AGENDA

Title of Meeting Trust Board Meeting (Public)
Date 25th January 2024
Time 09.30 – 12.30
Venue Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/23-24/109	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/23-24/110	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/23-24/111	3.	Personal Story – Alan's Journey	FN	Verbal	DHS	09.35
TB/23-24/112	4.	Quality Improvement – Combined Personal Passport Project	FN	Verbal	VK	09.45
STANDING ITEMS						
TB/23-24/113	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/23-24/114	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/23-24/115	7.	Chair's Report	FN	Paper	Chair	10.00
TB/23-24/116	8.	Chief Executive's Report	FN	Paper	SS	10.05
TB/23-24/117	9.	Board Assurance Framework	FA	Paper	AC	10.15
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/23-24/118	10.	MHLDA Provider Collaborative Progress Report	FD	Paper	AR	10.25
TB/23-24/119	11.	Right Care, Right Person Report	FD	Paper	AR	10.35
TB/23-24/120	12.	Progress against Purposeful Admissions Programme	FD	Paper	VK	10.45
TB/23-24/121	13.	Community Mental Health Framework Update	FD	Paper	DHS	11.00
OPERATIONAL ASSURANCE						
TB/23-24/122	14.	Integrated Quality and Performance Review	FD	Paper	SS	11.10
TB/23-24/123	15.	Urgent and Emergency Care Impact Report	FD	Paper	DHS	11.30
TB/23-24/124	16.	Finance Report	FD	Paper	NB	11.40
TB/23-24/125	17.	Workforce Deep Dive – Health and Wellbeing	FD	Paper	SG	11.45
TB/23-24/126	18.	Freedom to Speak Up – Six-month interim report	FD	Paper	RC	12.00
CONSENT ITEMS						
TB/23-24/127	19.	Report from Quality Committee (incl Mortality Report)	FN	Paper	SW	12.10
TB/23-24/128	20.	Report from People Committee	FN	Paper	VB	
TB/23-24/129	21.	Report from Mental Health Act Committee	FN	Paper	KL	
TB/23-24/130	22.	Report from Finance and Performance Committee	FN	Paper	MW	
CLOSING ITEMS						
TB/23-24/131	23.	Any Other Business			Chair	12.15
TB/23-24/132	24.	Questions from Public			Chair	
	Date of Next Meeting: 28th March 2024, Cathedral Lodge, Canterbury.					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Sean Bone-Knell	SB-K	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
Shelia Stenson	SS	Chief Executive
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer/ Deputy Chief Executive
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnership and Transformation
In attendance:		
Dr Valsraj Koravangattu	VK	Deputy Chief Medical Officer (Quality & Safety)
Kindra Hyttner	KH	Director of Communications and Engagement
Hannah Stewart	HS	Deputy Trust Secretary (Minutes)
Apologies:		
Dr Afifa Qazi	AQ	Chief Medical Officer
Kim Lowe	KL	Non-Executive Director
Tony Saroy	TS	Trust Secretary

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.10 hrs on Thursday 30th November 2023
Via Lifesize

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
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	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 Stewart	HS	Deputy Trust Secretary
	Kindra Hyttner	KH	Director of Communications and Engagement
	Graham Blackman	GB	Deputy Director of Acute Services
	Emily T	ET	Service User
	Shannon Paine	SP	General Manager Low Secure Services
	Ellie Tobin	ETo	Learning Disability Nurse
	John Murray	JM	Engagement Director, Deloitte
Apologies:			
Observers:			
			Members of the public accessed the meeting by way of livestream

Item	Subject	Action
TB/23-24/84	**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/23-24/85	**Declarations of Interest** There were no declarations of interest.	

Item	Subject	Action
TB/23-24/86	**Personal Story – Acute Directorate – Admission Experience** The Board received GB and ET, with ET describing to the Board her experience of acute services as an inpatient. She described the difficulties for patients who are neurodivergent, in terms of lighting, noise and other factors that overload the senses. ET stated that although staff were generally friendly and caring, some staff were resistant to certain items being on the ward which ET felt helped with her neurodiversity. The Board reflected on the personal story and explored why the Trust was not able to respond more positively to some of ET's requests although the Board recognised that there may be health and safety implications with some of the requests that patients make. The Board supported AQ's suggestion that she will meet with ET to discuss her inpatient stay experience. The Board thanked GB and ET for attending and **noted** the Personal Story – Acute Directorate – Admission Experience.	
TB/23-24/87	**Quality Improvement (QI) – Zonal Observations as an alternative to Enhanced Observations for Managing Sexual Risk in a Low Secure Learning Disability Service** The Board heard the QI story from SP and ETo. The Forensic Low Secure Learning Disability Service at Tarenfort Centre is a 20 bedded rehabilitation inpatient unit catering for adult men with a learning disability whose offending behaviour and complex mental health needs require care in a low secure setting. SP explained that the team needed to carry out appropriate levels of observations on patients, and that at least 10 staff members were needed for just four patients; for example, due to identified sexual risks, patients needed 1-to-1 observations. To address this issue, the service moved to a zonal observation process, whereby two staff members have full line of sight across all bedrooms down a corridor. This created two benefits: 1) Staff felt it was not as emotionally stressful as the previous observation process; and 2) The number of sexual incidents reduced from eight prior to the QI intervention (Jan 23 to Jun 23) to zero following the intervention (Jun 23 to Sep 23). ETo set out the flexible training that was put in place and how processes were adjusted in response to . The Trust confirmed that zonal observations could be replicated in other environments and will be rolled out by way systematically, as staff need to develop clinical confidence before implementing the new process.	

Item	Subject	Action
	The Board thanked SP and ETo for attending, and **noted** the Quality Improvement – Zonal Observations as an alternative to Enhanced Observations for Managing Sexual Risk in a Low Secure Learning Disability Service.	
TB/23-24/88	**Minutes of the previous meeting** The Board **approved** the minutes of the previous meeting with a request to note that AQ gave her apologies for the September 2023 meeting.	
TB/23-24/89	**Action Log & Matters Arising** The Board **approved** the Action Log with the following amendments: • The Board will receive the Bed Strategy paper in January 2024 and will be renamed. Current working title: Patient Flow Plan. There were no matters arising.	
TB/23-24/90	**Chair's Report** The Board reflected on the NED visit to the East Kent liaison psychiatry team, which is based within the William Harvey Hospital which is run by East Kent Hospital University NHS Foundation Trust (EKHUFT). Concerns were raised because a patient under the age of 18 had been sleeping on a plastic mattress on the floor within the allocated liaison room, which is meant to be used by adult patients. Concerns were also raised regarding the office environment and its impact on staff. The Trust confirmed that urgent discussions have occurred with EKHUFT and that EKHUFT has agreed the placing of child patients with adult patients was unacceptable and would be stopped. The Trust is working with EKHUFT regarding the environment. The Executive team assured the Board that the Liaison Psychiatry Service was safe but it was agreed that the situation required close monitoring and the Board would be updated on the situation. **Action: SS to provide a written Board briefing regarding the office environment for the East Kent Liaison Psychiatry Team by end of December 2023.** The Board **noted** the Chair's Report.	**SS**
TB/23-24/91	**Chief Executive's Report** The Board received and **noted** the Chief Executive's Report.	
TB/23-24/92	**Board Assurance Framework (BAF)** The Board received the BAF and reflected on the following matters: • Regarding the management of ligatures, it was confirmed that concerns raised from last year's audit had not been resolved. The Quality Committee retains oversight of the issue and has requested quick improvements.	

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Item	Subject	Action
	• The Quality Committee and Finance Performance Committee are also to receive a paper regarding Psychology Waiting Lists in January 2024. The Board **approved** the Board Assurance Framework.	
TB/23-24/93	**Trust Risk Register** The Board received the Trust Risk Register. According to the latest iteration of the Trust Risk Register, the Trust's risk profile has changed and the Board needs to determine if it is comfortable with the new risk profile. The Risk Register had been considered at Committee level, with Committees noting that some of the information is complete, and that some risk mitigation dates had passed. The Board determined that its line of sight regarding the newly presented extreme risks was not sufficient and that future papers regarding risks need to be adjusted so that it is clearer as who is the Executive Lead for each risk and which Committee is the lead committee. The Board recognised that some elements of risk management remain within our control (or internal to the Trust) whilst others are dependent on external (for example, Kent & Medway system) mitigation. The Trust Risk Register needs to differentiate along these lines and identify where and for what oversight is occurring. The Board explored the issue regarding delayed transfers of care (DToC), which needs to be led by the Integrated Care System (ICS). The Board was informed that the ICS is currently at the diagnostic stage and the Board will be updated regularly on the issue. **Action: AC to lead the adjustment of the Trust Risk Register so that it is clear as to who is the Executive Lead and which Committee is the Lead Committee, with confirmation of that adjustment given at the next Board meeting.** **Action: SS to ensure that future iterations of the IQPR includes a section on 'Internal and External Controls and Mitigations' by January 2024.** The Board **noted** the Trust Risk Register.	**AC** **SS**
TB/23-24/94	**Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report** The Board reflected on the MHLDA Provider Collaborative Report and the various risks as detailed in the report. The Board noted that the Provider Collaborative Risk Register was different in style and substance to the Trust Risk Register as it is aligned to its multi-agency role, and that it would be preferable to exclude those risks that are exclusively internal to KMPT. There is still work to be completed on providing progress against workstream timescales. It also appeared that there were many recorded	

Item	Subject	Action
	mitigations but it was unclear as to what effect, if any, they were having on the risk score. **Action: From January 2024, future iterations of the Provider Collaborative Board Progress Report to include a risk register that reflects the discussions that are to be had between AR and PC, with a greater focus on progress against timescales.** The Board noted that the dementia programme was moving out of the MHLDA Provider Collaborative to the Ageing Well workstream within the Community Provider Collaborative, with a dotted reporting line to the MHLDA. The Board highlighted that one of the dementia programme risks seems to move from a risk score of 16 to a risk score of 25 after mitigation is in place. The Board was informed that this will be resolved in future iterations. The Board **noted** the MHLDA Provider Collaborative Report.	**AR**
TB/23-24/95	**Integrated Quality and Performance Report (IQPR) – Month 7** The Board received the IQPR with the Board discussion focussed on the following: • The Board complimented the new summary and the use of statistical process control. • The Memory Assessment Service (MAS) has reduced the backlog that developed during COVID-19, but the Trust is struggling to manage the current demand. A dementia improvement programme is in place, with the staffing model needing to change. Improvements will only occur once the new staffing model is embedded. The Finance and Performance Committee will be monitoring the MAS performance. • Positive performance includes the improvement in the Friends and Family Test, and it was also noted the trust has the lowest number of out of area placements in the country. • It was discussed that the trust has had a recent history of not delivering in key areas, some of which seemed likely to be the result of plans and workstreams that were proving to be ineffective. The Board recommended timely review of such initiatives. • The flu-vaccination rates for staff remains a concern as only a third have been vaccinated. The Trust is working with the ICS to improve the vaccination rate. The Board **noted** the IQPR – Month 7.	
TB/23-24/96	**Finance Report – Month 7** The Board received the Finance Report and highlighted the following: • There has been no confirmation regarding sanctions for the overspending against the agency cap. The sanction would be applied at ICS level. • Although there has been a slippage against the capital plan, the Trust is expecting to spend the capital allocation by the end of the financial year. The Trust remains in a position to break-even by year end.	

Item	Subject	Action
	The Board **noted** the Finance Report – Month 7.	
TB/23-24/97	**Workforce Deep Dive – Medical Recruitment** The Board received the Workforce Deep Dive paper regarding Medical Recruitment. The Board reflected on, and noted, the following matters: • The Trust is the second lowest in the South East Region Mental Health Agency spend comparison and the Board recommended that the Trust reaches out to Berkshire Healthcare NHS Foundation Trust to discover best practice as it was the trust with the lowest agency spend as a percentage of total pay bill. • The Board noted that there were a large number of initiatives and the Board highlighted that these need to be monitored in order to ensure that they are yielding results. This included a clearer delivery plan for those new roles and responsibilities (non-medical staff) that resulted in less pressure on the medical staff. The Board requested that the People Committee monitor progress. **Action: AQ to produce a Medical Recruitment report for the People Committee by January 2024 that provides an update on the recruitment and retention initiatives, staff morale, non-medical consultant plan, and any patient safety risks. The paper should detail those matters that are KMPT-led and those that are ICS-led.** The Board **noted** the Workforce Deep Dive paper regarding Medical Recruitment.	**AQ**
TB/23-24/98	**Medical Revalidation Report** The Board received the Medical Revalidation Report. The Board expressed its concerns that the Audit and Risk Committee had received a limited assurance internal audit report regarding 'Compliance with Job Plans' and that the Committee had been dissatisfied by the management response. The Workforce and Organisational Development Committee (now known as People Committee) had also considered the internal audit and also had concerns. AQ confirmed that the General Medical Council had revalidated the Trust's doctors and that the recommendations set out within the relevant internal audit report had been completed. The Board suggested that assurance can be given by way of a re-audit, which could occur quite quickly. AQ committed to provide assurance to the chair of the Workforce and Organisational Development Committee, so that she may file the Medical Revalidation Report. The Board **approved** the Medical Revalidation Report subject to AQ providing an evidenced response to the internal audit recommendations to VB.	
TB/23-24/99	**Community Mental Health Framework Progress Report**	

Item	Subject	Action
	The Board received and **noted** the Community Mental Health Framework (CMHF) Progress Report.	
TB/23-24/100	**Standing Orders and Standing Financial Instructions** The Board **approved** the proposed amendments to the Trust's Standing Orders and Standing Financial Instructions provided that SO 5.8 is changed to 'Director of Partnerships and Transformation'.	
TB/23-24/101	**Committees' Terms of Reference** The Board **approved** the recommended changes to the Committees Terms of Reference.	
TB/23-24/102	**Report from Quality Committee (incl. Mortality Report)** The Board received and **noted** the Quality Committee Chair's report.	
TB/23-24/103	**Report from Workforce and Organizational Development Committee** The Board received and **noted** the Workforce and Organisational Development Committee Chair's report.	
TB/23-24/104	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/23-24/105	**Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee's Chair Report.	
TB/23-24/106	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/23-24/107	**Any Other Business** None.	
TB/23-24/108	**Questions from Public** The Board received questions from the Public regarding agency rates, with the Trust confirming that in terms of medical agency usage, it is working within a South East Collaborative to negotiate rates down.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 25th January 2024.	

Signed …………………………………………………………….. (Chair)

Date ……………………………………………………………..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/01/2024

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JANUARY 2024								
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		This is on the agenda for discussion, under the 'Right Care, Right Person' Report.	CLOSED
27.07.2023	TB/23-24/46	Bed Strategy	AQ to present the Purposeful Admissions Programme (previously Bed Strategy) progress report in July 2024.	AQ	January 2024		This is on the agenda for discussion.	CLOSED
30.11.2023	TB/23-24/90	Chair's Report	SS to provide a written Board briefing regarding the office environment for the East Kent Liaison Psychiatry Team by end of December 2023.	SS	December 2023		This was circulated on 21/12/23	CLOSED
30.11.2023	TB/23-24/93	Trust Risk Register	AC to lead the adjustment of the Trust Risk Register so that it is clear as to who is the Executive Lead and which Committee is the Lead Committee, with confirmation of that adjustment given at the next Board meeting.	AC	January 2024		The Trust Risk Register has been updated as suggested and will be taken to the next Audit and Risk Committee meeting	CLOSED
30.11.2023	TB/23-24/93	Trust Risk Register	SS to ensure that future iterations of the IQPR includes a section on 'Internal and External Controls and Mitigations' by January 2024.	SS	January 2024		This is included in the IQPR	CLOSED
30.11.2023	TB/23-24/94	MHLDA Provider Collaborative Report	From January 2024, future iterations of the Provider Collaborative Board Progress Report to include a risk register that reflects the discussions that are to be had between AR and PC.	AR	January 2024		Discussions have occurred between AR and PC and also with SS and JC, an update on the refresh and future way of working is provided for January. Future reports will be drafted from the standard update to the Provider Collaborative	CLOSED
30.11.2023	TB/23-24/97	Workforce Deep Dive – Medical Recruitment	AQ to produce a Medical Recruitment report for the People Committee by January 2024 that provides an update on the recruitment and retention initiatives, staff morale, non-medical consultant plan, and any patient safety risks. The paper should detail those matters that are KMPT-led and those that are ICS-led.	AQ	January 2024		This report went to the People Committee on 16/01/2024	CLOSED
ACTIONS NOT DUE OR IN PROGRESS								

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BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/01/2024

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
28.09.2023	TB/23-24/67	Board Assurance Framework	The Workforce Deep dive is to be focussed on Medical Recruitment	AQ	November 2023		This is on the agenda for discussion.	CLOSED
28.09.2023	TB/23-24/69	MHLDA Provider Collaborative Board Progress Report	Provider Collaborative Board Progress Report to reflect the discussions that are to be held between AR and PC.	AR	November 2023		This has been included within the report.	CLOSED

Action Log v2

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 25th January 2024**
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
- Non-Executive Directors Changes
- Board Development Day
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

This month, I have formally handed over the chairing of the Integrated Care System (ICS) provider collaborative for Mental Health, Learning Disability & Autism, to our Chief Executive, Sheila Stenson. I will now sit on the overarching Provider Collaborative Board for the ICS.

3. Non-Executive Director Changes

This is the final public Board meeting for Venu Branch, who will be coming to the end of her second NED term at the end of February. On behalf of the Board, I would like to thank her for her service and commitment to KMPT, including her leadership of our People Committee and her support to me in her role as deputy chair.

On 1st March 2024, Dr MaryAnn Ferreux will become a Non-Executive Director with KMPT. This is an opportune time for a refresh at committee level, with some rotation of NEDs. These changes will go live on 1st March.

4. Board Development Day

On 6th December, the Board met for a development day, with a focus on organisational culture. The Board had three sessions:

- Reflecting on our position in relation to the CQC criteria for 'good' and 'outstanding' well-led trust, presented by the Good Governance Improvement.
- Learning from Mersey Care NHS Foundation Trust's improvement journey in relation to embedding the right type of culture in a NHS trust.
- Considering the preliminary feedback from KMPT's recent work on our brand.

2024 will be important for ensuring an unwavering focus from the Board on our culture, the development of our leadership and embedding our work on equality, diversity and inclusion.

5. Trust Chair and NED visits

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

Where	Who
November 2023	
Liaison Psychiatry Team, East Kent	Catherine Walker
Thrive Team - Psychological support for birth trauma and perinatal loss	Catherine Walker
January 2024	
Jasmine Ward, Darent Valley Hospital	Dr Jackie Craissati
Trevor Gibbens Unit	Sean Bone-Knell
Thanet Community Mental Health Service for Older People	Stephen Waring

Catherine Walker's visit to Liaison Psychiatry Team in East Kent

Together with the KMPT Director of Transformation and Partnerships (DTP), I visited the Liaison Psychiatry Team in East Kent on 24.11.23. This is situated in the William Harvey Hospital (an EKHUFT site). Premises are a major problem as we have use of a small suite of windowless rooms at the back of the busy A and E. On the day of our visit there were at least six people there. This included a non KMPT CAHMS (Child and Adolescent Mental Health Services) patient who had been sleeping overnight on a mattress on the floor and their Dad. There was water ingress which was captured on disposable bed pads, a blocked fire exit and a shared toilet with no towels or soap. There was no shower. At times we were told that there could be a dozen people using the space and the longest stay staff were aware of in recent times was 12 days. The area had limited space for therapeutic conversations. The overcrowded office area for KMPT staff is 1/8 of a mile away from A & E which is less than ideal. KMPT executives are in dialogue with EKHUFT to get more appropriate space. KMPT medical staff cannot prescribe - this matter will be actioned by the DTP as a matter of urgency. Recruitment is a serious problem. On a positive note KMPT staff were clearly caring and passionate about doing the best for those in their care. We were told about a triage tool which may have wider application.

Catherine Walker's visit to Thrive Team - Psychological support for birth trauma and perinatal loss

It was an uplifting experience to visit the Thrive team on 27th November. This is a primary care service provided jointly by KMPT and the local acute trusts. It provides psychological interventions to those who are experiencing moderate to severe mental health difficulties as a result of, or triggered by, the maternity experience such as perinatal loss, birth trauma and Tokophobia (severe fear of pregnancy or childbirth). It is a great example of joint working between acute trusts whose specialist midwives are in the team and KMPT.

Thrive is recurrently funded by NHSE and is now in its third year having begun as a pilot. It has been cited as a model service. It operates at the moment more or less to capacity in the East and West, there is a newer service in Medway and recruitment of psychologists to provide a service in Dartford has just been completed. Its success is evident from the positive and emotional feedback from mothers who have been held and supported by this personally tailored trauma-based service.

Dr Jackie Craissati's visit to Jasmine Ward

This month I have focused on attending board committee meetings. My visit to Jasmine Ward took place after the writing of this report.

Sean Bone-Knell's visit to Trevor Gibbens Unit

I visited the Trevor Gibbens Unit (TGU) and spoke with both staff and patients. Some patients were willing to engage and talk about their experiences and concerns. Mainly this was around the condition of the outside therapy areas and general condition of the wards.

Staff were positive and very engaged with patients' daily routines and were looking forward to the introduction of the new catering contract with the addition of the hosting facility. It was clear that managers are being empowered to take local decisions through the new structure and this was evidenced in a number of areas such as the use of the local maintenance team (which has been a brilliant addition), use of office facilities and involvement in areas of refurbishment.

The few negatives I found were around the reaction time for minor premises issues which then led to negative patient experience through noise and disruption. TGU needs general refurbishment to eliminate a number of ligature points (as per the ligature assessment) on the older wards and I was assured this is in hand. Recruitment and retention for the team remains an issue, as it is across the Trust.

Stephen Waring's visit to Thanet Community Mental Health Service for Older People

On 18 December, I visited the Thanet Community Mental Health Service for Older People, currently based in the Elmstone Unit on the Queen Elizabeth the Queen Mother Hospital site in Margate. The service has been due to relocate to The Beacon in Ramsgate for some time, but there have been some delays. I was pleased there was good understanding of the rationale – which will collocate the service with the younger adult services – though for some staff, and potentially for some patients, travel may be slightly more difficult (as the QEQM is better served by public transport).

There is a good skill mix, and I met a range of staff – including community psychiatric nurses, support workers, therapists and psychologists – most of whom spend a lot of their time working out in the community. Bringing them together as a team on specific days to consider their own wellbeing and that of their colleagues was welcome and had had a positive impact.

Staff also impressed on me the value attached to peer support workers bringing lived experience, and to art and music therapy for their patient group. Some issues with remote access to RiO and diary scheduling were raised, as was the need for more flexibility and careful transition when care home places come up at short notice. They thought their improved duty system was working well. They recognised the value of physical health checks for their patients, but, without registered general nurses, stressed the importance of having the right equipment and training.

Chief Executive's Board Report

Date of Meeting: 25th January 2024

Introduction

I am nearly at the end of my 100-day plan and I have been getting out and about as much as I can. I have visited may services and had numerous introductory meetings with staff around the Trust either on a one to one basis or in groups hearing their feedback on what it is like to work for KMPT.

As a reminder my 6 priorities are:

1. Patient Flow
2. Access to Dementia Care
3. Mental Health Together (our community mental health transformation programme)
4. Reducing violence and aggression against staff
5. Recruitment retention and working differently to address staffing gaps
6. Reshaping KMPT's identity including our behaviours and values

All staff I have spoken to have welcomed the six priorities and feel it is now very clear what we are focussed on and agree with the priorities. I have had staff contacting me personally to share why they are pleased to see specific priorities included and what it means for them.

Whilst talking about our fabulous dedicated staff at KMPT, I would like to take this opportunity to thank all our staff who have worked tirelessly over the Christmas and New Year period ensuring that our patients are cared for, ensuring every day is a better day for them.

NATIONAL UPDATE

Planning

NHS England have delayed the release of its 2024/25 planning guidance whilst discussions continue with government; however operational planning has commenced at both a Trust and System level.

Due to the prevailing financial pressures the settlement for 2024/25 is expected to be more challenging than previous years, with an anticipated inflationary uplift of 0.7%.

Based on system level modelling it is anticipated that the Trust will be asked to make efficiencies of up to 4% in year.

Conversations are on-going with the Trust directorate teams to agree draft budgets, with these due to be presented at the March board. This work will bring together the finance, capacity and workforce modelling for services.

The Trust is anticipating that the continuation of the Mental Health Investment standard.

Growth in Workforce

In June 2023, the South East Region Director, set out an expectation that the Kent and Medway system examined its workforce growth between April 2020 and March 2023. Specifically, each organisation was asked to assess the value for money for any growth, and put in place a plan for retraction of growth where value for money was not demonstrated. The overall plan was to be signed off by the Trust Board and the Integrated Care Board. This will be done today in the private session of the Trust Board.

Junior Dr and Consultant Strikes

The junior doctors 6-day Industrial action in the new year from 3rd Jan to 9th Jan 2024 has been the longest strike in the history of the NHS. Despite the challenges and potential disruptions this could have caused for our patients, I am pleased to report that we provided safe care for our patients through proactive planning and support from staff and our teams. All patients requiring urgent care and treatment were offered care and treatment. We responded to requests from partner organisations across the whole system to support the significant pressure. Planning and collaborative working ensured measures were in place to provide adequate cover, a safe service for our patients and a safe working environment for staff and teams. We also engaged with the union representatives.

The risk remained moderate throughout the strike period for all our directorates. Cancelled appointments have been rescheduled. The number of doctors striking during the six-day period varied.

Carer advocate awarded a British Empire Medal

On behalf of KMPT, I congratulate Matthew McKenzie on being awarded a British Empire Medal (BEM) in the King's New Year Honours in recognition for his services to carers and NHS trusts across the UK.

Matthew worked in collaboration with KMPT to develop our Triangle of Care service which enables us to bring together and support carers, service users and professionals and continue to deliver outstanding care. He attends local meetings and events to help raise awareness of carers' rights and represents the trust at national Triangle of Care steering groups

INTERNAL UPDATE

Board Development Day

We had an excellent Board development day in December which gave us time as a Board to plan for the future and where we want to take KMPT next, especially on our culture and brand journey and also hear from other Trusts like Merseycare and their Chief Executive, regarding their successful story. The Executive team are now taking forward the actions we agreed which will be brought back to the Trust Board as part of the year one strategy review and the plan for year two of the strategy delivery.

EMT Away Day

The Executive team had an away day this month to plan the year ahead and how we develop into a high performing team that is focussed on delivery. We used the morning session to revisit our Myers-Briggs Type Indicator profiles as we have had new members in the team in the last year and a new CEO. We then used the afternoon session to think about our profiles and personality types and how we use our understanding of the profiles we have in our team to focus on how we become a high performing team and what this involves, especially relating to agreeing deadlines and delivering to these. We also agreed once we have agreed the delivery plan we will hold each other to account for this as well as supporting each other to deliver. We have a follow up session planned for April.

Speak to Sheila Sessions

I have now held two of the new Speak to Sheila sessions, both have been very well attended. The first session had nearly 60 staff in attendance and the second session had 53 staff in attendance. Staff have asked some great questions, shared ideas and also some concerns too. I have also followed up with some staff on a one on one basis to discuss in further detail. Staff have been very appreciative of the sessions and have said they will be encouraging other staff to attend. We are planning more of the sessions in the coming months as I feel it is imperative for me as your new CEO to keep engagement with staff going.

These are some of the themes coming from these sessions:

- Change/transformation and how people are feeling about it
- Estates - how we make better use of estate and ensure space is fit for purpose
- Staffing and resources
- Celebrating good work across KMPT
- Violence and aggression/Equality Diversity & Inclusion (EDI) culture etc
- People valuing the opportunity to speak up and for you to listen and act

Manager's Memo

We launched a monthly managers memo to all staff back in November my first month in post which has landed very well with managers and staff. This is led by my executive team and each month they take it in turns to prepare the introduction to this memo. The memo will cover key messages that we are asking managers to cascade to their teams at their monthly meetings.

Chief Executive Visits

In addition to introductory meetings, I have made the following visits across the Trust.

- Low & Secure & Forensic Team at Dartford
- Mother & Baby Unit at Dartford
- Attended the Keeping Connected Conference at Gillingham Football Club organised by our Engagement Team
- Liaison teams at Pembury Hospital, Maidstone, Medway and Dartford prior to Christmas
- Nursing & Governance Team
- Research Team
- Safeguarding Team
- Britton House, Medway Community Teams
- Ashford Liaison team

All my visits have been highly informative and I would like to thank staff for their time, for being so open with me and sharing how it feels to work at KMPT and what we could do to improve their working days.

Regarding Non-Executive Director (NED) visits, a paper setting out themes from recent NED visits and the Trust's response is appended to this report.

Executive Team Visits

The executive team have been out and about.

Sandra Goatley, Chief People Officer – St Martins (Bluebell, Foxglove, Heather and Fern) and undertook a working with day on Cherrywood ward.
Andy Cruickshank, Chief Nurse - Thanet Mental Health Unit
Donna Hayward-Sussex, Chief Operating Officer/Deputy Chief Executive at Eureka Place and Highlands House.
Adrian Richardson, Director of Partnerships & Transformation, ECT Suite at Priority House.

Summary and Conclusion

It has been a brilliant first 100 days for me in my new role, I have really enjoyed engaging with so many staff and external stakeholders. I look forward to continuing with the delivery of the six priorities. We have some key papers and plans for Board in the next few months, which will be focussed on year two of the Trust strategy, Equality, Diversity and Inclusion and the completed Brand work for KMPT.

Sheila Stenson
Chief Executive

Non- Executive Director visits to Trust services

Background

The Trust has benefited from Non-Executive Director (NED) visits to Trust services for a number of years. They are an established way of helping the Trust in fulfilling the Care Quality Commission's Well-Led framework, but of equal value, KMPT staff members have always welcomed NED visits as a way of expressing their pleasure and concerns.

The information that our NEDs obtain from staff members during their visits informs the discussions the Trust has at Board, Committee and Directorate level and has at times been the spark of a new idea or a new way of working.

In addition to Non-Executive Directors visits, Executive Directors also carry out regular visits and working with days with services across the Trust.

Arrangement of NED visits

The Executive Management Team welcomes NED visits to any of the Trust's services. Whilst visits to some services require more planning than others, the intention of the Board is for a wide range of services to be visited as possible.

Since the last NED Visit update, the new process for organising NED visits has been successfully implemented. In addition to this, each NED has now been assigned an area for visits, to ensure that all areas within the organisation are being regularly visited. Feedback from visits is provided directly to the Executive Management Team for comment or feedback to the relevant NED. A summary of each NED visit is also included in the Chair's Report at all Public Board meetings.

Themed outcomes of NED visits

Between April 2023 and December 2023, there have been 56 NED visits, across the Trust's geographical area. Services that have been visited include:

- Community Mental Health Services for Older People
- Community Mental Health Services for Younger Adults
- Rehabilitation Services
- Liaison Services
- Support Services and
- Corporate Services

Feedback

A great deal of feedback received remains positive of the work the Trust is doing. All feedback provided praised staff and the hard work they are doing every day. There were some issues that were raised and as a result of the NED visits, a number of themes were identified from the feedback given. These themes include: :

- Issues with the quality of the environment for patients and staff

- Maintenance of sites and the timeliness in getting issues fixed.
- Workforce including the retention of staff and juggling staff due to sickness and annual leave
- Various digital issues

The last report the Board received, one of the themes identified was concerns regarding food choices however, in recent NED visits feedback has been received that food choices available have since improved.

Helping to shape our services

Although the Board is regularly sighted on many of the issues, the raising of the themes from time-to-time gives the Board and the Executive Management Team the opportunity to re-focus on the matters concerned. Some of these matters are overseen by the Board, but other matters are overseen by either a Committee (for further assurance) or the Executive Management Team (for operational matters to occur). Many of themes also form part of the Trust's Strategy.

Conclusion

NED visits remain a valuable source of intelligence for the Board in understanding those issues that have an impact on patients and staff. Where issues were raised, the Board will be assured in noting that many of those issues were known to the Trust and where actions had not already commenced to resolve the issues, action was taken shortly afterwards. Appropriate oversight on the closing of those actions is provided through the Trust's governance structure.

It is clear that the NEDs continue to work together with the Executive Management Team to ensure that the Trust remains sighted on and deals with matters that may impact the quality of care provided to our patients.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
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 November 2023.

- No risks have been added to the BAF since November.
- One risk has changed their risk score since November
  - Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (Decreased to 12 (High) from 16 (Extreme))
- One risk is recommended for removal
  - Risk ID 07442 – Module Reporting via DATIX and InPhase (Rating of 4 (Moderate))

Board requested outline of process and oversight of risk from the Service level to the Board Assurance Framework. An outline of the current arrangements is included in this report.

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)

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 30th November 2023.

The Top Risks are

- Risk ID 07557 – Trust Agency Usage (Rating of 20 – 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 05075 – Community Psychological Services Therapy Waiting Times (Rating of 16 – Extreme)

Risk Movement

One risk has changed their risk score since the Board Assurance Framework was presented to Board in November:

- **Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (Decreased to 12 (High) from 16 (Extreme))**
  Funding has now been released from the ICB to the KMPT baseline. This has enabled contracting with Voluntary Community Social Enterprise (VCSE) strategic partners to commence with an anticipated award date of March 2024. This has allowed the risk score to reduce.

Risks Recommended for Removal

1 risk is being recommended for removal at this time:

- **Risk ID 07442 – Module Reporting via DATIX and InPhase (Rating of 4 (Moderate))**
  This risk is recommended for closure. All records have been confirmed with legacy actions. Project closure and handover into BAU will occur in January.

New Risks

No risks have been added since the BAF was presented to Board in November

Emerging Risks

No new emerging risks have been identified for this report.

Other Notable Updates

- **Risk ID 00410 - Increased level of Delayed Transfers of Care (DToC)**
  Progress is being made on Actions, but level of DTOC remains high. Risk score is unlikely to reduce until actions complete and the impact of those actions are felt.
- **Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand**

Trajectory development and Capacity planning due in Jan 2024 with new model to run from April 2024.

- **Risk ID 00256 – Long Term Financial Sustainability**
  Risk to be reviewed as part of initial planning with update for March 2024.

- **Risk ID 04682 - Organisational Risk - Industrial Action**
  While this risk was recommended for removal at the November Board, further strike action has been undertaken and there is a further ballot being undertaken by the BMA. This risk has been returned to the BAF while the level of industrial action and the impact on patients is uncertain.

Outline of Risk Review Process – Service level to BAF

Risks are added on to the InPhase system and form part of the review processes in place in Directorates. This is supported by the governance teams who are looking at ensuring risks remain in date for review and that actions are in place. They also support Risk Managers with describing the risks, and adding controls and actions where needed.
Directorates look at their risks at their internal meetings and the top risks are reported through QPR.

Following the realignment from Care Groups there is an increased scrutiny on risks held by Directorates. Historically, risks have been added reactively to address issues that are impacting the delivery of services, and preventing the risk of them happening again. However, discussions are beginning to turn to whether risk registers are truly reflecting the risks that are most concerning, and have an element of uncertainty, whilst trying to ensure that the risk register doesn't solely reflect issues that are affecting services. A lot of work is being undertaken to ensure risk managers really own their risks and the actions to address them, and ensure this is reflected on the risk record held on InPhase. However, there is room for this to be happening more consistently across the Trust.

Escalation of risks is expected to be through the directorate structures to senior management teams, but having looked into how this happens, it appears that there is room for a more formal process to be developed. It is clear that discussion about key risk areas is happening and escalating concerns via the QPR processes, but it could be more consistent across the Directorates. There is also the need to ensure that ownership is taken from a wider perspective when there are similar issue escalating from directorates. There is the need to look at where a risk is best held and by who to ensure that the steps to address a risk are taken at the right level and communicated to all those who may be affected or who would be involved in actions to mitigate the risk.

