Standing Orders & Standing Financial Instructions (SFIs)	NB to amend the Standing Financial Instructions and change the term 'Associate Director' to 'Deputy Director' throughout the document, by the next meeting.	NB	July 2023		The Standing Financial Instructions have been updated with the term 'Service Director' to reflect the new staff model.	**COMPLETE**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 28th September 2023**
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 four matters:

- Kent & Medway System
- Business case approval
- Renewal of tenures for Non-Executive Directors
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

I joined a national meeting of Chairs and Chief Executives with NHS England in early September. This was organised in light of the significant challenges facing the NHS, including the Louise Letby conviction, and ongoing industrial action. The focus of the meeting was on leadership and cultural change in relation to speaking up and staff well-being, as well as consideration of new regulation for senior managers.

3. Business case approval

Earlier this month, the Chief Executive and I approved a business case relating to the Trust's catering services following consultation with two Non-Executive Directors and advice from the Trust Secretary.

4. Renewal of tenures for Non-Executive Directors

Non-Executive Directors are independent members of the Board and are appointed by NHS England to support the Executive Management Team as well as being a critical friend.

I am pleased to announce that NHS England has renewed the tenures of Mickola Wilson and Sean Bone-Knell. NHS England has also extended Catherine Walker's final term by a year.

5. Board Self-Assessment

Recently the Board undertook a self-assessment of its performance against the Care Quality Commission's Key Line of Enquiries. Appended to my Chair's report is a paper setting out the results of the self-assessment and the proposed action plan. The action plan will need the Board's approval.

6. Trust Chair and NED visits

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

Where	Who
July 2023	
Dartford, Gravesham & Swanley Community Mental Health Team (DGS CMHT)	Jackie Craissati
Swale CMHT	Jackie Craissati
Head of Trust Security	Jackie Craissati
KMPT long service awards	Jackie Craissati
August 2023	
Boughton and Chartwell Wards	Kim Lowe
Mental Health Act Office	Kim Lowe
September 2023	
Perinatal Mental Health Team	Sean Bone-Knell

Chair visits

Community Mental Health Teams.
I always enjoy meeting teams as they go about their work, and these two visits were no exception: I observed a red board and triage meeting in DGT and a clinical & business meeting in Swale. It really brought home to me the complexity (and the frustrating) nature of the work.

Under immense pressure, the teams really are striving to do their best, and they are feeling very optimistic about the new place-based directorate. Some of the clinical examples raised questions about communication between the Psychiatric Intensive Care Unit contract and services in DGS, the lack of responsiveness of the police to violent incidents at the CMHT, and continuing inefficiencies regarding repetitive recording across teams of assessments in the clinical record. My discussions with staff also highlighted a very urgent need for refreshing the communications strategy for the Community MH Framework, as staff lacked knowledge of the vision and the timeline for implementation.

It was an absolute delight to attend the first KMPT long service awards. Our staff are amazing and I was immensely impressed by stories of loyalty and commitment to our service users and the organisation.

Kim Lowe, Mental Health Act Team

I visited the MHAC office with the new Deputy Medical Director Dr Valsraj. The team shared some of the good work they have completed to improve our compliance with both the Mental Health and Mental Capacity Acts. Our achievements remain positive and the prompts continually sent out by the Mental Health Act office are ensuring high compliance results. The main challenges are well known, with the priority remaining providing consistent Consultant cover to all the wards.

Kim Lowe, Boughton and Chartwell Wards

A very warm welcome by the teams on both wards. It was apparent that that the ward staff were extremely busy and operating with patients with a high acuity levels. The visit coincided with lunch service which looked fresh and appetising and patients were interacting socially whilst eating. Several ongoing issues were flagged and these have been passed on to the relevant managers for comment.

Sean Bone-Knell, Perinatal Mental Health Team

A very enjoyable visit to talk about the role of the Perinatal Mental Health Team with Clare Collins the Operations Team Leader. The team has an establishment of 85 with very low sickness absence mainly attributed to the less stressful working environment compared to other mental health services such as acute. The team has grown over recent years with funding from NHSE and this was pleasing to hear.

We discussed some of the barriers and one clear barrier was the team's work starting at age 18 and in some parts of Kent & Medway the high teenage pregnancy rate and subsequent MH needs that are currently been met through CAMHS. It was discussed that sometimes this crossover can be problematic in regards to patient records and referrals.

Kent and Medway
NHS and Social Care Partnership Trust

BOARD SELF-ASSESSMENT RESULTS REPORT 2022/23

1. Introduction

The NHS Well-Led guidance, issued by the healthcare regulator NHS England, recommends that an annual self-assessment exercise is carried out by Boards of Directors of NHS Organisations. In line with this guidance, the Trust Board has completed its review and the results are enclosed for Board discussion.

The well-led framework is structured around eight key lines of enquiry (KLOEs) and Board members have been asked to undertake a self-assessment around these KLOE. As Board members will see, recommendations have been made to continue to improve the Board's effectiveness and performance.

2. Summary of Board Responses

Board members were asked to provide a rating between strongly disagree to strongly agree for each question (1 = strongly disagree, 5 = strongly agree). The results have been analysed by averaging the scores for each KLOE and cross referenced with the NHSE well led rating framework. Overall, the rating and comments received from Board members demonstrated a positive response to the Board's function and performance. Most Board members scored four or five across all the KLOEs, with additional positive comments made regarding the involvement of the public, the management of board time.

Areas of improvement since last year's self-assessment includes the welcome addition of a new Associate Non-executive Director with specialist digital skills. There has also been improvement regarding Board development and staff engagement in developing and approving the new Trust strategy.

For consideration this forthcoming year are the following three areas, each of which could improve with greater focus:

The Board's score decreased this year in relation to understanding the role of each of its sub-committees. A comment was made that the workplans of the Board Committees need a further review, to avoid overlap between Committees, with agreement on how these items should be managed.

There was insufficient confidence that there are robust systems and processes in place for learning, continuous improvement and innovation. This is forming part of the Trust's Strategy under priority 5 – 'We are efficient, sustainable, transformational and make the most of every resource' and will be reviewed by the Board and its Committees. We need to ensure that we learn from a range of patient stories including times when there have been problems in the care provided.

The Board reported awareness of the organisation's equality and diversity position but recognised more needed to be done to create an anti-racist organisation. This will develop as we embark on our programme work this month.

In summary, the Board rated itself well against the Well-Led Framework. A further summary has been provided rating the Board's responses against each of KLOEs and an action plan has been produced against the feedback provided for the Trust Board to review and agree.

3. Average Scores

The table below shows a summary of the Trust's view against the Well-Led Framework based on the self-assessment conducted.

Key Line of Enquiry (KLOE)		Board's View 21/22 (Average scoring)	Board's View 22/23 (Average scoring)	Risk Rating
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	4.2	4.2	
KLOE 2	Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	4.4	4.2	
KLOE 3	Is there a culture of high quality, sustainable care?	4.5	4.1	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.6	4.4	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance	4.1	4.1	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	4.2	3.9	
KLOE 7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	4.4	4.2	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation:	4.1	3.7	

Key:

4 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions.
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery.
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery.
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver.

Additional question	Board operation/administration/governance	4.4	4.2	

4. Outcomes from last Action Plan

From this year's self-assessment, there has been both a decline and improved scoring across the KLOEs. Within last year's self-assessment action plan (where improvements were seen across all of the KLOEs), it was agreed to maintain the way the Board works, with a more holistic approach. It was noted that key to this would be the revision of the Trust's strategy as the strategy was due to expire at the end of March 2023 and it was agreed the Board should meet for a Board Development day with a focus on the Trust's strategy. This development day took place and the role of the new Trust Strategy was successful. There have also been the following key achievements:

- The Trust has recruited a new Non-Executive Director and two new Non-Executive Directors,
- Board meets with the Engagement Council twice a year, and
- The Board receives regular updates on Quality Improvement projects.

5. Proposed Action Plan

The Trust Board will focus on the following three key areas in the forthcoming year:

- To ensure Board members have a greater understanding of the role of each of the Board Sub-Committees and ensuring there is no overlap between Committees
- To gain further confidence in the Trust's systems and processes in place for learning, continuous improvement and innovation, which forming part of the Trust's Strategy. In addition, for the Board to receive a range of patient stories including times when there have been problems in the care provided.
- To continue to develop the Trust's equality and diversity position to aid the Trust in becoming an anti-racist organisation.

Chief Executive's Board Report

Date of Meeting: 28 September 2023

Introduction

In this, my last Chief Executive's Board Report before standing down, I start by recording my formal thanks to the remarkable colleagues I have met and worked with over the last seven years. We agreed at the start of my tenure in 2016, that we in KMPT shared one simple mission; to provide Brilliant Care through Brilliant People. That has remained our North Star. Over the last seven years I have been privileged to witness every day, KMPT colleagues focusing on delivering brilliant care and working tirelessly to drive up the quality of our services as well as being clear open and honest when we have fallen short. My board report today as always shares national, system and in-house updates but it starts and ends with my thanks to our staff and volunteers who make KMPT the remarkable organisation that it is.

Healthcare Leaders Update from NHS England

In August this year, and following the conviction of Lucy Letby, NHS England's Chief Executive Amanda Pritchard wrote to all NHS trusts. Amanda's letter is attached for information and sets out the expectation that NHS boards will follow guidance across a range of areas including applying the Fit and Proper Person test to board appointments and adhering to best practice in relation to Freedom to Speak Up Guardians. The Chief People Officer and Trust Secretary are reviewing the requirements set out in the letter and will once the review is completed, update the board. In the meantime, we have taken the decision to further emphasise the importance of a straight line of communication from the Freedom to Speak Up Guardian to the Chief Executive. To that end the reporting line will move from November 1st, directly to the Chief Executive making our commitment to this essential freedom absolutely explicit to everyone.

Reinforced Autoclaved Aerated Concrete (RAAC)

There has been a significant amount of media attention on the above building material and its presence in some NHS building. It is important to note that KMPT undertook an audit of our estate in 2022. No RAAC was identified at that point. We are for completeness revisiting that audit for further and final assurance.

National Urgent and Emergency Care Team Visit

In early September the Integrated Care Board (ICB) hosted a visit from National Health Service England's Urgent and Emergency Care Team. The visit and subsequent meeting with the team was focused on performance in East Kent hospitals in particular and aimed at assessing how robust and effective Kent's integrated system is at ensuring good flow for patients through a range of points of care, but especially in to and out from the Emergency Department (EDs). KMPT's Chief Executive joined this three-hour, in person meeting in Whitstable and outlined some of the initiatives that are underway. These include front door mental health triage, moving safe havens geographically closer to EDs and our work on ensuring that our own KMPT patients are able to move out of our wards as soon as they are ready for discharge. At any one time, KMPT has 40-50 patients who are ready to be discharged but whose package of care or onward placement has been delayed in circumstances that are beyond KMPT's control. Feedback from the national team about our system's approach was positive. They will continue

to offer support and ensure that we have productive links with other parts of the country from which our system could learn.

Integrated Care Board (ICB)

The ICB board undertook a development day for board members including partner members in August (KMPT's Chief Executive holds the shared partner member place for the mental health and community trust). The day was the first of a series of facilitated events designed to create a high performing board. KMPT's incoming Chief Executive will retain the partner member's place for a further twelve months, handing over to the community trust's Chief Executive in November 2024.

In September the ICB approved the business case to establish a single Health Based Place of Safety (136 suite). The suite will be on KMPT's Maidstone site and will significantly improve the quality of our offer to people who have been detained in a public place by the police. It is anticipated to open in 2025.

Dementia Diagnosis Rates

The board and its committees remain focused on this area of significant and growing demand, mindful that we have set out our plan to ensure that by the end point of the Trust's current strategy 95% of patients will receive their diagnosis within six weeks of referral.

There is much work to do but it is positive to note that at the end of September, we have met our target of eliminating the backlog of 753 patients who had been waiting in April this year.

The Chief Medical Officer is the executive lead for this work which as the board will hear later is now accelerating the pathway for patients waiting, through deployment of an improved model of assessment.

Long Service Awards

On Tuesday 12th September the Chair and I hosted KMPT's first (now to become annual) long service awards event at the Chilston Park Hotel. We were joined by colleagues including volunteers who have worked for KMPT for ten years and upwards and the afternoon was a true celebration of dedication and commitment.

New Ruby Ward

Along with other colleagues from the executive team I visited the new ward in August. Whilst it was still a building under construction it was clear to see what a light, airy and therapeutic environment our patients will enjoy there. The Ruby ward team is looking forward to the building being handed over and I am proud to say that KMPT will at that point become a mental health trust free of dormitory wards.

Changes to the Executive Team and Senior Clinical Appointments

Sheila Stenson takes over as KMPT's new Chief Executive on November 1st. At the same time, Nick Brown takes up his new role as Chief Finance and Resources Officer and Chief Operating Officer Donna Hayward-Sussex becomes Deputy Chief Executive. The board will I know welcome colleagues in to their new roles and I warmly wish them every success.

In the meantime, we have appointed five new Heads of Psychiatry as set out in the Fit for the Future restructure.

Dr Sheeba Hakeem (North Directorate)

Dr Aaliya Majeed (East Directorate)

Dr Chidibere Uwadoka (West Directorate)

Dr Vinodini Vasudevan (Acute Directorate)

Dr Chidi Nwosu (Forensic and Specialist Services Directorate)

These important senior new roles will drive the delivery of excellent care and will be essential in improving patient flow through our services, ensuring that everyone receives the care they need in the right place, at the right time.

At the time of writing, appointments to the Clinical Director roles are in the process of being made.

Summary and Conclusion

As always at KMPT, in our system and beyond, there is much work to be done. In the coming weeks, before I hand over, I am looking forward to visiting as many of our sixty-six sites as I can, to say a personal thank you to my KMPT colleagues, friends and volunteers.

Helen Greatorex
Chief Executive

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
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 July 2023, and ARC on 30th August

- Four risks have been added to the BAF since July.
  - Risk ID *02241 – Compliance with food legislation - temperature control checks of food (Rating of 16 (Extreme))
  - Risk ID *07556 – Expiry of lease for Littlebrook (Rating of 9 (High))
  - Risk ID *07557 – Trust Agency Usage (Rating of 12 (High))
  - Risk ID *05075 – Community Psychological Services Therapy Waiting Times (Rating of 16 (Extreme))

- Three risks have changed their risk score since July
  - Risk ID *00871 – Recruitment and Retention (decreased from 16 (Extreme) to 12 (High))
  - Risk ID *04347 – Implementation of the Community Mental Health Framework across Kent and Medway (increased from 9 (High) to 16 (Extreme))
  - Risk ID *07557 – Trust Agency Usage (Increased from 12 (High) to 20 (Extreme))

- One risk is recommended for removal
  - Risk ID *00050 – 2023/24 Financial Planning (Rating of 12 (High))

Governance

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

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The Board Assurance Framework

The BAF was last presented to the Board on 27th July 2023. It was updated for presentation to the Audit and Risk Committee on 30th August and has since been updated.

The Top Risks are

- Risk ID *07557 – Trust Agency Usage (Rating of 20 – Extreme)
- Risk ID *00119 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID *00410 – Increased level of Delayed Transfers of Care (DTOC) (Rating of 16 – Extreme
- Risk ID *00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID *02241 – Compliance with Food Legislation, Temperature control checks of Food (Rating of 16 - Extreme)
- Risk ID *04347 – Implementation of the Community Mental Health Framework across Kent and Medway
- Risk ID *05075 – Community Psychological Services Therapy Waiting Times (Rating of 16 – Extreme)

Risk Movement

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

- **Risk ID *00871 – Recruitment and Retention (decreased from 16 (Extreme) to 12 (High))**
  Improved visibility of issues and improved current position (retained within target over a number of months) has enabled a reduction in current likelihood rating from 4 to 3 compared with level most recently reported to ARC. Will review again in December and if vacancy levels remain below 14% in December, will recommend for closure in preference for local vacancy risks

- **Risk ID *04347 – Implementation of the Community Mental Health Framework across Kent and Medway (increased from 9 (High) to 16 (Extreme))**
  The CMHF programme is complex and large in scale. There is a reliance on funding being received from the ICB to support all phases of the transformation. Funding is yet to be transferred to KMPT. This creates a risk to progressing the programme. KMPT are not in a position to mitigate the financial risk. Delays in funds being transferred have a direct impact on delivery timelines, therefore the risk score has been increased.

- **Risk ID *07557 – Trust Agency Usage (Increased from 12 (High) to 20 (Extreme))**
  This risk has increased in risk score due to the high level of agency spend currently in use across the Trust.

Risks Recommended for Removal

1 risk is being recommended for removal at this time:

- **Risk ID 00050 – 2023/24 Financial Planning (Rating of 12 (High))**
  The 23/24 planning round is now complete and therefore this risk is being recommended for removal from the BAF and will be closed. The actions included are either completed or form part of the Long-Term Financial Sustainability risk.

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New Risks

Four risks have been added since the BAF was presented to Board in July

- **Risk ID *02241 – Compliance with food legislation - temperature control checks of food (Rating of 16 (Extreme))**
  This risk has been open since January 2020 due to concerns about the monitoring of food temperatures at the point of food service. This has now been escalated to the BAF as the issue persists and catering concerns have been highlighted frequently through patient complaints and in recent CQC visits.

- **Risk ID *07556 – Expiry of lease for Littlebrook (rating of 9 (High))**
  This risk has been added due to the uncertainty around the lease of Littlebrook and the impact on Trust finances.

- **Risk ID *07557 – Trust Agency Usage (Rating of 12 (High))**
  This risk has been added due to the impact of agency spend on Trust finances.

- **Risk ID *05075 – Community Psychological Services Therapy Waiting Times (Rating of 16 (Extreme))**
  This is a longstanding risk originally opened in 2014, this has recently been updated for inclusion on the BAF. It is of relevance and importance as we move through the transformation piece and Mental Health Together so that each current patient on our waiting lists is transferred to their appropriate stepped care intervention

Emerging Risks

No new emerging risks have been identified for this report.

