Kent and Medway NHS and Social Care Partnership Trust

AGENDA

Title of Meeting	Trust Board Meeting (Public)
Date	26th November 2020
Time	09:30 to 12.00 (including 15 minute break)
Venue	Boardrooms A & B, Farm Villa and video conferencing

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/20-21/105	1.	Welcome, Introductions & Apologies		Verbal	Chair	09:30
TB/20-21/106	2.	Declaration of Interest		Verbal	Chair	
PERSONAL STORY						
TB/20-21/107	3.	Liaison Psychiatry	FI	Verbal	AK	09:40
STANDING ITEMS						
TB/20-21/108	4.	Minutes of the previous meeting – 29/10/2020	FA	Paper	Chair	09:50
TB/20-21/109	5.	Action Log & Matters Arising	FN	Paper	Chair	
TB/20-21/110	6.	Chair's Report	FN	Paper	JC	10:00
TB/20-21/111	7.	Chief Executive's Report	FN	Paper	HG	
STRATEGY						
TB/20-21/112	8.	ICS accreditation submission	FA	Paper	HG/SS	10:10
TB/20-21/113	9.	People Strategy	FA	Paper	SG	
TB/20-21/114	10.	Integrated Care System Mental Health Improvement Board Update	FI	Paper	HG	
TB/20-21/115	11.	Recovery and Transform Update	FD	Paper	VB2	
OPERATIONAL ASSURANCE						
TB/20-21/116	12.	Integrated Quality and Performance Report – Month 7	FD	Paper	HG	10:30
TB/20-21/117	13.	Finance Report: Month 7	FD	Paper	SS	10:50
TB/20-21/118	14.	Chief Operating Officer's Report	FD	Paper	JMG	
TB/20-21/119	15.	Becoming a Non Racist Organisation (Black, Asian, and Minority Ethnic (BAME) Progress Update)	FI	Paper	HG	
TB/20-21/120	16.	Mortality Report (Quarter 2)	FN	Paper	MM	11:00
TB/20-21/121	17.	Integrated Audit and Risk Committee Chair Report	FN	Paper	PC	11:10
TB/20-21/122	18.	Mental Health Act Committee Chair Report	FN	Paper	VB	
TB/20-21/123	19.	Workforce and Organisational Development Committee Chair Report	FN	Paper	RA	
TB/20-21/124	20.	Quality Committee Chair Report	FN	Paper	AMD	
TB/20-21/125	21.	Finance and Performance Committee Chair Report	FN	Paper	MW	
CONSENT ITEMS						
TB/20-21/126	22.	Review of Standing Orders and Standing Financial Instructions	FA	Paper	HG	11:30
TB/20-21/127	23.	Register of Interests	FN	Paper	TS	

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

NHS
Kent and Medway
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TB/20-21/128	24.	Board Assurance Framework	FA	Paper	MM	
TB/20-21/129	25.	Any Other Business			Chair	
TB/20-21/130	26.	Questions from Public			Chair	11.50
	Date of Next Meeting: 28th January 2020					

Members:		
Dr Jackie Craissati	JC	Interim Trust Chair
Venu Branch	VB	Interim Deputy Trust Chair
Mark Bryant	MB	Associate Non-Executive Director
Tom Phillips	TP	Associate Non-Executive Director
Rod Ashurst	RA	Associate Non-Executive Director
Anne-Marie Dean	A-MD	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Interim Senior Independent Director)
Sean Bone-Knell	SB-K	Associate Non-Executive Director
Mickola Wilson	MW	Associate Non-Executive Director
Fiona Carragher	FC	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Helen Greatorex	CE	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Executive Medical Director
Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
Mary Mumvuri	MM	Executive Director of Nursing & Quality
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Communication
In attendance:		
Tony Saroy	TS	Trust Secretary (Minutes)
Kelly August	KA	Assistant Director of Communications
Apologies:		

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the meeting held at 1235 to 1307hrs on Thursday 29th October 2020
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Interim Trust Chair
	Venu Branch	VB	Non-Executive Director (Interim Deputy Trust Chair)
	Anne-Marie Dean	A-MD	Non-Executive Director
	Rod Ashurst	RA	Non-Executive Director
	Tom Phillips	TP	Non-Executive Director
	Sean Bone-Knell	SB-K	Associate Non-Executive Director
	Fiona Carragher	FC	Associate Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Associate Non-Executive Director
	Mickola Wilson	MW	Associate Non-Executive Director
	Helen Greatorex	HG	Chief Executive (CEO)
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CEO
	Mary Mumvuri	MM	Executive Director of Nursing and Quality
	Dr Afifa Qazi	AQ	Executive Medical Director
	Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
	Sandra Goatley	SG	Director of Workforce and Communications
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
Observers:			
Apologies			
	Mark Bryant	MB	Associate Non-Executive Director
	Catherine Walker	CW	Non-Executive Director (Interim Senior Independent Director)

Item	Subject	Action
TB/20-21/96	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, which was livestreamed. Apologies were received from MB and CW. The executive management team were at Farm Villa, the Non Executives dialled in on LifeSize. Paul Bentley, Chief Executive of Kent Community Health Foundation Trust, was welcomed as a guest. He had been invited to address the Board on item TB/20-21/101.	
TB/20-21/97	**Declarations of Interest** No declarations of interest were made.	
TB/20-21/98	**Minutes of Previous Meeting**	

Item	Subject	Action
	The Board **approved** the previous minutes as an accurate reflection of the meeting.	
TB/20-21/99	**Action Log & Matters Arising** The Board **agreed** the Action Log as it stood, save that: Action TB/19-20/146 – WFODC Report (FTSU activity profile and effectiveness) – Self-assessment for FTSU: Item to be postponed until November 2020.	
TB/20-21/100	**Chief Executive's Report** The Chief Executive's Report was received by the Board. The Board was updated that Board members were now able to make in-person site visits provided that the advice given by the Director of Infection Prevention and Control was observed. To this end, the Chief Executive has committed to making two in person visits per week and yesterday visited both The Grove in Ramsgate, and 111 Tonbridge Road in Maidstone. The Chief Executive noted the very focused approach taken by both houses, in ensuring the safety of residents, staff and visitors. The Board noted the Trust's successful application to become an early implementer for a new Maternal Mental Health Service. The Board noted that it was a good example of service-led business development by highly skilled and passionate staff. The Board **noted** the Chief Executive's Report.	
TB/20-21/101	**KMPT- Kent Community Health Foundation Trust (KCHFT) Memorandum of Understanding** Paul Bentley, Chief Executive of KCHFT, and Helen Greatorex, Chief Executive of KMPT spoke to this item. Further to its discussions in June and September 2020, the Board received a paper regarding the potential Memorandum of Understanding (MoU) between the Trust and KCHFT. The Board was updated regarding progress on the potential MoU and was informed that KCHFT's Board had agreed that such an agreement would be a positive initiative. There are three areas of focus for KMPT and KCHFT: o Dementia; o Neurodevelopmental pathways for adults; and o Physical health for learning disability and Serious Mental Illness. The Board was informed that these three areas would be where the two trusts could work in closer partnership delivering improvements in the care available in the system to service users. The Board reflected on the fact that many of KMPT's patients are also patients of KCHFT, both trusts used RiO to manage patient records and there was a significant overlap in the geographical area the	

Item	Subject	Action
	two trusts serve. The Board was taken through the example of joined up working in neurodevelopmental pathways for adults, which was recognised as a fragmented pathway at the moment. The two trusts have created a neurodevelopmental pathway model for commissioners to consider. That model reduces friction between the services KMPT and KCHFT provide respectively, allows for better delivery of care and reduces the risk of patients falling in the gap between service providers. The primary benefit of the MoU is the delivery of measurably improved care by the system for patients, over and above that which could be delivered by either trust on its own. It is not being driven by the need to save money, although the Board recognised that as a secondary benefit, money would be saved by the system as patients received timely local care rather than delayed care being delivered out of area. The Board reflected on the matters discussed and determined that development of an MoU would be beneficial. The Board **endorsed** the development of the MoU and asked that it receive the final draft for ratification at its November meeting. *Paul Bentley left the Board meeting.*	
TB/20-21/102	**CQC Update** Due to time constraints, this item was not discussed at the meeting. However, a CQC update paper is available in the Diligent Reading Room for Board members.	
TB/20-21/103	**Executive Assurance Committee Terms of Reference** The Board received the Terms of Reference for the Executive Assurance Committee. The Board noted the request for a change in the membership structure, the wider scope of Purpose and the formal delegation of business case approval to the Business Case Review Group (BCRG). The Board reflected on the composition of BCRG (which is led by SS and frequently joined by either MM and/or JMG) and noted that appropriate Quality Impact Assessments are being carried out. The Board **approved** the Executive Assurance Committee's updated Terms of Reference.	
TB/20-21/104	**Any Other Business** There was no Any Other Business.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 26th November 2020.	

Item	Subject	Action

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 12/11/2020

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN NOVEMBER 2020								
30/01/2020	TB/19-20/146	WFODC Report (FTSU activity profile and effectiveness)	CEO, SG and TS to allocate Board time for self-assessment in relation to Freedom To Speak Up	TS	Mar 2020	~~October 2020~~ November 2020	Self-Assessment exercise to be arranged with a range of Board members and Senior members of staff. Item to be closed as Board action.	Complete
24/09/2020	TB/20-21/82	Action Log & Matters arising (Recovery & Transform Work)	HG to share a table setting out which Committees have oversight over which aspects of Recovery and Transform programme. Table to be appended to the November Chief Executive's report.	HG	November 2020		Within Board pack	Complete
24/09/2020	TB/20-21/85	IQPR (Caring)	MM to include themed compliments within the Caring domain in the IQPR by November 2020.	JMG	November 2020		Within IQPR	Complete
30/07/2020	TB/20-21/63	Chief Operating Officer's report	TS to arrange for George Matuska to present Overview of Learning Disability and Autism position in Kent in October 2020.	TS	Oct 2020	November 2020	Board Seminar arranged for 26th November	Complete
ACTIONS NOT DUE OR IN PROGRESS								
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
24/09/2020	TB/20-21/85	IQPR (Responsive)	HG and JMG to discuss performance improvement plan with respect to the 4 week standard and 18 week standard, with Board to be updated in October 2020.	HG & JMG	October 2020		Update for Board has been scheduled	Complete
25/06/2020	TB/20-21/39	Patient Story – Simon Cook presentation re	Action: Chief Executive to update board on progress	HG	Oct 2020		Included within Chief Executive Report	Complete

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BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 12/11/2020

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
		KMPT Black Lives Matter	towards becoming an anti racist organisation					

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 26th November 2020**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Interim Trust Chair**
Presenter	**Dr Jackie Craissati, Interim Trust Chair**
Purpose	**For Information**

1. Introduction

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

- Meetings and Attendances; and
- Chair and NED Visits.

2. Meetings and Attendances

In addition to attending the usual system wide meetings, I have been discussing the importance of supporting the Mental Health Improvement Board with the Chief Executive; this Board provides an important opportunity to achieve our ambition for a really effective mental health pathway for local people; we will continue to report on this Board's agenda and progress over the coming months.

I have also embarked on a series of virtual visits to MPs across Kent & Medway, with six completed thus far. This is an opportunity to reach out and ensure that we are responsive to the concerns of the MPs' constituents. There are some themes emerging - concerning waiting times and the management of transitions between teams - that are known concerns, and which we need to resolve over the coming year.

3. Chair and NED visits

I am pleased to say that Board members had been able to recommence in-person site visits since August 2020. I am grateful to Mary Mumvuri, Executive Director of Nursing and Quality, for giving us advice and guidance as to how to carry out Covid-secure visits.

Interim Trust Chair Visit to Older Adults Community Team, Swale

This month I visited - sadly only virtually - our older adults community team in Swale; I was pleased to join the 'Red Board meeting' where the whole team meets to liaise and prioritise those service users of particular concern that day. As ever I was warmly welcomed and it was an informative and well run meeting.

As we chatted after completion of the business, we focused on the team concerns during this second period of lockdown. It is clear that an effective relationship with

social care is central to the smooth running of the pathway for older adults and there are some obstacles to achieving this; in the short term the team expressed concern for care home staff during Covid, who carry a considerable burden during periods of lockdown.

Where	Who
September 2020	
Britton House, Gillingham (Medway CMHT)	Venu Branch, Mikola Wilson
October 2020	
Community Rehab Unit in Swale	Kim Lowe
Bay Tree House	Peter Conway
Procurement Team	Catherine Walker

Venu Branch, Interim Deputy Trust Chair and Mikola Wilson's visit to Britton House on 29th September 2020.

Venu and Mikola visited Britton House in Gillingham on 29 September to view the new facility and hear about the work of Medway CMHT. A number of services are located or re-locating here including the CMHT, the Older Adults CMHT, and the Crisis Team. Sarah Hodge, Service Manager, was on hand to show us around.

We saw the new facilities and Sarah talked us through the treatment pathways for patients, the operation of the Depot Clinics and the IAPT work. We discussed the demographic context in Medway and the implication for services. Sarah highlighted pressure points as the relationships with GPs, particularly over referrals, the wait times from referral to treatment and the lack of system wide co-ordination for those who frequently need services or who return to KMPT services. Venu tested the appetite for further working with third sector partners which was received positively.

Catherine Walker, Senior Independent Director - judging the KMPT Unsung hero award 2020 – 14 October 2020

I spent the best part of a day reading through the nominations for the KMPT 2020 award for Unsung Heroes as category judge. 48 brilliant individuals or teams demonstrating brilliant care by brilliant people. I learned a lot more about how colleagues have worked above and beyond in these tricky times. I was humbled by what I read. I would have gladly given a prize to all 48.

Kim Lowe's visit to Community Rehab Unit in Swale on 16th October 2020

I visited the Community Rehabilitation unit in Swale. I was met by Heather Penn, the operational lead for the service across East Kent. The unit comprised of a block of 8 well furnished, modern flats in a residential area of Sittingbourne. I learned that the service provides vital 'middle ground' support for clients who require extra clinical support and can alleviate the need for people to go back into costly acute hospital situations.

I also met Angie, one of the Nurse Practitioners, who took me through her journey to become a qualified NP. I was taken aback by the sheer joy and high level of job satisfaction she obtains from seeing people recover because of what she does. Both Heather and Angie demonstrated great team ethics, a love of their job and support for each other.

The take always for me were:

- To understand the Nurse Practitioner role more closely to see if we can expedite that journey if possible. Hierarchical bands, London pay weighting and access to courses were all discussed.
- To understand why this service only exists in East Kent and not in the West. As the business case for this service feels very strong.
- To understand how the relationships between housing associations/ local authorities could be strengthened even further, as finding suitable 'move on' housing can cause blockages. A point also raised at Rivendell for their residents.

Catherine Walker's visit to the Procurement Team, Maidstone on 20th October 2020

I visited our KMPT procurement team on October 20th. I was hosted by Victoria French, Deputy Director of Finance and currently holding the relatively new procurement portfolio.

I have been hearing such positive things about the efforts this team have made to get PPE to KMPT sites keeping colleagues and patients safe.

In the early pandemic days the team were trying to get stock from a variety of creative local sources eg a ball gown manufacturer made PPE in rainbow colours. The NHS central supply chain kicked in by June and push supplies now arrive in one KMPT site leaving the KMPT team to get items round the patch - often doing it themselves by foot or their own car. The content and quality of push supplies has at times been variable. The bill for Covid related costs such as PPE is being centrally covered by the NHS. I was told that local NHS organisations have worked well together over the Pandemic to share resources and expertise.

I would like to thank the team for their hard work and the warm welcome extended to me.

Peter Conway's visit to Bay Tree House 23rd October 2020

I visited Bay Tree House on 23rd October. Bay Tree House is the Maidstone Community Mental Health Service for Older People, caring for people over the age of 65 with a functional mental health difficulty including young onset (aged under 65) in the community.

I met with Clare Lux, Service Manager, her two team leaders (James and Tara) and 5 members of staff. It was an enjoyable visit to the team which lasted for two-and-a-half hours. There were no actions arising to log or follow through.

Kent and Medway
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Front Sheet

Title of Meeting	Trust Board meeting	**Date**	26 November 2020
Title of Paper	Chief Executive's Report		
Author	Helen Greatorex, Chief Executive		
Executive Director			

Purpose: the paper is for:	• **Delete as applicable**
• **Noting**	

Recommendation:
The Board is asked to note the content of the report.

Summary of Key Issues:	• **No more than five bullet points**

This is the Chief Executive's thirty sixth report to the Board.

Key Items include

- Mental Health Improvement Board
- County-wide Black, Asian and Minority Ethnic Chairs Group
- Covid – Phase 2
- Reverse Mentoring

Strategic Objectives:	• **Select as applicable**

☒ Consistently deliver an outstanding quality of care

☒ Recruit retain and develop the best staff making KMPT a great place to work

☒ Put continuous improvement at the heart of what we do

☒ Develop and extend our research and innovation work

☒ Maximise the use of digital technology

☒ Meet or exceed requirements set out in the Five Year Forward View

☒ Deliver financial balance and organisational sustainability

☒ Develop our core business and enter new markets through increased

partnership working ☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership
Implications / Impact:
Patient Safety: N/A.
Identified Risks and Risk Management Action: N/A
Resource and Financial Implications: N/A
Legal/ Regulatory: N/A
Engagement and Consultation: N/A
Equality: N/A
Quality Impact Assessment Form Completed: Yes/ No

1. Introduction

Since the board's last meeting at the end of September a second national lockdown has commenced. We, in KMPT, were ready for such an eventuality and have sustained Business as Usual as far as possible.

In practice, this has meant the continued strict adherence on all our sites and in all our buildings, to the 2 metre rule, carefully rota'd working to reduce the number of staff physically present unless essential and face coverings worn by all staff.

It has also meant that the board is again unable to meet physically in person, and will instead use a combination of presence in the board room with the Chief Executive and Trust Secretary attending in person, and other board members joining virtually.

As always, we value contact with those we serve and it remains important that members of the public are aware that they can still submit questions to the Board. People are able to submit questions to the Board via the following methods :

- Email to kmpt.trustsecretariat@nhs.net
- Through the lifestream chat facility
- Via the form which can be located on our website at https://www.kmpt.nhs.uk/about-us/trust-board/board-meetings/board-26-november-2020/

2. County Wide

Mental Health Improvement Board

The third meeting of this newly constituted system-wide group met on 17th November. The role of chair is shared by the Integrated Care System's (ICS) Improvement Director and KMPT Chief Executive. Key items considered in November included the imperative of delivering the Learning Disability and Autism programme, and the development of a Mental Health Improvement framework. The Board will receive a more detailed update on the work of the Mental Health Improvement Board during today's meeting.

Chief Executives Meetings

The six NHS provider Chief Executives across Kent continue to meet monthly in order to ensure that all six NHS trusts work effectively together. The benefit of these discussions can be seen in evidence across the system, especially currently during the second phase of Covid.

County-wide Black, Asian and Minority Ethnic Chairs Group

This group is next due to meet in December. A key decision at that point will be the timing of a paper to be presented to each of the six provider trusts across the county, aimed at establishing a shared understanding of the direction of travel and required changes. In the meantime, Non Executives from the provider trusts are in discussion about how best to contribute to this county-wide work.

3. In House

COVID Phase 2

A clear focus on preparedness and responsiveness has enabled the organisation to manage the potential impact on services. This time, in the second wave, we already have in place well established and tried and tested systems of daily communication, as well as well organised distribution systems for Personal Protective Equipment.

Reverse Mentoring Programme Launch

The board will hear more today about the work underway to ensure that KMPT becomes and can easily be seen to be, an anti-racist organisation. The work in order to achieve this has many elements to it, one of which is mentorship being provided by BAME colleagues whose experience of both the organisation and life is different from those they mentor. The first of a series of workshops to introduce the concept took place this month, with more to follow.

Black History Month Virtual Celebration

Members of the executive team joined the KMPT online celebration marking the end of Black History Month. The event which had originally been planned as an in person event, worked extremely well as a virtual celebration and the combination of in-house and national speakers created an uplifting and memorable afternoon. Some delegates commented that whilst they would not have been able to attend such an event in person, the opportunity to

join remotely made it possible. Planning has commenced for 2021's event which will reach even more colleagues and friends.

Annual Staff Awards

The advent of a second lockdown has meant that the plans for this annual celebration (due to be held in December this year) have had to be revised. We are confident that the alternative plans for a week long series of events right across the organisation, will be enjoyed by everyone.

Visits

Prior to lockdown I was able to visit in person, a number of services.

These included most recently our new community hub, Britton House in Gillingham, and our supported rehabilitation house, The Grove in Ramsgate. I was impressed during both visits at how thoughtfully the safety of staff and service users was being protected. As always during the pandemic, plans for visits in person are first approved by the Director of Infection Prevention and Control, Mary Mumvuri. In the meantime, visits made virtually continued and over the last month, members of my team have joined the Red Board meetings in the Community Mental Health Teams. The teams welcomed the visits and plans are now in hand to follow with virtual visits to other meetings in a range of services and settings.

Recover and Transform Programme Reporting

Recover and Transform Project	Trust Board Committee	External Governance
Demand and Capacity Modelling (D&C)	Finance and Performance	
Increasing recruitment (NHS Long Term Plan)	Workforce and organisational development	
Providing Flexible Access (PFA) (This was previously referred to as agile working to build on COVID-19 innovations relating to agile working, use of technology and estate going forward where they add value)	Workforce and organisational development if staff consultation is required	
Open Access Crisis (OAC) (To ensure open access crisis services, with partners, are available to meet the needs of local population. This includes the 24/7 crisis helpline business case)	• Finance and Performance for the business case • Workforce and OD if staff consultation is required	**Integrated Care System (ICS) Group** - MH Workstream Group **Mental Health & Learning Disability / Autism Improvement Board (MHIB)**
Psychological Support / Staff Health & Wellbeing (To provide enhanced psychological support for NHS / healthcare staff, the general population and to provide KMPT staff psychological support.)	Workforce and organisational development	ICS System restart and recover Board for psychological support to wider NHS and partner organisations
Digitally Enabled Care (DEC) (To increase access to services supported by technology and having clear guidance, training and reporting mechanisms of how we use technology to support care delivery.)	• Quality committee • Finance and Performance	
Annual Health Checks (AHC) for people with Learning Disability (LD)	Quality committee	**Integrated Care System (ICS) Group** - LDA Programme Board **Mental Health & Learning Disability / Autism Improvement Board (MHIB)**
Health Inequalities Group (HIG) (To ensure consistent KMPT representation on ICS / ICP forums, to ensure population health intelligence informs planning and decision-making and alignment with the Mental Health Investment Standard).	Quality committee	**Integrated Care System (ICS) Group** - STP / ICS Prevention
Better Safer Buildings (BSB) (To ensure buildings and work environments are made as safe as possible for staff and patients so that services can be delivered as effectively as possible.)	Finance and Performance	

Executive assurance for all projects is through the Recover and Transform Board and Executive Assurance Committee

Kent and Medway NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Trust Public Board	**Date**	26th November 2020
Title of Paper	STP/ICS Budget		
Author	Sheila Stenson, Executive Director of Finance		
Executive Director	Helen Greatorex, Chief Executive		

Purpose: the paper is for:	• **Delete as applicable**
• **Approval:** *A report containing the details of the STP/ICS budget for 20/21 and 21/22*	

Recommendation:

The Trust Board are asked to:
Receive this update on the proposed budget for 20/21 and 21/22 and asked to approve the budget.

Summary of Key Issues:	• **No more than five bullet points**

The attached paper sets out the proposed STP/ICS budget for 20/21 and 21/22.

An agreement was reached when setting the system budget, that the budget could not increase and that there was an expectation that some functions would move into CCG business as usual to free up resource for ICS, ICP and PCN development. The latter part of this has been completed and is part of the proposed plan.

KMPT contribution is £237k the same as last financial year. The majority of this payment contributes to the Mental Health and system development work, which is facilitated by the Mental Health Development Board.

There is a clear set of budget principles for the system.

Report History:

N/A

Strategic Objectives:	• **Select as applicable**

☒ Consistently deliver an outstanding quality of care

☐ Recruit retain and develop the best staff making KMPT a great place to work

☒ Put continuous improvement at the heart of what we do ☐ Develop and extend our research and innovation work ☐ Maximise the use of digital technology ☒ Meet or exceed requirements set out in the Five Year Forward View ☒ Deliver financial balance and organisational sustainability ☒ Develop our core business and enter new markets through increased partnership working ☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership

Implications / Impact:
Patient Safety: N/A
Identified Risks and Risk Management Action: Risk ID 6098 - Long term financial sustainability Risk ID 6570 - New finance regime 2020/21 Risks managed through BAF
Resource and Financial Implications: Trust included in system discussions regarding the LTP and financial plan delivery
Legal/ Regulatory: Deliver system control total
Engagement and Consultation: Long Term Plan approved by Trust Board in October 2019
Equality: None
Quality Impact Assessment Form Completed: ~~**Yes**~~**/** ~~**No**~~**/NA**

Kent and Medway Integrated Care System accreditation submission

Context

- The 'Kent & Medway ICS accreditation submission' has been prepared for NHS England and NHS Improvement (NHSE/I). Currently, the Kent and Medway system is a Sustainability and Transformation Partnership (STP). ICSs are more advanced forms of STPs, with greater responsibilities for working as a system and for holding regionally delegated authorities/autonomies (as agreed with NHSE/I) that further facilitate the integration of care.
- The NHS Long Term Plan, published in January 2019, set out the intention that all systems across England would become Integrated Care Systems by April 2021. The onset of the COVID-19 pandemic delayed the submission of K&M's application to be accredited as an ICS, and it was jointly agreed between the STP Partnership Board and NHSE/I that a submission would be made in the autumn of 2020.
- As this document has been prepared for NHSE/I it is technical in nature. At the point of being accredited as an Integrated Care System, we will publish an accessible and meaningful summary of what being an ICS will mean in K&M and the benefits for our population.
- This document has been developed to demonstrate evidence of our readiness for accreditation against the NHSE/I minimum operating requirements and ICS Maturity Matrix. It is therefore necessarily comprehensive.
- The document also provides helpful context about the system's achievements to date, direction of travel as a system, and on-going development activities. The document was endorsed by the STP/ICS Partnership Board at the meeting on 18th September.
- In evidencing our readiness to be accredited as an integrated care system, the main submission contains the building blocks of a strategy and plan. However, it is important to note that this submission is not our refreshed strategy or full plan. In our response to the Long Term Plan in autumn 2019, we committed to a strategy refresh process planned to commence in spring 2020. Due to the COVID-19 pandemic, the timeframe has been amended to Q3/Q4 of this year.

How our ICS accreditation has been developed

- The submission is a reflection and summation of the work to date of the Kent and Medway STP. In setting out our readiness to be accredited as an Integrated Care System, we have needed to describe the achievements and progress to date of the STP. Much of this was set out in our draft Strategy Delivery Plan 2019/20 to 2023/24 – our local response to the national NHS Long Term Plan. There is therefore clear alignment between the ICS accreditation submission and our Strategy Delivery Plan.
- Following its development by a large range of stakeholders, our Strategy Delivery Plan was submitted to NHSE/I in the autumn of 2019. Publication and discussion of the plan at our Health & Wellbeing Boards was impacted by both the 2019 election (purdah) and the COVID-19 pandemic, with systems being advised by NHSE/I to delay publication. As outlined above, locally we will be producing a refreshed ICS strategy in Q3/Q4 of this year and we will liaise with NHSE/I to understand the national process for future publication and discussion.
- The ICS accreditation was discussed at a dedicated workshop of the K&M STP/ICS System Development Group on 8th September. The System Development Group is comprised of membership from each of our four ICPs, the Kent and Medway CCG, Kent County Council, Medway Council and the Local Medical Committee. Included within the ICS accreditation is a vision, purpose and set of principles to guide our system development, which was developed by the System Development Group in dedicated workshops in July and August.

Key messages from the ICS accreditation submission

"We have a clear vision for system working across the system, Integrated Care Partnerships and Primary Care Networks. A key enabler is to agree the delegation of authority and responsibility to the system from NHSE/I that will allow system leaders to align incentives, sanctions and decision making. This is essential in order to secure progress towards our vision. The system has developed considerably in recent years and now meets the 'maturing level' of the NHSE/I ICS maturity matrix.

"We will work together to make health and wellbeing better than any partner can do alone"

Structure and features of our Integrated Care System

- **Primary Care Networks (PCNs) are the foundational building blocks of the ICS** – Primary care needs to be resilient and built on a strong foundation. However, PCNs are about more than integrated primary and community care – we will develop networks around neighbourhoods working closely with local government and the third sector. The delivery of Local Care (our K&M banner name for care closer to home) is also heavily dependent on a strong community services infrastructure at both the neighbourhood level and at higher levels of scale/critical mass where this is necessary to provide effective and high quality care.
- **Integrated Care Partnerships (ICPs) are the engine room for change** – increasingly we will see decisions made at place level to re-align available resources to enhance integration and improve outcomes with clinical input at the heart of these decisions. ICPs are focusing on redesigning pathways so that patients get the best care from the most appropriate services, delivered in the right place. Out of hospital care will be the default, to the benefit of both patients and the system. This will drive improvements in the health and wellbeing of local populations through prioritising keeping people safely at home, independent and self-managing; with the need to visit a hospital kept to circumstances when emergency or specialist care is required.
- **The ICS/STP Partnership Board will become the decision making forum of the ICS** *(within applicable statutory boundaries)*, providing oversight of whether the ICS is achieving its vision, purpose and priorities. It will be supported by a System Delivery Group (initially focused on COVID-19 recovery of services) and a System Development Group. The separation of these groups is to ensure sufficient focus on these two important agendas. The 'end state' governance for the ICS is currently being developed and will involve looking at the interactions between CCG committees and future committees of the ICS, to ensure the governance is streamlined.
- **We will apply the principle of subsidiarity, by which we mean that tasks and decisions should only be undertaken at system level when these cannot effectively or meaningfully be performed at local level**. Examples of areas needing a system approach are where we are likely to need a critical mass of scale or expertise beyond the place level; where all places are experiencing similar challenges (potentially to different degrees) which may benefit from collective problem solving; where we believe that working together will create greater power / influence / impact than working alone. Underpinning all of these circumstances, is the underlying driver that by working together as a system we will deliver better outcomes for our population.
- **The Health and Wellbeing Board and oversight and scrutiny committees** will remain a critical part of our infrastructure for strategy setting, decision making and oversight. Local authorities and the NHS, through the CCG, will continue to have a duty to prepare a joint strategic needs assessment and health and well-being strategies for the

population, overseen by the Joint Health and Well-Being Board. Scrutiny Committees will continue to examine the provision of health and care services, act as a critical-friend and where required hold organisations to account in ensuring the care needs, quality and experiences of local people are fully considered.

- **The CCG will act as a servant and enabler of system working** – beyond its statutory responsibilities the CCG now has a central role in supporting and resourcing development of the system; this will be through a clear focus on 'central' resources supporting wider system development and the increasing alignment of staff to work as part of ICPs. The system developer role will become a core purpose for the new CCG. Key areas for focus are supporting PCN development; supporting the service transformation agenda both at place level and for a small number of issues at ICS level; reducing formal financial contracting activity to a minimum.

Key ways of working

An increased focus on addressing variation
The best systems focus on standardisation and directly address unwarranted variation – this needs to cover differences in outcomes/quality, differences in access and differences in productivity and cost base. We will achieve this through:

- *A data driven and data supported approach to improvement* – this is a fundamental building block which will be supported through sharing of data through a common platform having a single source of truth
- *A common approach and system wide framework for Quality Improvement* – all partners agree that a Quality Improvement approach is essential and most organisations have or are considering adopting a single methodology (with many ogranisations adopting the NHSE/I Act Academy's Quality, Service Improvement and Redesign approach - QSIR). Clinical and patient-engagement will be a central thread, along with understanding root causes.
- *A new approach to commissioning* – Commissioning will be about transformation and not transaction. It will be light touch, focused on service improvement and increasingly shifting to a population health management approach that sets outcomes as the target for services. Resources are being aligned progressively with ICPs and this has already commenced following the creation of ICP facing resources as part of the merger of the eight legacy CCGs.

Living by a ICS values and behaviours
We have started work on our ICS values and behaviours, including a dedicated leadership event on this in September 2020. We have been working with NSHE/I and the NHS Leadership Academy on a programme of work for system wide organisational development which has been approved.

Greater integration leads to better quality of care and better outcomes for our population – Our overriding focus will be integrated service delivery for defined populations, with an agnostic view on how integration is achieved in organisational terms, identifying opportunities for shared budgets and aligned workforce approaches across employers where possible but with the main focus being on integrated care delivery. Integration is being pursued across organisations and sectors, with integration of physical and mental health and with health and social care. Together, the system can be more than the sum of the parts and we will achieve more for the health and wellbeing of our population by maximising the integration of services.

Clinical and service professional engagement must be at the heart of what we do – Strategic initiatives should be led / supported by clinical and professional leaders across health and social care; we will develop and nurture clinical alliances and networks as a means of driving change with a focus on shared learning and improvement founded in a

desire to eliminate unwarranted variation, ensure safety and maximise quality. We are building on the work to date of the STP Clinical and Professional Board and recent appointment of system wide clinical leads for services/programmes.

Engaging with and meaningfully supporting the third sector – The voluntary sector plays an important role in care delivery and integration and is a vital link to local communities. As Primary Care Networks further develop we will place the involvement of the voluntary sector very much at its heart. This will include the need to consider the impact that COVID-19 has had on the viability of some voluntary and third sector partners and how we can best support them.

Meaningful and realistic engagement with local government – Local government are critical members of the Integrated Care System and our councils are longstanding members of our STP/ICS Partnership Board and groups throughout our governance structure. We have many examples of great integration initiatives in both commissioning and delivery of services, but we recognise that there is more we can do, both strategically and operationally to drive greater integration. Initial discussions with both KCC and Medway Council suggest that we can further align around Health and Wellbeing strategies as the focus for agreeing our areas of strategic common focus for Kent and Medway as a whole.

Previous committees where the K&M accreditation has been discussed in detail

- K&M STP/ICS System Development Group – 8th September
- STP/ICS Partnership Board – 18th September – where the submission was endorsed.

Next steps

- This document was submitted to NHSE/I on 19th October. The next step is a regional assessment discussion on 4th November; further assessment processes will be determined following the discussion on 4th November. The outcome of our bid to be accredited will likely be communicated in December (TBC by NHSE/I).

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NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Trust Board	**Date**	26/11/20
Title of Paper	People Strategy 2020-2023 – revised		
Author	Jennie Cogger, Deputy Director of Workforce and OD		
Executive Director	Sandra Goatley, Director of Workforce and Communications		

Purpose: the paper is for:	• **Delete as applicable**
Approval	

Recommendation:
The purpose of the report is to provide revised version of Strategy, following the publication of national People Plan.

Summary of Key Issues:	• **No more than five bullet points**

- The initial draft strategy was presented to Workforce and Organisational Development Committee in July 2020
- The national People Plan was published and so the KMPT plan has been revised to reflect this accordingly. The revised version was presented to Workforce and Organisational Development Committee in November 2020 and approved

Report History:
To WF&OD Committee in July 2020 and November 2020

Strategic Objectives:	• **Select as applicable**

- ☒ Consistently deliver an outstanding quality of care
- ☒ Recruit retain and develop the best staff making KMPT a great place to work
- ☒ Put continuous improvement at the heart of what we do
- ☐ Develop and extend our research and innovation work
- ☐ Maximise the use of digital technology
- ☐ Meet or exceed requirements set out in the Five Year Forward View
- ☐ Deliver financial balance and organisational sustainability
- ☐ Develop our core business and enter new markets through increased partnership working

☐ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership
Implications / Impact:
Patient Safety: None
Identified Risks and Risk Management Action: None
Resource and Financial Implications: None
Legal/ Regulatory: None
Engagement and Consultation: None
Equality: None
Quality Impact Assessment Form Completed: N/A

1. Background

The strategy was updated and presented to Workforce and Organisational Development Committee in July 2020.

In order to bring the strategy in line with national People Plan, We are the NHS: People Plan for 2020/2021 – action for us all and 'Our People Promise', we have revised the plan.

The revised strategy was presented and approved at Workforce and Organisational Development Committee in November 2020.

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2. Recommendation

The Board is asked to ratify the approval of the revised strategy.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

OUR KMPT PEOPLE STRATEGY

CONTENTS

Welcome from our Chief Executive, Helen Greatorex

Our simple aim at KMPT is to deliver brilliant care through brilliant people. That is why our people are so important. Making the most of our talent is a key part of our strategy and culture which is why diversity and inclusion is a priority. We recognise we need to have a diverse workforce to deliver brilliant care

As a specialist trust, we provide care and treatment to people when they are at their most vulnerable, twenty-four hours a day, three hundred and sixty five days a year.

We value our people and the contribution they make, whether they work in support services, enabling front line employees to deliver high quality care, or directly with the people who use our services and their loved ones, they need to be the very best they can be, all the time, every day.

It is because of this, that I am so pleased to be introducing our People Strategy which is designed to create the right environment for our staff to thrive. If we are to recruit and retain the very best employees, we need to have a clear strategy in order to do it. This in turn, leads to brilliant care and high quality services, consistently.

I hope you feel, as I do, that this strategy it is easy to read, and that you can understand and commit to it. Importantly, it needs to be a document that lives and breathes our values and they can be seen everywhere, in every situation at KMPT.

To help us do this, the strategy is supported by a plan. The plan is structured around our ‘cultural heart’ which has three pillars:

The pillars set out the framework by which we can make sure we are delivering the improvements we need to, whilst continuing to learn and reflect. We will be reporting our progress regularly to everyone across KMPT and everyone who would like to join us in continuing to implement our plan will be warmly welcomed. We need all the talents to help us to make this a reality. Achieving our vision of a truly high quality organisation, staffed by brilliant people, whose talents are released to create even better services makes this strategy vital, and everyone’s commitment is essential.

With Best Wishes

Welcome from our Director of Workforce and Communications, Sandra Goatley

This is an exciting time for us in KMPT. This strategy sets out our vision for our people.

By delivering the three elements of our cultural heart together we'll create the environment where you feel you want to come to work and feel valued, developed and heard, believe you add value each time you are at work, have an opprotunity reflect on what went well and what could be improved and then when you go home you are able to switch off and recharge.

We'll do this by:

- Looking after our people
- Encourage belonging
- New ways of working and delivering care
- Growing for the future

We also support the national NHS People Promise at KMPT

#KMPTProud? I am!

Developing our strategy

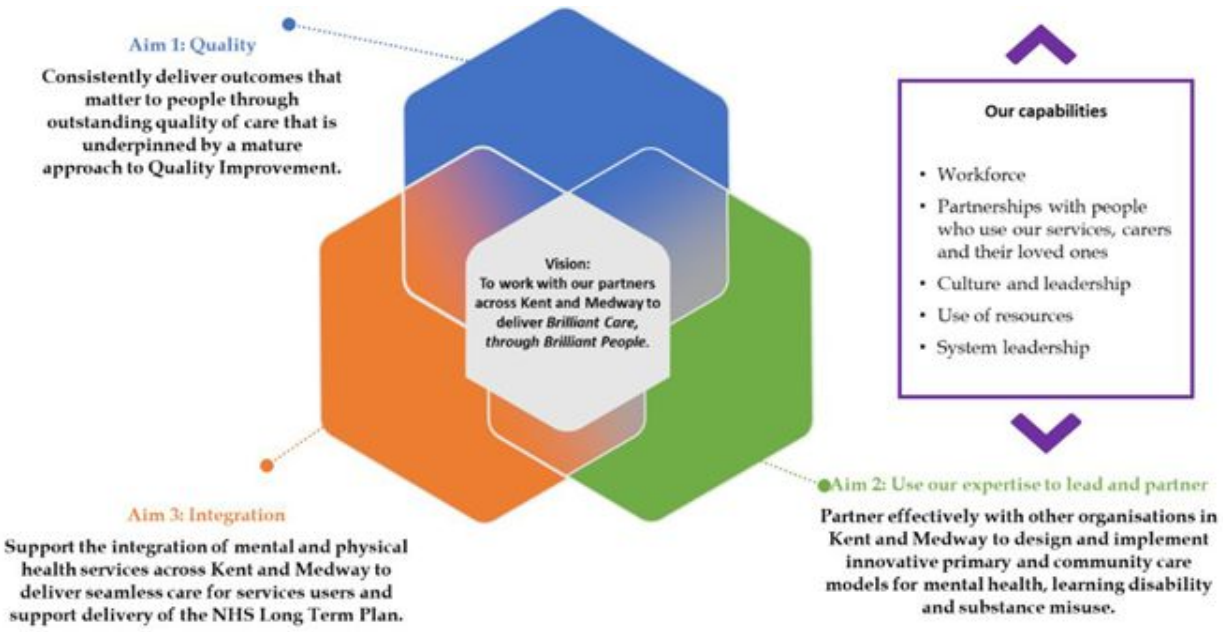
In developing our people strategy we have ensured that it aligns with the national strategies and the KMPT strategy:

NHS People Plan – https://www.longtermplan.nhs.uk/

NHS Long Term Plan – https://www.longtermplan.nhs.uk/

KMPT Strategy 2020-2023

The KMPT strategy sets out our vision, three main aims and five enabling capabilities:



Our KMPT People Strategy - Our cultural heart

Our KMPT People Strategy links all of the above to meet the national and KMPT priorities. We believe our cultural heart, made up of three pillars, will enable to us to be an Outstanding organisation and a brilliant place to work and learn.

Just and learning approach

We will embed a just and learning approach across KMPT; 'just' meaning fair and 'learning' to enable reflection. This will underpin all of our workforce practices and support employees and managers to embed the cultural heart.

We will continuously strive to improve our services. We accept everyone make mistakes, especially in pressured environments and situations. We will review our systems and our processes and focus on safety and quality not blame. We will learn from experience and share this with others. We will ask what we should do differently.

An empowered team of teams

We will be one team with a shared purpose and vision. To operate effectively and remain agile we will organise ourselves into smaller teams with clear roles and responsibilities. These teams are empowered to make decisions and work together, always with service users at the heart of what we do. We will grow strong networks with other teams and align our goals and efforts to deliver the KMPT objectives.

Living our values

We will act according to our shared values. We will recruit, develop, reward and manage by them. We respect the contribution of everyone, openly working together and we value people for their individuality and the difference they bring. We do not tolerate poor or disrespectful behaviours. We seek, listen and act on feedback to help us work together more effectively. Everyone counts, everyone has a voice.

Embedding our cultural heart is a transformational journey and we anticipate this will take three years to fully develop, we aim to take a quality improvement (QI) approach to delivering this, listening to feedback and adapting to meet the needs of our people and services. We will measure our progress annually through employee engagement results, our key performance indicators and delivery of our people objectives.

People Delivery Plan

Our people delivery plan is agreed annually and reviewed by the Workforce and Organisational Development Committee, a sub-committee of the Board. These detail how we aim to achieve the national strategy, through our strategy, but have the following broad aims:

Looking after our people

- We will develop and evolve our 'Thrive @KMPT' wellbeing strategy
- We will be an exemplar in Mental Health First Aider practice in the NHS
- We will introduce innovative approaches to involve and engage people in their own health and wellbeing.

Encourage belonging in the NHS

- We will work together to develop and embed our Cultural heart
- We will pro-actively measure our progress and gain feedback from our people
- We will embed our just and learning approach across all areas
- We will enable a culture which allows employees to be accountable and part of empowered teams
- We will clearly communicate and ensure the KMPT values are in all our people practices
- We will engage all employees in the Freedom to Speak Up Guardian agenda.
- We will attract diverse and talented candidates through recruitment events here and internationally, and by developing our employer brand
- We will be open about our Workforce Race and Disability Equalities Standard priorities and progress
- We will work together to introduce a range of opportunities for employees to be involved in this work, including through our staff networks, training and development
- We will work towards a zero tolerance of bullying and harassment at work through the implementation of our Staff Charter and Hate Crime Policy

New ways of working and delivering care

- We will ensure we challenge our thinking to create innovative workforce models for the future
- We will enhance technological opportunities for learning and development delivery
- We will support employees through a QI approach to learning
- We will have clear management and leadership career pathways and profiles
- We will have future fit leadership development programmes

Growing for the future

- We will open our doors to enable potential employees to meet us and understand our services
- We will have pro-active approaches to retaining our people throughout their careers
- We will support employees through their time with us; from Induction, through supervision, appraisal, career conversations and personal development planning
- We will focus support to under-represented areas or teams who have identified specific needs
- We will develop clear career pathways across all employee groups.
- We will support all employees in their strive for excellence, by enabling access to learning and development opportunities
- We will develop our coaching culture across KMPT.