There is also room to be more forward looking with risk management and add risks which could impact services, adding those things that are a worry, rather than an issue, although this can be challenging due to the level of uncertainty involved. It also requires the key points from risk discussions to be reflected on the system under existing and any new risks in a more robust way than is currently happening.

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.

Version Control: 01

Updated: 11 January 2024

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

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 - We deliver outstanding, person centred care that is safe, high quality and easy to access																			
1.1 - Improving Access to Quality Care																			
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	"MAS recovery programme " started in Aug 2023 to work on a number of initiatives to address capacity and demand and diversifying diagnostic skill-mix. Waiting List Initiative, COVID backlog has come to an end in Nov 2023 Capacity Planning Productivity Initiatives - Service flow, Job Planning with minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners, skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form. Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by 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	⟷	See actions below	Chief Medical Officer		3	3	9	31/03/2024
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	⟷	See actions below	Chief Operating Officer		1	2	2	30/08/2024

ID 00580 timeline:
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 demetia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st Septmber.
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**

ID 00580 Planned Actions and Milestones:

Actions to reduce risk	Owner	Target Completion (end)	Status
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

ID 05075 timeline:
30/08/2023 — BAF Risk Opened

ID 05075 Planned Actions and Milestones:

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
Recruitment of new supervisory posts for Mental Health Together	Director of Psychological Therapies	31/10/2024	A

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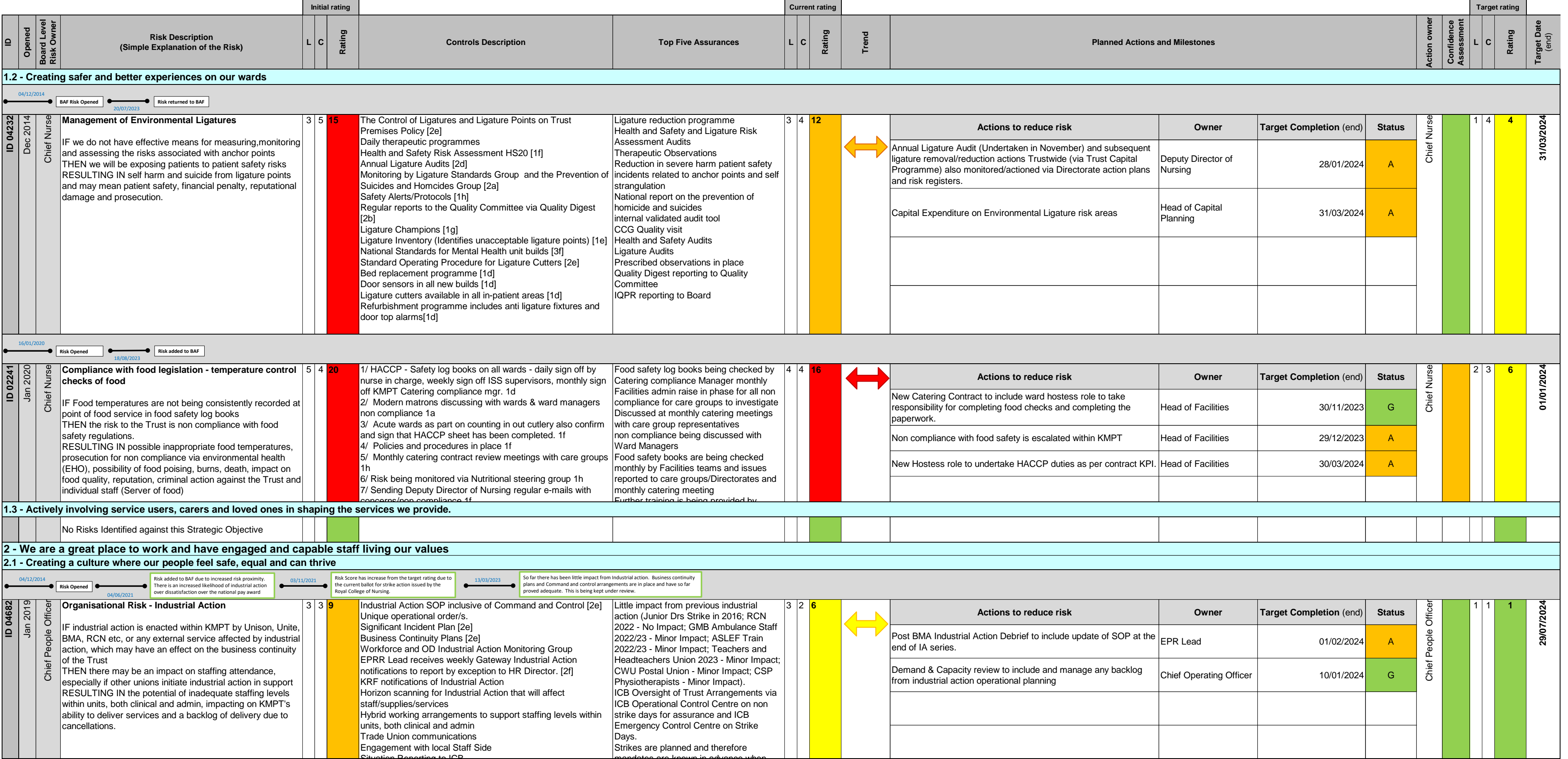

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	C	Rating	Controls Description	Top Five Assurances	Current rating L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	C	Rating	Target Date (end)
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 BAF Risk Opened; 20/07/2023 Risk returned to BAF																			
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	3	4	12	↔	**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 Capital Expenditure on Environmental Ligature risk areas / Head of Capital Planning / 31/03/2024 / A	Chief Nurse		1	4	4	31/03/2024
16/01/2020 Risk Opened; 18/08/2023 Risk added to BAF																			
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	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	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 / G Non compliance with food safety is escalated within KMPT / Head of Facilities / 29/12/2023 / A New Hostess role to undertake HACCP duties as per contract KPI. / Head of Facilities / 30/03/2024 / 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.																			
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 and a backlog of delivery due to cancellations.	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	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 / 01/02/2024 / A Demand & Capacity review to include and manage any backlog from industrial action operational planning / Chief Operating Officer / 10/01/2024 / G	Chief People Officer		1	1	1	29/07/2024

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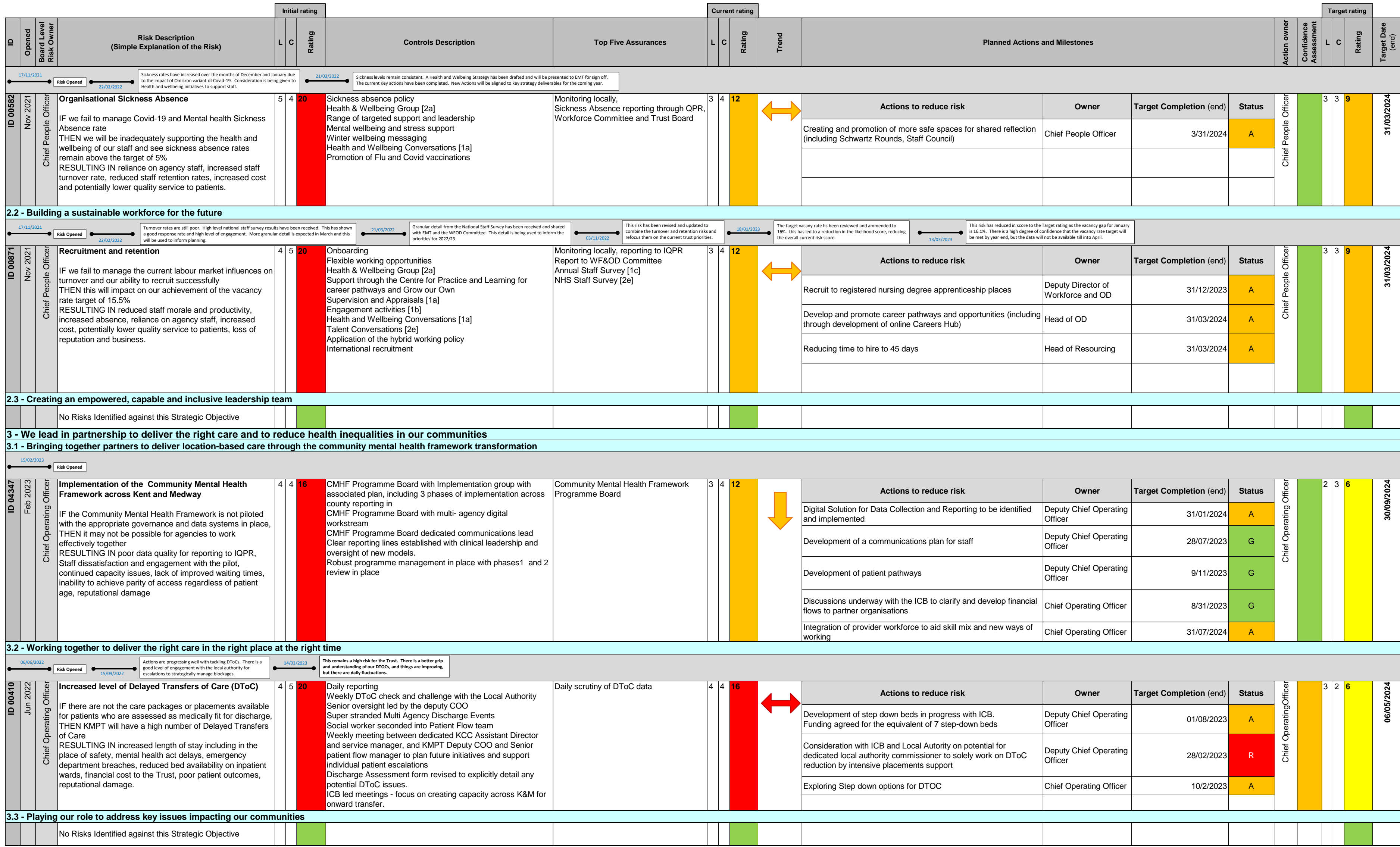


ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	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 Welbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year.																			
ID 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 / 3/31/2024 / 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 vacany 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.																			
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] Support through the Centre for Practice and Learning for career pathways and Grow our Own Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e] Application of the hybrid working policy 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	3	9	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																			
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	3	4	12	↓	**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 / 31/01/2024 / A Development of a communications plan for staff / Deputy Chief Operating Officer / 28/07/2023 / G Development of patient pathways / Deputy Chief Operating Officer / 9/11/2023 / G Discussions underway with the ICB to clarify and develop financial flows to partner organisations / Chief Operating Officer / 8/31/2023 / G Integration of provider workforce to aid skill mix and new ways of working / Chief Operating Officer / 31/07/2024 / A	Chief Operating Officer		2	3	6	30/09/2024
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.																			
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 / 10/2/2023 / A	Chief OperatingOfficer		3	2	6	06/05/2024
3.3 - Playing our role to address key issues impacting our communities																			
			No Risks Identified against this Strategic Objective																

Page 3 of 5

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target 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; 11/01/2024 Risk recommended for closure																			
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	2	2	4	⟷	See actions below	Executive Director of Finance		2	2	4	**01/01/2024**
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.																			
ID 00256	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) has been launched in the organisation and is being led by the deputies. Monthly reporting is taking place through QPRs and Finance report, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs. Service Line reporting data has been utilitised to identidfy loss making services and to focus discussions on opportunities. Papers reported to FPC and Trust Board. SLR data reviewed routinely to ensure Directorates clear on the position.	3	4	12	⟷	See actions below	Executive Director of Finance		3	3	9	**31/03/2024**
22/08/2023 Risk Opened																			
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	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 Weekly monitoring of agency spend	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	⟷	See actions below	Executive Director of Finance		3	3	9	**31/03/2024**
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																
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																

Planned Actions and Milestones – ID 07442

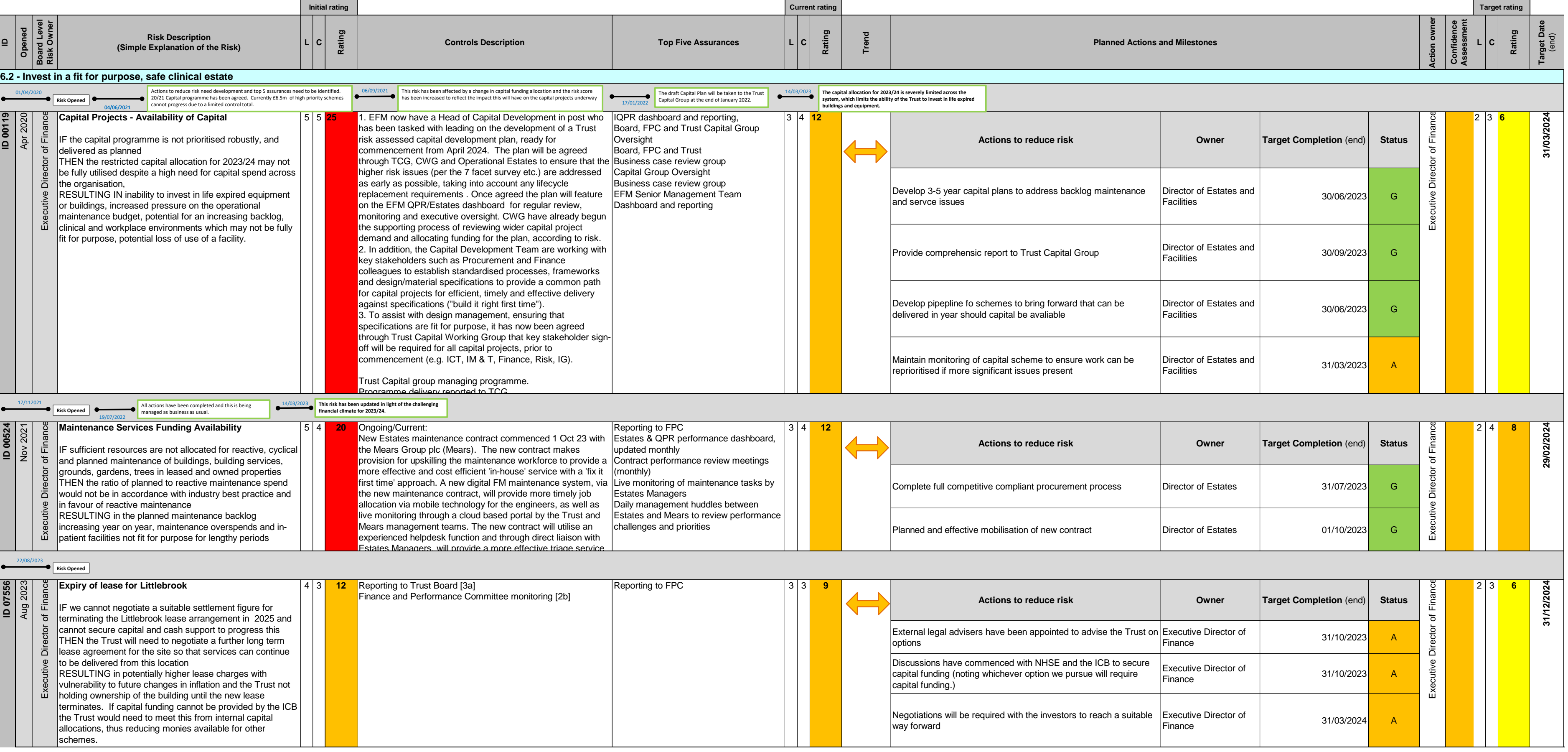
Action	Owner	Target Completion	Status
Data Migration	Director of Digital and Performance	31/08/2023	G

Planned Actions and Milestones – ID 00256

Actions to reduce risk	Owner	Target Completion (end)	Status
Delivery of multiyear efficiency programme	Deputy Director of Finance	09/01/2024	G
Review of six identified loss making services to identify drivers to the position	Deputy Director of Finance	09/01/2024	G
Review activity and service data to identify any unwarranted variation within the loss making services	Deputy Director of Finance	1/9/2024	A
Review of underlying deficit position for 2024/25 planning	Deputy Director of Finance	1/9/2024	G
Review pricing and contracting for services prior to 2024/25 planning round	Deputy Director of Finance	1/9/2024	A

Planned Actions and Milestones – ID 07557

Actions to reduce risk	Owner	Target Completion (end)	Status
Executive led agency control meetings	Deputy Director of Finance	30/09/2023	G
Implementation of No agency admin being progressed, policy being implemented with no new agency being agreed	Deputy Director of Finance	30/09/2023	G
Present agency establishment being review to identify the impact of removing the staff and opportunities for permanent recruitment.	Deputy Director of Finance	9/30/2023	A
Position statement for EMT review provided monthly	Deputy Director of Finance	9/30/2023	G
Any exceptions to be discussed with ICB before requesting regional approval	Deputy Director of Finance	9/30/2023	G



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)
6.2 - 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.**																			
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	1. EFM now have a Head of Capital Development in post who has been tasked with leading on the development of a Trust risk assessed capital development plan, ready for commencement from April 2024. The plan will be agreed through TCG, CWG and Operational Estates to ensure that the higher risk issues (per the 7 facet survey etc.) are addressed as early as possible, taking into account any lifecycle replacement requirements . Once agreed the plan will feature on the EFM QPR/Estates dashboard for regular review, monitoring and executive oversight. CWG have already begun the supporting process of reviewing wider capital project demand and allocating funding for the plan, according to risk. 2. In addition, the Capital Development Team are working with key stakeholders such as Procurement and Finance colleagues to establish standardised processes, frameworks and design/material specifications to provide a common path for capital projects for efficient, timely and effective delivery against specifications ("build it right first time"). 3. To assist with design management, ensuring that specifications are fit for purpose, it has now been agreed through Trust Capital Working Group that key stakeholder sign-off will be required for all capital projects, prior to commencement (e.g. ICT, IM & T, Finance, Risk, IG). Trust Capital group managing programme. Programme delivery reported to TCG	IQPR dashboard and reporting, Board, FPC and Trust Capital Group Oversight Board, FPC and Trust Business case review group Capital Group Oversight Business case review group EFM Senior Management Team Dashboard and reporting	3	4	12	↔	**Actions to reduce risk / Owner / Target Completion (end) / Status** Develop 3-5 year capital plans to address backlog maintenance and servce issues / Director of Estates and Facilities / 30/06/2023 / G Provide comprehensic report to Trust Capital Group / Director of Estates and Facilities / 30/09/2023 / G Develop pipepline fo schemes to bring forward that can be delivered in year should capital be avaliable / Director of Estates and Facilities / 30/06/2023 / G Maintain monitoring of capital scheme to ensure work can be reprioritised if more significant issues present / Director of Estates and Facilities / 31/03/2023 / A	Executive Director of Finance		2	3	6	**31/03/2024**
17/112021 Risk Opened; 19/07/2022: 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.**																			
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	Ongoing/Current: New Estates maintenance contract commenced 1 Oct 23 with the Mears Group plc (Mears). The new contract makes provision for upskilling the maintenance workforce to provide a more effective and cost efficient 'in-house' service with a 'fix it first time' approach. A new digital FM maintenance system, via the new maintenance contract, will provide more timely job allocation via mobile technology for the engineers, as well as live monitoring through a cloud based portal by the Trust and Mears management teams. The new contract will utilise an experienced helpdesk function and through direct liaison with Estates Managers, will provide a more effective triage service	Reporting to FPC Estates & QPR performance dashboard, updated monthly Contract performance review meetings (monthly) Live monitoring of maintenance tasks by Estates Managers Daily management huddles between Estates and Mears to review performance challenges and priorities	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 / G	Executive Director of Finance		2	4	8	**29/02/2024**
22/08/2023 Risk Opened																			
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	↔	**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**

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) 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 of developments of Provider Collaboratives across Kent and Medway for 2024 and an update for the Mental Health, Learning Disability and Autism Provider Collaborative (PC) and the plans for the PC.

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 (workstreams).

Governance

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

Version Control: 01

Provider Collaborative Board Development 2024

From January 2024 the wider Provider Collaborative work across Kent and Medway is undergoing an expansion and refresh. A Provider Collaborative (PC) Board has been formed which is attended by the Provider CEOs, Provider Trust Chairs and going forward the Chief Strategy Officer for the system. The PC Board reports to the ICB Board. Reporting into the PC Board will be three Provider Collaboratives:

- MHLDA Provider Collaborative
- Community, Social and Primary Care Provider Collaborative
- Acute Provider Collaborative
- And Diagnostic and Imaging networks

The reporting arrangements for the three Provider Collaboratives and wider governance is attached in appendix A.

MHLDA Provider Collaborative 2024

With the wider changes for Provider Collaboratives across Kent and Medway the MHLDA PC which was established in May 2022 is undergoing a refresh, the Chief Executive of KMPT has taken on the Chair of the PC as overall Senior Responsible Officer (SRO) for the PC from January 2024.

The programmes (workstreams) of transformation the PC will be overseeing has been refreshed:

- Community Mental Health Transformation Programme
- LDA, including out of area placements Project
- Children and Young Person neurodiversity, transitions and out of area placements project
- Dementia – with a view of transferring to Ageing Well Programme, with an oversight by the MHLDA PC
- Mental health urgent and emergency care (UEC)

The PC will also be exploring the following workstreams with an aim of including these in its transformation portfolio:

- Suicide Prevention Project
- Mental health frequent attenders project (to be part of the UEC programme)
- Delivery of the Mental Health Digital Strategy

The refresh includes membership, programme documentation (charters) and risk management. The membership which has been extended to include other agencies with the flexibility of representation moving into or out of the PC depending on work the PC is undertaking. The revised membership is:

KMPT	Kent County Council	Medway Council
VCSE Representation	KCHFT	Medway Community Health
ICB	Primary care	NELFT
SECAM	Acute Provider(s)	Kent Police
	Lived Experience representation	

To ensure the PC remains a strategic committee the Operational Delivery Group (ODG) will oversee the progress of each workstream monthly and report to the PC on progress against timelines and outcomes. Regular deep dives of each workstream will also be undertaken at the PC where appropriate.

Version Control: 01

Charters articulating the aims, objectives, achievements and timeframes for delivery for each workstream are being drafted, examples from two of the workstreams are included in appendix B. It is intended that these charters are utilised across all three PCs from this year.

Over the next three months the ODG and PC are working with the workstream SROs and programme teams to ensure deliverables are mapped to timeframes and can articulate the advantage to the citizens of Kent and Medway including measurable outcomes where appropriate.

The accountability of each workstream sits with various organisations and as such the methodologies and programme risks vary in line with the transformation process of each organisation. Each programme will have a risk log that will be managed by the SRO and reported to the PC as part of the programme updates. The risk log will primarily focus on the risks to the programme being delivered. There may on some occasions an interdependency on KMPTs BAF but this will be managed on a risk by risk basis. The ODG and PC will work with individual provider organisations to ensure standardisation is achieved as much as possible.

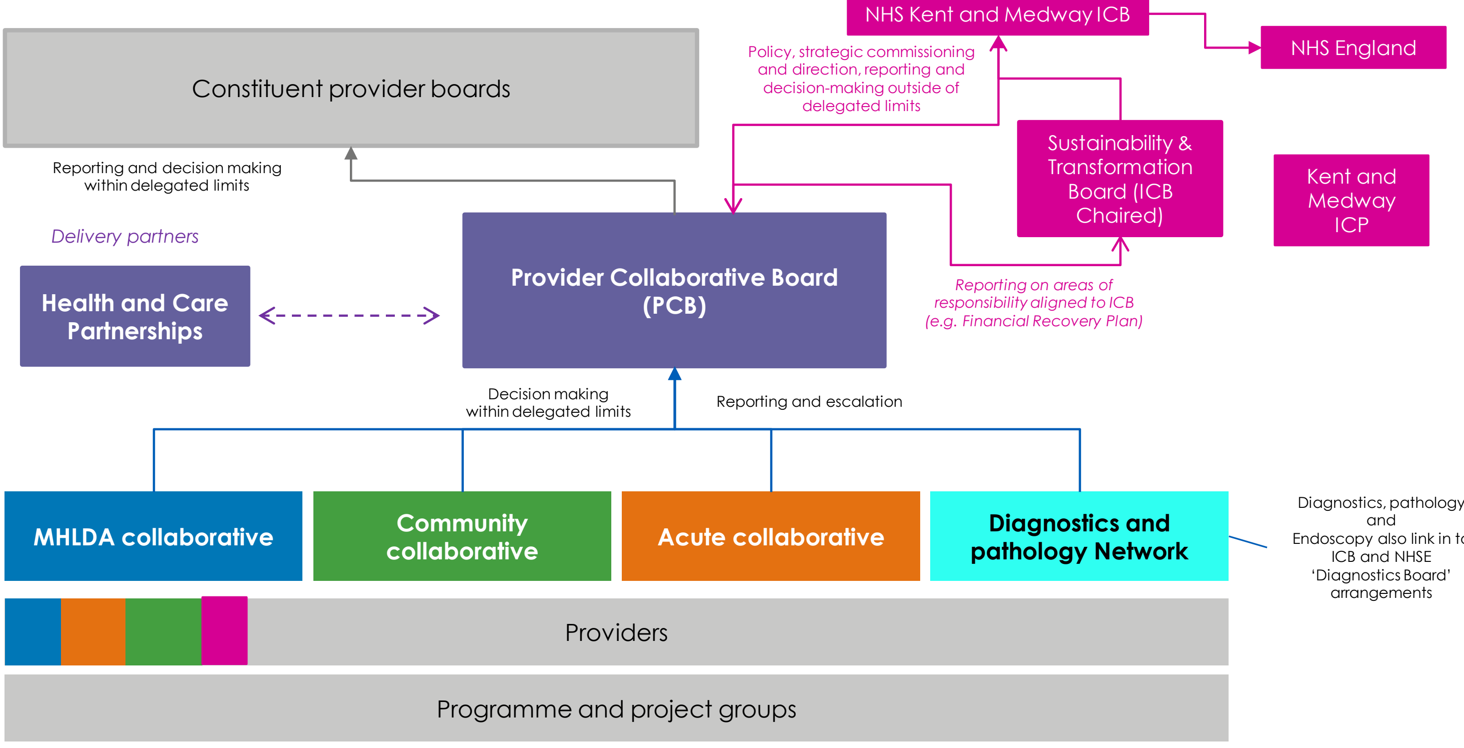
An aim of the wider PC changes across Kent and Medway is alignment of methodologies towards a continuous improvement approach. This methodology is already being introduced as part of the Operational Excellence model across KMPT.

Next Steps

- Over the next three months the ODG and PC will be working with each workstream SRO and programme team to ensure timeframes on deliverables are set and mapped.
- Clear articulation on the benefits of the transformational changes will be established.
- The ODG will then report to the PC on progress, any risks that need to be bought to the PC attention and key benefits realised from the transformation workstreams.
- This report will then be provided to each provider organisation for their internal use including KMPT.
- It is intended that this will then form the regular update to the KMPT Board along with a narrative on highlights from the workstreams during the period along with any risks that could impact the organisation.

Version Control: 01

Proposed governance of the at scale provider collaborative structure



DEMENTIA

Programme Name: Dementia

Date: 20Nov23 **Updated By:** Victoria Nystrom-Marshall

1. Governance

Exec Sponsors: Lee Martin (ICB) and Adrian Richardson (KMPT)
Clinical leads: Rakesh Koria (Aging Well ICB), and Efiong Ephraim (KMPT)
Information Lead: Poppy Whitehead
Finance Lead: Kevin Tupper
Quality Lead: Ian Brandon
Project Managers: Debbie Poynton and Wendy Lakin

Gateway

2. Description

Aim: The overarching aim of the Kent and Medway Programme is to increase the level of pre and post-diagnostic support for people affected by dementia by 1) Supporting people to live healthy lives, 2) Supporting people with dementia to receive their diagnosis, 3) Improving the care for people with dementia or suspected dementia, and 4) Providing support for carers and families.

24/25 System Objectives: Increase diagnostic capacity across the system to obtain and sustain a diagnosis rate of 66.7% in line with best practice which states people commence treatment within 6 weeks where appropriate. Develop a stepped model of provision by delivering: 1) systematic introduction of DiADem in local care, 2) procurement of community-based diagnostic service, and 3) optimisation of specialist acute memory assessment service.

Not currently resourced: a) awareness raising including dementia showcase to promote services, EDI opportunities outside of planned works above, and promotion of research opportunities, b) mild cognitive impairment pathway linked to CVD prevention, c) dementia coordinator re-procurement (alignment to social navigation), d) joint dementia strategy, e) recommissioning of carer contracts and access to admiral nursing, f) crisis services for people with dementia, g) dementia diagnostic imaging pathway, h) QOF Annual Reviews, and i) digital integration.

Key Interdependencies:
Integrated Neighbourhood Teams, Mental Health Together (workforce and access points), and Imaging Network (access to diagnostic imaging)

3. Timeline and key milestones

Lead	Milestone/Target Description	Date	RAG
ICB	DiADem Pilots in Local Care	Oct23	On Track
ICB	DiADem – scale across Primary Care Networks	Mar24	Planned
ICB	Community based diagnosis pilots	Nov23	On Track
ICB	Community diagnostic service model approved	Oct23	Delayed
ICB	Community diagnostic service model procurement	TBC	Planned
KMPT	Standalone specialist memory assessment service model	Apr24	On Track
KMPT	Optimisation of specialist memory assessment model	25/26	Planned

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF the programme is not appropriately resourced **THEN** it will not be possible to deliver **RESULTING IN** delays to implementation, scope change and reputation damage	16	Dementia Programme substantive resource 0.6WTE B7 move to Aging Well 15.01.24 at which point the programme and resource required will need to be reviewed	16
IF the national DDR target of 66.7% 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	9 GPwER supporting additional diagnoses in KMPT DiADeM embedded in frailty pathway in DGS. DiADeM pilot in Medway and Swale active DiADeM pilot in West Kent agreed	12
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	KMPT BI to produce trajectory to understand backlog and recovery plan GPwERs undertaking additional sessions to diagnose between Sept23 – Apr24	20
IF recurrent funding is not approved **THEN** a community-based MAS will not be possible **RESULTING IN** insufficient diagnostic capacity in K&M, loss of skills developed in primary care, and reputational risk	15	Funding is to be identified within existing budget, SBAR progressing through ICB double lock governance in Oct23	15

5. Impact Assessment

Impact Assessment	RAG	Date completed	Date approved	Review date	Key issues raised (if applicable)
Quality Impact Assessment		TBC			Not started
Equality Impact Assessment		TBC			Not started
Privacy Impact Assessment		TBC			Not started

6. Activity Assumptions

Achieve 66.7%: 1,865 additional people need to be diagnosed.
Sustain 66.7%: Estimated flow 110 diagnosis per week or 150 diagnostic appointments

Dementia Diagnosis Gap: As of Sept23, the national target is 66.7% and the gap equates to 1,865 people. An estimated 25,124 people in Kent and Medway will have dementia. Of these, only 14,892 people or 59.3% are on the Dementia Register. Compared to other ICBs, Kent and Medway is 10th from bottom. Broken down by local authority area, Tonbridge and Malling (2nd), Thanet (5th) and Gravesham (7th) are all within the bottom 10 areas. There is variation between HCPs with DGS at 61.1%, WK at 59.8%, EK at 59%, and M&S at 58.3%.

Diagnostic Capacity:
Acute MAS services are currently the main source of diagnostic capacity in Kent and Medway. It has experienced sustained high levels of demand since 2020 that outstrip capacity. The combined service responds to both organic and functional needs.
A stand-alone service is being developed with the intention of generating consistent capacity to support the diagnosis of patients who cannot otherwise be diagnosed in local care using DiADeM or via a community based service.
GPwERs are currently working within the acute MAS to support service capacity. The community-based model proposed should deliver 50% of the required diagnostic capacity, releasing pressure from acute MAS services and sustaining the DDR.

Project RAG

7. Financial Overview

The community diagnostic model is costed at £1.82m.

The acute MAS model is built into the CMHSOP block contract that services both functional and organic activity.

DiADem in care homes is built into the EHCH contract but it is not felt that funding is sufficient to mobilise. The alternative approach proposed is to standardise the use of DiADem through Integrated Neighbourhood Teams.

8. Route to Market

Full procurement is required for the community diagnostic model.

9. Non Financial Benefits and Quality Metrics

- Increase Kent and Medway Dementia Diagnosis Rate (DDR)
- Reduction in waiting list
- Increase in people and their carers able to effectively access better information and support
- Increase in ongoing support and advice to enable people to continue to live well with dementia including advanced care planning

10. Communication and Stakeholder Engagement

- Extensive engagement with partners and people living with dementia and the people who care for them in developing the system-based model. This included people that we traditionally find hard to reach, those with rarer dementia, and people with learning disabilities.
- Community model service specification has been developed with people with dementia and it is proposed will include them as part of the procurement exercise.
- Design of the stand-alone acute specialist MAS model includes support from the Dementia Envoys

Out of Area Specialist Placements

Programme Name: OOA Specialist Placements

Date: 08 January 2024 **Updated By:** Geoff Lawrence

1. Governance

Exec Sponsors: Nick Brown
Information Lead: Nigel Lowther
Finance Lead: Nicola George
Clinical Lead: Amanda Fuller
Programme Director: Vicky Stevens
Programme Manager & SRO: Geoff Lawrence

Gateway

2. Description

Aim: This project supports KMPTs strategic ambition to deliver outstanding, person-centred care that is safe, high-quality, and easy to access. It focuses on providing care close to people's homes in the least restrictive settings.

Objectives:

- Continue to deliver RRT service.
- Assist in implementation of Lead Provider model
- Assist in implementation of KMPT Partnership Arm
- Establish Lead Provider for out of area specialist placements
- Implement lead provider status and agree new contracts with private providers
- Implement new contracts with private providers and agree a plan for OOA specialist placements by March 2025
- To drive efficiencies for the system

Key Interdependencies:
Purposeful Admission Programme

3. Timeline and key milestones

Lead	Milestone/Target Description	Date	RAG
KMPT	Reduce number of Out of Area Specialist Placements to 30	Apr24	On Track
KMPT	Reduce annual expenditure by 10%	Apr24	On Track
KMPT	Planning Assumption: Having reached target level, maintain and sustain	Apr25	Planned

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF activity and referrals for specialist placements increase where no local/County alternative is appropriate i.e. sever eating disorders **THEN** this will result in OOA beds being used **RESULTING IN** reduced quality of provision for patients and additional cost	9	Scorecard developed to monitor performance.	6

5. Impact Assessment

Impact Assessment	RAG	Date completed	Date approved	Review date	Key issues raised (if applicable)
Quality Impact Assessment		Apr21	TBC	TBC	
Equality Impact Assessment		Apr21	TBC	TBC	
Privacy Impact Assessment		TBC			Not started

6. Activity vs Target

Outcome Measure	Baseline	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Eliminate inappropriate specialist out of area placements (including dementia) to target	34	30	30	33	32	32	30	30	29	27	28			
Reduce annual expenditure by 10% by Apr24	-	10%	3.5%	6.8%	7.6%	12.6%	14.8%	15.1%	17.3%	18.7%	18.7%			

The Activity vs Target table above shows achievement of out of area specialist placements by the end of Q3 2023/24 subject to all initiatives as part of KMPT's strategic ambition and the targets set by the Kent & Medway Mental Health & Learning Disability/Autism Provider Collaborative.

Project RAG
G

7. Financial Overview

Aim is to reduce expenditure by 10% (£625k) on 22/23 bed costs (£6.2 million) with ongoing reductions

8. Route to Market

NA

9. Non Financial Benefits and Quality Metrics

- Reduction in the number of specialist out of area placements
- Maintain an average length of stay of under 12 months for all admissions post April 2021.
- Cost saving - driving efficiencies for the system that will be re-invested by KMPT with the Provider Collaborative into front line services.
- Improved patient outcomes and satisfaction

10. Communication and Stakeholder Engagement

- Work in Progress. Initiatives in place to maintain robust patient experience questionnaires as service users are stepped down to Community services and whilst RRT supports transition over 3/6 months to our local CMHT's.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
Title of Paper:	Right Care, Right Person - Update
Author:	Christine Hemmings, Quality Assurance Director
Executive Director:	Adrian Richardson, Director of Partnerships and Transformation

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested.