Other Notable Updates

- **Risk ID 04682 (Datix: 5991) – Organisational Risk – Industrial Action (Rating of 6 (Moderate))**
  This risk remains under review, and will be updated with learning from any of the periods where Consultants and Junior Drs are taking co-ordinated strike action. There is also consideration being given as to if this risk should be updated to reflect any backlog or delay in treatment caused by the periods of IA

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: 15 September 2023

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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

				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)
1 - We deliver outstanding, person centred care that is safe, high quality and easy to access																			
1.1 - Improving Access to Quality Care																			
12/01/2022 BAF Risk Opened → The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021. → 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 dementia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st September. → 31/10/2022 Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target. → 10/02/2023 **The system wide Dementia SIG has begun to meet again, chaired by KCC. There remains a question around the system wide clinical lead role for Dementia, but it is positive the SIG is meeting again. A draft strategy has been completed and is in the process of being shared with stakeholders**																			
InPhase ID 00580	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. EMAIS roll out for one step diagnosis as opposed to previously used two step model. 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 March 2023. 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** Trajectory development to reduce wating list from 1200 to 200 (Covid Backlog). This includes work on understanding the impact of the backlog work and new referrals on current waiting list. / Chief Operating Officer & Chief Medical Officer / 30/09/2023 / G Recruitment of additional medical capacity within KMPT to address the backlog as a result of additional funding approved and released to KMPT by the ICB. / Chief Medical Officer / 30/09/2023 / G MAS Recovery programme setup meeting twice a week / Chief Medical Officer / 31/03/2024 / A Dementia Strategy Development / Chair of K&M Dementia Service Improvement Group / 31/03/2024 / A Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment / Chief Medical Officer / 31/03/2024 / A	Chief Medical Officer		3	3	9	31/03/2024
30/08/2023 BAF Risk Opened																			
InPhase ID 05075	Aug 2023	Chief Operating Officer	**Community Psychological Services Therapy Waiting Times** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1.Active Review is in place in each CMHT locality. This involves an understanding and review of risk on a regular basis for all patients who are waiting some form of intervention. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3. Psychological Services to maintain spreadsheet database to track patients in pathway. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO. 6. Hybrid working in place as requested by patients needs 7. Expansion of psychological practice workforce use of Mental Health Wellbeing Practitioners, Clinical Associate Psychologists, Recruit to Train staff and Assistant Psychologists continues to grow. 8. Ongoing group interventions to reduce waiting times and parity of offer at place.	Assurances from dashboard data	4	4	16	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Waiting list review for mental health together / Director of Psychological Therapies / 31/08/2024 / A Psychological Practice Strategy / Director of Psychological Therapies / 31/10/2023 / A	Chief Operating Officer		1	2	2	30/08/2024

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)
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 BAF Risk Opened – 20/07/2023 Risk returned to BAF																			
InPhase ID 04232	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	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** Annual Ligature Audit (Undertaken in November) and subsequent ligature removal/reduction actions Trustwide (via Trust Capital Programme) also monitored/actioned via Directorate action plans and risk registers. / Deputy Director of Nursing / 28/01/2024 / A	Chief Nurse		1	4	4	31/03/2024
16/01/2020 Risk Opened – 18/08/2023 Risk added to BAF																			
InPhase ID 02241	Jan 2020	Chief Nurse	**Compliance with food legislation - temperature control checks of food** IF Food temperatures are not being consistently recorded at point of food service in food safety log books THEN the risk to the Trust is non compliance with food safety regulations. RESULTING IN possible inappropriate food temperatures, prosecution for non compliance via environmental health (EHO), possibility of food poising, burns, death, impact on food quality, reputation, criminal action against the Trust and individual staff (Server of food)	5	4	20	1/ HACCP - Safety log books on all wards - daily sign off by nurse in charge, weekly sign off ISS supervisors, monthly sign off KMPT Catering compliance mgr. 1d 2/ Modern matrons discussing with wards & ward managers non compliance 1a 3/ Acute wards as part on counting in out cutlery also confirm and sign that HACCP sheet has been completed. 1f 4/ Policies and procedures in place 1f 5/ Monthly catering contract review meetings with care groups 1h 6/ Risk being monitored via Nutritional steering group 1h 7/ Sending Deputy Director of Nursing regular e-mails with concerns/non compliance 1f 8/ training required lead by catering compliance Mgr. 1d	Food safety log books being checked by Catering compliance Manager monthly Facilities admin raise in phase for all non compliance for care groups to investigate Discussed at monthly catering meetings with care group representatives non compliance being discussed with Ward Managers Food safety books are being checked monthly by Facilities teams and issues reported to care groups/Directorates and monthly catering meeting Further training is being provided by Catering compliance Manager and ISS	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** New Catering Contract to include ward hostess role to take responsibility for completing food checks and completing the paperwork. / Head of Facilities / 30/11/2023 / A Non compliance with food safety is escalated within KMPT / Head of Facilities / 29/12/2023 / A	Chief Nurse		2	3	6	01/01/2024
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																			
			No Risks Identified against this Strategic Objective																
2 - We are a great place to work and have engaged and capable staff living our values																			
2.1 - Creating a culture where our people feel safe, equal and can thrive																			
04/12/2014 Risk Opened – 04/06/2021 Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award – 03/11/2021 Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing. – 13/03/2023 So far there has been little impact from industrial action. Business continuity plans and Command and control arrangements are in place and have so far proved adequate. This is being kept under review.																			
InPhase ID 04682	Jan 2019	Chief People Officer	**Organisational Risk - Industrial Action** IF industrial action is enacted within KMPT by Unison, Unite, BMA, RCN etc, or any external service affected by industrial action, which may have an effect on the business continuity of the Trust THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services	3	3	9	Industrial Action SOP inclusive of Command and Control [2e] Unique operational order/s. Significant Incident Plan [2e] Business Continuity Plans [2e] Workforce and OD Industrial Action Monitoring Group EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side Situation Reporting to ICB	Little impact from previous industrial action (Junior Drs Strike in 2016; RCN 2022 - No Impact; GMB Ambulance Staff 2022/23 - Minor Impact; ASLEF Train 2022/23 - Minor Impact; Teachers and Headteachers Union 2023 - Minor Impact; CWU Postal Union - Minor Impact; CSP Physiotherapists - Minor Impact). ICB Oversight of Trust Arrangements via ICB Operational Control Centre on non strike days for assurance and ICB Emergency Control Centre on Strike Days. Strikes are planned and therefore mandates are known in advance when they overlap or and concurrent.	3	2	6	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Post BMA Industrial Action Debrief to include update of SOP at the end of IA series. / EPR Lead / 31/10/2023 / A	Chief People Officer		1	1	1	29/07/2024

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)
			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.												
InPhase ID 00582	Nov 2021	Chief People Officer	**Organisational Sickness Absence** IF we fail to manage Covid-19 and Mental health Sickness Absence rate THEN we will be inadequately supporting the health and wellbeing of our staff and see sickness absence rates remain above the target of 5% RESULTING IN reliance on agency staff, increased staff turnover rate, reduced staff retention rates, increased cost and potentially lower quality service to patients.	5	4	20	Sickness absence policy Health & Wellbeing Group [2a] Range of targeted support and leadership Mental wellbeing and stress support Winter wellbeing messaging Health and Wellbeing Conversations [1a] Promotion of Flu and Covid vaccinations	Monitoring locally, Sickness Absence reporting through QPR, Workforce Committee and Trust Board	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Creating and promotion of more safe spaces for shared reflection (including Schwartz Rounds, Staff Council) / Chief People Officer / 31/03/2024 / A	Chief People Officer		3	3	9	31/03/2024
2.2 - Building a sustainable workforce for the future																			
			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 03/11/2022: This risk has been revised and updated to combine the turnover and retention risks and refocus them on the current trust priorities. 18/01/2023: The target vacancy rate hs been reviewed and ammended to 16%. this has led to a reduction in the likelihood score, reducing the overall current risk score. 13/03/2023: This risk has reduced in score to the Target rating as the vacancy gap for January is 16.1%. There is a high degree of confidence that the vacancy rate target will be met by year end, but the data will not be available till into April.												
InPhase ID 00871	Nov 2021	Chief People Officer	**Recruitment and retention** IF we fail to manage the current labour market influences on turnover and our ability to recruit successfully THEN this will impact on our achievement of the vacancy rate target of 15.5% RESULTING IN reduced staff morale and productivity, increased absence, reliance on agency staff, increased cost, potentially lower quality service to patients, loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Health & Wellbeing Group [2a] Career paths [2e] Early 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] Application of the hybrid working policy Support through the Centre for Practice and Learning for career pathways International recruitment	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c] NHS Staff Survey [2e]	3	4	12	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recruit to registered nursing degree apprenticeship places / Deputy Director of Workforce and OD / 31/12/2023 / A Develop and promote career pathways and opportunities (including through development of online Careers Hub) / Head of OD / 31/03/2024 / A Reducing time to hire to 45 days / Head of Resourcing / 31/03/2024 / A	Chief People Officer		3	4	12	31/03/2024
2.3 - Creating an empowered, capable and inclusive leadership team																			
			No Risks Identified against this Strategic Objective																
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																			
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																			
			15/02/2023 Risk Opened																
InPhase ID 04347	Feb 2023	Chief Operating Officer	**Implementation of the Community Mental Health Framework across Kent and Medway** IF the Community Mental Health Framework is not piloted with the appropriate governance and data systems in place, THEN it may not be possible for agencies to work effectively together RESULTING IN poor data quality for reporting to IQPR, Staff dissatisfaction and engagement with the pilot, continued capacity issues, lack of improved waiting times, inability to achieve parity of access regardless of patient age, reputational damage	4	4	16	CMHF Programme Board with Implementation group with associated plan, including 3 phases of implementation across county reporting in CMHF Programme Board with multi- agency digital workstream CMHF Programme Board dedicated communications lead Clear reporting lines established with clinical leadership and oversight of new models. Robust programme management in place with phases1 and 2 review in place	Community Mental Health Framework Programme Board	4	4	16	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Digital Solution for Data Collection and Reporting to be identified and implemented / Deputy Chief Operating Officer / 11/09/2023 / R Development of a communications plan for staff / Deputy Chief Operating Officer / 28/07/2023 / A Development of patient pathways / Deputy Chief Operating Officer / 11/09/2023 / A Discussions underway with the ICB to clarify and develop financial flows to partner organisations / Chief Operating Officer / 31/08/2023 / A Integration of provider workforce to aid skill mix and new ways of working / Chief Operating Officer / 30/03/2024 / A	Chief Operating Officer		2	3	6	30/04/2024
3.2 - Working together to deliver the right care in the right place at the right time																			
			06/06/2022 Risk Opened 15/09/2022: Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages. 14/03/2023: **This remains a high risk for the Trust. There is a better grip and understanding of our DTOCs, and things are improving, but there are daily fluctuations.**																
InPhase ID 00410	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly DToC check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events Social worker seconded into Patient Flow team Weekly meeting between dedicated KCC Assistant Director and service manager, and KMPT Deputy COO and Senior patient flow manager to plan future initiatives and support individual patient escalations Discharge Assessment form revised to explicitly detail any potential DToC issues. ICB led meetings - focus on creating capacity across K&M for onward transfer.	Daily scrutiny of DToC data	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Development of step down beds in progress with ICB. Funding agreed for the equivalent of 7 step-down beds / Deputy Chief Operating Officer / 01/08/2023 / A Consideration with ICB and Local Autority on potential for dedicated local authority commissioner to solely work on DToC reduction by intensive placements support / Deputy Chief Operating Officer / 28/02/2023 / R Exploring Step down options for DTOC / Chief Operating Officer / 02/10/2023 / A	Chief OperatingOfficer		3	2	6	01/09/2023
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones				Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
4 - We use technology, data and knowledge to transform patient care and our productivity																						
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																						
13/03/2023 Risk Opened																						
InPhase ID 07442	Mar 2023	Executive Director of Finance	**Module Reporting via DATIX and InPhase** IF DATIX abruptly ceases access by KMPT to the archive data sets available prior to 13 March 2023 THEN KMPT will be reliant only on the new InPhase modules in so far as they have been migrated and reports built. RESULTING IN inability to present complete data in a recognised format against requests for assurance and compliance on statutory and contractual obligations.	5	4	20	InPhase Project Board Access to the licence key for Datix until Aug 23 Most data has been migrated to InPhase Database access to Datix.	Data Migration Audit	3	4	12	⟷	Data Migration	Director of Digital and Performance	31/08/2023	A	Executive Director of Finance		3	3	9	16/05/2023
4.2 - Enhance our use of IT and digital systems to free up staff time																						
			No Risks Identified against this Strategic Objective																			
4.3 - Effective digital tools are in place to support joined-up, personalised care																						
			No Risks Identified against this Strategic Objective																			
5 - We are efficient, sustainable, transformational and make the most of every resource																						
5.1 Achieve financial sustainability																						
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. → 14/03/2023 This risk has been reviewed and updated for the coming financial year.																						
InPhase ID 00256	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not continue to focus on cost savings, productivity and efficiency initiatives to ensure services are financially sustainable THEN it may move back into an underlying deficit position, RESULTING IN increased scrutiny from NHSE/I, potential for financial sanctions to 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. Monthly reporting is taking place through QPRs and Finance Reports, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs. Service Line reporting (SLR) data has been utilitised to inform of services with underlying deficits and update papers provided to FPC and Trust Board. SLR data being reviewed routinely to ensure Directorates clear on actual and underlying SLR position.	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance		3	3	9	31/03/2024
													Delivery of multiyear efficiency programme	Deputy Director of Finance	31/07/2023	A						
													Review of six identified loss making services to identify drivers to the position	Deputy Director of Finance	30/09/2023	A						
													Review activity and service data to identify any unwarranted variation within the loss making services	Deputy Director of Finance	30/09/2023	A						
													Clear workplan and detailed approach to unwarranted variation work	Deputy Director of Finance	30/09/2023	A						
													Review of underlying deficit position for 2024/25 planning	Deputy Director of Finance	30/09/2023	A						
													Monthly reporting is taking place through QPRs and Finance Reports	Deputy Director of Finance	30/09/2023	A						
													Review pricing and contracting for services prior to 2024/25 planning round	Deputy Director of Finance	30/09/2023	A						
22/03/2022 Risk Opened → 14/03/2023 Risk updated for the 2023/4 financial year → 22/08/2023 Risk recommended for Closure																						
InPhase ID 00050	Mar 2023	Executive Director of Finance	**2023/24 Financial Planning** IF the Trust fails to deliver on the 2023/24 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] Forecast papers for FPC Agreed contracts with commissioners	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance		2	3	6	31/03/2024
													Agency monitoring to be implement for Month 2 Reporting	Deputy Director of Finance	31/05/2023	A						
													Review of the £6.15m vacancies identified in planning to be completed in Quarter 1	Deputy Director of Finance	30/06/2023	A						
													2023/24 Cost improvement programme to be fully agreed in Quarter 1	Deputy Director of Finance	30/06/2023	A						
													Signed Commissioner Contracts	Director of Contracting, Information Governance and Business	30/06/2023	A						
22/08/2023 Risk Opened																						
InPhase ID 07557	Aug 2023	Executive Director of Finance	**Trust agency usage** IF the Trust fails to contain agency spend within the 2023/24 spend cap 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. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	12 (High) to	Monitoring of agency usage and compliance with usage and rate limits is an NHSE expectation of all systems and providers with established governance processes in place to oversee agency staffing.	4	5	20	↑	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance		3	3	9	31/03/2024
													Executive led agency control meetings	Deputy Director of Finance	30/09/2023	A						
													Implementation of No agency admin being progressed, policy being implemented with no new agency being agreed	Deputy Director of Finance	30/09/2023	A						
													Present agency establishment being review to identify the impact of removing the staff and opportunities for permanent recruitment.	Deputy Director of Finance	30/09/2023	A						
													Position statement for EMT review provided monthly	Deputy Director of Finance	30/09/2023	A						
													Any exceptions to be discussed with ICB before requesting regional approval	Deputy Director of Finance	30/09/2023	A						
5.2 Exceed the ambitions of the NHS Greener programme																						
			No Risks Identified against this Strategic Objective																			
5.3 Transform the way we work																						
			No Risks Identified against this Strategic Objective																			

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)
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																
6.2 - Invest in a fit for purpose, safe clinical estate																			
	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. 14/03/2023 The capital allocation for 2023/24 is severely limited across the system, which limits the ability of the Trust to invest in life expired buildings and equipment.															
InPhase ID 00119	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not prioritised robustly, and delivered as planned THEN the restricted capital allocation for 2023/24 may not be fully utilised despite a high need for capital spend across the organisation, RESULTING IN inability to invest in life expired equipment or buildings, increased pressure on the operational maintenance budget, potential for an increasing backlog, clinical and workplace environments which may not be fully fit for purpose, potential loss of use of a facility.	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** Develop 3-5 year capital plans to address backlog maintenance and service issues — Director of Estates and Facilities — 31/03/2023 — G Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available — Director of Estates and Facilities — 30/06/2023 — A Provide comprehensive report to Trust Capital Group. — Director of Estates and Facilities — 30/09/2023 — A Maintain monitoring of capital scheme to ensure work can be reprioritised if more significant issues present — Director of Estates and Facilities — 30/09/2023 — A	Executive Director of Finance		2	3	6	31/03/2024
	17/11/2021 Risk Opened 20/07/2022		All actions have been completed and this is being managed as business as usual. 14/03/2023 This risk has been updated in light of the challenging financial climate for 2023/24.																
InPhase ID 00524	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	3	4	12	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Complete full competitive compliant procurement process — Director of Estates — 31/07/2023 — G Planned and effective mobilisation of new contract — Director of Estates — 01/10/2023 — A	Executive Director of Finance		3	4	12	30/09/2023
	22/08/2023 Risk Opened																		
InPhase ID 07556	Aug 2023	Executive Director of Finance	**Expiry of lease for Littlebrook** IF we cannot negotiate a suitable settlement figure for terminating the Littlebrook lease arrangement in 2025 and cannot secure capital and cash support to progress this THEN the Trust will need to negotiate a further long term lease agreement for the site so that services can continue to be delivered from this location RESULTING in potentially higher lease charges with vulnerability to future changes in inflation and the Trust not holding ownership of the building until the new lease terminates. If capital funding cannot be provided by the ICB the Trust would need to meet this from internal capital allocations, thus reducing monies available for other schemes.	4	3	12	Reporting to Trust Board [3a] Finance and Performance Committee monitoring [2b]	Reporting to FPC	3	3	9	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** External legal advisers have been appointed to advise the Trust on options — Executive Director of Finance — 31/10/2023 — A Discussions have commenced with NHSE and the ICB to secure capital funding (noting whichever option we pursue will require capital funding.) — Executive Director of Finance — 31/10/2023 — A Negotiations will be required with the investors to reach a suitable way forward — Executive Director of Finance — 31/03/2024 — A	Executive Director of Finance		2	3	6	31/12/2024

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Strategy Delivery Update
Author:	Sheila Stenson, Chief Finance Officer and Deputy Chief Executive
	Adrian Richardson, Director of Partnerships and Transformation
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview update on the delivery of the KMPT Trust Strategy.

Issues to bring to the Board's attention

In April 2023 KMPT agreed the 2023-26 Trust Strategy which sets out the direction for the organisation, a transformative one with specific outcomes that will need to be delivered by the organisation.

Progress has been made on a number of the outcomes and where the outcome is off track delivery plans are in place to adjust the processes and necessary resourcing to deliver the outcomes by March 2026.

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board

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Introduction

This paper provides an update and assurance to the Trust Board on progress against the Trust new ambitious three-year strategy.

KMPT agreed the 2023-26 Trust Strategy which sets out the direction for the organisation, a transformative one with specific outcomes that will need to be delivered by the organisation. Appendix A was part of the paper presented to Trust Board in March 2023 outlining the delivery of the strategy. The overall delivery is on track as set out in the March paper. Through that work we have identified areas of focus and details are contained within this report.

The strategy is based on three strategic ambitions and three strategic enablers. Each ambition and enabler have a number of outcomes associated with it and as such will require transformative change support to successfully implement.

Strategic Ambition	**Number of Outcome Objectives**
We deliver outstanding, person centred care that is safe, high quality and easy to access	14
We are a great place to work and have engaged and capable staff living our values	15
We lead in partnership to deliver the right care and to reduce health inequalities in our communities	11

Strategic Enabler	**Number of Outcome Objectives**
We use technology, data and knowledge to transform patient care and staff productivity	9
We are efficient, sustainable, transformational and make the most of every resource	14
We create environments that benefit our service users and people	7

Current State

The below table sets out the performance at the end of quarter two.

Strategic Ambition	**Areas Proceeding to Plan**	**Areas of Focus**
We deliver outstanding, person centred care that is safe, high quality and easy to access	8	6
We are a great place to work and have engaged and capable staff living our values	10	5
We lead in partnership to deliver the right care and to reduce health inequalities in our communities	9	2

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Strategic Enabler	Areas Proceeding to Plan	Areas of Focus
We use technology, data and knowledge to transform patient care and staff productivity	7	2
We are efficient, sustainable, transformational and make the most of every resource	11	3
We create environments that benefit our service users and people	7	0

EMT Areas of Focus

The below provides a brief summary of the areas of focus and the actions being taken to mitigate the delivery.