As an employee or prospective employee of KMPT, we hope this strategy conveys the passion and dedication of our organisation to achieving **Brilliant care through brilliant people.**

Document Reference No.	KMPT.HR.65.01
Replacing document	N/A
Target audience	All employees
Author	Director of Workforce, OD and Communications
Group responsible for developing document	Workforce and Organisational Development Committee
Status	Approved
Authorised/Ratified By	Trust Board
Authorised/Ratified On	TBC
Date of Implementation	TBC
Review Date	March 2023
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
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DOCUMENT TRACKING SHEET

PEOPLE STRATEGY

Version	Status	Date	Issued to/approved by	Comments
1.0	Approved	24/11/2016	Trust Board	Ratified

REFERENCES

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Public Trust Board	**Date**	26th November 2020
Title of Paper	Integrated Care System Mental Health Improvement Board Update		
Author	Helen Greatorex, Chief Executive		
Executive Director			

Purpose: the paper is for:	• **Delete as applicable**
• **Information**	

Recommendation:
The Board is asked to consider the content of the paper, its implications and KMPT's role in leading this important work.
Summary of Key Issues: • **No more than five bullet points**
• To provide the Board with an overview of the development of the Integrated Care System and Integrated Care Partnerships, and an update on the newly formed Mental Health Learning, Disability, Autism Improvement Board
Report History:
None

Strategic Objectives: • **Select as applicable**
☒ Consistently deliver an outstanding quality of care
☐ Recruit retain and develop the best staff making KMPT a great place to work
☒ Put continuous improvement at the heart of what we do
☐ Develop and extend our research and innovation work
☐ Maximise the use of digital technology
☒ Meet or exceed requirements set out in the Five Year Forward View
☒ Deliver financial balance and organisational sustainability
☐ Develop our core business and enter new markets through increased

partnership working ☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership

Implications / Impact:
Patient Safety:
Identified Risks and Risk Management Action:
Resource and Financial Implications:
Legal/ Regulatory:
Engagement and Consultation:
Equality:
Quality Impact Assessment Form Completed: Yes/ No

Background and Introduction

This paper sets out at high level, the architecture of the health and social care system across Kent and Medway and describes where Kent and Medway NHS and Social Care Partnership Trust (KMPT) fits in.

The last twelve months have seen a series of significant changes, in particular, the creation of four Integrated Partnerships and Primary Care Networks, and most recently, the Integrated Care System.

Understanding KMPT's place in the system, is important in order to ensure that we continue to drive the improvements we know need to be made not only in the services we provide but those of other partners in the county who also provide mental health, learning disability and autism services.

The Integrated Care System (ICS)

The ICS is a relatively new entity, built on what were the Sustainable Transformation Partnerships (STPs) established across the country in 2016. For us in Kent and Medway, the approval to become an ICS is awaited. In the meantime, we continue to work as a health and social care system, with the aim of improving both the efficiency and quality of all that we do.

In 2016, the imperative driving the creation of STPs was twofold; to rebalance the NHS's finances, ensuring that each local system was financially sustainable and, to address the significant variance in the quality of provision.

The Kent and Medway STP oversaw the bringing together of multiple individual organisations including the six provider NHS trusts, Kent County Council and Medway Unitary Authority, Healthwatch, the Ambulance Trust and the regional NHS/E. It also set the ambition to halve from eight to four, the number of Clinical Commissioning Groups and for them to become Integrated Care Partnerships (ICPs). Those changes were enacted in April 2020 and the Integrated Partnerships, underpinned by Primary Care Networks are now an established presence though still in the early stages of development.

The emphasis now, is on thinking and acting as one system. This includes a new expectation of explicit mutual aid including the finances of each system. The control total that was previously set for each organisation is now overlaid by a system control total.

Delivering Improvements in Mental Health, Learning Disability and Autism Services

KMPT is one of only two county-wide organisations in the ICS (the other is the Ambulance Trust) and the change from eight CCGs to four Integrated Care Partnerships, was welcomed because it halved the number of commissioning bodies the Trust was required to report to. This change also offered an opportunity to consider how best to ensure that the required improvements in KMPT's and other mental health, learning disability and autism providers' services was driven.

Over the last six months in particular, careful consideration has been given in order to ensure that delivery of the Long Term Plan is placed front and centre of our shared, system priorities. After a series of multi-agency discussions through the Winter of 2019, it was agreed by the ICS, that a dedicated Mental Health, Learning Disability and Autism Improvement Board (MHLDA IB) should be established.

The Mental Health Learning Disability and Autism Improvement Board

Established in September 2020 the Board has four key functions;

1) Provide leadership, oversight and partnership working to improve the mental health and mental wellbeing outcomes of the population of Kent and Medway.

2) Bring together senior representatives from across the integrated care system to work collaboratively to drive delivery of Mental Health Learning Disabilities and Autism Improvement priorities at scale across Kent and Medway.

3) Operate as a strategic board, supporting development of the vision, outcomes, purpose and scope of Kent & Medway Mental Health Strategy, and alignment with the Long Term Plan.

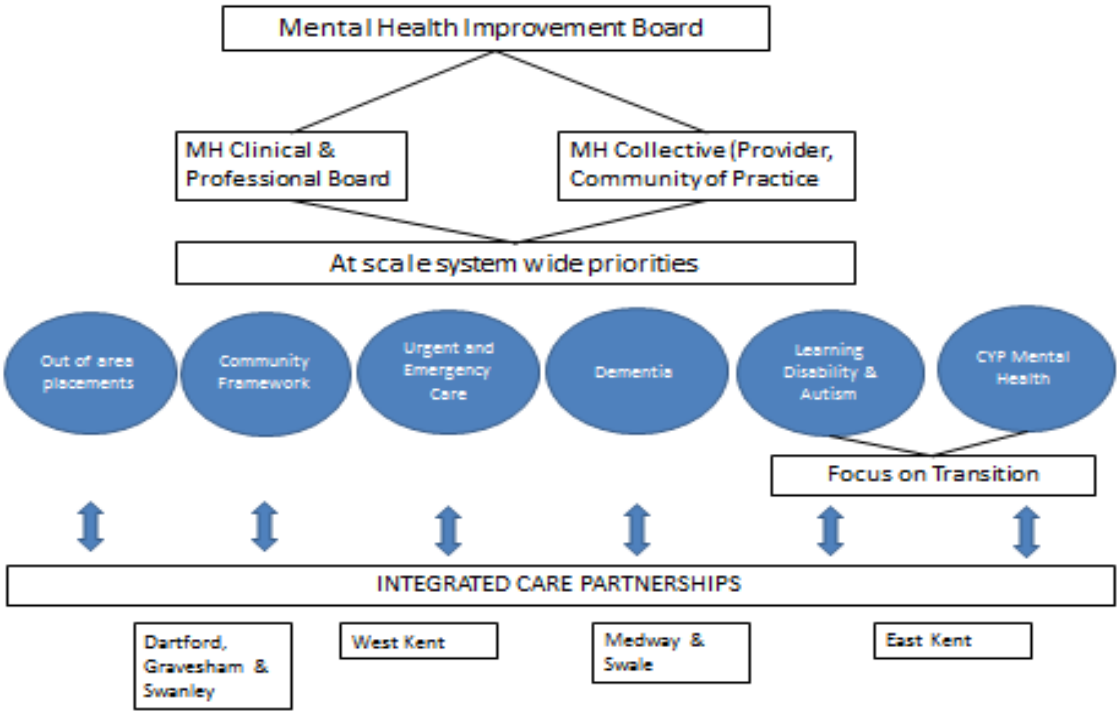
4) To ensure that the Integrated Care System (ICS) is working collaboratively with Integrated Care Partnerships (ICPs) to ensure local innovation is considered and supported within the mental health, learning, disability and autism programme of work.

The role of Chair is shared by the ICS Executive Director of Health Improvement and the Chief Executive of KMPT. Membership includes key stakeholders from across the county. The Board reports to the Integrated Care System Partnership Board.

Early in its development, the Board agreed that in order to maximise its impact and truly deliver benefits for service users, it must work to a small set of priorities. These are set out below

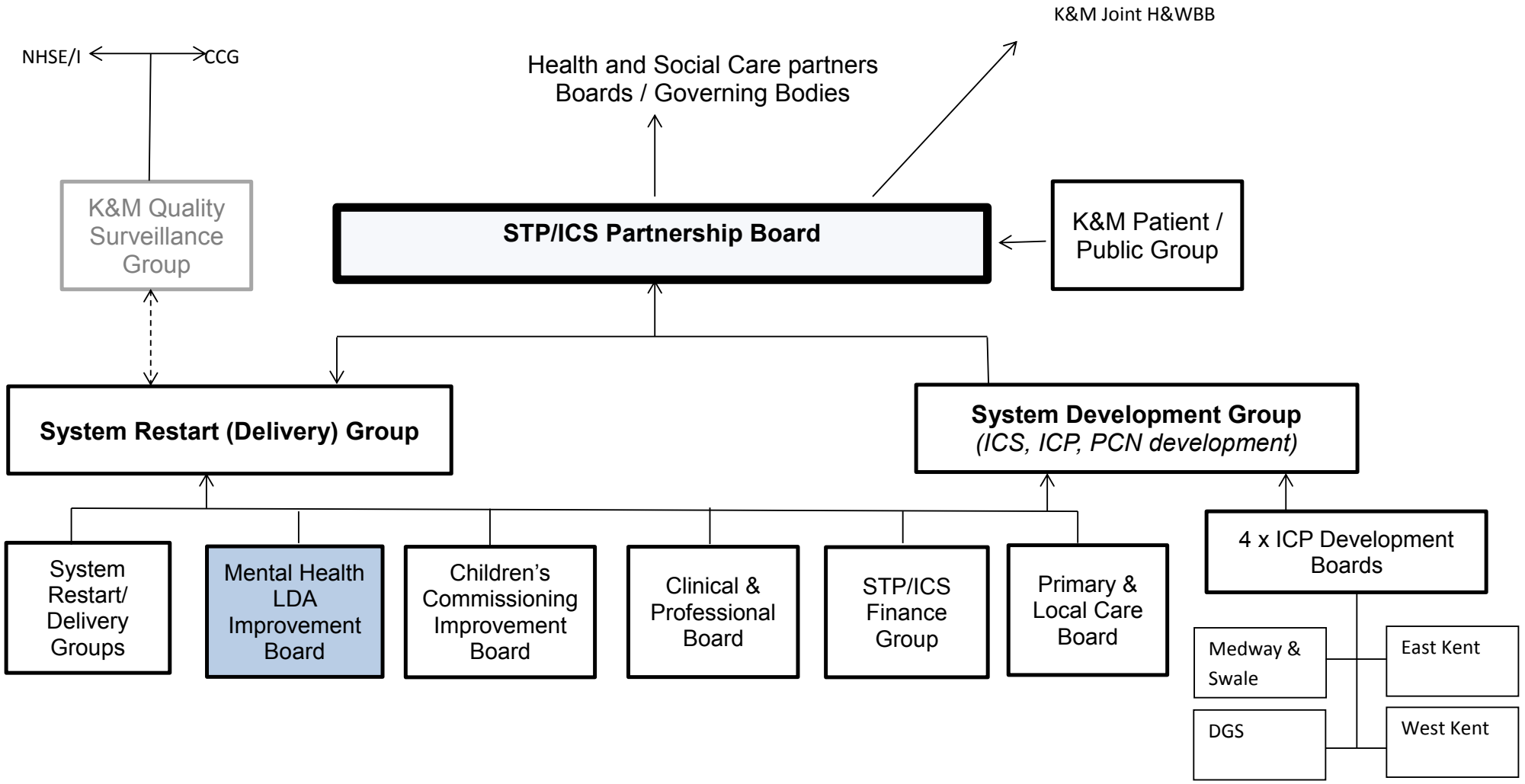
- Learning Disability and Autism
- Dementia Care
- Children and Young Peoples Services
- The Community Mental Health Framework and Transformation
- Mental Health Urgent and Emergency Care
- Out of Area Specialist Placements

The illustration below, shows the MHLDA Board's relationship to the Integrated Care Partnerships, and its key areas of focus


Mental Health Improvement Board
MH Clinical & Professional Board
MH Collective (Provider, Community of Practice
At scale system wide priorities
Out of area placements
Community Framework
Urgent and Emergency Care
Dementia
Learning Disability & Autism
CYP Mental Health
Focus on Transition
INTEGRATED CARE PARTNERSHIPS
Dartford, Gravesham & Swanley
West Kent
Medway & Swale
East Kent

From the diagram below, we can see where the new, MHLDA Improvement Board fits into the structure

K&M STP/ICS Interim Governance Framework



Summary and Conclusion

The newly formed MHLDA Improvement Board is pivotal in driving the agenda of service improvement and delivery of the Long Term Plan. Supported by a series of senior led task and finish groups, improvements are expected to be easily tracked, with variance from trajectory corrected by the system. The Board will be updated quarterly on the work of this group.

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Front Sheet

Title of Meeting	Public Trust Board	**Date**	26th November 2020
Title of Paper	Recover and transform programme		
Author	Martine Mccahon, Assistant Director Transformation and Improvement		
Executive Director	Vincent Badu, Executive Director Partnerships and Strategy/Deputy Chief Executive		

Purpose: the paper is for:	• **Delete as applicable**
• Discussion	

Recommendation:

The Board is asked to receive the report on progress of the Recover and Transform Programme to enable new ways of working to be sustained and embedded across the organisation.

Summary of Key Issues: • **No more than five bullet points**

- In May 2020 in response to the COVID-19 pandemic KMPT established a recover and transform programme board, chaired by the Executive Director Partnerships and Strategy/Deputy CEO, which provides oversight and strategic direction of the recover and transform programme
- As key members of the system restart programme KMPT have been connecting and engaging with system partners to share and embed learning and this has influenced our programme. Our vision is Adopt and Adapt so that we do not disadvantage our service users, capture data and evidence, undertake meaningful staff engagement and continue to respond to the COVID-19 pandemic
- KMPT are cognizant we need to collectively juggle our response to an emergency pandemic, recovery, resilience, meeting the national requirements, innovation and working differently. Maintaining high quality of care, productivity and financial sustainability alongside continued periods of emergency response will be required for a prolonged period as we navigate a phased post pandemic period
- We are focused on supporting our most vulnerable staff and service users and as a result we have established a Health Inequalities Group and Digitally Enabled Care has a strong focus on inclusion - it is essential we translate what will work for different patient populations and how we adapt for example older people, people with learning disabilities and autism
- During these past months there have been additional requirements from NHSE set out in the Phase 3 letter/ Planning Guidance on 7 August 2020 which have been further informing our work. This includes NHS E's priorities to invest in 24/7 crisis lines; digitally enabled services creating more flexible services; mental health support for NHS staff and addressing health inequalities
- The programme is in programme management stage 3 where measurable outcomes and KPIs are being defined and measured for each project within the recover and transform programme

Report History:

Trust Board have been receiving highlight reports for the recover and transform programme since May 2020. This report provides an overview of the progress delivered over the past 6 months and provides assurance on some of the tangible transformation projects which have driven forward in relation to :-

- Demand and capacity, modelling, challenges, mitigations and innovative practice
- Psychological Support and Staff Health and Wellbeing
- Agile working to ensure our services are accessible and available to meet the needs of patients
- Digitally enabled care, exploring how services can be delivered digitally (virtual) by default.

Capturing what we have done well, learning from the emergency responding phase at a local system and regional levels have been integrated into our programme to support our ongoing focus on embedding the good improvements and sustaining transformation.

Strategic Objectives:	• **Select as applicable**
☒ Consistently deliver an outstanding quality of care	
☒ Recruit retain and develop the best staff making KMPT a great place to work	
☒ Put continuous improvement at the heart of what we do	
☒ Develop and extend our research and innovation work	
☒ Maximise the use of digital technology	
☒ Meet or exceed requirements set out in the Five Year Forward View	
☒ Deliver financial balance and organisational sustainability	
☒ Develop our core business and enter new markets through increased partnership working	
☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership	

Implications / Impact:

Patient Safety:

Patient safety is considered across the recover and transform programme and within all project areas

Identified Risks and Risk Management Action:

If the organisation does not deliver transformed care pathways and embed new ways of working across services then there will be increased risk of unwarranted variation and inequitable service provision, inadequate clinical effectiveness and financial pressure. Establishment of programme framework to deliver change and ensure transformation are based on learning from research evidence and engagement of key stakeholders will support robust risk management actions to be in place and effectively implemented.

Resource and Financial Implications: Programme and project management is being provided by the transformation team who are working in collaboration with clinical and operational leads and support services (Finance, Performance HR and OD, Estates, and Professional Leadership) across KMPT
Legal/ Regulatory: For providers to effectively respond to the COVID 19 pandemic whilst continuing to deliver high quality services
Engagement and Consultation: Clinical, operational and support staff across all care groups and directorates have been driving forward this recover and transform programme
Equality: We are focused on supporting our most vulnerable staff and service users and as a result we have established a Health Inequalities Group and projects have a strong focus on inclusion
Quality Impact Assessment Form Completed: No

Recover and transform programme

1. Background and context

In response to the COVID-19 pandemic KMPT are looking at how we move to a new normal through establishing and delivering a programme focused on recovery planning and transformation. We must ensure that any changes we make are based on clear evidence and progress carefully and strategically while delivering brilliant care and ensuring our staff are protected and remain safe. The Board is keen that we do not lose the creative and innovative ways of working that this unprecedented times has encouraged us to adopt. It is essential we minimise operational fatigue and continue to deliver and sustain our innovative and new ways of working and ensure they result in positive and measurable change for our patients, carers, staff and partners.

In May 2020 in response to the first wave of the COVID-19 pandemic we established a recover and transform programme board which is chaired by the Executive Director Partnerships and Strategy/Deputy Chief Executive . The programme board is responsible for ensuring we successfully drive forward our programme of change, deliver transformation projects whilst ensuring communications and engagement; contracting, performance and information; digital; estates; finance; partnerships; research and development; and workforce and organisation development are key enablers. The recover and transform programme is adhering to KMPT's programme management framework which includes six programme stages, gateway criteria, governance and reporting structure with a focus on measurable benefits. Programme and project level highlight reports are submitted to the monthly programme board including escalation of risks and issues. These provide assurance to the Executive sponsor and clinical lead with regards to delivery.

The recover and transform programme is adhering to KMPT's programme management framework where during stage one (start out) an overarching description of the work was agreed, it was identified who needs to be involved in this work, there is clear alignment with the NHS Long Term Plan and evidence based practice and research have informed our work. Completion of stage one was approved by the programme board on 24 June 2020.

Although the recover and transform programme has progressed into programme management stage 2 there have been additional requirements from NHS England set out in the Phase 3 letter/ Planning Guidance on 7 August 2020 which have been further informing our work. This includes NHS E's priorities to invest in 24/7 mental health crisis lines; digitally enabled services creating more flexible services; mental health support for NHS staff and enhanced focus on addressing health inequalities.

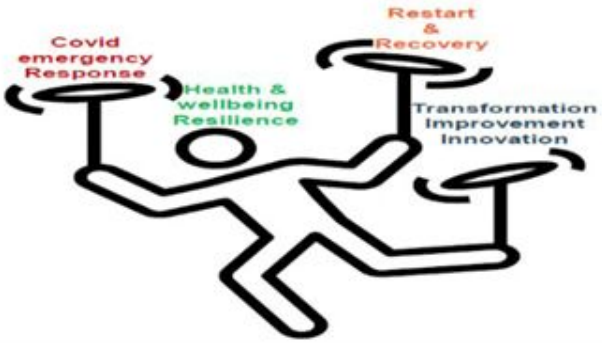
The successful delivery of programme management stage 2, define and scope, was approved on 09 September 2020 by the programme board. This included articulation of the service transformation for the programme, key enablers and interdependencies, co-production, inclusion and equality. We are focused on supporting our most vulnerable patients and staff and as a result we have established a Health Inequalities Group and our work stream focused on Digitally Enabled Care has a strong focus on inclusion - it is essential we translate what will work for different patient populations and have clarity on how we adapt for example to meet the needs of older people, people with learning disabilities and autism in the changes and transformations we take forward.

As key members of the Kent & Medway Integrated Care System (ICS), restart programme KMPT have been connecting and engaging with system partners to share and embed learning and this has also influenced our programme. As a result of this work we have participated in Kent Surrey & Sussex Academic Health Sciences Network's (KSS AHSN), system review which included a focus on the significant changes undertaken in response to

COVID-19 and the positive impact on patients and staff. KSS AHSN were very positive with regards to KMPT balancing the need to meet our patients needs and supporting our staff's wellbeing during the pandemic, innovatively delivering services using digital technology, successfully recruiting to our workforce in a different way and empowering front line staff and service users to make innovative changes. KMPT are working in collaboration with KSS AHSN and system colleagues to, for example, understand the impact of changed pathways on the deployment of workforce and explore how remote working can help address workforce issues and strengthening relationships with voluntary sector. KMPT are now members of the Medway Innovation Hub whose ambition is to create an innovative ecosystem driven by understanding key system problems and enabling collaborative, creative solutions at scale to be developed and pursued. In January 2021 it is planned there will be a focus on digital inclusion and exclusion and relevant colleagues from KMPT will attend to maximise our impact and influence.

During October 2020 KMPT joined stakeholders from across the region for the launch of the Kent Surrey Sussex AHSN Innovation Leads network a forum through which innovation leads come together in the spirit of shared learning and collaboration. This provided an opportunity to learn from regional and local system colleagues, exchange best practice and a reflection on how innovation is driven and embedded through engagement of clinicians and front line staff. Leadership must empower creativity, innovation must be deliberate, have a concentrated effort, have a robust focus on implementation and a culture must be developed where innovation can happen. People must feel supported and those who use services must be involved in the development and deployment of innovation. A quality improvement philosophy is essential where front line staff are empowered to develop the solutions – sustainable new ways of working will only be successfully embedded if there is effective engagement and buy in from the early beginning.

During the innovation leads network KMPT were introduced to the 2020 balancing act (shown below) and the recover and transform programme board are cognizant we need to collectively juggle our response to an emergency pandemic, recovery, resilience, meeting the national requirements, innovation and working differently;



The recover and transform programme is currently in stage 3, measure and understand, where we are focusing on our impact and the outcomes delivered. This includes agreeing the baseline for each project, measurable improvements at an individual and organisation level, evidencing improved productivity and high quality care. We are aligning our programme with Getting it Right First Time (GIRFT) and we are working with system colleagues to evidence future changes in demand.

By January 2021 the recover and transform programme will achieve stage 3, measure and understand, and be delivering stage 4, design and plan. There will be clarity with regards to the key milestones for the next 6-12 months, robust implementation plans where innovation will be rolled out and sustained across the Trust and celebration of success. Our vision is

Adopt and Adapt – we want to move away from multiple short term pilot projects that are not always followed through for example due to lack of funding or non-delivery of measurable outcomes through embedding our improvement culture and approach.

Our culture and leadership continue to be imperative – our pace of change, growing risk appetite, sharing learning, moving forward more rapidly from things that do not prove to work successfully first time, less dwelling on unsuccessful projects, more rapid sharing and spreading learning to support progress toward delivery of improvement goals and transformational changes .

2. An overview of the recover and transform programme

There are nine projects within the recover and transform programme and each has an identified Executive and operational and clinical lead. Project groups report on a rotational basis to the recover and programme board including escalation of risks and issues. The transformation and improvement team provide project support to each of the nine projects which is essential in supporting clinicians and ensuring progress within a robust programme structure. Please see appendix one for a brief overview of each project.

3. Four tangible transformations that have been driven forward

This Board report focuses on four tangible transformations that have been driven forward as result of the recover and transform programme and provides an overview of what has changed post the phase 1 COVID-19 pandemic. This includes milestones around how these new ways of working are being embedded, rolled out and sustained across KMPT for;

- Demand and capacity
- Psychological Support and Staff Health and Wellbeing
- Agile working
- Digitally Enabled care

3.1 Demand and Capacity

Below summaries the findings of KMPT's demand and capacity work undertaken during the first wave of COVID-19;

- There was a significant suppression of demand during the first wave of COVID – something that may repeat itself in the current wave although distinguishing between this and seasonal variation will be difficult to judge
- Whilst demand in terms of people coming through the front door remains suppressed in a number of areas, the evidence indicates that the need (demand) has resulted in higher levels of acuity
- With the rising number of COVID-19 cases since the last review there has also been the need to extend the period over which 'normal' demand is likely to be suppressed over the winter, potentially storing up greater levels of complexity and higher levels of demand in the medium to longer term
- The above has not yet been modelled past March 2021
- The combination of increased acuity and continued suppression of underlying need could lead to significant challenges early in 2021, which may already be starting to emerge.
- A full and detailed analysis report of demand and capacity modelling including system challenges, mitigations and innovative practice has been provided by the Executive Sponsors, is available in the Board reading room (Diligent) and should be considered alongside summary below.

3.1.1 Case study showing actions undertaken to prepare for the increased demand in mental health services

From April to June (end of lockdown) community mental health teams (CMHTs) and Community Mental Health Service for Older People) CMHSOP initiated their emergency response protocol which focussed on urgent response. This saw the teams operate 7 days a week from 08:00 to 20:00. Post June 2020 the need to address waiting lists for more of the routine work has required review and adaptation

- **CMHTs** – In response all teams improved their use of digital technology. Use of video and telephone contacts increased by 70% during lockdown returning to around 50% from June onwards. Use of lifesize video and telephone for virtual assessments, therapeutic delivery and implementation of care is now part of everyday working and performance reporting
- The teams also operated 7 days a week during lockdown focusing on urgent crisis responses. From June onwards some weekend and extended evening working across localities is in operation. This change required funding of £215k to support the enhanced capacity and enhanced weekend hours. This was supported as part of the MHIS system planning and is built into our future modelling to maintain
- CMHT has used the mental health investment standard monies to incorporate the routine work and can evidence improvement in contact rates compared to last year

- **CMHSOPs** – Pre COVID the older adults Care Group were reviewing the Memory Assessment Service (MAS) provision; lockdown necessitated a shutdown of the MAS pathway and the community teams supported the urgent care services. Post lockdown the CMHSOP have initiated TICS (Telephone Interview for **Cognitive** Status) which will offer MAS to allow a percentage of people contact to continue through any future lockdown
- The care group has completed a demand and capacity exercise presented to FPC in September. The MAS pathway requires a system response to ensure it is fit for purpose and forms a key strategic aim of the mental health, learning disability and autism improvement board. The care group is focusing on development of four clinical pathways to take learning from COVID – set out below;
    - Complex pathway - Dementia
    - Complex pathway - MDP
    - Complex pathway –complex emotional difficulties
    - Non Complex pathway - Memory Assessment
- Importantly recruitment has been maintained throughout COVID. Recruitment helps to maintain steady state and implement work begun pre COVID such as clinical care pathways, however to fully meet the likely needs the new investment (circa 10 million into the Kent system) in the next 3 years aligned to delivery of the community mental health framework is required to fully achieve the benefits realised through the new ways of working

- **Community resolution home treatment (CRHT)-** The crisis teams have received additional funding to enhance the 24/7 urgent assessment response alongside improving home treatment fidelity (as an alternative to hospital admission). The funding allows for 14.5 WTE new practitioner posts. All are recruited to and work is in place to provide the enhanced assessment service out of the newly developing Kent wide urgent centres.
- The CRHT services are working closely with the Safe Havens providing clinical input – these are new services to Kent and the partnership approach is imperative

- **Admissions –** post lockdown the number of admissions to younger adult beds has generally increased whilst older adult admissions have generally decreased. The

levels of people admitted under a Section of Mental Health act have increased overall highlighting an increase in acuity. There has been a surge of people needing crisis care who are autistic alongside an increase in people who have had, up until COVID, a well-managed psychosis illness. In July and August there an increase in admissions for people with complex emotional disorders however that has subsequently reduced across September and October. Services to support this group such as crisis team groups, Support and Signposting service and the Safe Havens may be helping to reduce admissions of this group of people

- There has been a decline in older adult admissions overall and a review is underway to examine the reasons.
- An area of impact has been an increase in delayed transfers of care and a small increase in average length of stay. The system issues are impacting on delayed transfers of care and are being highlighted via a number of senior meetings

- **Single point of access (SPOA)** –In April 2020, in response to lockdown, NHSE requested the development of an NHS led crisis telephone line was bought forward and KMPT expanded the SPOA to achieve this aim. To sustain this increased funding of £987k per annum is required and this was fast tracked as part of the mental health investment standard discussions and has been agreed. Recruitment to the full team is underway. As part of this work a review has started and a new telephony system will be implemented to support this service longer term. The service will also be moving to a 0800 number, a national ask to support improved access and minimise inequalities. The aim is for this final action to be completed by the end of the calendar year

3.2 Psychological Support and Staff Health and Wellbeing

This objective of this project is to provide enhanced psychological support for NHS / healthcare staff and the general population and to provide KMPT staff psychological support. KMPT have provided leadership support to the Kent and Medway System to ensure appropriate access psychological support and interventions in response to the Covid-19 pandemic. Workstreams have been established focusing on enhanced psychological support to NHS/Heath Care Staff and psychological support for the General Population and this has resulted in;

- KMPT working closely and flexibly with providers of acute and community services to identify, support, and put in place a range of psychological interventions that reflect the national principles. KMPT's direct contribution has been to provide self-help support leaflets and videos, managers help line (advice and signposting), reflective practice, operational review, operational debriefing sessions, supervision for psychological first aiders, and guidance and support to those already providing support in the hospitals;
- A stepped model of psychological support defined for NHS/Health Care staff and developed a business case that is being used by partners across the system. Feedback from the Trust's has extremely positive with one commenting on "how pleased [they are]… that our network came to such a positive and exciting consensus… around this consistent approach to psychological support across the patch. Having only floated the idea and suggested this a few weeks back I think it is testament to the network we are part of that we can come together on a project like this so swiftly and truly enjoy system-level working."
- Developed a bid to implement a Resilience Hub on a Kent and Medway footprint during 2020/21 that will provide signposting and psycho-educational support;
- Worked with care home commissioners and care home managers directly providing a training workshop and reflective practice sessions;
- Providing low level of CBT and mindfulness training to Kent and Medway GPs including contributing to the regional 'Coping with Covid – Empowering Primary Care' event on 19Nov20;

- Supported partners to develop community pathways for people who have experienced an acute admission for Covid-19;
- Worked with the voluntary sector to identify opportunities to support those who have been bereaved. There is a developing focus on primary care training and peer support groups;
- For KMPT staff exclusively, have overseen management development webinars, supported reflective practice for staff, trained workforce development advisors, and completed a review of staff wellbeing spaces with recommendations made to the recover and transform programme board in October 2020.

In November 2020 the psychological therapies bid for Kent and Medway has been approved providing £343k non recurrent to the system for staff health. This is an outstanding example of about how KMPT are using our capacity and expertise to support workforce across the system innovatively and collaboratively. Each of the 7 hospital sites will be provided with two people (KMPT psychology and IAPT clinician) who will work flexibly and whilst the model is hospital facing, this may need to be adjusted.

The milestones for the next quarter for psychological support and Staff Health and Wellbeing are;

- Psychological Support for NHS/Health Care Staff: confirmation of funding (Nov20), mobilise stepped model (Dec20 - Feb21)
- Staff Wellbeing Spaces: Implementation plan to be developed (Dec20), implementation of short term options (Jan21-Mar21)
- Staff Health and Wellbeing: Review of reflective practice offer (Dec20), Annual wellbeing check-in (Jan20)
- Resilience Hub: Confirmation of funding (Nov20), implementation plan to be finalised (Dec20), mobilise model (Jan-Mar21)
- Primary Care: Low level CBT training (Nov20), bereavement training (Jan20)
- Care Homes: Review psychological support offer. Linked to Resilience Hub (Dec20)
- Bereavement: Facilitated peer support groups (Feb20)

3.3 Agile Working (providing flexible access)

Our vision is our services are accessible and available to suit the needs of our service users. Our ambition of this work is to embed a providing flexible access culture and practice across the organisation (community, urgent and emergency care). This will need to include support services in order to provide flexible access. The objective of this project is to explore the needs of service users and the health and care system with regards to if more of our services should work extended hours..

Demand and capacity modelling is currently being undertaken to agree the baseline, evaluate impact and forecast future demand and capacity requirements and map the service user journey through KMPT. Robust engagement has been undertaken with staff and service users, led by organisational development, and the themes are being finalised with regards to identifying the changes in working practice introduced and learning from feedback from staff involved in the changes - what has worked well and what hasn't worked well. In parallel evaluations on the use of digital technology are being undertaken including the impact, risks and benefits for delivering care.

Please find below a case study which demonstrates KMPT have changed our working practices to effectively deliver services through digital technology with the resulting impact of reducing readmission rates reduced, maintaining service user engagement and onward transition and effective cross team working was maintained.

3.3.1 East Kent Crisis Group Provision

The East Kent Crisis Group Provision comprises the Skills and Support Group and the Complex Emotional Difficulties Crisis Group. Both these groups work in tandem for both the North East Kent and South East Kent Crisis Resolution and Home Treatment Teams and both have had to move from face to face to working on line using video conferencing via Lifesize.

These are a few case studies where service users have used the group whilst the group has been on Lifesize and have been compiled by Tracie Fountain, Clinical Nurse Specialist and Lee Laurence Clinical Lead for the Complex Emotional Difficulties Crisis Group.

3.3.2 East Kent Skills and Support Group – Lifesize Sessions

The East Kent Skills and Support group is a psycho-educational intervention using skills derived from CBT (cognitive-behavioural therapy) and DBT (dialectical behaviour therapy) in the context of psychologically informed group support. The skills and strategies covered include emotional regulation, distress tolerance, mindfulness, interpersonal effectiveness and problem solving. The group is an open, rolling group over the duration of 12 weeks 24 sessions in total (face to face) or via Life-size 6 weeks 12 sessions. The group runs twice weekly.

3.3.3 A Brief Case Study

X is a 51 year old who has been known to secondary mental health services for over 20 years. They have a current diagnosis of Emotionally unstable personality disorder (EUPD) and Dissociative conversation disorder and has had multiple admissions /136 place of safety assessments/East Kent Liaison Psychiatry assessments and interventions under the crisis home treatment teams. There is a consistent presentation of increased suicidal gestures and increased self-harm. AA engaged in the group through life-size for 12 sessions over 6 weeks this summer and since has had no further admissions or attendance to accident and emergency (A & E) /136 detentions. Although they have been referred to the crisis home treatment team twice since completing the group their input has been over a far lesser time period due to AA exhibiting a greater level of self-awareness and willingness to engage in alternative interventions without admission to hospital.

X is a 34 year old who was not well known to secondary mental health services but had a longstanding presentation treated by their GP of depression and self-harm. They had presented on numerous occasions to the A & E department following episodes of self-harming or suicidal threats. At that time they had a diagnosis of Borderline personality disorder (BPD) - current working diagnosis of EUPD. BB engaged initially with the group when being facilitated face to face, they continued to engage when delivered through Lifesize and completed their sessions in June 2020. A referral to Ash Eaton complex emotional difficulties outreach programme was discussed with BB and made prior to them completing the group. They have subsequently now engaged with the outreach programme and has only presented to A & E twice since completing the Skills and Support group. There have been no further requests for admission or CRHTT intervention. This is an excellent example of cohesive /seamless cross service working.

3.3.4 Complex Emotional Difficulties (CED) Crisis Group Case Study

The complex emotional difficulties crisis group was established in April 2019 and the criteria for the group is that the service users have to be under the crisis resolution home treatment team, have a formal diagnosis of Personality Disorder and are HONOS (Health of the Nation Outcome Scales) Cluster 8. The model KMPT developed creates a holding environment to offer a high degree of emotional containment. The group runs three times week, Monday, Wednesday and Friday. Each session is two hours long from 12:30 to 14:30 and the group

was meeting at St Martins Hospital with service users commuting from all of East Kent. With lockdown the group went from face to face on the Monday to being on Lifesize on the Friday.

The structure is that the first hour is an open discussion and service users are invited to speak about how they have been managing between the sessions. Service users speak openly about their suicidal feelings/ acts and self-harm as ways of managing their emotional distress. Service users have over time feel able to discuss distressing interpersonal relationships and trauma in the sessions. We are humbled by the openness of service users and the ability to take a risk in opening up to strangers and how this is met with a willingness to understand and empathise.

After an hour we built in a break because often people with CED struggle with the social interactions. The group stayed together and social interaction did develop although a lot of this has been lost as the group is now online.

3.3.5 Case Study

X started in the group in the midst of lockdown and despite being aged 18, they have had a significant amount of contact with mental health service previously being involved with Child and Adolescent Mental Health Services. They engaged in the CED crisis group from May – September 2020, attended the 35 sessions and completed the group. Below is the data that has been compiled about their use of service before, during and after the group as well as the Clinical Outcome measures used for all group members;

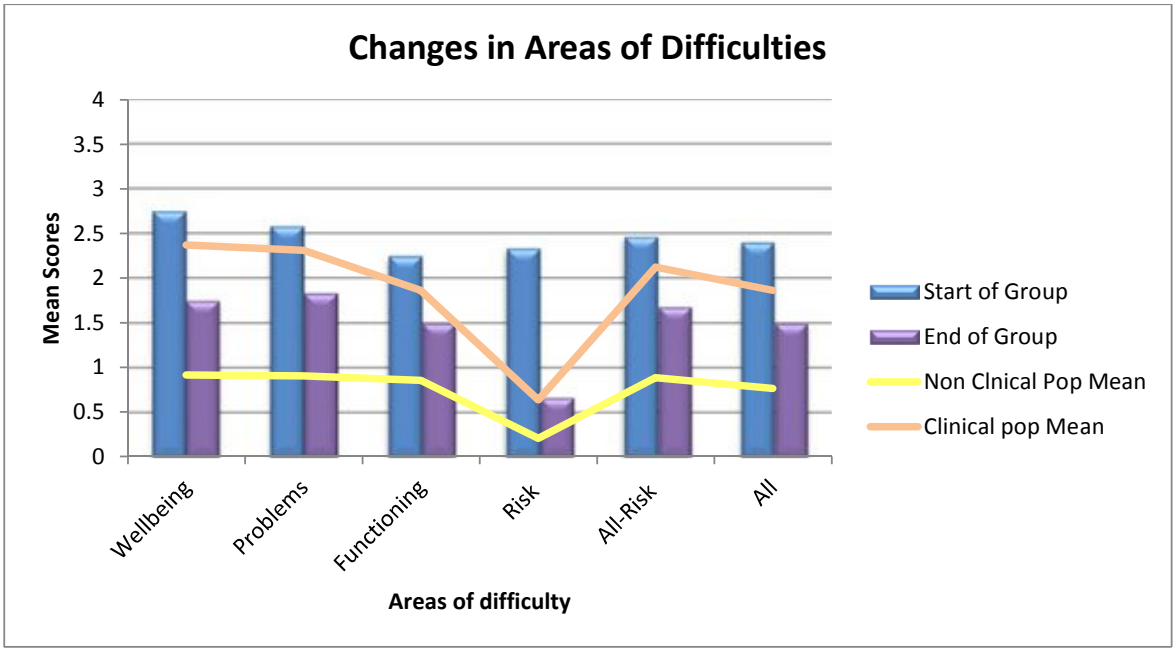
3.3.6 Number of S136s and Admissions

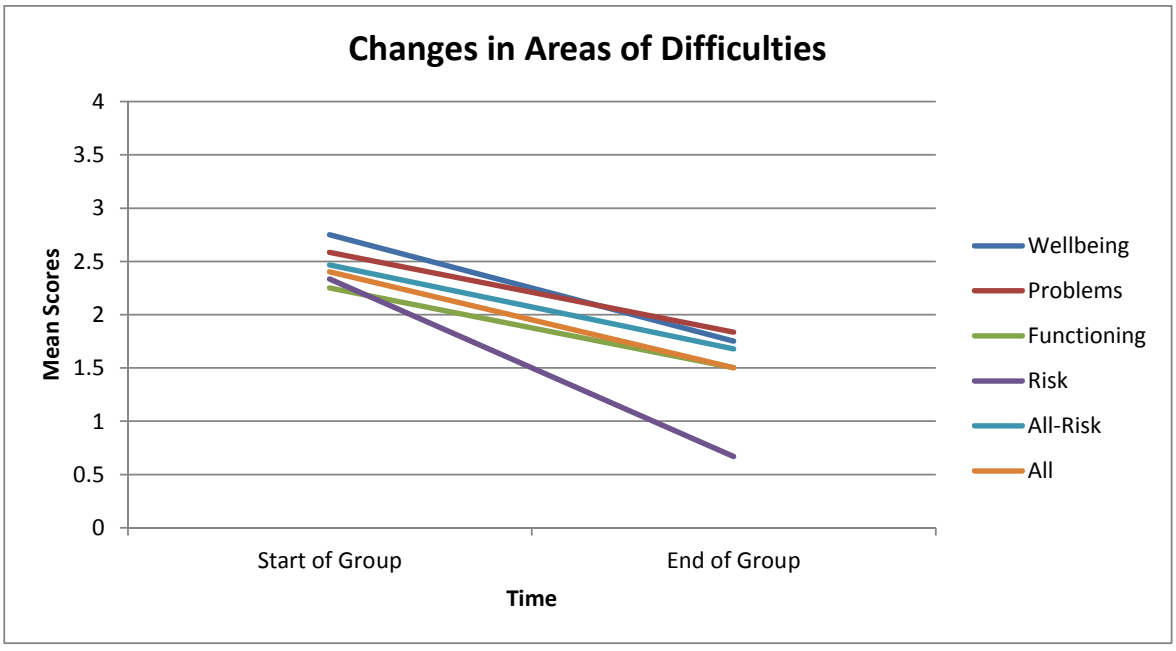
	S136s	Admissions
Totals over 1 year period (15/11/19- 15/11/20)	8	5 admissions of 35 bed days
Total from lockdown to start of group (20/3/20-7/5/20)	1	0 admissions
Totals while in the group (8/5/20 – 11/9/20)	2	1 admissions of 1 bed day
Totals from time leaving the group to now (12/9/20-15/11/20	2	1 admission of 9 bed days

3.3.7 Service user related outcome measures

Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM)

The CORE-OM assesses psychological distress and a reduction in a mean score of 0.5 suggests a reliable improvement. The service user's scores decreased in all areas of difficulty and their global distress (total score) decreased from "moderately severe" to "moderate", and their total score reliably improved;





3.3.8 Recovering Quality of Life (ReQoL)

The ReQoL assesses quality of life and an improvement in a total score of 5 suggests a reliable improvement. A score of 24 or less is considered within clinical ranges. The Service user's ReQoL score reliably improved and reached the clinical cut-off of 24;

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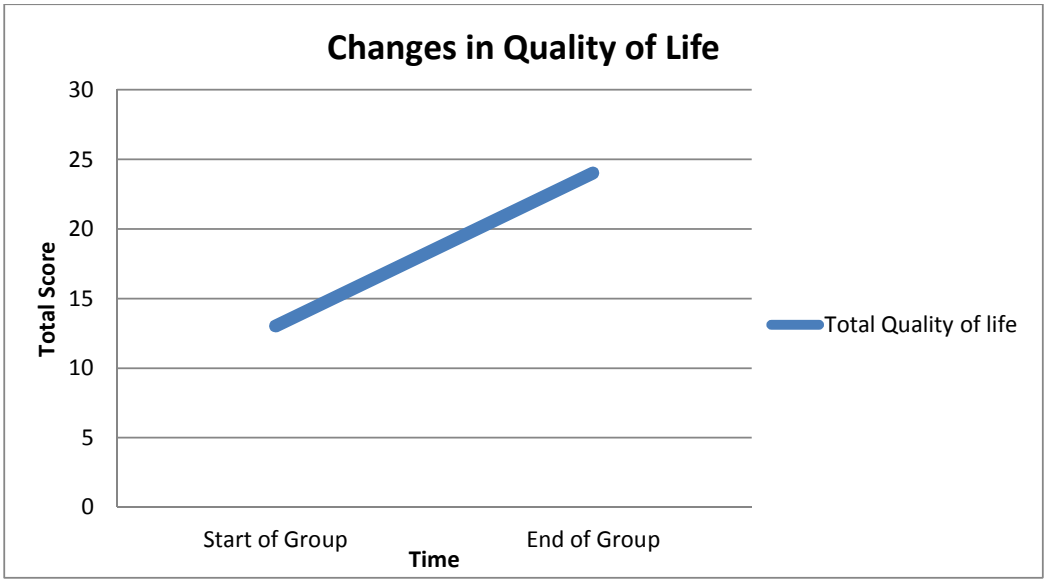
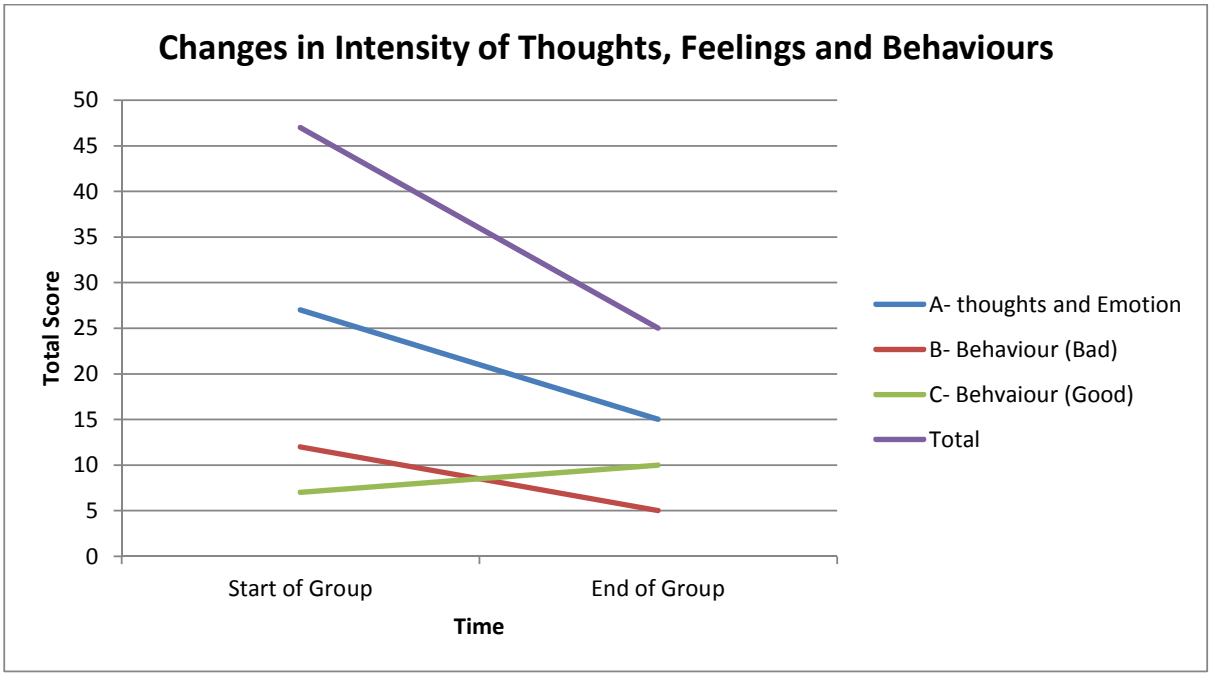


3.3.9 Borderline Evaluation of Severity over Time (BEST)

The BEST allows service users to rate the intensity of their thoughts feelings and behaviours. A reduction in A (thoughts and emotions) and B (Bad behaviours) suggests the intensity of these problems reduced at the end of the group. An increase in C (good behaviours) suggests the service user was utilising more positive behaviours at the end of the group;



3.3.10 Conclusion

The move from face to face was initially extremely rapid for both groups and has introduced interesting dynamics that both the staff and service users have had to adjust too. For the staff it has invited them in the service user's personal space and this has brought up issues

about the boundaries. For example the difficulty of having a protected space that they are able to speak in freely without partners or family being in the room or listening in and there are the additional challenges with pets!