Overview of Paper

Right Care, Right Person is an approach developed originally by Humberside Police. This presentation summarises the current context within KMPT focusing on work to date undertaken, work planned for the remaining period, considerations, risks and issues and with some positive news to conclude with.

Issues to bring to the Board's attention

The Right Care, Right Person approach has the potential to significantly improve the experience of service users and carers by ensuring that any police involvement is warranted. It has the potential to reduce distress to service users and carers and prevent unnecessary criminalisation from occurring.

The Right Care, Right Person approach however is a significant programme of work with many elements both for KMPT and partners to assess impact. There are a number of risks and issues identified which are currently being addressed through the programme of work. These are being worked through in order of priority and greatest impact. There is a high possibility that additional resource will be required to support the workforce to mitigate any unintended additional risk that may occur if these is not adequately scoped.

Governance

Implications/Impact:	This is a large significant programme of work that Kent Police would like to be delivered by April 20204. It is likely that there will be a potential resource gap. This is currently unknown awaiting confirmation of data estimated to be available by end of January.
Assurance:	Limited
Oversight:	Trust Wide Patient Safety and Mortality Review Group

Version Control: 01

Right Care, Right Person (RCRP)

1 Introduction

Police are often contacted in relation to people with mental health needs. This may lead to unwarranted police involvement. It is known that for some, police involvement can be distressing and result in increased use of force and the criminalisation of mental health problems. However, it is recognised that policing on some occasions will have its part to play. Right Care, Right Person was introduced in Humberside within this context in January 2019 until October 2022. Right Care Right Person – Humberside Police | College of Policing.

Following the work undertaken in Humberside, a National Partnership Agreement (NPA) with the National Police Chiefs' Council, NHS England, and the Home Office has set out the principles of Right Care Right Person and encourages a national roll-out. A draft version of the NPA has been shared with Kent partners to provide feedback and comments on. The aim is that it will provide a framework for local areas to adopt the principles of the RCRP approach, with implementation planned locally through partnerships with police forces, health bodies and local authorities, to ensure that patient safety is maintained and people in mental health crisis are not left without support.

It is on this basis that the Trust is partnering Kent Police's roll out of Right Care, Right Person (RCRP) due to be implemented in April 2024. The initial work being undertaken is to assess the probable impact of this change of approach and to map out the Trust response to this. Following this a proposal will be devised as to how any potential gaps in service delivery may be filled and for appropriate risk mitigation to be identified.

The four main areas for the Trust to focus on are as below. These have been developed into work streams:

- The returning of service users that are absent without leave to wards and the practice of asking the police to assist.
- Requests by KMPT staff for the police to attend service users' normal places of residences when there is a concern for their welfare and they have not attended appointments.

- Activity that involves the detention of service users by the police under section 136 of the Mental Health Act
- Requests to transport mental health service users

2 Work completed to date

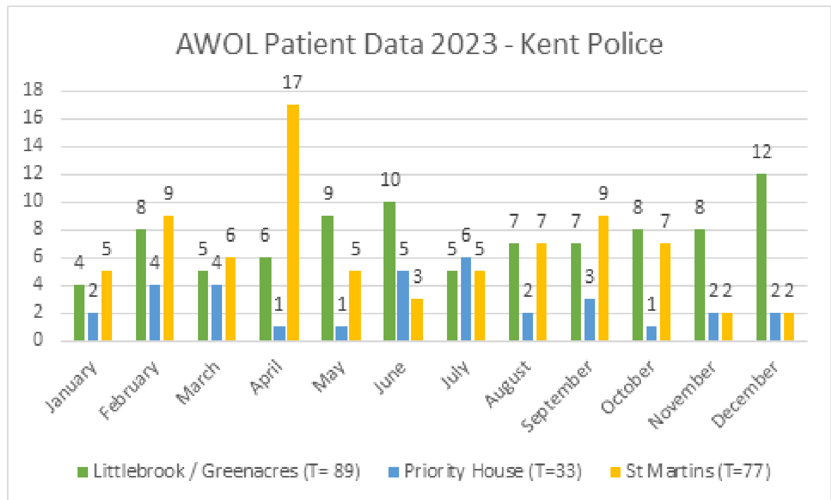
2.1 Internal Governance and structure

The structure which will support the implementation of Right Care, Right Person Project continues to be developed. The Trust Executive, Strategic and Implementation Leads have been identified. Further support is also being provided to the Project by the newly appointed Head of Operational Excellence. The Project plan is in development as is the mapping of stakeholders. The RCRP project will be monitored by the Trust Wide Patient Safety and Mortality Review Group.

2.2 Data Analysis

To estimate any potential resource impact of Right Care, Right Person, available Trust data opportunities have been explored. These include Rio and Inphase. However, neither of these either individually or combined are able to give a complete picture. Therefore, Kent Police have been approached and are in the process of supporting the Trust with providing data. This will hopefully most accurately reflect the scale of unwarranted police activity. This will help analyse the potential impact of the removal of unwarranted police intervention under the new approach. Initial data for the incidences of Kent Police support in the event of service users who are absent without leave are as below.

Further analysis is being undertaken to explore whether all of those police interventions included in the below data set are indeed all unwarranted or whether on some occasions the use of police was proportionate to the risk posed.



2.3 Feedback on Draft of "Resource to Support Implementation of National Partner Agreement to support implementation of Right Care, Right Person."

NHS England's Mental Health Team have worked to produce the above draft guidance to support local system partners with implementing the National Partner Agreement Right Care, Right Person.

It was produced working with an expert reference group including people with lived experience, people working in health services (mental health – inpatient, crisis and community, acute hospitals, ambulance services, learning disability and autism services, primary care), police forces, Approved Mental Health Professional (AMHP) services, social care services and VCSE organisations. It includes jointly agreed principles and ambitions for police, health and social care in relation to mental health and policing. It is considered that RCRP as an approach can be applied more broadly than cases relating just to mental health, the NPA: RCRP's scope was limited to mental health, and that is the focus of this resource that has been provided.

As it has been shared as an interim document, there has been an opportunity to provide feedback. The Service Directors as a group have reviewed and concerns have been expressed about the expectations for Crisis Resolution and Home Treatment Teams going forward. The draft guidance has suggested that the 'default position' for requesting 'non-urgent' concerns for welfare checks rest with Crisis Resolution and Home Treatment Teams. This could impact undeniably on the core functions of these services so alternative approaches are being explored. Whatever the new approach is that's adopted, it will need to protect these critical resources by avoiding the unintended consequence of adding additional risk into the system by diverting the Crisis Resolution and Home treatment Resource.

2.4 KMPT staff engagement at partner workshops.

KMPT staff have been represented at multi - agency partnership workshops. These workshops have assisted partner agencies in working through the potential scenarios that may be understood and planned for in the preparation for Right Care, Right Person. There are further training scheduled in the forthcoming months, both for front line police officers and partners.

3 Next work to be completed

3.1 Meaningful service user and carer representation within the work streams.

The work continues with a particular focus on ensuring that the service user and carer voice is fully integrated into the Trust work streams. Representation currently being sought for those with lived experience preferably that is specific to the use of the police in these circumstances if possible.

3.2 Data analysis to inform potential resource requirement utilising police data to identify unwarranted use to map resource requirement.

Analysis to continue with the request for additional data to be provided by Kent Police that relates to calls to police by trust staff for *Concern for Welfare* and *Security* incidents on Trust premises. This will allow full analysis and assessment of impact.

3.3 Training needs analysis specifically for interventions off trust premises.

Training needs analysis being undertaken by Interim Deputy of Nursing of Nursing and Practice and Promoting Safe Services Manager. This includes understanding of any additional scope of practice for staff working with service users not on Trust premises. This will be informed by collaborating by other mental health trusts that have previously been involved in the implementation of RCRP.

3.4 Policy and associated practice both known and unknown scoped and amended with stakeholder engagement.

Work has begun on reviewing Trust Policies and Standing Operating Procedures that will be impacted on by the introduction of RCRP. This work will be managed through the Project Groups and will involve collaboration with stakeholders. This is in progress.

3.5 Establish KMPT pathways for welfare checks and AWOL concerns and scope resource implications potential for a site response and duty within community teams.

This work will be informed by data analysis to gain an accurate picture of what the necessary resource required may be. This will include scoping anticipated resource required for inpatient services to support the return of service users to wards, resource required to manage potentially the " concerns for welfare" and finally the incidents on trust premises that previously the police would have attended that may need to be scoped for introduction of security staff resource.

4 Considerations from learning from Humberside

The Learning from Humberside identified the main barriers that needed to be overcome was the internal culture (staff and officers being cautious about declining to deploy support) and partnership relationships. These required careful consideration and management.

For the implementation to be effective, it was identified that it needs to supported by tight governance, with senior police officer buy-in and with clear partnership working and effective systems. The experience of health partners is currently being gathered from Humberside as this has been thought to be helpful.

Finally in summary a robust legal and evidential basis for change, a shared partnership vision, adequate training and support, proper evaluation and monitoring processes, and consideration of internal culture all supported effective implementation of Humberside' s Right Care, Right Person Approach.

5 Risks and Issues

Potential risks and issue include a potential for increase in Patient Safety Concerns arising from additional requirements of workforce. This could lead to a decreased service user, carer and family experience. As previously identified the increased expectations of Crisis, Home Treatment and Rapid Response services to respond to non-urgent welfare concerns as detailed in *Draft of Resource to Support Implementation of National Partner Agreement –RCRP* could result in service delivery gaps.

There is also a potential for additional training as there may be potential knowledge and skill gaps and move to more community focussed physical interventions as this will be a shift from usual practice. There is a need to mitigate the risk of the impact of media focus on Metropolitan police roll out on service user, carer and staff engagement. There are current challenges with partners ability to access information through KMCR and this may cause additional risk of not being able to work across partners in the most efficient and effective way.

This is a significant programme of work and the timescales for April implementation are tight and this in itself creates the risk of the Trust and other health partners not being fully prepared by this date. There is a challenge that relates to supporting the Trust workforce that may understandably have reservations and concerns re their ability to respond to this once April arrives.

6 Positive news

There is no doubt that Right Care, Right Person has the potential to improve experience of service users and carers by removing the unwarranted police involvement that has developed within mental health services. This affords an opportunity to refocus police activity to support service users, carers and staff for the most appropriate interventions. The early indications are that the part of the workforce currently involved are engaged and want to work collaboratively. Finally, RCRP affords an opportunity to work across the system to more readily meet the needs of service users and carers in a more efficient way utilising current Transformation work.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 25th January 2024

Title of Paper: Purposeful Admission Programme Update

Author: Dr Afifa Qazi, Chief Medical Officer

Executive Director: Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose: Discussion

Submission to Board: Board requested

Overview of Paper

The Trust Board ratified the Bed Strategy 2023-2026 in July 2023. This underpins the development and delivery plan for the Purposeful Admission Programme, one of the six priorities of the new CEO (patient flow). This paper provides an update on the progress and delivery of initiatives within this programme.

Issues to bring to the Board's attention

Overall, the Purposeful Admission Programme is on track to deliver the Trust's strategic ambitions.
1) Bed occupancy is at 93.4% against a target of 95.7% by the end of Quarter 4 2023/24.
2) The Out of Area Acute Bed usage has reduced from 200 days in Quarter 1 to zero days in Quarter 3.

Areas of concern:
1) Crisis Houses: This Integrated Care Board initiative has been partially delayed with the first Crisis house in Medway not opening till Feb 2024.
2) Onward Support Service: Implementation of the Onward Support Service requires support from system partners. Discussions are underway and opportunities are being explored with the voluntary, community, and social enterprise (VCSE) sector.
3) Bed Management system: The MDT Board review of patients is on track with measurable impact however the RiO element of this initiative is delayed.

Item of excellence:
1) Recruitment to all in-patient consultant posts has been achieved in Dec 2023, this will support the delivery of this programme by providing robust clinical leadership at ward level.

Governance

Implications/Impact: Trust Strategy – We deliver outstanding, person-centred care that is safe, high quality and easy to access

Assurance: Reasonable

Oversight: Trust Board

Purposeful Admission Programme Update

Purposeful Admission Programme Update: January 2024

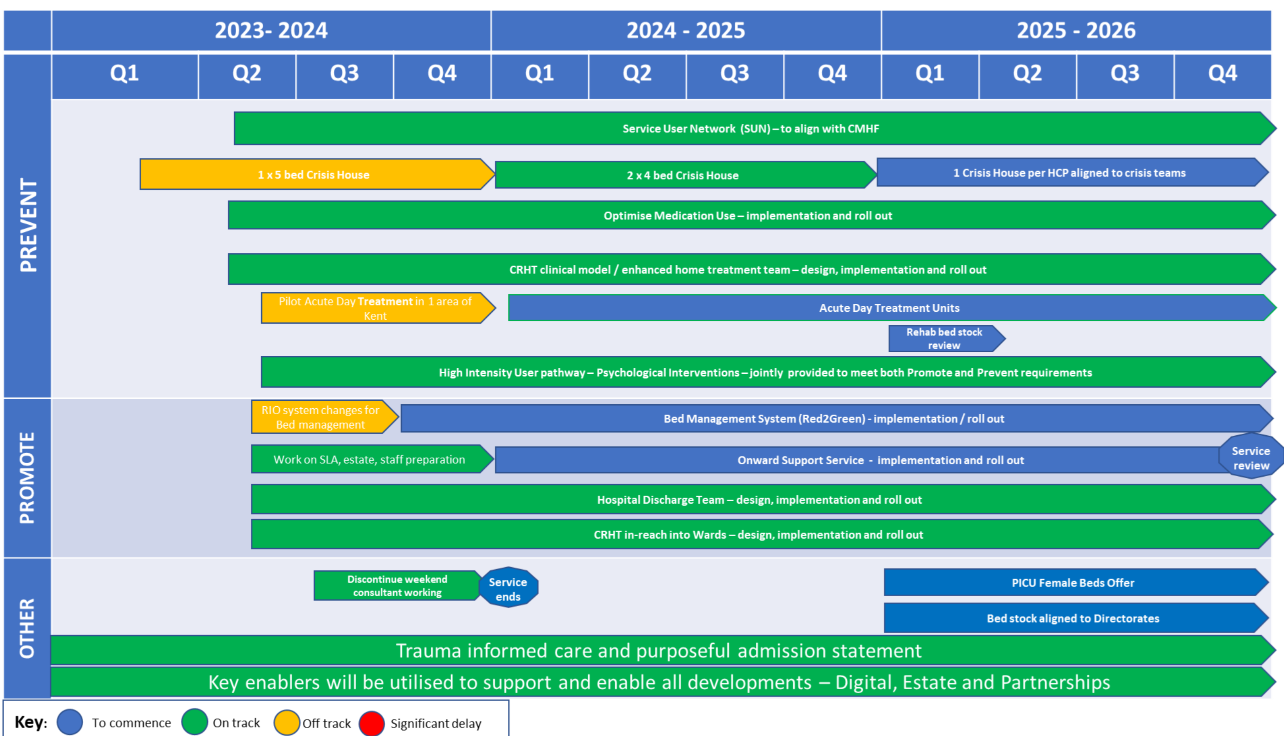
1 Purpose

1.1 The Trust Board ratified the Bed Strategy 2023-2026 in July 2023. This has been used to underpin the development and delivery plan overseen by the Purposeful Admission Programme. This paper provides an update on the progress and delivery of the programme to December 2023.

2 Background

2.1.1 The Purposeful Admissions Programme supports our strategic ambition to deliver outstanding care that is safe, high-quality, and easy to access. It focuses on providing care close to people's homes in the least restrictive settings, in line with NHSE guidance on in-patient care in mental health settings[1]. The programme has been built around two key themes, **'preventing'** (avoidable admission) and **'promoting'** (timely discharge). The initiatives identified in the programme support the strategic ambition to reduce bed occupancy to less than 85% by Quarter 1 2025/26. Further details about these initiatives are outlined in Appendix One.

3 Programme Update



3.1 Bed occupancy is at 93.4% against a target of 95.7% by the end of Quarter 4 2023/24.

3.2 The total number of out-of-area bed days (acute plus non-contracted PICU) has decreased from 493 in Quarter 1 2023/24 to 319 in Quarter 3. Within this, the number of out of area acute bed days has reduced from 200 in Quarter 1 to 0 in Quarter 3.

[1] NHS England » Acute inpatient mental health care for adults and older adults

Version Control: 08

Purposeful Admission Programme Update

3.3 Progress of Programme Initiatives

	Programme Initiative	Details of work completed	RAG Rating
Prevent	Service User Network (SUN)	Clinical staff have been recruited to the network which will go live for KMPT staff in January 2024. Lived experience staff recruitment is underway and will go live from April 2024. The network is an enabler for the successful implementation of the Crisis Houses.	Green
Prevent	Crisis Houses and Safe Haven	KMPT is supporting the Integrated Care Board to launch the Medway Crisis House in February 2024. This will provide 5 supported beds that will prevent avoidable admissions. A further crisis house has been delayed and is planned for July 2024. Complimenting this work, the ICB has commissioned Safe Havens in Kent and Medway. The Medway Safe Haven has transitioned to noon-midnight delivery and has demonstrated a higher footfall that is discussed further in the Urgent and Emergency Access Update paper on the January Trust Board agenda.	Amber
Prevent	Medicines Optimisation	Consultant Connect (App-based communication platform) is live, training is underway, and information governance issues have been resolved. This app connects clinicians with national experts, directly and in 'real-time', without the need for a referral and bypassing GP and hospital switchboards. The app will enable our clinicians to tap into 14 specialties ensuring timely advice and support for our prescribers and treatment for our patients. Point of Care (PoCHi) near to-patient blood testing machine for clozapine patients, are now operational across the majority of the CMHTs, with only the Ashford and Dover & Deal CMHTs remaining to go live within the next 12 months. This expansion aims to increase community Clozapine initiation, allowing patients to access Clozapine treatment without requiring admission to an inpatient ward.	Green
Prevent	CHRT Clinical Model	The Enhanced Home Treatment Team model is on track with recruitment to the multi-disciplinary team underway.	Green
Prevent	Acute Day Unit	The Trust has commissioned a Bed Usage Diagnostic Assessment that is due to report in February 2024. The timeline has been extended to ensure that the findings from this assessment inform the Acute Day Unit model. The pilot will now commence in Dartford in Quarter 1 of 2024/25.	Amber
Prevent	High Intensity User Pathway	The pilot is on track. An evaluation will take place in February 2024. This will inform the full rollout from April 2024.	Green
Promote	Bed Management System (Red/Green)	This initiative is Amber-rated due to the planned RiO changes being scheduled for February 2024, this has not delayed progress in rolling out the bed management process which includes a daily MDT Board review of all patients on the ward. The Red to Green pilot on Foxglove ward is complete. The data collected from the pilot has showed a reduction in the length of stay by an average of four days. Rollout of the process on all in-patient wards in a phased manner is planned from Jan 2024.	Amber
Promote	Onward Support Service	The Trust and the ICB have commissioned a Bed Usage Diagnostic Assessment that is due to report in February 2024. The output from this will inform the model for the Onward Support Service. Opportunities are currently being explored with the voluntary, community, and social enterprise (VCSE) sector.	Green

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Purposeful Admission Programme Update

Promote	Hospital Discharge Teams	This initiative will be informed by the Bed Usage Diagnostic Assessment. In the interim, the patient flow team are supporting this function.	Green
	CHRT Clinical Model	CRHT in-reach into wards to commence from January 2024. The enhanced CHRT will enable discharges to continue over the weekend.	Green
Other	Weekend Consultant Service	To be discontinued by end of Jan 2024.	Green
	Segmented beds aligned to Directorates	Scheduled to start in 2025-26.	Not started

4 Recommendation

4.1 The Board is asked to **NOTE** progress outlined in this report and **SUPPORT** further discussions with System partners to progress external initiatives that will support delivery of the purposeful admission plan.

4.2 A further update will be brought to the Board in September 2024 as part of the Strategy Delivery Plan Update.

Appendix One: 10 Initiatives within the Purposeful Admission Programme

Service proposal	**Outline details**	**Expected outcome**
Onward Support Unit	A voluntary, community, and social enterprise (VCSE) sector run 20 bed residential Onward Support Unit to support planning and pathways to move people out of a hospital setting. To be reviewed in Year 3 with the intention to close as demand will have been reduced by other initiatives within the Purposeful Admission Plan.	Reduced delays in transfer of care/clinically ready for discharge for people waiting for placements with providers in the community Reduction in number of bed days
Crisis Houses	Short-term (7 days) 24/7 supported accommodation as an alternative to inpatient admissions Commissioned by the ICB, delivered via Voluntary, Community and Support Services Sector (VCSE) in partnership with KMPT providing the gate-keeping function. Model based on national best practice and co-produced with ICB NB: It must be noted that commissioning of this service falls within the remit of the ICB and is out of the direct control for KMPT	Prevent avoidable admissions of patients mostly with complex emotional needs presenting in a crisis situation Reduction in the number of bed days

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Purposeful Admission Programme Update

Hospital Discharge Teams	Dedicated team for CRfD to achieve hospital discharge by working proactively with and supporting providers with placements of patients with complex mental health needs Workforce model achieved by remodelling of patient flow team	Promote timely discharge Reduced delays of transfer of care/clinically ready for discharge Reduced bed days
Bed Management system (Flow/Red to Green)	Red to Green is a process and set of principles to support patient flow within mental health inpatient settings; by focusing on resolving issues which prevent patients progressing on the discharge pathway	Promote timely discharge Reduction in bed days
CRHT Clinical Model	Home treatment teams to offer enhanced support to inpatient wards. Work towards an increase in the number of in-patients accepted for home treatment. Pilot clinical model to split ward/CRHT consultant model	Promote timely discharge Reduction in bed days
Acute day treatment units aligned to CRHTs	Acute Day Unit (ADU) in one Directorate initially to expand to one per HCP. Initial pilot developed to evaluate the provision The acute unit (CRHT staff) will offer a range of interventions including close monitoring and medication management. This will provide crisis focused and a time limited non-residential service	Prevent avoidable admissions Reduction in the number of bed days
High Intensity User pathway (Psychological interventions for people with Complex emotional needs)	Psychologically informed co- produced safety plan for reducing the number of admissions to hospital for people with complex emotional needs	Prevent avoidable admissions Reduction in the number of bed days
Service User Networks (SUN)	Service in the community which will support people with complex emotional needs and offer support to avoid going into a crisis situation and promote use of crisis houses where appropriate	Key enabler for the implementation and successful delivery of crisis houses across the county with focus on reduction in avoidable admission and reduced bed days
Optimise use of medication / anti-psychotics	Community Clozapine initiation to allow patients to access Clozapine treatment without requiring admission to an inpatient ward	Increase number of patients receiving Clozapine initiation in the community Reduction in avoidable admissions

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Purposeful Admission Programme Update

Segmented beds aligned to Directorates	Inpatient beds aligned to Directorates in year 3. This will allow each Directorate to manage their own bed stock with community teams and CRHT working closely with acute services to admit people only when care in a bed becomes absolutely essential	Better ownership of flow through beds Prevent avoidable admissions and promote early discharge Reduction in the number of bed days

Version Control: 08

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 25th January 2024

Title of Paper: Community Mental Health Framework – Quarterly Update

Author: Victoria Stevens, Deputy Chief Operating Office

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 of the new models of care within the Community Mental Health Framework Programme.

Issues to bring to the Board's attention

On the 15 January 2024, Thanet locality commences the phased 'test and learn' for the new model of community care. The new Mental Health Together service in Thanet will be utilising existing resource from all current providers. The full model implementation will follow once strategic partner recruitment is complete.

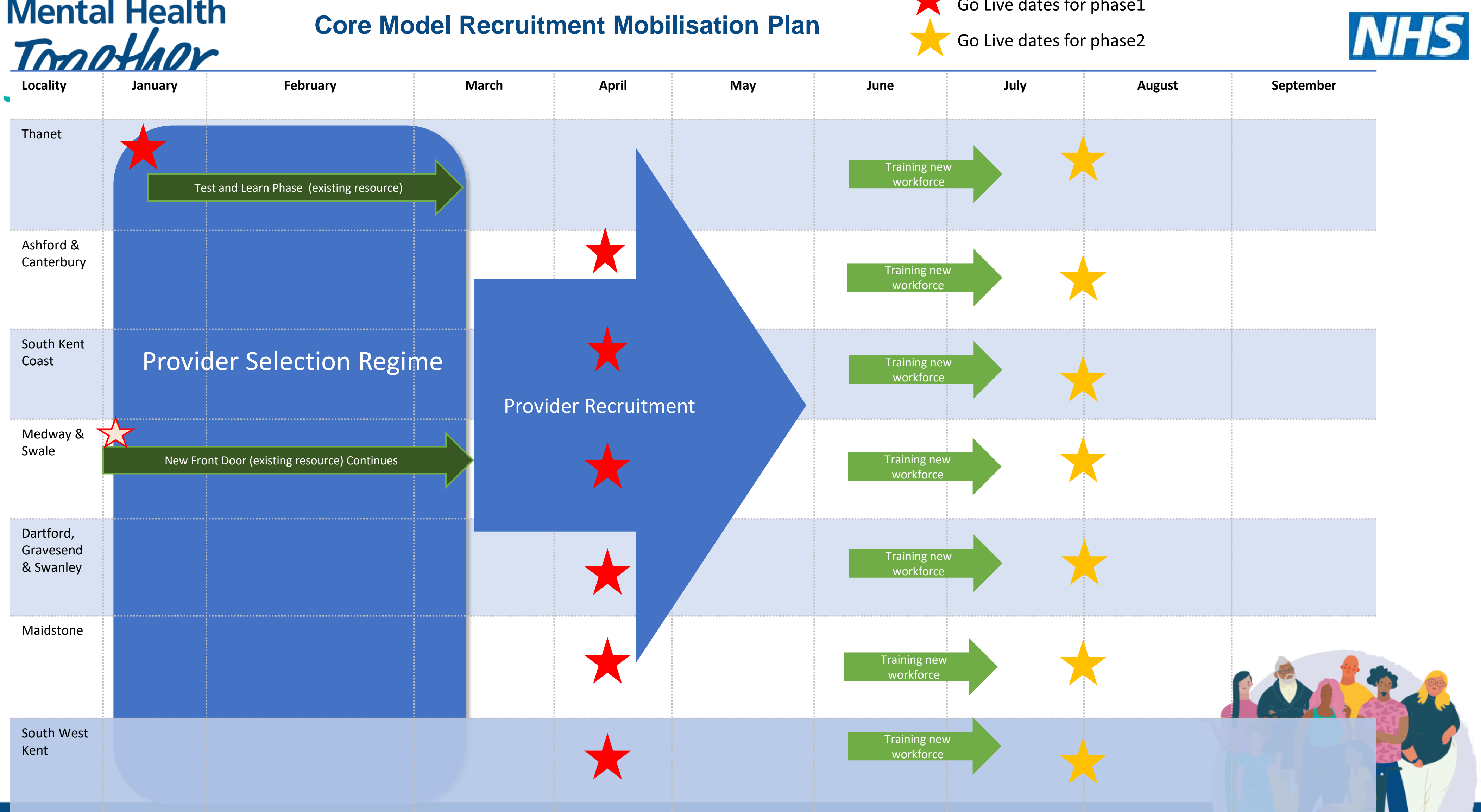
Governance

Implications/Impact: The Trust has recently received confirmation of the Lead Provider arrangements which enables the Provider Selection Regime to commence. It is expected that recruitment to new roles will begin in March 2024 with Mental Health Together being implemented across the county thereafter.

Assurance: Reasonable

Oversight: Executive Management Team

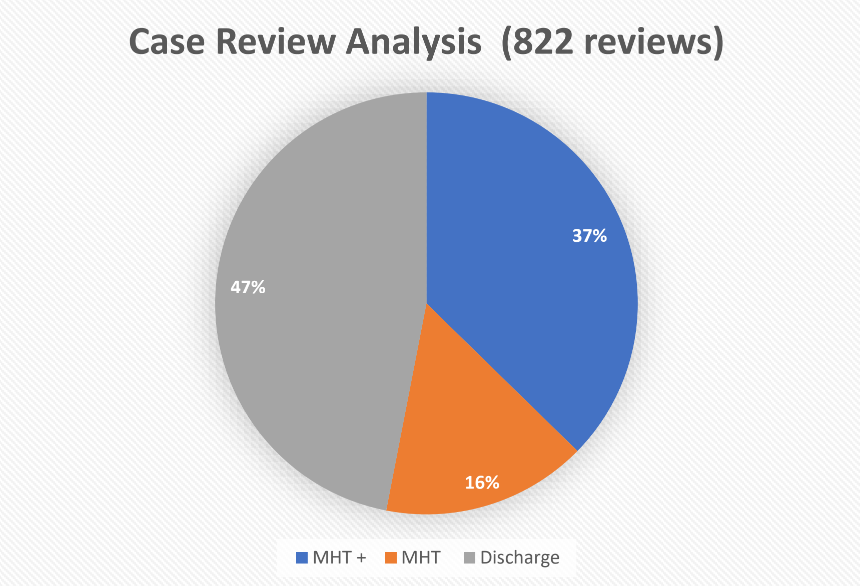
Mental Health
Together
NHS
Community
Mental Health
Framework
Quarterly Update – January 2024


Mental Health Together
Core Model Recruitment Mobilisation Plan
Go Live dates for phase1
Go Live dates for phase2
NHS
Locality
January
February
March
April
May
June
July
August
September
Thanet
Ashford & Canterbury
South Kent Coast
Medway & Swale
Dartford, Gravesend & Swanley
Maidstone
South West Kent
Test and Learn Phase (existing resource)
Provider Selection Regime
Provider Recruitment
New Front Door (existing resource) Continues
Training new workforce
Training new workforce
Training new workforce
Training new workforce
Training new workforce
Training new workforce
Training new workforce

Weekly Caseload Review Activity

	Maid	SWK	Total
Total to be reviewed:	1128	741	1869
	Maid	SWK	TOTAL
Total reviewed so far:	534	288	822
Pathway allocation:			
Mental Health Together + total	211	119	330
CED pathway (inc. Drugs & Alcohol)	33	12	45
Legacy pathway	48	10	58
Enduring pathway	115	91	206
Urgent Pathway	11	3	14
Frailty Service	0	0	0
Memory Assessment Service	1	0	1
Brenchley	2	2	4
Open to Maudsley (remain open to CMHT)	0	1	1
Other MHT+ service i.e. Brenchley	1	0	1
Mental Health Together total	91	48	139
Understanding CED	7	1	8
Managing Emotions Programme	0	0	0
Complex Trauma Package	5	1	6
Initial Interventions	11	15	26
STEPPS	11	0	11
CED Change	26	4	30
Drug and Alcohol Programme	2	2	4
CBT Psychosis	1	3	4
CBT Bipolar	3	1	4
OT assessment and plan	6	0	6
Individual Psychological Therapy	16	15	31
Aging Well Group	0	6	6
Broad Complex MH Need	3	0	3
For discharge:	157	86	243
Awaiting to be discharged	42	29	71
Discharged	115	57	172

West Kent Data



Progress across Workstreams

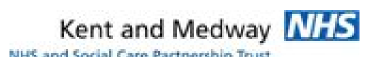
THE CMHF Programme Workstreams meet fortnightly to take forward critical activity to support delivery. Risks and issues are managed through a programme risk register that is monitored by the CMHF Programme Board.

Workstream	Progress
Model of Care & Outcomes	▪ **SUN Model** – Clinical lead has recruited to KMPT roles and funding for Lived Experience roles will be transferred 1 April 2024. ▪ **Outcome Measures** – SNOMED coding implemented and DIALOG+ training underway. Both will support the 4WW and DIALOG+ for all patients.
Workforce	▪ **Demand and Capacity Modelling –** Is now complete across all of Kent & Medway with new roles being phased into the system across 23/24 and 24/25 ▪ **Band 7 Mapping** – Consultation will commence February 2024. ▪ **ARRS Workforce** – PCN Clinical Director engagement session 8 January 2024 to develop model and workforce in line with Mental Health Together.
Data and Digital	▪ **Recording data** –The new methods of recording the 4ww wait and patient PROM DIALOG+ are now clearly defined in the new SOP. Dashboard under construction. ▪ **Website development –** Agreement has now been reached on an approach for an MHT website skin which will be a single point of truth for MHT services users.
Finance & Contracting	▪ **Finance** – The ICB has signed off the allocation of £2.64million for the remainder of 23/24 and £8.38million for 24/25 ▪ **Contracting** – Award of contracts anticipated March 2024. Recruitment to additional posts anticipated from March 2024.
Comms & Engagement	▪ **GP engagement –** A communication has been sent to all GPs in Thanet locality to support referral management and pathway allocation. This will be replicated across all localities as the model goes live. ▪ **Patient engagement** – A communication has been sent to all current patients advising them of Mental Health Together and the terminology associated with the new model .
Estates	▪ **Estate Planning –** continues across all partners and localities for all MHT interventions ▪ **Workstream Mobilisation –** mobilisation projects continue with North Kent completed by March 2024, West Kent completed by March 2024, and East Kent to be completed by March 2025. Phase-2 in planning.

Key Risks

Significant progress has been made since the last Board meeting in September but risks around contracting and data recording are still being worked through.

Risk Description	Consequence	Rating Initial	Current Rating	Rating Target	Controls/ Mitigation
IF we cannot establish the right contracting mechanism THEN we will not be able to subcontract with partners.	RESUTLING IN delays to phase-2 of the trailblazer.	20	20	4	• Scope of KMPT's Lead Provider responsibilities has been clarified • Director of Contracting is working closely with ICB • New governance structure for contracting being established • Anticipated award contract to Strategic Partners March 2024.
IF the D&D Workstream does not move with pace THEN there will be delays in the Go Live date for the trailblazers.	RESULTING IN Inability to effectively monitor and evaluate the trailblazer	15	12	4	• Business Analysist lead has agreed Rio processing. • Digital Design Workshop has given the workstream a clearer direction and the activity needed to implement • A detailed programme plan has been developed along with a critical pathway • SoP outlining 4 week wait process for data capture and recording is complete
IF the transformation do not transform the culture of patient centred directed care using the new PROMs THEN the uptake will be low.	RESULTING IN there not being enough paired clinical outcome measures to evaluate the trailblazer.	16	12	9	• DIALOG+ training has commenced with excellent feedback and good uptake. • The SoP has clear instructions on recording DIALOG+. • A simple PROM sequencing implementation plan has been developed, which outlines DIALOG+ for go live and ReQoL-10 and GBO to commence September 2024. • A comms strategy to support the culture shift and a clear training model has been developed.



TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 25th January 2024

Title of Paper: Integrated Quality and Performance Report (IQPR)

Author: All Executive Directors

Executive Director: Sheila Stenson, 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 services 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 overview on the key areas of greatest focus for the trust at present, which are in our strategy and six priorities:

1. **Patient flow:** Days lost to those **Clinically Ready for Discharge** continues to impact the trusts performance negatively. The majority of patients currently delayed are older adults which are also impacting on the average length of stay for older adults overall. The diagnostic process led by the ICB is due to be available in February and we welcome seeing the report and recommendations. It is positive to note that whist the impact is significant a reduction in LoS for those delayed was experienced in December. Executive responsibility is the Chief Operating Officer.

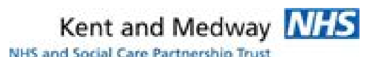
2. **Dementia diagnosis:** CMHSOPs are not meeting the 6 **weeks to initial assessment and 18 weeks to second appointment performance target for dementia**. This has resulted in 2,500

(reduced from 2,700 in November) patients waiting for an initial assessment with a further 800 awaiting a second appointment. Now that we have cleared the diagnosis backlog created by Covid, and had the opportunity to learn from the pilot we launched in 2022 to offer an enhanced memory assessment and intervention service, we will be creating a new service model to ensure we can meet the growing demand in referrals and have a service fit for the future. A proposed model will be presented to the Executive Team next month for review and comment. Monitoring of the memory assessment improvement programme continues via the transformation programme. Executive responsibility is the Director of Partnerships and Transformation.