1. 95% of people referred for a dementia assessment will be seen within 6 weeks, Forecast mental health capacity and meet demand – Work has been undertaken to reduce the Covid backlog with a trajectory to bring this to zero by the end of September. A programme of work has been developed to address the longer-term challenges of increasing demand, variation in clinical practice, difficulty in recruiting to roles and challenges around mixed caseloads. Accurate demand and capacity modelling will be undertaken in October and this will be reported to Quality Committee.
2. Increase satisfaction for in-patient experience by 10%, Reduce in-patient harms relating to medicine incidents, self-harm, falls and sexual safety by 10%, Increase service user experience of receiving care, Improve patient outcomes – preparatory work is now underway to ensure data definition, collection and review processes are in place. Work around Dialog+ and bringing this forward within the organisation plan is underway. As a result, the anticipated work is reporting as red but with preparation over Q3 it is anticipated a change in this as the strategy enters Q4.
3. Reduce racist violence and aggression incidents to 15%, in line with the national average – there has been slippage in some of the workshop plans at senior leadership level. A revised plan is underway.
4. Reduce our agency spend to 3.7% of the trust total pay bill – A draft options plan is being reviewed at EMT with options to reduce agency spend by 42% in months seven to 12.
5. Process Re-Engineering of corporate support systems, Process Re-Engineering of operational support systems – A review of areas of opportunity has begun and resourcing identification is underway. Support services are reviewing their workplans to assist predominantly around digital capability and how this fits in with the digital strategy areas.
6. Delivery of the digital outcomes has undergone an extensive review and has been mapped against the digital strategy, the opportunities within process re-engineering and prioritised to meet the need to enable the success of the ambitions. The delivery plan will be adjusted for Q3 and beyond and it is expected that this will move those off-track to on-track throughout Q3 and Q4.

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Review

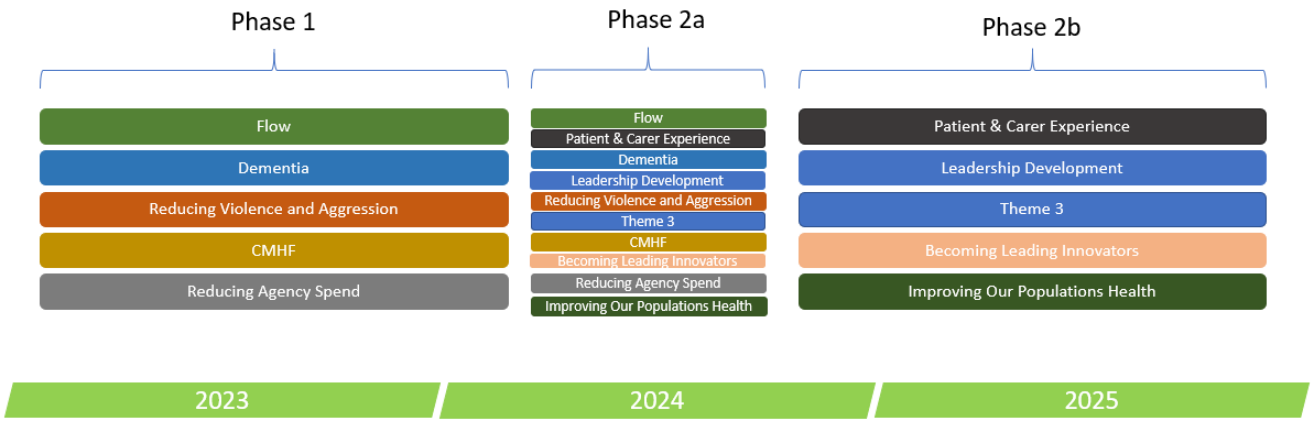
As a number of the outcomes have similar themes and with the scope of the strategy running over three years, we have always been very clear it is necessary to phase resourcing and delivery over the life of the strategy. This will also allow for preparation of a number of the outcomes where there is work needed either from a data, infrastructure, interdependency or resource perspective to ensure success.

This will allow the outcomes to be designated as either a:

- Driver – this is an outcome that is a priority and effort is being concentrated on this to deliver in the current timeframe.
- Preparation – work is underway in the background to ensure success where effort is concentrated on the outcome in the coming months.
- Watch – the outcome is being monitored and reported to the Strategy Deployment Group frequently but active effort is not being concentrated at the current time.

As we move into quarter three it is clear it is necessary to prioritise those outcomes that are drivers as themes over the course of the strategy therefore delivering the strategy in 3 phases. This will allow us to communicate the five themes more clearly to staff and for us to map out the interdependences which are becoming apparent now with a number of the ambitions/enablers.

An example of this is set out below.



Conclusion

The organisation has mobilised behind the new KMPT strategy and its delivery using our new methodology. The structure and scope of the strategy has highlighted priority areas for year one and also the conditions needed to ensure success of other outcomes within the strategy.

The phasing of delivery will ensure concentrated effort while preparing for further success and ensuring that improvements are sustainable.

Where workstreams are not running to trajectory mechanisms are in place to identify the cause and correct the course, with progress monitored by the appropriate board subcommittees.

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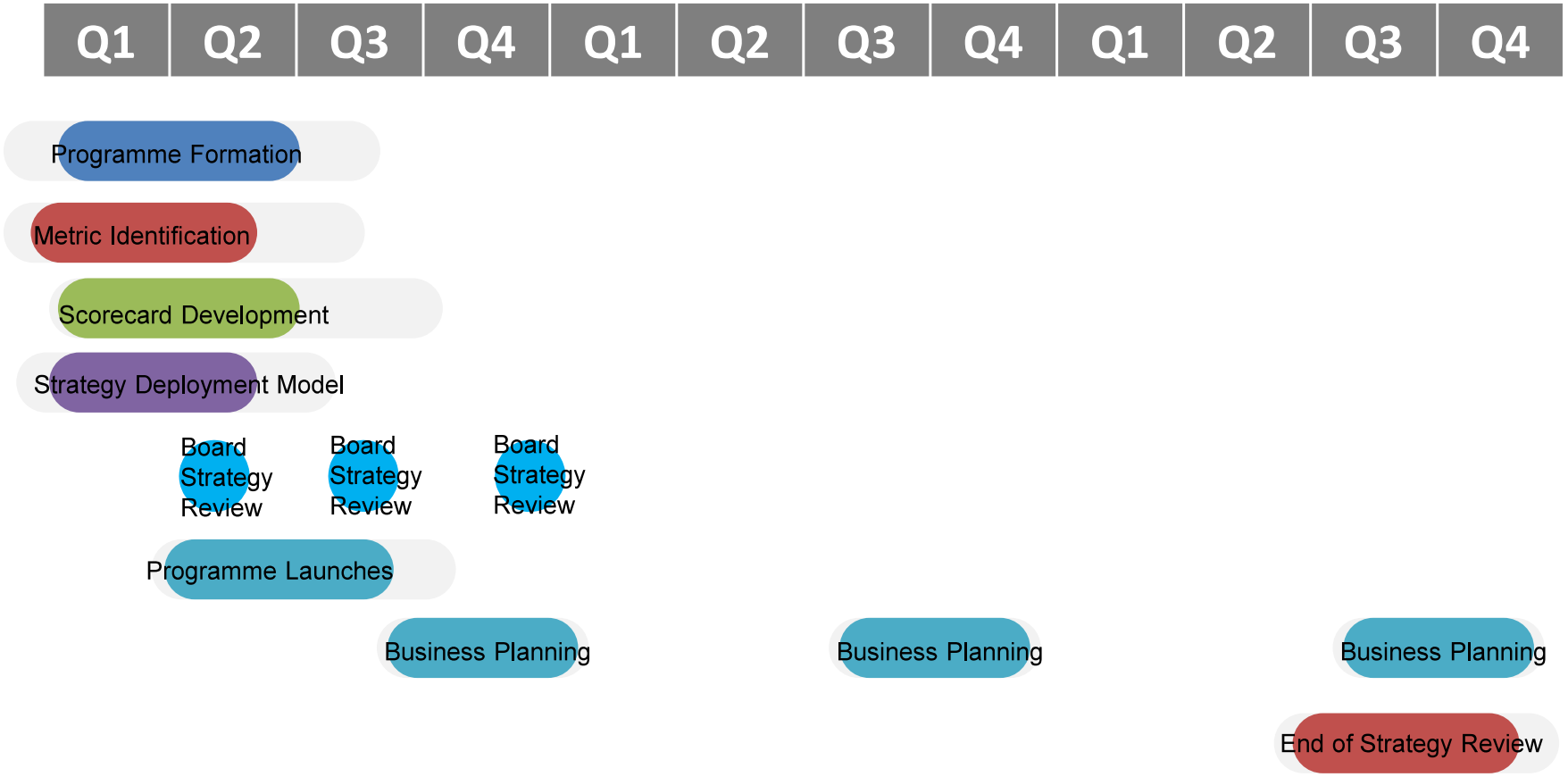
Setting Us Up For Success



Detailed Plans to be monitored via appropriate Board-Sub Committees

Brilliant care through brilliant people

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative Update
Author:	Adrian Richardson, Director of Partnerships & Transformation
Executive Director:	Adrian Richardson, Director of Partnerships & Transformation

Purpose of Paper

Purpose:	For discussion
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview update for the Board meeting of the Collaborative and progress of its work programmes on the 19th July 2023. It also outlines the risks that have been identified within a number of the workstreams.

Issues to bring to the Board's attention

The Provider Collaborative (PC) for Mental Health, Learning Disability and Autism held its inaugural meeting in May 2022.

The PC operates at a strategic level aimed at continuous improvement. Supporting it are multiagency working groups focusing on each of the PC's priority areas.

Governance

Implications/Impact:	KMPT Trust Strategy - Use our expertise to lead and partner
Assurance:	Reasonable
Oversight:	Integrated Care Board

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July Provider Collaborative Board Meeting

The meeting followed the current standard agenda of:

- Patient Story
- Priority Workstream Deep Dives
- Standard Operational Items
- Strategic Finance Items

Patient Story

Presented by Jacqui Davis (Programme Lead – Kent and Medway ICB) the meeting heard of two case studies from Community Crisis Alternative Services, that are funded by service development funding, donated by NHS England (NHSE).

One case study was on the use of Safe Havens which provides an alternative location to Emergency Departments and other secondary care settings and the impact on providers that can be achieved from these.

The second case study was on the Crisis Peer Alternative Service which provides 16 weeks of tailored support, delivered by peer support workers.

Deep Dives

The PC undertakes Deep Dives into workstreams at every meeting. In July these were:

Psychological Wellbeing

The meeting received information about the NHS Talking Therapies Oversight Group. It was noted that key performance indicators for May 2023 had been achieved and were slightly above target. Workforce issues around recruitment and retention remain a risk and this is comparable to other services nationally.

It was recognised that the performance of Talking Therapies is monitored by the ICB and is now business as usual and as such this workstream has been removed from the PC.

Mental Health Urgent and Emergency Care

The meeting received an update on Safe Havens and the intention to increase these across Kent and Medway from five to nine Safe Havens, three of which will be open for 24 hours. Locations for Safe Havens in East Kent has been problematic and KMPT are assisting with a possible location within our estate.

In March 2023 NHS 111 select option two was launched. As a result, there has been a reduction in use of the South East Coast Ambulance Trust (SECAMB) Mental Health service. A few challenges have been identified – some less urgent calls are coming through 111 – this is being looked into.

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Out of Area Specialty Placement

The meeting was briefed that the target is to get to 30 Out of Area Placements by the end of the financial year. The programme is on track to achieve this target. There has been a reduction of 12% in costings.

A comprehensive overview has been achieved of people remaining in out of area beds. This work is KMPT-led but works across the system. The PC agreed to remove this workstream as this was now business as usual.

Learning Disability and Autism Delivery Partnership Update.

A new multi-agency approach is underway for inpatients with Learning Disability/Autism. Funding is in place for a proposed improvement in the discharge process for these patients. There was a request for support from the PC for this.

In Kent & Medway there is a significant increase in demand for the adult ADHD pathway, this matches or exceeds a 400% to 700% increase nationally, resulting in a seven year wait. The commissioned financial envelope does not meet demand, and the clinical offer has to be limited to focus on medical prescribing until additional funding is received.

The intention is to redesign the pathway to establish how to support people who may have ADHD, to then create self-management and community structures and to set up a number of workstreams working in partnership with people with lived experience.

Dementia

For June the dementia diagnosis rate had increased from 58.4% in May to 58.6%.

Over 600 people attended a Dementia Showcase event as part of Dementia Action Week which aimed to raise awareness of dementia across the county, identify opportunities for research and to drive discussions on how to align different components of transformation across Kent and Medway to support dementia services.

A deep dive into dementia services will be undertaken at the Provider Collaborative Seminar in October.

Risk Register

In May KMPT Board requested that a risk register for workstreams contained within the PC was provided. Following leadership changes within the ICB in June the Operational Delivery Group has been working to provide a uniformed understanding of risks across all the workstreams.

There has been a number of challenges to ensure uniformity however throughout July and August a number of workstreams have aligned to provide this. The remaining workstreams are working on this throughout September and it is anticipated that all workstreams within the PC will be reporting in a standard way from October.

The current risk register is attached as appendix A. There are 5 risks with a score above 12 for the Urgent and Emergency Care workstream and 3 for the Dementia workstream. The Community Mental

Health Framework risks are due to be reviewed at the Operational Delivery Group in September and will therefore be reported in the next report to KMPT Board.

Anticipated Plan

A PC Development Session is planned for 2nd October where a discussion will be facilitated on the future strategic direction of the PC including a review of the workstreams that remain in scope and to highlight additional workstreams that will benefit from being part of the PC.

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Kent and Medway

Adult Mental Health Team Risk Register Overview

August 2023

NHS
Kent and Medway

Summary of Risks Scoring 12 or Above by Programmes

Adult Mental Health Team Programme	Number of Risks (Scoring 12 or Above)	Risk Title
Community Mental Health	0	
Urgent and Emergency Care	5	Urgent Crisis Line (NHS111 Select 2) Safe Haven Service Older Adult Length of Stay MH Patients Clinically Ready for discharge Out of Area Placements (OAP's)
Dementia	3	Dementia Diagnosis Rate Dementia Programme Resource MAS
NHS Talking Therapies	0	
Corporate	0	
Workforce	1	Mental Health Long Term Plan – Workforce

Risks Register Summary

NHS Kent and Medway

Date Raised	Risk Description	Likelihood	Impact	Risk Rating	Owner	Mitigation Action
27/10/2021	There is a risk that the Mental Health Programmes will not achieve the additional workforce growth required to meet LTP ambitions. Leading to a reduction in capacity and activity, as well as an increase in waiting times for assessment and treatment, resulting in poor outcomes for patients, and an increased demand on secondary care and emergency services			12	Jill Lane	Collaborative partnership signed by 3 providers. Lead provider gathering momentum working up resources required for next 2 years to expand in line with LTC expectations Shawtrust have recruited some posts, and they're confident in their ability to fill the remaining.
10/06/2022	IF the local 23/24 DDR target of 61.25% is not achieved THEN people living with an undiagnosed dementia will have a lack of access to information, guidance and appropriate support RESULTING IN delays to people accessing care, diagnosis and treatment, increase in crisis situations, reduction in appropriate and timely end of life planning, national scrutiny and damage to the systems reputation.			12	Victoria Nystrom-Marshall	GPwER supporting additional diagnoses in KMPT DiADeM pilot in Medway and Swale KMPT committed to reducing the waiting list by Mar 24, including addressing any patients referred prior to 1st Apr23 by Dec23 20% additional Dementia Co-ordinators in 23/24 implemented DGS Frailty and Delirium pathway delivered. DDR 62.23% Apr23
10/04/2023	IF the programme is not appropriately resourced THEN it will not be possible to deliver all of the initiatives proposed RESULTING IN delays to implementation, scope change and reputation damage			20	Victoria Nystrom-Marshall	Clear budget and appropriate programme workforce aligned to agreed deliverables
10/06/2022	If the waiting list is not reduced, then the 6 week to diagnosis ambition will not be met leading to patients not receiving cholinesterase inhibitors that will delay the progression of dementia. Resulting in lack of effective management of symptoms, not maintaining independence in own homes and a rise in crisis situations leading to avoidable hospital/care home placements			20	Victoria Nystrom-Marshall	KMPT BI to produce trajectory to understand backlog and recovery plan
10/2023	Delays in KMPT Urgent Crisis Line (NHS111 Select 2)response to calls is compromised due to delay in implementation of Referral Management Hubs (part of CMHF).			12	Jacqui Davis	Lack of locally agreed KPIs
10/2023	Delay in meeting the target of 2021/22, for all areas to provide crisis resolution and home treatment teams (CRHTTs) that are resourced to operate in line with recognised best practice delays improvement to the 4hr urgent response rate and capacity for home treatment. This impacts patient safety, patient experience, inpatient bed capacity and corporate reputation.			12	Jacqui Davis	KMPT to share performance target against 4hr urgent assessment response time to inform whether or not risk rating can be reduced. Benchmarking both the Crisis Response function and Home Treatment Function against the national fidelity model will take place by end of Q2 and will inform whether or not risk rating can be reduced.

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Kent and Medway

Date Raised	Risk Description	Likelihood	Impact	Risk Rating	Owner	Mitigation Action
10/2023	There is a risk that with no identified space for revised safe haven service in WHH, QEQM Leading to lack of alternatives to ED attendance/S136 presentation resulting in halting the programme initiative.			12	Jacqui Davis	No identified space to site Revised Safe Haven Service (Urgent Care Hub) in Thanet, Ashford and Medway will halt this Programme Initiative to provide a viable community crisis alternative for individuals in crisis, as an alternative to ED, 136 or inpatient admission
10/2023	Increased numbers of inpatients clinically ready for discharge, mean people are waiting for admission in environments that are clinically unsafe and could lead to major injury.			16	Louise Clack/Jacqui Davis	Use of private beds ICS Action Plan in place with key stakeholders overseen by ICB/KMPT exec including:-appointment to senior Social Care DToC Lead, market engagement/stimulation by KCC with supported living providers, appointment by KMPT of a discharge transitions team to inreach post discharge, senior system partner leader attendance at weekly DToC call. Crisis House and Safe Haven procurement in process as alternatives to inpatient admission
10/23	Increased numbers of inpatients clinically ready for discharge and subsequent long lengths of staf means people are waiting for admission in environments that are clinically unsafe and could lead to major injury, and those medically fit for discharge are at risk of deconditioning and relapse.			16	Louise Clack/Jacqui Davis	ICS Action Plan in place with key stakeholders overseen by ICB/KMPT exec including:-appointment to senior Social Care DToC Lead, market engagement/stimulation by KCC with supported living providers, appointment by KMPT of a discharge transitions team to inreach post discharge, senior system partner leader attendance at weekly DToC call. Crisis House and Safe Haven procurement in process as alternatives to inpatient admission.

Kent and Medway NHS
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**28th September 2023**
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

The IQPR provides an overview of wide range of trust service across numerous indicators, this represents one element of the trusts Performance Management Framework and is supported by monthly Directorate Quality Performance Review meetings as well as local structures for reviews of performance within the directorates. The following represents a strategic view of the areas of greatest focus across the trust:

Days lost to those **Clinically Ready for Discharge** increased by 0.6% to 13.6% the highest position of the last 12 months, the majority of patients currently delayed are older adults which also impact on length of stay. Colleagues in the ICB have commenced a piece of work to support KMPT in helping to secure the most appropriate onward provision for those delayed. Options include utilising funding to offer short term support to providers on the Kent County Council Framework to accept complex patients on the understanding that KMPT will provide in-reach support.

CMHSOPs are not meeting the 6 **weeks to initial assessment and 18 weeks to second appointment performance target for dementia**. This has resulted in 2,700 patients awaiting an initial assessment with a further 800 awaiting a second appointment. Immediate actions are being taken to address the issues experienced in ongoing waits, which includes the teams continuing to review caseloads to ensure accuracy of waiting lists and understanding capacity available to deliver each aspect of the

pathway. Actions are overseen by the Chief Medical Officer. A Memory Services Improvement Programme, made up of six task and finish groups, has been launched to implement the changes to the service model needed to achieve the 6 weeks to diagnosis target with agreed timelines monitored via transformation programme and via the monthly Quality Performance Reviews.