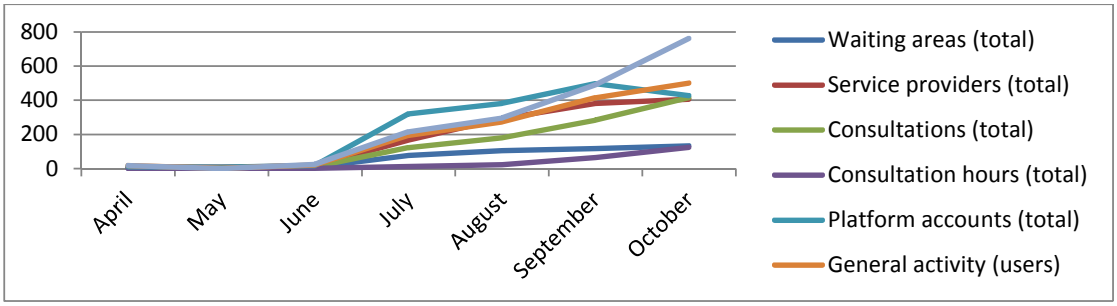
It has also lost some of the interpersonal interactions especially in the breaks as service users leave the group and therefore some of the group cohesion. The CED group has tried, were possible, to build in periodic socially distanced walks to promote some group cohesion. Some service user find the on line group difficult to engage in as it initially is felt to be too impersonal were as others find that they can attend because they don't have to commute.

4. Digitally Enabled Care

Our Vision is that our services are digital (virtual) by default and below summarises the decisions that have been made during the past eight months;

- KMPT continues to use digital platforms as a medium for supporting service users building on the success of its use during the initial lockdown. Telephone calls are also be available if the person is not able to use or access digital platforms. Face to face is offered to service users when this is required based on service user need
- KMPT uses Attend Anywhere for initial assessments, follow ups, diagnostic appointments and psychological support. Connectivity tests are set up initially with service users and clinicians to ensure that service users are able to use the equipment and that they have access to a suitable space. This in turn maximises productivity and effectiveness as the number of DNAs are reduced and service users get better outcomes as they feel more confident to use the solution during the consultation
- Therapeutic activity and supportive interventions to prevent relapse or escalation of mental health needs for people with SMI in the community are delivered through digital technology
- Attend Anywhere was initially used for younger and older adults (April to October 2020) before being adoption by specialist and forensic services (from November 2020)
- Attend Anywhere is used for service user facing individual sessions. Lifesize is the more appropriate medium for group therapy, although it can also be used for individual sessions with service users providing different meeting rooms are set up for each session
- Digital/virtual meetings are not offered to people who are actively acutely unwell
- Digital/virtual meetings are used for red board, MDT and referral meetings
- Digital inclusion – virtual, telephone and face to face options are maintained by the organisation to ensure that people are not unfairly impacted by the lack of access to digital technology. Consideration of health or social factors such as learning disability, dementia or digital poverty are factored into the appointment booking process to make sure that service users are offered the most appropriate medium
- Risk assessments are carried out in line with KMPT agreed policies and processes to ensure health inequalities or other impacting issues are considered. The risk assessment guidance will be updated to show the type of medium used to help inform further clinical input
- Staff who are shielding continue to work through using KMPT digital platforms from home

Below provides a summary of the usage within KMPT of Attend Anywhere between April – end October 2020 which shows that during this reporting period the use of Attend Anywhere has significantly increased;



Please note –

- Waiting areas are like onsite waiting rooms, service users arrive in these virtual rooms first before attending their consultation
- Service Providers - the level of access to a particular room. A provider can see the other person (on screen) in the room, a referrer can only move person to a room. For example, reception staff will be providers in the main waiting room so that they can meet and greet, but only referrers to the doctors or clinicians' room.
- Consultations - the number of consultations
- Platform accounts - the number of accounts (people) set up to use Attend Anywhere
- General activity - the usage of Attend Anywhere broken down

Below summarises the milestones which have been delivered over the past eight months and the milestones which will be delivered;

Milestones delivered

- Since the beginning of April 2020 all clinicians who provide psychological services in the CRCG and specialist personality disorder service (approx. 80 clinicians) have been using Lifesize to deliver virtual individual and group therapy
- A COVID videoconferencing Standard Operating Procedure was published in June 2020 and this includes guidance on how to assess clinical risk when delivering services through video conferencing and telephone (this is currently under revision and soon to be updated.)
- The University of Kent were commissioned in June 2020 by KMPT to undertake research and an evaluation of the experience of clinicians and service users use of video or telephone therapy - this will be reported to quality committee in January 2021. KMPT will publish these findings nationally and internationally in early 2021
- An evaluation of the clinical use of video-consultation with service users during the COVID19 pandemic across KMPT was reported to Clinical Effectiveness Outcomes Group (CEOG) in August 2020 which included recommendations for improvement; for example, improved technical support for staff and clients
- In November 2020, a Professor who works for KMPT submitted an online psychotherapy paper to the British Journal of Psychotherapy. The paper focuses on the nuance of therapeutic relationships when delivering services through video conferencing rather than face to face – we are awaiting approval and acceptance

Milestones to be delivered

- In November 2020, a proposal is being taken to CEOG for the liaison services self-harm pilot where follow ups will be delivered through Attend Anywhere linked to the Core 24/7 offer
- Identified clinical leads to drive forward our vision of digital/virtual by default to be confirmed by 30 November 2020
- The Acute care group to confirm if and how they will use Attend Anywhere by 30 November 2020, particularly for Crisis resolution and home treatments
- The Standard Operating Procedure guidance for virtual consultations will be reviewed and published by 31 December 2020
- Attend Anywhere and Lifesize to be rolled out where appropriate for service user appointments across specialist and forensic services by 31 January 2021
- NHS Digital to confirm continued funding of Attend Anywhere (or alternative platform) beyond 31 March 2021

- The Kent and Medway ICS will look to procure a county wide solution for virtual/digital consultations which delivers a sustainable solution to delivering KMPT's vision of digital/virtual by default along with providing a standard solution for all service users accessing care using video (commence from April 2021)
- Our new models of care will be agreed including how we sustainably deliver our vision of digital/virtual by default by 30 June 2021. This will include the percentage of appointments delivered digitally/virtually and the amount of capacity and travel costs which will be reinvested into services
- Reduced travel for service user; resulting in less time spent traveling and less incurred costs to/from appointment/s
- Reduced travel for staff; allowing for additional clinical/operational time and service user contact time and reduced travel costs for the clinician and organisation. Some savings from reduced travel claims within KMPT are being used as part of the 2020/21 Cost Improvement Programme (CIP) for older adults and CRCG although the amount of savings for older adults has reduced since a face to face option was reintroduced in July 2020. Our new models of care need to be agreed including how we sustainably deliver our vision of digital/virtual by default before these savings can be reinvested on a recurrent basis
- Digital technology has accelerated the opportunity for CMHSOPs to align the two duty rotas in South West Kent (SWK) where one doctor attends the virtual red board meetings. Prior to COVID-19 two doctors were overseeing two red board meetings in SWK. The second doctor's capacity has been released for them to focus on telephone interview for cognitive status (TICSm)
- Reduced carbon footprint in line with sustainability through reduced travel for staff and service users

Some of the learning from the digitally enabled care work is provided below;

- Following successful programme of engagement that helped inform our Clinical Technology strategy we need to capitalise on our clinical partnership to realise our vision of our services being digital/virtual by default.
- Some service users are unable to access digital/virtual services because they do not have access to the right devices and/or it may not be safe for them to use digital/virtual services at home – alternative solutions must be agreed to ensure their care continues
- Attend Anywhere was a solution provided free of charge from NHS Digital a permanent solution needs to be assessed in greater detail to ensure it meets the needs of all service users. Consideration has to be given to a Kent wide ICS solution.
- The required outcomes are not being achieved for therapy in community groups (specialist personality services) – these groups can only be delivered effectively face to face
- There is a recognition that being able to release clinical time to engage and drive forward our vision during a global pandemic (COVID-19) whilst in parallel adopting a new digital solution and innovative ways of working is difficult there are times where this could improve services more quickly.
- Being able to implement robust project management from the start of a project to business as usual where the digital solution is sustainably embedded in practice greatly improves the adoption of new digital solutions.
- Find a mechanism to capture and report on information relating to performance, e.g. usage numbers and outcomes for digital solutions relating to staff and service users
- Because KMPT already had Lifesize as a platform pre COVID, this allowed KMPT to mobilise rapidly within 2 weeks so that all psychological treatment could be delivered virtually within CRCG and specialist complex emotional difficulty services
- The digital platforms available need to include functionality to effectively provide individual sessions as well as group treatment.

- It is essential a county wide approach to a whole system digital platform; particularly where KMPT teams are based for example in acute Trusts where connectively can be reliant on acute IT services providing connectivity
- As an organisation KMPT should be realistic when capacity will be sustainably released and savings reinvested through staff working in a very different way; digital/virtual by default
- When new ways of working are identified there should be early engagement with IT with regards to how KMPT can ensure supported delivery and capture and report on activity.

RECOVER AND TRANSFORM PROGRAMME

Project Scope v1.0 as at 27 October 2020

NHS
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NHS and Social Care Partnership Trust

OPERATIONAL RECOVERY GROUP (ORG): oversight for delivery of specific operational recovery plans with regular reporting, including escalation of risk and recommendations, to RTB

Prepare for long term demand increase due to COVID19	Demand & Capacity Modelling	**To develop a clinically supported demand and capacity model and embed existing Patient Tracker List (PTL) across the organisation.**
	Increasing recruitment (NHS Long Term Plan)	**To actively recruit in line with the NHS Long Term Plan to meet increased demand.**
Better Safer Buildings (BSB)		**To ensure buildings and work environments are made as safe as possible for staff and patients so that services can be delivered as effectively as possible.** *Project closed / handed over to business as usual (Sep20)*
Providing Flexible Access	Community	**To identify, retain and build on COVID-19 innovations relating to agile working, use of technology and estate going forward where they add value, and cease or change those working practices which do not add value where this can be evidenced.**
	Corporate	
Open Access Crisis Care		**To ensure open access crisis services, with partners, are available to meet the needs of local population.**
Psychological Support / Staff Health & Wellbeing		**To provide enhanced psychological support for NHS / healthcare staff, to provide psychological support for the general population and to provide KMPT staff psychological support.**

Digitally Enabled Care	**To increase access to services supported by technology and having clear guidance, training and reporting mechanisms of how we use technology to support care delivery.**
Annual Health Checks (AHC) for people with Learning Disabilities	**To work with colleagues in primary care, to ensure those people with a learning disability have an AHC.**
Health Inequalities Group	**To ensure consistent KMPT representation on ICS / ICP forums, to ensure population health intelligence informs all planning and decision-making and alignment with the Mental Health Investment Standard (MHIS).**
Communications and Engagement	**To ensure timely and accurate communication and engagement of all RTP activities.**

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RESPECT · OPEN · ACCOUNTABLE · WORKING TOGETHER · INNOVATIVE · EXCELLENCE

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Title of Meeting	Trust Board	**Date**	26/11/2020
Title of Paper:	Integrated Performance and Quality Report (IQPR) Performance Update as of: October 2020		
Author:	All Executive Directors		
Presenter:	Helen Greatorex, Chief Executive		
Executive Director:	Sheila Stenson – Executive Director of Finance		

Purpose: the paper is for:	**Delete as applicable**
• **Discussion and information.**	

Recommendation:

The Board is asked to consider October's Integrated Quality and Performance Report (IQPR) noting the key areas of focus.

Summary of Key Issues: **No more than five bullet points**

Each section has been written by the Executive lead for the domain. The report provides Trust-wide performance data, with Care Group and locality data monitored by the Executive and their teams.

The report highlights where performance has improved, is on track and has declined.

Report History:

None

Strategic Objectives: **Select as applicable**

- ☒ Consistently deliver an outstanding quality of care
- ☐ Recruit retain and develop the best staff making KMPT a great place to work
- ☒ Put continuous improvement at the heart of what we do
- ☐ Develop and extend our research and innovation work
- ☐ Maximise the use of digital technology
- ☐ Meet or exceed requirements set out in the Five Year Forward View
- ☐ Deliver financial balance and organisational sustainability
- ☐ Develop our core business and enter new markets through increased partnership working

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☐ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership

Implications / Impact:
Patient Safety: Patient safety is a key priority and issues that may affect this, are highlighted in the report and considered by the Board.
Identified Risks and Risk Management Action: Risks set out in the report are all reflected in the Trust's risk register or BAF. All risks are outlined within the paper below
Resource and Financial Implications: Failure to achieve some of the regulatory, performance or data quality metrics could result in a financial penalty under the NHS Standard Contract and importantly, to a poor quality service for patients potentially leading to claims.
Legal/ Regulatory: None
Engagement and Consultation: Not applicable
Equality: None
Quality Impact Assessment Form Completed: No

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Introduction

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

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

Each member of the Chief Executive's team provides the commentary to the area for which they are the lead. This adds a further strengthening to the actions outlined, and ownership and accountability where improvements are required.

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

Our nine Strategic Objectives (for 2016-19) are set out at the start of the report under our aim of Brilliant Care Through Brilliant People. This along with the Care Quality Commission's five Domains (Safe, Caring, Effective, Responsive and Well Led) helps focus the report on both the national and local context. New trust objectives will be reviewed and mapped to each CQC domain.

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Brilliant care through brilliant people

Strategic Objectives:

- Consistently deliver an outstanding quality of care
- Recruit, retain and develop the best staff making KMPT a great place to work
- Make continuous improvement at the heart of what we do
- Develop and extend our research and innovation work
- Maximise the use of digital technology
- Meet or exceed the requirements set out in the Five Year Forward View
- Deliver financial balance and organisational sustainability
- Develop our core business and enter new markets through increased partnership working
- Ensure success of STP through active participation and leadership

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Executive Commentary

The data provided to the Board is drawn from performance in October and is shown at Trust-wide level.

Indicators to highlight in month include:

- Continued high performance in the treatment of patients on CPA (Care Programme Approach) receiving a 12 month review, again exceeding the National target for this cohort of patients (95.9%) for the sixth month in a row.
- The % of patients on CPA Followed Up within seven days of discharge was 98% in October, above the 95% target for the tenth successive month.
- The Early Intervention in Psychosis service is made up of 5 teams across Kent and Medway. The teams have continued to meet the required national standard (60%) for referral to treatment within 14 days, generally well above the required national trajectory.
- Following the improvement last month with the use of inappropriate out of area bed days, October saw an increase to the highest monthly position since May 2020.
- Despite a further decline in performance of the % of patients with a valid CPA care plan (82.7%) further work has been completed to increase assurance that those within the CMHT Support plan pilot are receiving plans despite not being counted within the indicator currently whilst waiting review and agreement of the QIA. The indicator continues to be achieved for all patients on CPA.
- Overall staff sickness increased by 0.7% in month to 4.4%, the first month the target of 4.22% has been exceeded since May 2020. Covid related sickness accounts for 0.6%

A trend line over twelve months is provided after each section enabling the reader to see a year's performance at a glance. Trust-wide data is drawn from a range of sources and includes individual, team, Care Group and locality information. That data is reviewed and explored by members of the Executive Team with every Care Group at the monthly Quality Performance Review meetings. In addition, where an area is receiving additional attention as a result of concerns, special reporting and monitoring mechanisms are implemented, supported by trajectories for improvement.

Not all areas of performance (including those nationally set) have a target set against them. This is an area for further consideration with the board as the report evolves. It is helpful to note that in the absence of a national waiting time target for mental health service users, the Trust has set its own local target for two key indicators. We have made one change to the report this month and it is detailed in the change table below.

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Underpinning the IQPR is a series of Executive chaired meetings. They bring together KMPT experts in their field in order to understand the data at a granular level and test that actions in hand to resolve concerns are strong enough and delivering improvements in a timely way.

Supporting the work of the board, are its sub-committees each of which considers in detail, aspects of the IQPR. This report, when working as we expect it to, will enable the board to operate at strategic level, confident in the work of the sub-committees in testing assurance and understanding further detail provided by the executive and their teams.

The report is now a familiar tool and point of reference in the Trust and as we had hoped, further strengthening our ability to triangulate information and explore in detail areas of concern. My team will provide detail on the work being done to understand and address these areas of concern whilst maintaining improved performance across a range of other areas.

Helen Greatorex
Chief Executive

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IQPR Change Tracker

Date	Change	Report Reference
January 2020	Data Quality Maturity Index (DQMI) updated to reflect new definition – expanded to 30 items	004.E
	Additional Finance Measure: *Distance From Financial Plan YTD (%)*	006a.W-F
February 2020	Settled accommodation and employment indicators retired	002.E & 003.E
March 2020	Additional measures added to Responsiveness Domain:	
	Patient cancellations- 1st Appointments	009.R
	Patient cancellations- Follow Up Appointments	010.R
	Trust cancellations- 1st Appointments	011.R
	Trust cancellations- Follow Up Appointments	012.R
April 2020	Removed safety thermometer as retired as a measure nationally.	014.S
May 2020	Removed clustering measures as no longer part of contract monitoring: % Reviews Undertaken Within The Maximum Cluster Review Period & % Of Service Users Assessed With Cluster Assigned	009.E & 010.E
	Removed staff survey measures as only reported annual and will be detailed in narrative once available	010& 011.WW
	Amended Emergency Readmission Within 28 Days target to reflect mean of national benchmarking	004.S
	Workforce metric targets updated:	
October 2020	'Issues of Concern' text box added to each domain to highlight areas of risk and mitigating actions in place	All Domains
	Definition change for waited times measures to include all appointment types (Face to face, video & telephone) where duration is 30 minutes or more. Previously counted face to face only of any duration.	002.R & 003.R
November 2020	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) – Measure adjusted retrospectively from May 2020 to reflect additionally purchased capacity within Kent.	005.E

Changes made prior to 2020 removed from table, can be viewed in IQPR versions pre November 2020

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Regulatory Targets – Single Oversight Framework (SoF)

Overview

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

The Framework aims to help NHSI to identify NHS providers' support needs across five themes:

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

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

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

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

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

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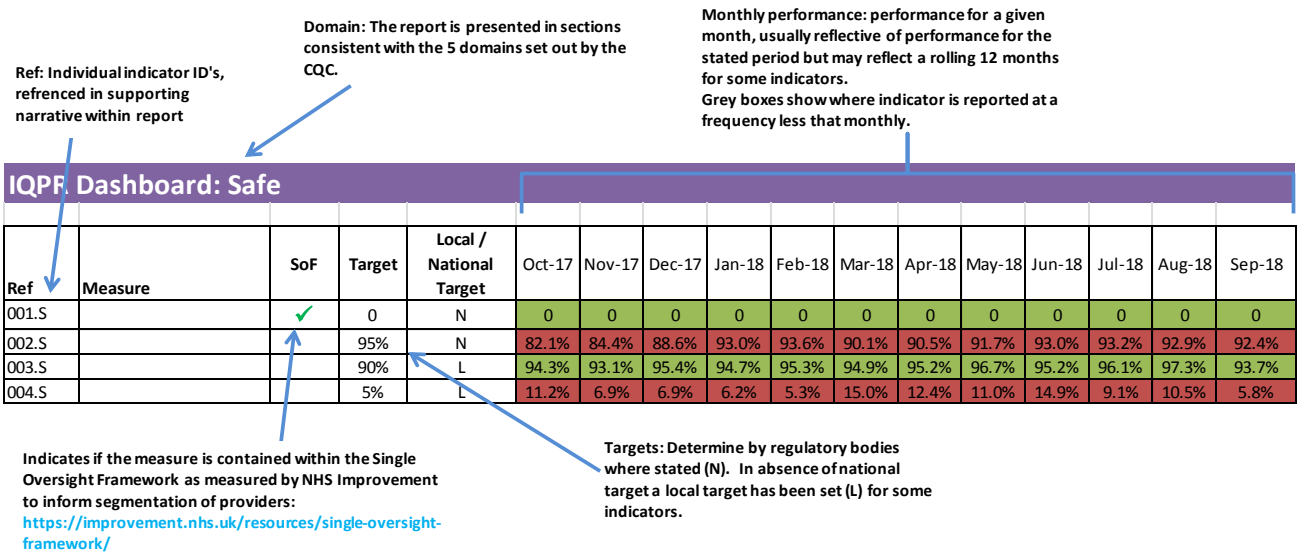
IQPR Dashboard Guide

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

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



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

Statistical Process Control (SPC) Charts Explainer

- SPC Charts are used to study how a process changes over time. Data is plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data, usually over 12 months within this report. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).
- Upper and Lower control limits are set by calculating the average +/- 2 standard deviation (a quantity expressing by how much the members of a group differ from the mean value for the group.)
- Where significant process change is implemented you may recalculate the mean and control limits to reflect this change.
- The SPC charts within this document only apply the basic rule set of identifying breaches of control limits, charts can however be developed further to identify additional triggers for investigation, such as a succession of 9 or more data points on the same side of the mean.

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Trust IQPR by CQC Domains, Trust Strategic Objectives & Board Assurance Framework

CQC Domain	Safe
Trust Strategic Objective & Board Assurance Framework	• **Consistently deliver an outstanding quality of care**

Executive Lead(s): Executive Director of Nursing & Quality
Lead Board Committee: Quality Committee

Issues of Concern
Prone restraints

Executive Commentary

The following metrics have continued to show a positive position:

- Inpatient physical health checks completed within 72hours
- A reduction in mortality incidents, further information and analysis of mortality incidents is included in the Quarter 2 Mortality Review report on the Board's agenda.
- No nosocomial infections reported
- No inpatient ligature related incident resulting in moderate or severe harm
- CPA formal 12 month review remains sustained performance above the required standard of 95%.
- Readmission rates are improved by moving downwards over the past 3 months and in October stand at 7.7%. Quality committee received a report on readmission rates outlining actions taken in the last 12 months to bring down the number of frequent admissions (those persons admitted more than once in less than 28 days following admission)

Number Of Grade 1&2 Serious Incidents Confirmed Breached Over 60 Days (008.S)

Serious Incidents (SIs) continue to fluctuate throughout the year and this is to be expected as these cannot be predetermined. The total number of SIs slightly increased from 15 in October to 17 in November but still lower than the highest reported year to date of 25 incidents in March. Yearly average is 13.5 incidents per month.

Of the 17 SIs reported in month, 7 were within the community. The incidents are varied and include: an information governance breach; a near miss security breach; self-harm in community; safeguarding; a fall resulting in a fracture; pressure ulcer and a physical deterioration.
Following a peak in safeguarding allegations of 9 reported in August, there were no safeguarding

related SIs reported in September and only two reported in October. All incidents are still undergoing the Root Cause Analysis (RCA) learning review process.

A deep dive of all unexpected deaths reported during the pandemic will be completed and presented to the Quality Committee in January 2021 to establish if there are additional learning themes to inform future practise improvement. This is in addition to the learning already shared and implemented following each individual RCA.

When data is analysed per care group, there has been a gradual reduction of SIs from the Older Adults Care Group and Community Recovery Care Group has remained relatively stable. A slight increase was however noted from Forensic and Specialist Care group and Acute services where there was an increase of two incidents each compared to last month.

Recruitment to the Central SI team is complete, with new staff expected to take up post from January 2021. The increased resource should provide much required capacity to undertake investigations in a timely manner and to ensure that the quality of reports continues to be of a good standard.

Restrictive Practice (011.S – 013.S)

The Trust's approach to the use of restraint is carefully monitored and reviewed in line with national best practice. The use of restraint is always a last resort, staff are trained in de-escalation techniques which are always considered before restraint is implemented. All use of restrictive interventions is monitored in line with Trust policy with strategic oversight by the Promoting Safe Care group which has membership from all care groups and subject matter experts. The strategic monitoring ensures that there is additional scrutiny in order to provide assurance on compliance with Mental Health Act Code of Practice and Human Rights Act.

The Trust has considered at the Trust Wide governance meetings including Quality Committee, the findings from the recent Care Quality Commission report on "*Out of Sight- who cares: A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition"* published in October 2020. A Trust self-assessment will be completed by multi-disciplinary team members and subject matter experts. This is in keeping with our standard practise when there are newly published national reports. A report following this work will be shared at relevant governance meetings in the New Year.

Restraints

There were 146 reported incidents of restraint needing to be used in October 2020, an increase of 14 from the previous month. Both the Forensic and Specialist care group (FSCG) and the Older Adult care group (OACG) have shown decreases of seven and four respectively, with the Acute Care Group (ACG) showing an increase of twenty-five. The majority of restraints occurred in the Acute Care

Group (ACG) with 106 reported in October. The data indicates that Willow Suite had the highest number of restraints (20) in October compared to (7) in September. The twenty restraints involved fifteen different patients. This change would indicate a high level of acuity and admissions over the last month.

Prone restraints

Prone restraints have decreased from (13) in September to (11) reported incidents in October. All prone restraints occurred in the ACG. The duration of the restraints are also monitored.

Seclusion

The use of seclusion has increased from 22 instances in September to 29 in October 2020. The majority of these occurred in the ACG (23) with the remaining 6 in the FSCG. The Psychiatric Intensive Care Unit reported the highest number of incidents, eleven seclusion episodes which involved four different patients followed by a male acute ward. All instances of seclusion are reviewed and an overview retained in order to identify any patterns and to ensure additional support from the Promoting Safer Services team.

There have been no incidents of patients with a confirmed diagnosis of Covid being subject to restraint; however there were two Covid-19 related restraints during October 2020. These both occurred in the Acute Care Group. ,

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IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	93.6%	94.9%	95.0%	96.0%	94.9%	94.0%	95.6%	95.8%	95.9%	96.0%	95.6%	95.9%
003.S	% Inpatients With A Physical Health Check Within 72 Hours		90%	L	96.1%	98.1%	93.4%	94.7%	95.8%	95.1%	95.2%	97.7%	95.8%	97.0%	95.4%	97.5%
004.S	Emergency Readmission Within 28 Days		8.8%	L	13.6%	12.1%	9.9%	9.8%	8.5%	10.9%	9.6%	10.6%	7.0%	13.6%	11.6%	7.7%
005.S	Number Of Unplanned Absences (AWOL and Absconds on MHA)		-	-	19	16	17	24	25	6	19	26	19	16	17	21
006.S	Serious Incidents Declared To STEIS		-	-	7	11	10	8	18	11	8	22	20	24	15	17
007.S	% Serious Incidents Declared To STEIS within 48 hours		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
008.S	Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days		0	L	8	7	16	8	12	8	4	8	3	8	17	12
010.S	All Deaths Reported On Datix And Suspected Suicide		-	-	271	205	319	235	172	375	206	286	232	218	140	134
011.S	Restrictive Practice - All Restraints		-	-	94	172	135	111	159	131	105	152	129	159	132	146
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	3	2	3	4	11	5	5	6	1	10	13	11
013.S	Restrictive Practice - No. Of Seclusions		-	-	38	49	28	25	38	25	28	39	22	32	22	29
015.S	Ligature Incidents - Ligature With Fixed Points (moderate to severe harm)		0	L	0	0	0	0	0	0	0	0	0	0	0	0
016.S	Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm)		-	-	0	0	0	0	0	0	0	0	0	0	0	0
017.S	RIDDOR Incidents		-	-	2	3	3	1	3	1	1	0	2	2	4	4
018.Sa	Infection Control - MRSA bacteraemia		0	N	0	0	0	0	0	0	0	0	0	0	0	0
018.Sb	Infection Control - Clostridium difficile				0	0	0	0	0	0	0	0	0	0	0	0
019.S	Safer staffing fill rates		80%	L	97.6%	100.5%	95.8%	97.3%	102.9%	108.9%	114.7%	116.4%	114.7%	114.5%	111.9%	111.2%

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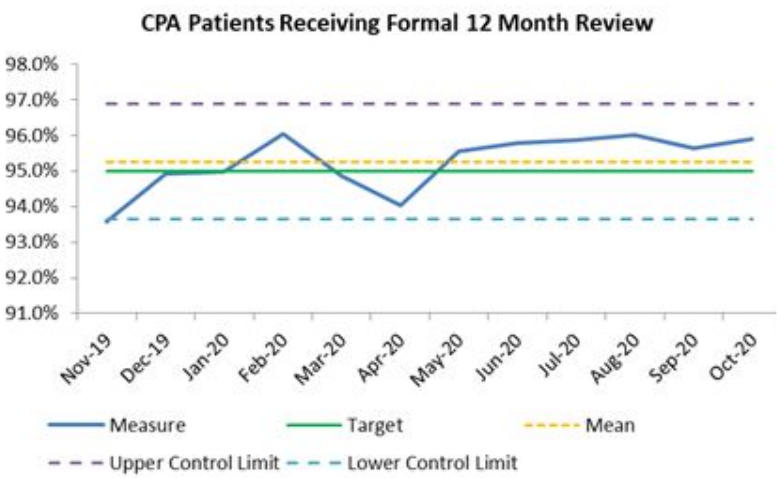
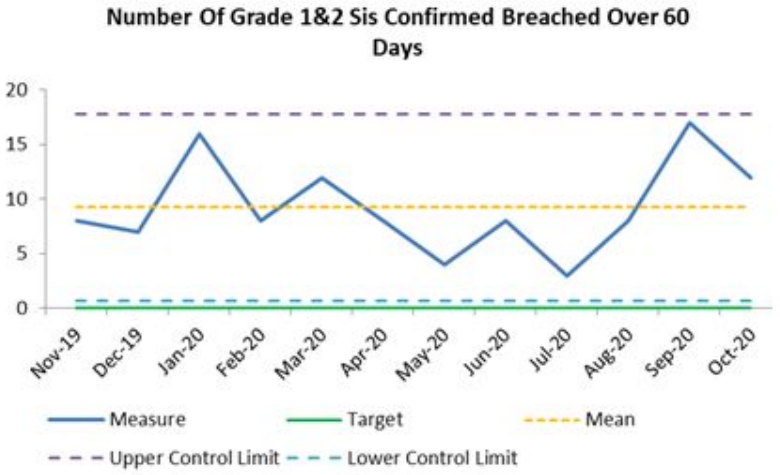
Domain Indicators in Focus
The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard



Actions in place:

- Continued focus from CMHT leads
- Administrative staff to support process for scheduling reviews within required time period
- Additional staffing agreed to support safe transition of cases



- Weekly tracking of progress and escalation to managers as appropriate
- Root Cause Analysis Investigation capacity has been pooled into a central function and recruitment has been completed to expand the Centralised SI investigation team

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CQC Domain	Effective
Trust Strategic Objective & Board Assurance Framework	• **Make continuous improvement at the heart of what we do** • **Develop and extend our research and innovation work**

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

Issues of Concern
Inappropriate out of area placements: of note male PICU use increased in month due to gaps in available care for autistic people with subsequent behavioural impact requiring specialist crisis response and on-going care and high levels of acuity generally post lockdown. The trend is not expected to continue The older adults care group has an issue with the reporting of care plans. The issue is understood and will be resolved via the data quality group.

Executive Commentary

Issues of concern are highlighted above. A point to note is the increase in the number of home treatment team episodes. For two months the teams have met the locally set standard of 224. To meet the standard requires the team recording against 3 face to face contacts, 1 assessment contact and 2 follow up contacts. A number of people referred to the CRHT will not require the 3 contacts as they offer urgent assessment, therefore a level of activity in the CRHT services is not reported on in the IQPR. By meeting this standard evidences the teams are busy and possibly points to higher levels of acuity as more people need to the full 3 contacts and on-going treatment.

Inappropriate out of area placements for adult mental health services (005.E)

The number of days used in out of area placements has increased from 88 in September to 195 in October.

The Acute Care Group had seven male patients that occupied beds in an out of area PICU placement, of the seven male patients three have now been repatriated to a KMPT bed or discharged. This is an unusual position; this was driven by an upsurge in demand for male psychiatric intensive care beds due to the rise in acuity noted post covid lockdown. Of the 7 patients, 4 had a primary diagnosis of autism. The Kent system has no intensive care or crisis response for autistic people currently. The weekly clinical meetings via a conference call ensure people do not remain out of area for longer than is necessary. It is expected the trend will move downwards in the next two months

Please note that we have amended the reported number since May 2020 to exclude those bed days used as part of the private provider contract the Trust has in places as these beds are within Kent.

Delayed Transfer of Care (006.E)

Delayed Transfers of Care (DToC) has risen in the last two months as the wards have become busier following lock down ending in June 2020. The patient flow team manage DToC and have a daily report to review the reasons and take action. In month the Chief Operating Officer escalated to Kent County Council some of the challenges with their recent reorganisation and the impact on DToC. The response was positive in terms of agreeing escalation routes.

% of Patients with Valid CPA Care Plan or Plan of Care & Crisis Plans (All Patients) (007.E & 008.E)

These measures count those with a care plan created or updated in the last 12 months for all patients on a CPA or non CPA pathway. Changes to the documentation required for non CPA patients in order to ensure affective planning continue to be piloted which impact the %'s reported. The following tables show that for those patients under CPA both targets are achieved.

Table 1: % of Patients with Valid CPA Care Plan or Plan of Care - CPA only

	2020-08	2020-09	2020-10	*Latest Denominator (CPA)*
Community Recovery Service	98.6%	98.6%	99.0%	*2,116*
Forensic and Specialist	98.7%	97.5%	97.9%	*237*
Older Adult	99.4%	99.7%	98.5%	*340*
Grand Total	**98.7%**	**98.7%**	**98.8%**	*2,693*

Table 2: Crisis Plans - CPA only

	2020-08	2020-09	2020-10	*Latest Denominator (CPA)*
Acute Service	100.0%	100.0%	90.0%	*10*
Community Recovery Service	97.9%	97.4%	97.7%	*2,113*
Forensic and Specialist	94.8%	96.2%	96.2%	*234*
Older Adult	96.3%	96.1%	95.3%	*338*
Grand Total	**97.4%**	**97.2%**	**97.2%**	*2,695*

CMHT and CMHSOPs contribute over 80% of this standard as they are the lead coordinator of care for the majority of the 14,598 patients on a pathway. In October the CMHTs had 87.5% valid care plans (6,217 case files) and the CMHSOPs are at 72.5% (5,804 case files). The CMHTs have a new standardised Personal Support Plan in pilot phase and is not yet being reported on. Older adults CMHSOPs have a standard letter for Memory Assessment; both replace the more traditional care plan and require a new process to be set up so this can be reported on.

Table 4 shows the impact of personal support plans in CMHTs; in summary it shows the inclusion of support plans would see an increase from 87.5% to 90.8%. This takes into the account the requirement to review the support plan at least once every 8 weeks. The pilot of the use of the

personal support plan for those not subject to CPA in CMHTs, is coming to an end; the results and suggested protocol changes are due for a final scrutiny and sign off at the Quality Committee in November. Not all teams are part of the pilot and therefore there is variance in its impact to date.

Table 4: Impact of inclusion of personal support plans into care planning standard for CMHTs

				Any date valid			Valid in last 8 weeks		
	Original Numerator	Denominator	%	Adjusted Numerator	Adjusted %	Variance	Adjusted Numerator	Adjusted %	Variance
Trust	**12072**	**14598**	**82.7%**	**12394**	**84.9%**	**2.2%**	**12277**	**84.1%**	**1.4%**
Community Recovery Service	**6552**	**7432**	**88.2%**	**6874**	**92.5%**	**4.3%**	**6757**	**90.9%**	**2.8%**
CMHT	5359	6127	87.5%	5681	92.7%	5.3%	5564	90.8%	3.3%
Ashford Community Mental Health Team	471	485	97.1%	473	97.5%	0.4%	473	97.5%	0.4%
Canterbury & Coastal Community MHT	402	559	71.9%	517	92.5%	20.6%	453	81.0%	9.1%
DGS Community Mental Health Team	981	1054	93.1%	981	93.1%	0.0%	981	93.1%	0.0%
Dover & Deal CMHT	407	489	83.2%	437	89.4%	6.1%	431	88.1%	4.9%
Maidstone Community Mental Health Team	649	700	92.7%	649	92.7%	0.0%	649	92.7%	0.0%
Medway Community Mental Health Team	744	903	82.4%	792	87.7%	5.3%	781	86.5%	4.1%
Shepway CMHT	377	494	76.3%	467	94.5%	18.2%	434	87.9%	11.5%
Swale Community Mental Health Team	280	302	92.7%	280	92.7%	0.0%	280	92.7%	0.0%
SWK Community Mental Health Team	600	639	93.9%	600	93.9%	0.0%	600	93.9%	0.0%
Thanet Community Mental Health Team	448	502	89.2%	485	96.6%	7.4%	482	96.0%	6.8%

Currently the memory Assessment plans are provided in the form of a letter which is not reportable from within RiO, work is underway to assess the pilot and agree how this can be incorporated into the reporting going forward.

On the conclusion of the pilots, new indicators for monitoring performance can be agreed and will be reflected in the IQPR.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

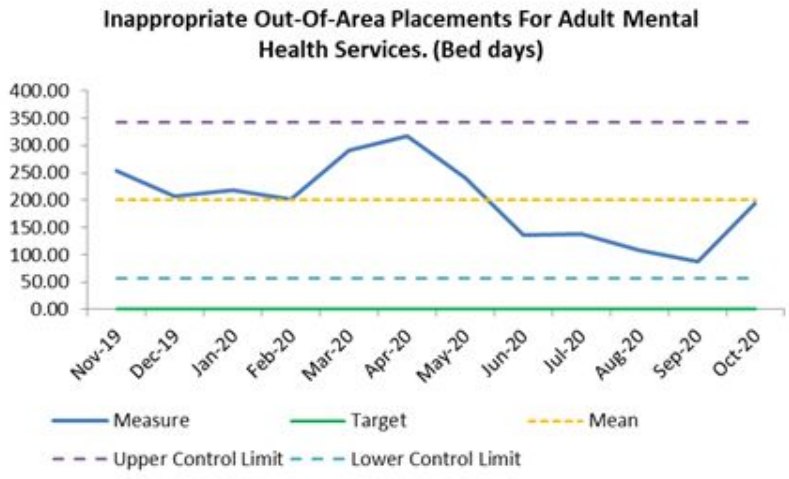
IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
001.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	94.4%	94.1%	98.4%	95.9%	95.6%	95.3%	98.9%	95.9%	97.6%	95.5%	98.2%	98.0%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	94.1%	94.4%	94.7%	94.7%	94.3%	95.7%	95.5%	95.1%	95.0%	95.4%	95.2%	95.3%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	254	208	219	201	292	318	241	137	138	108	88	195
006.E	Delayed Transfers Of Care		7.5%	N	8.5%	10.0%	9.3%	8.6%	9.4%	10.7%	9.8%	8.0%	6.8%	6.4%	8.1%	10.7%
007.E	% Of Patients With Valid CPA Care Plan Or Plan Of Care		95%	L	88.5%	88.2%	87.5%	87.3%	87.5%	88.1%	87.8%	87.7%	88.0%	86.3%	84.2%	82.7%
008.E	Crisis Plans (All Patients)		95%	L	89.2%	88.6%	87.8%	87.6%	87.1%	88.6%	88.2%	88.9%	90.0%	89.5%	88.1%	87.3%
011.E	Number Of Home Treatment Episodes		224	L	171	183	195	218	164	128	159	174	204	219	225	248
012.E	Average Length Of Stay(Younger Adults)		25	L	26.11	25.27	29.01	31.66	26.78	36.38	26.64	23.71	24.74	18.30	26.25	25.29
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	69.28	70.44	92.80	73.32	69.50	62.11	82.25	57.93	57.98	49.32	66.31	64.35
013b.E	Average Length Of Stay(Older Adults - Continuing Care)		-	-			1485.00	2003.00	437.00							
014.E	Care Plans Distributed To Service User		75%	L	65.2%	65.9%	65.9%	66.2%	64.4%	68.2%	67.0%	66.8%	68.6%	68.1%	67.2%	68.1%

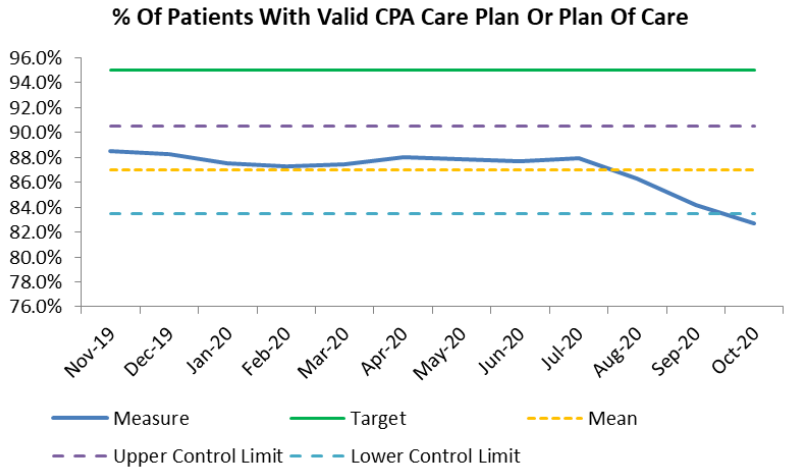
- *New methodology introduced and target for DQMI (004.E) in June 2019 and further methodology update reflected in figures from August 2019 onwards*

Kent and Medway NHS
NHS and Social Care Partnership Trust

Domain Indicators in Focus
The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard

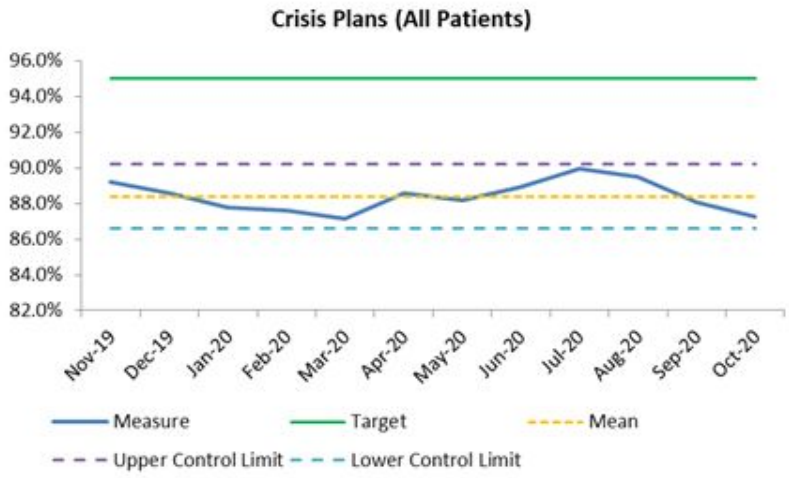


- Weekly PICU clinical review group



- All information triangulated through quality performance reviews to maintain Executive scrutiny, ascertain areas of concern and ensure key issues are actioned planned

- The Community Recovery Care Group leadership required to ensure all persons on CPA remain prioritised for review of care and risk



- Pilot of Personal Support Plan underway for those not subject to CPA in CMHTs

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Domain	Well led – Workforce
Trust Strategic Objective & Board Assurance Framework	• **Recruit, retain and develop the best staff making KMPT a great place to work**

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

Issues of Concern
Sickness increase of 0.7% from September 2020 to October 2020. However, this is comparable to October 2019; it is the same rate of 4.4%. There are increases in long term and short term sickness absence. Tactical Covid meetings reviewing sickness twice per week to consider hotspot areas. Older Adults are only area showing a decrease since previous month.