3. **Recruitment and retention:** It is positive to note that all eight workforce metrics that have a target set are currently being met, **Vacancy Rates** and **Turnover** are stable for the last three months in a much-improved position compared the same period last year. This means that the Trust continues through winter with a more stabilised workforce supported by initiatives including the roll out of the flu vaccination for staff.

Governance

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



Chief Executive Overview

The board is presented with the Trust's Integrated Performance and Quality Report (IQPR) which is supported by a range of reports across board committees and within the supporting Performance Management Framework across directorates. The content of the report is regularly reviewed with consideration of evolving national metrics and local intelligence of the need for new metrics to address areas of concern as well as identifying and sharing good practice.

Looking at all measures addressed within this report, as at the end of December 2023 there are:

- 10 measures of concern due to their trend of performance
- 2 measures of an improving nature
- 26 common cause or movement which is not significant at this stage

The underlying cause of these trends are reviewed with a focus on supporting the Directorates, teams or wards which are subject to the greatest variation to drive improvements.

The following table summarises the metrics where targets are currently consistently falling below the given target levels using a statistical process control (SPC) approach. In all cases these measures are against locally defined targets, no measures from the Single Oversight Framework are currently showing as consistently not being delivered.

Section	Measure Name	Area Level	Area Name	Month	Target	Actual	V	A	LCL	Mean	UCL
Caring	006.C: Complaints responded to within 25 days	Trust Wide	TrustTOTAL	Dec-23	100.0%	78.0%			81.4%	89.9%	98.5%
Effective	006.E: Clinically Ready for Discharge	Trust Wide	TrustTOTAL	Dec-23	7.5%	14.5%			10.3%	12.4%	14.5%
Effective	015.E: %Patients with a CPA Care Plan	Trust Wide	TrustTOTAL	Dec-23	95.0%	81.0%			83.9%	86.8%	89.7%
Effective	017.E: Non CPA Care Plans & PSP	Trust Wide	TrustTOTAL	Dec-23	80.0%	70.9%			67.2%	70.2%	73.2%
Responsive	016b.R: Care spell start to Assessment within 6 weeks (MAS only)	Trust Wide	TrustTOTAL	Dec-23	75.0%	34.4%			29.7%	44.2%	58.7%
Responsive	017.R: Care spell start to Treatment within 18 weeks	Trust Wide	TrustTOTAL	Dec-23	95.0%	74.4%			69.8%	74.9%	80.1%
Well Led (Finance)	010.W-F: Agency Spend Against Cap YTD (%)	Trust Wide	TrustTOTAL	Dec-23	0.0%	21.9%			9.5%	17.7%	26.0%

Community Teams

As stated last month performance in CMHTs and CMHSOPs is not where we would want it to be. There are capacity issues and a high degree of variability between teams. The Board will be aware that the trusts current practice for 72hr follow goes beyond that which is recommended by the National Confidential Inquiry into Suicide and Safety in Mental Health (2022). The practice adopted by the Trust places significant demand on our Community Mental Health Teams and we want to ensure that we absolutely meet the needs and requirements for those patients being discharged from hospital

and that in addition to this that we can treat patients waiting to be seen by a community team in a timely manner. Analysis undertaken in West Kent demonstrated that on average follow up requests equates to 49.7 appointments / calls per day for the directorate. We can assume this is similar in other community teams across our directorates, it is therefore unsurprising that performance is not where we would expect it to be. Plans are underway to change current practice in line with the nationally recognised standard from March 2024. This will release capacity in our community teams. We will quantify the additional capacity available to teams and the impact this can have on our current waiting times.

As part of next year's improvement programme and year two of the Trust strategy we will be reviewing variability of performance across teams via the unwarranted variation work.
It is, however, positive to note that the first stage of Mental Health Together (our community mental health framework (CMHF) programme) went live on the 15th January in Thanet and we are already capturing intelligence that will inform our future approach to deliver the strategic outcomes. The Board will be kept sighted on the roll out through the CMHF update report provided by the Chief Operating Officer. The long term ambition is this will support the community teams overall performance as the new models of care are implemented.

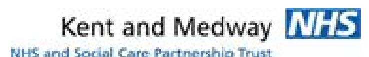
Length of Stay

The table below highlights KMPTs performance nationally regarding LOS. The trust is an outlier with regards to Older Adults LOS. It has been agreed this will be addressed via the Purposeful Admission Programme which is part of our Patient Flow priority.

Despite these pressures it is positive to note that KMPT continues to be the highest performing trust nationally for Inappropriate adult acute mental health out of area placement bed days in the most recent provider oversight data.

	Metric	KMPT 2022/23	National Mean	National Quartile	KMPT: 12 months to Dec 2023
YA Acute	Beds per 100,000 resident population	15	23	0-25	Unchanged
	Bed Occupancy (excluding leave)	96%	93%	51-75	93.9%
	Average Length of Stay	36	38	26-50	33.0
	Clinically Ready for Discharge	13%	7%	76-100	17.2%
OP Acute	Beds per 100,000 resident population	23	43	0-25	Unchanged
	Bed Occupancy (excluding leave)	96%	87%	76-100	96.1%
	Average Length of Stay	95	86	51-75	94.7
	Clinically Ready for Discharge	27%	12%	76-100	23.7%

Further details of actions in place to address these measures can be found within the report along with SPC trend charts for the areas in focus.



Conclusion

For April reporting, the executive team and I will have an agreed new set of metrics for monitoring KMPT's performance, and quality and safety. In addition to this we will have agreement on the metrics that we are confident improvements can be made following some of the actions we are taking for example 72 hr follow up and the impact on community teams waiting lists and performance. As stated above, sadly performance in a number of areas is not where we would want it to be, my objective working with the executives and within existing resources will be to set out for the Board where we can make improvements at pace and where others may take longer, set out a timescale for improvements and start to implement trajectories for performance that can be monitored proactively over time. I am confident that the priorities set out in my first 100 days are the right ones for us as a trust and will continue to be mine and the executives focus in this coming year.

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:

- 58 reported incidents of restraint needing to be used in December 2023, a slight increase of 14 from the previous month. Acute Directorate reported 49, Forensic & Specialist reported eight and East Kent reported one incident.
- The East Kent restraint was facilitated by Psychiatric Liaison team at Kent & Canterbury. No harm caused, excellent communication used throughout.
- No incidents reported moderate harm in December 2023
- There were two reported **Prone** restraints in December 2023, both occurring on Amberwood Ward involving two patients. No harm reported.

Seclusions:

- There were 29 reported episodes of seclusion in December, an increase of six from the previous month.
- Twenty-three episodes occurred within the Acute Directorate and involved 13 patients in total. Over half of the total seclusions for the Acute were reported by Willow Suite (13) and involved five patients in total. The Forensic and Specialist Directorate reported six episodes involving three patients in total.
- Twelve of the total seclusions were under 24 hours in duration, with an additional five under 48 hours. Two episodes lasted over seven days, both occurred within Willow Suite.

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-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		-	-	83	80	69	66	73	82	94	120	77	105	44	58
020.S	Unplanned Readmissions within 30 days		8.8%	L	4.1%	6.2%	8.2%	3.6%	3.8%	7.6%	9.4%	7.0%	4.3%	2.0%	5.1%	5.5%

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

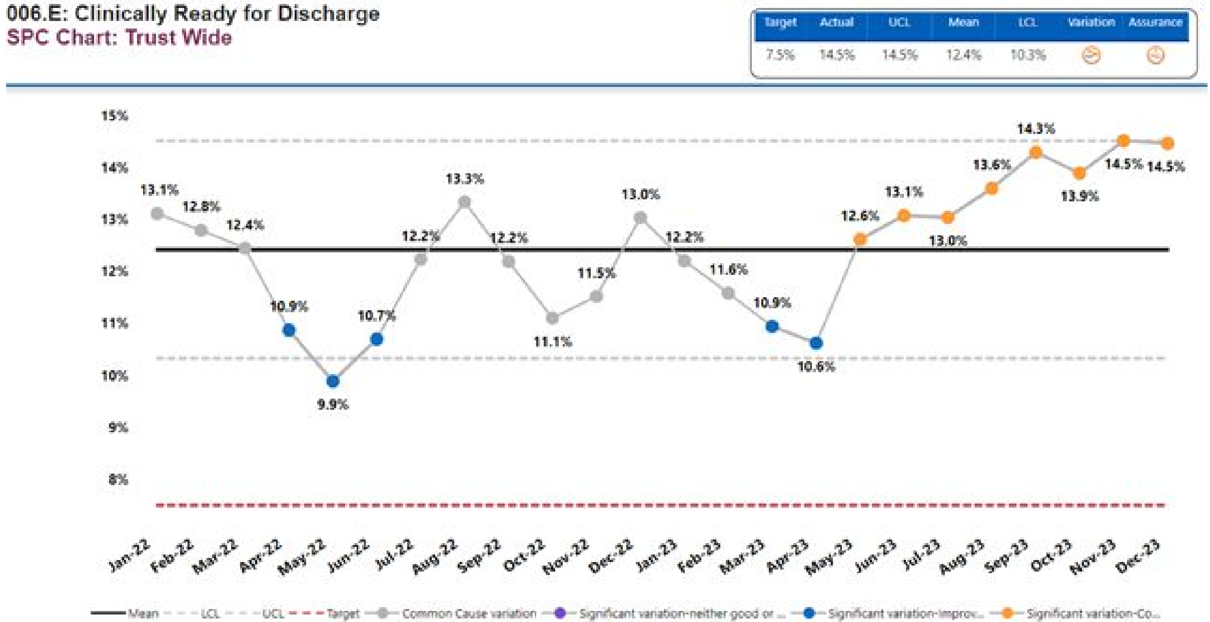
Issues of Concern
Bed pressures The trust retains a strong focus to enable the management of beds within capacity to minimise the impact on patients and carers by reducing inappropriate out of area patients. The table above in the CEO section of this report highlights how the Trust is performing nationally against peers for managing beds. Our LOS for Younger Adults is below the national average. There is more work to do with regards to our Older Adults LOS. Further work is required for Clinically Ready for Discharge patients with the local system. Actions being taken are set out in this paper. Our Purposeful Admission Programme (PAP) clearly sets out our ambition to reduce bed occupancy to 92% by the end of March. This year across acute beds, this has consistently been in excess of 95% for the last 12 months, however reduced to 92% in Quarter 3. Work will continue to maintain occupancy at this level. The most appropriate bed provision is continuously reviewed using available data. In recent months there has been continued pressure for female acute bed, therefore as such this has led the Executive team to make the decision to temporarily change Chartwell Ward from a male to female ward in January. This change will be monitored throughout the spring. 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. These beds achieve a Length of Stay below the national mean. The Trust is forecasting to use 6-8 beds with external providers (5 ideally within area) for the foreseeable future until a long-term solution is found for a female unit locally.

Executive Commentary

Clinically Ready for Discharge (006.E)

- Days lost to those Clinically Ready for Discharge remained at 14.5% in December, the highest position of the last 24 months. The overall position is driven by the days lost in YA acute beds (21.1%) and Older Adult Acute (23.7%), this relates to an average of 30 and 20 beds lost per day in November respectively. Of current patients identified as CFRD 40% are identified as requiring

housing, 21% awaiting residential placements and a further 14% awaiting a nursing home placement.



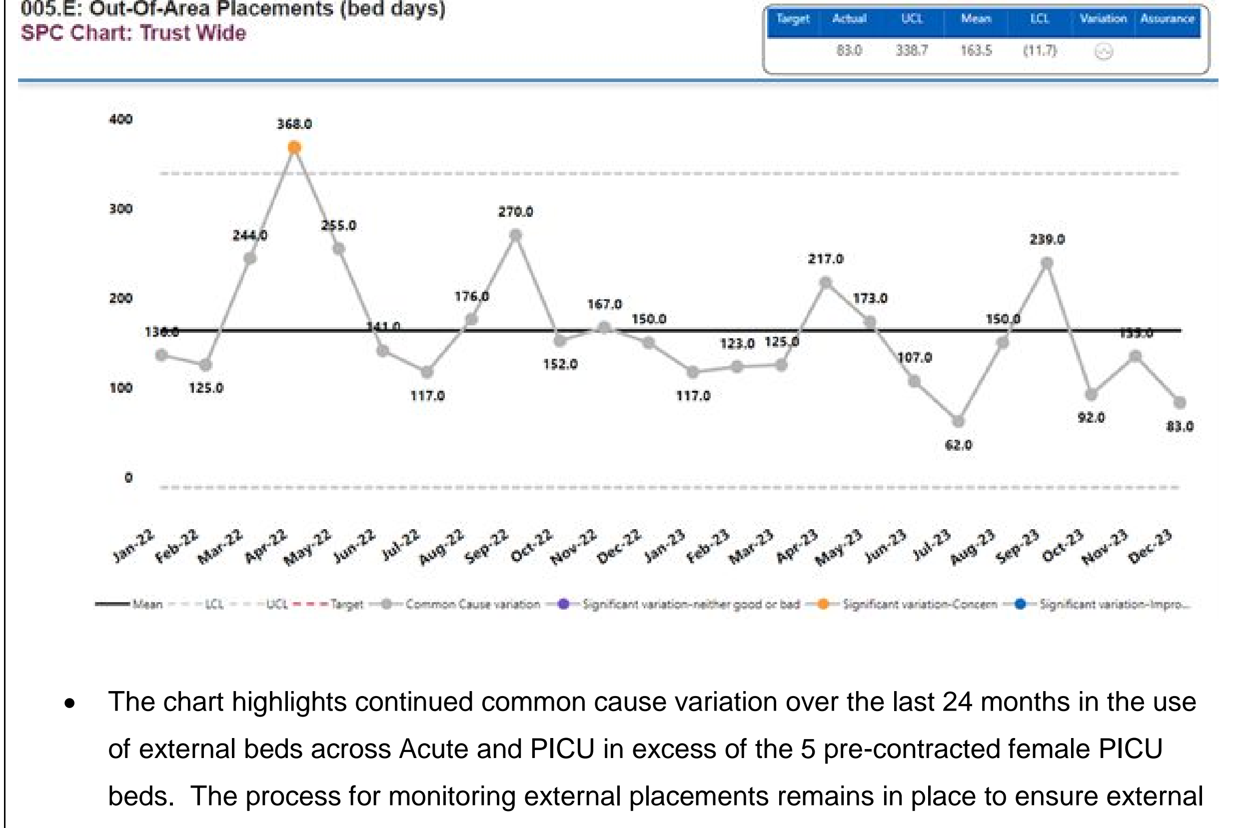
- The results from the diagnostic work undertaken by the ICB are due in February 2024. Thereafter plans will be developed with the ICB to address the continued high level of patients that require onward support.

	005.E: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			0.0	0.0	-12.3	74.0	30.8
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			83.0	0.0	-15.0	263.5	124.2
4	**Trust Total**			83.0	0.0	-12.8	322.9	155.0

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

- 83 bed days were used in December (0 YA Acute and 83 PICU), compared to 135 bed days used in November (0 YA Acute and 135 PICU).

Kent and Medway NHS
NHS and Social Care Partnership Trust



- The chart highlights continued common cause variation over the last 24 months in the use of external beds across Acute and PICU in excess of the 5 pre-contracted female PICU beds. The process for monitoring external placements remains 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			93.3%	95.0%	77.0%	96.4%	86.7%
2	Forensic and Specialist			90.0%	95.0%	88.1%	96.9%	92.5%
3	East Kent			85.1%	95.0%	87.4%	94.8%	91.1%
4	North Kent			78.5%	95.0%	76.7%	89.3%	83.0%
5	West Kent			72.0%	95.0%	77.9%	86.9%	82.4%
6	Trust Total			81.0%	95.0%	83.9%	89.7%	86.8%

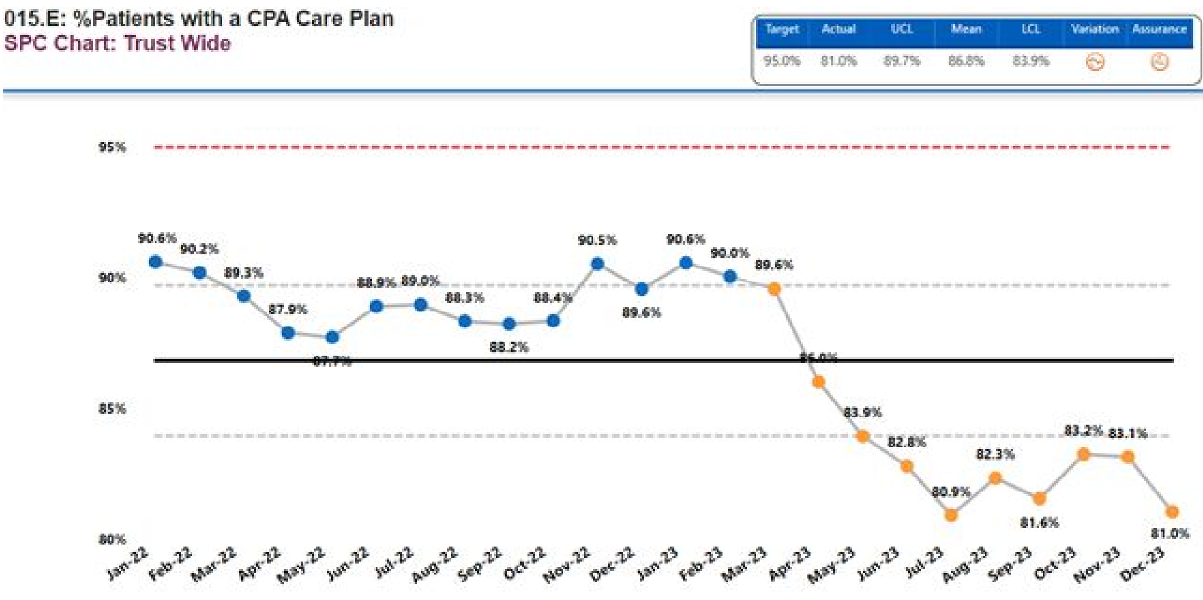
	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
2	Forensic and Specialist			84.6%	80.0%	64.9%	80.1%	72.5%
3	East Kent			74.5%	80.0%	73.4%	81.7%	77.5%
4	North Kent			63.6%	80.0%	61.0%	70.4%	65.7%
5	West Kent			66.2%	80.0%	53.8%	64.9%	59.3%
6	Trust Total			70.9%	80.0%	67.2%	73.2%	70.2%

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 a reduction on 2.1% in period, remaining 9% lower than 12 months previous.



- Community services are currently rolling out DIALOG+ training across the county which will support the formation of the care plan, pulling across from the assessment, therefore supporting long-term improved compliance. It is anticipated that the training will be complete by the end of January 2024.
- As part of work to deliver CMHF caseload reviews are underway across all directorates. Work to date has demonstrated a significant number on caseloads requiring discharge or onward transfer and once complete this will help improve performance by freeing up clinicians to embed high quality care planning.
- FSS and East Kent Directorates continue to exceed 90%, the Acute Care Group Figure reflects a low number of patients (15).

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

- Trust wide performance remains above the mean of the last 24 months, at the end of December the position is 3% higher than 12 months ago.
- The West and North Kent Directorates are outliers having achieved 66.2% & 63.6% respectively at the end of December.

- As highlighted above the role of Dialog+ will help inform enhanced care planning as part of the implementation of Mental Health Together.

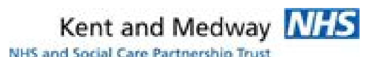
017.E: Non CPA Care Plans & PSP
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
80.0%	70.9%	73.2%	70.2%	67.2%		

Mean — LCL — UCL — Target — Common Cause variation — Significant variation-neither good or ... — Significant variation-Improv... — Significant variation-Co...

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
001b.E	CPA patients receiving follow-up within 72hours of discharge				84.6%	83.2%	84.5%	85.0%	76.8%	79.5%	78.6%	73.0%	80.6%	80.5%	75.9%	80.7%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.1%	95.4%	95.3%	95.5%	95.3%	95.4%	95.4%	95.5%	95.6%	95.3%	95.5%	95.3%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	117	123	125	217	173	107	62	150	239	92	135	83
006.E	Clinically Ready for Discharge		7.5%	L	12.2%	11.6%	10.9%	10.6%	12.6%	13.1%	13.0%	13.6%	14.3%	13.9%	14.5%	14.5%
012.E	Average Length Of Stay(Younger Adults)		34	L	36.48	37.94	36.24	30.31	28.11	34.81	35.61	36.38	29.90	33.36	32.18	27.28
013a.E	Average Length Of Stay(Older Adults - Acute)		77	L	113.50	76.24	106.36	70.80	97.59	121.03	109.81	83.58	60.17	94.81	110.27	80.70
015.E	%Patients with a CPA Care Plan		95%	L	90.6%	90.0%	89.6%	86.0%	83.9%	82.8%	80.9%	82.3%	81.6%	83.2%	83.1%	81.0%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	74.4%	73.7%	72.3%	69.9%	68.9%	72.7%	73.8%	75.6%	77.6%	79.1%	79.2%	77.4%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		80%	L	71.1%	71.0%	70.4%	68.6%	68.2%	69.2%	68.8%	71.4%	70.9%	71.2%	73.3%	70.9%
018.E	Bed Occupancy (Net)				95.3%	95.6%	94.4%	95.5%	97.0%	95.8%	95.0%	95.2%	94.1%	92.1%	92.4%	93.4%
019.E	Ave LoS for Clinically Ready for Discharge (at discharge)				214.5	76.9	87.4	337.2	244.9	207.3	116.5	174.2	83.7	150.9	100.8	80.7
020.E	% of Acute (YA & OPMH) discharges at weekends				4.7%	8.0%	4.8%	18.1%	23.2%	8.2%	15.0%	11.1%	9.0%	9.7%	14.6%	10.6%



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.

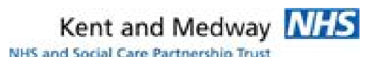
Executive Commentary

- Targets were achieved for all key performance indicators in December.
- It should be noted that the appraisal window has closed since last reporting, with 96% completion rate (exceeding the Trust's 95% target).
- Of all indicators, sickness presents the greatest concern, currently sitting only just within target, and with a gradual increase since September. Although this follows seasonal trends and would be expected to reduce as we enter the spring months, it will continue to be closely monitored. Levels of absence recorded as Covid-19 absence were in December more than double levels in November.
- Turnover, vacancy rates, safer staffing fill rates and essential training compliance all remain stable.

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
020.W-W	Establishment (Overall)							4088.5	4088.5	4088.5	4088.5	4088.5	4088.5	4088.5	4088.5	4088.5
001.W-W	Staff Sickness - Overall	✓	5.30%	L	5.42%	4.64%	4.54%	4.42%	4.95%	4.79%	4.72%	4.61%	4.37%	4.86%	5.12%	5.29%
005.W-W	Appraisals And Personal Development Plans		95%	L	95.8%	95.8%	95.8%					17.1%	42.2%	86.6%	95.4%	96.3%
006.W-W	Vacancy Gap - Overall		15.50%	L	16.1%	16.2%	14.3%	14.0%	14.0%	13.7%	13.6%	12.9%	12.9%	11.8%	11.8%	11.8%
012.W-W	Essential Training For Role		90%	L	93.8%	93.5%	93.9%	93.6%	92.8%	92.9%	93.6%	93.8%	93.4%	93.4%	93.7%	94.1%
015.W-W	Staff Stability (Overall)		85%	L	83.9%	84.1%	85.0%	84.5%	86.0%	85.3%	85.3%	85.3%	86.2%	85.4%	85.4%	85.4%
019.W-W	Staff Turnover (Overall)		16.50%	L				16.9%	16.9%	16.4%	15.9%	15.8%	15.7%	15.2%	15.7%	15.7%
019a.W-W	Staff Voluntary Turnover (Overall)		15.00%	L	14.7%	14.7%	14.3%	14.2%	14.2%	13.8%	13.1%	13.0%	13.4%	11.4%	11.3%	11.8%
023.W-W	Safer staffing fill rates		80.00%	L	100.2%	99.6%	100.5%	102.3%	103.7%	105.8%	108.7%	108.7%	105.5%	108.8%	109.3%	106.1%

- *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 Trust is forecasting to deliver its financial position in year. The Trust's agency run rate remains high, with the pressure sitting within the medical staff group. The Trust is presently forecasting to overspend its agency cap by £1.66m (£8.68m vs £7.02m).

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
004.W-F	In Month Budget (£000)		0.0	N	(12,526)	(12,659)	(12,571)	(13,296)	(13,279)	(14,931)	(13,739)	(13,651)	(14,390)	(13,607)	(13,941)	(13,756)
005.W-F	In Month Actual (£000)		-	-	(12,843)	(12,873)	(13,873)	(13,391)	(12,909)	(14,708)	(13,669)	(14,063)	(14,108)	(13,362)	(13,702)	(13,581)
006.W-F	In Month Variance (£000)		-	-	(317)	(214)	(1,302)	(95)	370	224	71	(411)	283	245	239	175
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	2.53%	1.69%	10.36%	0.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	565	565	565	549	545	566	633	559	645	612	630	594
008.W-F	Agency - In Month Actual (£000)		-	-	739	580	930	740	748	717	684	726	638	648	652	699
009.W-F	Agency - In Month Variance from budget (£000)		-	-	173	15	365	191	172	186	131	181	95	71	31	111
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	15.41%	14.25%	18.44%	34.77%	33.20%	33.06%	29.64%	30.16%	27.30%	24.96%	22.30%	21.90%

- *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

- **Complaints responded to within 25 days (or agreed timeframe)** (006.C) The reduction in performance is due to a change in accountability for the directorate structures, it provides a more robust accountability for not extending the timeframe for complaint responses to improve patient experience. A pilot project commenced in West Kent in December 2023 to focus on local resolution for complaints, this is showing some positive outcomes and a significant reduction in open complaints and overdue complaints.

IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	84.9%	85.1%	87.5%	87.5%	84.2%	85.8%	86.4%	83.4%	88.3%	87.1%		
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	99.0%	99.0%	98.0%		82.0%	83.0%	86.0%	96.0%	96.0%	98.0%	95.0%	97.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	97.0%	97.0%	97.0%		87.0%	84.0%	84.0%	87.0%	73.0%	65.0%	79.0%	78.0%
007.C	Compliments - actuals		-	-	114	101	106	78	114	97	115	112	117	106	131	115
008.C	Compliments - per 10,000 contacts		-	-	31.52	31.09	29.36	24.03	31.07	26.71	36.04	34.62	35.67	30.87	38.45	41.19
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	703	584	553	375	685	709	675	512	460	510	631	532
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	4.8	4.2	3.8	2.7	4.8	4.9	4.7	3.6	3.2	3.4	4.2	4.0
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.4	8.4	8.3	8.1	8.3	8.3	8.3	8.4	8.4	8.1	8.6	8.5

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 the ambition to have services live across the county by the summer of 2024.

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.

The Memory Services Improvement Programme continues to work towards a new 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 early Q4 for review and refinement with operational and clinical leads.

Executive Commentary

Liaison Psychiatry

Our liaison teams play a key role in supporting the local acute trusts on a daily basis to manage patients safely in emergency departments. KMPT liaison teams receive approximately 900 urgent referrals a month. Work is ongoing to better understand factors impacting all those that present at an emergency department who are open to KMPT, this requires enhanced data sharing across organisations.

Current KMPT measures focus on those that present at an emergency department who have an onward referral to KMPT liaison services. Currently there is mix of response times measured dependant on historic funding. For example, those services funded at CORE level are expected to respond within 2 hours and those funded at CORE24 level within 1 hour. The following tables show the compliance against the targets.

Urgent Referrals seen within 1 hour

1 hour response reflects those that are CORE24: Queen Elizabeth Queen Mother (Thanet) and Medway Foundation Trust

Directorate	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
East Kent		81.6%	80.8%	76.8%	83.4%	72.1%	76.1%	84.7%	86.7%	84.2%	86.0%	81.6%	87.4%
North Kent		92.7%	95.7%	94.0%	90.9%	95.3%	94.9%	85.3%	91.7%	88.4%	89.2%	86.1%	84.7%
		87.2%	88.0%	84.8%	87.1%	83.8%	85.8%	85.0%	89.4%	86.6%	87.6%	83.8%	86.0%

(West Kent teams are not currently measured against the 1 hour target due to variations in operating model)

Urgent referrals seen within 2 hours

2 hour response reflects all other services, those that are not currently CORE24

Directorate	Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
East Kent		82.1%	89.2%	92.8%	81.6%	76.5%	74.0%	73.6%	69.5%	67.3%	72.9%	72.9%	71.6%
North Kent		92.5%	94.7%	91.7%	87.5%	96.1%	93.2%	94.5%	95.8%	94.4%	94.8%	95.0%	96.8%
West Kent		95.8%	97.4%	93.3%	93.3%	93.8%	95.6%	94.4%	93.6%	96.3%	96.5%	92.0%	90.9%
		90.3%	94.0%	92.8%	87.9%	88.6%	88.0%	87.8%	86.9%	87.1%	88.5%	86.5%	86.4%

Whilst not routinely reported within the IQPR these metrics are reviewed monthly within the directorate QPR meetings. It is the Trusts ambition to achieve CORE 24 funding for all Liaison services to support a move to a 1-hour target for all teams.

Data collection is being implemented to allow a measure of admissions to KMPT within 12 hours for those patients who subsequently require an admission. This will provide assurance that time spent in the emergency department is minimised for this patient group. Changes to RiO to allow the

measurement of the metrics are being finalised with an estimated go live for late January, after which initial baselines can be established.

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	East Kent			59.5%	75.0%	60.4%	96.0%	78.2%
2	North Kent			55.2%	75.0%	34.8%	84.6%	59.7%
3	West Kent			74.0%	75.0%	52.2%	86.3%	69.3%
4	**Trust Total**			57.6%	75.0%	53.2%	84.9%	69.1%

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 in December following and increase in November, remaining some distance from target.

016a.R: Care spell start to Assessment within 4 weeks (Excl. MAS)
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
75.0%	57.6%	84.9%	69.1%	53.2%		

- Numbers on the waiting list remains static at approx. 1,200 as does the percentage of which who had already breached at approx. 40%
- Stepping up the full Mental Health Together (MHT) model is crucial as evidenced by the review of cases reported in the previous Board report. Data quality, such as not outcoming appointments remains a significant factor for the 4 week wait with data cleansing continuing.
- The Mental Health Together model, as part of the Community Mental Health Framework, commenced in East Kent on the 15th January 2024. 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 either a clinical or social 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.

	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			35.5%	75.0%	32.9%	65.1%	49.0%
2	North Kent			35.0%	75.0%	18.7%	50.3%	34.5%
3	West Kent			30.6%	75.0%	26.6%	66.8%	46.7%
4	Trust Total			34.4%	75.0%	29.7%	58.7%	44.2%

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.
- Performance against the 6 weeks target for Memory Assessment continues to be a challenge against known issues of demand. Performance remains relatively consistent but remains a long distance from target.

016b.R: Care spell start to Assessment within 6 weeks (MAS only)
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
75.0%	34.4%	58.7%	44.2%	29.7%		

- A Standard Operating Procedure has been developed to improve data quality and clarification of waits. Caseload reviews continue in line with the move to MHT and MHT+. The reviews will also support the number of people waiting. Actions are overseen by the Director of Partnerships and Transformation.

- 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, there is an improved position with regards to recruitment to nursing posts with more work to be done. Plans to co-locate the team to a single site are underway to increase the support available to all staff and further support recruitment.
- The service has negotiated an increase in GPwERs time, the team is exploring the development of evening and weekend clinics to support the assessment and diagnosis process.

IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-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	68.2%	61.1%	52.4%	68.8%	88.2%	60.7%	52.2%	88.2%	65.2%	76.9%	64.7%	94.1%
007.R	DNAs - 1st Appointments		-	-	11.5%	11.7%	11.8%	12.0%	11.9%	11.1%	11.8%	10.5%	10.7%	11.5%	11.2%	12.4%
008.R	DNAs - Follow Up Appointments		-	-	8.0%	7.9%	7.9%	8.9%	8.5%	8.7%	8.9%	8.7%	8.8%	9.0%	8.6%	9.1%
009.R	Patient cancellations- 1st Appointments		-	-	1.9%	2.5%	2.6%	2.3%	2.3%	3.1%	2.6%	2.6%	1.8%	2.0%	3.0%	2.3%
010.R	Patient cancellations- Follow Up Appointments		-	-	5.5%	5.9%	6.1%	5.5%	5.5%	6.2%	6.7%	6.5%	5.2%	5.2%	7.0%	6.1%
011.R	Trust cancellations- 1st Appointments		-	-	4.4%	4.0%	4.4%	4.4%	3.6%	3.9%	4.7%	3.8%	1.9%	2.2%	5.5%	4.2%
012.R	Trust cancellations- Follow Up Appointments		-	-	10.2%	10.6%	9.8%	8.9%	9.0%	8.6%	10.0%	10.4%	9.1%	9.3%	10.9%	10.6%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)		75%	L	62.0%	79.9%	74.0%	69.9%	73.3%	68.4%	60.5%	59.8%	58.6%	53.3%	63.7%	57.6%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)		75%	L	30.3%	38.4%	41.6%	34.2%	32.0%	28.4%	35.1%	38.2%	30.6%	36.6%	37.0%	34.4%
017.R	Care spell start to Treatment within 18 weeks		95%	L	74.6%	72.9%	69.0%	69.0%	68.4%	74.0%	76.6%	75.4%	71.9%	73.5%	75.2%	74.4%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)		-	-	30.2%	32.4%	33.8%	34.9%	45.5%	35.0%	38.7%	44.6%	42.2%	36.5%	40.4%	43.0%
022.R	Referrals to Rapid response assessed within 4 hours		-	-			50.0%	62.8%	62.7%	62.0%	70.8%	67.8%	53.0%	63.7%	55.8%	61.8%
023.R	Open Access Crisis Line: Calls received		-	-	2,603	2,552	3,984	5,172	5,016	5,433	5,245	4,910	5,248	5,249	5,473	5,380
024.R	Open Access Crisis Line: Abandonment Rate (%)		-	-	26.1%	36.2%	35.1%	37.1%	31.7%	38.1%	35.2%	38.6%	45.4%	41.4%	44.9%	43.7%
025.R	Open Access Crisis Line: Ave time to answer			-	*00:08:40*	*00:10:33*	*00:09:39*	*00:07:29*	*00:06:01*	*00:09:52*	*00:07:12*	*00:07:31*	*00:09:58*	*00:07:46*	*00:08:57*	*00:09:52*
026.R	Open Access Crisis Line: Ave call length		-	-	*00:11:19*	*00:12:25*	*00:11:57*	*00:12:24*	*00:12:39*	*00:12:23*	*00:10:48*	*00:12:02*	*00:12:53*	*00:12:00*	*00:11:44*	*00:11:23*

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

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Nov-23	Dec-23	Trend (Last 12 months where available, left to right)
001b.E	CPA patients receiving follow-up within 72hours of discharge		75.9%	80.7%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		135	83	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	64.7%	94.1%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.5%	95.3%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	5.3%	5.1%	5.3%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93.0%	0.0%		
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*

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
Title of Paper:	Urgent and Emergency Care Programme - Update
Author:	Victoria Stevens (Deputy Chief Operating Officer)
Executive Director:	Donna Hayward- Sussex (Chief Operating Officer)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

Historically, urgent and emergency access to mental health provision was via secion136 detention or through a visit to an Emergency Department (ED). In line with the NHS Long term Plan; the NHS Kent and Medway Operational Plan and the KMPT 3 Year Strategy 2023-2026 there has been a system wide approach to delivering urgent and emergency access and crisis care through a number of alternatives, with the purpose of reducing pressure on system partners along with providing better care and improved patient experience.

This paper provides an update on the mental health programmes associated with the Urgent and Emergency Care Programme following the presentation at the Board Seminar in June 2023.

Issues to bring to the Board's attention

- The changes outlined in the paper are all in line with nationally recognised initiatives requiring KMPT to either revise existing models of care or in some cases implement new.
- The changes relate to community services and at a time when the Community Mental Health Framework (Mental Health Together) transformation is underway.
- The scale of change is significant for community directorates.