In August there was a 2.6% increase trust wide in **Non CPA Care Plans and Personal Support Plans**, largely achieved by the work to ensure all MHLD patients is ongoing and has resulted in an improvement from 60.4% at the end of July to 86.1% at the end of August.

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.

Restrictive Practice

Restraints:

- 120 reported incidents of restraint needing to be used in July 2023, an increase of 28 from the previous month. Acute Directorate reported 118 and Forensic & Specialist reported one incident. Remaining one incident occurred in West Kent ECT suite
- One incident reported moderate harm, a patient self-harmed which initiated the restraint.
- There were 15 reported **Prone** restraints, all within the Acute Directorate and involved 13 patients. The reason stipulated in all incidents was for IM Injection purposes

Seclusions:

- 21 reported episodes of seclusion in August, a decrease of three from the previous month.
- All episodes occurred within the Acute Directorate and involved 17 patients with one patient being secluded four times

Long-Term Segregation (LTS)

- There were 26 long-term segregations across the inpatient services reported in August. 25 occurred in the Acute Directorate and one within the Forensic and Specialist Directorate.
- Further work is required across inpatient sites for staff to understand what constitutes LTS and how this differs from seclusion. This will also require cultural change work and close monitoring via managers/matrons' huddles and within the Promoting Safe Care Group.

Blanket Restrictions

- All ward managers complete a Blanket restriction log that is reviewed monthly as per policy. These reviewed by the Directorate Governance teams.
- This section of the new Use of Force Policy has been rewritten to provide clear guidance and stricter governance of blanket restrictions – due for consultation soon.

Rapid Tranquilisations

- There were 35 reported incidents of Intra muscular Rapid Tranquilisation being used under restraint during August, all occurred within the Acute Directorate.

- A further eight incidents reported giving oral rapid tranquilisation during restraint, all occurring in the Acute Directorate.

Additional Information

The Promoting Safe Care group have refreshed the agenda with LTS/Blanket Restriction Logs/reported crimes and aggression & violence against staff updates now becoming standing agenda items. The Group has also reviewed its Terms of Reference to have oversight on all initiatives, QI and QAP work in reducing aggression and violence and the use of restrictive practices. Increased monitoring, accountability and shared learning will further enable our services to review and reduce. Group membership to include more technical advisors, clinical staff and other stakeholders from all Directorates and Workforce to support staff/teams in this important area

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
011.S	Restrictive Practice - All Restraints		-	-	72	87	67	74	83	80	69	66	73	82	94	120
020.S	Unplanned Readmissions within 30 days		8.8%	L	4.4%	4.3%	5.0%	8.4%	4.1%	6.2%	8.2%	3.6%	3.8%	7.6%	9.4%	7.0%

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): Chief Medical Officer
Lead Board Committee: Finance and Performance Committee

Issues of Concern

Bed pressures

The trust retains a strong focus to enable the management of beds within capacity to minimise the impact on patients and carers by reducing inappropriate out of area patients. The trust continues to have a low bed stock when compared national means, 13.9 per 100,000 population compared to a national mean of 20.5 for Younger Adult acute beds and 21.2 compared to 42.4 nationally for Older Persons acute beds. To allow management within bed stock, KMPT has increased occupancy and lower lengths of stay compared to national averages. Despite these challenges there have been recent reductions in inappropriate out of area placements, over the last three months 38 acute bed days were used in non-commissioned placements, an average of 0.41 per day which is reduction compared to 1.76 per day over the last 12 months. The trusts bed strategy was presented to board in July 2023 which sets out the approach to ensuring the KMPT acute bed stock can meet the local populations needs in future years.

There is a continued need to use external PICU beds due to the local provision being insufficient to meet the needs of the population with Willow Suite being a male only 12 bedded unit. There continues to be 5 female PICU procured within the Kent and Medway footprint to ensure patients are placed as close to home as possible. In addition, there is an ongoing need for additional PICU placements, with an average of 3-4 per day over the last 12 months. The national benchmarking results for 2022/23 are expected to be published in October containing key information such as the national mean for LoS, findings will be considered and reported in future reports.

National benchmarking relates to 2021/22 data, 2022/23 report expected October 2023

Community Services

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. All community services continue to review caseloads in line with the implementation of the Community Mental Health Framework. The reduction of caseloads which can only be achieved with support from all agencies providing a suitable step-down model for patients whose mental state is stable.

Kent and Medway NHS
NHS and Social Care Partnership Trust

Care Planning

Care planning continues to be an area of challenge, ongoing monitoring within directorates ensures a focus is retained, it should however be noted that DIALOG + training is now planned for these services between now and March 2024 after which indicators around care planning will need to be reviewed.

Executive Commentary

Clinically Ready for Discharge (006.E)

- Days lost to those Clinically Ready for Discharge increased by 0.6% to 13.6% the highest position of the last 12 months, the majority of patients currently delayed are older adults which also impact on length of stay.
- Colleagues in the ICB are now leading a piece of work to support KMPT in helping to secure the most appropriate onward provision for those delayed.

	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			21.0	0.0	-9.8	83.6	36.9
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			129.0	0.0	2.5	240.5	121.5
4	Trust Total			150.0	0.0	16.3	300.6	158.4

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

- 150 bed days were used in August (21 YA Acute and 129 PICU), compared to 62 bed days used in June (0 YA Acute and 62 PICU).
- The use of PICU external bed days remains below the mean of the last 24 months
- A revised process for monitoring external placements is in place to ensure external placements are constantly reviewed.

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			66.7%	95.0%	75.7%	96.3%	86.0%
2	Forensic and Specialist			90.0%	95.0%	88.9%	97.5%	93.2%
3	East Kent			87.5%	95.0%	87.7%	96.5%	92.1%
4	North Kent			78.2%	95.0%	78.6%	91.3%	84.9%
5	West Kent			76.4%	95.0%	80.0%	88.8%	84.4%
6	Trust Total			82.3%	95.0%	85.3%	91.0%	88.1%

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	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
2	Forensic and Specialist			85.1%	80.0%	63.4%	77.6%	70.5%
3	East Kent			78.6%	80.0%	73.5%	82.1%	77.8%
4	North Kent			63.2%	80.0%	62.1%	71.0%	66.5%
5	West Kent			60.5%	80.0%	55.0%	65.2%	60.1%
6	**Trust Total**			71.4%	80.0%	67.8%	73.2%	70.5%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Special Cause Variation of a **Concerning nature** *Non CPA PSP & Care Plans:* Special Cause Variation of a **Concerning nature**
Assurance	Variation indicates consistently **failing short of target**

Narrative

CPA Care Planning

- Across the locality Directorates CMHTs, CMHSOPs and EIP teams contribute to over 80% of this indicator. The trust wide position represents an increase month of 1.4%, this has been driven by an increase of 7.7% across Early Intervention Services.
- In North and West Kent, where compliance is at the lowest, a data cleansing exercise has been undertaken and the team leaders are working with individual practitioners, through the supervision process on their caseload to ensure all patients have an up to date care plan/ PSP. It is expected to demonstrate significant improvement by October 2023.
- FSS Directorate continues to exceed 90%, the Acute Care Group Figure reflects a low number of patients (18).

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

- Trust wide performance increased 2.6% in August following a period of only minor variations in the last 12 months, although continuing to fall short of target.
- The North Kent Directorate had shown special cause variation due to a run of points below the mean of the last two years, positively the NK position increased by 3.5% in month this is driven by improvements of over 10% in Medway and Swale CMHTs.
- The Forensic and Specialist Directorate are no longer showing special cause variation, work to ensure all MHLD patients is ongoing and has resulted in an improvement from 60.4% at the end of July to 86.1% at the end of August.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
001b.E	CPA patients receiving follow-up within 72hours of discharge				77.2%	89.7%	78.7%	79.7%	84.6%	83.2%	84.5%	84.3%	76.4%	79.0%	78.1%	73.0%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.3%	95.2%	95.3%	95.4%	95.1%	95.4%	95.3%	95.5%	95.3%	95.4%	95.4%	95.5%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	298	183	169	150	117	123	125	217	173	107	62	150
006.E	Clinically Ready for Discharge		7.5%	L	12.2%	11.1%	11.5%	13.0%	12.2%	11.6%	10.9%	10.6%	12.6%	13.1%	13.0%	13.6%
012.E	Average Length Of Stay(Younger Adults)		34	L	34.76	36.14	36.33	34.49	36.48	37.94	36.24	30.31	28.11	34.81	35.61	36.38
013a.E	Average Length Of Stay(Older Adults - Acute)		77	L	98.88	78.42	89.65	125.16	113.50	76.24	106.36	70.80	97.59	121.03	109.81	83.58
015.E	%Patients with a CPA Care Plan		95%	L	88.2%	88.4%	90.5%	89.6%	90.6%	90.0%	89.6%	86.0%	83.9%	82.8%	80.9%	82.3%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	73.9%	76.1%	74.4%	74.9%	74.4%	73.7%	72.3%	69.9%	68.9%	72.7%	73.8%	75.6%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		80%	L	68.2%	68.5%	68.5%	69.0%	71.1%	71.0%	70.4%	68.6%	68.2%	69.2%	68.8%	71.4%
018.E	Bed Occupancy (Net)				96.1%	96.4%	96.4%	95.0%	95.6%	96.2%	94.5%	95.5%	97.1%	96.1%	95.4%	95.6%
019.E	Ave LoS for Clinically Ready for Discharge (at discharge)				58.3	51.8	77.8	34.9	64.3	37.8	51.9	18.5	58.0	53.3	81.8	31.5
020.E	% of Acute (YA & OPMH) discharges at weekends				8.4%	8.3%	7.6%	8.9%	4.7%	8.0%	4.8%	18.1%	23.2%	8.2%	15.0%	11.1%

Kent and Medway NHS
NHS and Social Care Partnership Trust

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): Chief People Officer
Lead Board Committee: Workforce Committee

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

Executive Commentary

- Good progress continues in relation to most areas of performance, with target being achieved for most metrics.

- Vacancy rates, safer staffing, stability and turnover show particular improvement and demonstrate a favourable year on year position.

- Sickness absence also continues to see an overall improving trend and remains below the 5% target.
    - Anticipated peak in respiratory illness through the Autumn and Winter months, infection prevention and control messaging has been reinforced alongside increased visibility of infection rates allowing appropriate interventions to be put in place.
    - KMPT's winter wellbeing offer is being developed, which will focus on support around financial wellbeing and mental health.

- The appraisal window is open at the moment, but lower participation is noted at this stage compared with the same time last year. Targeted and Trust-wide communications around appraisal are underway.

NHS
Kent and Medway

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
020.W-W	Establishment (Overall)											4088.5	4088.5	4088.5	4088.5	4088.5
001.W-W	Staff Sickness - Overall	✓	5.30%	L	5.0%	6.2%	5.7%	6.7%	5.4%	4.6%	4.5%	4.4%	4.9%	4.8%	4.7%	4.6%
005.W-W	Appraisals And Personal Development Plans		95%	L	71.6%	92.9%	94.7%		95.8%	95.8%	95.8%					17.1%
006.W-W	Vacancy Gap - Overall		15.50%	L	16.0%	15.8%	16.3%	16.2%	16.1%	16.2%	14.3%	14.0%	14.0%	13.7%	13.6%	12.9%
012.W-W	Essential Training For Role		90%	L	92.8%	93.1%	93.1%	93.6%	93.8%	93.5%	93.9%	93.6%	92.8%	92.9%	93.6%	93.8%
015.W-W	Staff Stability (Overall)		85%	L	83.7%	83.8%	84.2%	84.2%	83.9%	84.1%	85.0%	84.5%	86.0%	85.3%	85.3%	85.3%
019.W-W	Staff Turnover (Overall)		16.50%	L								16.9%	16.9%	16.4%	15.9%	15.8%
019a.W-W	Staff Voluntary Turnover (Overall)		15.00%	L	13.3%	13.4%	14.6%	14.8%	14.7%	14.7%	14.3%	14.2%	14.2%	13.8%	13.1%	13.0%
023.W-W	Safer staffing fill rates		80.00%	L	102.5%	99.9%	100.4%	99.1%	100.2%	99.6%	100.5%	102.3%	103.7%	105.8%	108.7%	108.7%

- *New targets were introduced April 2023; 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): Chief Finance and Resources Officer
Lead Board Committee: Finance and Performance Committee

Issues of Concern

The work around the vacancy gap has concluded and identified 68.4% of the target identified as part of this year's planning. The majority of the remaining gap sits within support services where spend is being held in line with run rate whilst a fuller review is completed. With regards to financial savings 100% of this year's plan has been identified, it is RAG rated as follows; 15% red, 64% amber ad 20% green. Once a large share of the amber schemes have been through the QIA process in the next month these should convert to green.

Executive Commentary

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
004.W-F	In Month Budget (£000)		0.0	N	(14,586)	(12,646)	(12,712)	(12,524)	(12,526)	(12,659)	(12,571)	(13,296)	(13,279)	(14,931)	(13,739)	(13,651)
005.W-F	In Month Actual (£000)		-	-	(14,402)	(12,888)	(13,242)	(12,746)	(12,843)	(12,873)	(13,873)	(13,391)	(12,909)	(14,708)	(13,669)	(14,063)
006.W-F	In Month Variance (£000)		-	-	184	(241)	(530)	(223)	(317)	(214)	(1,302)	(95)	370	224	71	(411)
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	-1.26%	1.91%	4.17%	1.78%	2.53%	1.69%	10.36%	0.71%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	565	565	565	565	565	565	565	549	545	566	633	559
008.W-F	Agency - In Month Actual (£000)		-	-	709	631	766	728	739	580	930	740	748	717	684	726
009.W-F	Agency - In Month Variance from budget (£000)		-	-	143	65	201	163	173	15	365	191	172	186	131	181
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	7.92%	8.44%	11.82%	13.72%	15.41%	14.25%	18.44%	34.77%	33.20%	33.06%	29.64%	30.16%

- *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

- Quality Committee have approved a reduction of the PREM target to 6%
- Complaint response performance is multifactorial the complaints team are working with directorates to ensure timeframes are met.
- Quality of responses for complaints is being reviewed
- Informal Complaints process under review with an aim to review informally where possible

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	84.8%	83.7%	87.1%	88.1%	84.9%	85.1%	87.5%	87.5%	84.2%	85.8%	86.4%	83.4%
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.0%		82.0%	83.0%	86.0%	96.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	97.0%	98.0%	97.0%	98.0%	97.0%	97.0%	97.0%		87.0%	84.0%	84.0%	87.0%
007.C	Compliments - actuals		-	-	145	123	120	143	114	101	106	78	114	97	115	112
008.C	Compliments - per 10,000 contacts		-	-	42.11	36.78	33.34	48.20	31.52	31.09	29.36	24.03	31.07	26.71	36.04	34.62
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	698	729	681	522	703	584	553	375	685	709	675	512
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	4.8	5.2	4.6	4.1	4.8	4.2	3.8	2.7	4.8	4.9	4.7	3.6
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.3	8.2	8.3	8.4	8.4	8.4	8.3	8.1	8.3	8.3	8.3	8.4

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

Community Services

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. All community services continue to review caseloads in line with the implementation of the Community Mental Health Framework. The reduction of caseloads which can only be achieved with support from all agencies providing a suitable step-down model for patients whose mental state is stable. Implementation of Mental Health Together has commenced with an ambition to have services across all Kent and Medway by the end of March 2023.

Waiting Lists

Demand for KMPT services remains high, resulting in continued challenges to meet waiting lists for assessment and treatment. For context CMHTs and CMHSOP on average receive 2,000 and 1,200 referrals per month respectively.

CMHSOPs are not meeting the 6 weeks to initial assessment and 18 weeks to diagnosis performance target for dementia. This is largely driven by the previous backlog, increasing demand (over the last 2 years when compared to pre-pandemic levels), variation in clinical practice, difficulty in recruiting to roles within CMHSOPs, and a mixed caseload of both older adults who require support for an organic need and those who have a functional mental health need.
Positive work has been made in tackling the backlog of referrals waiting for their second appointment, prior to a cut-off point of 1 April 2023. This list has been reduced from 785 as at 31st March to 33 as at 5th September, with completion planned for end of September.

A Memory Services Improvement Programme has been launched to implement the changes to the service model needed to achieve the 6 weeks to diagnosis target with agreed timelines monitored via transformation programme and via the monthly Quality Performance Reviews. Capacity planning is currently being completed with an initial trajectory expected in October for review and refinement with operational and clinical leads.

In the month of August 56% of patients (447) on the second appointment waiting list have been seen or removed from the waiting list following review. Demand remains high and despite demonstrating this throughput the list size remains static at around 800, prior to August this list was increasing month

on month. The first appointment waiting list continues to remain at approx. 2,700 patients reflecting the high number of referrals received by the teams, over 900 per month on average for memory assessment and complex dementia.

Executive Commentary

People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral (001.R)

- The % of those commencing treatment within two weeks improved to 88.2% further in month following the previous two months below national target at 60.9% to 50%, monthly values are subject to variation as the denominator for any given month is low (August 17).

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	East Kent			74.4%	75.0%	61.4%	94.1%	77.8%
2	North Kent			37.3%	75.0%	40.0%	87.1%	63.5%
3	West Kent			74.0%	75.0%	48.0%	90.8%	69.4%
4	**Trust Total**			59.8%	75.0%	54.8%	86.3%	70.5%

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

Narrative

- Overall trust performance decreased further from 60.5% in July to 59.8% in August, for the second consecutive month this is the lowest monthly figure since January 2022.
- Numbers on the waiting list reduced by 5% in August although the percentage of which who had already breached increased by 5.8% to 44.6%.
- The East Kent and West Kent Directorates are within 1% of achieving the target of 75%.
- The North Kent Directorate continues to see the largest challenge in achieving this target, the greatest challenge being in Medway and Swale CMHTs who achieved 32.3% and 34.6% respectively for the first five months of 2023/24. Stepping up the full Mental Health Together model in this area is crucial as evidenced by the review of cases reported in the previous Board report.
- The Mental Health Together model, as part of the Community Mental Health Framework, is planned to commence in East Kent in November starting with Thanet CMHT. Whilst this will not demonstrate a sudden impact on the 4 week wait, the new model of care will provide a streamlined pathway and allow people to be allocated directly into a clinical intervention.
- Work is ongoing to transition to a system wide target in line with previously highlighted national waiting time metrics for this patient group over the next 6- 9 months.

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	016.R: Care Spell start to Memory Assessment (Routine) Assessment Within 6 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	East Kent			36.3%	75.0%	32.7%	71.2%	52.0%
2	North Kent			31.7%	75.0%	22.6%	50.5%	36.5%
3	West Kent			52.4%	75.0%	28.2%	70.3%	49.2%
4	Trust Total			38.2%	75.0%	30.9%	62.4%	46.6%

Interpretation of results (Trust wide)	
Variation	Special Cause Variation of a **Concerning nature**
Assurance	Variation indicates consistently **failing short of target**

Narrative

- CMHSOPs are addressing three waiting lists: 4 weeks wait for functional presentations; 6 weeks wait to assessment & diagnosis for organic presentations and 18 weeks to treatment for all referrals. The vast majority of the activity sits within organic presentations.
- Immediate actions are being taken to address the issues experienced in ongoing waits, which includes the teams continuing to review caseloads to ensure accuracy of waiting lists and understanding capacity available to deliver each aspect of the pathway. Actions are overseen by the Chief Medical Officer.
- A longer-term plan to address the delivery of the memory assessment and diagnosis service provision has been formulated and is broken down into six key task and finish groups.
- There remains a large variance across teams in performance. It is recognised that Sevenoaks and Tunbridge Wells have significant workforce challenges, the leadership team are addressing through consideration of a shared caseload model.