Executive Commentary

Staff Sickness (001.W-W)

The overall sickness rate increased by 0.7% this month to 4.4% (4.2% year to date), compared to the target of 4.22%. This is the same rate as last year, October 2019. When we remove the Covid related sickness, the year to date figures would be 3.98% compared to the target of 4.22%.

The short term sickness is 2%, an increase of 0.3% since the previous month and long term sickness is 2.4%, a decrease of 0.4% since the previous month.

There is no Covid sickness recorded for June, July and August. September had 0.03% sickness and this increased to 0.32% in October. Currently we have 7 staff with a positive test result.

Activities in place to reduce sickness absence include:

- Successfully closed 23 long term sickness absence cases in October 2020, with 18 returning to same post, 1 has commenced maternity leave and the remainder have left KMPT. We are currently actively supporting managers with 53 cases of sickness absence.
- Pilot running with a health and wellbeing advisor recruited in the Acute Care Group, working on a range of health and well being initiatives, but specifically on a business case for Musculo-Skeletal provision.

Staff Turnover (004.W-W)

The 12 month rolling turnover for this reporting period is 9.61% which is a 0.5% decrease compared to the previous month. Therefore the current position is below the target of 10.5%. The decrease is across all Care Groups, except Support Services.

Activities to reduce turnover:

- Work on the Just and Learning culture – 'BluePrint for our cultural heart developed' and included in the new People Strategy
- A business case has been developed proposing the move of a percentage of our band 5 nurse roles moving to band 6 roles and Healthcare worker roles from band 2 to band 3, once they have reached certain competencies – this will also aid recruitment as more attractive for Band 5 nurses.
- HR Business Partners working to understand why people leave in the first 3 years and looking at ways of reducing this

Staff appraisal (005.W-W)

The appraisal window was deferred from starting in April 2020 to June 2020 instead. To date (as at 13/11/20) 97.3% have completed appraisals, a further increase from the 96.4% reported below as at the end of October.

Vacancy Gap (006.W-W)

The reported in month rate has increased from 12.8% to 13.4%. This is against the target of 11.85%.
Activities to reduce vacancy levels:

- Task and finish groups established as output of medical staff workshop; recruitment and retention (administration), recruitment and retention (research), recruitment and retention (additional roles) and locum use. Work stream restarted projects, with medical leads supporting
- Submitted bid for national funding to support international recruitment
- New video being developed to support attraction where we are unable to have prospective candidates visiting us

Freedom to Speak Up (FTSU) (013.W-W)

For October 2020, 23 concerns have been handled by the Freedom To Speak Up Guardian (FTSUG). 18 of these concerns were received via the Green Button. 4 of these concerns (17%), if accurate, would raise concerns around patient safety and safety of staff. The concerns are categorised and the FTSUG develops a plan of action according to the issue.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

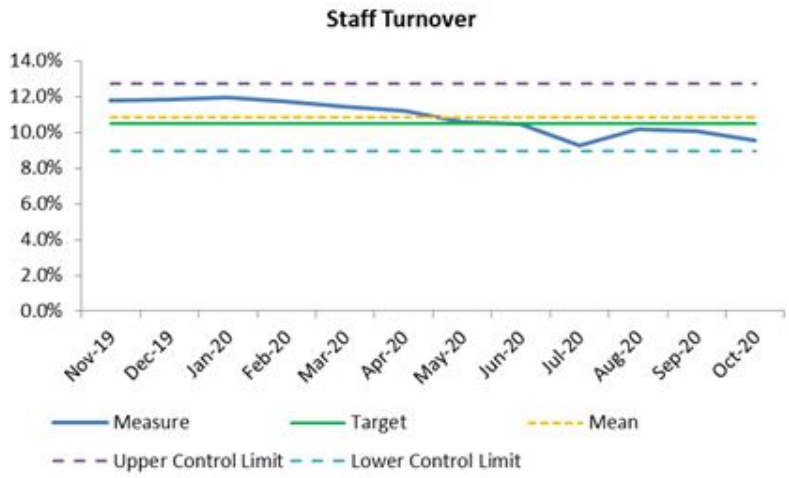
IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
001.W-W	Staff Sickness - Overall	✓	4.22%	L	5.3%	5.1%	4.8%	4.4%	5.2%	5.8%	4.5%	3.5%	3.6%	4.1%	3.7%	4.4%
002.W-W	Staff Sickness - Short term	✓	1.65%	L	2.6%	2.1%	2.2%	2.0%	3.0%	3.1%	1.6%	1.1%	1.0%	1.3%	1.7%	2.0%
003.W-W	Staff Sickness - Long term	✓	2.57%	L	2.7%	3.0%	2.6%	2.4%	2.2%	2.7%	2.8%	2.4%	2.6%	2.8%	2.0%	2.4%
004.W-W	Staff Turnover	✓	10.5%	L	11.8%	11.8%	11.9%	11.7%	11.5%	11.2%	10.6%	10.5%	9.3%	10.2%	10.1%	9.6%
005.W-W	Appraisals And Personal Development Plans		95%	L	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%	98.5%					96.4%
006.W-W	Vacancy Gap - Overall		11.85%	L	15.1%	16.6%	17.5%	14.5%	13.7%	14.3%	14.7%	15.9%	15.0%	14.5%	12.8%	13.4%
007.W-W	Vacancy Gap - Medical		-	-	48.3%	27.8%	29.1%	21.4%	21.9%	22.6%	15.5%	24.9%	23.0%	23.6%	22.2%	28.1%
008.W-W	Vacancy Gap - Nursing		-	-	14.3%	14.8%	14.6%	13.2%	12.7%	13.5%	15.2%	17.0%	17.0%	15.7%	14.3%	14.3%
009.W-W	Vacancy Gap - Other		-	-	15.7%	16.2%	16.3%	14.5%	12.1%	12.9%	14.3%	14.6%	13.0%	13.2%	11.3%	11.5%
012.W-W	Essential Training For Role		90%	L	92.5%	93.0%	92.7%	93.3%	92.4%	91.4%	90.4%	89.8%	90.7%	91.0%	90.4%	90.0%
013.W-W	Freedom to speak up issues		-	-	0.0%	35.0%	0.2%	1.1%	1.5%	0.6%	0.4%	0.5%	0.5%	0.6%		

- *New targets were introduced April 2020; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

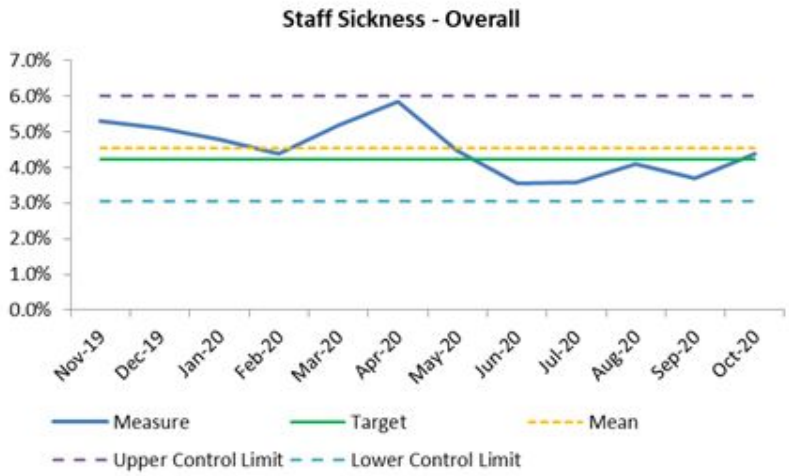
Domain Indicators in Focus

The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard



Activities to reduce Staff Turnover include:

- Work on the just and learning culture continues each Care Group has a People Plan which will include work to reduce turnover



Activities to support sickness absence include:

- Monthly case management reviews looking at individual cases and plans to return to work.
- Supporting managers with active cases
- Piloting use of Health and Wellbeing advisors

CQC Domain	Well led – Finance
Trust Strategic Objective & Board Assurance Framework	• **Deliver financial balance and organisational sustainability** • **Develop our core business and enter new markets through increased partnership working**

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

Issues of Concern

There are a number of concerns arising from the new finance regime in place as a result of the pandemic. In particular the current regime has based expenditure plans on month's 8-10 actual expenditure during 2019/20. This has led to a financial pressure for KMPT as the Trust moved its forecast favourably in month 10 last financial year. The impact is £5m per annum, of which £2.5m has been covered via the top up regime for months 1-6. This has been raised with NHSI/E and put forward to the national team. The Trust are awaiting advice as to whether this will be treated as an exceptional case and the baseline adjusted. Consideration needs to be made as to the impact this will have on the Trust's baseline for next year if the regime is kept the same and the baseline adjustment is not made.

Executive Commentary

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

The new financial architecture is now in place for months 7 to 12, which focuses on system control totals instead of national reimbursement. This has required coordination across system on key areas of spend such as Covid costs and capital. Regular conversations are taking place between finance colleagues to ensure that an integrated and joined up approach is taken and we have a system forecast that is managed to deliver the plan.

Projecting cash flow remains challenging due to the upfront payment of two months' contract income in April. It is not known when this will be unwound so we have projected cash flow with the assumption that this will be in March. Capital discussions are still ongoing, and this month is the first that the forecast has been amended to reflect the reallocation of slippage across the system for restore and restart priorities. KMPT's capital programme this year includes an additional £1.9m for Critical Infrastructure Funding, which is nationally funded. This will allow the Trust to address additional backlog maintenance and reporting commenced in November to the national team to evidence progress against these key schemes.

Our financial rating for use of resources is not currently being measured formally by NHS Improvement due to changes in the financial architecture. This has therefore been removed from reporting in the short term.

Income and Expenditure Margin YTD (%) (003.W-F)
In light of the financial architecture, KMPT is continuing to report a breakeven position. Patient Care Income is included as advised nationally, with an additional £4.0m year to date to reflect additional COVID-19 related costs and £1.7m to reflect the top up required between the block contract and the current run rate.

These additional costs for COVID-19 continue to be recognised in line with national guidance and include additional IT licences for remote working, and staffing costs for covering sickness absence and isolating staff. These costs are reducing as the pressure from Covid reduces but will continue to be monitored.

Other pressures separate to COVID include PICU placements, with private bed days increasing in October.

Agency Spend (008.W-F - 010.W-F)
Agency spend remains high this financial year, reflective of staffing pressures experienced due to vacancies and COVID-19. Spend within services with particularly high use continues to be monitored and analysed. This information is shared with executive members to support conversations with operational staff and better understand workforce pressures. Procurement colleagues are supporting conversations regarding rates paid, and how these align to nationally prescribed caps. Meetings are taking place with agencies during November.

CIPs (011.W-F - 013.W-F)
The programme for this year is £5.9m, with £2.6m achieved year to date. At the end of October the Trust is £0.5m behind plan with a forecast underachievement and unidentified balance of £1.3m. This is an improvement month on month from a £1.9m gap in September. Currently this is being mitigated in the forecast by non-recurrent benefits and vacancy slippage. Those Care Groups with gaps against target are being supported to find further efficiencies, both in terms of run rate reduction for agency spend and productivity initiatives through job planning and workforce redesign.

Long Term Financial Sustainability
National planning is ongoing, with a revised trust level plan submitted on 22nd October and a further submission requested for 16th November. This has been prepared jointly working across the system to agree control totals and top up funding for the last 6 months of the year. KMPT has submitted a

£112k deficit for this period, which includes support funding of £2.5m from the system for Covid and the underlying deficit. It is anticipated that there will be further submissions at a later date to revise capital plans in line with forecast.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Finance)

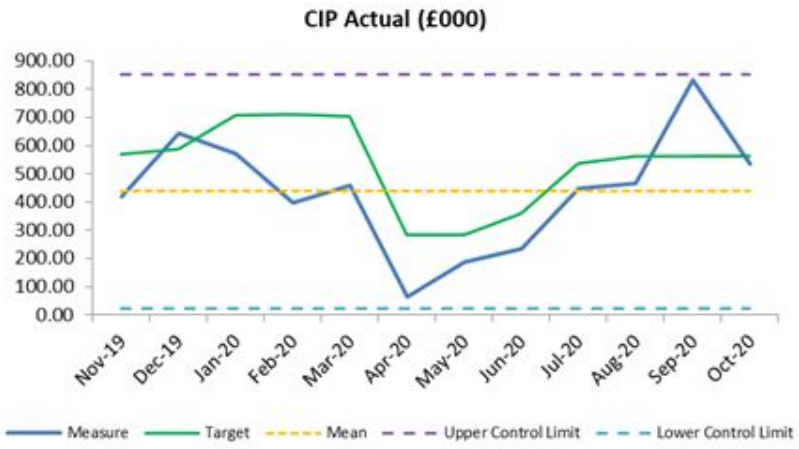
Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
001.W-F	Capital Service Capacity	✓	1.58	N	1.80	1.66	1.87	1.86	2.27							
002.W-F	Liquidity (Days)	✓	-11.1	N	-1.8	-1.4	-1.1	-2.1	-0.1							
003.W-F	Income And Expenditure Margin YTD (%)	✓	-0.7%	N	-0.46%	-0.44%	0.35%	1.00%	2.00%							
004.W-F	In Month Budget (£000)		0.0	N	(10)	(7)	212	206	153	0	0	0	0	0	0	0
005.W-F	In Month Actual (£000)		-	-	(10)	(6)	1,212	1,203	2,177	(0)	0	0	(0)	0	0	0
006.W-F	In Month Variance (£000)		-	-	0	1	1,000	997	2,024	(0)	0	0	(0)	0	0	0
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	0.00%	0.00%	0.64%	1.10%	2.00%							
007.W-F	Agency - In Month Budget (£000)		-	N	510	514	520	510	512	427	427	427	427	427	427	427
008.W-F	Agency - In Month Actual (£000)		-	-	501	437	576	571	568	596	638	724	823	743	804	825
009.W-F	Agency - In Month Variance from budget (£000)		-	-	(9)	(77)	56	61	56	169	211	297	396	316	377	398
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	2.79%	1.96%	1.80%	2.70%	3.40%	39.58%	44.46%	52.84%	62.84%	65.08%	68.95%	72.41%
011.W-F	CIP Plan (£000)		6m	L	570	587	708	710	702	282	282	358	537	564	564	564
012.W-F	CIP Actual (£000)		-	-	418	645	571	398	458	64	187	233	450	467	834	535
013.W-F	CIP Variance (£000)		-	-	(152)	57	(137)	(312)	(244)	(218)	(95)	(125)	(87)	(97)	270	(29)

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

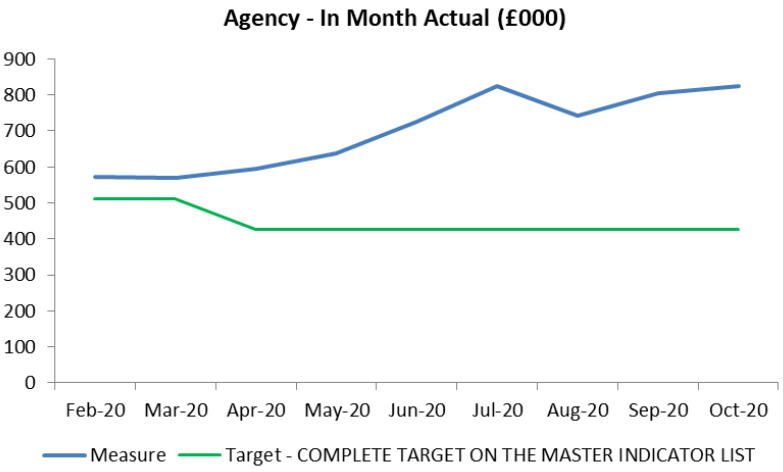
Metrics 001.W-F – 003.W-F & 006a.W-F have been temporarily removed from this report due to suspension of this monitoring at a national level for 2020-21 during the global pandemic

Kent and Medway NHS
NHS and Social Care Partnership Trust

Domain Indicators in Focus
The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard



- Fortnightly CIP meetings as part of CIP governance process
- Phase 3 planning just completed for the Trust and system
- CIP unidentified has reduced month on month



- Acute and Community Recovery Care Group completing an urgent action plan with regards to agency use – reduction in CRCG spend has been included in the forecast
- Review of medical agency and rates versus cap is completed, discussions on-going with suppliers

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Domain	Caring
Trust Strategic Objective & Board Assurance Framework	• **Consistently deliver an outstanding quality of care**

Executive Lead(s): Executive Director of Nursing & Quality & Chief Operating Officer
Lead Board Committee: Quality Committee

Issues of Concern

Executive Commentary

Complaints (004-6.C)

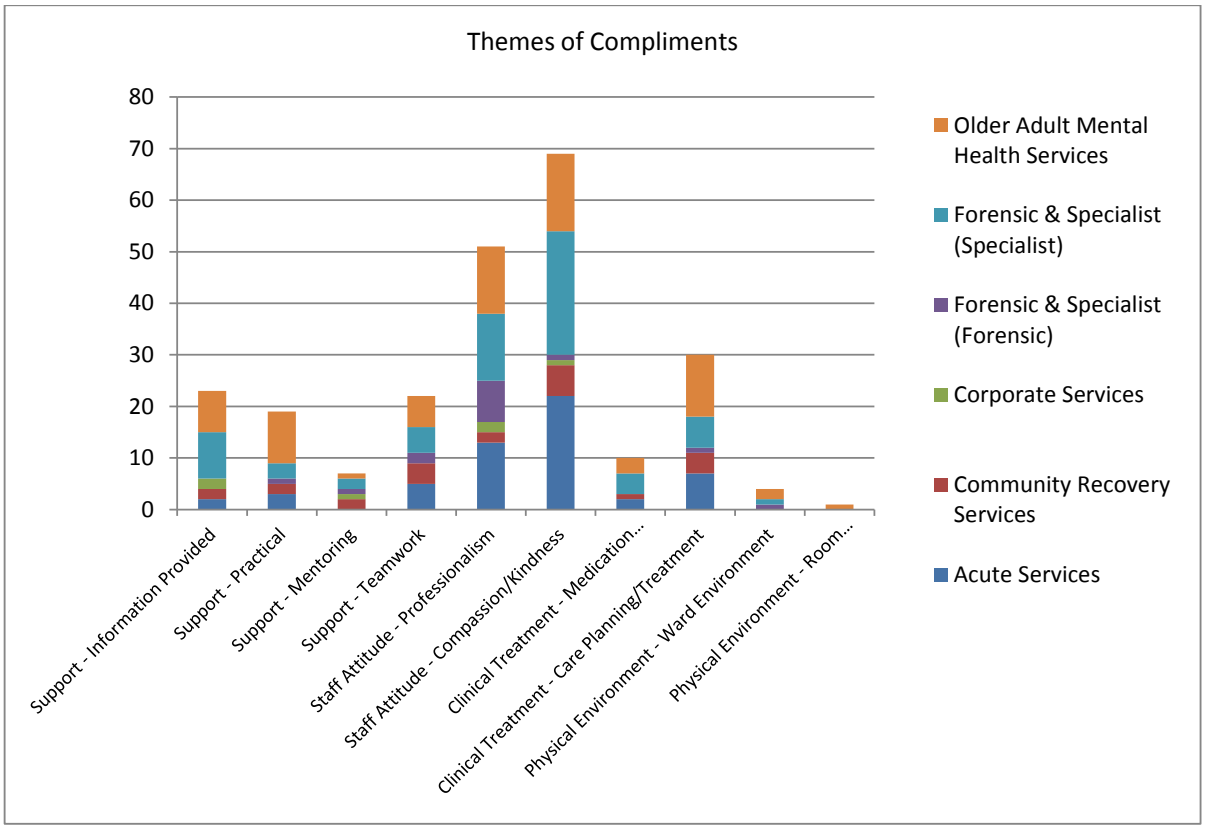
There were 146 complaints and PALS type contacts received for October 2020 which consisted of 29 new reportable complaints and 117 PALS cases, a reduction in both compared to September. CRCG and Forensic & Specialist reported a slight decrease in reportable complaints and/or PALS type concerns. 5 complaints were re-opened in this period (2 Acute, 2 CRCG and 1 Older Adult). Reopened cases are often resolved with further clarity provided on decision making or remit of services.

Access to service remains the top concern in this period relating to the on-going issue of rejected referrals, waiting times to be seen or access to an agreed or desired treatment. A positive is in month there are no cases with staff attitude highlighted within in the top themes reported during this period.

Compliments (007-8.C)

132 compliments were recorded across the Trust and for all care groups. Forensic and Specialist (Specialist) recorded the most compliments (54) followed by Older Adults (34) Acute (27) and CRCG (15) and corporate (2)

Compliments have been allocated themes since 1 August 2020. Below is a table of the subjects and how the compliments for each Care Group fit within these themes. Staff Attitude (both compassion and professionalism) have been the top reported subjects in all three months followed by care planning and treatment.



The compliments received across the Trust, highlighting the kindness and professionalism of staff and the good care planning and support are warm and uplifting. These vary from acute inpatient care and assessments to community support and those in recovery from addiction or the difficulties faced with new parenthood.

Patient Reported Experience Measures (013.C)

The PREM survey was restarted in September 2020 and includes eight questions each for inpatient and community settings. The survey questions were co-produced and designed to align with the Care Quality Commission National Patient Survey for Community Mental Health Teams. The realignment enables us to compare directly with the National Patient Survey scores which are rated out of 10. As such, the Board will notice that the metric is now reported out of 10 rather than the previous percentage score. The only scores that we will not be able to compare are for inpatients, specifically:

1. "Are you satisfied with the food and drink provided?" - these can be triangulated with PLACE audits
2. "Did we support you to feel safe" – this can be triangulated with complaints and incidents data.

The numbers of PREM surveys are slowing improving from 207 in September to 394 in October. The aim is to reach over a 1000 responses every month, a target of 10% of our monthly contacts. Each team receives a copy of their survey scores which is discussed in their quality governance meetings

and actions taken to address areas of concern reflected on the “You said, we did” notice boards displayed in clinical areas. The table 1.below shows average score for each Care Group and clinical setting as well as the overall Trust scores.

Table 1

	Overall PREM score	Community score	Inpatient score	Total responses	Patient Experience indicator
Older Adult Care Group	8.6	8.7	7.6	79	8.8
Acute Care Group	7.9	8.8	7.2	120	8.0
Forensics and Specialist Care Group	8.5	8.2	8.7	79	8.7
Community Recovery Care Group	8.3	8.3	9.0	116	8.5
Trust total	8.3	8.5	7.9	394	8.5

All wards and teams now have Carers champions whose role is to reach out to families/friends, and that they have relevant information to be able to participate in their loved ones’ care. A Trust wide information booklet has now been co-produced and published; it informs carers, friends and family members what they can expect in their respective roles. Additionally community managers are continuing to raise awareness of the Meet the Manager Sessions as a way of continuing to provide support to individuals and deal with any concerns at a local level.

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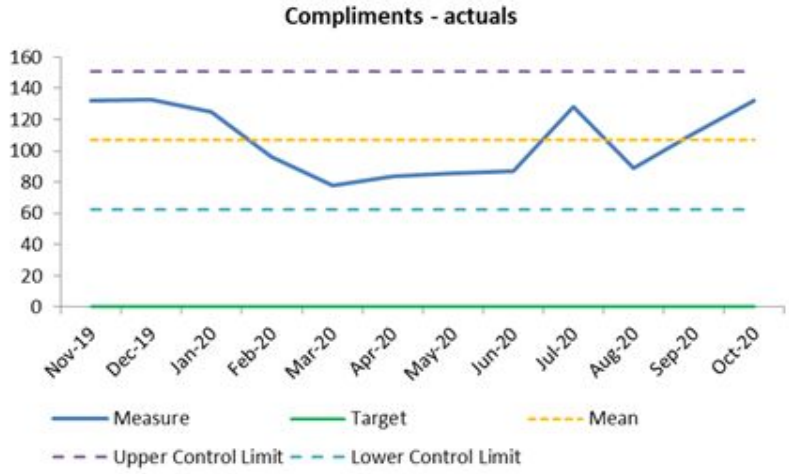
IQPR Dashboard: Caring

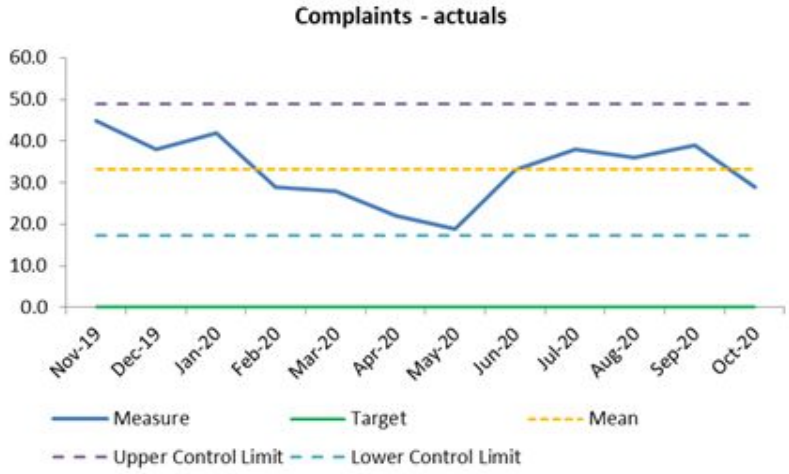
Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
003.C	Complaints - actuals		-	-	45	38	42	29	28	22	19	33	38	36	39	29
004.C	Complaints - per 10,000 contacts		-	-	15.06	14.99	13.40	9.97	9.54	7.25	5.86	8.67	9.92	11.00	10.63	7.79
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	96.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	97.0%	93.0%	96.0%	97.0%	95.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
007.C	Compliments - actuals		-	-	132	133	125	96	78	84	86	87	128	89	111	132
008.C	Compliments - per 10,000 contacts		-	-	44.18	52.46	39.89	33.01	26.59	27.67	26.54	22.85	33.42	27.20	30.26	35.46
010.C	PALS acknowledged within 3 days (or agreed timeframe)		-	-	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%
011.C	PALS responded to within 25 days (or agreed timeframe)		-	-	95%	100%	98%	97%	98%	100%	100%	100%	100%	100%	100%	100%
012.C	PALS - actuals		-	-	86	73	66	73	75	64	67	78	90	84	128	117
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	883	789	819	769	652						207	394
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	6.4	6.4	5.8	5.6	4.7							3
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	90.0%	93.0%	92.0%	93.0%	93.0%						8.4	8.3

Note: 015.C measure construction changed from September 2020 to be a score out of 10

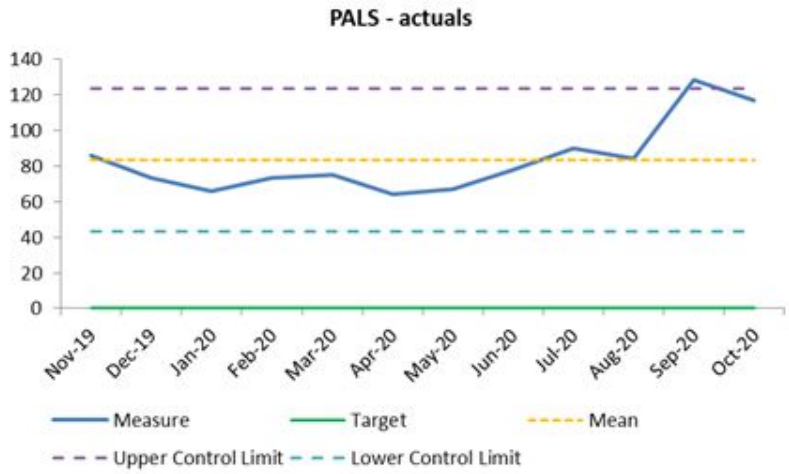
Domain Indicators in Focus
The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard



- A new complaints thematic review has been scheduled at regular intervals at the Quality Committee



- Continuation of analysis of complaints for any outliers in order to target specific support.



CQC Domain	Responsive
Trust Strategic Objective & Board Assurance Framework	• **Maximise the use of digital technology** • **Meet or exceed the requirements set out in the Five Year Forward View** • **Ensure success of STP through active participation and leadership**

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

Issues of Concern

The responsive section of the IQPR is under review by the Chief Executive, Chief Operating Officer and Director of Finance. There are a number of indicators that are under review and a deep dive will be completed. The majority of these indicators are included within the Responsiveness domain of the IQPR. These are:

- **4 week wait**
- **18 week wait**
- **% of waiting list over 28 days**
- **Cancellations**
- **DNAs**
- **Referrals – including bounce back rate**

However there is a few that have been chosen from the other domains for completeness. Appendix B of this report includes **the** indicators **under review and when this will be completed and by whom.**

Executive Commentary

Early Intervention Psychosis (EIP) (001.R)

The Early Intervention in Psychosis service is made up of 5 teams across Kent and Medway. The teams have continued to meet the required national standard for referral to treatment within 14 days generally well above the required national trajectory

Referral to Assessment within 4 weeks & 18 weeks Referral to Treatment (002.R & 003.R)
% of Liaison (urgent) referrals seen within 1/2 hours (005.R & 006.R)

A detailed report will be taken to Finance and Performance Committee (FPC) this month that sets out the current performance of the 4 week wait and the trajectories by team till March 2022.

A review is on-going for these two metrics, led by the Executive Director of Finance and Chief Operating Officer working with the Assistant Director of Performance and Information.
A review of the Liaison Teams performance within the 4/18 week waits metrics, has led to questions as to why this service is monitored using these two metrics where there are two clearly defined metrics specific to this service. We have included the telephone contacts in reporting from last month, this has now highlighted that the standard required for an assessment of 30 minutes has led to a reduction in the performance for liaison. The conclusion is that the liaison service will be removed

from these metrics from January 2021 and will not have the requirement of a 30 minute minimum duration for a response time as it is clinically appropriate for shorter durations with some patients.

Referral to Assessment within 4 Weeks: Care Group Breakdown

	2020-08	2020-09	2020-10	*Latest Denominator*
Acute Service	98.8%	98.9%	99.0%	*735*
Community Recovery Service	83.4%	76.0%	83.7%	*959*
Forensic and Specialist	91.1%	86.8%	90.8%	*665*
Older Adult	47.6%	35.9%	31.3%	*839*
Grand Total	**83.2%**	**74.2%**	**75.0%**	*3,198*

18 Weeks Referral to Treatment: Care Group Breakdown

	2020-08	2020-09	2020-10	*Latest Denominator*
Acute Service	99.1%	99.3%	98.6%	*356*
Community Recovery Service	93.4%	93.7%	91.1%	*572*
Forensic and Specialist	83.4%	85.4%	82.3%	*209*
Older Adult	49.1%	46.0%	53.0%	*530*
Grand Total	**79.7%**	**77.9%**	**79.5%**	*1,667*

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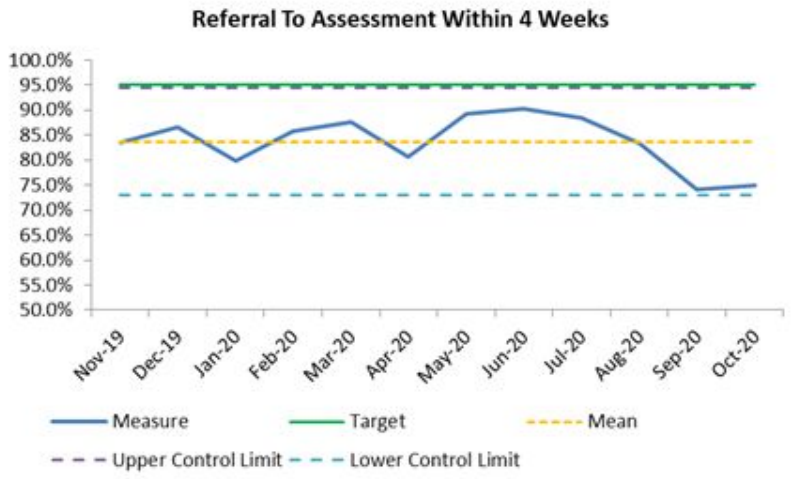
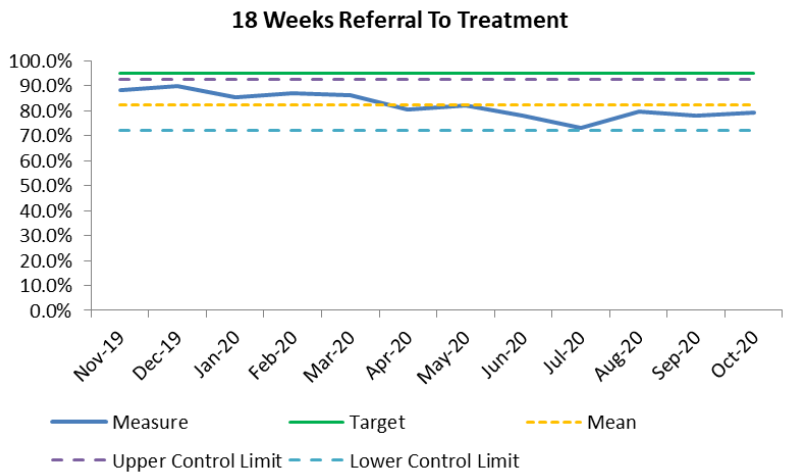
IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	78.9%	76.5%	78.9%	85.7%	75.0%	86.4%	90.0%	84.2%	66.7%	85.7%	81.3%	77.3%
002.R	Referral To Assessment Within 4 Weeks		95%	L	83.6%	86.6%	79.8%	85.8%	87.7%	80.6%	89.3%	90.3%	88.4%	83.2%	74.2%	75.0%
003.R	18 Weeks Referral To Treatment		95%	L	88.4%	89.9%	85.4%	87.1%	86.5%	80.4%	82.3%	78.2%	73.4%	79.7%	77.9%	79.5%
004.R	% Of Waiting List Over 28 Days		-	-	49.2%	51.6%	42.1%	42.0%	54.0%	72.1%	66.7%	63.6%	63.3%	67.4%	65.7%	55.3%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	91.8%	82.6%	88.6%	75.9%	85.8%	91.9%	84.8%	81.4%	77.0%	85.7%	91.0%	68.2%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	81.2%	85.7%	74.7%	74.0%	75.6%	86.3%	87.7%	91.0%	87.9%	90.4%	92.2%	82.4%
007.R	DNAs - 1st Appointments		-	-	8.2%	7.6%	8.3%	7.1%	7.5%	6.0%	6.8%	6.1%	6.2%	6.5%	8.4%	11.7%
008.R	DNAs - Follow Up Appointments		-	-	9.0%	8.3%	8.2%	7.7%	6.4%	4.3%	4.8%	4.4%	5.6%	5.9%	7.7%	11.4%
009.R	Patient cancellations- 1st Appointments		-	-	2.0%	2.6%	2.6%	2.8%	3.3%	0.4%	0.2%	0.4%	0.5%	0.6%	1.1%	1.0%
010.R	Patient cancellations- Follow Up Appointments		-	-	5.9%	6.7%	6.0%	6.7%	6.2%	2.1%	2.0%	2.4%	2.7%	2.9%	3.1%	3.1%
011.R	Trust cancellations- 1st Appointments		-	-	11.7%	10.5%	10.2%	12.0%	18.1%	14.7%	11.3%	13.0%	14.5%	19.9%	17.7%	18.6%
012.R	Trust cancellations- Follow Up Appointments		-	-	10.7%	11.8%	10.5%	10.9%	16.6%	16.3%	11.1%	9.9%	9.5%	10.8%	10.9%	9.8%
013.R	Referrals Received (ave per calendar day)		-	-	314.8	274.7	326.2	379.9	319.1	221.8	283.3	336.2	367.6	361.7	377.2	382.3
014.R	Referrals Received (ave per working day)		-	-	384.8	351.9	395.8	462.7	378.5	260.7	352.1	386.7	424.0	433.1	436.1	449.2
015.R	Referrals Received (per 10,000 Kent and Medway Registered GP population))		-	-	589.7	520.0	631.8	672.8	589.8	370.4	484.5	617.4	716.9	641.5	715.3	717.5

Domain Indicators in Focus
The graphs below provide a 12 month trend on areas of focus from the IQPR dashboard





Actions in place:

- Demand and Capacity review complete for 4 week wait
- Active vacancy management and use of additional staff as required
- Improved use of Primary Care mental health services
- All information triangulated through quality performance reviews to maintain Executive scrutiny, ascertain areas of concern and ensure key issues are actioned planned
- Clinical leaders are currently redefining the assessment process in line with the clinical care pathways

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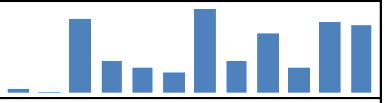
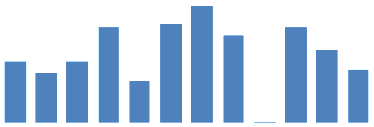
Appendix A

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Sep-20	Oct-20	Trend *(Last 12 months where available, left to right)*
001.S	Occurrence Of Any Never Event	0	0	0	
001.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	98.2%	98.0%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.2%	95.3%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		88	195	
001.W-W	Staff Sickness - Overall	4.2%	3.7%	4.4%	
002.W-W	Staff Sickness - Short term	1.7%	1.7%	2.0%	
003.W-W	Staff Sickness - Long term	4.2%	2.0%	2.4%	
004.W-W	Staff Turnover	1.7%	10.1%	9.6%	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	81.3%	77.3%	
001.W-F	Capital Service Capacity	158%			
002.W-F	Liquidity (Days)	-11.10			
003.W-F	Income And Expenditure Margin YTD (%)	0.0			
006a.W-F	Distance From Financial Plan YTD (%)	0.0%			
010.W-F	Agency Spend Against Cap YTD (%)	0%	68.95%	72.41%	

Metrics 001.W-F – 003.W-F & 006a.W-F have been temporarily removed from this report due to suspension of this monitoring at a national level for 2020-21 during the global pandemic

**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 here*

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Appendix B: Data Quality Update

As discussed at last month's Private Trust Board meeting there are a number of on-going projects that are being undertaken currently that relate to data quality and current Trust operational processes. The areas of focus agreed are set out below. Included for each focus area is the actions required, a timeframe for delivery and who is leading.

Focus Area	Actions to be taken	Monitoring	Deadline	Lead
Cancellations	Complete deep dive into teams with high cancellations	N/A	Nov-20	TB, PC
	Complete review of number of cancellations listed on RIO and amend RIO	N/A	Nov-20	PL,LP
	Amend DNA Policy where relevant	N/A	Dec-20	JMG
	Monitor cancellation performance	IQPR/QPRs	Jan-21	Trust Board
Demand and Capacity – 4 and 18 week wait trajectories	Complete demand and capacity model	N/A	Nov-20	PL
	Complete 4 week wait trajectory	N/A	Nov-20	PL,TB,PC
	Complete 18 week wait trajectory	N/A	Dec-20	PL,TB,PC
	Monitor trajectories	QPRs	Dec-20	EMT
Compulsory use of RIO diary	Validate training material for RIO diary use	N/A	Nov-20	LP
	Start communications to the organisation	N/A	Nov-20	JK
	Complete Standard Operating Procedure (SOP)	N/A	Dec-20	LP,TB,PC
	Cutover existing appointments from outlook to RIO diary	N/A	Dec-20	ALL
Referral review	Performance team review referral reporting against other Trusts and internal teams	N/A	Oct-20	NL
	Performance Team to communicate to trust leads regarding reports and type of referrals included	N/A	Nov-20	NL
	Communication to be sent out to Trust stating that internal referrals will be called internal transfers	N/A	Nov-20	NL
	Update SOP where relevant	N/A	Nov-20	NL
	Monitor referral levels	IQPR/QPRs	Nov-20	EMT
Estimated Discharge Date (EDD)	Complete review of EDD processes	DQ group	Oct-20	SS,PL
	Update SOP for Trust wide processes	N/A	Dec-20	SE
	Process to be signed off by Trust Wide Patient Safety Group	N/A	Dec-20	PL
Simplifying RIO	Trust wide workshop to be held on the 17th December	N/A	Dec-20	SS
	Programme plan to be compiled following workshop	EMT	Jan-21	MC,LP
Un-outcomed appointments	Full review of appointments that do not have an outcome	DQ group	Oct-20	PL

	Paper to be drafted and new process agreed by the Trust Wide Patient Safety Group	N/A	Dec-20	PL
	Monthly reports to be cascaded to all leads, to be monitored via supervision	I-Learn	Jan-21	PL
	Monitoring of Un-outcomed appointments	DQ group	Jan-21	SS
Un-validated progress notes	Full review of Un-validated progress notes	DQ group	Oct-20	PL
	Paper to be drafted and new process agreed by the Trust Wide Patient Safety Group	N/A	Dec-20	PL
	Monthly reports to be cascaded to all leads, to be monitored via supervision	I-Learn	Jan-21	PL
	Monitoring of Un-validated progress notes	DQ group	Jan-21	SS
ESR review	Scoping document to be produced	DQ group	Oct-20	DK
	Reconciliation to the Finance General Ledger	DQ group	Jan-21	DK
	Sign off of new monthly process	DQ group	Feb-21	DK
Emergency readmissions within 28 days	Full review of Emergency readmissions.	N/A	Dec 20	NL
	Paper drafted to outline issues and suggest new approach	DQ Group	Jan 21	NL
Liaison 1 hour / 2 hour	Review of Liaison reporting against contractual requirements	N/A	Dec 21	NL
	Paper outlining changes to reporting proposed alongside	N/A	Jan 21	NL
DTOC	Review of RIO reporting against National Guidance for DTOC	N/A	Jan 21	NL
	Paper outlining findings and proposed changes for discussion	DQ Group	Jan 21	NL
Average Length of Stay	Review of RIO reporting against LoS definition	N/A	Jan 21	NL
	Paper outlining findings and any proposed changes for discussion	DQ Group	Jan 21	NL
Safer Staffing fill rates	Definition Reviewed and Documented	N/A	Jan 21	DK
	Any proposed changes implemented	N/A	Jan 21	DK

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Front Sheet

Title of Meeting	Trust Board	**Date**	26th November 2020
Title of Paper	Finance Report for October 2020 (Month 7)		
Author	Victoria French, Deputy Director of Finance		
Executive Director	Sheila Stenson, Executive Director of Finance		

Purpose: the paper is for:	• **Delete as applicable**
• **Consideration:** *A report containing a positional statement relating to the delivery of the Trust's functions for which the Board has a corporate responsibility but is not explicitly required to make a decision*	

Recommendation:

The Board is asked to consider the financial position for month 7 (October 2020). This is consistent with the position submitted to NHS Improvement in the Month 7 Financial Performance Return.

Summary of Key Issues: • **No more than five bullet points**

The new financial architecture is now in place for months 7 to 12, which focuses on system control totals instead of national reimbursement. This has required coordination across system plans on key areas of spend such as Covid costs and capital. Regular conversations are taking place between finance colleagues to ensure that an integrated and joined up approach is taken.