Governance

Implications/Impact:	Staging of programmes is critical to ensure safety to patients, excellent staff engagement and stakeholder involvement.
Assurance:	Reasonable
Oversight:	Executive Management Team

Background

Previously, across Kent and Medway individuals who were experiencing a mental health crisis would attend an emergency department, as there was limited alternative provision. Conveyance to an emergency department would be via ambulance or police with some people making their own way. Historically there was an over reliance on departments being utilised as Places of Safety (emergency departments are designated Place of Safety for patients requiring physical and mental health care) due to capacity within the KMPT provision.

Investment in non-statutory alternative provision, although supportive to a large group of people, did not provide the desired outcomes which were to reduce the number of people being placed on section 136 by the police and to reduce the 'footfall' of people presenting at Emergency Departments. It was recognised that health and police colleagues were reticent to use Voluntary Community and Social Enterprise organisations, as alternatives sighting risk management as a concern.

Information demonstrated that:

- Over 50% of patients assessed in the emergency department by Hospital Liaison Psychiatry Services required no further mental health intervention.
- Less than 5% of patients assessed in the emergency departments by Hospital Liaison Psychiatry Services required inpatient admission.
- 50% of mental health attendances were conveyed by ambulance.
- Individuals with a primary mental health need account for 800 attendances per month across the county.

Alternatives in line with the Long-Term NHS Plan were sought with KMPT being a key partner in the developments.

Service Initiatives

New initiatives have been implemented or are in the process of implementation. In addition, some revision of existing services has taken place.

Safe Haven (Revised)

A revised safe haven model will be implemented across the county in 2024. To date two safe havens with extended hours have opened on acute hospital sites; Medway Foundation Trust in August 2023, operating with extended hours from 12:00- 24:00 in October 2023 and Queen Elizabeth the Queen Mother Hospital in November 2023. The safe havens are supporting the diversion from emergency departments by offering a welcoming, safe, comfortable, non-clinical environment. They provide de-escalation and emotional support for people in crisis along with help for social issues.

From January 2023 - July 2023 there were consistently between 60 - 95 people with a mental health presentation accessing the Medway Foundation Trust emergency department each week. From July 2023 this figure has dropped to less than 55 people per week, with an average of 37 people per week.

Figure 1 below outlines the Medway Foundation trust attendances:

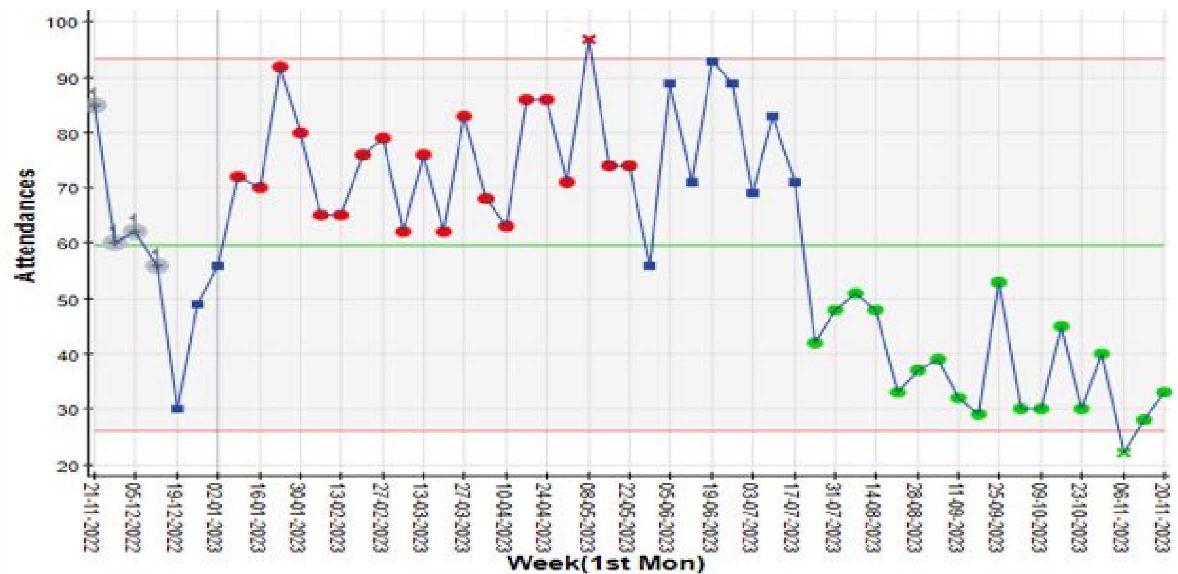


Figure 1 Medway Foundation Mental Health presentation

The safe havens on acute hospital sites are directly linked to the new diversion nurses who operate at the 'front door' of departments which helps patients get the right care at the right time. Figure 2 below outlines the Medway safe haven attendance.

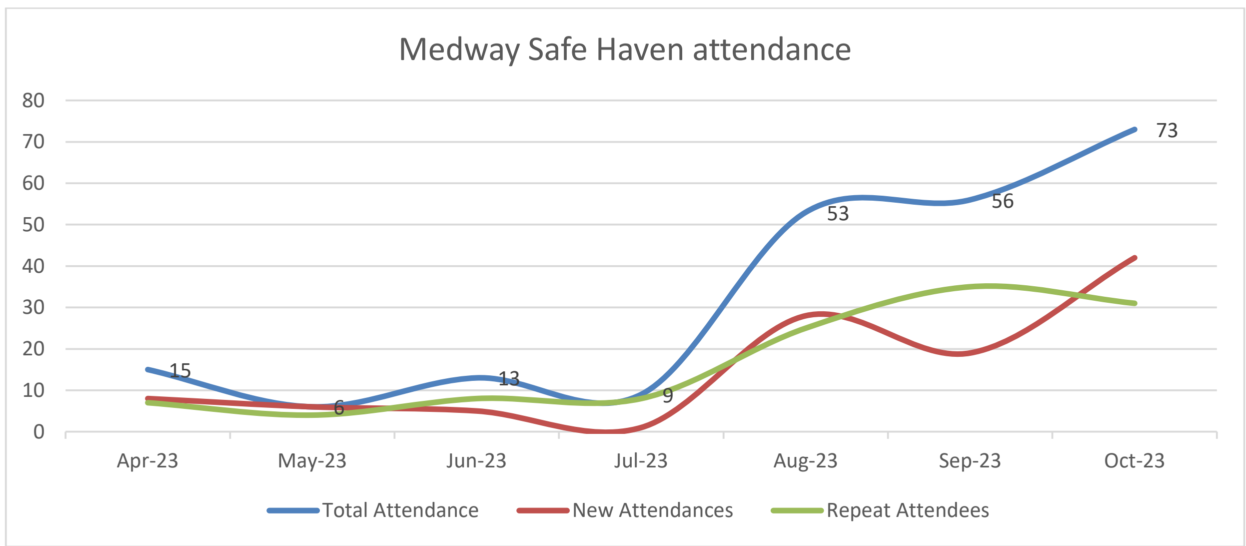


Figure 2 Medway Safe Haven attendance

Whilst more analysis is needed to accurately determine the impact of the haven, early assumptions would indicate that the triage diversion practitioner and safe haven pathway are having a positive impact on emergency department presentations for Medway Foundation Trust.

It is too early to draw any conclusions from the data on the haven at Queen Elizabeth the Queen Mother Hospital. We do however know that diversions are taking place including some direct ambulance transfers.

The Integrated Care Board (ICB) have plans in place for a further five safe havens which will operate in community settings. In addition, and confirmed on the 12th January 2023 there is agreement and space identified to operate a haven at the William Harvey Hospital from April 2024.

Triage/ Diversion Practitioners (New)
Core 24 standards for urgent and emergency mental health liaison services state that services should respond to a person attending the emergency department, within one hour of receiving a referral. It should be noted that two of our six Psychiatric Liaison Services are funded to CORE 24 standards. These are Queen Elizabeth the Queen Mother Hospital and Medway Foundation Trust.

An emergency response consists of a review to decide on the type of assessment needed, arranging appropriate resources for the assessment and where relevant diverting the individual to alternative services who can better meet the individual's needs.

The Liaison services workforce has been increased to provide the triage diversion function covering the hours of 17:00- 24:00 week days and 15:00- 24:00 at weekends, which mirrors the peak levels of activity for the liaison services. The purpose of the triage nurse is threefold a) eliminate the need for referral to Psychiatric Liaison (presence in the department) b) appropriately and only when indicated decrease the need for a full assessment c) ensure response within one hour.

Figure 3 below outlines urgent liaison referrals seen within 1 hour. It should be noted that for non-Core 24 services it can be challenging to meet the 1hour response time outside of the hours that the triage diversion nurse is on duty.

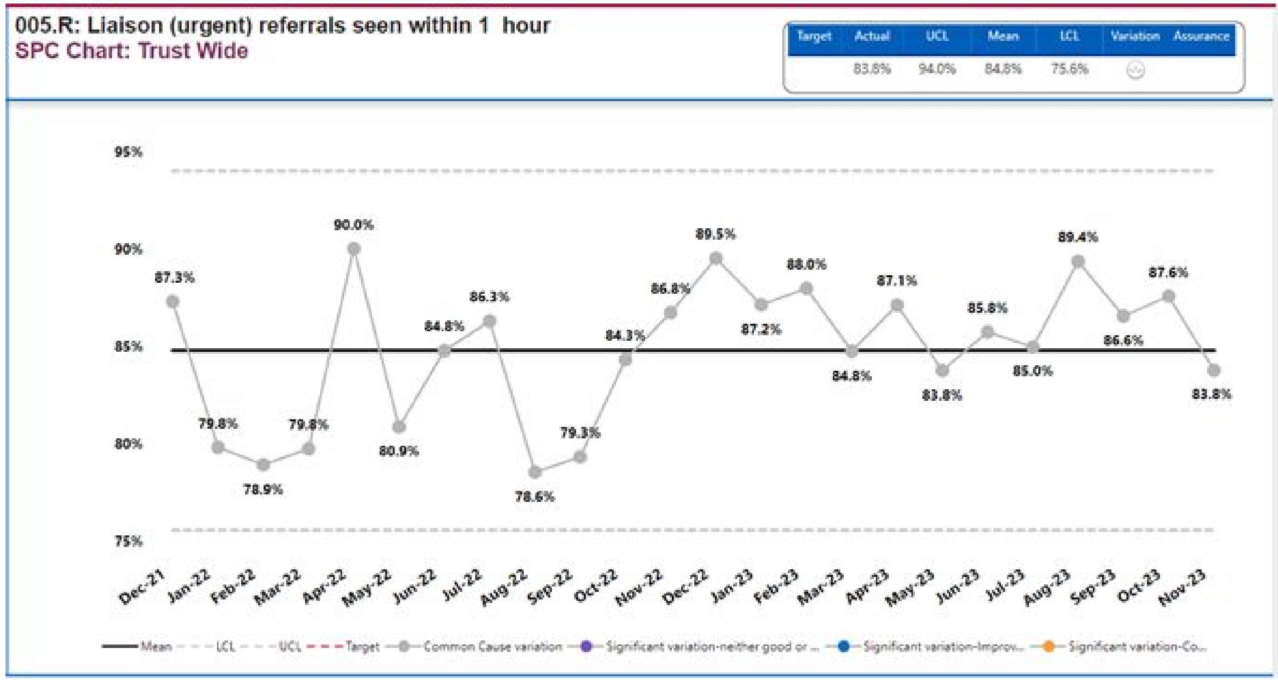


Figure 3 Liaison urgent referrals seen in 1 hour

Crisis House (New)
The ICB have procured a crisis house to support individuals where admission is not indicated but whose presenting issues require a short-term safe environment to aid recovery from crisis. The provision will be available for the population of Kent and Medway with the house located in Gillingham, Medway.

The aim of the model is to create a safe, non-clinical environment for individuals whose psychological distress or mental health needs are deemed to require intensive 24hr support for a period of up to 7 days or fewer.

The crisis house will take referrals through an agreed pathway with KMPT Crisis Resolution Home Treatment Teams acting as gatekeepers. Joint protocols are being developed to ensure a smooth pathway for people to access the crisis house and thereafter onward care.

The agreed outcomes are listed below:

1. Attendance/activity data:
- Number of referrals
- Number of attendees
- No of referrals not taking up support and reasons
- No of people who are deemed as exclusions/ where needs cannot be met by the Service and reasons why
- Number of Safeguarding incidents plus type

2. Times and dates of attendance/ intervention

3. Reasons for attending the Crisis House:
- Crisis Resolution (attending in a crisis)
- Crisis Prevention (attending to prevent crisis)
- Facilitation of Early Discharge from an Acute Inpatient Bed
- Other (to be specified

4. Interventions delivered at the Crisis House
5. Onward destination
6. Initial Patient Satisfaction Surveys
7. Follow-up Patient Satisfaction Survey (to be completed circa 4 weeks beyond Service intervention)

The crisis house in Medway will open in February 2024 with a further Crisis House planned for later in the year.

Rapid Response (Revised)
In April 2023 the Crisis Resolution and Home Treatment services separated the 2 functions of urgent assessment and home treatment, to form a dedicated 24-hour Rapid Response assessment function in north, west and east Kent. Rapid Response has a target of a 4-hour response from the point of the call with transfers received from 111/crisis line, community services and GP's. It is planned that this will be expanded to Mental Health Together once established.

Figure 4 below demonstrates current compliance against the 4-hour assessment target:

Figure 3 Rapid Response performance - Referrals and those seen in 4 hrs

Performance is impacted by peak levels of activity with further analysis required to understand the nature of referral source, outcome of assessment and developments for improvement in meeting the target. This is underway with Rapid Assessment Practitioners fully engaged.

Extend 836 Service (Possible Revision)

The 836 service was established in 2018 and offers a 24/7 telephone support to police colleagues, who are considering the use of section 136. There has been a significant reduction in the use of patients being placed on a S136 since it was launched and moreover a reduction in the inappropriate use of Places of Safety including emergency departments.

The chart below, figure 5 showed a significant drop in number of people being placed on s136, reduction in the inappropriate use of Places of Safety along with reduced police activity.

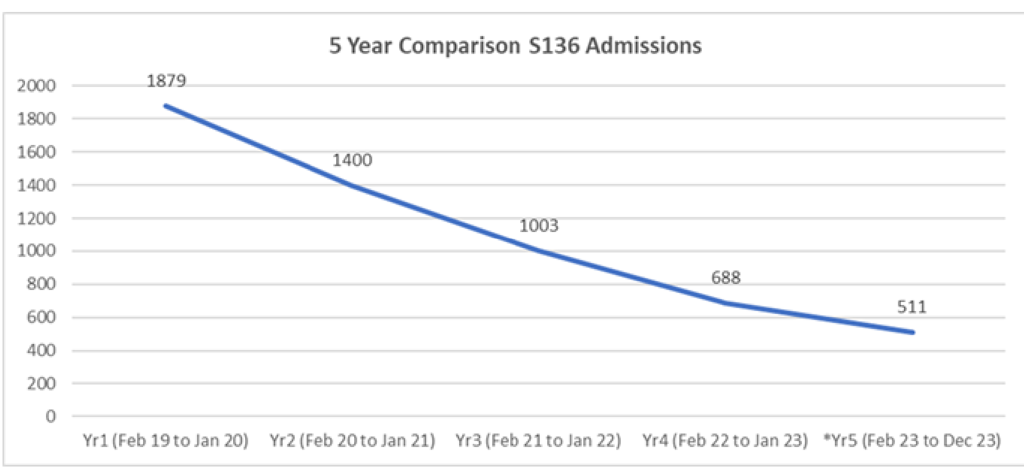


Figure 5 Number of 136 admissions

Further discussions with the ICB and SECAmb are underway regarding the possible expansion of the 836 Service to support a similar operating model for the ambulance service.

111 Press 2 (Revised)

From April 2024 people experiencing a mental health crisis across the county will be encouraged to access NHS111 - Mental Health Option. In conjunction with this the ICB recently issued a tender for a 24-hour mental health telephone and online support service. Once a provider is in place for the mental health telephone and online support service, KMPT will be in a position to warm transfer support calls to the new support line which will free up capacity to respond to 111 calls.

Additionally, as Mental Health Together services are implemented, GP's will be re-directed to their local teams for referrals thus reducing the routine activity in the current Crisis Line.

To conclude, the KMPT Crisis Line will cease to operate once a new provider is in place for the mental health telephone and online support service and Mental Health Together Services are implemented. The Trust will thereafter be in a position to fully concentrate on the NHS 111 service for mental health.

Summary

The development of the urgent and emergency services is varied and comprehensive. The staging of change is necessary to ensure that these services along with the Mental Health Together programme are 'knitted together' to make certain that an appropriate pathway is created and moreover that smooth transfers between provision takes place.

There is further work underway regarding data collection and reporting to allow the triangulation of information specifically related to Psychiatric Liaison, Rapid Response and Safe Haven activity. This along with close monitoring of outcomes when the 111 service becomes fully operational.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
Title of Paper:	Finance Report for Month 9
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 9 (December 2023).

Issues to bring to the Board's attention

As at the end of December 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. The Trust has an agency cap of £7.02m (c3.7% of its total pay bill). At Month 9, the Trust is forecasting to exceed this cap by £1.66m. The main driver to this position is vacancies within medical staffing.
2. The Trust is presently forecasting to deliver its £4.76 efficiency programme in full; with non-recurrent savings supporting recurrent full year delivery in the later part of the year.
3. The full year effect of these plans is being reviewed as part of planning but is anticipated to offset the non-recurrent impact in year.
4. At Month 9, the capital programme spend is £1.12m under plan, this is predominantly due to on Estate's schemes and the benefit of VAT reclaims
5. The cash position remains strong at £16.14m at the end of December 2023.

Version Control: 01

Governance

Implications/Impact:	Resource and Finance
Assurance:	Reasonable
Oversight:	Finance and Performance Committee

Version Control: 01

Finance Report
December 2023

Trust Board

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Executive Summary

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

Key Messages

For the period ending 31 December 23, the Trust has reported a break even position; and this is expected to continue for the rest of the year.

The impact of the system position conversations will be reflected into the Month 10 position which is in line with the South East system.

The key financial challenges for the Trust are:

- High Agency use, with a pressure in the Medical Staff group, and the continued use of nursing agency. This area is subject to external scrutiny through the use of an agency cap.
- There is a continued usage of external beds, in particular usage of female PICU beds above contracted levels.
- The capital programme is £1.12m behind plan, predominantly due to £0.57m due to delays on estates schemes and £0.69m relating to VAT reclaims. Plans are in place to utilise this money in full in-year.
- The Trust is presently forecasting to deliver its £4.76 efficiency programme in full; with non recurrent savings supporting recurrent full year delivery in the later part of the year. The full year effect of these plans is being reviewed as part of planning but is anticipated to offset the non-recurrent impact in year.
- NHS England have delayed the release of its 2024/25 planning guidance, however operational planning has been launched at both a Trust and system level. Due to the financial pressures in the system, the trust has been asked to plan for efficiencies of up to 4%.

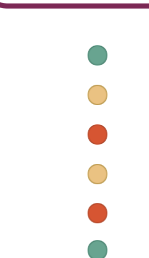
Income and Expenditure

Key pressures for December included the following:

- Agency spend remains high in month; year to date spend exceeds cap by £1.25m. Pressure continues to be seen within medical staffing with a high number of agency medics covering vacancy and sickness.
- If the current level of spend continues the Trust will exceed the annual agency cap by £1.66m (£8.68m Forecast vs £7.02m cap).
- Bank spend remained consistent with the levels seen in previous months. The run rate remains high and the Trust utilised 478 bank wte in month, 42 wte (10%) higher than usage in quarter 1.
- In December, the Trust used 11 female external female PICU beds, 6 above contracted levels, with 0.30 external male PICU beds (9 bed days) and zero external acute beds utilised.

At a Glance - Year to Date

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



Underlying Deficit

The Trust delivered a balance financial position in 2022/23, however 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

As at 31 December the overall capital position is £1.12m underspent, with a forecast capital spend position of £12.79m, which is as per plan.

In month the Ruby Ward scheme overspent in month by £0.17m, bringing year to date back to plan; further spend is expected and therefore is forecast to overspend overall by £0.20m.

VAT reclaims of £0.69m and Estates schemes are the main contributors to the year to date underspend, namely TGU Access Control and Pinpoint, Coleman House Windows and Allington and Tarentfort Windows; collectively the estates schemes are £0.57m underspent, it is expected that these schemes will progress over the coming months and deliver to plan.

Cash

The cash position increased in month by £0.63m to £16.14m; £1.31m over plan. The main drivers were a ICB block payment at a higher level than that received in November due to the November payment being lower due to the adjustment for the resettlement team (delayed until April 2024 and payments received in relation to EPCs).

The key reasons for the year to date cash position against plan relate to the higher opening cash position and VAT reclaims on prior year capital schemes.

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Income and Expenditure

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Budget	Budget	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Income	(256,231)	(21,533)	(22,274)	(740)	(193,467)	(193,757)	(290)
Employee Expenses	196,195	16,502	16,643	141	148,522	148,167	(354)
Operating Expenses	54,488	4,569	5,080	511	40,784	41,459	675
Operating (Surplus) / Deficit	(5,548)	(462)	(550)	(88)	(4,161)	(4,130)	31
Finance Costs	5,548	462	550	88	4,161	4,130	(31)
(Surplus) / Deficit	0	0	(0)	(0)	0	(0)	(0)

Commentary

To month 9, there is an favourable pay variance to budget of £0.35m. This includes a significant underspend on substantive pay of £16.42m (due to the level of vacancies) being partly offset by agency and bank usage.

Agency spend was in line with previous month's run rates with no reduction seen; pressure continues to be seen within medical, accounting for 48% of the year to date agency spend. The main pressure can be seen in the East Kent directorate with spend equating to nearly half of all medical agency spend.
If current spend levels continue the Trust will exceed the annual agency cap (of £7.02m) by £1.46m.

Bank spend in month was consistent to levels reported in recent months. The run rate remains high Trust wide, however, this will be partially due to vacancy and absence cover from annual leave and sickness.

The Trust utilised 478 bank wte in month, 78 wte (19.5%) higher than usage at the start of the financial year, however here has been a 5.38% reduction in the quarterly bank run rate overall, driven by reductions in HCA spend – this will partly due to the actions implemented on wards and some reductions in Extra packages of Care (EPCs) within the Forensic wards.

Other non pay includes a high level of spend on External placements compared to budget, with additional Female PICU beds utilised.

In month the external bed usage exceeded contracted levels with 11 female PICU beds being utilised; 6 over contracted levels. Of which 2 beds related to an extended package of care for a patient with complex needs.

There was the equivalent of 0.3 male PICU beds (9 bed days) and zero acute beds utilised in month.

Long Term Sustainability Programme

Long Term Sustainability Programme

Pillar	Plan	CIP scheme Risk Rating: Red	Amber	Green	Opportunity
	£000	£000	£000	£000	£000
Back Office	1,567	-	-	1,310	-
Service Line Reporting	1,804		600	2,121	-
Procurement and Purchasing	400		-	252	-
Workforce	437		-	-	-
Commercial Development	550	475	-	-	-
Unidentified	6	-	-	-	-
Trust CIP	4,764	475	600	3,683	-
		10%	13%	77%	0%

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 December, schemes have been identified to meet the full £4,76m CIP target; £3.39m, (94.8%) of the year to date plan has been achieved with some slippage in Estates and Human Resources Schemes.
Where there as been slippage against plan, assurance that the scheme will fully deliver needs to be provided or alternative schemes identified to ensure the full saving target is delivered.

Alongside this, focus remains on ensuring that any schemes currently rated amber or red progress to green and that the green rated schemes continue to deliver savings as expected. If there is slippage expected plans need to be identified in order to mitigate this pressure.

Planning has now launched and part of which work will commence to identify future efficiency opportunities. Due to the financial pressures in the system, the trust has been asked to plan for efficiencies of up to 4% which will be built into planning internally.

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Exception report

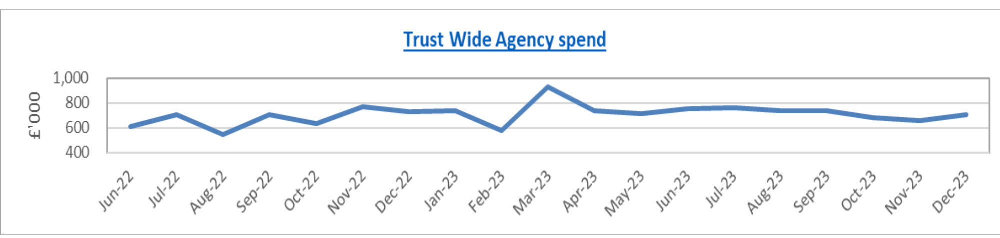
Temporary Staffing Spend

As at the end of December, the Trust reported a year to date underspend on pay of £0.35m. This consists of an underspend on substantive pay of £16.42m, offset by overspends on temporary staffing which total £16.07m; £9.56m on bank staff and £6.50m of agency spend.

Agency

Agency spend to month 9 totalled £6.50m and this is forecast to continue due to both vacancies and operational pressures. Medical agency spend remained consistent with levels seen in previous months. The highest level of spend is seen within the East Kent Directorate with high levels of spend on both medical and nursing agency.

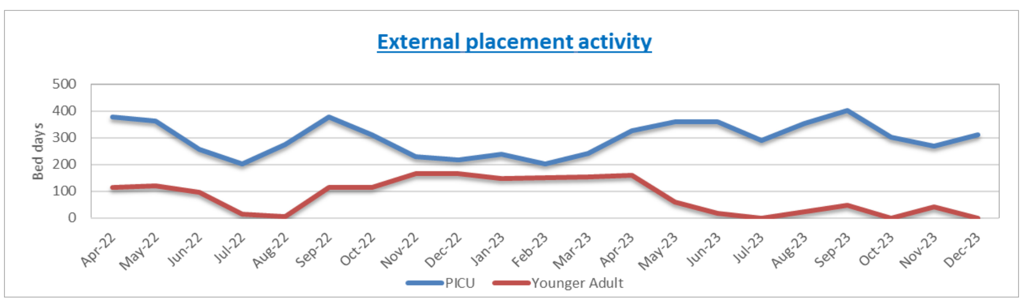
There continues to be focus and scrutiny on all agency spend as the financial year progresses to ensure spend is minimalised. The medical position is being closely monitored at an Executive Level.



External placements

December spend on external placements saw a small increase to November levels. Female PICU bed usage exceeded contracted levels with 11 beds being utilised; 6 beds over contracted levels; of which 2 beds related to an extended package of care for a patient with complex needs.

However other external bed utilisation was minimal with the equivalent of 0.3 male PICU beds and zero acute beds utilised in month.



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.

Trust Wide Bank spend (£'000)

	Actual				
	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3
Nursing	1,766	2,097	1,885	2,159	2,139
HCAs	2,685	2,768	2,760	3,342	3,086
Other	416	450	383	433	390
Total	**4,867**	**5,316**	**5,028**	**5,934**	**5,615**

Trust Wide Bank Usage (WTEs)

	Average				
	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3
Nursing	125	153	125	145	144
HCAs	280	309	277	321	299
Other	40	43	34	38	35
Total	**445**	**506**	**437**	**505**	**478**

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 patient.

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. There has been a 5.38% reduction in the quarterly run rate overall, driven by reductions in HCA spend – this will partly due to the actions implemented on wards including:

- Daily Rota review by General managers with temporary staffing reduced in line with clinical need
- Compassion Training with the aim to reduce violence and aggression on wards.
- Increasing substantive staffing (through international recruitment, and newly qualified nurses), reducing the need for temporary staffing. This has the benefit of increasing the stability and

Acute Inpatient HCA Bank Usage (WTEs)

Inpatient Area	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Older Adults Wards	45.61	38.82	36.77	47.58	37.88	41.92	36.12	44.6	42.54
Willow Suite	23.46	28.32	32.09	34.14	37.36	35.75	27.2	31.29	33.44
Younger Adult Wards	84.84	85.49	78.97	97.28	89.78	70.34	75.59	69.87	70.78
Total	153.91	152.63	147.83	179.00	165.02	148.01	138.91	145.76	146.76

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Appendices

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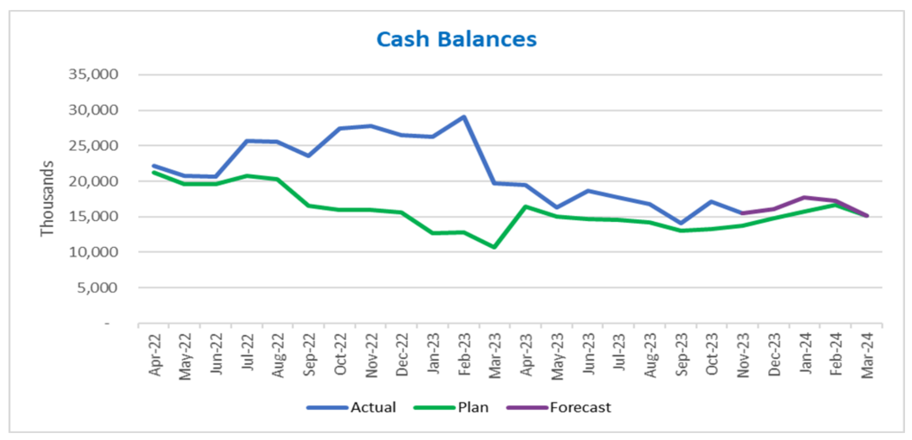
Balance Sheet

Statement of Financial Position

	Opening 31st March 2023 £000	Prior Month 31st October 2023 £000	Current Month 30th November 2023 £000
Non-current assets	172,052	173,531	173,482
Current assets	31,132	23,940	21,042
Current liabilities	(37,727)	(33,668)	(30,723)
Non current liabilities	(35,945)	(34,291)	(34,289)
Net Assets Employed	**129,512**	**129,512**	**129,512**
Total Taxpayers Equity	**129,512**	**129,512**	**129,512**



Commentary

Non-current assets

Non current assets have decreased by £0.37m in month, reflecting capital expenditure of £0.44m being offset by depreciation and amortisation £0.95m and £0.06m increase in right of use assets for remeasurements.

Current Assets

Within current assets the cash position remains strong at £15.2m including uncleared bacs payments of £1.45m.

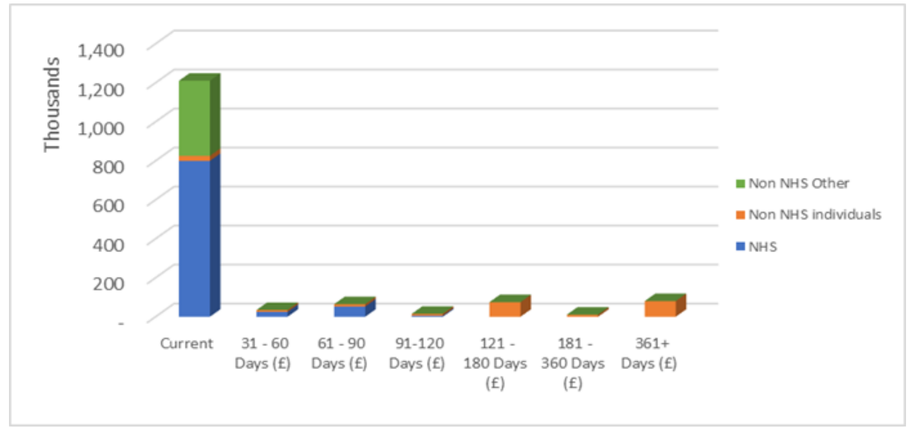
Trade and other receivables reduced by £1.01m. This consisted of £0.96m reduction in contracts debt and £0.06m in prepayments offset by £0.1m increase in other receivables.

Current Liabilities

Overall Trade and other payables dropped by £1.3m. Key contributors of this movement being decreases in capital payables £1.19m, deferred income £1.14 and £0.67m trade payables offset by £1.18m rise in accruals and other payables, £0.42m (the latter including the monthly accrual of £0.32m PDC charge).

Aged Debt

Our total invoiced debt balance is £1.49m, of which £1.2m is due within 30 days.



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Capital Position

Commentary

As at 31 December the overall capital position of £1.12m underspent.

In month the Ruby Ward scheme overspent in month by £0.17m, bringing year to date back to plan; further spend is expected and therefore is forecast to overspend overall by £0.20m.

The main drivers of the overall capital programme position are delays in Estates schemes (£0.58m) these are:

- TGU Access Control and Pinpoint, £0.31m
- Coleman House Windows, £0.22m
- Allington and Tarentfort Windows, £0.04m

The Frontline Digitisation Programme is now overspent by £0.08m due to the new contract for EMeds, this is a phasing issue and spend will be managed within the funded value.

The Section 136 scheme is behind plan by £0.13m and work relating to this scheme is on-going.

Following on from the VAT reclaims and an anticipated underspend on IT schemes, additional schemes have been agreed to be progressed in the remainder of the financial year.

Capital Resource Limit summary

Capital Resource Limit (CRL)	£000
Initial capital allocation	8,349
Confirmed Adjustments	
Section 136 Development	1,077
Total Confirmed Adjustments and Allocations	9,426
Anticipated Adjustments	
CRL required for PFI	49
Frontline Digitisation Programme	1,890
Cash reserves	1,427
Forecast CRL To Be Confirmed	**12,792**

Year to date and forecast performance against Plan

	Full Year			Current Month			Year to Date		
	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Scheme	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Information Management and Technology	584	(119)	(702)	42	15	(27)	382	(119)	(500)
Capital Maintenance and Minor Schemes	1,806	2,931	1,125	198	155	(43)	1,506	929	(577)
Ruby Ward and Improving Mental Health Services Infrastructure	7,386	7,585	199	0	171	171	7,386	7,388	2
Section 136 development	1,077	383	(694)	50	22	(28)	150	25	(125)
Frontline Digitisation Programme	1,890	1,890	0	250	71	(179)	1,090	1,173	83
MHRV (Ambulances)	0	73	73	0	0	0	0	0	0
PFI 2023/24	49	49	0	4	4	(0)	37	37	0
Total Capital Expenditure	**12,792**	**12,792**	**0**	**545**	**438**	**(107)**	**10,551**	**9,433**	**(1,117)**

Forecast

As at Month 9, the Trust is forecasting to spend the full capital budget of £12.79m by the end of the financial year; with a prioritisation process having been undertaken to allocate the underspend reported previously.

Additional schemes include

- Ruby Ward – The project is presently forecasting to overspend by £0.20m. Work is on-going to assure this position
- TGU Access Control and Pinpoint,
- Coleman House Windows
- Allington and Tarentfort Windows,
- Trust Wide Anti Ligature

Work is on-going with our estates leads to ensure that schemes are mobilised as planned. Where slippage occurs this is being identified early to ensure all funds are committed as expected.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th January 2024
Title of Paper:	Health and Wellbeing Deep Dive
Author:	Eric Barratt, Health and Wellbeing Lead
Executive Director:	Sandra Goatley, Chief People Officer

Purpose of Paper

Purpose:	For Discussion
Submission to Board:	Board requested

Overview of Paper

This paper sets out the Trust's programme of health and wellbeing which aims to create a positive working environment where staff can thrive. This includes how our offer has grown to place greater emphasis on how caring for our staff enables them to care for others.

Issues to bring to the Board's attention

It is widely acknowledged that the health and wellbeing of our staff is critical to the quality of services, and over the past 12 months, KMPT has delivered against a range of health and wellbeing priorities. KMPT's offer has recently received a number of accolades, and encouragingly, sickness absence has significantly improved over the past 12 months.

However, KMPT continues to seek a wider range of ways of assessing the impact of its programmes, and to look for opportunities to develop the offer in the future. Areas of concern include:

- Stress, alongside anxiety and other psychiatric illnesses continue to be leading reason for sickness absence followed by musculoskeletal problems.
- The closure of the Talking Wellness Service leaves a gap in psychological support provision.
- There has been a marked increase in complexity of referrals into the staff counselling service for both 'work issues' (68.4 % increase) and 'personal issues' (29.6% increase).
- There is presently no staff physiotherapy provision dedicated to supporting KMPT staff of who are suffering from musculoskeletal conditions that impact on their work.