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IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	76.2%	82.6%	87.5%	69.2%	68.2%	61.1%	52.4%	68.8%	88.2%	60.7%	52.2%	88.2%
007.R	DNAs - 1st Appointments		-	-	12.9%	13.2%	14.3%	13.8%	11.5%	11.7%	11.8%	12.0%	11.9%	11.1%	11.8%	10.5%
008.R	DNAs - Follow Up Appointments		-	-	8.5%	8.7%	8.6%	8.4%	8.0%	7.9%	7.9%	8.9%	8.5%	8.7%	8.9%	8.7%
009.R	Patient cancellations- 1st Appointments		-	-	2.4%	2.4%	2.4%	2.4%	1.9%	2.5%	2.6%	2.3%	2.3%	3.1%	2.6%	2.6%
010.R	Patient cancellations- Follow Up Appointments		-	-	5.6%	6.2%	6.2%	6.3%	5.5%	5.9%	6.1%	5.5%	5.5%	6.2%	6.7%	6.5%
011.R	Trust cancellations- 1st Appointments		-	-	4.9%	4.5%	4.3%	4.7%	4.4%	4.0%	4.4%	4.4%	3.6%	3.9%	4.7%	3.8%
012.R	Trust cancellations- Follow Up Appointments		-	-	11.5%	10.5%	10.3%	11.2%	10.2%	10.6%	9.8%	8.9%	9.0%	8.6%	10.0%	10.4%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)		75%	L	80.8%	84.4%	81.3%	83.3%	62.0%	79.9%	74.0%	69.9%	73.3%	68.4%	60.5%	59.8%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)		75%	L	50.7%	41.6%	46.4%	44.1%	30.3%	38.4%	41.6%	34.2%	32.0%	28.4%	35.1%	38.2%
017.R	Care spell start to Treatment within 18 weeks		95%	L	75.8%	75.5%	73.3%	75.4%	74.6%	72.9%	69.0%	69.0%	68.4%	74.0%	76.6%	75.4%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)		-	-	25.5%	24.3%	28.8%	44.7%	30.2%	32.4%	33.8%	34.9%	45.5%	35.0%	38.7%	44.6%
022.R	Referrals to Rapid response assessed within 4 hours		-	-							50.0%	62.8%	62.7%	62.0%	70.8%	67.8%
023.R	Open Access Crisis Line: Calls received		-	-	2,068	2,233	2,526	2,403	2,603	2,552	3,984	5,172	5,016	5,433	5,245	4,910
024.R	Open Access Crisis Line: Abandonment Rate (%)		-	-	12.4%	19.8%	26.7%	30.3%	26.1%	36.2%	35.1%	37.1%	31.7%	38.1%	35.2%	38.6%
025.R	Open Access Crisis Line: Ave time to answer			-	*00:03:57*	*00:06:54*	*00:09:28*	*00:09:19*	*00:08:40*	*00:10:33*	*00:09:39*	*00:07:29*	*00:06:01*	*00:09:52*	*00:07:12*	*00:07:31*
026.R	Open Access Crisis Line: Ave call length		-	-	*00:13:14*	*00:11:29*	*00:11:42*	*00:13:31*	*00:11:19*	*00:12:25*	*00:11:57*	*00:12:24*	*00:12:39*	*00:12:23*	*00:10:48*	*00:12:02*

Appendix A: Single Oversight Framework

Overview

The Single Oversight Framework (SOF) sets out how NHS England (NHSE) oversees Integrated Care Boards (ICB) and NHS trusts, using one consistent approach. The purpose of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

The first version of the SOF was published in September 2016 with amendments made annually.
The Framework aims to help NHSI to identify NHS providers' support needs across six themes:

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

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 2 as highlighted below, this is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met:

Segment	Description	Scale and nature of support needs
1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities.	No specific support needs identified. Trusts encouraged to offer peer support. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues.	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.
4	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme

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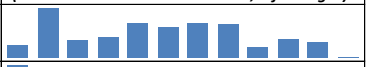
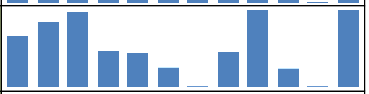
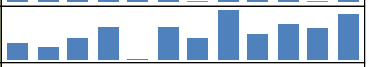
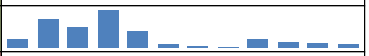
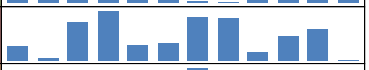
IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Jul-23	Aug-23	Trend *(Last 12 months where available, left to right)*
001b.E	CPA patients receiving follow-up within 72hours of discharge		78.1%	73.0%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		62	150	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	52.2%	88.2%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.4%	95.5%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	5.3%	4.7%	4.6%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93.0%	86.4%	83.4%	
006a.W-F	Distance From Financial Plan YTD (%)		0.0%	0.0%	

**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*

Kent and Medway NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28 September 2023
Title of Paper:	Finance Report for month 5 (August 2023)
Author:	Nicola George, Associate Director of Finance
Executive Director:	Sheila Stenson, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Committee:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 5 (August 2023). This is consistent with the position submitted to NHS Improvement in the Month 5 Financial Performance Return.

Items to bring to the Committee's attention

As at the end of August 2023 Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with plan.

For this financial year it is imperative focus continues on ensuring a breakeven position is delivered. It is important to note the following:

1. Focus needs to remain on minimising agency spend as much as possible. Agency caps continue this financial year and the Trust's spend cap has been set at £7.02m. The Trust is presently forecasting to overspend its cap by £1.66m.

2. Focus needs to continue on ensuring the progress on the sustainability programme. The Trust submitted a financial plan for 2023/24 predicated on the basis of delivery of a £4.76m CIP target so it is essential identified efficiency schemes deliver to plan and mitigations developed to offset any delays.

3. Capital programme spend is under plan - spend for month 5 is £2.43m behind plan due to slippage in Ruby Ward.

4. The cash position remains strong at £16.78m at the end of August 23.

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.
Risk Recorded on:	Trust Risk Register
Risk IDs:	6628
Oversight:	Oversight by Finance and Performance Committee

Finance Report
August 2023

Trust Board

Brilliant care through brilliant people

Contents

Brilliant care through brilliant people

Executive Summary

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

Key Messages

For the period ending 31 August 23, the Trust has reported a break even position; and this is expected to continue through this financial year, with the Trust forecasting to deliver a break even position in year.

The key financial challenges for the Trust continue to be:

- High Agency use, with a continued pressure in the Medical Staff group. This area is subject to external scrutiny through the use of an agency cap (£7.02m). Based on the present run rate, the Trust is forecasting to exceed the cap by £1.66m.
- An increased pressure associated with using external beds with Acute beds, and Female and Male PICU beds utilised in month. Non contracted external bed usage now requires executive sign-off.
- The capital programme is £2.43m behind plan, with delays on the Ruby Ward capital scheme accounting for £1.23m of this. The remaining difference relates to VAT reclaims of £0.70m and slippage on other estates schemes slippage.
- The Trust is presently forecasting to deliver its £4.76 efficiency programme in full; with non recurrent CIP in the first half of the year supporting recurrent full year delivery in the later part of the year. The full year effect of these plans will offset the non-recurrent impact

Income and Expenditure

Key pressures for August included the following:

- The trust overspent by £9.52m on temporary staffing to month 5; £5.80m on bank staff and £3.71m of agency spend. This position is offset by a £9.73m underspend on the substantive pay budget generating a £0.21m underspend YTD.
- Bank spend has increased in August. Whilst there is a slight decrease in wtes there is an increase in qualified nursing compared to previous months (with a reduction in healthcare assistants), presenting a higher cost per wte. Whilst some of this increase will be due to cover for seasonal annual leave, a large proportion of the increase is due to the acuity of patients within our inpatient services. The QI programme focussed on enhanced observations will confirm cost drivers as the programme progresses.
- Agency spend remains high and year to date spend exceeds cap by £0.86m. Pressure continues to be seen within medical staffing with a high number of agency medics covering vacancy and sickness.
- In August the trust utilised 0.7 external acute beds, and 1 male PICU bed. This reflected operational pressures and represents an increase from July when no beds were utilised. Female PICU also saw a small increase with 8 beds being used (compared to 7 in July).

At a Glance - Year to Date

Income and Expenditure	
Efficiency Programme	
Agency Spend	
Underlying deficit	
Capital Programme	
Cash	

Underlying Deficit

Following the completion of the planning round, the Trust has undertaken a review of its underlying position using the Trust's Service Line approach and is able to confirm that it entered the year with a breakeven position. To ensure the trust remains financially sustainable the Trust is shifting its focus to individual services; with a review of loss making services and unwarranted variation within its services being undertaken as part of the Trust CIP programme

Capital Programme

In August the Ruby Ward scheme overspent by a £0.19m, reducing the year to date underspend slightly to £1.23m. This is a key driver for the overall capital position of £2.43m underspent year to date.

Another significant cause of the underspend relates to £0.70m VAT reclaims from prior year schemes. To ensure the Trust uses its capital budget in full an updated review of capital priorities to commit these funds in year.

Other estates schemes are underspent due to delays in commencement, collectively these total £0.42m. It is expected that these schemes will progress over the coming months and deliver to plan.

Cash

The cash position decreased in month by £0.97m to £16.78m; £2.55m over plan. The main drivers of the reduction were payments to NHS Professionals (including the backpay associated with the pay uplift) and two months payments for the Ruby Ward.

The key contributors to the position against plan relate to the higher opening cash position, slippage in the capital position and VAT reclaims on prior year capital schemes.

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Income and Expenditure

Statement of Comprehensive Income

	Current Month			Year to date		
	Budget	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	(22,053)	(21,487)	566	(106,184)	(106,400)	(216)
Employee Expenses	17,463	16,711	(751)	81,952	81,745	(207)
Operating Expenses	4,128	4,354	226	21,920	22,447	527
Operating (Surplus) / Deficit	**(462)**	**(421)**	**41**	**(2,312)**	**(2,207)**	**104**
Finance Costs	462	421	(41)	2,312	2,207	(104)
(Surplus) / Deficit	**0**	**0**	**(0)**	**0**	**0**	**(0)**

Commentary

The year to date pay position is underspent by £0.21m. This includes a significant underspend on substantive pay due to the level of vacancies and is partly offset by agency and bank usage.

Bank spend was high in month at £2.11m; whilst there is a slight decrease in wtes. There was a higher proportion of registered Nursing staff being utilised compared to previous months, which has led to the higher cost. Some of this increase will be to cover for seasonal annual leave, however a large proportion of the increase is due to the acuity of patients within our inpatient services.

As per national guidance additional medical staff pay expenditure has been recognised this month in relation to the 23/24 pay award and income has been recognised to offset.

Agency spend was in line with the year to date average spend. The spend to date of £3.71m results in the Trust exceeding the agency cap by £0.86m (YTD). Currently the year end forecast for agency is £8.68m, of which £4.33m (50%) relates to medical staffing with the largest levels of spend in East Kent. This is £1.66m above the Trust's agency cap.

Non-pay

Other non pay includes a high level of spend on External placements compared to budget. August saw a higher levels of spend compared to July with both External Acute and Male PICU beds being utilised and Female PICU beds above contracted levels. The equivalent of 9 PICU beds were being utilised, 1 of which male and 8 female. .

Long Term Sustainability Programme

	CIP scheme Risk Rating				
	Plan	Identified	Red	Amber	Green
Pillar	£000	£000	£000	£000	£000
Back Office	1,567	1,310	-	1,060	250
Commercial Development	1,804	725	-	-	725
Procurement and Purchasing	400	75	75	-	-
Productivity	437	2,104	108	1,996	-
Workforce	550	550	550	-	-
Unidentified	6	-	-	-	-
Trust CIP	**4,764**	**4,764**	**733**	**3,056**	**975**
		100%	***15%***	***64%***	***20%***

Commentary

The Trust submitted a financial plan for 2023/24 predicated on the basis of delivery of a £4.76m CIP target. As at the end of August, CIP plans have been identified to cover 100% of the £4.76m target.

The focus is now to ensure that the schemes currently rated amber progress to green. The schemes rated amber are awaiting final sign off including QIA.

Taking into consideration the work that will be undertaken in the next month, on services such as EIP and working with support services to release their vacancies, it is anticipated that by next board meeting the green rated schemes will be 70% of the overall target.

Work will also continue to ensure there is a plan for the schemes currently rated red and if limited progress is made, consider alternative plans to mitigate the risk of them not delivering.

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Exception Reporting

Temporary Staffing Spend

Commentary

As at the end of August, the Trust reported a year to date underspend on pay of £0.21m. This consists of an underspend on substantive pay of £9.73m, offset by spend on temporary staffing which totals £9.52m; £5.80m on bank staff and £3.71m of agency spend.

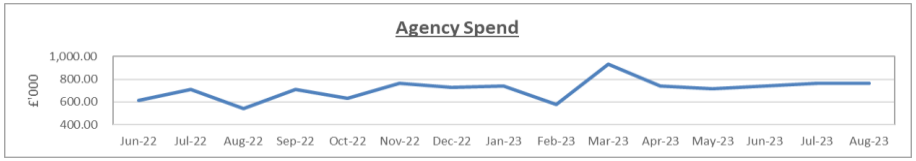
Agency

Agency spend to month 5 totalled £3.71m and this is forecast to continue due to both vacancies and operational pressures. The highest level of spend is seen within the Medical staff group, in particular within the East Kent Directorate.

There continues to be focus and scrutiny on all agency spend as the financial year progresses to ensure spend is minimalised. The medical position is being reviewed at both a directorate and staff group level.

NHS England have introduced agency caps at a system level to encourage reductions in agency spend. To support this approach KMPT have been allocated an agency limit of £7.02m. The Trust us presently forecasting to overspend its cap by £1.66m.

The Trust is supporting the focus on agency spend with Executive led agency meetings to support the development of action plans to address this issue.



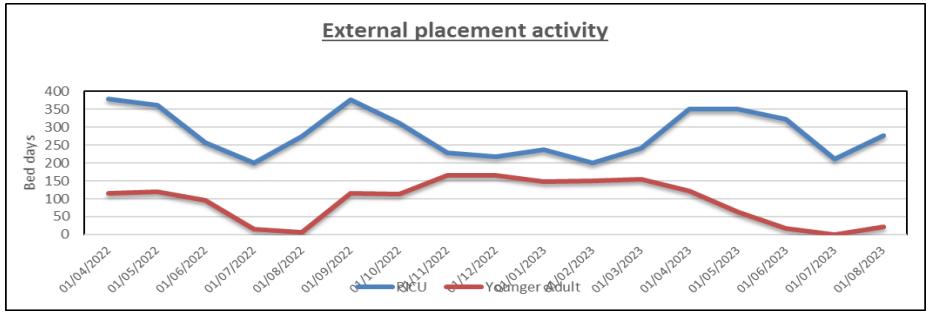
Bank

The Trust holds a budget for bank spend predominantly to cover the headroom in the rota. This is used to cover sickness absence, training and annual leave cover. Currently due to the level of vacancies and operational pressures there is a higher level of bank cover utilised than planned.

The Acute and Forensic Directorates report higher levels of bank usage due to the clinical requirements and the high level of observations of a specialist patients.

It is reported by the Directorates that there is a high level of observations required due to the acuity of patients with particular pressure seen within the Acute wards. The QI project with a focus on enhanced observations has commenced which will provide further insight into the drivers of the additional spend.

External Placements



Commentary

August saw higher levels of spend compared to those seen in July with both External Acute and Male PICU beds being utilised and Female PICU beds above contracted levels. The equivalent of 9 PICU beds were being utilised, 1 of which male and 8 female.

There were 5 beds used in the long term Cygnet female PICU block and an additional 2 PICU beds used. A further 2 beds are chargeable for beds closed around and to accommodate a complex patient.

TREND- BANK SPEND

	Actual					Actual	
	22/23 Qtr 1	22/23 Qtr 2	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	Jul-23	Aug-23
Nursing	1,797	1,892	1,766	2,097	1,885	711	750
HCAs	2,455	2,720	2,685	2,768	2,760	1,085	1,227
Other	421	454	416	450	383	152	144
Total	**4,673**	**5,066**	**4,867**	**5,316**	**5,028**	**1,948**	**2,121**

MONTHLY TREND- BANK WTE

	Average					Actual	
	22/23 Qtr 1	22/23 Qtr	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	Jul-23	Aug-23
Nursing	127	131	125	153	125	150	145
HCAs	274	298	280	309	277	342	320
Other	39	45	40	43	34	38	39
Total	**440**	**474**	**445**	**506**	**437**	**529**	**504**

Brilliant care through brilliant people

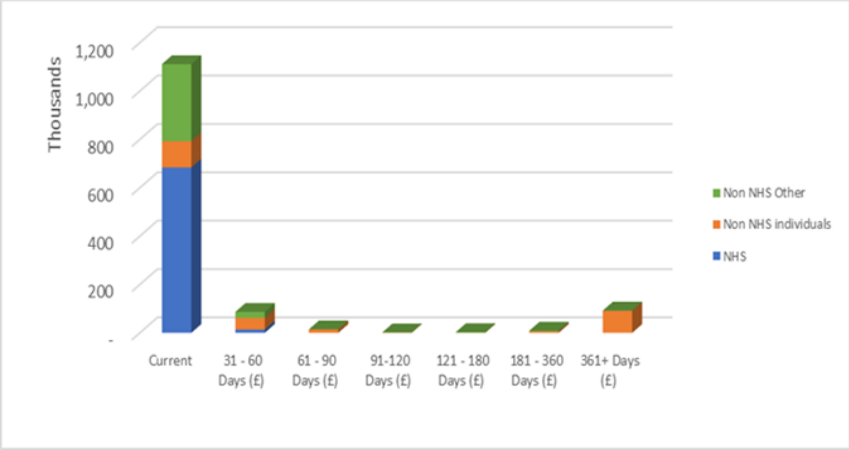
RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Appendices

Balance Sheet
Statement of Financial Position

	Opening	Prior Month	Current Month
	31st March 2023	31st July 2023	31st August 2023
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	172,052	172,842	172,574
Current assets	31,132	26,231	24,559
Current liabilities	(37,727)	(34,800)	(33,017)
Non current liabilities	(35,945)	(34,760)	(34,602)
Net Assets Employed	**129,512**	**129,512**	**129,514**
Total Taxpayers Equity	**129,512**	**129,512**	**129,514**

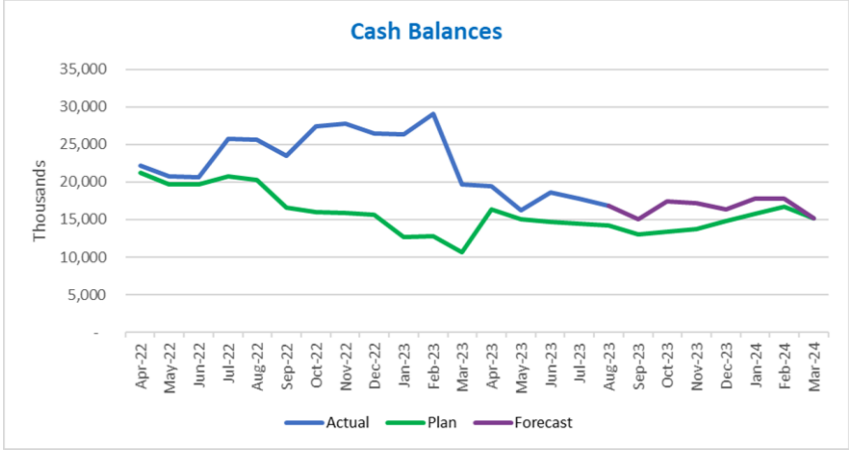
Aged Debt
Our total invoiced debt is £1.32m, of which £1.11m is within 30 days.



Commentary
Non-current assets
Non current assets have decreased by £0.27m in month, with capital expenditure of £0.67m being offset by depreciation of £0.91m

Current Assets
Within current assets the cash position reduced by £0.97m but remains strong at £16.78m.
There was an in month decrease of £0.70m in Trade and other receivables. The significant driver for this was the reduction in accrued income of £0.62m, with in month cash receipts for the uplift on the Provider Collaborative Block, CLRN and LVA (Low Volume Activity) income. Other decreases in the VAT receivable and prepayments were partially offset by an increase in invoiced debt.