Projecting cash flow remains challenging due to the upfront payment of two months' contract income in April. It is not known when this will be unwound so we have projected cash flow with the assumption that this will be in March.

Capital discussions are still ongoing, and this month is the first that the forecast has been amended to reflect the reallocation of slippage across the system for restore and restart priorities. KMPT's capital programme this year includes an additional £1.9m for Critical Infrastructure Funding, which is nationally funded. This will allow the Trust to address additional backlog maintenance and reporting commenced in November to the national team to evidence progress against these key schemes.

COVID cost reimbursement has been included at £4.0m year to date, based on costs for converting Jasmine Ward to the cohort ward, additional bank cover for absent staff and costs such as IT licences and equipment to support home working. In addition to this we have claimed £1.7m top up to enable the Trust to report breakeven.

Report History:
N/A

Strategic Objectives:	• **Select as applicable**
☐ Consistently deliver an outstanding quality of care	
☐ Recruit retain and develop the best staff making KMPT a great place to work	
☒ Put continuous improvement at the heart of what we do	
☐ Develop and extend our research and innovation work	
☒ Maximise the use of digital technology	
☐ Meet or exceed requirements set out in the Five Year Forward View	
☒ Deliver financial balance and organisational sustainability	
☐ Develop our core business and enter new markets through increased partnership working	
☐ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership	

Implications / Impact:
Patient Safety: *None*
Identified Risks and Risk Management Action: Control total of breakeven set for 2020/21 *CRL and EFL limits set that can be under shot but not over shot.*
Resource and Financial Implications: New financial regime being mapped out so at this stage the requirements regarding efficiencies are not clear. Auditable records are being maintained for all Covid related spend and the national message is for finance not to obstruct sensible decision making at this time.
Legal/ Regulatory: Reconciles to NHS Improvement in the Key Data return Delivery of statutory targets
Engagement and Consultation: *None*
Equality: *None*
Quality Impact Assessment Form Completed: ~~**Yes**~~**/ No N/A**

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Finance Report

Trust Board

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Executive Summary

Executive Summary for October 2020

The new financial architecture continues to develop. A revised plan was submitted on 22nd October, with another submission requested for 18th November. It is anticipated that there will be further submissions to change capital plans in line with the system reforecast but these are still to be confirmed.

Projecting cash flow remains challenging due to the upfront payment of two months' contract income in April. It is not known when this will be unwound as the national team have committed to continued cash support. Forecasting has assumed that no payment will be made in March until further confirmation is received.

Capital discussions continue as a system, with a capital working group meeting fortnightly to monitor spend and forecasts against our system control total. This month the Trust forecast has moved by £5m as agreed with the system, to release uncommitted funds to support Recover and Restore programmes.

Developments relating to Mental Health Investment in the Long Term Plan are accelerating and KMPT are the lead provider with MHIS system discussions. Bids are being put forward for national priorities, including the Community Mental Health Framework submission on 18th November.

Winter funding has been awarded for Liaison services to continue to support an enhanced service across A&E departments in the county.

Income and Expenditure

In light of the financial architecture, KMPT is continuing to report a breakeven position. Patient Care Income is included as advised nationally, with an additional £4.0m year to date to reflect additional COVID-19 related costs, and £1.7m top up to deliver breakeven.

The additional costs for COVID-19 have been recognised in line with national guidance and include additional IT licences for remote working, and staffing costs for covering sickness absence and isolating staff. This is reducing as the pressure on services as the impact of the pandemic eases.

Other pressures separate to COVID included the continued high levels of agency spend which is outlined further below, and private PICU placements which remain high in October.

We are continuing to focus internally on sound financial controls, budget management and opportunities for efficiency.

Agency Spend

Agency spend has remained high since April, reflective of staffing pressures experienced due to vacancies and COVID-19, with spend this year totalling £5.2m. Of this, £0.4m is directly related to COVID-19. The draft plan indicated from NHS Improvement that the ceiling set for the Trust in 2020/21 was a reduced total of £5m (£6.1m last year), so we have exceeded the pro rata target year to date.

Procurement colleagues are supporting conversations regarding rates paid, and how these align to nationally prescribed caps. Meetings are taking place with agencies during November.

Single Oversight Framework - Use of Resources

Due to changes in the financial architecture nationally, no risk ratings are being reported nationally for any trust. KMPT has therefore suspended its own reporting until we are advised nationally which metrics we are being measured against.

Capital Programme

The capital programme spent £362k in October. The year to date performance is currently £2.34m behind plan, with a total spend of £2.32m. The profile increases considerably in later months with initial delays due to the pandemic.

The programme for 2020/21 has been reprioritised, working with the wider Kent and Medway system to deliver our overall control total. This month is the first month KMPT is reflecting a lower capital programme, following the reallocation of slippage across the system for Restore and Recover programmes. The funding that has been returned to the system is expected back in 2021/22 and relates to slippage on strategic schemes. This has been agreed with the ICS.

There are a number of national programmes for which funding has been received included eradicating dormitories, critical infrastructure fund and adapt and adopt technology. These projects will proceed in the latter months of the year.

Cash

The new cash regime has resulted in the monthly block income being paid one month in advance. The Trust has therefore been holding an average of £30m cash in the bank since April. For cashflow purposes it is assumed that the Trust will not receive any block income in March to unwind this arrangement. Once guidance has been issued this will be amended.

The forecast is an £7.8m cash balance at March 2021. Top up funding has been assumed to continue for the rest of the year based on current trends and system plans for the last 6 months. Once the plan resubmission for 22nd October is completed this forecast will be revised.

The cash forecast now includes the receipt of sale proceeds from a property sale totalling £1.5m. The sale has generated an additional £0.6m profit above net book value.

Cost Improvement Programme

The programme for this year is £5.9m At the end of October the Trust is £0.5m behind plan with a forecast underachievement and unidentified balance of £1.3m. Currently this is being mitigated in the forecast by non recurrent benefits and vacancy slippage.

Throughout the pandemic KMPT has progressed productivity and efficiency initiatives where possible. Those Care Groups with gaps against target are being supported to find further efficiencies, both in terms of run rate reduction for agency spend and productivity initiatives through job planning and workforce redesign.

Conversations have commenced internally regarding how to structure the CIP programme for 2021/22 to ensure sufficient planning time for schemes to take full effect from April.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Statement of Comprehensive Income

	Current Month			Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income									
Income from Activities	(17,636)	(16,903)	733	(112,943)	(116,909)	(3,966)	(194,631)	(204,176)	(9,544)
Other Operating Income	(670)	(943)	(272)	(4,845)	(5,437)	(592)	(8,138)	(8,607)	(469)
Total Income	**(18,307)**	**(17,846)**	**461**	**(117,789)**	**(122,347)**	**(4,558)**	**(202,769)**	**(212,783)**	**(10,013)**
Expenditure									
Substantive	13,402	11,400	(2,001)	84,134	78,747	(5,387)	145,707	139,005	(6,703)
Bank	600	1,113	514	4,120	9,563	5,442	7,040	16,547	9,507
Agency	247	825	578	1,229	5,154	3,924	2,092	8,401	6,309
Total Employee Expenses	**14,248**	**13,339**	**(909)**	**89,483**	**93,463**	**3,980**	**154,839**	**163,953**	**9,114**
Clinical supplies	161	195	34	1,129	993	(136)	1,936	1,587	(349)
Drugs	245	304	59	1,718	1,889	171	2,944	3,206	261
Other non pay	2,663	2,994	331	18,824	19,574	750	31,329	32,662	1,333
Non Exec Director	12	13	1	83	71	(12)	142	136	(7)
Redundancy Costs	(0)	0	0	(0)	97	97	0	0	0
Depreciation	564	564	(1)	3,979	3,949	(29)	6,929	7,000	71
Total Non Pay	**3,646**	**4,071**	**424**	**25,733**	**26,574**	**842**	**43,281**	**44,590.916**	**1,310**
Total Expenditure	**17,894**	**17,409**	**(485)**	**115,216**	**120,038**	**4,821**	**198,120**	**208,544**	**10,424**
Operating (Surplus) / Deficit	**(413)**	**(437)**	**(24)**	**(2,572)**	**(2,309)**	**263**	**(4,650)**	**(4,239)**	**411**
Finance Costs	413	437	24	2,572	2,309	(263)	4,650	4,351	(298)
(Surplus) / Deficit	**0**	**0**	**0**	**0**	**(0)**	**(0)**	**0**	**112**	**112**
Impairment	0		0	0	0	0	0	0	0
Total (Surplus) / Deficit	**0**	**0**	**0**	**0**	**(0)**	**(0)**	**0**	**112**	**113**

Commentary

The October position has been reported based on known information. This includes areas highlighted below, and an adjustment of top-up income to ensure a breakeven position in line with national guidance. The budget for comparison is the internal plan developed with budget holders and managers.

The year end forecast reflects the submission on 22nd October for the phase 3 planning round. The system will be receiving support funding to ensure providers breakeven, so this has been assumed within this forecast and totals £2.5m support for the last 6 months. Of this £1.2m is for Covid and £1.3m is for the underlying deficit.

Income
Income from Activities includes nationally provided contract values for main commissioners. The key variances include an assumed £4.0m of income for COVID-19 related costs, an additional £0.5m for specialist placements and the Mother and Baby Unit, and top-up income for breakeven support of £1.7m year to date. This is offset by lower income in cost per case services with reduced activity during COVID-19.

Pay
Substantive pay is underspent due to vacancies. This has been offset by bank costs, which are higher due to additional shifts to cover staff affected by COVID-19. Income for these is recognised above. Agency spend remains high and is being actively reviewed within Care Groups.

Non-pay
Other non pay includes additional IT licences due to increased homeworking and estates cost to ensure Covid safe buildings, which have been included within the COVID-19 cost recovery.

Kent and Medway NHS and Social Care Partnership Trust

Statement of Financial Position

	Opening	Year to Date	Year End Forecast
	2020-21	*Actual*	*Forecast*
	£000	£000	£000
Non-current assets			
Property Plant and Equipment	124,062	121,736	128,302
Intangible Assets	461	285	463
Other non-current receivables	403	300	275
Total non-current assets	**124,926**	**122,322**	**129,040**
Current Assets			
Trade and other receivables	8,510	8,933	6,985
Cash and cash equivalents	15,678	32,699	7,844
Assets held for sale	0	0	0
Total current assets	**24,188**	**41,632**	**14,829**
Current Liabilities			
Trade and other payables	(19,809)	(35,190)	(13,718)
Provisions	(1,208)	(523)	(610)
Borrowings	(3,203)	(988)	(1,056)
Other Financial Liabilites	0	0	0
Total current liabilities	**(24,220)**	**(36,701)**	**(15,384)**
Non-current Liabilities			
Provisions	(1,492)	(2,072)	(2,057)
Borrowings	(10,941)	(10,325)	(10,765)
Total non current liabilities	**(12,433)**	**(12,397)**	**(12,822)**
Total Net Assets Employed	**112,461**	**114,856**	**115,663**
Total Taxpayers Equity	**112,461**	**114,856**	**115,663**

Commentary

The Statement of Financial Position plan has not been included for reporting by NHS Improvement. The year end forecast reflects the latest information available and reflects the current forecast I&E position.

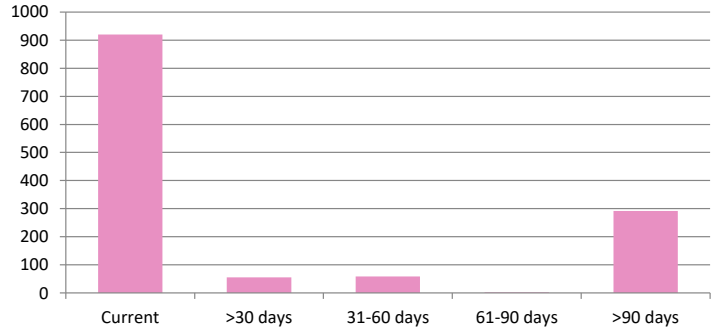
Non-current assets
The movement in Non Current Assets from Opening to Year to Date is due to capital spend being delayed and three months of depreciation. Variances to the capital expenditure plan are detailed on page 7 of this report.

Current Assets
The increased cash balance is a result of the COVID-19 financial regime whereby block contract sums are being paid a month in advance. This is expected to continue until March and has been assumed it will unwind within the current financial year.

Current Liabilities
Trade and other payables includes £15m of deferred income which is reflected in the cash balance and relates to the advance contract payments under the current regime.

Aged Debt
Following significant work from the Finance team, our total debt is £1.3m, of which £1m is current. 22% of our debt profile is aged at over 90 days and of this, a quarter relates to staff debt repayment plans. Overall, debt management is in a strong position within the Trust.

Aged Debt Analysis



NHS
Kent and Medway
NHS and Social Care Partnership Trust

12 Month Cashflow

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
	Actual	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Actual*	*Forecast*	*Forecast*	*Forecast*	*Forecast*	*Forecast*
	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000	£ '000
Cash brought forward	**15,678**	**32,125**	**32,654**	**31,189**	**30,678**	**30,434**	**32,419**	**32,491**	**30,802**	**29,550**	**28,124**	**27,730**
Receipts												
Block payment	30,706	15,353	15,353	15,354	15,354	15,354	15,354	15,504	15,404	15,404	15,404	-
Top-up funding	372	442	379	840	438	1,406	1,267	1,300	431	431	431	431
Other income	2,733	586	561	2,078	866	1,564	592	708	708	708	702	708
PSF / FRF Funding	-	2,091	-	-	-	-	-	-	-	-	-	-
Total Receipts	**33,811**	**18,472**	**16,293**	**18,272**	**16,658**	**18,324**	**17,213**	**17,512**	**16,543**	**16,543**	**16,537**	**1,139**
Payments												
Pay	(10,707)	(10,872)	(11,367)	(11,379)	(11,119)	(10,870)	(11,649)	(11,064)	(10,964)	(10,964)	(10,850)	(10,914)
Non-Pay	(6,377)	(7,071)	(6,489)	(7,540)	(5,923)	(6,824)	(5,492)	(6,481)	(6,831)	(7,005)	(7,080)	(8,455)
Loan repayment	-	-	-	-	-	-	-	-	-	-	-	-
Dividend payment	(280)	-	-	-	-	-	-	(1,656)	-	-	-	(1,656)
Total Payments	**(17,364)**	**(17,943)**	**(17,856)**	**(18,919)**	**(17,042)**	**(17,694)**	**(17,141)**	**(19,201)**	**(17,795)**	**(17,969)**	**(17,930)**	**(21,025)**
Financing Transactions												
Capital Sale Proceeds	-	-	-	-	140	1,355	-	-	-	-	-	-
PDC received	-	-	98	136	-	-	-	-	-	-	1,000	-
Total Financing Transactions	**-**	**-**	**98**	**136**	**140**	**1,355**	**-**	**-**	**-**	**-**	**1,000**	**-**
Net Cash Inflow/Outflow	**16,447**	**529**	**(1,465)**	**(511)**	**(244)**	**1,985**	**72**	**(1,689)**	**(1,252)**	**(1,426)**	**(394)**	**(19,886)**
Cash carried forward	**32,125**	**32,654**	**31,189**	**30,678**	**30,434**	**32,419**	**32,491**	**30,802**	**29,550**	**28,124**	**27,730**	**7,844**
NHSI Plan	**11,178**	**10,736**	**10,089**	**12,520**	**13,995**	**10,810**	**9,853**	**10,169**	**8,301**	**8,154**	**9,091**	**7,018**
Variance	***20,947***	***21,918***	***21,100***	***18,158***	***16,439***	***21,609***	***22,638***	***20,633***	***21,249***	***19,970***	***18,639***	***826***

Commentary

The new cash regime has seen the monthly block income paid one month in advance. There is no guidance yet as to when this will be unwound, so the assumption remains at March 2021. Support funding has been included to deliver a break-even position. This is currently paid 2 months in arrears, and has been adjusted to reflect system discussions for the last 6 months of the year.

The cash forecast includes assumed spend in line with the capital plan. PDC received has been adjusted to reflect the total expected for our main system project in 2020/21.

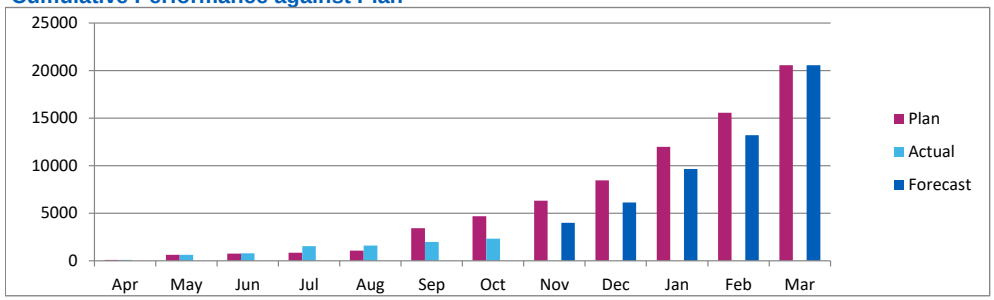
Capital sale proceeds were received in full in September following the transfer of a property sold at auction in July. This was sold above net book value and has therefore been a benefit to the projected cash position.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Capital Expenditure

	Current Month			Year to Date			Year End Forecast		
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Information Management and Technology	512	165	(347)	2,644	1,305	(1,339)	5,107	5,262	155
Informatics - Phase 2	125	0	(125)	250	0	(250)	250	250	0
HSLI - Kent Care Record	27	0	(27)	54	0	(54)	190	131	(59)
Capital Maintenance and Minor Schemes from 2019/20	266	184	(82)	695	302	(392)	4,763	3,511	(1,252)
Backlog Maintenance - Critical Infrastructure	315	0	(315)	315	7	(308)	1,900	1,900	0
Strategic Schemes	0	0	0	0	0	0	2,600	2,731	131
Maidstone mental health transformation project	0	3	3	0	3	3	5,000	1,000	(4,000)
PFI 2020/21	9	9	0	64	64	0	109	109	0
COVID-19 Schemes	0	0	0	641	641	0	641	641	0
Total Capital Expenditure	**1,254**	**362**	**(892)**	**4,662**	**2,322**	**(2,340)**	**20,560**	**15,535**	**(5,025)**

Cumulative Performance against Plan



Capital Resource Limit (CRL)

Limit	£000	*Funding Source*	£000
Initial CRL	6,139	Depreciation	7,035
Plus Funding Sources Approved		**Plus Funding Sources Approved**	
COVID-19 - PDC for 2019/20 spend	98	COVID-19 - PDC for 2019/20 spend	98
HSLI - Kent Care Record	190	HSLI - Kent Care Record	190
EPMA	136	EPMA	136
		Less Capital Commitments	
		PFI	(723)
		Finance Leases	(173)
CRL on Limits Report September 2020	**6,563**	**Subtotal**	**6,563**
Sale of Canada House	870	Sale of Canada House	870
Funding Sources Pending Approval		**Funding Sources Pending Approval**	
Cash brought forward	5,574	Cash brought forward	5,574
COVID-19 - 2020/21 spend	544	COVID-19 - 2020/21 spend	544
Maidstone mental health transformation project	5,000	Maidstone mental health transformation project	5,000
PFI Lifecycle Costs	109	PFI Lifecycle Costs	109
Backlog Maintenance - CIF	1,900	Backlog Maintenance - CIF	1,900
Forecast CRL	**20,560**	**Available Resources**	**20,560**

Commentary

During October the Trust has spent £362k on the capital programme against the revised plan of £1,254k.

The forecast position for 2020/21 has been adjusted to facilitate the release of uncommitted funds back to the Kent and Medway system to support the Recover and Restore programme.

NHSI have issued the Trust's Capital Resource Limit (CRL) of £6,139k plus additional funding relating to COVID-19 spend in 2019/20 £98k, HSLI - Kent Care Record £190k and EPMA £136k. This brings the current CRL to £6,563k as at the end of September, No CRL updates have been provided by NHSI for October.

The Trust Capital Group continues to closely monitor the progress of the 2020/21 programme, including the £1.9m Critical Infrastructure Fund that has been awarded to KMPT this year. Monthly reporting commences in November to the national NHSE/I team on progress against these schemes, including contract award dates and photographs of works undertaken.

The Trust has received initial feedback on the COVID-19 schemes, and is awaiting feedback from the national team to identify the level of cost that will be reimbursed.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Cost Improvement Programme

	In Month			Year to Date			Year End Forecast			Full Year Effect
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*	*Actual*
Care Group	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Acute	(112)	(116)	(4)	(782)	(709)	73	(1,341)	(1,341)	(0)	(1,152)
Older People	(54)	(29)	26	(283)	(189)	94	(555)	(555)	0	(229)
Community Recovery	(97)	(92)	5	(679)	(227)	452	(1,164)	(470)	694	(168)
Forensic & Specialist Services	(122)	(0)	122	(498)	(451)	47	(1,106)	(767)	339	(565)
Support Services	(156)	(114)	42	(694)	(865)	(171)	(1,472)	(1,212)	261	(546)
Trustwide	(23)	(21)	3	(163)	(146)	18	(280)	(250)	30	(250)
Total	**(564)**	**(372)**	**192**	**(3,100)**	**(2,586)**	**514**	**(5,917)**	**(4,594)**	**1,323**	**(2,909)**
Scheme Category										
Recurrent	(557)	(100)	458	(3,055)	(1,377)	1,677	(5,840)	(2,631)	3,209	(2,909)
Non Recurrent	(6)	(272)	(266)	(45)	(1,209)	(1,164)	(77)	(1,963)	(1,886)	0
Total	**(564)**	**(372)**	**192**	**(3,100)**	**(2,586)**	**514**	**(5,917)**	**(4,594)**	**1,323**	**(2,909)**
RAG Breakdown of Plan										
Green	(114)	(339)	(225)	(797)	(1,933)	(1,135)	(1,367)	(2,846)	(1,480)	(1,755)
Amber	(47)	(135)	(88)	(202)	(416)	(214)	(435)	(921)	(485)	(957)
Red	(69)	2	71	(280)	0	280	(623)	(153)	470	(197)
Pipeline	0	(40)	(40)	0	(238)	(238)	0	(674)	(674)	0
Unidentified	(334)	139	474	(1,821)	0	1,821	(3,492)	0	3,492	0
Total	**(564)**	**(372)**	**192**	**(3,100)**	**(2,586)**	**514**	**(5,917)**	**(4,594)**	**1,323**	**(2,909)**

Commentary

Year to date we are reporting £0.3m behind plan and forecast to underachieve the CIP programme by £1.3m for the full year.

The areas for which this is most prevalent continues to be the Community Recovery Care Group.

During October further discussions have taken place with Care Group management to progress schemes for the current financial year and also to develop future recurrent schemes.

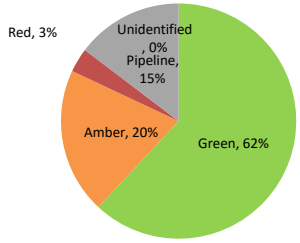
At this stage in the year, Care Groups are focusing on identifying recurrent schemes that will impact on 2021/22 and ensure that non recurrent savings delivered this financial year are sustained.

Areas currently being worked through and considered are Hub & Spoke models within Older Adults and CRCG, rota reconfiguration within Forensics, and Inpatient redesign. Non-pay savings continued to be explored further particularly those resulting from home working and such as travel and utility charges.

Top 5 Approved Schemes (by Value)

	Scheme Title	*Annual Plan*	*Forecast*	*Risk Rating*
1	PICU Placement reduction	973	973	
2	Tarentfort Staffing Merger	375	292	
3	Video Conferencing	250	250	
4	Reduction in CMHT staffing for Urgent & Emergency work being completed by CRHT	182	143	
5	Closure of NK POS	143	142	

Risk Adjusted Profile of Forecast



NHS
Kent and Medway
NHS and Social Care Partnership Trust

Care Group
Forensic & Specialist Services

Executive Summary

The net position for the Care Group at the end of October is a £24k overspend, following a £45k overspend in month.

The Care Group are currently working through:

- working differently to support medical staffing teams with long term vacancies by exploring the use of trainee ACPs

- building a case for the Provider Collaborative for a FOLS (Forensic Outreach Liaison Service) or FOLS+ for April 2021, pulling together learning from the SCFT (Specialist Community Forensic Team) Pilot that has been running for the last year, and the current FOLS.

Income and Expenditure

The Disablement Service running minimal cover during Covid lockdown, contributed £241k to this underspend in non-pay. For October however, the service has increased in line with expected levels and therefore spend is now at budgeted levels.

Non-pay is underspent across the Care Group, particularly in travel which is £156k underspent ytd and contributing to CIP - further CIPs will be explored when future working arrangements are confirmed.

Overspends in pay are due to increasing the use of temporary staffing, due to acuity of patients at MSU (Medium Secure Unit) and the LSU (Low Secure Unit). This acuity of patients is putting further pressure on the care group and is the main reason for the negative shift in position and forecast.

Cost Improvement Plans

The Tarentfort merger CIP has been completed, with the budgets transferred and the new rota being worked to. This has resulted in a £500k saving (full year effect).

The SLR position for Q2 gives an overall profitable position for the care group due to adjustments from 2019/20, non recurrent service changes during the pandemic and deferred income. However this is a good tool for providing ideas for CIPs and will form the basis for the next steps for the rest of 2020/21 and future schemes for 2021/22.

Financial Position

	Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(607)	(744)	(138)	(1,078)	(1,325)	**(248)**
Employee Expenses	17,572	18,159	587	30,424	31,405	**982**
Operating Expenses	2,316	1,891	(425)	3,996	3,394	**(602)**
Net Position	**19,282**	**19,306**	**24**	**33,342**	**33,474**	**132**

	Plan	*Actual*	*Variance*	*Forecast*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
CIP Summary	(498)	(451)	47	(1,106)	(767)	339

Agency

The newest agency consultant at the LSU is supporting the team with ongoing workload pressures, exacerbated by the lack of medical trainee onside since August. Following a meeting with the AMD and Care Group Director, there is a plan in place to increase the hours of the Medical Non-Prescriber at the Dartford site, relieving some of this pressure and allowing us to end this agency usage in January.

In MHLD there are currently 3.60 vacant medical posts, and another 0.60 on a career break, being supported by 2 agency doctors at consultant and career grade.

There are also agency doctors within Neuropsychiatry and the Mother and Infant MH services where there are long standing vacancies.

Work continues to explore new ways of working where recruitment isn't possible, including the work with trainee ACPs.
Nursing agency is historically minimal in the Care Group, but due to the acuity and rota issues causing pressures in the wards, where bank is unavailable, agency has been used which equated to 2.67 WTE in October.

Forecast

The forecast has favourably moved to an £132k overspend at the end of the year.

Whilst temporary staffing across all the wards due to the increased acuity and some rota changes, this impact has been kept to a minimum, allowing the forecast to slightly improve.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Care Group
Acute

Executive Summary

The Acute Care Group is underspent £407k year to date to October.

Vacancy levels still remain high in some areas where there have been investment although some new starters are expected over coming months.

Agency Spend has remained high in month within both Medical and Nursing Staff

The Care Group is seeing an increased acuity of patients being admitted to the inpatient units therefore requiring an increased level of observations.

Financial Position

	Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	0	(4)	(4)	0	(4)	**(4)**
Employee Expenses	17,601	17,419	(182)	30,446	30,405	**(42)**
Operating Expenses	2,796	2,576	(220)	4,794	4,386	**(407)**
Net Position	**20,397**	**19,991**	**(407)**	**35,240**	**34,787**	**(454)**

	Plan	*Actual*	*Variance*	*Forecast*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
CIP Summary	(782)	(709)	73	(1,341)	(1,341)	0

Income and Expenditure

There is a small element of income in relation to AMPS funding.

Vacancies continue across a number of services following new investments and difficult to recruit to positions. Temporary staffing is used to offset the impact of the vacancies and the level of agency utilised to backfill vacancies and support with operational pressures continues.

Agency

Medical Agency continues to be an issue within the Care Group. Work is continuing to reduce this.

Wards continue to use nursing agency when they are unable to book bank staff to cover shortages in their shifts due to issues such as vacancies and the level of observations.

Further analysis is being undertaken on a monthly basis of the total staff deployed to cover ward rotas with a particular focus on agency spend in order to better understand the requirement and how this fits with the expected ward rotas and staff ratios.

Cost Improvement Plans

The Care Group is staying within the contracted beds under the Cygnet contract however there have been bed days utilised with other providers. Overall the Care Group is achieving the CIP target.

The North Kent Place of Safety remains closed. The funding is being identified on a non recurrent basis.

The Care Group has underspent on travel due to vacancies and an increased use of video conferencing during the Covid 19 pandemic and this has been identified as a non recurrent CIP scheme for 20/21.

Forecast

The financial forecast for the Acute Care Group is an underspend of £454k.

Pay is forecast to be £42k underspent for this financial year. Larger underspends in expanding services such as Crisis Home Treatment, where recruitment has resulted in a phased spend profile this year are mitigating overspends in the inpatient service which is forecasting a £886k overspend mainly within Willow suite £556k. The wards have high levels of acuity resulting in an increase in staffing requirements. This level of acuity has increased significantly over recent months.

Non Pay is forecasting a £407k underspend with £259k relating to acute overspill. Generally the bed usage is below contract levels. The forecast is based on trend seen this financial year.

NHS
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Care Group
Older People

Executive Summary

The Older People's Care Group is underspent against plan in the year to October, reflecting vacancies above expected levels.

The run rate decreased by £59k over September spend, reflecting a lack of non-recurrent expenditure such as furniture purchases. The underlying financial position is stable in Older Adults.

The financial focus in the Care Group has been on ensuring the budgets enable a workforce fit for purpose in the long run, including the start of demand & capacity calculations for community teams and a trajectory for waiting lists, discussions around ACP and NMP roles to support and enhance the work of both medics and nurses and renewed focus on OT leadership for the Care Group. This will all be used to inform business planning for 21/22 and ensure that finances support the operational direction of the Care Group.

Financial Position

	Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	0	(2)	(2)	0	(2)	**(2)**
Employee Expenses	14,489	14,264	(225)	24,888	24,973	**86**
Operating Expenses	785	713	(72)	1,348	1,192	**(156)**
Net Position	**15,274**	**14,975**	**(299)**	**26,236**	**26,163**	**(73)**

	Plan	*Actual*	*Variance*	*Forecast*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
CIP Summary	(283)	(189)	94	(555)	(555)	0

Income and Expenditure

The £299k underspend is driven by nursing vacancies; inpatient services are £138k underspent on pay and community services £96k underspent on pay.

Recruitment continues with several posts expected to be filled in the coming weeks. This will reduce temporary staff usage.

Agency

Agency usage in the Care Group has cost £402k year to date. Non-medical agency increased in month with additional resource required to cover vacancies and maternity leave in Community teams. Usage on Inpatient wards remains consistent and low.

Medical agency reduced to 2wte, both of which are likely to remain until at least January. Agency cover is actively being sought for an upcoming vacancy whilst recruitment attempts continue. A previous request for agency cover for South West Kent to reduce backlogs will now be covered by additional sessions from retire & return medic.

Cost Improvement Plans

£26k savings have been achieved in month through reduction of posts and reduction of travel costs against a target of £54k. Achievement year to date is £94k short of the £283k target, this is mitigated by vacancies across the Care Group.

CIP meetings have been conducted with all budget holders throughout early November to review all vacancies across the Care Group and identify any part posts which could be permanently removed. These possibilities are being worked through, along with a schedule of slippages to describe better the non-recurrent savings. These should reduce the reported gap from November onwards.

Conversations also continue to explore hub & spoke possibilities for Community teams, Inpatient workforce redesign and medical productivity.

Forecast

The current forecast is for a £73k underspend. This reflects the latest intelligence on recruitment levels and timescales and also on forthcoming expenditure.

An overspend in pay includes unidentified CIP which is offset by vacancies. An additional offset is in travel costs which are suppressed non-recurrently in 20/21 and contribute to the non-pay underspend.

Medical agency premium is the largest adverse variance in pay. Nursing vacancies are likely to persist in some areas and underspends continue to offset this.

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Care Group
Community Recovery

Executive Summary

The Community Recovery Care Group has overspent against plan year to date by £434k.

The expansion of the Early Intervention in Psychosis service is underway following confirmation of funding from the CCG. Recruitment has commenced and has had some success to date, in line with recruitment projections.

The Liaison service continues to expand following Core24 investment, though recruitment proves to be challenging within certain teams.

The Single Point of Access business case to expand the service to 24/7 is being presented to Finance and Performance Committee this month, and has commissioner support, with funding identified. The new service is expected to go live from April 2021.

Financial Position

	Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(4)	(12)	(8)	(7)	(30)	**(22)**
Employee Expenses	23,281	23,600	319	40,337	41,114	**777**
Operating Expenses	1,773	1,896	123	3,038	3,183	**145**
Net Position	**25,049**	**25,484**	**434**	**43,368**	**44,267**	**899**

	Plan	*Actual*	*Variance*	*Forecast*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
CIP Summary	(679)	(227)	452	(1,164)	(470)	694

Income and Expenditure

The year to date overspend within employee expenses is largely due to the levels of agency consistently being used. Whilst this is primarily within the CMHTs, Liaison are also utilising medical agency.

Recruitment is ongoing but proves to be challenging in certain areas, South West Kent in particular. Discussions are ongoing around how these challenges can be overcome.

Operating expenses continue to be over spent due to drugs costs being higher than anticipated and some one-off spends on Therapeutic Equipment within the Rehablilitation service.

Income continues to be favourable to plan though is minimal throughout the Care Group.

Agency

Agency has increased on trend though this is soley within the medical teams.

Nursing agency remains consistent, though October does include prior year shifts within the CMHTs totalling £40k. Without these the spend would have decreased in line with the forecast assumptions made in September. This prior year adjustment is being discussed with NHS Professionals as our temporary staffing provider.

Recruitment is ongoing but continues to be challenging. There are ongoing monthly meetings between the Care Group, HR and Finance to monitor agency usage and compile recruitment projections, as well as in month reporting and discussions in order to work towards reducing spend without compromising the standard of care provided.

Cost Improvement Plans

The Care Group are forecasting not to deliver their full target this year. A total of £470k has been identified to date, leaving a remaining target of £694k for which there are currently no plans.

The Hub and Spoke scheme continues to be ongoing within the CMHTs and there are expected to be some subsequent savings that may be adjusted for in future months. The focus now is on how to ensure plans and changes are implemented to deliver savings on a sustainable and recurrent basis.

Forecast

The Care Group are forecast to over spend by £899k.

A significant over spend on pay is due to consistent agency usage in the CMHTs and Liaison.

Total agency spend is expected to be £3.7m, the majority of which is in the CMHTs.

Non-pay is expected to be over spent due to drugs costs and equipment costs in the Rehabilitation service.

Kent and Medway NHS and Social Care Partnership Trust

Care Group
Support Services

Executive Summary

PICU Private Beds which do not meet the PICU criteria remain under Operations and as such presents the main cost pressure in Support Services. The costs have increased in October however these are still forecast to reduce over the coming months.

The new Lead Social Worker post has started in October. This post will develop the social work workforce, and act as a key link between the two Local Authorities and Kent County Council.

The Flow business case is in the final stages of approval, which will see a new Bed Management Module implemented to support clinical and operational staff in delivering the right care to the right patient, at the right time through its bi-directional communication with the RiO database.

Financial Position

	Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(4,017)	(4,086)	(69)	(6,680)	(6,956)	**(276)**
Employee Expenses	16,077	16,644	567	28,068	28,934	**866**
Operating Expenses	12,208	12,990	781	20,939	21,987	**1,048**
Financing Costs	468	447	(21)	803	763	**(39)**
Net Position	**24,736**	**25,995**	**1,258**	**43,129**	**44,728**	**1,599**

	Plan	*Actual*	*Variance*	*Forecast*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
CIP Summary	(694)	(865)	(171)	(1,472)	(1,212)	261

Income and Expenditure

Operating Expenses is significantly overspent due to the cost of the Bed Overspills relating to the high dependency female patients, that do not fall under the PICU criteria (£959k). This is being mitigated by underspends on other non pay such as travel and conferences due to Covid-19.

The main drivers of overspend in Employee Expenses are the large element of unidentified CIP in the Medical Directorate totalling £175k. Bank cost remain high. Some are covering vacancies, but there is also a need to provide cover for Ancillary staff due to the extra cleaning requirements caused by Covid-19. These were previously being offset by vacancy slippage, but many teams have now allocated their vacancy slippage on a non-recurrent basis to meet their CIP target.

Income remains overachieved due to additional LDA income and income from Health Education England for Allied Health Professionals. There is also increased income shown in month 7 relating to the PATH Project. This income offsets costs in Employee and Operating Expenses.

Agency

Agency use has reduced further in October in line with the forecast. Ancillary cover is mainly being covered through bank now, so agency use is expected to reduce further over the coming months.

The fixed term agency worker supporting the work around the PICU private beds will continue in post until December. This continues to be part funded by the CCGs to support work around OATs (Out of Area Treatment) as well as supporting the Trust with PICU.

Cost Improvement Plans

All of the identified CIP schemes allocated have delivered both in month, and year to date, and many Directorates have now fully identified schemes to meet their balance of the 2020/21 CIP target.

Executive Nursing have now been able to fully meet their CIP target for 2020/21, by reviewing and allocating non recurrent vacancy slippage. Work will continue with their other pipeline schemes around benchmarking and rota reviews to form recurrent CIP schemes for 2021/22.

The only Directorate with a remaining CIP target is the Medical Directorate.

Forecast

Support Services is currently forecasting a £1.6m overspend. This is a £0.1m increase from September.

The two key areas for the forecast overspend are the Bed Overspills (£1.3m) and the unidentified CIP target in the Medical Directorate (£300k). The forecast overachievement of income, offsets costs on Operating and Employee Expenses relating to the PATH project, and a Health Education England Allied Health Professionals bid which was confirmed in month.

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Contracts and Income

Clinical Income by Type

	Current Month			Year to Date			Year End Forecast		
	Budget	*Actual*	*Variance*	*Budget*	*Actual*	*Variance*	*Budget*	*Forecast*	*Variance*
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Block contracts	(16,258)	(16,808)	(550)	(111,859)	(116,217)	(4,358)	(193,140)	(202,791)	(9,650)
Clinical Partnerships	(81)	(65)	16	(622)	(501)	121	(1,029)	(1,003)	26
Cost and volume contract	0	(30)	(30)	(462)	(191)	271	(462)	(382)	80
Total Patient Care Income	**(16,339)**	**(16,903)**	**(564)**	**(112,943)**	**(116,909)**	**(3,966)**	**(194,631)**	**(204,176)**	**(9,544)**

Commentary

Block contracts: All block contracts reflect the figures advised by NHS England and NHS Improvement as those deemed necessary to support providers during the current pandemic, based on 2019/20 income. These blocks have been updated for October to March and include additional funding from NHSE. Also included here is additional funding to satisfy the Mental Health Investment Standard, including extension to services in Specialist Community Forensics (SCFT), Liaison, Early Intervention in Psychosis (EIP), Crisis, Perinatal and Learning Disability (MHLD) as well as full funding for Community Recovery extensions which were agreed in 2019/20. The absence of this funding in the early part of the year is the cause of the adverse variance.

Cost and volume contract: All income shown here is with non-NHS providers or is for one specialist case which is outside of the current arrangements. Also included here is the recharge for additional costs associated with Covid (£4.00m) and top up funding from NHSE/I (£1.7m).

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2020**
Title	**Chief Operating Officer's Report**
Author	**Jacquie Mowbray-Gould, Chief Operating Officer**
Presenter	**Jacquie Mowbray-Gould**
Executive Director Sponsor	**N/A**
Purpose	**For Information**

1 Introduction

The report will cover key actions as required by the Board, highlight areas of strategic operational development and give an overview on any particular areas of interest the Board requests.

2 Updates from July Board report

2.1 Psychiatric intensive care unit (PICU)

In October CQC visited the Godden Green site, operated by Cygnet, where the contracted female PICU beds are based on Castle ward. CQC found some concerns regarding the care planning and staffing gender mix on Castle Ward, with staffing of the ward being too male dominated for a female ward. Cygnet was given a quick turnaround time frame of one week to develop an action plan.

Following the notification Tumi Banda, Deputy Director of Nursing for KMPT, visited Castle Ward on the 16th October 2020. He met with David Willmott, the Director of Nursing for Cygnet Health Care, and the multidisciplinary team (MDT)

A thorough quality inspection took place and he noted actions in place in response to the CQC findings; following the review of case files, care and risk plans alongside staffing rotas he found the organisation had taken quick and positive actions to address these two key areas of concern.

Cygnet will continue to share their CQC action plan with KMPT highlighting progress which will be closely monitored at the monthly contract meeting between KMPT and Cygnet. The monthly PICU contract meeting was held on the 13th of November; no concerns noted at the time of writing

2.2 Covid-19 response

With a national resurgence in Covid cases and a second lockdown in place, operational policies developed in response to Covid have been updated to reflect new guidance. The Executive team continue to work closely to align key requirements to ensure staff and patient safety during the on-going pandemic

whilst aiming to deliver business as usual, recovery and transform programmes alongside Covid safe provision.

2.3 New Developments

As set out in the last Chief Operating Officer's report a number of service area developments continue to move forward in response to both Covid and implementation of the Long Term plan for mental health

- As seen in the media and through the KMPT performance data people contacting mental health crisis support is rising exponentially. Most people will not require long term specialist mental health support but need a quick and easy access point to ensure their mental health needs are addressed effectively to prevent further distress or illness

  To respond NHSE asked for the service delivery of an NHS led crisis line to be brought forward by 12 months. In October the CCG have confirmed financial allocation to ensure KMPT Single Point of Access, SPOA, can safely expand to deliver a 24/7 crisis line. This is phase one of ongoing work with 111 and the wider system to ensure improved use of all resource across partners in delivery of a single crisis line and 24/7 urgent mental health crisis response.

- In month progress has been made with ensuring the 24/7 mental health crisis assessment can operate more effectively via access into the urgent treatment centres. Most of Kent is in development phase of urgent treatment centres and Deputy Chief Operating Officer (DCOO), Vicky Stevens, along with Louise Clack, Head of Service for Acute care, have been linking with the relevant Integrated Care Partnerships to ensure mental health is embedded in system urgent care delivery planning. The response has been very positive.

3 Responsive quality and performance metrics

3.1 4 and 18 week wait standards – memory assessment

Board in September expressed concern regarding the impact of Covid on routine work as seen in the 4 and 18 week local trajectories. Whilst nationally there are no specific standards for mental health referral to assessment and assessment to treatment standards (4 and 18 week wait) most mental health trusts use the national standards set for physical health services.

The greatest impact on inability to achieve these two standards has been noted in the Older Adults care group due to the national cessation of routine memory assessment in March 2020 following the national lockdown. Around 80% of referral activity to older adults is for memory assessment which, as an outpatient diagnostic process, generally requires a battery of face to face tests. The lockdown significantly impacted on older people, especially those over 70

years, many who were required to shield and would be the most likely age group to be requiring memory assessment.

Subsequently medical and psychological communities have been able to agree virtual options for memory assessment and KMPT older adults care group have trained their lead clinical staff in the use of these mandated options. Whilst not all persons will be able to benefit it has meant an element of routine memory assessments has begun to function once more

A detailed paper outlining the demand and capacity, key impacts at a team level and recovery actions has been completed by Teresa Barker, head of service for older adults, and Taps Mutakati, DCOO, for consideration at the October Finance and Performance committee.

3.2 Integrated quality performance report - IQPR

Both the Director of Finance and Chief Operating Officer are working closely to improve performance reporting in particular relation to the responsive element of the IQPR. During October and November the key areas under review are the 4 and 18 week wait, Trust cancellations and care planning. There has also been considerable work done to fully understand the demand on community teams against the available capacity.

4 Psychological Support

From the outset of Covid KMPT took a lead role in delivery of psychological care both internally and externally. Dr Lona Lockerbie, Care Group Director for forensic and specialist services, has led the organisation's response. There are 3 workstreams relating to psychological support in relation to the COVID pandemic.

- Psychological support to health and social care staff. This work has seen a number of outcomes including briefings, support videos, development of psychological support into the acute hospital and development of a local system resilience hub.

- Psychological support for the general population: With providers of mental health services across the ICS and public health, KMPT have helped model anticipated increased demand for mental health psychological support. From this the initial groups to be targeted for additional psychological support include those bereaved, those who have had Covid, those with existing mental health needs and those from a BAME background

- Psychological support for KMPT staff: To support the wide range of organisational options provided by the workforce directorate, Dr Lockerbie together with the KMPT organisational development (OD) team, have planned additional provision of psychological support across

the organisation. Key outcomes are webinars for staff have been rolled out including a section on recognising symptoms of trauma and managing symptoms and staying well.