Governance

Implications/Impact:	Staff feeling healthy and happy is a key predictor of employee retention, motivation and advocacy of the organisation as having a culture of health and wellbeing.
Assurance:	Reasonable
Oversight:	People Committee

Background and context

The focus of NHS staff health and wellbeing (HWB) programmes have in the past centred on 'reducing sickness absence'. COVID-19 has expanded this to include how we perceive HWB, placing greater emphasis on how caring for our staff enables them to care for others.

HWB of staff remains critical to the delivery of quality patient care and is central to our 3-year-strategy. At KMPT we have developed our HWB programme over a number of years and have forthcoming plans in place to further support growth.

In acknowledgment of the progress made with growing our offer, KMPT has been recognised in the prestigious *The Purpose Coalition Awards* as winners of the *Good Health and Wellbeing Award*. This prestigious recognition highlights KMPT's commitment to meeting the goals outlined in **Goal 8: Good health and wellbeing**, with a strong emphasis on addressing health and wellbeing inequalities.

1. Evaluation and Data Insights

A range of methods are utilised when evaluating the impact of HWB initiatives and the staff HWB programme as a whole, including:

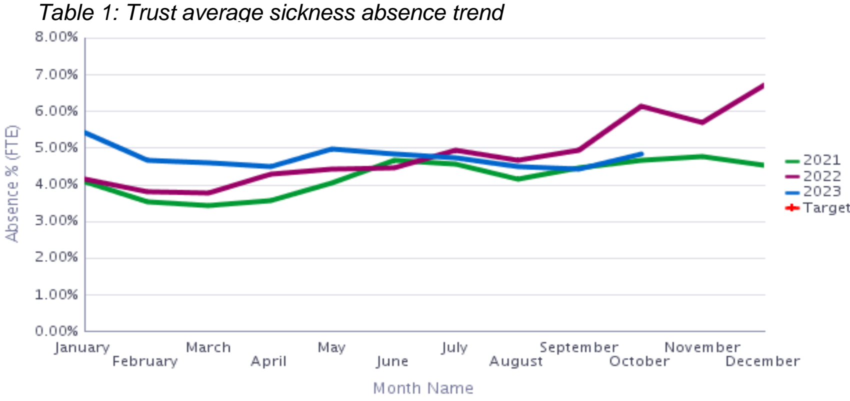
- pre- and post-intervention evaluations;
- Sickness absence levels and reasons for absence;
- Service supplier performance reports;
- staff satisfaction tools;
- NHS Staff Survey scores;
- Staff experience surveys – quantitative and qualitative data;
- Case studies;
- Return on investment for specific projects;
- Temperature check on health and wellbeing culture change.

Updates on some examples of these methods are detailed as follows:

Sickness Absence

Although sickness absence in 2023 started the year above 5%, over the spring and summer months the trend line dropped to below 2022 and 2021 levels a number of times. With data available up until 31st October 2023 (YTD) at the time of reporting sickness absence levels for the remainder of 2023 remain to be seen but are starting from a better place than the same time in 2022 and only slightly higher than 2021 levels, as displayed in the Table 1.

Table 1: Trust average sickness absence trend



Stress, alongside anxiety and other psychiatric illnesses, is consistently the most reported reason for sickness absence in the NHS and this is no different at KMPT accounting for 34.3% of absences in 2023 YTD. For the calendar year of 2022 it accounted for 29.5% and 35.8% in 2021.

Musculoskeletal problems (excluding backs) is the second most reported reason for sickness absence in 2023 YTD (10.7%). For the calendar year of 2022 it accounted for 9.9% and 11.7% in 2021. To help support the musculoskeletal health of staff we are looking at the feasibility of offering an occupational therapy and physiotherapy provision, with the intention to develop a business case over the coming six months.

Chest and respiratory problems are the third most reported reason for sickness absence in 2023 YTD (8.3%). For the calendar year of 2022 it accounted for 9.5% and 2.6% in 2021 which saw high levels of cold, cough and flu levels (7.8%) than subsequent years.

Staff Counselling Service Insights

Since Kent and Medway's *Talking Wellness Service* stopped accepting new referrals in Jun-23 we have seen a 10% increase in number of referrals into the staff counselling service for the 6-month period of Jun-Dec 2023 (104) compared to 2022 (93).

There has been a marked increase in complexity of referrals with both 'work issues' (68.4 % increase) and 'personal issues' (29.6% increase) as service users are more frequently listing multiple reasons for their referral. The leading issues for referral for Jun to Dec 2022 and 2023 are detailed in *Table 2*.

	Reason for referral: Work Issues	Reason for referral: Personal Issues
2023 Q2-Q3	1. Feeling undervalued (19) 2. Work overload (18) 2. Working hours (18)	1. Family Problems / marital / personal relationships (25) 2. Sleep problems (24) 3. Depression (23)
2022 Q2-Q3	1. Work overload (13) 1. Unrealistic job-demands (13) 1. Working hours (13)	1. Family Problems / marital / personal relationships (24) 2. Depression (15) 3. Sleep problems (14)

Table 2: Reason for staff counselling service referral

Details of our current approach and future plans to support staff mental health and wellbeing are detailed in Section 3 and 4.

2. Health and Wellbeing Strategy

KMPT has been shortlisted in this year's *Great British Workplace Wellbeing Awards* in two categories. Eric Barratt, Health and Wellbeing Lead, has been nominated in the *Most Inspiring Employee of the Year* category and our HWB Strategy has been shortlisted for the *Best Wellbeing in the Workplace Strategy - Public Sector category*.

These awards have been launched to recognise and champion the steps taken by employers, service providers and individuals in response to global wellbeing challenges. All winners will be announced on 22 February 2024.

In 2022, NHS England supported fourteen 'trailblazer' organisations to engage with and use the revised *HWB Framework* which helped to expand the way we think about HWB. One of the outputs from KMPT's participation as a trailblazer was the development of a new HWB strategy which has the seven HWB elements at its heart and has helped to define KMPT's future focus for HWB interventions over the coming years.

The purpose of this strategic plan is to grow and develop our culture where staff are empowered to enhance and maintain their physical, mental and social health and wellbeing. We used the HWB framework's self-assessment tool to establish our current status and areas to develop. *Table 1* shows a summary of the overarching element scores for KMPT completed in Sept-23 for which we will complete annually to review changes progress.

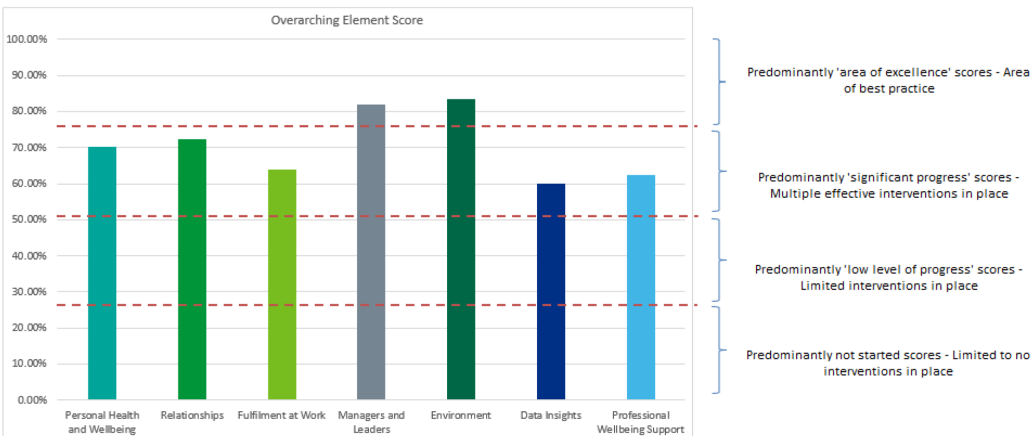


Table 1: Health and wellbeing framework diagnostic tool self-assessment scores

The new diagnostic tool results prompted us to consider wider elements than previously, for instance, we have included a section on Equality, Diversity and Inclusion for the first time.

We identified gaps in some of our available offers after using the diagnostic tool, so we have expanded our financial wellbeing offer, trained more Mental Health First Aiders, enhanced the physical environment and are expanding our Occupational Health and Employee Assistance Programme, as part of the implementation phase for the strategic plan.

KMPT's assessment is comparably similar to other Kent and Medway system partners. All trusts scored low for use of data which has been identified as an area of focus for system improvement through the Occupational Health and Wellbeing Subgroup.

3. Growing a culture of health and wellbeing

KMPT has a comprehensive health and wellbeing programme in place, evidenced by being awarded the top award of Platinum in December 2022 from the Kent and Medway Healthy Workplace Initiative having previously achieved Gold, Silver and Bronze awards in previous years. However, it is recognised there is room for continuous improvement and a need for adapting the HWB offer to meet the needs of staff as they change. Consequently, the following themes and actions provide a snapshot of how our offer has progressed and will grow in the future:

a. Staff support services procurement

Occupational Health Service

The current contract for occupational health services (OHS) is due to end Jun-24. A tender for a new contract went live Sep-23 and bid evaluations took place Dec-23. The appointed provider will have an 8-week implementation period prior to service going live Jun-24. Our ask of the new service is to:

- Reduce administrative burden on KMPT i.e. intuitive online portal, effective utilisation of existing staff records, continuity of care;
- Have a strong focus on disability, wellness and preventative health e.g. offers tailored/appropriate advice and guidance relating to reasonable adjustments;
- A supportive, customer-orientated, values-based supplier;
- Appropriately staffed offering timely referrals to physicians and specialists.

Employee Assistance Programme

Presently staff have access to 6-sessions of free counselling via an independent service provider. With the *Talking Wellness Service* closing in Oct-23 there has been an increased demand for psychological support beyond what counselling can typically provide. Consequently, in time for the end of the counselling service contract, expiring May-24, we are working to procure an Employee Assistance Programme (EAP) via a procurement framework. Working with procurement colleagues', frameworks and procurement options are being explored. Like with the OHS, the supplier will have an 8-week implementation period prior to service going live Jun-24.

The EAP service will be able to provide a wider range of support for a variety of issues which may include: legal, financial, medical, family, stress, consumer and work-related support.

b. Financial wellbeing

The impact of rising living costs has impacted the budgets of KMPT staff with concerns raised specifically about the cost of energy, fuel and food on regular occasions.

Subsequently, we've progressed a number of financial wellbeing initiatives including:

- A 10p-a-mile increases on mileage expenses to help with the rising cost of fuel;
- Reimbursement of the £4.99 cost of purchasing a *Blue Light Card* which to date has seen 247 staff take up the offer and provides discounts at a range of high street and online retailers;
- Introduced the digital financial wellbeing solution *Wagestream* which has had an uptake of over 10% of eligible staff and offers financial coaching, favourable savings rates and early access to salary designed for emergency purposes.

c. Schwartz Rounds

Schwartz Rounds are a confidential forum for all staff to regularly come together to reflect on the non-clinical aspects of caring for patients – that is, the emotional and social experiences associated with their work.

Rounds are currently held online and have 70+ staff attending each session with the last one held on Carers Rights Day on the 23rd November with the theme 'Life as a working carer'. The next Schwartz Round is scheduled for Time to Talk Day on the 1st February with a theme of 'How I really feel'.

In 2023 we have introduced an additional aspect to the offer in the form of 'Pop-up Rounds' which were developed to increase reach by taking Rounds to audiences (e.g. ward-based staff or conference attendees) to help staff to access the reflective space.

So far four pop-up Schwartz Rounds have taken place including as a workshop at the Research, Innovation and Quality Improvement (QI) conference.

The agreement with Point of Care Foundation who issue the licence to organisations to be able to run Schwartz Rounds initially expired Sep-23. It was agreed to renew the licence for a further 2 years with a plan to continue online trust-wide Rounds with in-person Rounds delivered in partnership with the new directorates.

d. Staff Safety

KMPT has joined the membership charter ‘Employers Initiative on Domestic Abuse’ (EIDA). The Charter sets out mutual commitments that will enable better support for staff affected by domestic abuse. We are developing a project plan to enhance the support available and raise awareness amongst staff.

We recognise that we have staff who experience sexual abuse and harassment, and consequently are looking to implement the Sexual Safety Charter which commits all participating organisations to vigilance of inappropriate behaviour and will ensure that the safety of our staff is a top priority.

e. Mental Health First Aid

We presently have around 100 staff trained in Mental Health First Aid (MHFA). MHFA is a training course which teaches people how to identify, understand and help someone who may be experiencing a mental health issue. We have received excellent feedback on the training and how it has been put into practice to support the mental HWB of colleagues and are set to train an additional 30 staff in MHFA each year. We are also arranging refresher training for staff who have been a MHFAer for more than 3 years.

f. Leadership in Health and Wellbeing

In 2020 trusts were asked to appoint a non-executive director as wellbeing guardian to their executive board. Kim Lowe has been fulfilling this role which involves seeking assurance, independently challenging, and holding the senior leadership team of a healthcare organisation to account for developing a compassionate and inclusive culture of health and wellbeing. In Oct-23 NHS England published new guidance changing the title to ‘health and wellbeing guardian’ to reflect the full breadth of both health and wellbeing aspects of what the function covers.

We have included HWB champion training into the Healthcare Support Worker programme which has seen a further 80 champions trained in 2023.

Our managers are fundamental to creating a positive and healthy working environment for our staff. It’s important that our managers are equipped with the right skills and capabilities to support their own HWB and that of those around them.

Having already established a fortnightly HWB session at corporate inductions for new starters, we have further developed and implemented a manager’s HWB induction session which takes place monthly. We’re soon to launch a managers HWB training course to upskill managers on important initiatives to help further grow a culture of HWB including having safe and effective wellbeing conversations with the staff they manage.

We’re also running monthly HR clinics in each operational directorate with the aim of upskilling managers around supportive absence management and successful return to work.

g. Smoke Free KMPT

Stopping smoking is the best thing a person can do for their health. It has been observed that some staff continue to smoke so in partnership with the Medway Stop Smoking Service we have set up our first onsite stop smoking group intervention where quitters will receive a free vape starter kit, due to begin Feb-24.

We recognise that many of our patients also continue to smoke and particularly for in-patients, reduced opportunities to smoke have resulted in incidents of violence and aggression. For a number of years, we have been delivering our in-house stop smoking practitioner programme which has seen over 70 staff trained and accredited as stop smoking practitioners. This year we have developed and launched a refresher programme due to staff demand from those trained some time ago wanting to update their skills and knowledge.

h. Communication

Back in 2020 our weekly HWB newsletter *Wellbeing Wednesday* was launched in response to the pandemic. In 2022 this evolved into a monthly publication called *You 1st* which has the highest open rate of all regular publications.

With the announcement of a new intranet we are excited to utilise this opportunity to further engage with staff on HWB matters, in the meantime we are in the process of updating our existing *iConnect* pages dedicated to HWB.

i. Reasonable Adjustments

KMPT has created and piloting a new central process for Reasonable Adjustments which is anticipated to support improved HWB. This will include a new policy and easy to follow guidance in applying for workplace reasonable adjustments. There will be one central budget and therefore will negate the need for local managers to identify funds for reasonable adjustments from local budgets. KMPT recently bid successfully for a Workplace Adjustment Award, as a result of which we were awarded funding of £11,999 by NHS England to support this work.

j. Return to Work

It's inevitable that some of our staff may become unwell and we have looked to improve how KMPT can better manage sick leave and return to work. Following good practice guidance, we've revised our policy to support a robust phased return to work. Within the occupational health service specification, it's explicit in requiring the new service to go further in the help and advice they offer managers particularly in terms of return to work planning and inputting to the newly established reasonable adjustments process.

4. Summary

A comprehensive award-winning HWB offer is in place for our staff which continues to evolve and grow based on need and in line with our strategic plans.

We are embedded within a number of national and regional networks to share and learn about what other organisations are doing to support the HWB of staff for which will continue to be valuable in informing our HWB programme.

We also have ambitions to innovate and grow our examples of excellence with initiatives planned or underway including:

- We are supporting the health and wellbeing of international nurses as evidenced by pastoral support accreditation and establishment of Florence Nightingale support;
- Supporting staff who are victims of violence/aggression with bespoke, in-house psychological support;
- A QI project is underway with regards to enhancing wellbeing awareness amongst psychiatric trainee doctors;
- Expanding our HWB café support following the successful growth and embedding of our menopause café which now has a membership of 300+ staff and we are currently applying for accreditation as a menopause friendly employer.

In order to review the impact, the HWB programme is having on staff we will:

- Continue to review feedback on NHS staff survey results with the 2023 survey results due to be released shortly;
- In 2021 we conducted a Health Needs Assessment of 12% of the workforce which provided insights into the health status of staff and informed the development of our HWB offer. We intend to re-run a similar assessment this year and adapt our offer to meet the changing needs of staff;
- We'll repeat the Health and wellbeing framework diagnostic tool self-assessment annually in September to gauge progress against previous assessments.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 25 January 2024

Title of Paper: Freedom to Speak Up Report –

Author: Rebecca Crosbie, the Guardian Service

(Cover sheet authored by Sheila Stenson, Chief Executive)

Executive Director: Sheila Stenson, Chief Executive

Purpose of Paper

Purpose: Discussion

Submission to Board: Regulatory Requirement

Overview of Paper

A paper formally updating the Board on the Freedom to Speak Up (FTSU) Guardian Service.

Issues to bring to the Board's attention

During the period of 1st April 2023 to 30th September 2023, a total of 40 concerns were raised with the FTSU Guardian (FTSUG) in comparison to 36 for the previous 6-month period.

In addition to the 40 concerns raised, 25 concerns were carried over from the previous year under active case review. Of these 25 concerns 20 have now closed and 5 remain open with the guardian working proactively with the trust to resolve.

The majority of concerns raised (65%) were rated as 'green' concerns which fall into the category of general workplace grievances. One concern (2.5%) raised fell into the higher risk 'red' category with an element of patient safety or quality of care.

The top three primary themes for the period were Systems and Processes (12), Behaviours/Relationships (10) and Management Issue (8). The top three secondary themes were System and Processes, Behaviours/Relationships and Worker Safety/Wellbeing.

This report includes a number of new tables that look at the number of concerns raised within a staffing group or location against the number of staff employed within that staff group or location. This has enabled us to see that Allied Health Professionals have raised the highest number of concerns and that the location of Dover has also seen the highest number of concerns raised over this reporting period.

The latest available benchmarking data (2022/23) available from The National Guardian Office shows the national average for a small NHS trust (up to 5,000 workers) at 34.6 (for two quarters) which implies KMPT is slightly above average for trust size. However, for the data specific to Mental Health and Learning Disability Trusts (MHLD) the current average is 58.6 which has increased from 44.8 in the previous year which puts KMPT under average for concerns raised within MHLD trusts.

Version Control: 01

Governance

Implications/Impact:	Trust Strategy: Growing our capability to deliver
Assurance:	Reasonable
Oversight:	Oversight by Workforce Committee/Trust Board

Version Control: 01

Biannual Report
1 April 2023 to 30 September 2023

Circulation:

Main point of contact
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FTSU Guardian
The Guardian Service Ltd.

December 2023

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1. Executive summary

This is the Freedom to Speak Up (FTSU) biannual report for the 2023/2024 half year period of 1st April through to 30th September 2023. This report provides and overview of the FTSU activity and performance at Kent and Medway NHS and Social Care Partnership Trust (KMPT) inclusive of any key themes which are crucial to informing organisational learning and improvement.

- A total of 40 concerns were raised with the FTSU Guardian (FTSUG) during this period in comparison to 36 for the previous 6-month period.

- In addition to the 40 concerns raised, 25 concerns were carried over from the previous year under active case review. Of these 25 concerns 20 have now closed and 5 remain open with the guardian working proactively with the trust to resolve.

- The latest available benchmarking data (2022/23) available from The National Guardian Office shows the national average for a small NHS trust (up to 5,000 workers) at 34.6 (for two quarters) which implies KMPT is slightly above average for trust size. However, for the data specific to Mental Health and Learning Disability Trusts (MHLD) the current average is 58.6 which has increased from 44.8 in the previous year which puts KMPT under average for concerns raised within MHLD trusts.

- The majority of concerns raised (65%) were rated as ‘green’ concerns which fall into the category of general workplace grievances. One concern (2.5%) raised fell into the higher risk ‘red’ category with an element of patient safety or quality of care.

- Of the 40 concerns raised 45% were escalated to the trust, 30% with names. The remaining 55% were kept confidential within the remit of The Guardian Service. In these cases, the individual either sought impartial support from the guardian to escalate independently or used the service for emotional support and information.

- The top three primary themes for the period were Systems and Processes (12), Behaviours/Relationships (10) and Management Issue (8). The top three secondary themes were System and Processes, Behaviours/Relationships and Worker Safety/Wellbeing.

- The job groups who raised the most concerns during the period were Administrative and Clerical (27.5%), Nursing and Midwifery (25%) and Additional Clinical Services (17.5%). However, if we look at the number of concerns raised within a staffing group against the number of staff employed within that staffing group, Allied Health Professionals leads on this.

- Of the 40 staff who engaged with The Guardian Service, 40% stated their reason for doing so was to seek impartial support and 32.5% felt that they have raised their concerns internally but hadn’t felt heard. Those fearing negative consequences or believing they will not be heard made up the remaining 27.5% in near equal portion.

- There has been one case during this period where a staff member alleges to have suffered a detriment as a result of their speaking up experience, this individual has subsequently resigned. There has been a second case where an individual raised a perceived experience of detriment following making a protected disclosure and this is under investigation by the trust.

2. Purpose of the paper

Following guidance from the National Guardian Office (NGO) this paper provides insight, themes and data on the Freedom to Speak Up service delivered by GSL at KMPT for the first half of the financial year 2023-2024.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in 2022 on 6th June.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational corporate induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

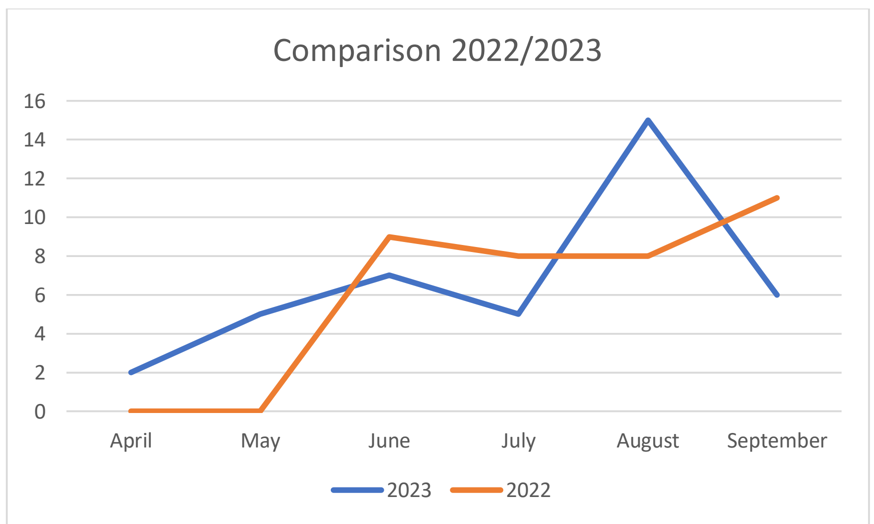
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager or service director, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

In the period between 1 April and 30 September 2023 (Q1 and Q2), 40 concerns were raised. The service was not live for April and May 2022 but for the remaining quarter a comparison from 2022 is provided below.

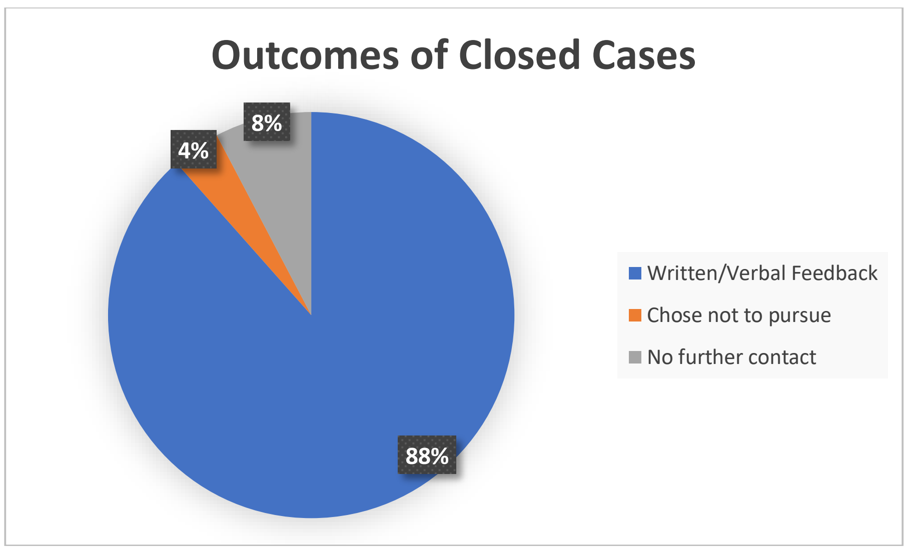


The most prior six month period (Q3 & Q4 2022/2023) saw 36 cases brought to the service which shows an increase of 4 cases during this 6 month period.

7.1. Case Activity By Month

The minimum number of cases raised within any one month was 2 and the maximum number of cases was 15. August saw an increase due to a cluster of concerns coming in from one service. Remaining months stayed between 5 and 7 concerns consistently. Current activity and NGO data suggests this will increase throughout Q3 & Q4.

Out of the 40 cases 26 (65%) have been closed. 88% of the cases that have been closed have received verbal or written feedback which has been provided to the member of staff including any actions being taken which has in all cases led to the individual raising the concern being satisfied with the case being closed.



8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	22	55%
Permission to escalate with names	12	30%
Permission to escalate anonymously	0	0%
Permission to escalate without name	6	15%
Total	**40**	

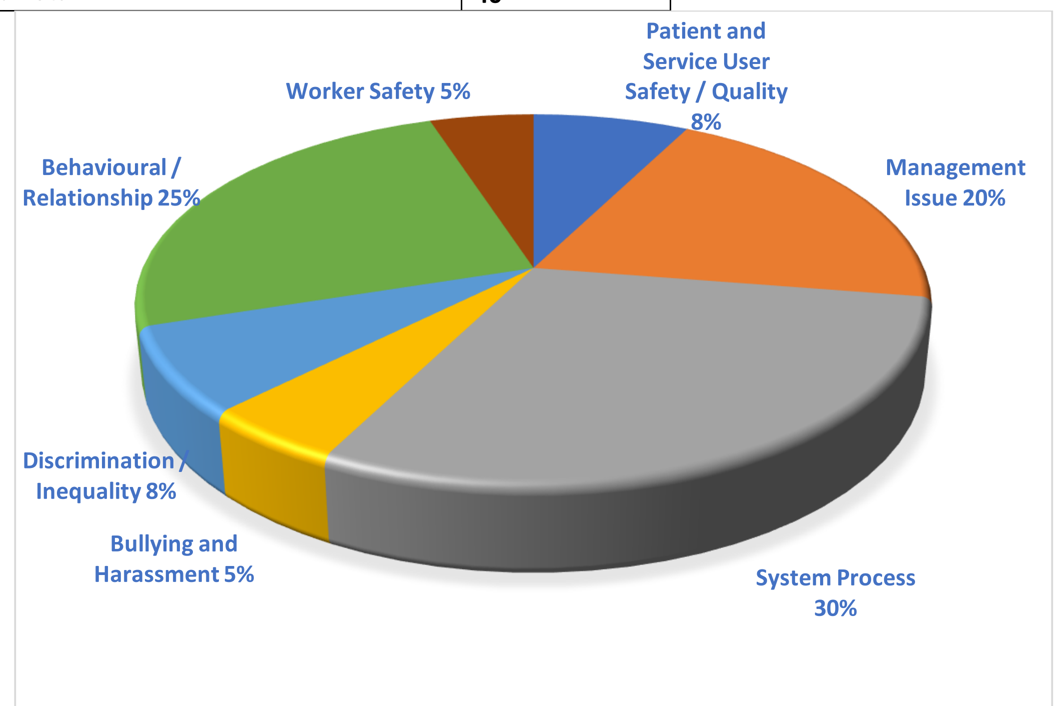
Just over half of the staff (55%) who raised concerns with GSL asked for their concerns to be kept confidential within the remit of the service. It is worth noting that 40% of those who contacted the service reported doing so for impartial support and when looking at outcomes staff were often able to rely on their conversations with the FTSUG to support raising their concerns internally whilst using the FTSUG as a sounding board and source of impartial support. 40% of the cases raised were escalated to

the trust by the FTSUG either with or without a name and there were no anonymous cases during this period.

9. Themes

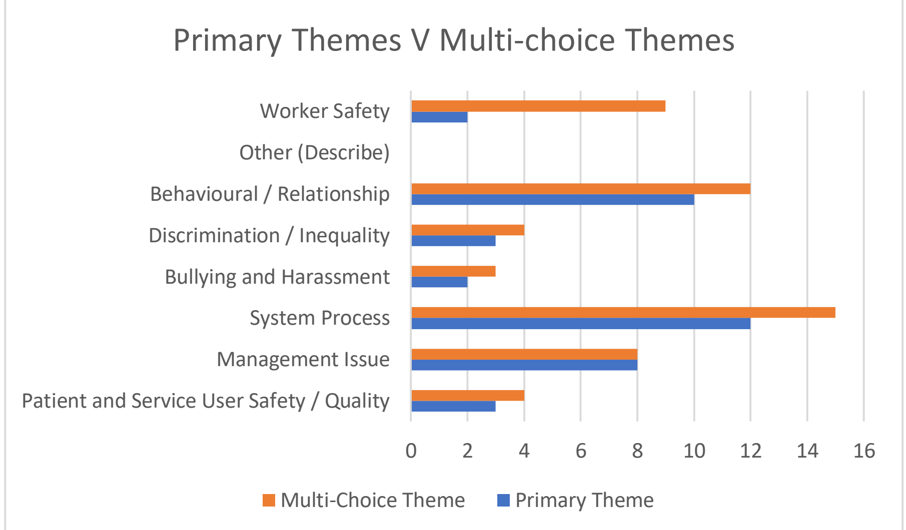
Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	3
B Management Issue	8
C System Process	12
D Bullying and Harassment	2
E Discrimination / Inequality	3
F Behavioural / Relationship	10
G Other (Describe)	0
H Worker Safety	2
Grand Total	**40**



9.1. Primary Themes/ Multi Choice Themes

The Guardian Service has expanded its reporting capabilities to include multiple themes per case in addition to the 'Primary Theme'. A 'Primary Theme' would refer to the leading theme and then any subsidiary themes would be listed as 'Multi Choice'. An example of this would be if a staff member raises a concern about a process which is reviewing their work environment, and they don't feel the process is purposeful it may be that the 'Primary Theme' is 'System/Processes' but as part of the discussion we identify it could also impact worker safety if the process isn't carried out robustly a 'Multi Theme' may be added of 'Worker Safety'. This gives us a wider insight into themes and impact.



We can see that System/Processes and Behaviour/Relationship issues remain the leading themes for both primary and multi-choice themes but Worker Safety increases quite significantly from 2 primary theme cases to 9 multi-theme cases. Bullying and Harassment, Patient Safety/Quality of Care and Discrimination/Inequality were raised the least number of times in both Primary and Multi Choice themes.

10. Trends in Cases

The Guardian Service did not go live until June 2022 so we cannot compare data from the same quarters last year but there has been a 10% increase from the preceding 6-month period. Nationally there has been a 25% increase overall in cases raised within trusts in England.

For Mental Health and Learning Disability Trusts the average number of cases per submission nationally for 2021/22 was 22.4 and for 2022/23 increased to 29.3. This average is collected across all trust sizes.

Mental Health and Learning Disability Trusts	
Year	**Average number of cases (half year)**
2022/23	58.6
Year	**KMPT (half year)**
2023/24	40

NGO data shows that KMPT is below average for Mental Health and Learning Disability Trusts on the average number of cases per half year period. This differs if we compare average figures by trust size.

Figure 4. Average number of cases per submission by NHS Trust size (2022/23)

The average number of cases for a small trust for a 6-month period is 34.6. KMPT had 40 cases for this six-month period this is 13.5% greater than average for a small trust. *(Submission refers to one quarter of a year)*

Small Trusts (up to 5,000 Workers)
Average number of cases (half year)
34.6
KMPT (half year)
40

11. Assessment of Cases

11.1 Management Issues (8)

Management issues is within the top three leading themes for concerns raised in the half year period. This theme includes staff perceptions of their experiences of management including accountability, leadership style, decision making, consistency and a range of workplace issues that fall under managerial control and authority. The issues which came out of concerns raised under this theme were:

-Management decisions and approach around implementation of reasonable adjustments

-Support and understanding around staff with disabilities

-Management decisions around and handing of investigations

-Management style and professionalism

-Not feeling heard by management

In some of these cases simply speaking with the FTSUG guardian was enough to enable the individual to take things forward independently using the FTSUG as a sounding board and support mechanism. Other outcomes included HR informally reviewing issues, internal and external investigations and meetings facilitated by the FTSUG.

Themes which have arisen from these concerns which will help to inform the comments and recommendations in **section 17** of this document included:

- A lack of compassionate leadership
- Communication skills and awareness
- Leadership and management style/experience
- Consistent approaches to leadership
- Listening Up

11.2 Systems and Process (12)

Systems and Process is the leading theme for cases raised within this half year period. It is important to note that this is also the leading multi-choice theme and has consistently remained the overall leading theme since The Guardian Service launched in June 2022. This theme explores staff experiences and feedback on service and organisational systems and/or their concerns around internal policies and procedures. The FTSUG ensures that they have awareness of internal policies and procedures and in many cases is able to support individuals with how to access these as well as helping them to understand these. The FTSUG continues to give regular feedback on the accessibility of policies to the trust.

The key issues which were identified through these concerns being raised were:

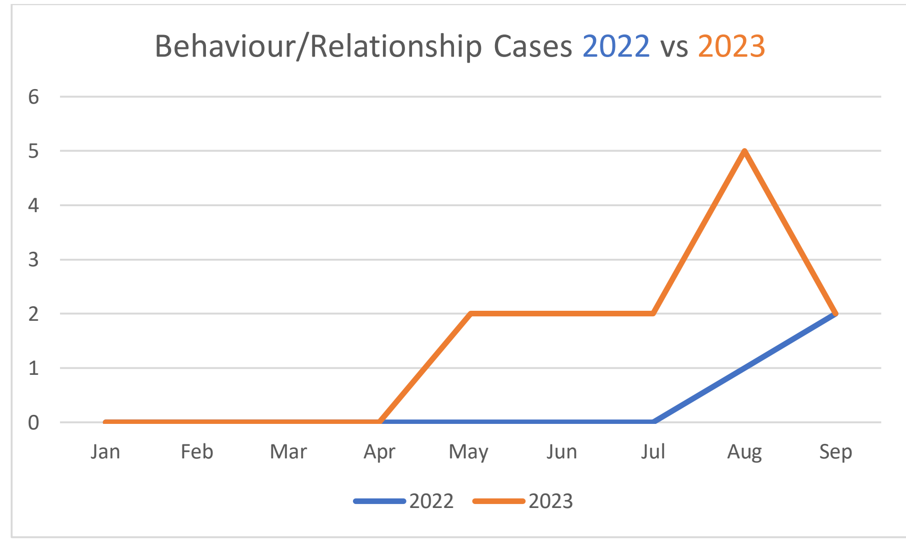
- Organisational change – communication, feedback, approach, and impact
- Sickness including return to work and reasonable adjustments.
- Pastoral support – formal processes and whistleblowing
- Formal processes – timeframes and consistency

The feedback received from staff during promotional visits and when handling these concerns was that approaches across the organisation were inconsistent, timeframes were extended beyond what was felt to be reasonable and that communication was lacking. It is reportedly felt by these individuals that the inconsistencies, extended timeframes, and difficulties receiving communication was also having a significant impact on staff wellbeing, retention, sickness and service performance. This feedback related to formal investigations or grievances and organisational change.