Current Liabilities
Overall Trade and other payables decreased by £1.81m. Capital payables reduced by £0.69m, largely due to two months payments being made to Kier for the Ruby Ward. Deferred income fell by £1.23m with the release of a months LDA income and a reduction in the amount deferred from the ICB. These decreases were partially offset by the monthly increase for the PDC dividend payable.



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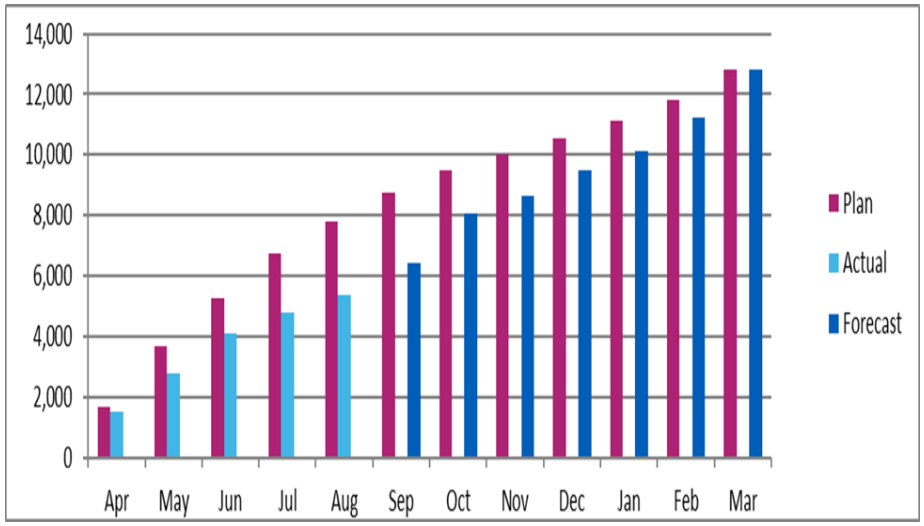
Capital Expenditure

	Current Month			Year to Date			Full Year	Full Year
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000	*Actual* £000	*Variance* £000	*Plan* £000	*Forecast* £000
Information Management and Technology	42	(311)	(354)	212	(207)	(419)	584	(126)
Capital Maintenance and Minor Estates Schemes	268	35	(233)	753	(45)	(798)	1,806	2,833
Ruby Ward and Improving Mental Health Services Infrastructure	620	811	191	6,510	5,281	(1,229)	7,386	7,069
Section 136 development	25	(0)	(25)	25	3	(22)	1,077	1,077
Frontline Digitisation Programme	100	73	(27)	290	330	40	1,890	1,890
PFI 2023/24	4	4	0	20	21	0	49	49
Total Capital Expenditure	**1,060**	**611**	**(448)**	**7,810**	**5,382**	**(2,428)**	**12,792**	**12,792**

Cumulative Performance Against Plan



Commentary

In August the Ruby Ward scheme overspent by £0.19m, reducing the year to date underspend slightly to £1.23m. This is a key driver for the overall capital position of £2.43m underspent year to date.

Another significant reason for the underspend is the VAT reclaims from the prior year, these now total £0.70m with £0.33m for IT schemes and the remainder for estates.

Other estates schemes which are underspent due to delays in commencement are TGU Access Control and Pinpoint , Coleman House Windows, Allington and Tarentfort Windows and Trust wide Anti-Ligature.

Collectively these schemes are £0.42m underspent, it is expected that these schemes will progress over the coming months and deliver to plan.

Following on from the VAT reclaims and the anticipated underspend on IT schemes, a prioritisation process is being put in place to determine how these funds should be spent in the remainder of the financial year.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Workforce Deep Dive: Anti-Racism Plan
Author:	Yasmin Damree-Ralph – Diversity and Inclusion Manager
Executive Director:	Sandra Goatley, Chief People Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper provides an update to the Board on the work in train and the forward plan for improving the working environment for staff and starting the journey to become a truly inclusive organisation.

Issues to bring to the Board's attention

Items of concern and hot spots

- Racism exists within KMPT and needs addressing
- Racism continues to be underreported in KMPT
- KMPT 2022 staff survey highlighted that 50.8% (443) of BAME staff believed that KMPT provided equal opportunities for career progression or promotion which decreased slightly from 2021 staff survey 51.5% (474). The average for mental health trusts in 2021 was 46.8% and for 2022 the average was 49.6% an increase of 2.8%.
- KMPT 2022 staff survey 35.7% (446) of BAME staff stated that they had experienced harassment, bullying or abuse from patients / service users, relatives or the public in the last 12 months, this is a slight increase from 2021 staff survey 34.5% (463). The average for mental health trusts in 2021 was 31.8% and for 2022 the average was 31.5%.
- The 2022 staff survey also highlights an increase in percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months has increase to 19.8%, a 1.8% increase from 2021 staff survey. The average for mental health trusts in 2021 was 22.9% and for 2022 the average was 22.8%.

Governance

Implications/Impact:	Staff belonging, feeling valued and psychological safety is a key predictor of employee retention, motivation and advocacy of the organisation that is anti-discriminatory/anti-racist.

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	Improved BAME service user access, outcomes and trust in fair, respectful and equitable experience of mental health services that invites and includes the voices of experts through lived experience
Assurance:	Limited
Oversight:	Workforce and Organisational Development Committee

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1. Background and context

24.8% of KMPT's employees come from a Black, Asian, Minority Ethnic (BAME) background, which aligns with the national average of 24.2%[1].

While the Trust embraces its diverse workforce, it is essential to recognise that between 1st August 2022 and 31st July 2023, 18.4% (216) of KMPT's BAME staff members left the Trust. During the same period, 14.44% (371) of KMPT's white staff members left the Trust. This suggests a potential disparity for individuals from BAME backgrounds in the workforce.

It is clear that there are issues of racism in KMPT. We know this through:

- Violence and aggression reporting, much of which includes a racist element
- Staff survey results;
- Anecdotal feedback from the BAME Network;
- Grievances and Dignity at work issues;
- Concerns raised through Freedom to Speak Up;
- Two members of staff shared their experiences via a video to the March 2023 Board meeting.

KMPT recognises that now is the time to address this. The work planned will constitute a movement for change to start the cultural journey to become a truly inclusive organisation where everyone is valued for the difference they bring.

This paper provides an update to the Trust Board in relation to the work already in train and the forward plan.

2. Work Currently Underway

We have a KMPT BAME Network which provides a space for BAME staff to share ideas and concerns and provides flexibility for BAME staff to access a committee member with lived experience to hear their concerns.

We have analysed the 2023 Workforce Racial Equality Standard (WRES) data and this has highlighted areas where we need to improve. The areas of concern have been developed into actions to support KMPT's strategic objectives and the strategic initiation projects (operational excellence).

The Equality, Diversity and Inclusion (EDI) Team continue, together with the Organisational Development team, to deliver culture workshops where teams request this.

Additionally, in collaboration with the International Recruitment Pastoral Care Leads and the Lead Nurse for Education and Development, the EDI team is supporting an adapted culture workshop to help teams prepare to receive our international nurses. This will provide education to teams helping them understand the cultural nuances that international staff will be accustomed to and those which may be new to them.

We have participated in the debiasing and values-based recruitment training via the Integrated Care Board, which an initial cohort of 19 recruiting managers from KMPT attended. We have also participated in the Aspiring Development Programme (ADP) hosted by the Integrated Care Board. This is a programme designed for Band 5 nurses who are looking to progress their careers, and KMPT Healthcare Support Workers are currently involved in designing a similar programme for Healthcare Support Workers.

[1] NHS England » NHS Workforce Race Equality Standard (WRES)2022 data analysis report for NHS trusts

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Protected Characteristic training delivered by the EDI team is available to all staff. Workshops are being delivered in person across the 3 main sites with capacity to train 400 staff by March 2024.

The EDI team is presenting to medical postgraduate continuing professional development (CPD) groups to raise awareness of health inequalities for protected characteristic groups, resources and initiatives for further professional learning and development.

3. Violence and Aggression

BAME staff continue to report anecdotally that racialised incidents are a daily occurrence. They describe that the reason for under reporting is because of the frequency of the incidents and a lack of confidence in reporting owing to previous experience that, even when reported, no actions are taken.

A project group has been established to reduce incidents of violence and aggression by 15% over the next three years. This is being led by our Chief Nurse, Andy Cruickshank. An initial listening event was delivered at Littlebrook Hospital, inviting staff to attend to share their experiences of violence and aggression, the impact, and discuss what solutions could reduce incidents and improve staff experience. 33 members of staff attended, ranging from frontline staff to senior managers, with the Quality Improvement team facilitating the session and the Chief Nurse opening and closing the session. An evaluation of the session was held and it was agreed further sessions to replicate the event will need to be conducted, to ensure that more staff from Littlebrook have the opportunity to attend and contribute. Future plans to roll out replica events across West Kent and East Kent are being discussed to and provide staff with the opportunity to share their experiences and ideas.

To address this, we will look at how we can:

- Reduce violence and aggression
- How we increase reporting
- What consequences can be deployed
- How we support staff (trauma informed care)
- How we feedback to staff following an incident
- Improving our relationship with the police.

4. Speaking up

BAME staff have expressed via the BAME Network meetings that concerns about speaking up and a fear of repercussions can impact BAME staff willingness to speak up. They have shared concerns that their reports will not be taken seriously due to previous experience and inaction from managers.

It is important to ensure that the BAME Network provides a safe space for BAME staff to share racialised incidents. The Network is currently considering different arrangements whereby the meeting is split into two halves with allies attending for one of those halves. It is considered that this is necessary in order to allow a safe space for BAME staff to raise concerns and engage fully in the meetings and to facilitate greater attendance by BAME staff at the meetings.

Additionally, in order to ensure robust support to staff affected by racism, there is a process in place for signposting staff to the Freedom to Speak Up Guardian, senior managers, EDI team or the People Team.

5. Next Steps

The strategic delivery plan includes a number of pieces of work which will be delivered by March 2024:

- The introduction of the Employee Council
- Improving psychological safety for all
- Work with the Executive Management team and the deputies developing a coaching culture and compassionate leadership.

Changing the Culture – The journey

Recent papers to Board have considered the current position in relation to racism and KMPT's culture. Specifically, it has been highlighted that:

- Racism and racial discrimination have a negative impact on the health and wellbeing, physical and mental health of people from BAME groups, as well as limiting their potential and contributions, as indicated in KMPT's staff survey and Workforce Race Equality Standard.

- Although KMPT has a strong history of investing in equality, diversity and inclusion, intelligence available suggests KMPT has some way to go.

- BAME staff are hesitant to speak up due to lack of confidence and fear of reprisal. This has been a common theme discussed at the BAME network and has been raised in listening circles.

KMPT has committed to start a cultural change journey. We will do this by creating a movement to deliver significant change. We recognise that this work is difficult; not only do we face the issues within KMPT but also even more deeply rooted societal issues. We have to make a start. We know that our staff are more trusting of people independent of KMPT when there are difficult thigs to discuss. We have seen this when we changed our Freedom to Speak Up service to an external partner. We know that we will have some significant challenges to resolve to ensure KMPT becomes a truly inclusive organisation.

To ensure we start on the journey to make this step change we have appointed an external consultant, Sylvia Stevenson, Head of Diversity, Equity and Inclusion Development at IC24. Sylvia will partner with KMPT to gain a deeper understanding of KMPT's culture in relation to racism and then recommend what we need to do to improve inclusivity in KMPT (see appendix one for the plan). This work will be delivered through engagement with:

- The Board and top 100 leaders
- The KMPT network groups
- Engagement with 500 staff at all levels of KMPT through:

    - A pulse survey
    - Listening circle sessions
    - 121 meetings.

At senior level it will also include:

- Zone of uncomfortable debate (ZOUD) sessions
- A cultural competence questionnaire and explorations of the results.

Following the completion of this work analysis will be completed and then a full report with recommendations provided. A 5-year Equality, Diversity and Inclusion (EDI) plan will then be agreed in April 2024.

The Anti-Racism plan will:

- Be developed in collaboration with key stakeholders within KMPT and will deliver sustainable and measurable change
- Put plans in place to improve data collection, recording and reporting in relation to racial disparity.
- Have a focus on high priority areas that will make a positive difference to our staff.
- Deliver better health outcomes for staff workforce by focusing on health and wellbeing.
- Commit and invest in ongoing programmes of work focused on improving the experience and wellbeing of our Black, Asian and Minority Ethnic staff.
- Ensure the opportunity to co-design the long-term strategy “Nothing about me without me” with our staff
- Ensure everyone sees equality and inclusion as their responsibility and adopt a proactive approach that is embedded within the KMPT culture.

The anti-racism plan will include the work already underway. This will include the priorities for the Equality Delivery System 2022 the WRES action plan and the worked detailed in the strategic delivery plan. This work includes a talent management approach to support progression of BAME staff into roles at Band 7 and above, ensuring fairness in relation to BAME staff through capability and disciplinary processes, and managing violence and aggression against BAME staff.

We are working with the Communications team to plan the communication of this work across the organisation.

The EDI culture work is a journey that KMPT is embarking on - a movement for change. This work will be delivered in conjunction with our internal leadership programmes that are being developed and the work we are doing at a senior leadership level on developing a coaching culture and compassionate leadership

6. Conclusion

Working towards becoming a truly inclusive organisation is an exciting time and will be challenging. This work will ultimately benefit everyone who works for and receives a service from KMPT. Commitment and role modelling from the most senior level of the organisation will provide the key for the success of the initiatives and hard work that will take this plan and EDI to the next level.

7. Recommendation

The Board is asked to discuss the contents of this paper and provide any feedback on the planned work

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Appendix 1

Cultural Plan – The Journey

September-: Planning and Promoting Awareness.

Due to competing operational priorities, the Cultural Change programme will adopt a viral strategy for driving awareness and encouraging staff members to participate where required.

- **Diversity Survey – Phase 1 promoting diversity survey:**
  Planning is currently underway for launching a Diversity Survey. The aim is to gain a baseline understanding of the demographic makeup of the workforce and assess feedback on any potential disparities that may exist in policies, practices, and working culture. The rollout in September is a viral cascading strategy through targeted teams who will receive a short presentation, have an opportunity to ask questions, and be invited to participate in the survey.
    - LGBT Staff Network – 29 August
    - Workforce & OD Away Day – 14 September, tbc
    - BME Network – 15 September
    - Faith Network – 7 September
    - Disability and Wellness Network [DAWN] - 10 October
    - Black History Event – 19 October

- Examples survey questions: -
    - **I feel that my organisation fosters a culture of Diversity and Inclusion.**
      Strongly Agree – Agree – Undecided / Neutral - Disagree - Strongly Disagree
    - **I feel my cultural background is represented by the leadership in my organisation.**
      Strongly Agree – Agree – Undecided / Neutral - Disagree - Strongly Disagree
    - **There is a culture of recognition and appreciation for my achievements in the workplace, both as an individual and as part of my team.**
      Strongly Agree – Agree – Undecided / Neutral - Disagree - Strongly Disagree
    - **I feel comfortable providing feedback to colleagues from different cultural or demographic backgrounds.**
      Always – Often – Sometimes – Seldom – Never

October: Creating a Movement.

The Cultural Change programme will gather momentum with the support of the Internal Comms Team.

- **Communications & Engagement Marketing Strategy**.
  - The Diversity Survey and Listening-into-Action initiatives will be officially launched with a video featuring Executive Sponsors and the external Diversity Consultant.
  - Briefing packs on the Change Programme with the Diversity Survey link will be cascaded to all People Managers via the weekly comms channel.
  - A generic briefing will also be prepared for SMT.
  - Posters and eFlyers will be distributed to key locations and a screensaver designed for promoting participation in the survey.

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- **Leaders Event (ZOUD and Cultural Competence) – 31st October 2023**
  Where leaders will have the opportunity to apply the principles and techniques through realistic case studies. This hands-on experience will enable leaders to identify unconscious bias, practice active listening, and self-reflection as part of their on-going personal development. In addition to the ZOUD session, leaders will be requested to complete the Cultural Competence questionnaire prior to attending the Leaders event in preparation for small group facilitated sessions. The intention is for Senior Leaders to help facilitate key parts of the Away Day in October.

- **Listening-into-Action Sessions: October 2023 – March 2024**
  The primary objective of this initiative is to proactively invite and gather valuable feedback from approximately **500 employees at all levels** of the organisation to improve KMPT's commitment to Diversity and inclusion in the workplace. By creating an open, safe, and inclusive feedback loop, the intention is to identify what's working well, as well as opportunities for improvement. Feedback from these sessions will be added to the analysis from the Diversity survey to strengthen understanding of the various perspectives and experiences within the organisation.
  - The meetings are scheduled each week on Wednesdays from 12:00 pm to 2:00 pm, for 45 minutes each. Individuals between bands 2-7 will be able to register for an online peer-to-peer session, accommodating up to a maximum of 10 participants.
  - The plan is to engage the senior leaders (Band 8+) at the Away Day in October.
  - Attend each staff network meeting between October and March (BAME, DAWN (disability and wellness network), Faith, LGBTQ++ and Neurodiversity)
  - The targets per bands are as follows (however these targets may vary depending on staff engagement): -
    - **Workforce Bands 2-5**: 60% of target = **300** individuals
    - **Management Bands 6-7**: 30% of target = **150** individuals
    - **Senior Leader Bands 8+:** 10% of target = **50** individuals

- **Black History Event – 19 October**
  Given the strategic focus on Anti-Racism, this event will be an ideal opportunity to promote the Cultural Change programme and encourage participation in the survey and Listening-into-Action sessions.

- **Leading by Example.**
  In line with the NHSE EDI improvement plan published on 8 June, Senior Leaders will be invited to take an online Self-Assessment.

  - **The Cultural Competence Assessment**
    This is a simple online questionnaire with 25 questions regarding 5 components of Cultural Competence. The aim is to encourage self-reflection and group discussions on the overall cultural competence of Senior Leadership.
  - The questionnaire should take no more than 15-20 minutes and once finished, leaders will have the option to assess and obtain their personal report.
  - The link to the assessment will be issued in advance of the Board Development session.
  - This action aligns with the internal objective for agreeing EDI goals.

- **ZOUD Podcast**

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To sustain momentum, the plan is to film a ZOUD session with 2 or 3 members of the Board/Senior Leadership. Key messages will be agreed nearer the time and the intention is to address key insights gathered from the survey and the Listening-into-Action sessions.

November-December 2023 – Engaging the 'easy to ignore' areas

- **Presentation to Board & ZOUD Session 3-hours – Date TBC**
  It is essential to present the high-level plan to the Board in order to gain support and ensure successful implementation of the agreed actions. As they are responsible for making strategic decisions that impact the organisation, it is important that they take the lead and understand the rationale, benefits, risks, and costs associated with any key change as a result of this programme.

- **Board Cultural Competence & EMT Delivery Group - date TBC**
  Trust board will be provided with a link to complete a cultural competence questionnaire. A debrief of the outcome will take place virtually, to provide an understanding of the results. A facilitated session will be conducted at an EMT Delivery Group meeting, to debrief the cultural competencies outcomes.

Majority of the time in November and December will focus on increasing engagement in the areas difficult to engage and easy to ignore. These include visits to the main sites in St Martin's Canterbury, Priority House Maidstone, and Littlebrook Dartford, for LIA sessions and promoting participation in the Diversity Survey.

January-February 2024 – Reviewing Leadership Accountability

The Board session update in this period will focus on engaging with Leaders ahead of the roadmap planning session in April 2024. The intention is to start critical thinking about how the Diversity Strategy will align with strategic goals for the next Financial Year. This will include any potential risks and mitigations, resource allocation and overall organisational effectiveness.

March/April 2024: Transforming insights into impact.