5 Volunteering

The Chief Operating Officer is the executive sponsor for volunteering; the trust has a vibrant volunteer team and they were one of many champions of the initial response to Covid however their work is not often highlighted. This is a short overview of the role and actions taken by the KMPT volunteering services during Covid. In March 2020 voluntary services suspended significant elements of delivery however set up an emergency responder service to ensure some targeted activity could take place. The volunteer team, led by Helen Collins, recruited 50 emergency responder volunteers that took on a number of roles including:

- Drivers to deliver PPE to busy clinical teams
- Ensuring prescription collections and delivery were made for shielding patients
- Arrangement and delivery of emergency food parcels,
- Telephone befriending and co-ordinating voluntary efforts for kit and goodie packs

Helen went on to develop Covid response role descriptions, produced an explanatory booklet for all volunteers and completed a standard operating procedure for volunteers in KMPT to ensure they operated safely.

Post the acute COVID response volunteering in KMPT is now very different and restarting volunteers within patient services the main focus; there are many opportunities for the volunteering team to expand their services. The service would like Board to note the value volunteers add to our clinical and support services in KMPT and hope this short overview highlights their very positive contribution to the organisation

6 Care pathways

Throughout Covid clinical teams across the community and acute services continued to develop and implement the Care Pathways programme. Dr Kirsten Lawson, Clinical Director for the programme, updated Quality and Finance and Performance committees on the progress made. This work builds a solid foundation to deliver the aspirations and requirements of the long term plan. The first staff briefing was published in October, see appendix 1

7 Conclusion

Board are asked to note this paper

INSPIRING CHANGE
Celebrating our Clinical Care Programme

NHS
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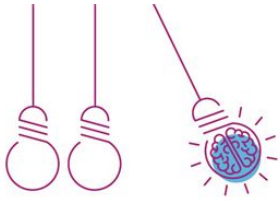
Welcome to our new newsletter 'Inspiring Change', which focuses on the Clinical Care Pathways (CCP) and the projects (initial interventions, complex emotional difficulties, mood and psychotic disorders) that staff are helping to deliver across the Trust.

Each month we'll feature highlights from a number of areas as well as studies, staff profiles and service users' testimonials.



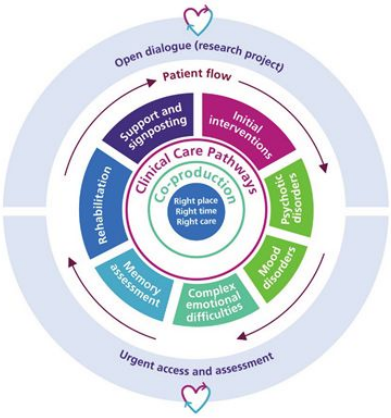
Whether you are involved directly in the programme or hearing about it for the for the first time, our aim is to give you a quick summary of what has happened so far, what is happening in the future, the clinical and support teams leading on the work and where you can find out more.

Don't worry if you miss an edition, previous issues will be available on i-connect so you'll be able to catch up on the latest news on the CCP pages too; so you'll always have the most up-to-date information about the pathways.

We hope you enjoy reading Inspiring Change and would love to hear from you about your role within the projects too - drop us a line at kmpt.communications@nhs.net

The Clinical Care Pathways revealed
The Clinical Care Pathways (CCP) have been co-produced alongside clinicians and service users to provide clear pathways of care for everyone who requires specialist mental health care (community or inpatient). The CCP includes a wide variety of services and sets out the journey a person can expect to make with KMPT from assessment to recovery and finally discharge.

The clear and structured programmes which have been co-developed, mean we are able to provide the right care, in the right place at the right time in partnership with other providers for the people we support.



There are three programmes within the CCP - community, acute and older adult.

Within each programme sit a number of projects or enabling services (inspiring change) which you can see in further detail by taking a look at the CCP diagram included.

The community programme includes:
- Initial interventions
- Complex emotional difficulties
- Mood disorders
- Psychotic disorders (unusual experiences).

The acute programme includes:
- Urgent access and assessment
- Place of safety.

The older adult programme includes:
- Memory assessment.

A rehabilitation programme is in development too and will form its own programme.

Open dialogue is a community-based research project aimed at responding to people who are in immediate crisis while the support and signposting service, launched in April 2019 as a pilot, has recently been reviewed to evaluate the impact it has made and whether it receives the necessary funding to become a permanent service.

The whole CCP is supported by additional teams who help with delivery including the Patient flow team, Kent Police (Section 136) and other multi agency departments who are leading on work to improve access to Safe Havens across Kent and our collective Suicide Prevention Strategy.

Initial Interventions
The initial interventions project is a community - based talking therapy (Cognitive Behaviour Therapy, CBT) which provides psychological support to people to help them understand their difficulties, learn new coping strategies and come away with a clear individual recovery plan.

INITIAL INTERVENTIONS

We spoke with Jack Fagg, Support time recovery worker (STR), who has been involved in the initial interventions pilot and the service since its launch in 2018.

Jack said: "I was lucky enough to be involved in the pilot when it was launched in Folkestone and Dover and I was new to the team. This meant I could really hit the ground running which was great.

"It was pretty clear to me right from the very first person I was involved in supporting that initial interventions was going to very helpful to people who really engaged with it. As part of the evaluation process, people completed a questionnaire which looked at the full process and more importantly, how the person felt at the end of the four week programme and what the results showed was that each person was able to feel more positive and manage their distress in a more productive way.

"At the end of the pilot the evidence was overwhelmingly clear that the psychological support received was allowing people to learn coping strategies that they could apply practically, which in turn helped them to take massive steps in their recovery.

"Initial interventions was rolled out across KMPT and I was privileged to be asked to support across the Trust with various training and presentations.

“I am really pleased to say it is has now been fully embedded in each Community mental health team across Kent and Medway, and two years later I am still embracing initial Interventions and seeing the difference it makes to people’s lives.

“Not only does it provide clients with strategies to manage their distress, it also helps the wider team to understand where their strengths and weaknesses lie, which in turn helps to inform further treatment in and around the service.

“Hand on heart, I can honestly say the programme is very much valued within our team and as an STR worker, it helps provide great job satisfaction.

“Currently we have seven STR workers who each carry a caseload of six clients per week - the process is well embedded.”

COMPLEX EMOTIONAL DIFFICULTIES

Complex Emotional Difficulties – what’s in a name?
Brilliant care means seeing the person behind the diagnosis…

We spoke with Dr James Osborne about how the renaming of the personality disorder pathway will help to change attitudes and improve care by starting a new conversation.

People with a personality disorder, just like anyone who has mental health difficulties, can be stigmatised because of their diagnosis. This can attract fear, anger and disapproval rather than compassion, support and understanding, often impacting on the person and causing their condition to spiral.

Clinical lead for the complex emotional difficulties project, Dr James Osborne said: “personality disorder is still seen by some as a diagnosis of exclusion, meaning they often feel unsupported and just labelled.

In January of this year, the Trust held a workshop entitled Inspiring Change and Transforming Attitudes, facilitated by The National Collaborating Centre for Mental Health, which brought together over 150 people for one day to discuss these aspects of the CCP including language used around personality disorder and its treatment.”

James explained: “We wanted a workshop-style forum where all interested people including service users, carers, clinicians, and commissioners, could talk openly about their experiences of the use of the term personality disorder and consider the naming of the pathway among many other things.

“What became very apparent during the workshop was that people broadly fell into two categories – those that wanted to change the pathway’s name and try to move away from the stigma of the diagnosis, and those that were happy with sticking with calling it the personality disorder pathway as it clearly links it to a recognised diagnosis.

“After discussion and debate, we were left with was several key phrases including complex trauma, trauma related difficulties, complex emotional difficulties, complex needs and through this, what became quite clear was that people didn’t like the term ‘disorder’. However, no one clear name emerged as preferred over and above every other suggestion.”

Dr Osborne added: “Really, if I am honest, the conversation throughout the workshop became less about whether a change of name was the right thing to do and more about whether that name change would help serve as a catalyst for a change in attitude, something I hear over and over again. On balance, this seemed a good enough reason to change the name and work has now begun to embed the new name of the pathway.”

James added: “Our work is only just beginning. My hope from this name change across the organisation is that it prompts discussion and begins a new narrative to force us to focus on the person behind the label.”

Job plan - a new approach to planning for the future
The concept of job planning is not a new one across healthcare and the distinct benefits of this type of operational and strategic modelling are not just financial.

Knowing what the demand for a service is and forecasting what it is likely to be in the future, including mapping staff resources to deliver key service improvements, has made a dramatic difference to the delivery of the clinical care programme.

Louise Gascoyne**,** Allied health professional lead, explained: “As part of the CCP work, each lead was asked to look at how many people we were supporting across each intervention. Dr Kirsten Lawson, Clinical director of care pathways, Community recovery care group and Acute, took the figures we each provided and used them to map where each person would naturally be placed in the CCP if all the projects were up an running and delivering care. This allowed each lead to then consider exactly how many clinical staff were required to meet the demand for each service, which was then mapped together with the grade of each role too.

“From the mapping exercise we have been able to create a specific job plan for each clinician. The plans not only include the CCP projects identified for each professional group but the time needed for other activities such as team meetings, mandatory training and supervision too.

“The work has supported professional groups to have protected time to complete profession specific interventions and it is the first time we have been in a position where we have been able to effectively prove the exact staffing levels required to meet the needs of our current service user population based on evidence which is amazing.”

The benefits that this piece of work will bring to the Trust are huge in terms of creating more efficiency and staff fully understanding the skill set needed to carry out their role. Kirsten said: “This has been a really useful exercise and will help to provide a clear path for our staff as well as helping us to identify where further investment is needed and how much that will cost.”

Your care explained
Amy Daniels, Allied health professional, acute care group lead, has been leading on creating this new approach, together with support from Holly Till, Project manager from the transformation and improvement team. They shared with us the thinking behind it and why it will help to outline a more inclusive culture at all levels as well as setting clear expectations for staff that can support patients’ health and wellbeing for the best outcomes.

Amy said: “This menu of interventions or guide to a person’s

care will be delivered as a patient leaflet and will clearly set out the main treatments and interventions we can offer based on patients particular conditions, but always ensuring individual needs are being met.

“All of the interventions offered are what we call ‘evidence-based’ in line with research and new ways of working. They will be provided by a multidisciplinary team who will work to ensure that our service is realistic and sustainable as well as of the highest quality.”

There are three main disorder groups: complex emotional difficulties, mood disorders and psychotic disorders. Within these disorder groups there are a number of areas of support which are:

- Psychological therapy
- Daily life
- Medication
- Carers, family and friends
- Physical health care
- Self-management
- Additional interventions

Amy continues: “As part of the work we are doing, we are co-designing a patients’ leaflet which will be accompanied by a clinical guide to explain about the resources needed, what we are hoping to achieve, and the things we are putting in place to deliver our training plan too.

“To help us, we have used a series of workshops since last year to engage with a wide range of staff and experts by experience with support from the transformation team. These workshops allowed us to map what happens on wards; from admission to discharge and everything in between.

“Co-production has been a real focus for us and with the development of the Trust’s new Participation and Involvement Strategy, we have ensured the patient leaflet has been developed alongside patients who are currently on our inpatient wards.

“This project will shape the future of acute inpatient services and its therapeutic support and will help us to identify where increases in our staff are needed as well as developing the skills of our existing staff.”

Meet Jake from Ash Eton’s Community mental health team
They say ‘choose a job you love and you’ll never have to work a day in your life!’

That was the phrase that sprung to mind when we met Jake Reading who is a Support time recovery worker in Folkestone.

Jake took the time during his busy day to answer a few questions about his role, what he loves about it and the benefits, in his opinion, of the Initial Interventions project.

What does your role involve each day?
“One of my key responsibilities is to work with people through our Initial Interventions programme which is a guided, self-help treatment suitable for a variety of mental health difficulties. As part of my role at Ash Eton, I work alongside the psychology team to support training delivered to other Community mental health teams too.

“Support time recovery workers usually cover many different aspects of the services and so we are pretty good at juggling a number of things which always helps as the role can be challenging.

“I support the active review team to make contact with people who are held within a team awaiting one or more interventions too. This gives me the opportunity to monitor progress at least every four weeks by telephone or, where possible, through face-to-face review.”

Why is the role important in your opinion?
“We’re there to support the nurses and occupational therapists to maintain contact with a large caseload of clients effectively and safely.

“The initial interventions approach is incredibly supportive and STR workers help to make sure that people are aware of and are directly involved in their care and support. We also support the qualified staff to carry out initial assessments and reviews and this can sometimes lead to specific support work with that person.

“Support work can include providing ‘graded exposure’ into the community, for those who have found it hard to leave the house or carry out activities that they were once able to but now find hard owing to them experiencing a deterioration in their mental health.”

If you had to name one essential quality to be an STR worker; what would it be and why?
“Wow, there are so many!

“We help enable people to feel in control of their mental health and to overcome barriers which they face. It is essential to build a good rapport with people and make them aware of all the good progress they are making.

“I suppose the ability to build trust, be approachable and not judgemental are key, but in all honesty there are so many it is difficult to name one above the other. You learn very quickly to adapt and flex your approach to give that person what they need.”

What do you enjoy about your role?
“I find the job very rewarding and am able to strike up a good rapport with people through working in mental health for the last 10 years. No two days are ever the same and being able to support and help is what I really like most of all. I really feel I have made the right decision to work within community mental health and I plan to further my career within KMPT and pursue a nursing degree.”

You said your work can be challenging so what do you do to relax?
“Outside of work I am a keen musician and often find I can establish a good link with clients, through my eclectic taste in music. Music is a good way to connect with people and, as with people I work with, find music good for my own mental health - whether playing or listening to it.

“I have also connected through fitness as I have been able to train and run a few marathons over the last few years and like to keep healthy and encourage others to do the same to promote good mental health.

“Aside from this, I am a family man and enjoy being able to spend time with my wife and daughter and soon to be next child!”

Best of luck Jake with your paternity leave and we hope to see you very soon.

Supporting the pathways and ensuring success
The Transformation and Improvement team has been a constant support throughout many of the CCP projects. Their role has been to offer guidance and support as well as helping to establish the correct framework in which to deliver the projects and key performance indicators through which their impact and success can be measured.

Martine McCahon, Assistant director of transformation and improvement, has been leading the team since September 2019 and said: “As project managers we are here to empower those leading on projects and support them to find the solutions they need. As well as guiding them, we also challenge their thinking where necessary to

ensure the changes or service improvements being made are the best for patients, carers and staff.

“The ideas must come from the people with lived experience, clinicians and experts; we facilitate change and help to make it happen.

“One of our key aims is to create a safe space in which people can discuss their ideas and have their voices heard equally. This means that all ideas and views can be reflected and taken into account - from housekeeping staff right through to executive and board level.

One of the many strengths of the team is that we have a good understanding of how processes work internally within KMPT as well as how the commissioning side of services work too.

Martine explains: “I was a former commissioner and my career included a wide variety of work areas from programme and project management to performance and service improvement. Since arriving over 14 months ago in the Trust, these particular skills have been welcomed and proven very useful when moving forward our own programmes, projects and pathways.

“Many of our projects are clinically-led and this is important, while others may be led by other experts within the organisation. We strive to really get to the heart of the current position and our understanding of what it is that needs to be done before jumping straight into solution mode. Having the wealth of experience is often the difference between a project that works and one that fails to get the correct traction and support from colleagues.

“We are constantly learning as a team and upskilling within our role is vital. It is also really important that as an organisation everything we do is always evidence-based so we can understand the needs of the population fully to make sure we are designing, testing and embedding the right projects which will make a positive difference.

“I am so inspired every day by the work taking place and incredibly proud of what the team has helped to achieve so far.”

Share your experiences (comms)
If you are involved in the Clinical Care Pathways and would like to share your experience, please contact the Communications team by email kmpt.communications@nhs.net

Our staff and the people we support are inspiring change each day and we want to be able to share that each month so we can continue to celebrate great practice and highlight where we can make service improvements together.

Be part of that change and be #KMPTProud.

We are proud to be smoke free

Interim Trust Chair – Dr Jackie Craissati
Chief Executive – Helen Greatorex

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Public Trust Board	**Date**	26th November 2020
Title of Paper	Becoming a Non Racist Organisation (Black, Asian, and Minority Ethnic (BAME) Progress Update)		
Author	Helen Greatorex, Chief Executive		
Executive Director			

Purpose: the paper is for:	• **Delete as applicable**
• **Information**	

Recommendation:

The board is asked to note progress made in relation to becoming an anti-racist organisation, to ask any questions of the Chief Executive and her team and to endorse the direction of travel

Summary of Key Issues: • **No more than five bullet points**

- If the Trust's determination to become a non--racist organisation is to be made reality, it must be underpinned by a clear set of measurable actions progress against which should be reported to the Board or an appropriate sub-committee.

Report History:

This is the first update report to the Board

Strategic Objectives: • **Select as applicable**

☒ Consistently deliver an outstanding quality of care

☒ Recruit retain and develop the best staff making KMPT a great place to work

☒ Put continuous improvement at the heart of what we do

☐ Develop and extend our research and innovation work

☐ Maximise the use of digital technology

☒ Meet or exceed requirements set out in the Five Year Forward View

☒ Deliver financial balance and organisational sustainability ☐ Develop our core business and enter new markets through increased partnership working ☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership

Implications / Impact:
Patient Safety:
Identified Risks and Risk Management Action:
Resource and Financial Implications:
Legal/ Regulatory:
Engagement and Consultation:
Equality:
Quality Impact Assessment Form Completed: Yes/ No

Becoming a Non Racist Organisation (Black, Asian, and Minority Ethnic (BAME) Progress Update)

Background and Introduction

The Board was addressed at its June public meeting, by Simon Cook, our KMPT BAME Network Chair. Simon had written an open letter (attached) following the killing of George Floyd in Minneapolis and the Black Lives Matter protests that had followed.

The letter was shared across the Trust and proved to be the catalyst for conversations between colleagues that had not previously happened. There was a sense across KMPT that whilst we had always espoused an anti-racist culture, now was the time to do more and step up our ambition.

The Board meeting that Simon addressed was made available for anyone who wanted to join it (we were meeting virtually, due to the pandemic) and about fifty members of KMPT staff joined the board to watch the discussion. Simon talked powerfully about his personal experience of racism, and of his ambition that KMPT would become even more assertive in tackling it and working to become a non-racist organisation.

The Board accepted Simon's challenge, and made a public commitment to step up its ambition, working more overtly towards eradicating racism wherever and however it occurs in KMPT.

The Chief Executive undertook to update the board on progress with this important work and this paper is the first in what will now become a quarterly update.

Simon's Challenge and The Organisation's Response

Simon in his letter made 7 requests of the board. They were:

1. That non BAME colleagues become more involved in the BAME Network and forthcoming conference
2. That we elevate training around Race, Ethnicity and Respect to a more prominent position
3. That we actively support staff to feel sure that we will support them to report racist incidents to the police
4. To actively support all staff to challenge any racial incident that makes them feel uncomfortable whether it was directed at them or not
5. To insist that Race and Diversity is included on all meeting and supervision agendas
6. To consider developing a champion network for BAME staff
7. To educate ourselves as a board, in particular, in order to understand how we can be part of the solutions for change.

In response to Simon's challenge, a series of actions followed. These included establishing a granular action plan (attached) the progress of which is reported to a sub committee of the board (the Workforce and Organisational Development Committee).

Next Steps

Simon's letter and the supporting action plan are focused on improving the experience of our staff.

Equally important is the experience of those we serve. To that end, similar profile is being ascribed to the work that other sub-committees of the board are undertaking. Examples include setting stretch targets for our recording of the ethnicity of service users, improving our analysis of the use of the Mental Health Act, improving our outreach to communities who may not naturally seek help from our services.

This work will be brought together in the same way that that work related to staff has been, so that there is a clear line of sight from the board to the ward, in highlighting our areas of risk, poor performance and shortfall in the service of people whose background is BAME.

The executive team will be learning from national exemplars in this work, and bringing best practice to KMPT. If additional resource is required to properly fund this important work, we will identify and invest it.

Summary and Conclusion

The events of this Summer along with the global pandemic and increased risks to people whose background is BAME, have provided a catalyst for change. Many more open exchanges and discussions about heritage, ethnicity and racism have taken place as a result and a new dialogue has started across KMPT. We will now build on the foundations that we are laying, accepting and addressing Simon's challenge and pushing ourselves beyond that expectation so that whether someone is a service user, a carer, member of staff or visitor, they can feel safe and confident in the knowledge that KMPT is a non racist organisation.

Creating an anti-racist KMPT

The table below sets out the work to date on becoming an anti-racist organisation. The Board will receive a quarterly update for assurance against the actions. The reporting begins at Q2.

	Action	Update	Lead/Involvement	Status				Timescale	Measures
				Q1	Q2	Q3	Q4		
1	Risk register includes risk for KMPT not protecting its BAME workforce by completion of risk assessments.	Risk wording developed with BAME Network Chair and given to KMPT Risk Manager for inclusion in risk register.	Equality Diversity and Inclusion (EDI) Manager KMPT Risk Manager Chair of BAME staff network Director of Workforce and Communications			-	-	August 2020	Numbers of staff leaving KMPT Exit interview data Will be reported to WFOD
2	Carry out a recruitment review to evaluate KMPT's recruitment practices from vacancy to appointment in order to improve KMPT's capacity to attract, recruit and retain diverse applicants.	There will be a number of 'work streams' from the review to implement the recommendations. WFOD to receive updates on implementation of recommendations. This will include: Where we advertise What stops BAME staff from applying Reviewing conversion from application to shortlisting, interview and appointment.	HR Business Partners (HRBPs) EDI Manager EDI Facilitator and Trust WRES Expert Freedom to Speak Up Guardian Workforce Development Advisor Recruitment Team Leader Legal Team					Follow up review of changes by November 2021	Staff Survey shows that BAME staff are supported and offered the same opportunities across KMPT. Workforce Race Equality Standard (WRES) reporting indicators 5, 6 & 8 Benchmark against other Trusts
3	Formal launch of Hate Crime Strategy	Hate Crime Strategy to be launched in January. Ongoing work with Police and other NHS Trusts to develop Compact agreement and begin Operation Cavell.	Deputy Chief Executive KMPT Security Manager EDI Manager EDI Facilitator BAME staff network Kent Police Kent and Medway NHS Trusts					Operation Cavell - December 2020 January 2021 - Hate Crime Strategy Launch	Increase in recording of incidents on Datix Increase in prosecutions for hate crimes against KMPT staff
4	Increase number of BAME Freedom To Speak Up (FTSU) Ambassadors	Further recruitment of BAME staff as FTSU ambassadors has taken place. Increased from 8 to 15	FTSU Guardian EDI Facilitator BAME staff network					March 2021	FTSU BAME Ambassador numbers to be at 20
5	Carry out a training review to evaluate KMPT's training application processes for non-mandatory training and CPD.	Ensuring equality around provision of external and internal training opportunities – monitoring of how many BAME staff apply for training and are successful reported on quarterly basis to KMPT Training Panel.	Head of Learning and Development EDI Manager Training Panel BAME staff Network					To feedback recommendations to L&D end of January 2021	WRES reporting indicator 4 Benchmark against other Trusts Staff Survey shows that BAME staff are supported and offered the same opportunities across KMPT.
6	Support staff learning on the issues faced by staff from different backgrounds through self-directed learning/ BAME network events/ Communications.	BAME Ally sessions being delivered with 148 attendees across four sessions: Being an Active BAME Ally Moving to being Anti-Racist Understanding White Privilege and White Fragility Why it's a micro-aggression	EDI Facilitator BAME staff Network					December 2020	Increase number of BAME allies to 160 by end of March 2021 Increase in BAME staff network membership. Staff Survey results. WRES reporting indicators 5, 6 & 8.
		All FTSU Ambassadors to attend the 'Being and Active BAME Ally' session.	EDI Facilitator FTSU Ambassadors				-	November 2020	All FTSU Ambassadors have attended training.

		Buy and distribute books for self-learning across KMPT site.	Chief Executive BAME staff Network Communications Manager			-	-	July 2020	350 copies of each of the titles distributed across KMPT sites for all staff to share and learn. Communications to add iConnect quotes from staff who have read them and what they thought. WRES reporting indicators 5, 6 & 8.
		iLearn to have specific area for self-directed learning.	Head of Learning and Development EDI Manager BAME staff Network					Spring 2021 for iLearn changes	Area available and being utilised by staff. WRES reporting indicators 5, 6 & 8.
7	Introduce reverse mentoring for KMPT leaders	Applications from BAME staff to act as mentors currently being sought.	Organisational Development (OD) Specialist EDI Facilitator Joint partnership with MTW NHS Trust BAME staff network					July 2021	Sixteen mentors and mentees recruited and completed reverse mentoring pilot. Positive feedback from both mentors and mentees. Reverse mentoring to continue beyond cohort 1.
8	In order to remove the glass ceiling for BAME staff ensure coaching opportunities are available and attended by BAME staff (Bands 7 and above) to support those wishing to move into leadership roles.	KMPT have secured the Wellbeing Collective to deliver 3 x 90mins group coaching session for all BAME staff from Band 7 and above. The sessions will each focus on different areas of challenges that BAME staff face moving up into leadership roles. The Opening Doors programme also supports this work.	OD Specialist Wellbeing Collective EDI Facilitator					Coaching sessions complete January 2021	Staff Survey shows that BAME staff are supported and offered the same opportunities across KMPT. WRES reporting indicators 2 & 4
9	The upcoming addition of an annual wellbeing conversation for all staff and wellbeing Induction for all new starters will all include elements of equality and diversity and flexible working as per NHS People Plan.	This will take place from the beginning of January 2021	OD Specialist EDI Facilitator dis(Ability) staff network					End of Supervision Window 22 February 2021	Staff Wellness Passport and wellness recovery action planning (WRAP) tools available and utilised. Decrease in staff sickness More staff working flexibly
10	National WRES Expert trained staff member within Diversity and Inclusion Team to have knowledge of best practice in implementing WRES and is aware of the latest evidence in what works in closing the race equality gap.	National course on hold due to Covid-19	EDI Manager					TBC by National WRES Expert Team	Staff member trained and able to support KMPT in closing race equality gaps. WRES Indicators 2-8
11	Working with NHSP to support BAME NHSP staff at KMPT sites	KMPT to be a pilot for NHSP in developing support on sites for their staff.	EDI Manager NHSP Strategic Account Manager HRBPs					January 2021 – but dependent on NHSP	Seek feedback from NHSP staff about their experiences working within KMPT. NHSP report that NHSP staff are supported to carry out their duties whilst on KMPT sites
12	Health and Wellbeing Sessions to specifically support BAME staff.	Reflective sessions developed specifically to BAME staff have offered but not yet begun.	OD Specialist					March 2021	Feedback from reflective sessions shows that BAME staff have felt supported.
13	KMPT will set stretch targets to reach equality in BAME representation across the workforce pipeline by 2028. This is as set out in the NHS England Model Employers strategy.	Data being analysed to set stretch targets for each Care Group to reach a minimum of 22% BAME staff in each CG. Where that is already higher a further stretch target will be set. Supported by action 8	EDI Manager Recruitment Manager HRBPs					Targets to be set by January 2021	Minimum target of 22% BAME staff at all areas of KMPT.
14	Review of disciplinary process and its implementation, including review of why	As part of the Just and Learning Culture programme a specific work programme has	OD Practitioner ER Manager					March 2021	WRES Indicator 3

	BAME staff are 1.8 times more likely to enter a formal disciplinary process.	been set up to look at early resolution and the disciplinary and grievance processes.	Culture Programme Board EDI Manager BAME staff Network Chair						
15	Mandatory coaching in place for managers.	EDI manager met with Head of Equality, Diversity and Inclusion at NHS England and NHS Improvement (South East) to look at models in place and will attend NHSE/I course to adapt for KMPT	EDI Manager OD Practitioner					July 2021	WRES indicator 8
16	Effective patient data reports are reported to the Equality and Diversity Steering Group and sent to teams to understand their patient demographics.	First report went to EDSG in September 2020 as planned. A subgroup of the EDSG has been set up to look at accuracy of data, what the issues are in recording data and how to improve.	Equality & Diversity Steering Group EDI Manager					April 2021	Improvement in data accuracy of patients' demographics to enable further metrics to be set to look action 17.
17	Patient data is interrogated in detail to look at level of care during involvement with KMPT – including medication usage, care plans etc.	List has been drawn up of potential specific reports but data accuracy needs to be improved.	Equality & Diversity Steering Group Assistant Director of Information & Performance					April 2021	Reporting shows no difference to the care a person received regardless of ethnicity.
18	Glossary of Terms Development	Glossary written and with Communications to brand.	EDI Manager Communications Manager All staff networks					December 2020	FTSU Ambassadors and managers have confidence in having conversations using new and evolving terminology.
19	Cross County BAME Network	Cross County BAME network is Chaired by KMPT CEO Working with all NHS providers across Kent to look at equality of opportunity and becoming anti-racist work places	Chief Executive Officer Chair of BAME staff network				-	Taking place regularly	KMPT uses influence to support other NHS Trust in becoming anti-racist.
20	Development of anti-racist intervention programme for patients	Low secure forensics detailing and testing a patient based training course which aims to look at, educate and tackle racism. Course to be evaluated and amended as required for roll out across KMPT	Service Manager Forensic and Specialist Care Group EDI Manager HRBPs					May 2021	WRES indicator 5
21	Ensure that BAME specific health inequalities are considered and actions to reduce them are within the Recovery and Transformation work	BAME staff are actively involved in the discussions to understand and adequately address the staff implications from Covid-19 And to facilitate new learning and approaches to addressing health inequalities in our patient cohorts highlighted by Covid-19	Assistant Director of ICP Development					2022	Involvement of the BAME population within the recovery and transformation work Reduction in the gap the health inequalities gap that exists for BAME people.

RAG Rating

Red	Not started
Amber	Underway
Green	Complete

Letter from Simon Cook :

Dear All

In my capacity as BAME Chair, and as a member of the Black community as well as the NHS for 36 years, I feel qualified to comment on current issues around race and ethnicity. I am pleased to acknowledge the support I have had from many individuals and groups, that have helped me grow and become who I am today; and I am proud, extremely proud to have been associated and nurtured in this way. My work in both the BAME community and the NHS is not yet complete and I am more convinced there is a need to continue to do the best I can for what I believe is right, just and fair. I do hope that you as senior colleagues can agree with my sentiments, frustration and upset at this particularly poignant time in our history.

I have spoken with many BAME staff within the Trust over the past few weeks, as well as white colleagues (some of which have been in tears), not only about the disproportionate impact of COVID-19 on the workforce but about the levels of subtle racial abuse they face on a daily basis, working in and for the NHS. These concerns are not only about the behaviour of patients but unfortunately, from colleagues including peers and senior staff. They continue to work and provide the best possible service they can.

I respectfully request that the executive and other senior colleagues, across all care groups, counter this pandemic of racism with the same vigour, intelligence and professionalism with which we have together, tackled COVID-19. It is reassuring to know that we have on the Board a good BAME representation, but I feel we still need your help to move this issue on and look for true equality, respect as well as challenge intolerance.

I think it is now timely and important, that our White colleagues (I truly hate going down the lines of colour) stand with us and put a ‘mark in the sand’ and say these abuses need to stop and will not be tolerated; this will increase the respect and admiration to the Board and it will send out a clear message that enough is enough.

I would love to see the next BAME conference led by my White colleagues, and race equality promoted loudly throughout the Trust and wider society. This is such an important matter that it requires strong and visible leadership as well as grass roots engagement.

My mother and father came to the UK in the early 50’s to help rebuild the infrastructure of the UK. Dad was a carpenter whilst my mother was a nurse in our NHS. They tolerated years of abuse yet were always polite towards others in public whilst crying angry tears at home. I have also faced racist abuse throughout my life but have had the opportunity to challenge and question this. When I consider my grandchild’s future and development, I hope with all my heart that he will not have to experience the hurtful misery of racist abuse.

I consider the Trust’s ambition is to commit to causing every individual to feel included, valued and respected through the efforts we all make on a daily basis. No one is asking for exclusivity, together we should look to develop a level playing field which I believe should be afforded to all staff and service users. I for one have tried to support, nurture, guide not only my children but family, friends and colleagues through challenging times and it is always easier to work at something collectively rather than alone.

With the above backdrop, can I suggest that consideration is given to the following suggestions for the further development of our Trust and its individual leaders and other employees.

Non BAME colleagues more involved in the BAME Network and forthcoming conference
Elevate training around Race, Ethnicity and Respect to a more prominent position
To support staff to feel sure that we will support them to report racist incidents to the police
To actively support all staff to challenge any racial incident that makes them feel uncomfortable whether it was directed at them or not
To insist that Race and Diversity is included on all meeting and supervision agendas
To consider developing a champion network for BAME staff
To educate yourselves and how you can be part of the solutions for change.

Here are some suggestions:

Books to read:
Why I'm no longer talking to white people about race – Reni Eddo-Lodge
So you want to talk about Race – Ijeoma Oluo
White Privilege: The myth of a post-racial society – Kalwant Bhopal
White Privilege unmasked: How to be part of the solution – Judy Ryde

YouTube:
Deconstructing white privilege – Robin DiAngelo
https://www.youtube.com/watch?edufilter=NULL&v=DwIx3KQer54

Akala on Racism and the British Empire https://www.youtube.com/watch?edufilter=NULL&v=prn7sE9K-tQ

I would be more than happy to discuss any of the above with my senior colleagues, and wider staff groups and look forward from hearing further from the executives.

I remain yours accountably
Simon Cook
Service manager, forensic and specialist
BAME Chair

Front Sheet

Title of Meeting	**Trust Board**	**Date**	26 November 2020
Title of Paper	Quarterly Mortality Review (Quarter 2)		
Author	Frances Lowrey, Mortality Review Manager Annie Oakley, Head of Patient Safety Fiona Delahey, Datix Administrator		
Executive Director	Mary Mumvuri, Executive Director of Nursing, AHPs and Quality		

Purpose: the paper is for:	• **Delete as applicable**
Noting	

Recommendation:

This paper was discussed and scrutinised by the Quality Committee at their meeting on 20 October 2020. The Board is asked to note assurances in place to review mortality incidents, including progress on Structured Judgement Reviews.

Summary of Key Issues: • **No more than five bullet points**

The Board is aware of this paper's history which provides assurance of compliance with the key governance processes in line with National Quality Board's (NQB) Learning from Deaths guidance (March 2017) and NHSI regulatory requirements. The guidance ensures that all deaths of people under our care or with previous contact are reviewed at the correct level of scrutiny and that organisational learning occurs where indicated.

- Structured judgement review (SJR) training was successfully delivered by the Improvement Academy on 14th September 2020. A total of 18 staff members including 13 doctors are now trained. SJR fields have been added to Datix to enable the process to begin.
- 593 mortality incidents were reported on Datix in Q2 compared to 868 at the end of Q1 in 2020/21. There has been a reduction of COVID-19 related deaths, 25 reported in Q2 compared to 102 in Q1, which will in part contribute to the decrease in figures. All COVID-19 related deaths in Q2 were in the community and are not attributable to the Trust.
- Twenty four serious incidents were reported relating to mortality incidents in Q2 of 2020/21 of which 13 were reported as suspected suicides of people in the community. All 13 are currently undergoing root cause analysis investigation.
- While all incidents relating to mortality have significantly reduced in Q2 compared to Q1, however serious incidents have increased and they are under review in line with Trust policy.
- Of the total 593 mortality incidents in Q2, one patient had a diagnosis of a learning disability and had complex physical health needs. Although the patient's death was unexpected, it is not believed to be attributable to the care provided by the Trust. In line with national policy, this was reported through the Learning Disabilities Mortality Review (LeDeR) process which is led by University of Bristol University.

Report History:	
A Q1 report was presented to the Board in July 2020 as per NHSI's expectations for Mortality Reporting.	
Strategic Objectives:	• **Select as applicable**
☒ Deliver outstanding quality of care across all of our domains ☒ Deliver and embed continuous improvement in all we do.	
Implications / Impact:	
Patient Safety: Training for the SJR process has now been delivered to a total of 18 staff members including 13 doctors.	
Identified Risks and Risk Management Action: There is an organisational risk if learning from investigations is not embedded into practice.	
Resource and Financial Implications: Additional funding for recruitment of a Mortality reviewer member was agreed and the post has been recruited to. The staff member commenced in post in March 2020.	
Legal/ Regulatory: The Structured Judgement Review process is a national requirement for provider organisations.	
Engagement and Consultation: Engagement with other Mental Health NHS organisations.	
Equality: None identified.	
Quality Impact Assessment Form Completed: No	

1. INTRODUCTION

1.1 The expectations in relation to reporting, monitoring and the Board's oversight of mortality incidents is set out in the 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 the University of Bristol. This is further reflected in our local policies and procedures to ensure we discharge our duties effectively, and as such the Board would be familiar with the report history and purpose.

2 MORTALITY SCRUTINY

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

2.2 Mortality incidents are further scrutinised by the Mortality Review Manager, who commenced in post in March 2020. This allows further analysis across the Trust and identification of themes and trends. To date, this has included separate homicide and suicide thematic reviews which were presented to the Quality Committee.

3 ANALYSIS OF INFORMATION

3.1 In Q2, a total of 593 mortality incidents were reported on Datix. The graph (1) below indicates that since July 2019, we have been reporting and collating the data on all mortality cases which includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality in Q2 have significantly reduced, whereas serious incidents have increased since Q1. 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 high proportion of older people and also with more nursing or residential homes.

3.2 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 SI and Mortality Panel or sub-panel to assure the organisation and external bodies, including families as necessary, that there were no contributory factors relating to the death of the patient. In the event that any additional learning points are identified, the individual incidents are reviewed and action is taken to prevent reoccurrence. Additionally, work is ongoing in relation to Trust-wide action plans in order to ensure that learning is shared across teams and services.

Graph 1 Mortality reported cases

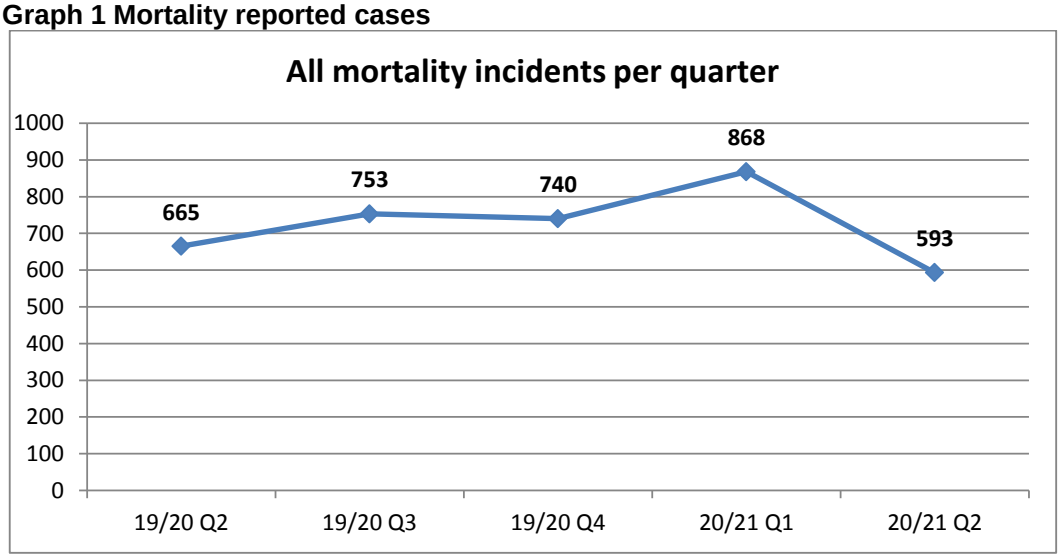


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Sep -19	Oct-19	Nov -19	Dec -19	Jan -20	Feb -20	Mar -20	Apr-20	May -20	Jun-20	Jul-20	Aug -20	Sep -20	Total
Suicide (actual)	3	3	4	4	0	3	5	2	2	7	3	5	6	47
All Deaths reported on Datix	360	276	271	206	320	236	184	375	206	287	238	216	139	3314

3.3 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q2, 2% of deaths of patients are suicide or suspected suicide related. This compares to 1% reported in the previous quarter. The average number of deaths for the above 13 months was 255 per month. For this quarter, there was an average of 198 per month. This is a reduction when comparing last quarter's data and is believed to be linked to the decrease in COVID-19 related deaths and automatic notifications on the patients' records from primary care.

3.4 On review of the suicide cases over the 13 months, there were 12 suicides in the Older Adult Care Group, two of which were reported in September 2020 and related to different teams. The two incidents are both undergoing thorough reviews through the Root Cause Analysis investigation. An initial review of the 48 hour management report and scrutiny of care in SI and Mortality panel highlighted in one case a concern about the COVID-19 response to face to face visits while the other case indicated concerns around follow up processes.

3.5 Seven of the suspected or confirmed suicides in Q2 were in the Community Recovery Care Group; this is an increase of two since Q1 20/2021. Two cases were for Maidstone CMHT; both have been STEIS reported and are undergoing investigation. Terms of reference were set to explore pain management and communication with the patient and external agencies. The remaining five suspected suicides were all for different teams.

3.6 **Analysis by age and gender**

3.6.1 On reviewing the mortality incidents in Q2, the following tables (2 and 3) indicate the deaths reported on Datix by gender and age.

Table 2 All deaths recorded on Datix by age

Age Band	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	Total
100+	2	3	4	3	4	**16**
90-99	141	169	159	162	94	**725**
80-89	245	288	289	348	232	**1402**
70 to 79	126	131	136	192	118	**703**
60 to 69	50	61	44	53	52	**260**
50 to 59	48	46	44	45	33	**216**
40 to 49	27	30	35	34	34	**160**
30 to 39	17	15	15	24	13	**84**
20 to 29	7	7	13	6	11	**44**
10 to 19	1	1	1	0	2	**5**
Unknown	1	2	0	1	0	**4**
Total	**665**	**753**	**740**	**868**	**593**	**3619**

Table 3 Deaths reported on Datix by gender and age in Q2

	100+	90-99	80-89	70-79	60-69	50-59	40-49	30-39	20-29	10-19
Male	0	42	101	62	35	21	25	11	9	1
Female	4	52	131	56	17	12	9	2	2	1

Table 4 COVID-19 deaths by gender and month

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Total
Female	21	17	10	6	4	1	59
Male	21	19	14	8	4	2	68
Total	42	36	24	14	8	3	127

3.6.2 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age and residing in residential or nursing homes and presenting with co-morbidities. Nonetheless, the incidents are subject to the same scrutiny as younger age group when reported by KMPT staff.

3.6.3 In Q2 the decrease in numbers of mortality cases, particularly in the 80 to 89 and 70 to 99 year old brackets are likely to be due to a number of factors e.g. reduction in the amount of Datix Death notifications from primary care as reported by the Performance Team in addition to improvements in care groups reporting of death incidents as they are notified. In Q2, there were 304 Datix Death Notifications, 241 of these for Older Adult Services compared to 404 in Q1 where 307 incidents related to Older Adult Services. Another likely explanation for the reduction in older adults

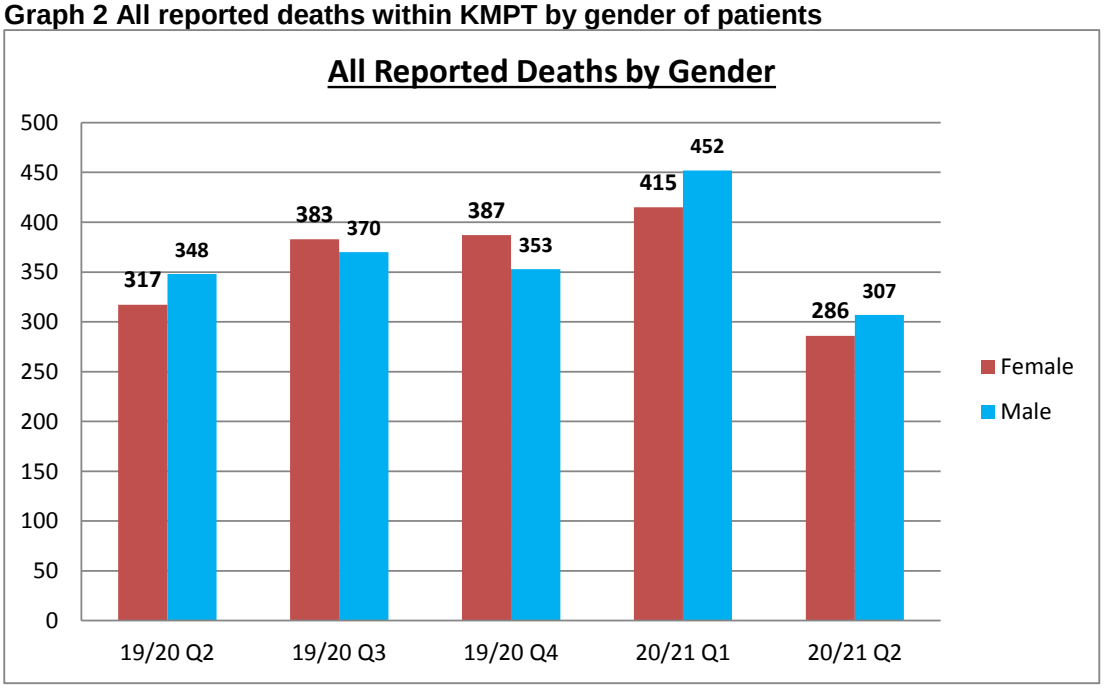
mortality is the decrease in COVID-19 related deaths. In Q1 there were 102 COVID-19 related deaths in the community compared to 25 in Q2. This is likely to fluctuate over coming months, due to the rise in infection and death toll according to government figures.