Some of these cases had a multi-theme of Worker/Safety and Wellbeing as it was reported that experiences had led to an impact on mental wellbeing and cases of work-related stress absence.

11.3 Behaviour/Relationship (10)

This was the second leading primary and multi-choice theme for concerns raised within this half year period. It is important to note that in the annual report for 2022/2023 which covered a 10-month period, from the service going live in June 2022, there were only 6 concerns raised under this theme. For this six-month period there were 10 concerns raised within this theme showing quite a sharp increase.



It is also worth noting that only 3 of these concerns were escalated to the trust. With cases relating to interpersonal difficulties and behaviour there can be increased fear around the escalation process due to a perception that the behaviour may worsen and/or that concerns may not be believed. It has also been the case that managers don't feel supported when dealing with complex behaviours from staff that they manage and a perception that if they ask for help their management skills may be questioned.

Within this theme there have been issues such as:

- Incivility and microaggressions in the workplace
- Team dynamics
- Managing challenging behaviours from staff
- Perceived inappropriate or hostile management behaviours.
- Behaviour and communication style of medical staffing

- Impact of behaviour on team and service

Of the 3 cases escalated to the trust one has been closed following meetings which have been organised by the FTSUG. These meetings and wider concerns raised helped to inform the decision to open an investigation which is ongoing. The remaining 2 cases escalated to the trust remain open and have informed some of the recommendations in **Section 17**.

In 2023 the trust launched its Early Resolution Policy. This policy aims to resolve concerns, such as interpersonal issues, early without the need for formal process to take place. Feedback has been that there is a lack of understanding and awareness around the use of the policy due to limited communications having been shared.

11.4 Discrimination and Equality (3)

Discrimination and Equality is one of the lesser themes which arises in cases raised with the FTSUG. It is important to note that on promotional visits to services, experiences relating to discrimination and equality come up in conversation regularly, but it is often shared that individuals would not feel comfortable raising these as concerns due to a fear of reprisal or having experienced a lack of action and not felt heard in the past.

These three cases related to alleged discriminatory treatment shown to staff on race or disability grounds. The guardian received feedback through these concerns that there is a perception that racial discrimination is accepted within the organisation and that there are underlying cultural issues. When individuals experience discrimination or unfair treatment regularly this can often result in the normalisation of this behaviour in the workplace. This can negatively impact workplace culture and have an adverse impact on organisational outcomes such as staff turnover, performance, and attendance. It is important that the trust strengthens its message around the trusts values, takes action early and calls out poor behaviour.

As part of a proactive approach to improve the culture within the Trust an Equality, Diversity, and Inclusion (ED&I) consultant has been commissioned to carry out a piece of work by the organisation. In addition to this the FTSUG meets regularly with the Diversity and Inclusion Manager to share themes and discuss relevant cases.

11.5 Patient Safety/Quality of Care (3)

Three cases were raised under this theme within the 6-month period with an additional case under the multi-theme option. These cases were relating to staffing shortages and behaviour towards patients impacting quality of care.

In the cases of staffing shortages plans were created with management of which staff were supporting of, however staff did not all feel that these would be sufficient mitigations and informed the guardian that they would raise further concerns in the future if needed. In relation to staffing levels there has been a theme on promotional visits where services have been witnessed by the FTSUG under significant pressures but it would appear that the shortages have become normalised, and that staff don't feel that escalating these issues to the trust will result in positive change. The FTSUG reinforces the message to all staff on promotions that sharing their feedback and experiences of staff shortages is essential to prevent normalisation of the experience.

In cases related to staffing behaviour towards patients these are both being investigate by the trust and there has been the introduction of compassionate communication and respect training within one service. Consideration for this to become a trust wide training initiative within patient facing services could be beneficial.

There is some disparity between the response times and processes of the trust when dealing with behaviours towards patients from medical and non-medical staffing with it taking longer and the process being less clear for action to be taken place with medical staffing issues.

All concerns under the primary theme of Patient Safety/Quality of Care raised within this period have been closed. One remains open at the time of writing the report, under the multi-theme category.

11.6 Worker Safety/Wellbeing (2)

The theme of Worker Safety/Wellbeing has seen a reduction in cases for this 6-month period compared to 2022/23 with only 2 cases being raised with this as a primary theme. It is important to note, however, that if we look at Worker Safety/Wellbeing under the multi-theme cases it falls into the top three themes with 9 cases containing an element of Worker Safety/Wellbeing.

When looking at these 9 multi-theme cases 2 of these related to operational issues which were resolved swiftly following the FTSUG escalating to the trust. Issues related to insufficient access to personal alarms and attendance at handovers to inform safety on a ward. Solutions to these issues were shared with the wider staff team who agreed they were satisfied with the outcome.

The remaining 7 cases all had an element of work-related stress or impact on mental health due to experiences within the workplace. There has been an overall theme when handling cases that staff report not feeling supported if they experience work related stress and that if this causes a sickness absence staff feel there is a lack of pastoral support or review to mitigate the situation on returning to work.

11.7 Bullying and Harassment (2)

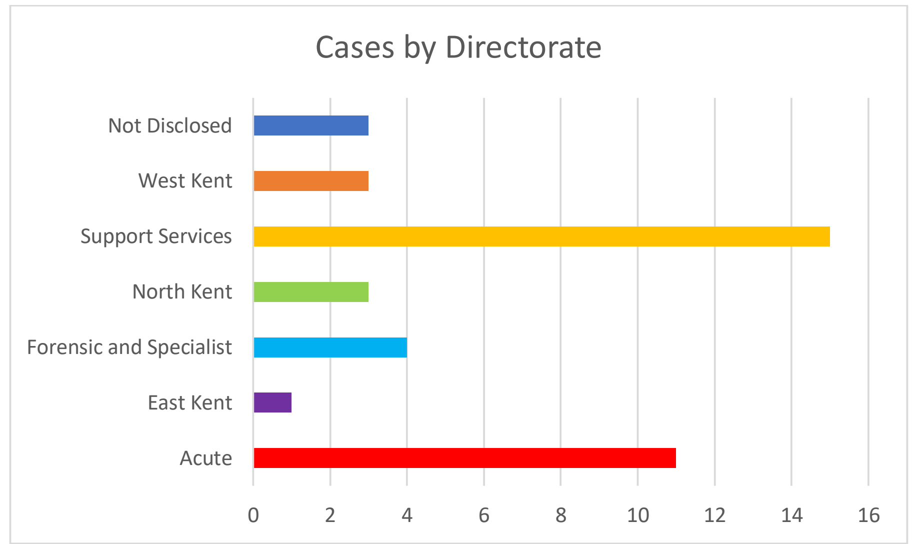
Bullying and Harassment was the least prevalent theme within primary (2) and multi-theme cases (3). These cases contained reports of perceived bullying behaviour from a manager, harassing behaviour from a colleague and targeted harassment from group of individuals on one staff member.

It is important to note that the FTSUG proactively explores allegations of bullying and harassment with individuals when the use this terminology to identify whether this theme is appropriate or whether the case relates to a management style or behavioural/communication issue.

In one case an individual had tried to resolve matters internally over an extended period of time but did not feel the trust was taking their concerns seriously. This case remains open under further investigation internally with proactive review and emotional support being provided by the FTSUG.

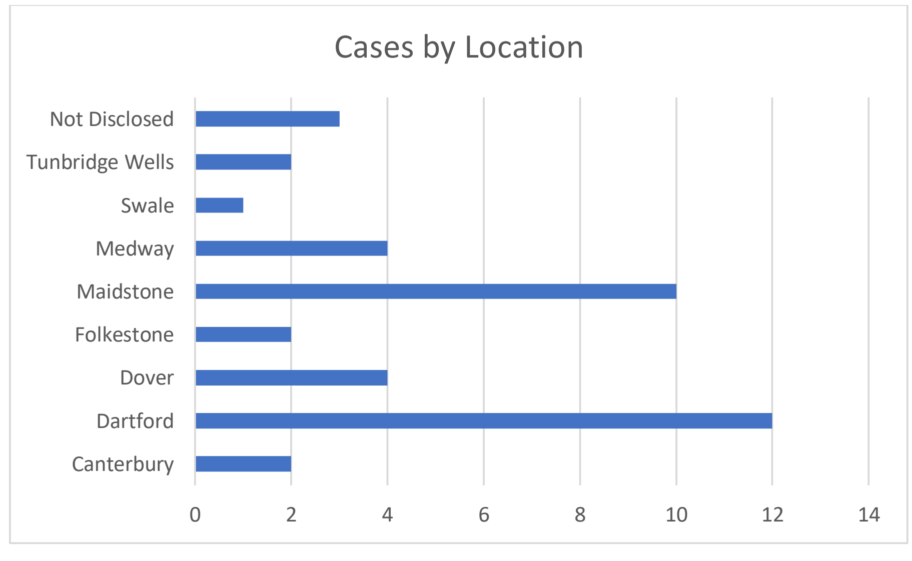
12. Statistical Graphs

Concerns raised by Directorate



Directorate	Employee Count	Concerns	% staff raising concerns
Acute Directorate	620	11	1.77%
East Kent Directorate	655	1	0.15%
Forensics and Specialist Services Directorate	761	4	0.52%
North Kent Directorate	390	3	0.76%
Support Services	879	15	1.70%
West Kent Directorate	528	3	0.56%
Not disclosed		3	
Total	**3833**	**40**	

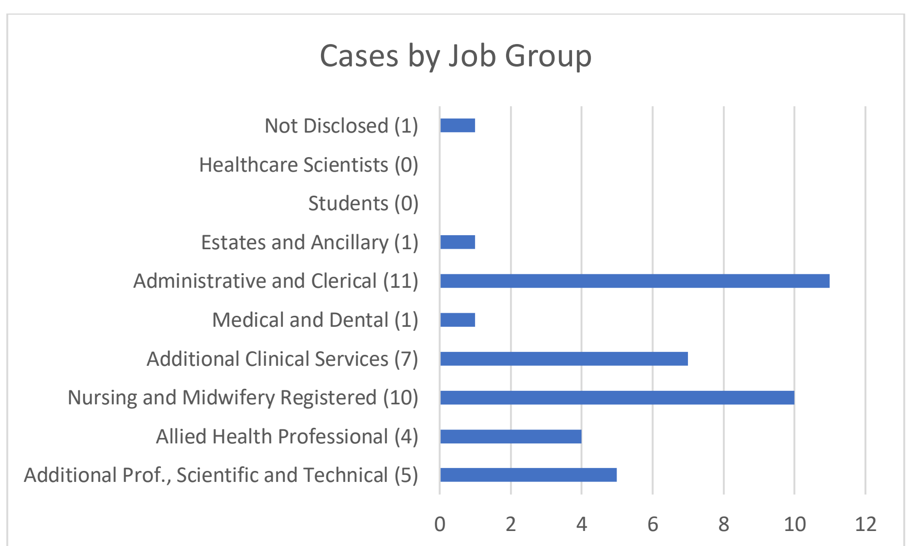
Concerns raised by Location



Location	Employee Count	Concerns	% of total staff

Dartford	718	12	1.60%
Gravesham	4		
Sevenoaks	44		
Tonbridge and Malling	179		
Maidstone	975	10	1.02%
Tunbridge Wells	85	2	2.35%
Swale	151	1	0.66%
Ashford	122		
Canterbury	719	2	0.27%
Folkstone and Hythe	102	2	1.96%
Dover	77	4	5.19%
Thanet	304		
Medway	280	4	1.42%
Unspecified	46		
Not disclosed		3	
Grand Total	**3806**	**40**	

Concerns raised by Job Group



Job group	Employee Count	Concerns	% of staff group
Add Prof Scientific and Technic	317	5	1.50%
Additional Clinical Services	955	7	0.73%
Administrative and Clerical	965	11	1.13%
Allied Health Professionals	229	4	1.74%

Estates and Ancillary	181	1	0.55%
Medical and Dental	216	1	0.46%
Nursing and Midwifery Registered	961	10	1.04%
Students	9	0	0%
Not disclosed		1	
Total	**3833**	**40**	

13. Why do staff use The Guardian Service?

The data available shows us that the principal reason for staff contacting GSL is to receive impartial support (40%), with verbal feedback being that staff feel encouraged the FTSUG is independent from the trust. Having someone impartial to speak to, without risk of judgement or reprisal can often be enough of an outlet for an individual to be able to resolve their concern.

A further 32.5% of staff report that they have raised their concern internally prior to speaking with the Guardian but do not feel they have been listened to. The figure offers an area for reflection and learning within the trust around individuals experiences of speaking up internally.

Reason	Cases	Percentage
Impartial Support	16	40%
Fear of Reprisal	6	15%
Believe they will not be listened too	5	12.50%
Have raised the concern before but not been listened too	13	32.50%
Other	0	0%
	40	100%

14. Detriment

There have been two reports of detriment during this period. One report of detriment as a result of raising a concern where an individual felt they had been treated without dignity or respect by a manager. As a result of this experience the individual engaged a formal grievance and resigned. The manager also resigned and so it was not possible to explore the claim of detriment further with the manager.

A second report of detriment was raised as a concern by an individual who had made a protected disclosure. This is being investigated formally by the trust and the Guardian will continue to support the individual whilst the investigation takes place.

The Guardian Service encourages staff to speak up whilst maintaining that they will not suffer any detriment.

The FTSUG spends a great deal of time with staff members creating a psychologically safe space for them to be able to share their experiences openly, reassuring them that if they do feel they have suffered detriment they must report this to the FTSUG immediately. This is part of the process and gives staff confidence they will continue to be supported.

Detriment is a major concern that is associated with speaking up and has a huge influence on FTSU culture. The FTSUG will not close cases without approval of the staff member raising the concern. The staff member is encouraged to keep the lines of communication with the FTSUG open throughout their case and following closure so that any cases of perceived detriment can be raised with the Trust and looked at.

15% of staff who raised concerns within this period contacted GSL through fear of reprisal.

15. Action taken to improve the Freedom to Speak Up Culture

1. The FTSUG regularly attends meetings, events and services to brief staff about The Guardian Service and the range of support that is available. This promotes staff getting to know who their FTSUG is and what to expect from the service.
2. The FTSUG liaises with the communications team to ensure that FTSU is accessible with up-to-date information published on the intranet helping to enhance the Guardians visibility.
3. The Guardian shares NGO bulletins with the Exec Lead and NED for FTSU.
4. The Guardian presents at all corporate inductions and has prerecorded content within the managers induction.
5. Monthly meetings take place with the Executive Lead for FTSU to review activity reports, outcomes, themes and learning. Quarterly meetings are also held with the NED for FTSU. No individual can be identified through activity reports and no individuals are identified without consent in any of these meetings.
6. The trust has launched their ‘It’s OK to say’ campaign which positively encourages open dialogue and speaking up.
7. The trust is implementing the new national standard policy for speaking up which all Trusts must have implemented by January 2024.
8. The Trust has made NHSE Speak Up and Listen Up training mandatory to staff and managers.
9. The new incoming CEO has launched a series of drop-in sessions for staff to speak up, share ideas and ask questions.

Visits and Briefings

The Guardian has engaged in 100 visits during this 6-month period. These visits are a combination of on-site promotions, virtual and face to face briefings to staff teams and meetings to promote the service. The Guardian aims to complete an average of 8 of these a month.

Activity	Visits
Promotion (On Site)	27
Site Briefing	24
Online Briefing	10
Site Meeting	6
Online Meeting	33
Total	100

16. Learning and Improvements

- The Guardian attends fortnightly peer discussions with fellow GSL Guardians. This ensures complex cases are shared with colleagues for learning and improvement and that the Guardian has access to peer support regularly.
- The FTSUG attends events and meetings arranged by the NGO to stay up to date with relevant information relating to FTSU. The FTSUG ensures they feedback to their trust all relevant information.
- As the Guardian Service has clients across several NHS Trusts, we are able to compare and contrast best practice approaches in respect to policy, service implementation, and organizational response.
- All FTSUGs are Mental Health First Aid Trained and have quarterly supervised meetings with a mental health first aid instructor as part of a 'Practice Enhancement Training' schedule.
- The FTSUG attends regional meetings with fellow FTSU Guardians to discuss developments in FTSU arrangements and access peer support.
- The FTSUG has regular 1-1s with their operations manager where they discuss best practice, caseload, and case management.

17. Comments & Recommendations

Status of previous comments and recommendations from period 2022/23 – This feedback has been collected from the Exec Lead for the period.

Communication – KMPT reports there being a lot of work around the employee voice at the moment with the imminent launch of Staff Council. Employee voice through addressing concerns is also part of the wider Trust Strategy.

Discrimination and Equality – An anti-racism programme has commenced with some development already in place for board, senior leadership, and HR. A wider reaching diagnostic to commence in January to support the understanding of KMPTs current state.

Management Training – FTSU training for managers is mandatory. A Leadership and development programme is currently being refreshed, including managers' inductions, specific programmes, and leadership learning zone. This will include management of ER cases.

Neurodiversity Awareness – The new Neurodiversity Staff Network group launched on 21st November 2023.

Investigations and Formal Processes – Central investigations team has now been recruited, training and ready to mobilise.

Comments and Recommendations for the first half year period 2023/24 (April to September).

1. **Handling of concerns relating to medical staffing** – consideration to review processes and responsiveness for the handling of concerns relating to medical staffing. To ensure that action is taken within reasonable timeframes and that there is no disparity between the handling of medical and non-medical staffing concerns.
2. **Communication around organisational change and transformation** – consideration to review the communication around organisational change and the support offered to teams going through transformation. Feedback from teams and managers has been that they don't feel informed and when asking for further information report not feeling heard.
3. **Support for managers** – To build on existing management programmes with consideration for focus on upskilling managers in compassionate leadership, communication skills and awareness, management style and impact, consistency and listening up. Support and training for middle managers to empower them to be able to inform and support teams through change, manage complex interpersonal relationships within teams and engage in difficult conversations. These are essential leadership skills which will support development of a positive workplace culture.
4. **Whistleblowing and detriment** – to review how the trust records and supports those who have made a protected disclosure and to investigate reports of detriment.
5. **Early Resolution Policy** – Since being published it has been reported that there has been a lack of communication and training around the new policy. For this policy to become effective and for those who engage it to have a positive experience it is a recommendation that the trust prioritise a communication and training initiative around this to ensure consistent use of the policy and best practice.
6. **Work Related Stress** – Feedback from cases has been that individuals don't feel supported when they experience work related stress, with their perception being that the trust does not fully explore what led to the stress to mitigate any future experience. Recommendation to review processes for supporting staff with work related stress including monitoring of situations leading to work related stress to mitigate sickness absence and resignation.
7. **Pastoral Support** – Pastoral support has been raised as a recurring theme within cases. It is a recommendation to ensure sufficient resources and clear expectations for pastoral support for those undergoing a formal process or those on long term sickness absence due to work related stress.
8. **Workplace Incivility** – Management and behavioural issues continue to be key themes within cases including incivility in the workplace. Consideration for a trust wide initiative into compassionate communication and respect. Inclusive of communication towards both patients, colleagues, and compassionate leadership skills.
9. **Consistency within formal processes** – A recurrent theme within cases has been a lack of consistency across formal processes – this includes timeframes, practice, and feedback delivery. Although there is the new central investigations team in post there will still be processes which fall outside of this team. Consideration to explore how consistency can be achieved and maintained across internal processes is recommended.
10. **Follow Up training for senior leaders** – To consider making the NHSE Follow Up FTSU training for senior leaders mandatory to promote all elements of the speaking up experience and process within KMPT.
11. **Board reflection and planning tool** – for the board to collaborate with the Executive Lead for FTSU; to complete the NHSE Board Reflection and Planning tool at least once every two years to identify the trusts current position on FTSU and high-level actions for the organisation.
12. **Action plan** - The FTSU Guardian remit is to ensure the Trust has an action plan in place to review and/or take forward any comments/recommendations identified within the FTSU board reports.

It is recommended that the Executive Lead establish this action plan with the board and monitor progress with the FTSUG during monthly meetings.

18. Staff Feedback

- Thank you so much for all of your support and help during this case and after. I have highly valued yourself and the Guardian Service.
- Since speaking to yourself, it was managed efficiently and effectively. I actually started to feel heard with visible actions. I will always remember and be grateful for your service.
- My journey has not been smooth, but at every step, the guardian has been informative, polite, respectful, very kind to my needs and at times a needed friend.
- I have been involved in a very complex situation and have really valued Rebecca's advice and support when I have been under a lot of stress.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25 January 2024**
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 covers a very broad agenda across the breadth of the Trust's work. It will therefore continue to work with other committees to minimise duplication while ensuring good communication with them. Some potential for duplication of work with the Workforce and Organisational Development Committee (WFOD) was identified for further discussion.** • **The Committee had only limited assurance from the Quality Risk Register relating to three 'extreme' risks and six 'high' risks deemed 'poorly controlled'. Also, the need to manually extract data for the report from InPhase meant full action data on wider risks was unavailable. Work is underway to improve the reporting process.** • **The committee acknowledged significant improvements and progress made against the Participation and Involvement Strategy. However, feedback was given that more work needed to be done to define how the success of the Strategy is measured. In addition, the Committee highlighted the need to ensure the engagement pool is more diverse and reflective of the population KMPT serves.** • **The committee received an update on suicide prevention, noting that CAMS (Collaborative Assessment and Management of Suicidality) training will be rolled out to over 800 staff and Community Mental Health Framework partners shortly.** • **The committee noted the Patient Safety Incident Response Framework (PSIRF) must be introduced across the Trust by the national deadline of 1st April 2024. Work is ongoing to ensure staff are engaged with the new process.** • **Noting the statistic that "a KMPT staff member is assaulted and requires A&E or First Aid treatment every 2.7 days" the Committee looked forward to receiving future assurance that the initiatives to reduce violence and aggression are bearing fruit.** • **The committee recognised the important work being undertaken to implement the 'Right Care, Right Person' approach, and the importance of working closely on this with system partners, including South East Coast Ambulance Service.** • **The Committee received an update on Psychology Practice Waiting Lists and recognised the plan in place to eradicate this.** • **The Committee received and noted the Mortality Report and the Guardian of Safe Working Hours Report. The Committee did not raise any concerns for either report.**

Items referred to other Committees (incl. reasons why)
No items were referred to other Committees, though further consideration will be given to whether some items currently covered by the Quality Committee could be more appropriately considered elsewhere.

The Quality Committee was held on 16th January 2024. The following items were discussed and scrutinised as part of the meeting:

1. Quality Risk Register
2. CQC Updates
3. Participation and Involvement Strategy
4. Suicide Prevention
5. Patient Safety Incident Response Framework
6. Immediate Life Support and Basic Life Support Training Compliance
7. Violence and Aggression (including the Safer Services Strategy)
8. Psychology Waiting Lists
9. Right Care, Right Person
10. Quality Digest
11. Quality Impact Assessments
12. Mortality Report
13. Guardian of Safe Working Hours

The Board is asked to:

1) Note the content of this report.

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

2.1 The Trust Wide Serious Incident and Mortality Review Panel (TWSIMRP) meets once a week to review all mortality incidents reported on Inphase. The membership has been consistent and includes Directorate leads, Information Governance, physical health, medical input and subject matter experts as necessary.

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

3 ANALYSIS OF INFORMATION

3.1 In Q3, a total of 567 mortality incidents were reported on InPhase. The graph (1) below shows the figures relating to mortality that have been reported since October 2022. This includes natural causes, expected, and unexpected deaths of patients. When data is compared to the previous quarterly mortality report, there has been a 25% decrease in mortality reported incidents (755 reported in Q2 2023/24). When comparing to the Q2 report, Q2 mortality figures are now shown as 755 (compared to 774 in the previous report). This is due to a number of incident duplicates identified by the Inphase team.

3.2 Although the mortality figures have decreased, the figures are still higher when compared to previous quarters. This is due to the historic death project that has been ongoing for a number of months. More detail is included within this report (page 14).

3.3 The number of STEIS reported mortality incidents in Q3 was 8. This compares to 12 in Q1 2023/24. The majority were for East Kent, which is the same as previous reports.

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

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

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

Graph 1 Mortality reported cases

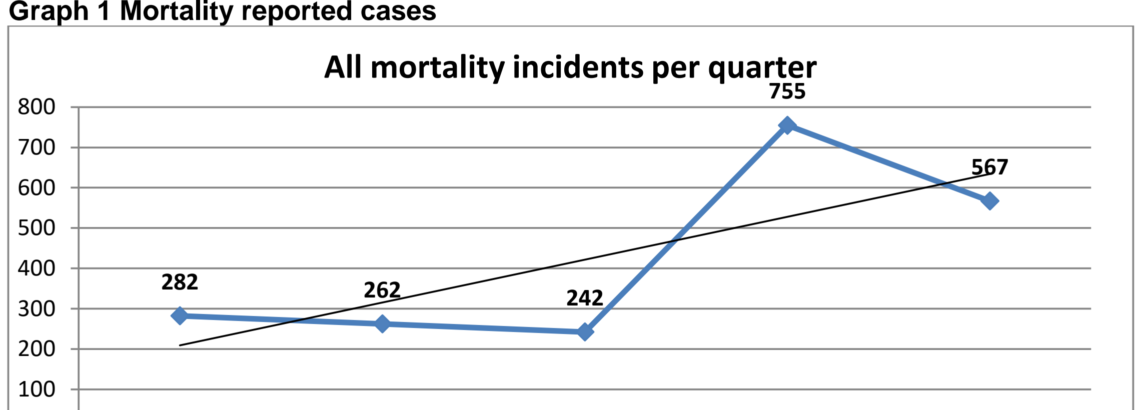


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Total
Suspected or actual suicide	2	3	4	1	6	9	10	7	3	6	4	9	5	69
All Deaths reported on Datix / InPhase	90	125	78	59	74	78	90	87	128	540	231	160	176	1916

3.6 Graph (1) shows all mortality incidents reported on InPhase while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q3 2023/24, 3.1% are reported as suspected or confirmed suicides. This compares to 1.8% reported in Q2 2023/24. The percentage change is expected given the overall mortality incidents reported. Suspected suicides have slightly increased this quarter (18 compared to 16 in Q2), with a third of these being STEIS reported.

3.7 It is likely that our suicide figures may appear to be higher in recent quarters. This is due to the Trust now being able to capture all suicides (including those not attributable to KMPT). We would expect to see figures levelling out in the next quarter or so. This will then enable us to determine our baseline figures.

3.8 The average number of deaths for the 13 months above was 147 per month. For this quarter (Q3), there was an average of 189 per month. This compares to 258 in Q2 2023/24. Numbers have fluctuated due to the historic death project work.

3.9 On review of the suspected suicide incidents over the 13 months, East Kent continue to report higher number of suspected/ confirmed suicides, with a total of 10 reported in Q3 2023.

4 Analysis by age and gender

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

Age Band	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
100+	1	1	0	0	0	**2**
90-99	40	46	33	152	94	**365**
80-89	81	81	76	303	238	**779**
70 to 79	61	61	39	159	122	**442**
60 to 69	27	24	26	50	42	**169**
50 to 59	31	14	29	44	24	**142**
40 to 49	14	14	15	24	21	**88**
30 to 39	18	16	15	14	20	**83**
20 to 29	7	5	9	7	5	**33**
10 to 19	2	0	0	2	1	**5**
Unknown	0	0	0	0	0	**0**
Total	**282**	**262**	**242**	**755**	**567**	**2108**

Table 3 Deaths reported by gender and age

	100+	90-99	80-89	70-79	60-69	50-59	40-49	30-39	20-29	10-19	Total
Male	0	38	113	71	23	18	14	15	5	1	298
Female	0	56	125	51	19	6	7	5	0	0	269

4.1 As expected, the majority of incidents relate to older people living in the community, in particular, those over 70 years of age, residing in residential or nursing homes and presenting with co-morbidities. Deaths of males tend to be higher each quarter, as reflected also in the Q3 data. This is usually the same for STEIS reported deaths, with there being higher numbers for males.

4.2 Three female deaths were reported on STEIS and are subject to a Root Cause Analysis investigation in Q3. This is consistent with the previous mortality report, indicating that STEIS reported deaths in females have not increased. All three incidents are believed to be suicide related, affecting a patient in their thirties, sixties and seventies.

4.3 Five male deaths have been STEIS reported and are subject to a Root Cause Analysis investigation, three are suspected suicides. The most common age category for STEIS reported male deaths was 50 to 59, the same as the previous two mortality reports.

4.4 As previous mortality reports would indicate, and confirmed in this report, the overall figures of mortality are higher in older adults. 84% of the total mortality incidents reported in Q3 2023/24 related to natural causes deaths of patients over the age of 65.

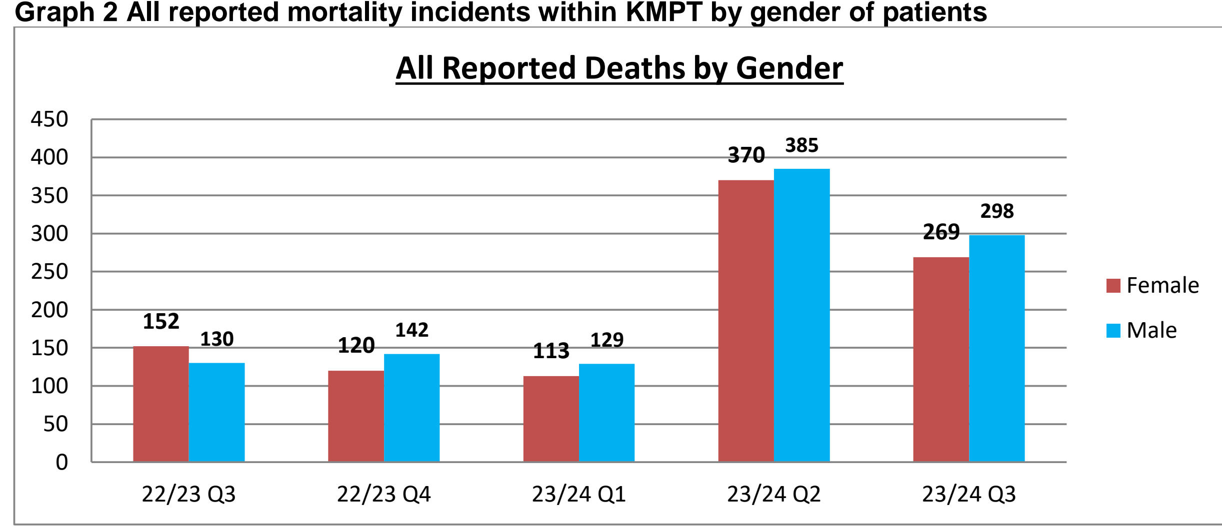
4.5 The number of deaths of patients under the age of 20 seems to fluctuate each quarter, with two deaths reported in Q2. In Q3, one patient, aged 16 is reported to have died. This is a death notification. The patient was known the Early Intervention in Psychosis Service (EIPS). He was discharged to children mental health services out of area, six months before his death. Circumstances around the patients death are not currently known, however no KMPT care or service delivery issues were identified.

4.6 Four patients who were autistic died in Q3. Three male and one female. Two patients were in their sixties, one in their seventies and one patient was in their forties at the time of their death. Two incidents were reported as part of the historical death project. Additionally, two patients died as a result of natural causes. No gaps in care have been identified.

4.7 There were five deaths of females in their thirties in Q3. Five patient deaths were reported to KMPT by the Coroner. Following a review of the care leading up to the patients deaths, five incidents found no care or service delivery issues, and deemed that the criteria for investigation was not met. One incident however, relating to a 31 year female, was declared as a serious incident, due to potential gaps in care when referred to the Liaison Psychiatry Service. The investigation is not yet complete.

4.8 24 mortality incidents were for patients in their fifties. Six were historic deaths. Two (not historic deaths) have been declared as a serious incident and reported on STEIS. Both patients were male and under the care a CMHT within the East Kent Directorate.

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



4.9 In Q3, the 18 cases of suspected suicide by age and gender were as follows in table 5.

Table 4 Suspected suicides by age and gender

Age	Male	Female
10 – 19 years	0	0
20 – 29 years	1	0
30 – 39 years	6	2
40 – 49 years	2	0
50 – 59 years	2	1
60 – 69 years	0	1
70 – 79 years	2	1
80 – 89 years	0	0
90 – 99 years	0	0
Total	**13**	**5**

4.9.1 18 suspected suicides were reported in Q3 2023/24, compared to 16 (recorded as 14 in the Q2 report, but as InPhase is a live reporting system, figures are often subject to

change). Previous reports usually align with the national data in that middle-aged males between 40- 54 are an outlier. Q3 however, is a different representation. Common age for both male and female was 30-39.

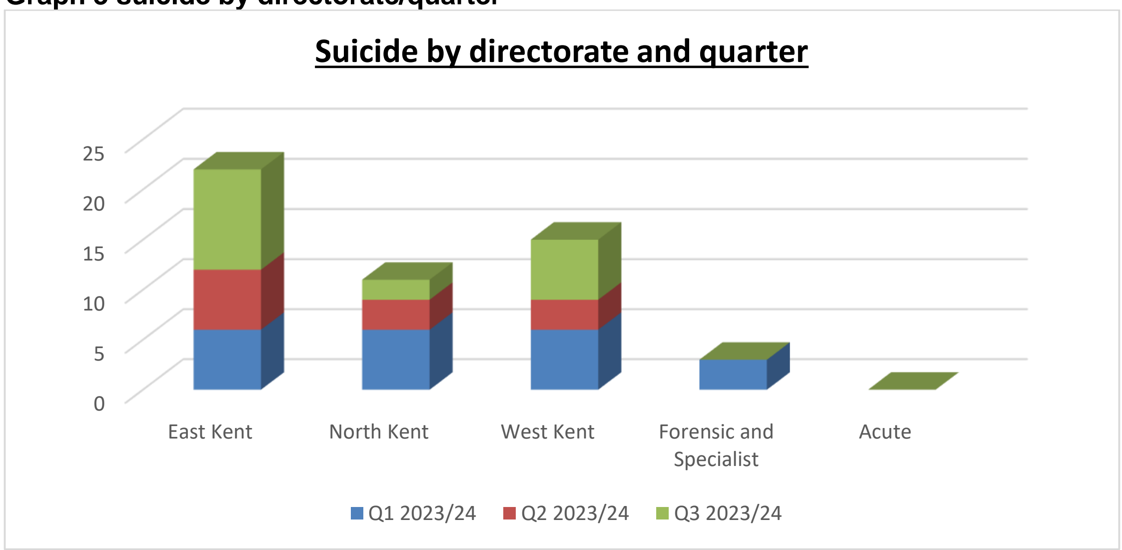
4.9.2 Looking at the suicide deaths reported this quarter, six were STEIS reported, due to concerns raised at initial review. East Kent were the highest reporters with a total of five.