Majority of the time in March and April will focus on analysing the data collated from The Diversity Survey and Listening-into-Actions sessions and agreeing the approach for the Roadmap Action Planning session in April 2024. A date will need to be agreed for the proposed final session.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Community Mental Health Framework – Quarterly Update
Author:	Neil West – CMHF Programme Director
Executive Director:	Donna Hayward-Sussex, Chief Operating Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The quarterly update highlights the progress made and key upcoming activity regarding the implementation the new models of care within the Community Mental Health Framework Programme.

Issues to bring to the Board's attention

It is intended that the new Mental Health Together Services will be implemented across Kent and Medway by April 2024. The scale of the change is significant and is considered the crucial foundation of the larger transformation piece for community services.

Slippage in recruitment for both partner organisations and KMPT are now being experienced due delays in confirmation of Lead Provider arrangements and CMHF funding. Whilst working towards resolution a focus on the contracting elements with partners is underway.

Governance

Implications/Impact:	Delays in confirmation regarding Lead Provider arrangements and funding means that KMPT are unable to confirm contract arrangements with CMHF partners. The delay is having an impact on the programmes ability to establish Mental Health Together services.
Assurance:	Reasonable
Oversight:	Executive Management Team

Mental Health Together

NHS

Community Mental Health Framework

Board Update - September 2023

CMHF Implementation Update

Since the CMHF Programme Board in July 2023, the programme has generated momentum in the implementation of Mental Health Together (MHT).

Approach

Test & Learn
Learning from Medway and Swale has provided opportunities to refine the engagement processes with service users leading to an increased uptake in attendance of new group programmes.

Outcomes
We are working to solve process blockers that are stopping the capture of data with the 4 week wait and DIALOG+ being prioritised in the short-term.

Communication & Engagement
A detailed communication plan has been put together with Leading Through Change sessions for managers already being delivered.

Risks

Contracting
KMPT are yet to receive confirmation of the Lead Provider extension with CMHF funding remaining with the ICB.

As Lead Provider KMPT are unable to confirm contract arrangements with partners which is likely to delay recruitment to new posts and the full implementation of Mental Health Together.

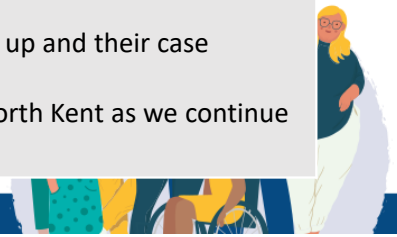
Whilst resolving the Lead Provider arrangements steps are being taken in collaboration with partners to establish the principles of decision making regarding finance and management of performance across the programme.

East Kent

Progress
- The implementation group has momentum with a highly engaged team working towards ambitious delivery goals.
- The Thanet trailblazer is targeting a start date of early November and is on track to meet this.
- The trailblazer will pilot the use of patient record system, Rio to enable the sharing of patient data across different partners.

West & North Kent

North and West Kent
- Medway and Swale's (M&S') trailblazers have received very positive feedback. Funding is needed to complete the Mental Health Together Model.
- West Kent implementation group has been stood up and their case review is underway.
- East Kent is benefiting from the learnings from North Kent as we continue to refine processes across the directorates.

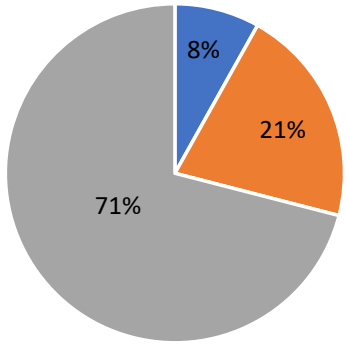


Thanet Caseload Review

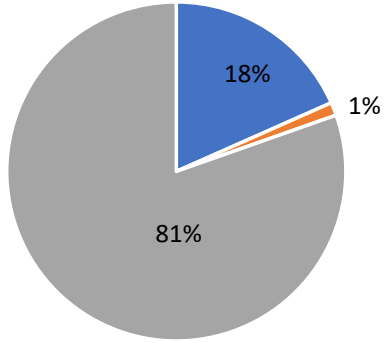
Please see Thanet's caseload review below:

Outcomes
Caseload : 641
Discharge: 8%
MHT 21%
CMHT 71%

CMHT Caseload Review Results



CMHTSOP Caseload Review Results



Outcomes
Caseload: 719 (including Memory Assessment)
Discharge: 18%
MHT: 1%
CMHT/Memory Assessment 81%

Thanet CMHT were the first community service to move to a shared case load model. In addition to having a shared caseload East Kent benefits from having a Primary Care Mental Health Service. As a consequence the outcomes of the caseload review are vastly different to that experienced in Medway where at least 33% required a Mental Health Together (primary care service) with 41% requiring discharge.

Insights

- Improvement in patient flow is achievable by utilising the resource from the existing Primary Care Service and Thanet CMHT's.
- Streamlining processes and decision making will yield a reduction in wait times.
- The case reviews identified 21% of patients could be supported to step down to the new Mental Health Together model.
- Long wait lists for psychological therapy (PT) will be reduced with a new step care model.
- It is noted that acuity in Thanet means that 71% require a CMHT.
- Older adults analysis is ongoing as Memory Assessment demand skews the findings.

Enabling Workstreams

THE CMHF Programme Workstreams are taking forward critical activity to support delivery. Each workstream meets fortnightly to ensure progress. Risks and issues are managed through a programme risk register that is monitored by the CMHF Programme Board.

Model of Care & Outcomes	▪ **Eating Disorders** – FREED (rapid early intervention eating disorders) has now successfully met the NHSE transformation criteria for all 42 PCNs in Kent and Medway and has widened its offering to the 16-25 age range. ▪ **Community Rehabilitation** – An implementation team has been stood up – waiting for funding from the ICB to commence recruitment. ▪ **Outcome Measures** –Challenges have emerged regarding capturing data points. Digital leads are revising plans to address shortfall.
Workforce	▪ **Demand and Capacity Modelling –** Capability planning for Thanet is progressing well. Trailblazer Thanet will inform MHT rollout across Kent & Medway. ▪ **Establishing Current Capacity** – Work is continuing with key partners to understand current capacity that can be utilised in MHT and the total programme budget for trailblazers and moving forward.
Data and Digital	▪ **Recording data** – A single point of truth for patient records is being implemented across service providers using the Rio patient records system. A mandatory PROM, DIALOG+ has been embedded and tested, and training for all users is now scheduled. ▪ **Website development –** An options paper has been produced in collaboration with procurement to set out the key considerations for the website. A specification is being developed for a mini-competition tender, which will speed up the procurement process of the provider.
Finance & Contracting	▪ **Community Mental Health Baseline** – The gap between current and future budget for MHT has been forecasted. The Thanet trailblazer will provide test case for demand and planning assumptions for wider rollout. ▪ **Contracting Approach** – MOA between KMPT and KCC is set to be agreed by the end of September for the rollout of SUN model. The MOA and governance approach being developed will provide a simple template for further contracts with KCC and other providers.
Comms & Engagement	▪ **Mental Health Together Broadcast –** A comms plan for a monthly broadcast has been put together to help educate and engage the workforce and partners around MHT. ▪ **Engaging PCNs** – Robust engagement plan is in development to continue the engagement of all 42 PCNs in Kent and Medway.
Estates	▪ **KMPT Estates Mapping –** Thanet have identified an estate for co-location for MHT's VCSE partners. ▪ **Workstream Mobilisation –** Service Directors are adopting a focused approach locally to estates which includes the core model as well as Community Rehabilitation.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28 September 2023
Title of Paper:	Emergency Planning, Resilience and Response (EPRR) Annual Report, Compliance Self-Assessment Statement, EPRR Policy and 2023/24 Work Plan.
Author:	Jessica Scott, Emergency Preparedness and Resilience Lead
Executive Director:	Andy Cruickshank, Chief Nurse (Accountable Executive Officer, EPRR)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Statutory Compliance

Overview of Paper

This paper has been supported by the Audit and Risk Committee (ARC) to give assurance that the Trust is assured against the Civil Contingencies Act (CCA) 2004 and fully aligned to the NHS England and Emergency Preparedness, Resilience and Response Framework/Core Standards Assurance Programme.

Issues to bring to the Board's attention

The Audit and Risk Committee were asked to support this EPRR Annual Report for submission to the Board and in doing so: The Board are requested to accept this annual report and re-affirm its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) and

- Note the closing of the 2022/2023 EPRR work plan.
- Note the EPRR 2022/23 Statement of Compliance (Appendix 1)
- Note the EPRR Improvement Plan (Appendix 2).
- Note the EPRR Policy (Appendix 3) – Contained within the Board Reading Room on Diligent.
- Note the content of the 2023/2024 EPRR work plan commencing 1 September 2023 (Appendix 4).
- As requested by NHSE Board are requested to share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Governance

Implications/Impact:	The EPRR Policy is owned by the Board. The portfolio of EPRR has an accountable Executive Officer: The Chief Nurse. Independent of the trust, to confirm compliance with the Civil Contingencies Act, 2004 the Trust is audited against the NHS EPRR Core Standards on an annual basis via a Kent and Medway Integrated Care Board (ICB) submission to NHSE The NHSE 2022 audit assurance confirmation was received late in Q4 denoting that the trust had maintained a status of 'substantially compliant'. The 2023 NHS EPRR Core Standards self-assessment process, which was conducted in July 2023, will be again validated via ICB audit and the results ratified by NHSE and submitted to ARC in Q4 2023/24. Outside of the EPRR Risk Register, the Board Assurance Framework (BAF) denotes EPRR risks which require assurance against the Trust's Strategic Objectives.
Assurance:	The EPRR work plan runs annually from 1 September, following the July self-assessment and adheres to the governance principle; that the work is undertaken via a trust-wide EPRR working group chaired by the Accountable Emergency Officer. The work plan is assured in its delivery to the Audit and Risk Committee (ARC) via the Trust-wide Health, Safety and Risk Group. 2022 – 'Substantially Compliant' validated by NHSE 2023 – Self assessed at 'Substantially Compliant'
Oversight:	This paper was supported by the Audit and Risk Committee 30/08/2023

Emergency Preparedness, Resilience and Response – Annual Report to Board (Period September 2022 – August 2023)

Background and context

1. The Civil Contingencies Act (2004)

1.1. The Civil Contingencies Act (2004), requires the trust to put in place the following duties with fellow Category 1 responders:

- Risk Assessment
- Develop Emergency Plans
- Develop Business Continuity Plans
- Warning and Informing
- Sharing Information
- Co-operation with other local responders.

1.2. This annual report provides assurance to the Board that the Trust has embedded plans and processes that will ensure that it is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response (EPRR) as defined within the duties above.

2. Assessing and documenting compliance

2.1 The NHS EPRR Core Standards Framework is the mandated method for assessing compliance and giving assurance across the NHS in the subject of Emergency Preparedness, Resilience and Response.

2.2 Assessment is undertaken firstly by all NHS providers using an NHSE&I predetermined set of data, as part of a self-assessment which aligns to the duties held within the Civil Contingencies Act 2004.

2.3 In 2022 KMPT was requested to submit evidence within the self-assessment for the audit against 55 lines of inquiry. Of those 55 the Trust was fully compliant with 52 and scored 94.5%.

2.4 The 2022 self-assessment data sets were audited by the ICB and the regional results collated and submitted for ratification by NHSE. NHSE confirmed the ratified position via a confirmation letter. In May 2023 the letter was received and presented to the Audit and Risk Committee, where it was noted as receiving Substantial rating.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve.

	For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

2.5 The gap in assurance, set out in the EPRR Improvement Plan was addressed via the agreed EPRR Work plan for 2022/23.

2.6 For 2023 KMPT have been requested to submit evidence within the self-assessment for the audit against 58 lines of inquiry. Of the 58 the Trust is fully compliant with 56 and has self-assessed at 96.5%.

2.7 The remaining 3.5% are rated at 'partially compliant' and accompany this report on the prescribed EPRR Improvement Plan template (appendix 1) for Board approval and noting of inclusion into the EPRR Work plan for 2023/24 (appendix 2)

3. Risk assessment

3.1. The Trust EPR Lead is the deputy chair of the Kent Resilience Forum Risk Assessment Group. As a member of the Local Health Resilience Partnership and the Kent Resilience Forum the Trust fully supports the review of the Community Risk Register against the National Security Risk Assessment held by the Cabinet Office.

3.2 Annually, or as a new risk or threat emerges the Trust reviews its position using its own internal risk management process. The Emergency Preparedness, Resilience and Response Risk Register is managed to ensure risks are escalated to the Trust Risk Register and additionally submitted to the Board Assurance Framework for assurance against the Trust Strategic Objectives.

4. Develop emergency plans

4.1 Within 2022/23 with the exception of a revised Fit Testing Standard Operating Procedure, which is currently in consultation between all the incumbent departments, all existing plans due for review have been republished.

4.2 The outstanding Communication Incident Response plan on the 2022/23 EPRR Improvement plan was published in May 2023. This plan, owned by the Trust Communication Team is dovetailed to the ICB Communication Incident Plan to ensure that a seamless process is in place across both organisations.

5. Develop business continuity plans (aligned to ISO 22301)

5.1. The EPRR Policy defines the scope of the Business Continuity programme. The management of business continuity is detailed within the trust Management of Business Continuity Policy and template documents.

5.2 The Audit and Risk Committee have reviewed the rolling audit work plan and listed a business continuity audit for 2024/25; to confirm that the trust is conforming with its own business continuity programme outside of the Annual EPRR Core Standards Framework audit where is currently is rated at fully compliant.

6. Warning and informing

6.1 Via the Trust Communications Team, arrangements are in place to make available information on resilience and response to the public and staff. Examples of this in the 2022/2023 work plan have in in relation to summer and winter preparedness, Planned Information Technology down time potentially requiring IT System Business Continuity Plan activation, planned motorway closures, Met office forecasts, South East water outages and the continued COVID19 Regional Major Incident response.

7. Sharing information

7.1. The Trust as part of the Kent Resilience Forum has processes in place to share information with other local responder organisations to enhance co-ordination both ahead of and during an incident.

7.2 The KMPT page on Resilience Direct was rolled out by the trust as a resilient EPRR repository; this has given on call staff a designated point of truth for plans, templates and briefings as the 'Master on call file' and allowed for sharing of information in response across the Kent Resilience Forum such as common information pictures.

7.3 Throughout the national level 4 and regional level 3 response to COVID19 and Industrial Action planning and response the trust has been fully compliant with command and control arrangements. Situation Reports (SITREPs) flowed via the Mental Health Cell to the Kent and Medway Operational and Incident Control Centres and briefings, instructions and information has been received as briefings and items for action.

8. Co-operation with other local responders.

8.1. The Trust as part of the Kent Resilience Forum, KMPT has processes in place to co-operate with other local responder organisations to enhance co-ordination both ahead of and during an incident. To support this approach the Joint Emergency Services Interoperability programme principles are embedded into the EPRR Policy, Significant Incident and Major Incident Plans.

9. Training programme

9.1. During 2022/23 and to date, training has been limited to:

- eLearning induction
- Loggist training
- New staff entering onto either the Director on call rota or Manager on call rota
- Those requiring support with Business Continuity Plans.
- Refresher training sessions.
- eLearning for management of self-referrals with a hazardous material contamination, at reception areas across the Trust
- Fit testing, to maintain a list of trained Fit testers and tested staff for FFP3 Masks

10. Exercise programme and Incidents

10.1. The duty placed on the Trust within the NHSE&I Core Standards is that it performs a communications cascade bi-annually and a table top exercise annually with a live exercise tri-annually. These elements have all been achieved in the last work plan.

10.2 Internally two table top exercises were undertaken, to allow for learning in support of Service Business Continuity Plans; outside of that gained from the COVID response.

- Exercise Noble was conducted on 17 January 2023 and was used as a vehicle to test an external contractor and service business continuity planning in relation to a denial of service for catering.
- The Trevor Gibbens Unit (TGU) annual table top exercise (Exercise Globe) was executed on 24 March 2023

10.3 Externally the trust has attended regional and local exercises which have allowed for the review, validation and adaptation of the following response topics and plans:

- Exercise Artic Willow 14-18 November (Industrial Action, Planned Power outage and Severe Weather)
- The trust nominated the Director of Estates and Facilities to assist with the local planning of Exercise Mighty Oak (National Power Outage). KMPT was stood down from exercise play by the ICB but used the opportunity to review the lessons identified via the published Kent Resilience Forum exercise report.
- Regional Exercise Hiertan, 29 July 2023 Whole Site Evacuation of an Acute Trust; this will lead to a local exercise within the 2023/24 Local Health Resilience Partnership delivery group work plan for Kent and Medway.

10.4 Within 2022/2023 the trust responded to the following Business Continuity/Major Incident/Regional Incident declarations:

- COVID19 (National and Regional) for ongoing variants. The response formally closed at a regional level, after the National level on 19 May 2023.
- Tunbridge Water Outage (Kent Incident) affecting Hylands House (KMPT Business Continuity) December 2022
- Junior Doctors and Consultants Industrial Action (Level 3 Incident Declarations - Regional responses) July and August 2023.

11. Methodology on opening of the 2023/2024 EPRR work plan

11.1. Duties, core standards and NHS Contract have been reviewed for change against a refresh of the corporate EPRR Policy.

11.2 The NHS Core Standards Framework self-assessment has been undertaken and used to generate the EPRR Improvement Plan (2023).

11.3 The process of monitoring and managing risks to the lowest level is a continuous process and will move seamlessly from one plan year to the next.

11.4 Identification of Plans, Policies and Standard Operating Procedures for 2023/2024 is set against master index held by the Trust Policy Manager.

11.5 Identification of new plans is set against risk methodology to close actions and provide further risk controls.

11.6 Trust Business Continuity Programme baseline at September 2023 and forward plan against the priority of a plan.

11.7 Exercises which are mandated against the NHS EPRR Core Standards Framework.

11.8 Training to be set against an EPRR Training programme and Training Needs analysis aligned to the EPRR National Occupational Standards, 2022.

12. Workforce Resource 2023/24

12.1. The current resource available to EPRR for a substantive team is:

Chief Nurse	Accountable Emergency Officer
Deputy Director of Quality and Safety	Deputy Accountable Emergency Officer
Emergency Preparedness and Resilience Lead	Subject Matter Expert
Emergency Preparedness and Resilience Officer	Non-Clinical Subject Matter Expert
Resilience and Risk Administrator	Office functions

13 Action required from the Board

13.1. The Board are requested to accept this annual report and re-affirm its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) and

- Note the closing of the 2022/2023 EPRR work plan.
- Note the EPRR 2023/24 Statement of Compliance (Appendix 1)
- Ratify the EPRR Improvement Plan (Appendix 2).
- Note the EPRR Policy (Appendix 3)
- Note the content of the 2023/2024 EPRR work plan commencing 1 September 2023 (Appendix 4).
- Share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Appendix 1.

Emergency Preparedness, Resilience and Response 2023/24 Statement of Compliance.

EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2023/24**, Kent and Medway NHS and Social Care Partnership Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 58 of the core standards which are applicable to the organisation, Kent and Medway NHS and Social Care Partnership Trust.

- is fully compliant with 56 of these core standards;

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

- The overall rating is: Substantially Compliant

Andy Cruickshank
Kent and Medway NHS and Social Care Partnership Trust
17 August 2023

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Appendix 2.

Emergency Preparedness, Resilience and Response 2023/24 Improvement Plan

EPRR Improvement Plan:
Version: 1.0

Kent and Medway Partnership Trust (KMPT) has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2022/2023. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
59	Partially Compliant	HAZMAT live Exercise	May 2024	EPR Lead	To test the Trust and maintenance contractor's documentation and processes against live exercise play for a chemical release with KFRS. (New contract starts 01 October 2023)
66	Partially Compliant	Fit Testing SOP	November 2023	EPRR Lead	Redefining operational delivery outside of Pandemic Response as 'business as usual' activity for fit training and testing.