3.6.4 In Q2, there were 11 mortality incidents recorded for individuals aged 20 to 29. This is an increase of five compared to Q1. None of the deaths of patients in this age category have been reported as serious incidents, this is because they were all deemed unrelated to KMPT following scrutiny in Panel. Of the 11 reported deaths, eight were reported to Legal Services by the Coroner and were individuals who had been appropriately discharged from services at the time of their unexpected deaths.

3.6.5 In Q2, there were two mortality incidents recorded for individuals aged between 10 to 19years compared to zero in Q1. Both patients were 19 years old. One of the patient's last contact was with Single Point of Access where the referral was not accepted and this is a key aspect of the Root Cause Analysis investigation. The other patient was discharged appropriately from Ashford CMHT nine months prior to the death. Legal services were notified by the Coroner however cause of death is not yet known. There were no care or service delivery issues identified in the initial incident review therefore this will be not be subject to further investigation until the cause of death is confirmed. Depending on the findings, a review of the incident will be completed to determine if a further investigation is indicated.

3.6.6 When the mortality data is analysed according to gender, indications are that there are slightly more incidents in men than women in Q1 (see graph 2). Females however make up 51% of the population according to the last England and Wales census in 2011 (Gov.UK Male and Female Populations (May 2019).

Graph 2 All reported deaths within KMPT by gender of patients



3.6.7 In Q2, the 14 cases of suspected suicide by age and gender were as indicated in table 5 below:

Table 5 Suspected suicide by age and gender

Age	Male	Female
10 – 19 years	1	-
20 – 29 years	-	-
30 – 39 years	2	1
40 – 49 years	4	1
50 – 59 years	-	-
60 – 69 years	2	-
70 – 79 years	1	1
80 – 89 years	-	1
90 – 99 years	-	-

3.6.8 Nationally, middle-aged males (between the ages of 40 and 60 years) are at a higher risk of death by suicide although suicide occurs in all ages and genders as reported through the National Confidential Inquiry into Suicide and Homicide (NCiSH). It would be expected that figures for male suicides in this age group would be over-represented. Nationally, there is a steep rise in suicide from the age of 15 to 25 years which plateaus and then begins to decline after 60 years approximately.

3.6.9 The National Confidential Inquiry into Suicide and Homicide has extended their national suicide prevention support role to include responding to local areas' concerns specific to the pandemic. They are:

- Providing local areas with quality-assured publications regarding COVID-19 and mental health/suicide prevention;
- Discussing challenges and providing advice on suicide prevention concerns via email contact and virtual interactive webinars;
- Facilitating shared learning by linking mental health providers/local areas together.

The above observations have been considered as part of our system suicide prevention work. Since the start of the pandemic, trusts have seen significant changes in the pattern of demand, and source of referrals for mental health support. There has been a decline in the number of referrals particularly from GPs, for services such as Child and Mental Health Services and Improving Access to Psychological Therapies. However, many trusts have seen an increase in self-referrals and a rise in the number of people presenting in crisis. The Royal College of Psychiatrists has similarly reported increased numbers of people needing urgent and emergency mental health care, alongside a reduction in routine care, especially for older adults, for children and young people, and within general hospitals. Trusts are also starting to report significant additional new demand for mental health services from those affected by the economic, social and loss of life factors associated with COVID-19, and from health and care staff coping with the consequences of having to provide frontline COVID-19 care in extremely difficult circumstances *(NHS providers.org).*

3.7 Mortality review by ethnicity
Table 6 Deaths by ethnicity

	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1	20/21 Q2	Total
Bangladeshi	0	0	0	0	1	1
Black African	1	0	0	3	1	5
Black Caribbean	1	1	0	2	2	6
Chinese	1	0	0	1	0	2
Indian	1	0	1	2	1	5
Mixed white and Asian	2	1	0	0	0	3
Mixed white and black African	0	0	0	2	0	2
Mixed white and black Caribbean	0	0	2	1	0	3
Not stated	68	84	72	76	65	365
Other Asian	4	2	1	3	4	14
Other Mixed	0	0	0	0	2	2
Other ethnic category	0	4	0	1	0	5
White - British	572	640	652	757	504	3125
White - Irish	7	5	4	7	3	26
White - other white	8	16	8	12	10	54
Unknown	0	0	0	1	0	1
Total	665	753	740	868	593	3619

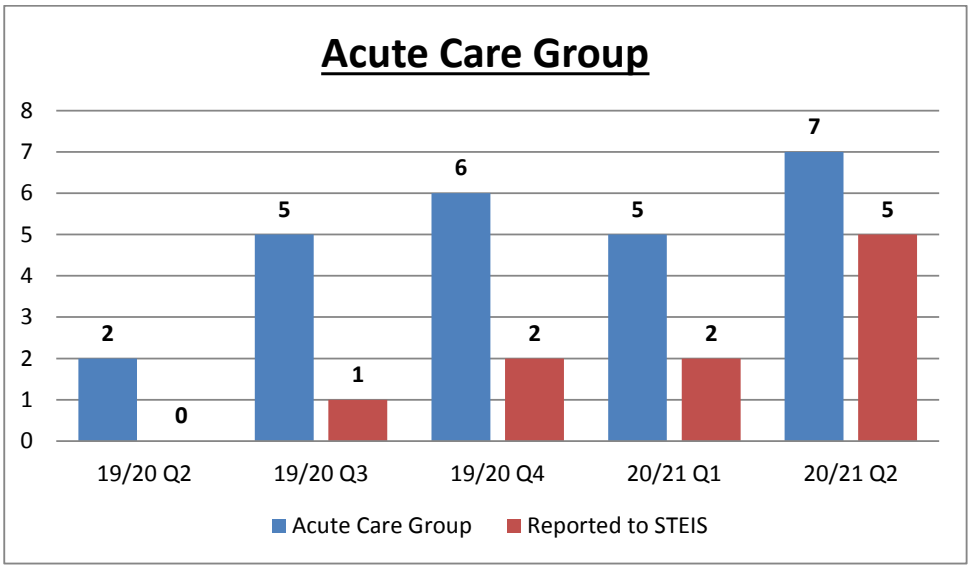
3.7.1 The majority of the incidents relate to people who are from a White British background. This is consistent with the local population profile being predominantly White British. Reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were 11 in Q2 2020/21 compared to 15 in Q1 in 2020/21. Of the BAME deaths in Q2 2020/21, seven were Datix death notifications (this may have been related to GP practices completing administration work). For the remaining four BAME deaths, two were suspected natural causes and two are where cause of death is currently unknown. None of the BAME related deaths were attributable to the Trust and have therefore not reported as serious incidents following scrutiny at SI and Mortality Panel. One patient had a diagnosis of a learning disability and has been LeDeR reported.

3.7.2 Of the 593 incidents reported on Datix during Q2, 65 (11%) had no ethnicity recorded. This has not improved since Q1 where 9% had no ethnicity recorded. No ethnicity documented could be due to some patients declining to provide their ethnicity, or more vigilance required in reporting ethnicity when reporting on RiO, particularly in relation to data reconciliation. Many of those without ethnicity recorded were people under KMPT care for a number of years before the renewed focus on ethnicity reporting. The performance team continue to work with operational services to ensure improvement on ethnicity recording and for staff to indicate when individual service users refuse to provide this.

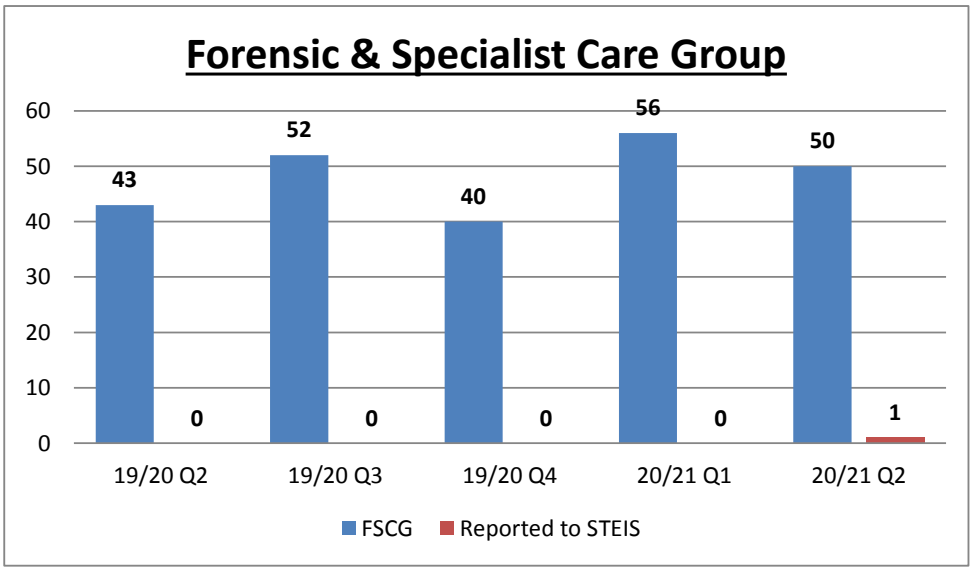
3.8 Serious Incidents and LeDeR cases

3.8.1 The following graphs (3 to 6) show the mortality incidents reported for the period 01/07/2019 to 30/09/2020 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

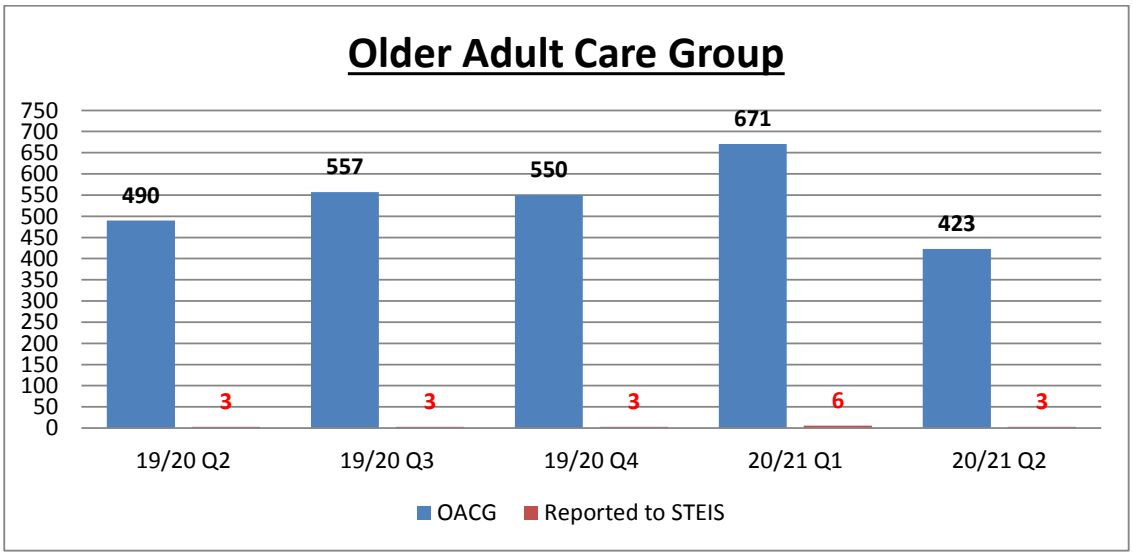
Graph 3 Mortality by Acute Care Group and numbers of those reported as serious incidents on STEIS.



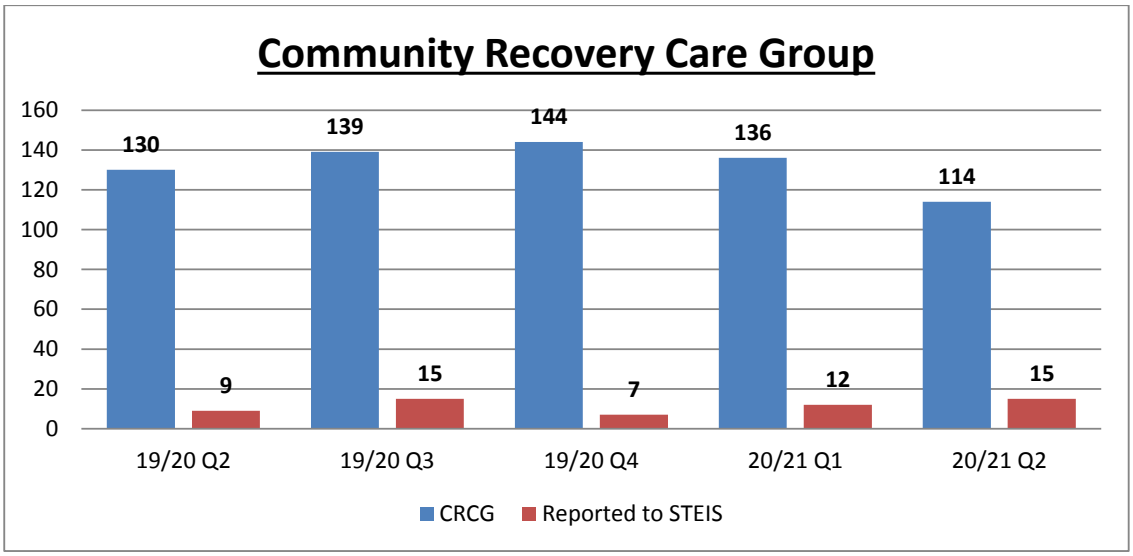
Graph 4 Mortality by Forensic and Specialist Care Group and numbers of those reported as serious incidents on STEIS.



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



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



3.8.2 Community Recovery Services and Older Adult Services mortality figures have reduced significantly compared to other care groups. For Older Adult services, there has been a reduction in figures by 248 from Q1 to Q2. This is due to reduced amount of Datix Death notifications as already mentioned and to COVID-19 deaths reported. Serious incidents have been almost consistent for Older Adult Services, with the

exception of a peak in Q1 2020/21. Community recovery services however, have seen an increase in serious incidents in Q2, despite the reduction in overall deaths reported.

3.8.3 In Q2, there was one mortality incident where the service user had a diagnosis of a learning disability which was reported to LeDeR. This related to a male patient aged 25 years and open to Forensic and Specialist Care Group Mental Health in learning Disability. No care or service delivery problems were identified following review in SI and Mortality Panel, therefore not reported as a serious incident.

4. UPDATE ON THE STRUCTURED JUDGEMENT REVIEW (SJR) PROCESS

4.1 The NHS Improvement Academy successfully delivered SJR training to 18 KMPT members of staff, this included 13 doctors. The Mortality Review Manager and Datix Administrator have worked closely together over recent months and are pleased to advise that the SJR form has now been added to the Datix incidents module. The Mortality Review Manager will now begin implementation of the process for the Trust and will work with the Head of Patient Safety to develop this.

5. CONCLUSION AND NEXT STEPS

5.1 Mortality incidents recorded on Datix decreased for Q2 (from 868 in Q1 to 593 in Q2). There was a decrease of deaths that were related to COVID-19, with 25 reported in Q2 compared to 102 in Q1. These were not related to the care provided by KMPT. The number of serious incidents increased from 15 cases in Q1 to 24 in Q2. Likely themes will be in relation to the COVID-19 response and how the pandemic has impacted patients. Common individual risk indicators identified thus far are loss of work, often leading to financial struggles, fear of contracting COVID-19 and disruption of daily activities due to social isolation. The function of KMPT services during the pandemic will be an area of focus in the investigations in particular; impact of disruption of business as usual such as reduced face to face visits, virtual therapies and staffing changes in some teams. This will however be analysed in greater detail following completion of RCA's as part of themed work for mortality as well as a COVID-19 Mental Health impact review, currently in progress and led by the Mortality Review Manager. The Board can draw assurances from the embedded systems and processes in place to report, review and monitor mortality reported incidents.

5.2 The appointment of a Mortality Review Manager in March 2020 is starting to make an impact already with providing much needed additional capacity to the Patient Safety Team in reviewing historical mortality incidents and to coordinate the Structured Judgement Review (SJR) process for cases not meeting the serious incident criteria but requiring review under that process.

	Title of Meeting	**Board of Directors (Public)**
	Meeting Date	**26th November 2020**
	Title	**Integrated Audit and Risk Committee (IARC) Report**
	Author	**Peter Conway, Non-Executive Director & Chair of IARC**
	Presenter	**Peter Conway, Non-Executive Director & Chair of IARC**
	Executive Director Sponsor	**N/A**
	Purpose	**For Information/Assurance/Approval**

Executive Summary

The Integrated Audit and Risk Committee (IARC) met on the 11th November 2020. The Committee discussed the following:

- External Audit Report;
- Internal Audit Progress Report;
- Counter Fraud Progress Report;
- Standing Orders and Standing Financial Instructions;
- NHS Audit Committee Handbook Checklist;
- Community Recovery Care Group Risk Register;
- Trust Risk Register;
- Register of Interest;
- Health and Safety Annual Report;
- Emergency Preparedness, Resilience and Response (EPRR) Policy 2020/21

The Committee received reports from:

- The Health, Safety and Risk Group; and
- The Information Governance Group.

The Committee would like to bring the following matters to the attention of the Board:

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Management	Community Recovery Care Group Risks and Trust Risk Register: partial assurance. Both need greater precision plus focus on key actions (what by whom by when) to remediate risks to agreed risk appetite levels.	Peter Conway to help the Risk Team refine the reports that come to Board and sub-committees. Target completion by 3.2021 in time for Annual Governance Statement

Audit and Assurance (3rd party)	1)Internal Audit: 3 audits completed, 2 reasonable (QIA PIP and Quality Performance Review) and 1 substantial (ICT Legacy Equipment). No high priority recommendations. No overdue actions. Audit Plan on target (3 audits at draft report stage, 7 underway and 5 in planning). Overall positive assurance 2)Counter Fraud: Positive assurance 3)External Audit: information update only	
Internal Controls and Assurance	1)Health & Safety: positive assurance apart from Fire risk 2)Emergency Preparedness, Resilience and Response (EPRR) Policy: updated policy OK. Sean B-K to be nominated EPRR NED. 3)NHS Audit Committee Handbook Checklist: positive assurance 4)Register of Interests: positive assurance 5)Information Governance: positive assurance except data quality	1) IARC to consider Fire risks at next meeting in January plus greater insight over the severity of the 1466 open risks 2) IARC recommends that Board approves the EPRR policy 5)The Board is already sighted on data quality issues. Under F&PC reporting.
Financial Management	Standing Orders and Standing Financial Instructions: comprehensive update undertaken by Finance and Secretariat	Subject to some minor textual changes, IARC recommends their approval to Board
Other	Committee operation and business	Peter Conway to submit proposals to January IARC which will then come to Board for approval if agreed

1 Recommendation

The Board is asked to:

1) **Note the content of this report.**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30 October 2020**
Title	**Mental Health Act Committee Report**
Author	**Venu Branch, Non-Executive Director & Committee Chair**
Presenter	**Venu Branch, Non-Executive Director & Committee Chair**
Executive Sponsor	**Dr Afifa Qazi**
Purpose	**For Information/Assurance**

Executive Summary

The Mental Health Act Committee (MHAC) met on 12 October 2020 and discussed the following:

- Report from Mental Health Legislation and Operational Group (MHLOG)
- Thematic Review of Homicides between 2015-2019
- Thematic Review Scrutiny MHA
- CQC Mental Health Act (MHA) Monitoring Visits Report
- MHA & MCA Training Data
- Report from Associate Hospital Managers
- S136 Update on Trust Dual Diagnosis
- Consent to Treatment Policy

The Committee would like to bring the following items to the attention of the Board:

1 Consent to Treatment Policy and EIA

The Committee received the policy and were informed that a working group had been formed consisting of four responsible clinicians and the MHA Compliance Manager to review the policy and update. The main changes were highlighted and the Committee were advised that during the meetings the Group discussed the new ways of working and an appendix was added to ensure staff were updated on the protocols. The Committee ratified the policy as requested.

Prompted by this policy, the Committee held a wider discussion around the completion of Equality Impact Assessments (EIAs) and agreed that it was good practice to have the EIA to read in conjunction with the policy when being brought to the Committee for ratification. It was therefore agreed that going forward all policies that are brought to MHAC for ratification would have the completed EIA attached. The Chair also said she would raise the quality of EIAs with the Board to see whether their quality merited further scrutiny.

2 CQC MHA Monitoring Visits and Scrutiny Visits

The Committee received the report and were informed that the CQC conducted a two day unannounced inspection in early September which focussed on seclusion, long term segregation and the psychiatric intensive care ward at Littlebourne Hospital, Dartford. The visit was undertaken to review the impact of the decommissioning of the extra care unit in February 2020, due to the unit being used to care for a young patient with complex needs, and the effect this had on the wider use of seclusion on the site. The CQC identified areas of concern which included staff morale was low, the effect of pressure on seclusion facilities throughout the Trust, environment issues on PICU around the newly fitted doors and patients being secluded in their bedrooms.

Actions have been identified by the CQC which are being addressed and a provider action statement is due for submission to the CQC on 15 October 2020. A number of actions have been completed including reviewing of the seclusion and segregation policy which will now be split into two policies with clearer detail and guidance. Localised training will be completed once the policy is ratified.

The Committee were informed and reassured that these actions are taken to the internal CQC Oversight Group who monitors these until closure. It was also highlighted that this is the same in respect of the MHA Scrutiny Visits, which are ongoing across the Trust on a rota basis during the pandemic. Outcomes and actions from these visits are taken to both the MHLOG meetings and the CQC Oversight Group. There is a particular focus on the s132 rights over the next six months, striving to aim for 100% compliance across all sites and Community Teams.

3 S12 App and Digital Platforms

The Committee were informed that a business case for the s12 App had been submitted and has passed the first phrase and permission has been given to pull together a full business case. The CCG has confirmed that they will be funding the App for use by KMPT and the Approved Mental Health Professionals (AMHP) Services.

It was highlighted to the Committee that the Trust is alert to the way patients are experiencing digital interaction and this is being monitored. As part of the monitoring feedback surveys are going out to patients to establish how digital platforms are working for quality of care for patients within the Trust.

Recommendation

The Board is asked to:

1) Note the content of this report.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2020**
Title	**Workforce and Organisational Development Committee Report**
Author	**Rod Ashurst, Non-Executive Director & Committee Chair**
Presenter	**Rod Ashurst, Non-Executive Director & Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Information/Assurance/Approval**

Executive Summary

The Workforce & Organisational Development Committee (WFODC) met on Tuesday 17th November 2020 and discussed the following agenda:

The Committee would like to bring the following items to the attention of the Board:

1. Community Recovery Care Group presentation
2. Workforce and Organisational Development (WFOD) Slide Deck
3. Agency Spend
4. Culture Change
5. Health & Wellbeing
6. STP Temporary Staffing workstream
7. People Strategy and Plan
8. Employee Relations
9. Learning and Development
10. Medical Recruitment and Retention
11. Workforce Race Equality Standard (WRES)
12. Workforce Disability Equality Standard Reports (WDES)
13. Freedom to Speak up
14. Communications

Community Care Group Presentation

The Committee received a comprehensive presentation which captured a wide range of data sets and commentary relevant to Workforce and Organisational Development matters.

The Committee noted the Clinical Care Pathway model and the Patient Journey from referral to treatment completed. Other key points included positive examples of different pathways breakdown by numbers of interventions, which Service Users are waiting for. Job plans have been introduced which allow staff to plan weekly, maintaining the focus on what is required. The Committee heard details of their KPI performance, including very successful recruitment in progress which will move the Care Group towards full establishment, but also hopefully increase of staff supervision which has taken place.

WFOD Slide Deck

The Committee received a comprehensive slide deck which captured a wide range of data sets and commentary relevant to Workforce and Organisational Development matters.

There was a strong discussion around vacancies and the impact on use of Bank and Agency Workers. It is felt that there is a requirement for the data to be cleansed so there is a better understanding what the gaps are. This will allow recommendations going forward on what tolerance levels are acceptable for vacancies.

Agency Spend

One area of concern was raised around risk of vacancies for recruitment, especially for Medical Staffing and failing to recruit appropriate number of healthcare professionals. This would impact on the ability to meet safe staffing, which had been discussed at IARC and the Chair of Workforce Committee would be addressing again at the next Quality Committee.

Culture Change

The Big Conversation went virtual for the first time due to the Covid pandemic with great success, with over 100 participants who joined, whereby normally the attendance is around 70/80 if face to face.

Health & Wellbeing

The Committee heard that there is a shortage of Flu Vaccinations across the county. KMPT are expecting further delivery of vaccinations in December and assured that we will meet the demand for all staff that wish to have the Flu vaccination.

COVID testing is being maintained for staff. There will be COVID self-testing kits available soon which will be delivered direct to frontline Staff whereby the results will be reported and monitored.

STP Temporary Staffing workstream

The group will be reporting to the STP Productivity Board an alternative approach to the Temporary Staff demand and associate spend, by refocussing to concentrate on recruitment and retention activities collectively.

People Strategy and Plan

The Committee approved the People Strategy and Plan report presented by the Director of Workforce and Communications.

Employee Relations

The Committee heard there will be a deep dive around Black and Minority Ethnic (BAME) processes around disciplinary and grievances. With the number of disciplinary and grievances that are being investigated, nearly 50% of these are BAME employees. Employee Relations team will work closely with the Equality & Diversity team.

Learning and Development

Many courses can continue to be delivered on-line. However, practical courses, such as CPR/AD/PSS requiring face to face are still struggling due to the COVID pandemic. The Head of Learning and Development will be in discussion with the Director of Quality on how to move forward. There are a number of areas with reduced levels of training since the last report. Corporate Induction is now fully virtual, plus the introduction of a check in with new staff members on the afternoon of their first day has been successfully received.

Supervision has achieved its highest percentage of 73% since last reporting at Workforce and OD Committee.

Medical Recruitment and Retention

One area that needs addressing from this report was from the risk register for Medical Staffing recruitment within Acute Care Group. This has been raised at IARC and Quality Committee. The Committee heard that a recruitment video for consultants has been released from the Medical Director which has received positive feedback.

Workforce Race Equality Standard (WRES)

KMPT have seen an increase of BAME staff by 2.5% over the last two years**.**

The impact of COVID and subsequential staff risk assessments highlighted that there are more staff from a BAME background than data currently held on ESR. A sub group of Equality and Diversity Steering Group has been set up to improve the data held within ESR.

The Committee heard from the Director of Workforce and Communications that there will be a piece of work looking at the end to end recruitment process and experiences for all new recruits, so we can collectively see what improvements may need to happen.

Workforce Disability Equality Standard (WDES)

Overall the data gathered in this year shows a representation of disabled staff across KMPT of 6% a slight increased from 5.8%.

COVID has had an impact in the delivery of some of the actions within the action plan, but it proposed that the action plan is extended to cover 3 years to allow time to deliver delayed actions that will be carried out and new proposed actions.

Freedom to Speak Up

It was reported that the area of concerns were around attitudes and behaviours in the work place. There had also been an increase in concerns anonymously raised. Further communications around the main concerns are in hand, but a simple flow chart could provide more evidence on what is being done.

Communications

The Committee heard there will be a Communications Strategy developed by the end of the year and due to COVID, KMPT Staff Awards will be held from 14-18 December 2020 over a period of five days. This will be across the County to celebrate the good work achieved by KMPT staff. Also this week we saw the first issue of Wellbeing Wednesday.

Recommendation

The Board is asked to note the content of this report and the decisions and recommendations within it.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th November 2020**
Title	**Quality Committee Report**
Author	**Dr Jackie Craissati, Interim Trust Chair & Committee Chair, October & Anne-Marie Dean, Quality Committee Chair, November meeting**
Presenter	**Anne-Marie Dean, Quality Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Information/Assurance**

Executive Summary

The Quality Committee met on 20 October 2020 and 17 November 2020. In line with the Committee work plan the October meeting consisted of a short formal Committee meeting followed by a Quality Account Priority Workshop.

The key item discussed at the formal October QC meeting was:

1. Mortality Report Q2

The Workshop session discussion covered:

2. Progress against the 3 Trust Quality Account Priorities for 2020-21
    - Patient Safety – Violence and Aggression incorporating PSS overview report
    - Patient Experience – Care Planning
    - Clinical Effectiveness – Clinical Outcomes

The key items discussed at the November QC meeting were:

3. Quality Digest
4. Quality Risk Register
5. Quality Impact Assessments
6. High Profile Serious Incident Report
7. Readmissions Deep Dive
8. Video Consultations Evaluation
9. KMPT Brilliant Research Strategy 2021 – 2025
10. Female PICU Contract

The Committee received reports from:

- CQC Oversight Group
- Clinical Effectiveness and Outcomes Group

Additionally the Committee approved the Terms of Reference for:

- Quality Impact Assessment Group
- Trustwide Patient Safety and Mortality Review Group

The Committee would like to bring the following items to the attention of the Board:

1. Mortality Report Q2 2020-21

The Committee was reminded that this was a regular regulatory report which the Board will receive later on this agenda.

The Committee heard that the key items in the report were the reduction in overall mortality incidents including a decrease in COVID incidents; the increase in overall Serious Incidents reported and the increase in mortality incidents in younger people. The Committee discussed the Community and COVID impact within the numbers and heard that work is being undertaken by the Trust on the potential for the Trust's COVID SOPs to have contributed to incidents and a full report on COVID SOPs impact would be reported to the Committee in forthcoming meetings.

2. Quality Account Priorities Workshop

Discussion focused on the three priority areas: Patient Safety – Violence and Aggression; Patient & Carer Experience – Care Planning and Clinical Effectiveness – Clinical Outcomes. The impact of COVID on achievement of Q2 targets was acknowledged.

The Committee heard an outline summary of progress on each of the priorities from the Priority leads, had an open question session with workshop participants and reset Q3 targets in light of progress to date and issues discussed.

Violence and Aggression – fundamental to this priority was the implementation of the violence prediction tool, BrØset. The Committee heard that the training target had not been met due to changes in training delivery required by COVID requirements. The target was reset to 90% staff trained by the end of Q3.

Care Planning – the Committee heard that the Q2 target of developing standards and a process for implementation had not been met but that a workshop had taken place which had established two workstreams focussing on cultural change and professional responsibilities. The Q3 target was reset to agreeing standards and implementation process with training materials ready to be delivered.

Clinical Outcomes – the Committee heard that Clinician Reported Outcome Measures (CROMs) recording had significantly improved but that Patient Reported Outcome Measures (PROMs) completion remained low and would take longer to deliver. The Q3 target was reset to 75% CROMs completion and 50% PROMs completion.

A monthly highest outcome completions rates award had been created and the first winners were Canterbury & Coastal Psychology Services; East Kent Personality Disorder and Thanet Horizon. All of whom had 100% outcome completion rates.

November 2020 Meeting

3. CQC Transition Arrangements

The Committee was updated on the new transitional regulatory approach outlined by the CQC in response to the Covid Pandemic. The approach is based on 4 elements and will lead to a new strategy being implemented in 2021. The elements of the transitional arrangements are; being flexible and iterative, a strengthened approach to monitoring, a greater use of technology and targeted and focused inspection activity. The new strategy will include a focus on four elements; people, safe, smart and improvement. The CQC will also be focusing on closed cultures within organisations which they have identified as being a greater risk due to the pandemic. They have also published a new set of key questions linked to the previous KLOEs but as yet it is unclear how these questions will be asked or what evidence Trusts will be required to produce.

4. CQC Report – Out of Sight

The Committee noted the CQC publication; Out of sight – a review of restraint, seclusion and segregation for those with LD/autism and were informed that the Trust will be carrying out a self assessment exercise against the recommendations in the report.

5. Readmissions Deep Dive

The Committee received the report on the readmissions deep dive which had been delayed as a result of the pandemic. It was confirmed that KMPT was not an outlier in terms of 28 day readmissions but that the deep dive had provided better understanding of the issue.

6. Video Consultation Evaluation

The Committee reviewed the Video Consultation Evaluation report and noted the overall conclusion that the approach was useful but with some concerns which needed to be addressed. The Committee discussed the main concerns which were space and IT skills and were informed of the roll out of Attend Anywhere across Kent. The Committee agreed that this method of contact should be included in future blended models of service offerings but stressed the importance of maintaining equality of access for both older and younger people.

7. Research and Innovation Strategy

The Committee was presented with the KMPT Research and Innovation Strategy. The Committee commended the work and the ambition underlying the strategy. In particular the focus on meaningful co production was noted and suggestions made for further development. The Committee agreed that the finalised Strategy should be taken to the Board in 2021.

During the presentation of the Research strategy it was noted by QC the work of David Cousins who recently died. A colleague and friend to KMPT, David was a person of great passion in driving meaningful engagement with people with lived experience in all we do. His role in developing this strategy was significant and it is his legacy that will ensure we deliver the aims and objectives in true partnership, engagement and co-production with the people who use or have used our services.

8. Serious Incidents – Management of Clozapine Clinics

The Committee noted that a number of the serious incidents related to the Management of Clozapine and the following actions had been taken to improve prescribing and monitoring:

- An updated clozapine policy with clearer guidance around the running of the clozapine clinics in the CMHTs and monitoring particularly when patients stop smoking, develop constipation, recurrent chest infections and severe pneumonia.
- Ensuring patients have 6 monthly reviews by a clinician which takes into account therapeutic response and recognised side-effects as well as identifying possible relapse indicators
- Clozapine management standards are now included in the CMHT CliQ checks with compliance being monitored and reported
- New clozapine e-learning course for Doctors/ Medical Prescribers at KMPT
- Training of nursing staff who run the clozapine clinics by the pharmacy team
- Training and guidance has been provided to staff in all the acute hospitals to ensure patients on clozapine are monitored safely. It is important all patients prescribed clozapine that are admitted to the Acute Trust should be and remain open to the liaison psychiatry team for ongoing monitoring for the duration of the admission.
- Dr Qazi has been working with Kent LMC (Local Medical Committee) and the G.Ps have agreed to support us with physical investigations for our patients. If we fill out the forms and ask patients to go to their surgeries the G.Ps will have blood tests and ECGs carried out at the surgeries. Jag Bahia (Chief Pharmacist) has been working with the Acute Trusts so all our clinicians can access blood tests results from all the pathology labs in Kent. Registration forms have been sent to all Consultants so they can be registered with the pathology labs separately. This will avoid unnecessary delays in receiving results
- KMPT will be participating in the next national quality improvement audit on clozapine management in January 2021 with the Prescribing Observatory for Mental Health. Each participating Trust will receive a customised audit report that allows its performance against the practice standards to be compared with the total national sample and each other participating organisation

9. Female PICU Contract

The Committee were reminded of the private sector contracting arrangements for the provision of female psychiatric intensive care in Kent and informed that CQC had visited the unit and raised concerns. The Committee heard how the Trust had responded to these concerns and requested a full report at their March 2021 meeting.

The Board is asked to:

1) Note the content of this report.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Trust Board (Public)	**Date**	26 November 2020
Title of Paper	Updated Standing Orders, Standing Financial Instructions and Scheme of Delegation		
Author	Victoria French, Deputy Director of Finance Tony Saroy, Trust Secretary		
Executive Director	Helen Greatorex, Chief Executive		

Purpose: the paper is for:	• **Delete as applicable**
Approval	

Recommendation:
The Board is recommended to review and approve the amended Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Summary of Key Issues:	• **No more than five bullet points**

The Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board, Scheme of Delegation are required to be reviewed on an annual basis.

The review date was May 2020 but this was suspended due to the pandemic.

The main document includes yellow highlights for key changes, and the table below outlines the previous wording, the new wording and the rationale.

The Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board, Scheme of Delegation have been amended in accordance with Integrated Audit and Risk Committee (IARC)'s recommendations, which met on 11th November 2020.

Report History:
This report was previously submitted to IARC on 11th November 2020.

Strategic Objectives:	• **Select as applicable**

☐ Consistently deliver an outstanding quality of care

☐ Recruit retain and develop the best staff making KMPT a great place to work

☒ Put continuous improvement at the heart of what we do

☐ Develop and extend our research and innovation work ☐ Maximise the use of digital technology ☐ Meet or exceed requirements set out in the Five Year Forward View ☒ Deliver financial balance and organisational sustainability ☐ Develop our core business and enter new markets through increased partnership working ☐ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership

Implications / Impact:
Patient Safety: *None*
Identified Risks and Risk Management Action: None
Resource and Financial Implications: None
Legal/ Regulatory: Policy forms integral part of Trust governance
Engagement and Consultation: *None*
Equality: *None*
Quality Impact Assessment Form Completed: ~~Yes~~/ No N/A

Summary of Key Changes

Changes are highlighted in **bold** in the table below and highlighted in yellow in the draft policy.

SO/SFI number	Current wording	New wording	Reason
2.1	The Kent and Medway NHS and Social Care Partnership Trust (the Trust) is a body corporate which has been established under **the Kent and Medway National Health Service and Social Care Partnership Trust (Establishment) and the West Kent National Health Service and Social Care Trust and the East Kent National Health Service and Social Care Partnership Trust (Dissolution) Order 2006 (SI 2006/825)**	The Kent and Medway NHS and Social Care Partnership Trust (the Trust) is a body corporate which has been established under **the Establishment Order.**	The phrase "Establishment Order" is already a defined term
4.2	N/A	**"Associate Non-Executive Director" shall mean a Non-Executive Director who is non-voting and who has been appointed by the Chairman following open competition, which has been conducted by NHSE/I**	New role within the Trust included under definitions. This was approved by Trust Board in July 2020
4.2	"**Chairman**" is the person appointed by the NHSI on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the **Chairman** of the Trust" shall be deemed to include the Deputy **Chairman** of the Trust if the **Chairman** is absent from the meeting or is otherwise unavailable	**"Chairperson"** is the person appointed by the NHSI on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the **Chairperson** of the Trust" shall be deemed to include the Deputy **Chairperson** of the Trust if the **Chairperson** is absent from the meeting or is otherwise unavailable	Gender neutral. Defined term will be cascaded throughout the document
4.2	"Executive Management Team" means the group of Executive Directors of the Trust appointed by the Chief Executive or minimum of three of that	"Executive Management Team" means the group of Executive Directors of the Trust appointed by the Chief Executive **as defined in SO 5.8** or	The list at SO 5.8 includes DW&C and COO, so this just allows EMT to be

SO/SFI number	Current wording	New wording	Reason
	group	minimum of three of that group	defined as including those two roles
4.2	“Executive Assurance Committee” means the group of Executive Officers and Senior Officers appointed by the Chief Executive and listed in the Terms of Reference of the Committee responsible for the review of business cases and the oversight of transformation projects	“Executive Assurance Committee” means the group of Executive Officers and Senior Officers appointed by the Chief Executive and listed in the Terms of Reference of the Committee responsible for **the matters as set out in its Terms of Reference**	EAC conducts a wider range of business, including performance. EAC’s ToR are approved by Board.
4.2	"NHSI" means NHS Improvement responsible for the oversight of NHS trusts and NHS foundation trusts, with delegated authority from the Secretary of State for the appointment of the Non-Executive Directors, including the Chairperson;	"NHSI" means NHS **England and** Improvement responsible for the oversight of NHS trusts and NHS foundation trusts, with delegated authority from the Secretary of State for the appointment of the Non-Executive Directors, including the Chairperson;	Included expanded title following merger of NHS England and NHS Improvement
4.2	New Item	**“Senior Independent Director” means the Non-Executive Director appointed by the Board to provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary**	New role within the Trust included under definitions. Wording adapted from the Good Governance Handbook and benchmarked with other Trusts
4.3	New Item	**With respect to the appointment and powers of the Senior Independent Director, the following shall apply:** 4.3.1 **The Board of Directors may appoint any member of the Board, who is also a Non-Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a**	This wording provides a more detailed level of the SID role. Wording adapted from the Good Governance Handbook and benchmarked with other Trusts

SO/SFI number	Current wording	New wording	Reason
		member of the Board, as they specify on appointing him. For the avoidance of doubt, the Deputy Chairperson may also be the Senior Independent Director. 4.3.2 **The Senior Independent Director will provide a sounding board for the Chairperson and act as intermediary for other directors as and when necessary** 4.3.3 **The Senior Independent Director will be available to the other Non-Executive Directors and Executive Directors to address any concerns or issues they feel have not been adequately dealt with through the usual channels of communications; and** 4.3.4 **Meet at least annual with Non-Executive Directors without the Chairperson present to lead the review of the Chairperson's performance and to provide feedback to the Chairperson**	
5.3	The Trust has the functions conferred on it by the **Schedule 2** of the NHS Act 2006 and by its Establishment Order	The Trust has the functions conferred on it by **Schedules 4 and 5** of the NHS Act 2006 and by its Establishment Order	Functions etc for NHS Trust is found at Schedule 4. Financial provisions for NHS Trust are found at Schedule 5.
5.6	The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and	The Trust has resolved that certain powers and decisions may only be exercised or 5.6made by the Board in formal session. These powers and	The Standing Orders are not a policy so consistency of language

SO/SFI number	Current wording	New wording	Reason
	decisions are set out in sections 39 and 40 **of this policy**.	decisions are set out in standing orders 39 and 40.	
5.16	New Item	5.16 **Role of Members** - The Board will function as a corporate decision-making body. Executive and Non-Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions. 5.16.1 Executive Members shall exercise their authority within the terms of the Standing Orders, Standing Financial Instructions and the Scheme of Delegation. 5.16.2 The Chief Executive shall be responsible for the overall performance of the Executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives. 5.16.3 The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/She shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions. 5.16.4 Non-Executive Members shall not be granted nor shall they seek to exercise any individual Executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when	New section included to add clarity around role and function of members within the Board

SO/SFI number	Current wording	New wording	Reason
		chairing a Committee of the Trust which has delegated powers. 5.16.5 The Chairperson shall be responsible for the operation of the Board and shall chair all Board meetings when present. The Chairperson has certain delegated Executive powers and must comply with the terms of appointment and with these Standing Orders. 5.16.6 The Chairperson shall liaise with NHS Improvement over the appointment of the Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance. 5.16.7 The Chairperson shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate	
6.4	**Notice of Meetings** - Before each meeting of the Board a written notice of the meeting, specifying the business proposed to be transacted at it, and **signed** by the Chairman or by an Officer authorised by the Chairman to sign on his behalf shall be delivered to every Director, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least three clear days before the meeting.	**Notice of Meetings** - Before each meeting of the Board a written notice of the meeting, specifying the business proposed to be transacted at it, and **approved** by the Chairman or by an Officer authorised by the Chairman to sign on his behalf shall be delivered to every Director **electronically**, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least three clear days before the meeting.	Inclusion of electronic notice of meetings
6.8	Before each meeting of the Board a public notice of the time and place of the meeting, and the	Before each meeting of the Board a public notice of the time and place of the meeting, and the	Correction of reference

SO/SFI number	Current wording	New wording	Reason
	public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting (Required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4)(a))	public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting (**Required by s1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960**)	
7.5	Schedule of Reservation of Powers to the Board and Delegation of Powers – the Board shall adopted a schedule of Reservation of Powers to the Board and Delegation of Powers ("Scheme of Delegation") setting out the matters for which approval is required by the Board and details of the Directors and Officers of the Trust to whom responsibility has been delegated for deciding particular matters.	Schedule of Reservation of Powers to the Board and Delegation of Powers – the Board shall adopted a schedule of Reservation of Powers to the Board and Delegation of Powers ("Scheme of Delegation") setting out the matters for which approval is required by the Board and details of the Directors and Officers of the Trust to whom responsibility has been delegated for deciding particular matters. **The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.**	Inclusion of right to propose amendments between annual review
8.10.1	Primary Role: To ensure effective internal control arrangements are in place. In addition, the Integrated Audit and Risk Committee provides a form of independent check upon the executive arm of the Board. The Committee shall set the strategic direction for managing governance and risk and implement a framework to ensure risk and governance issues are managed effectively throughout the organisation.	Primary Role: To ensure effective internal control arrangements are in place. In addition, the Integrated Audit and Risk Committee provides a form of independent check upon the executive arm of the Board. ~~The Committee shall set the strategic direction for managing governance and risk and implement a framework to ensure risk and governance issues are managed effectively throughout the organisation.~~	The strategic governance for managing governance and risk is a matter for Board.
8.10.2	Remuneration Committee	Remuneration **and Terms of Service** Committee	Updated title for Committee
8.10.6	Primary Role: To provide the Board with assurance concerning all aspects of MHA activities. Specifically that there are systems, structures and processes in place to support the	Primary Role: To provide the Board with assurance concerning all aspects of Mental Health Act **and Mental Capacity Act activities**. Specifically that there are systems, structures and	Inclusion of Mental Capacity Act 2005 matters

SO/SFI number	Current wording	New wording	Reason
	operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007) and other related legislation within inpatient and community settings.	processes in place to support the operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007), **Mental Capacity Act 2005** and other related legislation within inpatient and community settings.	
11.4	The Trust requires interests, employment or relationships so declared by Officers to be entered in a Register of Interests.	The Trust requires interests, employment or relationships so declared by Officers to be entered in a Register of Interests. **All parties involved within a Procurement procedure shall be required to register any interests held which may represent a Conflict of Interest. This shall be undertaken by the Procurement Department with any Conflicts of Interest mitigated as deemed appropriate.**	Inclusion of Procurement procedure comment to strengthen in line with Procurement strategy
12.5	Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. The entry shall be signed by the persons who approved and authorised the sealing of the document and attested the seal.	Register of Sealing - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose. ~~The entry shall be signed by the persons who approved and authorised the sealing of the document and attested the seal.~~	With remote working, it is likely that this will prove to be difficult. Board receives assurance through Quarterly reports regarding Sealing Register
14.8	Availability of Standing Orders - It is the duty of the Chief Executive to ensure that all existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be issued to staff designated by the Chief Executive. New designated Officers shall be informed in writing and shall receive copies where appropriate of SOs.	Availability of Standing Orders - It is the duty of the Chief Executive to ensure that all existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be made available through the Trust's Intranet. ~~issued to staff designated by the Chief Executive~~. ~~New designated Officers shall be informed in writing and shall receive copies where appropriate of SOs.~~	The Standing Orders are on the staff intranet, so there is no need to provide each member of staff with a copy.