Table 5 common ages for suicide by quarter

	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24	Q3 2023/24
Male	20-29 60-69	N/A	40-49 50-59	20-29 60-69	40-49 50-59	20-29 50-59	40-49 50-59	30-39
Female	40-49	50-59	50-59	N/A	N/A	30-39 40-49	N/A	30-39

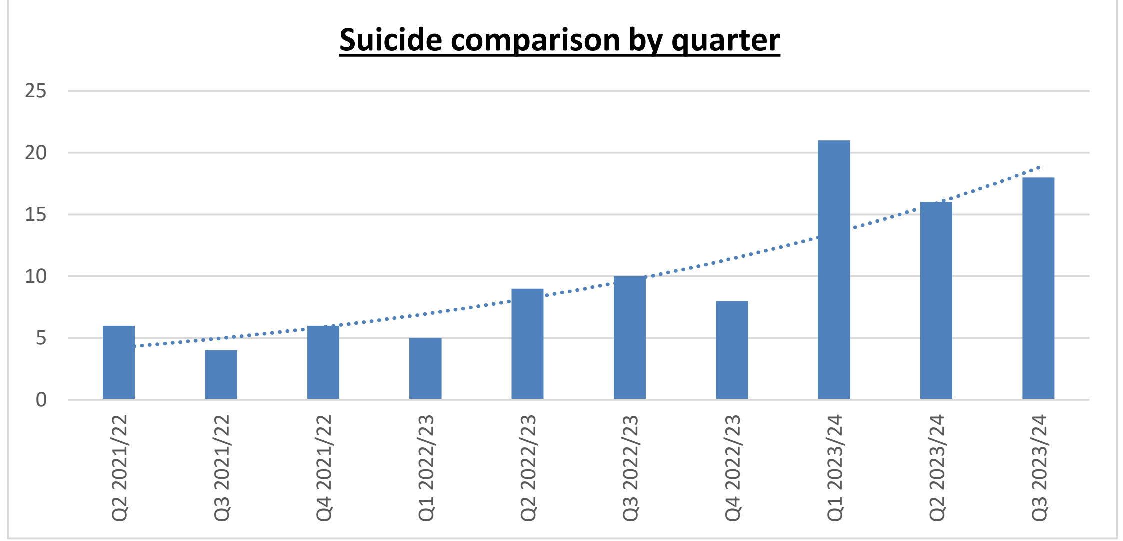
NB. Where N/A is stated, this either means that there were no suicides or there was no outlier for age in that particular quarter.

Graph 3 suicide by directorate/quarter



4.9.3 The Q2 and Q3 2023/24 mortality reports have identified that suicides in East Kent are higher, as shown in graph 3. Due to new ways the Trust records suicides in InPhase, we would expect to see the numbers increase. It would be less common to see suicides reported within the Acute directorate, due to this covering inpatient wards only. Both forensic and specialist and Acute services, did not report any suspected or confirmed suicides in Q2 and Q3 2023/24. East Kent STEIS reported 50% of the suspected/confirmed suicides within their directorate in Q3.

Graph 4 suicide reported by quarter



4.9.4 As expected, (due to new ways of reporting) suspected/confirmed suicides have been higher in the 2023/24 financial year compared to 2022/23. Suspected/confirmed suicides reported in Q3 have slightly increased.

5.0 Mortality review by ethnicity

Table 6 Deaths by ethnicity

	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	23/24 Q3	Total
Asian or Asian British - Any other Asian background	2	0	1	0	3	6
Asian or Asian British - Indian	0	1	1	0	4	6
Bangladeshi	0	0	0	2	0	2
Black, African, Caribbean or Black British – African	3	1	2	3	0	9
Mixed or Multiple groups - White and Asian	2	2	0	0	1	5
Mixed or Multiple groups - Any other mixed or multiple ethnic background	1	4	2	3	1	11
Mixed white and black African	0	1	1	0	0	2
Not stated / Unknown	22	30	28	175	81	336
Pakistani	0	0	0	1	0	1
White - British	249	253	207	563	471	1743
White - Irish	2	2	0	0	0	4
White - Any other White background	1	5	0	8	6	20
Total	282	299	242	755	567	2145

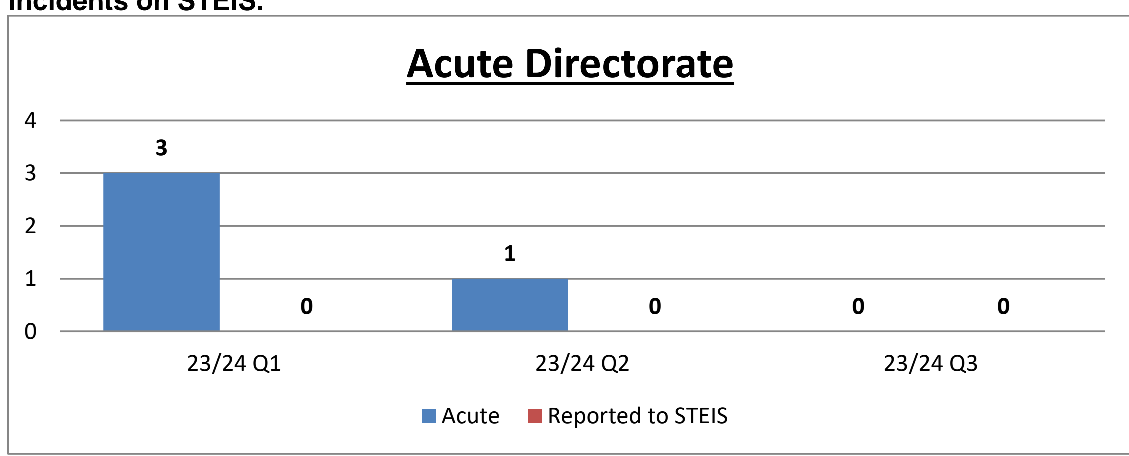
5.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British. On reviewing the ethnic minority deaths, nine were reported, compared to seven in Q2 2023/24. Six were reported as part of the historic death work. No gaps in care have been identified, and appear to be a result of poor physical health/natural causes.

5.2 Of the mortality incidents reported on InPhase, during Q3 2023/24, 14% had no ethnicity recorded. Recent and ongoing themed reviews (mapping health inequalities and self-harm audit) have identified poor recording of demographics in RiO. Work is ongoing via a digital transformation project to improve this.

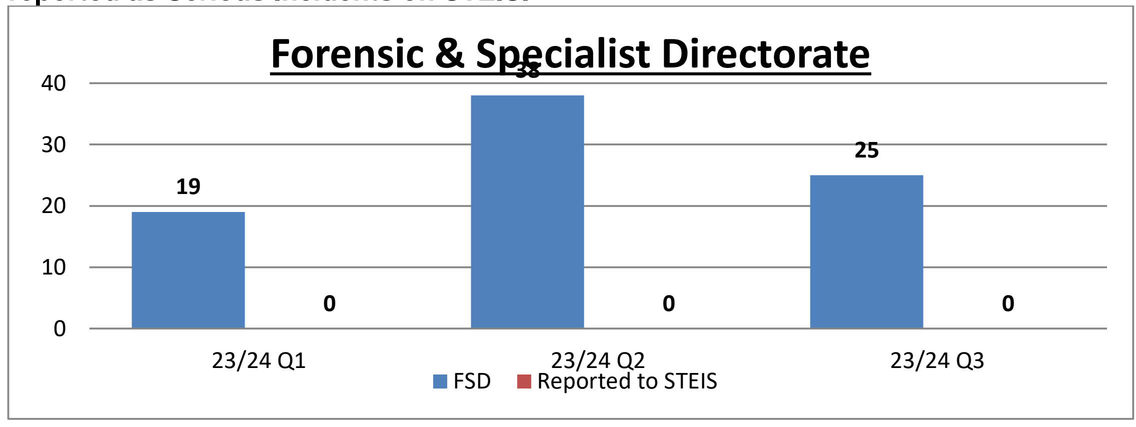
6 Serious Incidents and LeDeR cases

6.1 The following graphs (4 to 8) show the mortality incidents reported for the period 01/04/2023 to 31/12/2023 by Directorate. All mortality related serious incidents are subject to Root Cause Analysis investigation as per current national framework and KMPT policy.

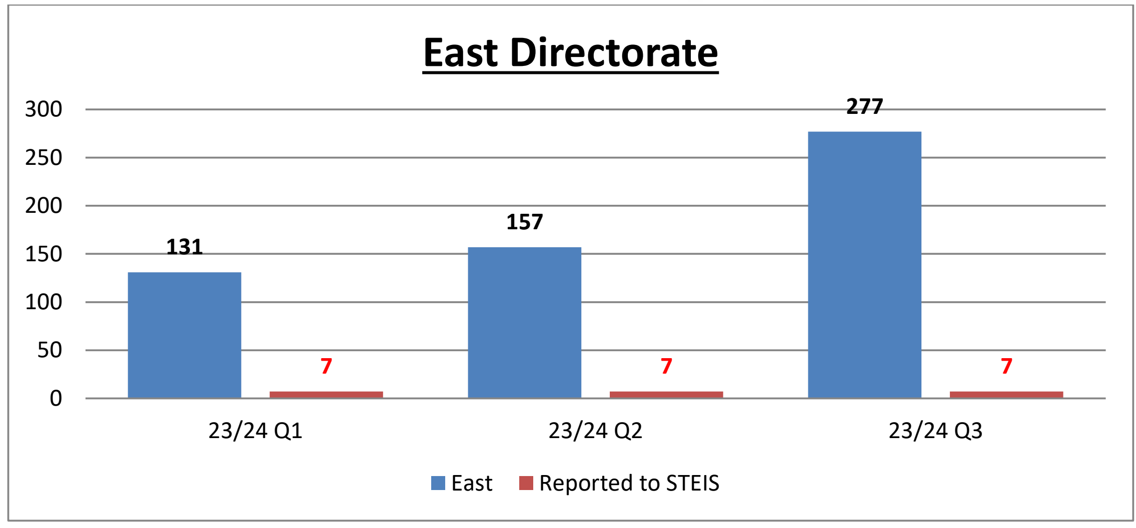
Graph 5 Mortality by Acute Directorate and numbers of those reported as Serious Incidents on STEIS.



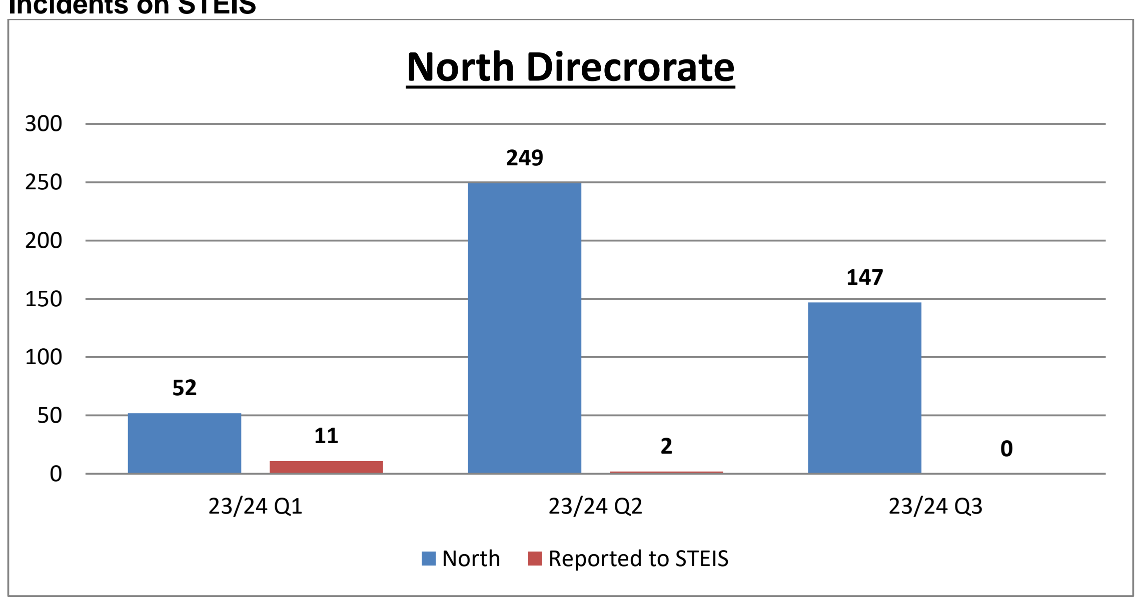
Graph 6 Mortality by Forensic and Specialist Directorate and numbers of those reported as Serious Incidents on STEIS.



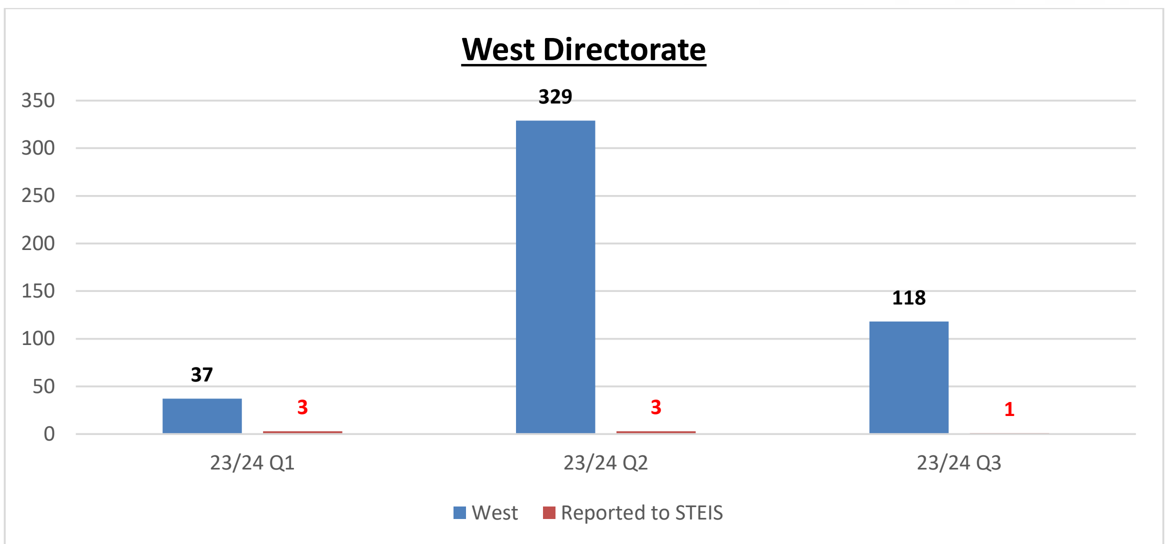
Graph 7 Mortality by East Directorate and numbers of those reported as Serious Incidents on STEIS.



Graph 8 Mortality by North Directorate and numbers of those reported as Serious Incidents on STEIS



Graph 9 Mortality by West Directorate and numbers of those reported as Serious Incidents on STEIS.



6.2 A total of eight mortality serious incidents were reported in Q3 2023/24, compared to 12 in Q2 2023/24. The percentage of serious incidents compared to the overall mortality in Q2 is 1.4%. This compares to 1.5% in Q2 2023/24.

Graph 10, Quarterly mortality/STEIS percentage

Quarterly mortality/ STEIS percentage

Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24	Q3 2023/24
4.70%	4.20%	3.00%	4.00%	8.00%	9.80%	6.80%	8.70%	1.50%	1.40%

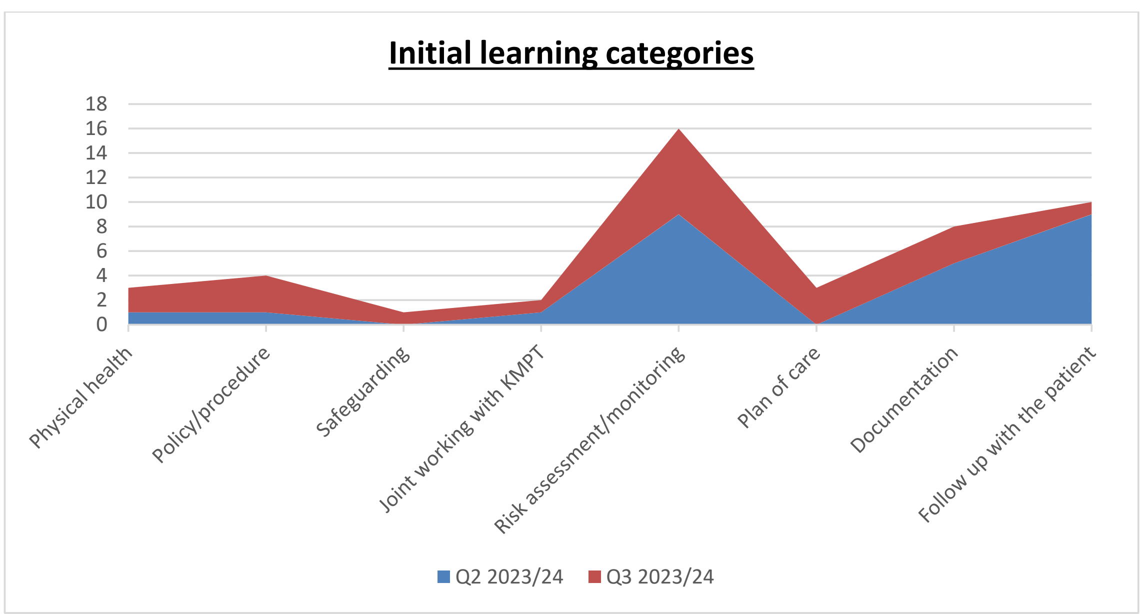
6.3 In reference of graph 10, we would expect to see lower percentages of STEIS reported incidents in Q2 and Q3, given the overall increase in mortality incidents reported. However, STEIS reported deaths have decreased since Q1 (where a total of 21 were reported).

6.4 On review of the eight Serious Incidents relating to mortality that were reported on STEIS in Q3, six are suspected/confirmed suicides, this is similar to the previous quarter figures.

6.5 The remaining two STEIS reported incidents are where the circumstances around the death are not known, but gaps in care have been identified. One of which was reported to KMPT Legal services by the Coroner.

6.6 Initial learning from the STEIS reported cases

Graph 11, Learning categories for serious incidents relating to suicide and unexpected deaths



6.6.1 A review of the initial learning for STEIS reported incident has been undertaken. The findings have been compared to against the Q2 initial learning categories (Graph 11). As shown, there are some consistencies some of the learning points identified, such as:

- Risk assessment and monitoring and
- Documentation.

6.6.2 Risk assessment and management

The areas of learning included:

- Consideration of KMPT ward admission/ MHA assessment
- Physical health issues not considered in the risk assessment
- Apparent lack of exploration of concerns raised by family
- Newly qualified staff holding high risk patient
- Delay in discussion at RED Board
- LPS assessment offered instead of full assessment
- Exploration of reason for call to the crisis line

Commonly, there is a theme around exploration and assessment of risk. Positive steps are being taken by the Trust to improve the risk assessment documentation and staff training (CRAM and CAMS). The changes will enable the trust to align with NICE guidance self-harm: assessment, management and preventing recurrence[1].

6.6.3 Documentation

Learning relating to documentation is a common theme identified in thematic reviews and serious incident investigations. Most issues relate to task factors (high workload/capacity).

[1] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

Issues found in STEIS reported incidents this quarter, correlate with care plans, core assessments and risk assessments not being updated.

6.6.4 Policy and procedure

Three incidents identified a lack of adherence to a policy or protocol. These included:

- Staff absence policy
- Co-occurring conditions joint working protocol
- Kent and Medway Mental Health Crisis Line (KMMHCL) SOP

These will be explored further over the course of the serious incident investigation, and as part of the terms of reference set.

6.7 In Q3, eight patients had a diagnosis of a learning disability or autism. These were reported to LeDeR as per national guidelines for reporting learning disability and autism deaths. Four patients were autistic. Each incident was reviewed by the directorate and identified no care or delivery issues, therefore further investigation or review was not required.

7. STRUCTURED JUDGEMENT REVIEW LEARNING

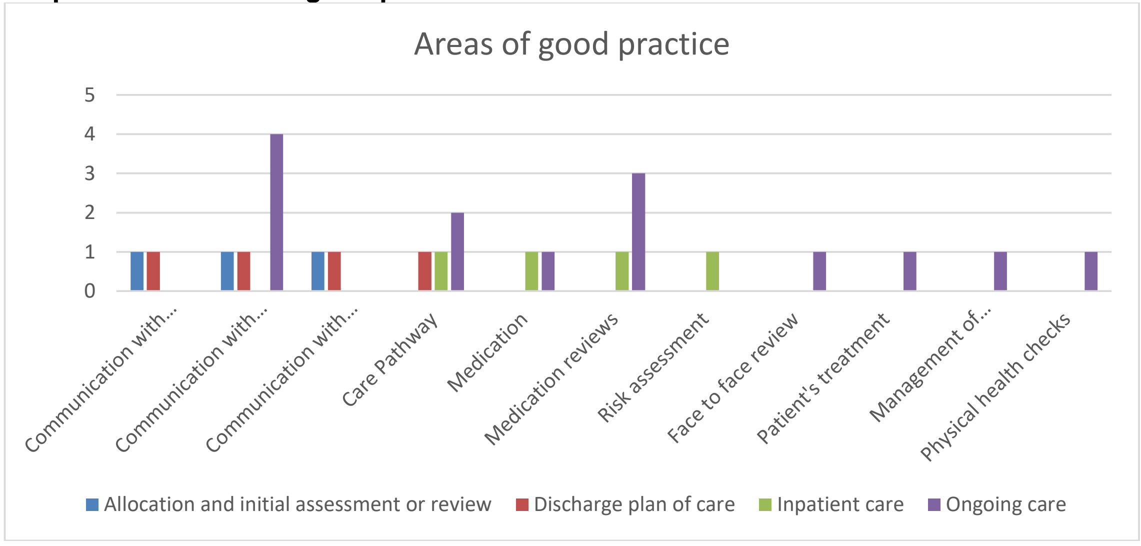
7.1 33 patient deaths met the criteria for Structured Judgement Review in Q3. Diagnosis (psychosis) during last episode of care, remains the most common criteria for SJR.

Although learning identified in SJR reviews, there have been no cases where the serious incident criteria was met. The following has been pulled from the completed SJR reviews.

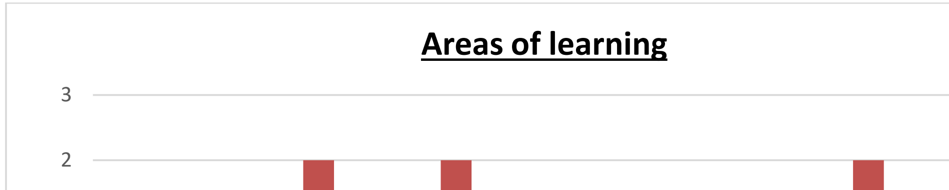
Table 7 SJR per directorate

East Kent	15
North Kent	9
West Kent	9
Forensic and Specialist	0
Acute	0

Graph 12 SJR areas of good practice



Graph 13 SJR areas of learning



7.2 Learning identified from Structured Judgement Reviews is shared with the directorates for team dissemination.

7.3 There are still improvements to be made to our current SJR processes. A job description is currently being shared with the doctors, with request for expression of interest. It is anticipated that two KMPT doctors will be appointed to support the SJR process, with support from the patient safety team. Implementation of PSIRF in the upcoming financial year will likely support this process.

8. OFFICE FOR NATIONAL STATISTICS

8.1 Courtesy of the Kent and Medway Suicide Prevention Programme team, the following summary has been extracted from the Office for National Statistics, following the release of the data- suicides in England and Wales: 2022 registrations[2].

8.2 The Office of National Statistics (ONS) publish suicide statistics annually. These are usually released in September, but in 2023 were released on Tuesday 19 December 2023.

8.3 The latest statistics include suicides in England and Wales that had 2022 registrations. It is important to note that given a death can only be confirmed as a suicide after a coroner inquest, so there is often a time lag of many months in suicide statistics. Therefore, while these are the latest available official statistics, they only cover up to the end of 2022.

8.4 As graph 13 below shows, there has been a small increase in the Kent suicide rate (3 year rolling average per 100,000), and it remains above the national rate:

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

Graph 13 Kent and Medway Suicide Rates Compared to England

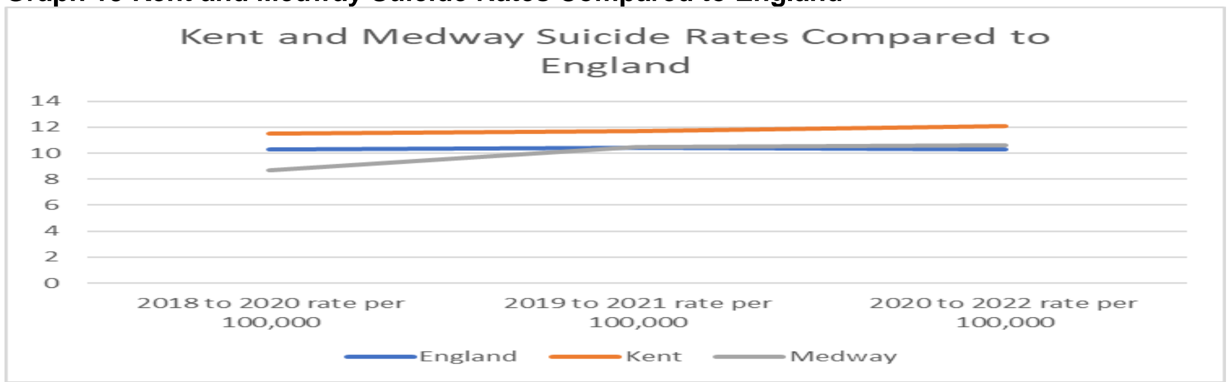


Figure 1. Kent Suicide Rate compared to England suicide rate (rate per 100,000, all people, 3 year rolling averages) Source - Suicides in England and Wales by local authority - Office for National Statistics (ons.gov.uk)

8.5 While any increase is very disappointing, the above Figure shows that there has not been a dramatic or substantial increase in the either the local or national suicide rates during the main COVID years of 2020 and 2021, or the cost of living crisis which gained widespread attention from 2022. This is contrary to the concerns of many at the time, when the mental wellbeing of the whole population was being severely tested leading to increased demand on mental health services.

8.6 Analysis at district level paints a varied picture. The 3 year rolling average has decreased since the previous rolling rate in a third of Kent districts, as Figure 2 shows below. Most of these decreases are notably larger than the national decrease of 0.1 between 2019 to 2021 and 2020 to 2022.

8.7 On the other hand, the majority of districts have seen an increase. The steepest of these have been in Ashford and Swale. Ashford has the highest three year rolling average per 100,000 in the latest data, but Swale has seen the biggest increase from the 2019-2021 rate and even bigger on from the 2018-2020 rate.

Table 8 rates of suicide in each district

District	2020 to 2022 rate per 100,000	2019 to 2021 rate per 100,000	2018 to 2020 rate per 100,000
Ashford	**15.1 (↑2.0)**	**13.1**	**10.9**
Canterbury	**10.3 (↓1.8)**	**12.1**	**12.9**
Dartford	**8.7 (↑1.4)**	**7.3**	**11.0**
Dover	**14.9 (↑1.2)**	**13.7**	**13.0**
Folkestone and Hythe	**11.8 (↑0.3)**	**11.5**	**12.6**
Gravesham	**10.4 (↓0.2)**	**10.6**	**12.3**
Maidstone	**11.1 (↓2.0)**	**13.1**	**11.5**
Sevenoaks	**11.3 (↑0.1)**	**11.2**	**8.7**
Swale	**13.4 (↑2.9)**	**10.5**	**8.6**
Thanet	**13.4 (↓1.1)**	**14.5**	**15.7**
Tonbridge and Malling	**13.8 (↑1.4)**	**12.4**	**10.9**
Tunbridge Wells	**10.2 (↑0.8)**	**9.4**	**11.3**

Figure 2. Suicide Rate per Kent district (rate per 100,000, all people, 3 year rolling averages) Source - Suicides in England and Wales by local authority - Office for National Statistics (ons.gov.uk)

8.8 The latest ONS report will be discussed at the upcoming Kent and Medway Strategic oversight board meeting, due in February 2024. KMPT will continue to work with the Kent and Medway Suicide Prevention Programme regarding the monitoring of suicide numbers and joint preventative work.

9 HISTORIC DEATH WORK

9.1 In Q3 2023/24, 270 Death Notifications (historic death records) were reported. this compares to 460 reported in Q2. There were no STEIS reported historic death records in Q3.

Table 9 historic deaths per directorate Q3

East	96
Forensic and Specialist	8
North	99
West	67

9.2 A review of historic death notifications has identified the following:

- 219 patients were of white British ethnicity
- Less than 10 patients were of ethnic minority
- 253 patients were over the age of 65 years
- One patient was 16 years old (known to EIP and transferred back to CAMHS out of area 6 months before death. Not open to KMPT services)
- One patient was a 21 year old male (discharged from CMHT one month before death)
- 133 were male and 137 were female
- 237 patients were open to older adult mental health teams, the majority of whom were on the memory pathway. A large number of these had highlighted that patients died prior to assessment of memory or diagnosis, (due to known delays with memory assessment waiting lists). Deaths seem to be mostly natural causes (including patients who lived in residential or nursing care).

9.3 As part of the historic death project, deaths reported on the National spine are compared to against the deaths recording on InPhase. Directorates now receive a weekly report from the business intelligence (BI) team, detailing the number of deaths that are not registered on InPhase.

The weekly report as of 4 January 2024, for unmatched deaths was as follows:

Current numbers unmatched to InPhase by directorate;

These deaths may be recorded on InPhase, and have different spellings/typos etc. we just can't match them exactly between the two systems.
This is a live data set and some deaths are recent so InPhase may be updated by the time these are reviewed.

Number of Patient Deaths	Month of Death												
No Match by Directorate	2017-10	2022-12	2023-01	2023-04	2023-05	2023-06	2023-08	2023-09	2023-10	2023-11	2023-12	2024-01	Grand Total
No Match	**1**	**1**	**1**	**1**	**1**	**2**	**3**	**3**	**5**	**12**	**39**	**2**	**71**
Forensic and Specialist								1		1	4		6
East Kent			1		1	2		1	1	3	16	1	26
North Kent	1						1		2		4		8
West Kent				1			2	1	2	8	15	1	30
Non KMPT Activity		1											1
Grand Total	**1**	**1**	**1**	**1**	**1**	**2**	**3**	**3**	**5**	**12**	**39**	**2**	**71**

9.4 Deaths unmatched with InPhase will continue to be identified via BI and shared via the weekly report. The directorates have worked hard to report and review the backlog of historic deaths in Q2 and Q3, only one incident was STEIS reported.

9.5 It will be expected that we will start to understand what the Trusts baseline is for rates of mortality within each quarter, over the next financial year. This is due to the backlog of deaths now being cleared, and with new ways of identifying and reporting patient deaths in a timelier and more robust manner.

9.6 The mortality review manager and quality assurance director will meet with the BI and RiO team in Q4, to review the effectiveness of the process. Any actions will be feedback through Governance and operational leads and TWPS.

Title of Meeting	People Committee (PC)
Meeting Date	25th January 2024
Title	People Committee Chair's Report
Author	Venu Branch, Chair of People Committee
Presenter	Venu Branch, Chair of People Committee
Executive Director Sponsor	Sandra Goatley, Chief People Officer
Purpose	Noting

Matters to be brought to the Board's attention

Workforce Race Equality Standard (WRES)
The Committee noted the WRES Report, which provided an update against the 2023 WRES action plan and metrics for KMPT.

It was reported to the Committee, that BAME representation in the workforce has increased to 25.0%, this indicator has exceeded in KMPT's target of 22%.

10.8% of BAME staff stated they had personally experienced discrimination, this has slightly improved from 12.6% in 2021/2022. There is a task and finish group in place to reduce violence and aggression incidents of which a proportion are racially motivated.

There has been a decrease in BAME applicants being appointed from shortlisting in 2022/2023. There are specific target actions which include Talent Management, reintroducing inclusion ambassadors on recruitment panels and ICB Debiasing Recruitment Training.

It was reported to the Committee there is ongoing work and a Disciplinary Project Group has been established to look at BAME staff entering into a formal disciplinary process, as this has significantly increased. Work will include working closely with the Central Investigation Team (CIT) to try and understand the root causes and process as well as a deep dive into reasons/comparisons.

Workforce Disability Equality Standard (WDES)
The Committee noted the WDES report which provided an updated against the 2023 WDES action plan and Metrics for KMPT.

- It was reported staff with disabilities experiencing harassment, bullying or abuse from patients has decreased to 31.6%.
- Staff with disabilities experiencing harassment, bullying or abuse from managers has decreased to 11.3%
- The figure for staff experiencing harassment, bullying or abuse from colleagues had increased from 17.5% last year to 17.1%
- Staff with disabilities reporting last time they experience bullying or harassment at work also increased to 64.7%.
- The proportion of staff who have reported a disability is currently 7.33%, however the staff survey indicates 31.6% of staff having a disability. KMPT has 19.89% of staff declaring an unknow status.

KMPT has recently launched a new Neurodiversity Network to work alongside the existing Disability and Wellness network (DAWN). This will help raise awareness and ensure a safe place for staff with Neurodivergent conditions.

Violence and Aggression deferred to March's People Committee
This remains a priority and is being addressed through the Trust Strategy, Quality Account Priority and CQUIN and is one of Sheila Stenson's, CEO, top priorities. It was decided by the Chair for this

paper to be deferred to March's People Committee to allow a suitable time slot to enable a more in-depth discussion.

Although the report was deferred to March's People Committee, the Chair did want the Board to know on the reporting of Immediate Life Support and Basic Life Support Training, as this is a concern. The Chief Nurse informed the People Committee due to the frequency of the training this will always be an issue. One of the biggest challenges is being able to free up staff to attend this training and prioritising on the day.

People Strategy 2024 - 2025
The Committee was informed the Work of Protection Act 2023 would be reflected in the People Plan for 2024 -2025. It was also agreed that the Employee Value Proposition and the values refresh will align with the Communications work and be postponed in the plan to 2024/25.

West Kent Long Term Recruitment
The Committee received a report on the efforts being made in West Kent to improve recruitment in West Kent. The Committee thanked the staff for their hard work, tenacity and innovation in addressing a pressing issue and urged the team to share their learning.

Change of Chair
It was noted, People Committee for January 2024 would be Venu Branch's last meeting as Chair and as of March 2025, Kim Lowe, Non- Executive will take over. The Committee offered their sincere thanks and gratitude for the hard work which the Chair has undertaken throughout and passed on their best wishes for the future.

Items referred to other Committees (incl. reasons why)

- None

The following other items were discussed for assurance as part of the meeting:

- Support Service – Digital & Performance Presentation
- Support Service – Estates and Facilities Presentation
- People Risk Report
- Non-Medical/Multi-Professional Clinician Recruitment Report
- West Kent Long Term Recruitment Report
- HR Policies and Procedures
- New Risks Report
- Job Plans Internal Audit Report (Referred by Audit & Risk Committee) This will be deferred to March's People Committee
- PC Workplan

Title of Meeting	Board of Directors (Public)
Meeting Date	25th January 2024
Title	Mental Health Act Committee (MHAC) Report
Author	Sean Bone-Knell, Chair of MHAC
Presenter	Sean Bone-Knell, Chair of MHAC
Executive Director Sponsor	Dr Afifa Qazi, Chief Medical Officer
Purpose	Assurance

Matters to be brought to the Board's attention
• MHA Compliance and Monitoring • Bi-Annual DoLs Audit • Service Level Agreement (SLA) • S17 Leave

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

MHAC met on 15th January 2024 to consider:

Significant assurance:

- MHLOG Report
- Chief Medical Officer's Report
- CQC MHA Monitoring Review Report
- Associate Hospital Managers Report

Reasonable assurance:

- None

Limited assurance:

- Mental Health Act Compliance and Monitoring Report
- Bi-Annual DoLs Audit Report

MHA Compliance and Monitoring

Based on the numbers of patients admitted, the number of s132 rights not being read to patients is relatively low upon admission but improvement is still required. The whiteboard system on the wards is helping to ensure the s132 rights are being read, although some patients are too unwell on admission for them to receive these rights.

Bi-Annual DoLS Audit

The audit highlighted that some of the quality standards were compliant with three quality standards at 100%, but some required improvement and there was low compliance regarding the quality of the mental capacity assessments in relation to DoLS. Plans are in place to talk to staff members to ascertain the barriers and any system issues that could inhibit improving the quality of documentation to increase assurance.

Service Level Agreement

The Service Level Agreement (SLA) is now in place with East Kent Hospitals University NHS Foundation Trust. The implementation of the MHA training has commenced and ten sessions have taken place with further training scheduled for three times a month up until April 2024, when the need for any additional training will be reviewed with East Kent Hospitals.

S17 Leave

Digitalisation of S17 leave forms will ensure that the form will automatically be held on the patient records and will improve compliance. This is going to be piloted on Upnor Ward at Priority House in Maidstone for two months with the hope of this commencing in February 2024. Discussions are taking place regarding business continuity processes in the event of unexpected RiO downtime.