Appendix 3

Emergency Preparedness, Resilience and Response Policy

EPRRPolicyKMPT.Cor G.119.07.docx

Appendix 4

Emergency Preparedness, Resilience and Response 2023/24 Work Plan

Emergency Preparedness, Resilience and Response 2023/24 Work Plan.																	
	Item	Frequency	Owner	Chair	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Co-operation (Civil Contingencies Act -Duty) External Meetings																
	LHRP Executive Group	x3 Annually	Chief Nurse -AEO	UKHSA/NHSE			20/11/2023				25/03/2024				x	
	LHRP Delivery Group	Bi Monthly	EPR Lead	ICB		24/10/2023		12/12/2023		27/02/2024		x		x		x
	KRF Risk Assessment Grp	Bi-Annual	EPR Lead	KRF	21/09/2023							x				
	KRF Risk Assessment Grp - Workshops/ Consultations	Adhoc	EPR Lead	KRF												
	KRF Risk Chairs (Work) Meeting	Monthly	EPR Lead	KRT	21/09/2023	19/10/2023	16/11/2023	21/12/2023	18/01/2024	15/02/2024	21/03/2024					
	KRF Delivery Chairs (and Deputies) Meeting	Adhoc		KRT		03/10/2023										
	National Risk Working Group	Adhoc	EPR Lead	DLUHC	04/09/2023											
	KRF Horizon scanning and Chronic Risk Group	Adhoc	EPR Lead	KRT	05/09/2023											
	KRF National Power Outage Grp	Adhoc	EPRR Officer	KRF	04/09/2023											
	KRF Pandemic Grp	TBC	EPR Lead	KRF												
	Kent and Medway EP Leads Meeting	2 weekly	EPR Lead	ICB	12/09 and 26/09	10/10 and 24/10	07/11 and 21/11	05/12 and 19/12	02/01 and 16/01 and 30/01	13/02 and 27/02	12/03 and 26/03	x	x	x	x	x
	Southeast Community Providers EP Meeting	Quarterly	EPR Lead	Various	14/09/2023			07/12/2023								
	Medway Safety Advisory Grp	Monthly	EPR Lead	Medway Council	28/09/2023	26/10/2023	30/11/2023	28/12/2023	x	x	x	x	x	x	x	x
	Swale Safety Advisory Grp	Monthly	EPR Lead	Swale Council	*Via Event App only.*											
Internal Meetings																
	Trust Board - EPRR Paper	Annual		AEO/NED	28/09/2023											
	Audit and Risk Committee	Quaterly		NED	12/09/2023		13/11/2023				04/03/2024		x			
	TWHS&RG Meetings	Quaterly		AEO			29/11/2023			21/02/2024			x			x
	TWEPRR Meetings	Quaterly		AEO			15/11/2023			07/02/2024			x			x
Risk (Civil Contingencies Act - Duty)																
	Alignment to NRSA	Annual	EPR Lead/Risk Manager	NA		x										
	Alignment to KRF County Risk Register	Annual	EPR Lead/Risk Manager	NA		x										
	EPRR Risk Register review	Monthly	EPR Lead/Risk Manager	NA	x	x	x	x	x	x	x	x	x	x	x	x

2023 Self Assessment Outcome (NHS Core Standards Improvement Plan)																	
	66 - FIT Testing SOP		EPRR	NA	See New Plans Section												
	59 - HAZMAT CBRN Exercise		EPRR	NA	See Exercise Section												
Maintain plans (Civil Contingencies Act - Duty) - Updates																	
	Major Incident Plan		EPR Officer	NA						x							
	Significant Incident Plan		EPR Officer	NA						x							
	Summer Resilience Plan		EPR Lead	NA								x					
	Winter Resilience Plan		EPR Lead	NA													x
	Lockdown Plan		Trust Security Manager	NA											x		
	Mitigation using staff accommodation		EPR Lead	NA													x
	Infant Abduction Policy and Response Proceedure		EPR Lead	NA						x							
	Joint Emergency Services Interoperability Program (JESIP) Standard Operating Procedure		EPR Officer	NA			x										
	Management of Industrial Action Standard Operating Procedure		EPR Lead/HR	NA			x - Subject to Debriefs										
	Management of Business Continuity Policy and Templates		EPR Lead	NA			x										
	Master on call File - (ICB) Organisational Overview Document		EPR Lead/Asset Manager	NA	x												
	Cyber Resilience and Response Plan		EPR Officer/IT	NA			x										
	Data Protection and Confidentiality Policy		Information Governance	NA							x						
	Official Visitors Policy		Communications	NA									x				
	On Call Policy		Deputy Director - North	NA				x									
	Death of a patient due to COVID19 or suspected COVID19 SOP		EPR Lead/IPC Matron	NA													x
	Incident Control Centre Standard Operating Procedure		EPR Officer	NA			x										
	Incident Response Communications Plan		Communications	NA									x				
	Electrical Resilience Plan - Site specific information		EPRR Officer	NA			x										
	EPRR SITREP SOP		EPR Lead	NA			x										
	Water Resilience Plan - Site specific information		EPRR Officer	NA			x										
	EPRR Policy		EPR Lead	NA													x
Maintain plans (Civil Contingencies Act - Duty) - New Plans																	
	FFP3 Fit Testing SOP		EPR Lead/IPC Matron with Health and Safety Manager	NA			x										
	Zoonotic and Non Zoontic Animal Infectious Disease SOP (covering avian flu etc)		EPR Lead	NA			x										

Emergency Preparedness, Resilience and Response 2023/24 Work Plan.

Item	Frequency	Owner	Chair	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Exercise Programme (Core Standards)															
Communication Test 1		EPRR Function	NA												
Communication Test 2		EPRR Function	NA												
Table Top Exercise TGU		EPRR Function	NA							x					
Table Top Exercise LSU		EPRR Function	NA									x			
Table Top Exercise MBU (Infant Abduction)		EPRR Function	NA						x						
Exercise Melville (Hospital Evacuation)		ICB	NA			TBC									
HAZMAT Live Play Exercise		Trust Security Manager/EPR Lead/Fire Safety Team	NA								x				
Training Programme (Core Standards)															
EPRR Training Plan		EPR Officer	NA	x											
EPRR e-learning Induction		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	x
EPRR e-learning Hazmat		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	x
Clinical Leads on call - New		EPRR Function	NA	x		x		x		x		x		x	
Clinical Leads on call - Refresher		EPRR Function	NA		x		x		x		x		x		
Manager on call - New		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	x
Manager on call - refresher		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	x
Director on call - new		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	x
Director on call - refresher		EPRR Function	NA	x	x	x	x	x	x	x	x	x	x	x	
Loggist Training - New		EPRR Function	NA	x			x			x			x		x
Loggist Training - refresher		EPRR Function	NA		x			x			x			x	
MBU Infant Abduction response staff - Annual by agreement		EPRR Function	NA	TBC											
Switchboard response staff - Annual by agreement		EPRR Function	NA	TBC											
Writing and reviewing a BCP Plan		EPR Lead	NA	x	x	x	x	x	x	x	x	x	x	x	x
Crisis Media Training for Executives		Director of Communications	NA	TBC											

Emergency Preparedness, Resilience and Response 2023/24 Work Plan.																	
	Item	Frequency	Owner	Chair	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Monitoring, Self Assessment and Audit																
	CBRN Grab Boxes Monitoring		EPRR Admin	NA			x						x			
	Service Business Continuity Plans - Monitoring		EPRR Function/ Patient Safety Leads	NA	x	x	x	x	x	x	x	x	x	x	x	x
	IT System Business Continuity Plans - Monitoring		EPRR Function	NA	x	x	x	x	x	x	x	x			x	x
	IT System Business Continuity Plans - Annual Audit		EPR Lead/IT	NA										x		
	Estates Contract HAZMAT Risk Assessments/ Safe systems of work		Estates Contract Manager	NA			x						x			
	PPM and Servicing assurance and bowser coupling assurance - PFI Water Inject site		Estates Contract Manager	NA			x						x			
	PPM and Servicing assurance - Generators/ Generator Fuel		Estates Contract Manager	NA			x						x			
	Annual EPRR Core Standards Self Assessment		EPRR Function	NA											x	
Governance Reports																
	LHRP Executive Group Organisational update		EPR Lead				x				x				x	
	Highlight Reports to TWHS&RG from EPRR Working Group.		EPR Lead				x			x			x			x
	EPRR Annual Report to Board		EPR Lead/AEO													x
	KPI data on TWHS&RG Report to ARC		EPR Lead							x						x
Response and Incident Debrief Reports - To be added in year.																
			EPRR Function													
Continuous Improvement - Lessons Indentified added to EPRR Corrective Action Database - Core Standards																
	Management of EPRR Corrective Action Database		EPRR Function		x	x	x	x	x	x	x	x	x	x	x	x

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Changes to Standing Orders
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory

Overview of Paper

A paper setting out the proposed changes to the Trust's Standing Orders.

Items of focus

The Trust Board last approved the Standing Orders and Standing Financial Instructions in November 2022.

The Chief Executive announced in January that she would retire in Autumn 2023. Following a national recruitment process, Sheila Stenson was appointed as KMPT's new Chief Executive, to take effect on 1st November 2023.

Donna Hayward-Sussex, Chief Operating Officer has been appointed Deputy Chief Executive by Sheila Stenson and will take up her additional role on 1st November 2023.

Some of those changes affect the Board's composition, which require amendments of the Standing Orders and therefore Board's approval.

The changes approved by the Board will only take effect from 1st November 2023.

Governance

Implications/Impact:	The Standing Orders and Standing Financial Instructions are a statutory requirement for all NHS Organisations
Assurance:	Significant
Oversight:	Oversight by Trust Board

Kent and Medway
NHS and Social Care Partnership Trust

Standing Orders

1. On an annual basis, usually in November, the Trust Secretary and the Deputy Director of Finance carry out a full review of the Trust's Standing Orders and Standing Financial Instructions ('SOs & SFIs') respectively to ensure that they remain fit for purpose for the Trust as well as meeting any regulatory requirements.

2. Following Sheila Stenson's appointment as Chief Executive, which is to commence on 1st November 2023, her current additional role of Deputy Chief Executive will transfer to Donna Hayward-Sussex as of 1st November.

3. To record the changes concisely, the proposed changes are recorded in the table attached.

4. The Board is requested to approve the changes as proposed. The amended Standing Orders will take effect from 1st November 2023.

Key Changes Requested for Approval

Changes are highlighted in **bold** in the table below.

SO/SFI number	Current wording	New wording
5.8.4	Chief Finance and Resources Officer (Deputy Chief Executive)	**Chief Finance and Resources Officer**
5.8.6	Chief People Officer	**Chief People Officer (non-voting)**
5.8.7	Chief Operating Officer (non-voting)	**Chief Operating Officer (Deputy Chief Executive)**

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th September 2023
Title of Paper:	Register of Board Members Interests – September 2023
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

This paper sets out the updated Trust's Register of Board members' interests, which will be published on the Trust website.

Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

It is the Trust's practice to formally update the Register of Interests twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board is attached.

All Board members have made declarations to the Trust Secretary who has the responsibility of maintaining the Register of Interests including where the member had no interests to declare.

This information will be made publicly available on the Trust website following the meeting.

Governance

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable
Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Register of Board Members Interests – September 2023

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS
September 2023

Director	Position	Interest declared
Dr Jackie Craissati	**Trust Chair**	Jackie is Director of Psychological Approaches CIC, which is on the NHS England framework for Independent Serous Incident Investigations. However, the company does not undertake investigations relating to KMPT. Jackie is chair of Crohn's & Colitis UK. The charity works closely with the NHS but is not commissioned to deliver services. Jackie is Independent Governor on the Board of the University of East London. She is also the independent non-executive member of the Audit & Risk Committee for the Office of the Public Guardian. There is the unlikely possibility that a particular serious safeguarding incident in relation to Lasting Power of Attorney has links to Kent & Medway. Jackie is Chair at Dartford and Gravesham NHS Trust
Venu Branch	**Deputy Trust Chair**	None declared
Catherine Walker	**Non-Executive Director** (Senior Independent Director)	Lay Chair of the Advisory Appointments Committee at Kings College Hospital NHS Foundation Trust, London Catherine is Chair of an advisory and scrutiny Panel of the National Employment Savings Trust (' NEST')

		Corporation. NEST is the pension auto enrolment vehicle used by KMPT for workers who are not members of the NHS pension scheme. Catherine is holds judicial appointments with the Social Entitlement Chamber and the Health Service Products (Pricing Cost Control and Information) Appeals Tribunal.
Kim Lowe	**Non-Executive Director**	Kim is also a Non-Executive Director at Kent Community Health Foundation Trust. Lay member – University of Kent Chair of the Board of Trustees University of Kent Academies Trust start Nov 2020
Mickola Wilson	**Non-Executive Director**	Director of Seven Dials Fund Management and advisor to private investors in Real Estate and former CEO of Teesland plc and MD of Guardian Properties. Non-Executive director of Mailbox REIT. Member of the Property Committee of the Mercers Livery Company. Member of the Chartered Surveyors Livery Company
Sean Bone-Knell	**Non-Executive Director**	None declared
Peter Conway	**Non-Executive Director**	Non-Executive Director – Kent Community Health NHS Foundation Trust
Stephen Waring	**Non-Executive Director**	Board Trustee and Vice-Chair of Trustee Board (unremunerated) of The Disabilities Trust (a charity offering specialist community-based and residential support for adults with acquired brain injury and complex physical disabilities). Employed (on an interim basis) at Greater London Authority, Health and Wellbeing Team.
Dr Asif Bachlani	**Associate Non-Executive Director**	Director of Company – AMB Psychiatry Limited that provides ADHD/ASD assessments for patients at Priory Woking hospital. Consultant Psychiatrist for Priory Woking Hospital providing care for private mental health patients
Dr MaryAnn Ferreux	**Associate Non-Executive Director**	Trustee - Royal College of Physicians Edinburgh Doctoral Researcher – London School of Hygiene and Tropical Medicine Medical Director at Kent, Surrey & Sussex Academic Health Science Network
Helen Greatorex	**Chief Executive Officer**	Partner Member of the Kent and Medway Integrated Care Board from July 2022
Sheila Stenson	**Chief Finance and Resources Officer & Deputy CEO**	Sheila is the Chair HFMA Kent, Surrey and Sussex

Donna Hayward-Sussex	**Chief Operating Officer**	None declared
Dr Afifa Qazi	**Chief Medical Officer**	None declared
Andrew Cruickshank	**Chief Nurse**	None declared
Sandra Goatley	**Chief People Officer**	None declared
Dr Adrian Richardson	**Director of Partnerships and Transformation**	Spouse is an employee of Frimley ICS

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 28th September 2023

Title of Paper: Trust Sealing Report

Author: Nicola Legge, Legal Services

Executive Director: Tony Saroy, Trust Secretary

Purpose of Paper

Purpose: Noting

Submission to Board: Standing Order

Overview of Paper

The report is to give reassurance to the Board that all documents endorsed with the Trust Seal have been done in accordance with the Trust Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation.

Issues to bring to the Board's attention

Three documents have been signed and sealed as a deed during from Q1 and Q2 23/24. This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact: Regulatory compliance

Assurance Substantial Assurance

Oversight: Oversight by Board.

Version control: 1

Kent and Medway
NHS and Social Care Partnership Trust

Number	Date of Sealing	Description	Signatures	Comments
151	06.04.2023	Lease renewal of Coleman House	Helen Greatorex, Chief Executive Jackie Craissati, Trust Chair	Paper presented at EMT in October 2022. Lease renewal authorised. Ten-year lease with the ability to sublet

Version control: 1

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28th September 2023**
Title	**Quality Committee Report**
Author	**Stephen Waring, Non-Executive Director and Committee Chair**
Presenter	**Stephen Waring, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- The committee acknowledged the improvements made on the Quality Risk Register as a result of risks being reviewed locally within the directorates.
- The committee noted the completion of an Independent Report utilising the Sexual Safety Benchmarking Tool to improve sexual safety on our wards, ensuring our patients are safe and feel supported following the Dispatches program.
- The committee received a report on the Dementia Services Improvement Plan. While noting the good work done to deal with the Covid backlog, recognised that referrals were still exceeding assessments, and the need for removal of variation in clinical practice and an effective triage process ahead of implementing the enhanced memory assessment and intervention service model.
- The committee noted and approved the following reports:
    1. Violence and Aggression Reduction
    2. Support and Signposting Service
    3. KMPT Bed Strategy: 10 Point Plan – Risks (as requested by Trust Board in July 2023)

Items referred to other Committees (incl. reasons why)

No items were referred to other Committees.

The Quality Committee was held on 19th September 2023. The following items were discussed and scrutinised as part of the meeting:

1. CQC Updates
2. PSIRF (Learning from Incidents)
3. Improving Patient Experience – Partner Strategy (incl. Complaints Annual Report)
4. Suicide Prevention
5. Violence Reduction
6. Sexual Safety and Safeguarding
7. Physical Health
8. Quality Risk Register
9. Bed Strategy
10. Dementia Services
11. Support and Signposting
12. Quality Impact Assessments

13. Quality Digest
14. DPIC Annual Report and Declaration
15. Guardian of Safe Working Hours
16. Clinical Audit Annual Report – National Audits and Accreditation
17. Suicide Prevention

The Board is asked to:

1) Note the content of this report.

Note to: KMPT Board – public board meeting dated 28th September 2023
From: Peter Conway
Date: 30.8.2023

Subject: Audit & Risk Committee (ARC) meeting 30 August 2023

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Management and BAF	*Reasonable Assurance*	Good progress has been made post the In-Phase implementation problems and BAF now much improved giving rise to better quality conversations. BAF - Industrial Action risk to be redefined, Ligatures risk to be re-evaluated post November audit, CMHF to be recalibrated post September report to Board and positive progress with Littlebrook lease risk. TRR - Improving Quality and Safety risk (current rating 16) to be looked at by QC
Financial Reporting	*Reasonable Assurance*	Grant Thornton draft VfM received - ''no risks or significant weaknesses identified'' under the categories of Financial Sustainability, Governance and Improving Economy, Efficiency and Effectiveness (final report to be issued post CQC Inspection Reports). 3x Financial and 2x Governance improvement recommendations made all have/are being addressed
Financial Controls	*Substantial Assurance*	Substantial assurance received regarding Losses and Special Payments and Single Tender Waivers
(1) Internal Controls - Auditors	*Reasonable Assurance*	1)TIAA Progress Report - substantial assurance report for Data Security and Protection Toolkit, reasonable assurance reports for Financial Assurance, Quality Impact Assessment, Assurance Framework and Risk Management and Data Quality of KPIs. Limited assurance report for Medical Revalidation and Clinical Supervision. This report has been delayed with Management not agreeing with the assessment nor some of the recommendations. Exec are reviewing and it is suggested that People Committee scrutinise going forward 2) TIAA Audit Plan 2023-24: agreed 3)Anti-Crime Progress Report and Plan 2023-24: agreed
(2) Internal Controls - Trust	*Reasonable Assurance*	1)Health & Safety Review: reasonable assurance. Mandatory Patient Handling Training 13% short of target. KMPT not an outlier nationally, remediation actions underway but target unlikely to be achieved. Risk tolerated

		2)Fire Safety Report: reasonable assurance. The use of e-cigarettes is having a detrimental effect on number of activations so policy being reconsidered 3)Emergency Preparedness and BRP Reviews: reasonable assurance and Board to receive the Annual Report 4)Cyber and Cloud Security Effectiveness: reasonable assurance. Cloud strategy to be completed by Q4 and Cyber Essentials Accreditation by Q1 2025. 5)Data Quality Review: Reasonable assurance. Next report to include more quantitative metrics 6)Subject Access Request Assurance: substantial assurance
Other		Agency workers - People Committee to consider the controls and cultural implications of the number of agency workers in the Trust (as opposed to the specific BAF agency risk which is financial)