SO/SFI number	Current wording	New wording	Reason
21.2	Competitive tenders for commercial accounts should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board.	Benchmarking for commercial accounts should be undertaken at least every 5 years. The results of the benchmarking should be reported to the Board. Where benchmarking indicates the Trust is not achieving best value, alternative banking arrangements should be sought in line with Procurement requirements.	Reword paragraph in line with latest procurement best practice
22.3.4	New Item	In the event an external party is engaged to seek the recovery of monies due, this must be undertaken in accordance with the Concession Contract Regulations (2016).	Additional sentence in line with procurement best practice
25.1.3	The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.	The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services. **In the first instance this will ordinarily be the Procurement Department.**	Clarity regarding where professional advice should be sought
25.4.1(b) and 28.1.3(b)	Executive Assurance Committee can approve all requests from £75,001 to £250,000;	Executive Assurance Committee **or Business Case Review Group with delegated authority from Executive Assurance Committee** can approve all requests from £75,001 to £250,000;	Updated to reflect delegated power to BCRG
25.2.1	The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's **advisor on supply** shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and/or the Chief Executive shall be consulted.	The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's **Procurement Department** shall be sought. ~~Where this advice is not acceptable to the requisitioner, the Director of Finance and/or the Chief Executive shall be consulted.~~	In executing advice on behalf of the DoF (who has this delegated from CE), this sentence is not appropriate.

SO/SFI number	Current wording	New wording	Reason
28.3.4	Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).	Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). **Where assets are disposed of, best value must be achieved in consideration of the same principles as when procuring them.**	Enhance provision around disposal of assets to ensure value
29.5	For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those Officers authorised to requisition and accept goods from the store. The authorised Officers shall check receipt against the delivery note before accepting the charge.	For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those Officers authorised to requisition and accept goods from the store. The authorised Officers shall check receipt against the delivery note before accepting the charge. **All discrepancies must be reported within 24 hours of receiving goods.**	Enhance clarity around reporting of errosr with NHS Supply Chain orders
30.3.2	The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.	The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action. **Even where an item has nil or negligible value, such items are to be disposed of in accordance with these SFI's and Officers of the Trust are not permitted to obtain such items without the prior written authorisation of a Senior Manager.**	Additional clarity around disposal of assets added
32.5.1	systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's **Information Technology Strategy**;	systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's **Clinical Technology Strategy;**	Update strategy title

SO/SFI number	Current wording	New wording	Reason
36.5.1	insuring motor vehicles owned or leased by the Trust including third party liability arising from their use; and	insuring motor vehicles owned **or leased** by the Trust including third party liability arising from their use; and	To reflect that some Trust transport vehicles are leased not owned

Kent and Medway
NHS and Social Care Partnership Trust

Standing Orders,

Standing Financial Instructions

and

Reservation of Powers to the Board – Scheme of Delegation

Policy Reference No.	KMPT.Fin.XXX
Replacing document	KMPT.Fin.002.07
Scope	Trust wide
Originator	Executive Director of Finance and Trust Secretary
Responsible Group	Trust Board
Status	Draft
Version No	8.0
Authorised by	Trust Board
Date of Implementation	November 2020
Review Date	November 2021
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
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DOCUMENT TRACKING SHEET

Version	Status	Date	Issued to/approved by	Comments
5.1	Approved	Sept 2017	IARC	Reviewed by IARC
6.0	Approved	Sept 2017	Trust Board	Authorised
6.1	Approved	Sept 2018	IARC	3 month review date extension approved and changed from Sept 18 to Dec 18
6.2	Draft	April 2019	Internal review	
6.3	For Review	May 2019	Integrated Audit & Risk Committee	Ratified
7.0	Final	May 2019	Trust Board	Approved
7.1	Updated	September 2019	IARC	Minor changes to wording. Approved.
8.0	Draft	November 2020	Integrated Audit & Risk Committee	

REFERENCES

RELATED DOCUMENTS

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
May 2019	Deputy Director of Finance		Combined the individual Standing Financial Instructions, Standing Orders and Reservation of Powers to the Board – Scheme of Delegation into one document
Sept 2019	Trust Secretary		Addition of risk management wording, removal of Strategy Steering Group
Nov 2020	Trust Secretary and Deputy Director of Finance		Full review of policy, updated for current practices and new roles and committees

CONTENTS

FOREWORD

Standing Orders, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework, and shall apply irrespective of the source of funding. All Executive and Non-Executive Directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

Failure to comply with standing orders and standing financial instructions is a disciplinary matter which could result in dismissal.

INTRODUCTION

1 GENERAL

1.1 This document comprises the Standing Orders (SOs), Standing Financial Instructions (SFIs), and Reservation of Powers to the Board (Scheme of Delegation).

2 STATUTORY FRAMEWORK

2.1 The Kent and Medway NHS and Social Care Partnership Trust (the Trust) is a body corporate which has been established under the Establishment Order.

2.2 NHS Trusts are governed by Act of Parliament. Most health legislation since 1997 has been consolidated into the National Health Service Act 2006 (the NHS Act 2006), the National Health Service (Consequential Provisions) Act 2006 and the Health and Social Care Act 2012 (HSCA 2012).

2.3 The functions of the Trust are conferred by this legislation.

2.4 As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State. The Trust also has a common law duty as a Bailee for patients' property held by the Trust on behalf of patients.

2.5 The Code of Governance requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of SOs setting out the responsibilities of individuals.

2.6 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

3 NHS FRAMEWORK

3.1 In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further requirements and guidance. These are normally issued under cover of a circular of letter.

3.2 In April 2016 the NHS Trust Development Authority (NTDA) and Monitor became NHS Improvement (NHSI) (and now called NHS England/Improvement) with responsibility for the governance and performance arrangements in NHS Trusts and Foundation Trusts. NHSI adopted the Foundation Trust Code of Governance on the basis that NHS Trusts were required to comply as far as they were able. In addition the Single Oversight Framework was issued, which contains further requirements and guidance for NHS Trusts.

3.3 The Code of Governance requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board Directors.

3.4 The Code of Practice on Openness in the NHS, as revised by the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.

3.5 The Trust has power to delegate and make arrangement for delegation. This document sets out the detail of these arrangements.

3.6 Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 7) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State may direct. Delegated Powers are covered in sections 39 and 40 of this policy.

3.7 Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

4 INTERPRETATION

4.1 Save as permitted by law, at any meeting the Chairperson of the Trust shall be the final authority on the interpretation of the SOs and SFIs (on which he/she should be advised by the Chief Executive) and the decision shall be final and binding except in the case of manifest error.

4.2 Any expression to which a meaning is given in the NHS Act 2006, the HSCA 2012 and other Acts relating to the National Health Service or in the Regulations or Orders made under such Acts shall have the same meaning in this policy and in addition:

"ACCOUNTABLE OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive;

“ASSOCIATE NON-EXECUTIVE DIRECTOR” shall mean a Non-Executive Director who is non-voting and who has been appointed by the Chairperson following open competition, which has been conducted by NHSE/I

“BOARD" means the Chairperson, Non-Executive Directors and Executive Directors of the Trust collectively as a body;

"BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"BUDGET HOLDER" means the Director or Officer with delegated authority to manage finances (income and expenditure) for a specific area of the Trust;

"CHAIRPERSON” is the person appointed by the NHSI on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chairperson of the Trust” shall be deemed to include the Deputy Chairperson of the Trust if the Chairperson is absent from the meeting or is otherwise unavailable;

"CHIEF EXECUTIVE" shall mean the chief officer of the Trust;

"COMMITTEE” shall mean a committee created and appointed by the Trust functioning as an internal committee;

”COMMITTEE MEMBERS” shall be persons formally appointed by the Board to sit on or to chair specific Committees;

"DEPUTY CHAIRPERSON" means the non-executive director appointed to take on the Chairperson’s duties if the Chairperson is absent for any reason;

"DIRECTOR” shall mean a person appointed as a director in accordance with the Membership and Procedure Regulations and includes the Chairperson;

"DIRECTOR OF FINANCE” shall mean the chief finance officer of the Trust;

"ESTABLISHMENT ORDER" shall mean the Kent and Medway National Health Service and Social Care Partnership Trust (Establishment) and the West Kent National Health Service and Social Care Trust and the East Kent National Health Service and Social Care Partnership Trust (Dissolution) Order 2006 (SI 2006/825);

"EXECUTIVE DIRECTOR" shall mean a member of the Board who is an executive director or a person to be regarded as an executive director pursuant to Regulation 5 of the Membership and Procedure Regulations;

"EXECUTIVE MANAGEMENT TEAM" means the group of Executive Directors of the Trust appointed by the Chief Executive as defined in SO 5.8 or minimum of three of that group

"EXECUTIVE ASSURANCE COMMITTEE" means the group of Executive Officers and Senior Officers appointed by the Chief Executive and listed in the Terms of Reference of the Committee responsible for matters as set out in its Terms of Reference.

"FUNDS HELD ON TRUST" shall mean those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

"GBS" means the Government Banking Service;

"HSCA 2012" means the Health and Social Care Act 2012;

"MEMBERSHIP AND PROCEDURE REGULATIONS" shall mean the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI 1990/2024) as subsequently amended (SI 1996/1775, SI 1998/1975, SI 2000/2434, SI 2001/378/6, 2008/1269 and SI 2014/784);

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting;

"NHS ACT 2006" means the National Health Service Act 2006;

"NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs;

"NON-EXECUTIVE DIRECTOR" shall mean a member of the Board who is not an Officer of the Trust;

"NHSI" means NHS England and Improvement responsible for the oversight of NHS trusts and NHS foundation trusts, with delegated authority from the Secretary of State for the appointment of the Non-Executive Directors, including the Chairperson;

"OFFICER" means employee of the Trust or any other person holding paid appointment or office with the Trust;

"SECRETARY" means a person appointed to act independently of the Board to monitor the Trust's compliance with the law, SOs, guidance from NHSI and Department of Health;

"SENIOR INDEPENDENT DIRECTOR (SID)" means the Non-Executive Director appointed by the Board to provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary

"SFIs" means Standing Financial Instructions;

"SOs" means Standing Orders; and

"TRUST" means Kent and Medway NHS and Social Care Partnership Trust.

"TRUST CAPITAL GROUP" means the operational management group responsible for the monitoring and review of the capital programme.

4.3 With respect to the appointment and powers of the Senior Independent Director, the following shall apply:

4.3.1 The Board of Directors may appoint any member of the Board, who is also a Non-Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of their term as a member of the Board, as they specify on appointing him/her. For the avoidance of doubt, the Deputy Chairperson may also be the Senior Independent Director.

4.3.2 The Senior Independent Director will provide a sounding board for the Chairperson and act as intermediary for other directors as and when necessary

4.3.3 The Senior Independent Director will be available to the other Non-Executive Directors and Executive Directors to address any concerns or issues they feel have not been adequately dealt with through the usual channels of communications; and

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4.3.4 Meet at least annually with Non-Executive Directors without the Chairperson present to lead the review of the Chairperson's performance and to provide feedback to the Chairperson

4.4 Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

4.5 All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

4.6 Wherever the title "Chief Executive", "Director of Finance", or other nominated Officer is used in these SFIs, it shall be deemed to include such other Director or Officer who have been duly authorised to represent them.

4.7 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

STANDING ORDERS

5 THE TRUST

5.1 All business shall be conducted in the name of the Trust.

5.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

5.3 The Trust has the functions conferred on it by Schedules 4 and 5 of the NHS Act 2006 and by its Establishment Order.

5.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health.

5.5 The Trust has a central Board Assurance Framework, which is documented and tabled at Trust Board meetings held in public. There is also a Risk Management Strategy which is available on the Trust website.

5.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in sections 39 and 40.

5.7 **Composition of the Trust** - In accordance with the Establishment Order and Membership and Procedure Regulations the composition of the voting membership of the Board shall be:

5.7.1 The Chairperson of the Trust and;

5.7.2 Seven Non-Executive Directors and;

5.7.3 Seven Executive Directors.

5.8 The following are Executive Directors of the Trust:

5.8.1 Chief Executive;

5.8.2 Executive Medical Director (a medical practitioner);

5.8.3 Executive Director of Nursing and Quality (a registered nurse or midwife on the register maintained by the Nursing and Midwifery Council);

5.8.4 Executive Director of Finance

5.8.5 Director of Partnerships and Strategy (Deputy Chief Executive); and

5.8.6 Director of Workforce and Communications; (non voting)

5.8.7 Chief Operating Officer (non voting)

5.9 Appointment of the Chairperson and Directors - The Chairperson and Non-Executive Directors are appointed by the Secretary of State, as advised by NHSI.

5.10 The Trust shall appoint a panel whose members shall be the Chairperson and some Non-Executive Directors of the Trust whose function will be to appoint the Chief Executive of the Trust.

5.11 The Trust shall appoint a panel whose members shall be the Chairperson, some Non-Executive Directors and the Chief Executive whose function will be to appoint the Executive Directors of the Trust other than the Chief Executive.

5.12 **Terms of Office of the Chairperson and Directors** - The regulations governing the period of tenure of office of the Chairperson and Directors and the termination or suspension of office of the Chairperson

and Directors are contained in the Membership and Procedure Regulations and as directed by NHSI, under its delegated authority from the Secretary of State.

5.13 **Appointment of Deputy Chairperson** - For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairperson, the Directors of the Trust may appoint a Non-Executive Director from amongst them to be Deputy Chairperson for such a period, not exceeding the remainder of his/her term as Non-Executive Director of the Trust, as they may specify on appointing him/her.

5.14 Any Non-Executive Director so elected may at any time resign from the office of Deputy Chairperson by giving notice in writing to the Chairperson. The Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chairperson in accordance with SO 5.12.

5.15 **Powers of Deputy Chairperson** - Where the Chairperson of an NHS Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chairperson owing to illness, absence from England and Wales or any other cause, references to the Chairperson in the Schedule to these Regulations shall, so long as there is no Chairperson able to perform his/her duties, be taken to include references to the Deputy Chairperson.

5.16 **Role of Members** - The Board will function as a corporate decision-making body. Executive and Non-Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

5.16.1 Executive Members shall exercise their authority within the terms of the Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

5.16.2 The Chief Executive shall be responsible for the overall performance of the Executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

5.16.3 The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/She shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

5.16.4 Non-Executive Members shall not be granted nor shall they seek to exercise any individual Executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

5.16.5 The Chairperson shall be responsible for the operation of the Board and shall chair all Board meetings when present. The Chairperson has certain delegated Executive powers and must comply with the terms of appointment and with these Standing Orders.

5.16.6 The Chairperson shall liaise with NHSI over the appointment of the Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

5.16.7 The Chairperson shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate

6 MEETINGS OF THE TRUST

6.1 **Calling meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine. A minimum of 5 meetings shall be held each year.

6.2 The Chairperson may call a meeting of the Board at any time.

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6.3 If the Chairperson refuses to call a meeting after a requisition signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chairperson does not call a meeting within seven days after such requisition has been presented to him/her, at the Trust Headquarters, such one third or more Directors may forthwith call a meeting.

6.4 **Notice of Meetings** - Before each meeting of the Board a written notice of the meeting, specifying the business proposed to be transacted at it, and approved by the Chairperson or by an Officer authorised by the Chairperson to sign on his behalf shall be delivered to every Director electronically, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least three clear days before the meeting.

6.5 Lack of service of the notice on any Director shall not affect the validity of a meeting.

6.6 In the case of a meeting called by Directors in default of the Chairperson, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

6.7 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

6.8 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting (Required by s1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960).

6.9 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

6.10 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairperson at least 10 clear days before the meeting, subject to SO 6.9. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairperson.

6.11 The agenda will be sent to Directors four clear days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than four clear days before the meeting, save in emergency.

6.12 **Notices of Motion** - A Director of the Trust desiring to move or amend a motion shall send a written or electronic transmission notice thereof to the Chairperson at least 10 clear days before the meeting. The Chairperson shall include in the agenda for the meeting all notices so received that are in order and permissible under the appropriate regulations.

6.13 SO 6.12 shall not prevent any motion being moved or withdrawn at the meeting without notice on any business mentioned on the agenda for the meeting.

6.14 **Emergency Motion -** A Director of the Trust may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairperson's decision to include the item shall be final.

6.15 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

6.16 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

6.16.1 An amendment to the motion.

6.16.2 The adjournment of the discussion or the meeting.

6.16.3 That the meeting proceed to the next business. (*)

6.16.4 The appointment of an ad hoc committee to deal with a specific item of business.

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6.16.5 That the motion be now put. (*)

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.

No amendment to the motion shall be admitted if, in the opinion of the Chairperson of the meeting, the amendment negates the substance of the motion.

6.17 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairperson.

6.18 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director(s) who gives it and also the signature of four other Directors.

6.19 When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chairperson to propose a motion to the same effect within six months; however, the Chairperson may do so if he/she considers it appropriate. SOs 6.18 and 6.19 shall not apply to motions moved in pursuance of a report or recommendation of a committee or the Chief Executive.

6.20 **Written Motions** - In urgent situations and with the consent of the Chairperson, business may be affected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

6.21 If all members of the Board of Directors have been notified of the proposal and a majority of the Directors entitled to vote at the meeting of the Board of Directors confirms acceptance of the written motion either in writing to electronically to the Secretary within five clear days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gather in one place.

6.22 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Director who has previously indicated acceptance can withdraw and the motion shall fail.

6.23 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

6.24 **Chairperson of Meeting** - At any meeting of the Trust the Chairperson, if present, shall preside. If the Chairperson is absent from the meeting the Deputy Chairperson, if there is one and he/she is present, shall preside. If the Chairperson and Deputy Chairperson are absent such Non-Executive Director as the Directors present shall choose shall preside.

6.25 If the Chairperson is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chairperson, if present, shall preside. If the Chairperson and Deputy Chairperson are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

6.26 **Chairperson's ruling** – Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairperson of the meeting on questions of order, relevance and regularity (including procedure on handling motions) and the interpretation of the SOs and SFIS, at the meeting, shall be observed.

6.27 **Quorum** - No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Directors are present including on or after the operational date at least one Executive Director and one Non-Executive Director.

6.28 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

6.29 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 9) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a

position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

6.30 The requirement at SO 6.27 with in respect of at least one Executive Director forming part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

6.31 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Directors present (as defined in SO 6.27 – 6.30) and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

6.32 All questions put to the vote shall, at the discretion of the Chairperson of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

6.33 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

6.34 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

6.35 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

6.36 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

6.37 An Officer attending the Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting of the Board shall be recorded in the minutes.

6.38 **Joint Directors** - Where the office of an Executive Director is shared jointly by more than one person:

6.38.1 Either or both of those persons may attend or take part in meeting of the Board;

6.38.2 If both are present at a meeting they should cast one vote if they agree;

6.38.3 In the case of disagreements no vote should be cast;

6.38.4 The presence of either or both of those persons should count as the presence of one person for the purposes of SO 6.27 (quorum);

6.39 **Record of Attendance** - The names of the Chairperson and Directors present at the meeting shall be recorded in the minutes.

6.40 If a Director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

6.41 **Minutes** – At each meeting of the Board the Chairperson shall appoint a person attending to record the minutes and proceedings. The Minutes will be submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

6.42 No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.43 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public (required by the Code of Practice on Openness in the NHS).

6.44 **Annual Public Meeting** - The Board will publicise and hold an annual public meeting by 30 September each year for the purpose of presenting audited accounts, annual reports and any reports on the accounts.

6.45 **Admission of public and press** - The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

> "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

6.46 The Chairperson (or Deputy Chairperson) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

6.47 "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

6.48 Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in SOs 6.45 and 6.46 above, shall be confidential to the members of the Board.

6.49 Non-Executive Directors and Executive Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'in confidence' or minutes headed 'items taken in private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

6.50 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

7 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

7.1 Subject to SO 5.2 and such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 8.1 below or by a Director or an Officer of the Trust. In each case these arrangements shall be subject to such restrictions and conditions as the Board thinks fit.

7.2 **Emergency Powers** - The powers which the Board has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chairperson (acting jointly) after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairperson shall be reported to the next formal meeting of the Board for ratification.

7.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The terms of reference of these committees and their specific executive powers shall be approved by the Board.

7.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Trust, shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

7.5 **Schedule of Reservation of Powers to the Board and Delegation of Powers** – the Board shall adopted a schedule of Reservation of Powers to the Board and Delegation of Powers ("Scheme of

Delegation") setting out the matters for which approval is required by the Board and details of the Directors and Officers of the Trust to whom responsibility has been delegated for deciding particular matters. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

7.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

7.7 The Scheme of Delegation is found in sections 39 and 40 below.

8 COMMITTEES

8.1 **Appointment of Committees** - Subject to SO 5.3 and such directions as may be given by, or on behalf of, the Secretary of State, the Trust may appoint Committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust. Committees will be subject to review by the Board from time to time.

8.2 A Committee appointed under SO 8.1 may, subject to such directions as may be given by, or on behalf of, the Secretary of State or the Board, appoint Committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

8.3 The SOs of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or Governance Group.

8.4 Each Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Each Committee shall approve the terms of reference of each Governance Group reporting to it. Such terms of reference shall have effect as if incorporated into the SOs.

8.5 Committees may not delegate their powers unless expressly authorised by the Board.

8.6 The Board shall approve the appointments to each of the Committees and Governance Group which it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a Committee, the terms of such appointment shall be determined by the Board. The payment of travelling and other allowances shall be in accordance with such sum as may be determined by the Secretary of State with the approval of the Treasury (see section 233 of the NHS Act 2006).

8.7 Minutes, or a representative summary of the issues considered and decisions taken, of any Committee appointed under this SO 8 are to be formally recorded and submitted for inclusion onto the agenda of the next possible Board meeting. Minutes, or a representative summary of the issues considered and decision taken of any Governance Group shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.

8.8 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

8.9 The Committees to be established by the Trust will consist of statutory and mandatory and non-mandatory Committees.

8.10 The Committees established by the Trust are:

8.10.1 **Integrated Audit and Risk Committee**

Primary Role: To ensure effective internal control arrangements are in place. In addition, the Integrated Audit and Risk Committee provides a form of independent check upon the executive arm of the Board.

8.10.2 **Remuneration and Terms of Service Committee**

Primary Role: To determine and approve appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior Officers.

8.10.3 **Workforce and Organisational Development Committee**

Primary Role: To provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff. To assure the Board through consultation with the Integrated Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services. To assure the Board that where there are workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives that these are being managed in a controlled and timely way.

8.10.4 **Quality Committee**

Primary Role: To provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. To assure the Board through consultation with the Integrated Audit and Risk Committee that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. To assure the Board that where there are risks and issues that may jeopardise the Trust ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.

8.10.5 **Finance and Performance Committee**

Primary Role: To provide the Board with assurance concerning all aspects of finance and performance relating to the provision of care and services in support of getting the best value for money and use of resources. To assure the Board, through consultation with the Integrated Audit and Risk Committee that structures, systems and processes are in place and functioning to support broad and long term Financial, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively, To assure the Board that where there are risks and issues the may jeopardise the Trust's performance in respect of its key Financial Performance targets that these are being managed in a controlled and timely way.

8.10.6 **Mental Health Act Committee**

Primary Role: To provide the Board with assurance concerning all aspects of Mental Health Act and Mental Capacity Act activities. Specifically that there are systems, structures and processes in place to support the operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007), Mental Capacity Act 2005 and other related legislation within inpatient and community settings.

8.11 **Confidentiality** –There is no requirement for meetings of Committees and Governance Groups to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the Freedom of Information Act 2000 and there is no legal justification for non-disclosure.

8.12 Other than by the circulation of draft minutes a member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

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8.13 A Director of the Trust, a member of a Committee or any other employee of the Trust shall not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

9 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

9.1 **Declaration of Interests** – All existing Directors and any senior Officers who may act up to an Executive Director post should declare interests which are relevant and material to the Board on an annual basis, or as otherwise required. Any Directors or senior Officers appointed subsequently should declare these interests on appointment.

9.2 Interests which should be regarded as "relevant and material" are:

9.2.1 Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

9.2.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

9.2.3 Majority or controlling shareholding in organisations likely or possibly seeking to do business with the NHS;

9.2.4 A position of authority in a charity or voluntary organisation in the field of health and social care; and/or

9.2.5 Any connection with a voluntary or other organisation contracting for NHS services.

9.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chairperson.

9.4 At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

9.5 If a conflict of interest is established during the course of a Board meeting, whether arising from a declared interest or otherwise, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting.

9.6 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

9.7 **Register of Interests** - The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of Directors. In particular, the Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both Executive Directors and Non-Executive Directors.

9.8 These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

9.9 The Register of Interests will be available to the public via the Trust website.

10 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

10.1 Subject to SO 11 and the provisions of this SO, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the

contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

10.2 The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this SO in any case in which it appears to him/her in the interests of the NHS that the disability shall be removed.

10.3 The Board, or any Committee or Governance Group, shall exclude a Director from a meeting of the Board Committee or Governance Group (as relevant) while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

10.4 Any remuneration, compensation or allowances payable to a Director by virtue of section 233 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this SO.

10.5 For the purpose of this SO the Chairperson or a Director shall be treated, subject to SO 11.2 – 11.4 and SO 11.8 – 11.12, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

10.5.1 he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

10.5.2 he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

10.5.3 And in the case of married persons or persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this SO to be also an interest of the other.

10.6 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

10.6.1 Of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

10.6.2 Of an interest in any company, body or person with which he/she is connected as mentioned in SO 10.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

10.7 Where a Director:

10.7.1 Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

10.7.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

10.7.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

this SO shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

10.8 SO 10 applies to Committees or Governance Groups of the Board as it applies to the Board and applies to any member of any such Committee or Governance Group (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

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11 STANDARDS OF BUSINESS CONDUCT

11.1 Policy – All Officers must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff', 'Code of Conduct for NHS Managers', 2002, the seven principles set out by the 'Committee on Standards in Public Life', published by the Professional Standards Authority, November 2012, and the Trust's policy as amended from time to time. The following provisions should be read in conjunction with these documents.

11.2 Interest of Officers in Contracts - If it comes to the knowledge of a Director or an Officer that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

11.3 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

11.4 The Trust requires interests, employment or relationships so declared by Officers to be entered in a Register of Interests. All parties involved within a Procurement procedure shall be required to register any interests held which may represent a Conflict of Interest. This shall be undertaken by the Procurement Department with any Conflicts of Interest mitigated as deemed appropriate.

11.5 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors or members of any Committee directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this SO shall be included in application forms or otherwise brought to the attention of candidates.

11.6 Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

11.7 Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

11.8 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or Officer of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

11.9 Directors and Officers of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

11.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or Officer of the Trust.

11.11 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the SO headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

11.12 In order to protect the interests of both Officers and the Trust, a confidential register is to be maintained by the Chief Executive or such senior Officer as he/she may designate, listing all employees who have any pecuniary activities outside of their employment with the Trust, including such activities as other employment, directorships, consultant work, etc. It shall be the duty of all Officers falling within these and similar categories to declare such activities and they will also be entitled to see what information is recorded against their name. The list may be limited to the Board and those Senior Officers and other staff who occupy positions where they are able to influence the awarding of contracts.

11.13 **Gifts and Hospitality -** The following paragraphs in this section of SOs describe the legal position and set out guidance concerning gifts, rewards and hospitality. They are framed to protect individual Officers as well as the Trust.

11.14 The Chief Executive shall ensure that all Officers are aware of the Trust's policy on acceptance of gifts or benefits in kind by Officers as included in the Bribery Act 2010 and the Department of Health's guidance.

11.15 It is a criminal offence for an Officer corruptly to solicit or accept any gift or consideration as an inducement or reward. If the gift or consideration is from someone holding or seeking a contract with the Trust, it is deemed to have been received corruptly unless the Officer proves to the contrary. And it is a criminal offence for Officers to accept, as Officers, any fee or reward other than their proper remuneration. Accepting any gift or consideration in the knowledge or belief that it is intended as an inducement or reward is an offence, whether the Officer receiving it is actually influenced or not.

11.16 A gift or offer of hospitality may sometimes be so lavish that any reasonable person would consider that it is made with the intention of corrupting. Even if it is not as lavish as that, however, there may still be the possibility of corruption.

11.17 If an Officer of the Trust is in any doubt about what to do about any offer of a gift or hospitality, the advice of a more senior Officer should be sought. The question to be considered is whether the acceptance is likely to raise reasonable doubts about the person's integrity.

11.18 Although the offer of casual gifts by contractors, organisations, firms or individuals may not be in any way connected with the performance of official duty so as to constitute an offence, the offer should nevertheless, as a general rule, be declined.

11.19 The only exceptions to the rule are:

11.19.1 Small gifts or office equipment or stationery given by way of trade advertisements to a range of Officers or for use in the office. Nothing more elaborate than calendars, diaries, rulers or blotters would fall within this exception.

11.19.2 Small gifts of only token value given on the conclusion of an official courtesy visit, e.g. to a factory or other premises.

11.19.3 Gifts to an Officer of the Trust or a member of their family where the donor is a personal friend. Extreme care needs to be taken with gifts in this category, bearing in mind the legal position described above. Gifts which do not fall clearly within these exceptions and which are offered in person to an Officer of the Trust should be politely declined, and the person or organisation offering it should be told of the Trust's rule about gifts.

11.20 If a gift outside the exceptions noted above arrives without warning it must be handed over to the appropriate senior Officer to decide whether the gift should be returned (or passed to some good cause) and to ensure that the donor is informed of what has happened.

11.21 These rules apply also to offers by firms to members of staff of discounts going beyond those on general offer.

11.22 Offers of hospitality should always be approached with caution. Members of staff should ask themselves what a member of the public, who may be critical or suspicious, might think; and offers of hospitality, where any suggestion of improper influence is possible, must be refused. Hospitality should only be accepted when it is reasonably incidental, and on a scale appropriate, to the occasion or the circumstances. Acceptance may make it difficult to avoid some obligation to the party offering it, and might later be thought to have affected an officer's impartiality in dealing with official matters.

11.23 Some offers of hospitality are clearly unacceptable: offers of holiday accommodation are one example. Invitations to sporting fixtures or evenings at the theatre may only be acceptable when they are clearly required for the conduct of Trust business. Any hospitality on a lower scale than this might also be unacceptable. No absolute dividing line can be laid down.

11.24 There is an important difference between, for example, attendance in an official capacity at a function organised by a public authority and accepting hospitality from a private individual or firm standing to

benefit from the goodwill of the Trust. Particular care should be taken in dealing with contractors, developers, and firms or individuals in a comparable position.

11.25 However, it will not always be possible or even desirable to reject offers of hospitality on a modest scale. Acceptable examples would include official hospitality of a kind mentioned in the previous paragraph; a drink and a sandwich following a site visit; or a working lunch of a modest standard to enable the parties to continue to discuss business. The decision whether to accept or not must depend on the circumstances in each case. Where it is clearly evident that the work of the Trust would be facilitated, invitations to attend receptions, luncheons, cocktail parties and the like may be accepted under the following rules.

11.26 No member of staff below the rank of Senior Manager or equivalent may accept an invitation without first obtaining the approval of a senior officer at that level or above. In exceptional circumstances where it is not possible to seek prior approval, the facts should be reported immediately afterwards.

11.27 Invitations involving attendance outside normal working hours may be accepted only on the authority of a Director.

11.28 A confidential register is to be maintained by every Director in which, in relation to every offer of a gift or hospitality (apart from the exceptions for gifts set out above and the drink and sandwich level of hospitality), offered to a member of staff in their Directorate, including themselves, the following information will be (briefly) recorded:

- The person or body making the offer
- The member of staff to whom the offer was made
- The gift or hospitality offered
- The circumstances in which the offer was made
- The action taken by the member of staff concerned
- The action taken (if any) by the Director

11.29 In general, gifts will either fall within the exceptions, or ought to be refused; so far as gifts or hospitality are concerned, therefore, the register will mainly record offers where the value approximates to £25.00 or above and has been refused.

11.30 Every member of staff who receives or is offered a gift or is offered hospitality, which these guidelines require to be registered, is required to report the circumstances to their Director so that the record may be kept. Every member of staff is entitled to see what is recorded in the register against their name, and the Chief Executive is to have access to every register maintained.

11.31 A confidential register is also to be maintained by the Chief Executive giving full details and recording information on action taken regarding all complaints or allegations of corruption or fraud against any officer or officers of the Trust (see also the Trust's Fraud Policy and Response Plan). All those who have knowledge of such complaints or allegations are required to report the matter to the Chief Executive. Every member of staff is entitled to see what information is recorded against their name.

12 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Chief Executive in a secure place.

12.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board, or a Committee of the Board, or the Chairperson, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegation.

12.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by two members of the Board.

12.4 The Seal shall be affixed in the presence of the signatories.

12.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose.

12.6 A report of all sealing shall be made to the Board at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

13 SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

13.2 The Chief Executive or nominated Officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or Committee to which the Board has delegated appropriate authority.

14 MISCELLANEOUS

14.1 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the SOs, except for SO 14.6 (which may not be suspended), may be suspended at any meeting, provided that at least two-thirds of the Directors of the Trust are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

14.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

14.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

14.4 No formal business may be transacted while SOs are suspended.

14.5 The Integrated Audit and Risk Committee shall review every decision to suspend SOs.

14.6 **Variation of Standing Orders** - These SOs shall be amended only if:

14.6.1 A notice of motion under SO 6.12 has been given; and

14.6.2 No fewer than half the appointed Non-Executive Directors vote in favour of variation; and

14.6.3 At least two-thirds of the Directors who are eligible to vote are present; and

14.6.4 The variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

14.7 SO 14.6 may not be varied.

14.8 **Availability of Standing Orders** - It is the duty of the Chief Executive to ensure that all existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be made available through the Trust's Intranet.

14.9 **Documents having the standing of Standing Orders** - SFIs and Scheme of Delegation have been incorporated in to this, one single document.

14.10 **Review of Standing Orders** – SOs shall be reviewed annually by the Board.

STANDING FINANCIAL INSTRUCTIONS

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15 OVERVIEW OF SFIS

15.1 The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in all financial matters concerning the Trust.

15.2 These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should therefore be read in conjunction with the detailed departmental and financial procedure notes published by the Trust. All financial procedures must be approved by the Director of Finance.

15.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs, the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with, and comply with, the provisions of the SOs and the Reservation of Powers to the Board and the Detailed Scheme of Delegation.

15.4 These SFIs apply to all Officers, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs and SOs is a disciplinary matter that could result in dismissal.

15.5 Overriding SFIs – If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Integrated Audit and Risk Committee for referring action or ratification. All members of the Board and Executive Management Team and Officers have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

16 RESPONSIBILITIES AND DELEGATION

16.1 The Board exercises financial supervision and control by:

16.1.1 formulating the financial strategy of the Trust;

16.1.2 requiring the submission and approval of Budgets within approved allocations/overall income;

16.1.3 defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money); and

16.1.4 defining specific responsibilities placed on members of the Board/ Executive Management Team and Officers as indicated in the 'Reservation of Powers to the Board'.

16.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session.

16.3 The Board will delegate responsibility for the performance of its functions in accordance with the Reservation of Powers to the Board, Delegation of Powers adopted by the Trust.

16.4 Within these SFIs, it is acknowledged that the Chief Executive is the Accountable Officer of the Trust and:

16.4.1 is ultimately accountable to the Board, and as accountable officer to the Secretary of State, for ensuring that the Board of Directors meets it obligation to perform the Trust's functions within the available financial resources;

16.4.2 has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that the Trust's financial obligations and targets are met;

16.4.3 has overall responsibility for the Trust's system of internal control; and

16.4.4 is responsible for ensuring that all members of staff of the Trust are aware of and understand their responsibilities within these SFIs

16.5 Save for the decisions and actions reserved to the Board, the Chief Executive has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management.

16.6 The Chief Executive and Director of Finance may, within reason, delegate their detailed responsibilities, but they remain accountable for financial control.

16.7 The Director of Finance is responsible for:

16.7.1 implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

16.7.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

16.7.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and Officers, the duties of the Director of Finance include:

16.7.4 the provision of financial advice to other members of the Board and Executive Management Team and Officers;

16.7.5 the design, implementation and supervision of systems of internal financial control; and

16.7.6 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the organisation may require for the purpose of carrying out its statutory duties.

16.8 All members of the Board and Officers of the Trust, severally and collectively, are responsible for:

16.8.1 the security of the property of the Trust;

16.8.2 avoiding loss;

16.8.3 exercising economy and efficiency in the use of resources; and

16.8.4 conforming with the requirements of the SOs, SFIs and the Scheme of Delegation

16.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

16.10 For any Officers of the Trust who carry out a financial function, the form in which financial records are kept and the manner in which the Board, Executive Management Team and Officers of the Trust discharge their duties must be to the satisfaction of the Director of Finance.

16.11 Financial framework – the Director of Finance shall ensure that members of the Board are aware of the financial aspects of NHSIs Code of Accountability and Single Oversight Framework, within which the Trust is required to operate.

17 AUDIT

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17.1 **Integrated Audit and Risk Committee**

17.1.1 In accordance with SO 8 the Board shall formally establish an Integrated Audit and Risk Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

(a) overseeing Internal and External Audit services;

(b) reviewing financial systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

(c) monitoring compliance with SOs and SFIs;

(d) reviewing schedules of losses and compensations and making recommendations to the Board;

(e) reviewing the information prepared to support the annual governance declaration statements prepared on behalf of the Board and advising the Board accordingly.

as set out in the terms of reference approved by the Board.

17.1.2 Where the Integrated Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairperson of the Integrated Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHSI.

17.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Integrated Audit and Risk Committee shall be involved in the selection process if/when an internal audit service provider is changed.

17.2 **Fraud and Corruption**

17.2.1 In line with their responsibilities as set out in HSG(96)12 and Bribery Act guidance, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the Department of Health Directions on fraud, corruption and bribery.

17.2.2 The Director of Finance shall ensure that the Trust's Counter Fraud and Corruption Policy is maintained and remain up to date.

17.2.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist to deliver the requirements of the Trust's Counter Fraud and Corruption Policy.

17.2.4 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, when required.

17.2.5 The Local Counter Fraud Specialist will provide a written report to the Integrated Audit and Risk Committee, on an annual basis at least, on the counter fraud work completed within the Trust.

17.3 **Director of Finance**

17.3.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

(b) ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

(c) ensuring that the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit with senior management

(d) ensuring that there is effective liaison with the relevant Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud or corruption before any action is taken;

(e) deciding at what stage to involve the police in cases of misappropriation, and other irregularities not involving fraud or corruption;

(f) ensuring that an annual internal audit report is prepared for the consideration of the Integrated Audit and Risk Committee and the Board. The report must cover:

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care,
- major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- progress against plan over the previous year,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year;

(g) ensuring the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or corruption;

(h) ensuring there is effective liaison with the Trust's Local Counter Fraud Specialist or NHS Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud and corruption.

17.3.2 The Director of Finance or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board and Executive Management Team or Officers of the Trust;

(c) the production of any cash, stores or other property of the Trust under the control of a member of the Board or the Executive Management Team or an Officer; and

(d) explanations concerning any matter under investigation.

17.4 **Role of Internal Audit**

17.4.1 Internal Audit shall:

(a) Provide an independent and objective assessment for the Chief Executive, the Board and the Integrated Audit and Risk Committee on the degree to which risk management, control and governance arrangements support the achievement of the Trust's objectives.

(b) Operate independently of the decisions made by the Trust and its Officers; and of the activities which it audits. No member of the Internal Audit team will have executive responsibility.

17.4.2 Internal Audit will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

(b) the adequacy and application of financial and other related management controls;

(c) the suitability of financial and other related management data;

(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

- fraud, bribery and other offences,
- waste, extravagance, inefficient administration,
- poor value for money or other causes.

17.4.3 Whenever any matter arises which involves, or is thought to involve, material irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, including any act which involves the giving or receiving of bribes, the Director of Finance must be notified immediately.

17.5 **Head of Internal Audit**

17.5.1 The Head of Internal Audit shall develop and maintain an internal audit strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements.

17.5.2 The Head of Internal Audit shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Manual.

17.5.3 The Head of Internal Audit will normally attend Integrated Audit and Risk Committee meetings and has a right of access to all Integrated Audit and Risk Committee members, the Chairperson and Chief Executive and all Directors of the Trust.

17.5.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Integrated Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

17.6 **External Audit**

17.6.1 The external auditor is appointed by the Integrated Audit and Risk Committee via competitive tender and paid for by the Trust. The Integrated Audit and Risk Committee must ensure a cost-efficient service is provided. Should there appear to be a problem concerning the service provided by the external auditor, this should be raised with the external auditor and referred via the escalation process stipulated in the contract if the issue cannot be resolved.

18 ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

18.1 **Preparation and Approval of Business Plans and Budgets** - The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

18.1.1 a statement of the significant assumptions on which the plan is based; and

18.1.2 details of major changes in workload, delivery of services or resources required to achieve the plan.

18.1.3 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual business plan;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks.

18.1.4 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

18.1.5 All Budget Holders must provide information as required by the Director of Finance to enable Budgets to be compiled. All Budget Holders will sign up to their allocated Budgets at the commencement of each Financial Year.

18.1.6 The Director of Finance has overall responsibility for ensuring that adequate training is delivered on an on-going basis to Budget Holders to help them manage their Budget successfully.

18.2 **Budgetary Delegation -** The Chief Executive may delegate the management of a Budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

18.2.1 the amount of the Budget;

18.2.2 the purpose(s) of each Budget heading;

18.2.3 individual and group responsibilities;

18.2.4 authority to exercise virement;

18.2.5 achievement of planned levels of service; and

18.2.6 the provision of regular reports.

18.3 The Chief Executive and delegated Budget Holders must not exceed the budgetary total or virement limits set by the Board.

18.4 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

18.5 Non-recurring Budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance

18.6 **Budgetary Control and Reporting** - The Director of Finance will devise and maintain systems of budgetary control. These will include:

18.6.1 monthly financial reports to the Board in a form approved by the Board containing:

- income and expenditure to date showing trends and forecast year-end position;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

18.6.2 the issue of timely, accurate and comprehensible advice and Budget statements to each Budget holder, covering the areas for which each is responsible;

18.6.3 investigation and reporting of variances from financial, workload and manpower Budgets;

18.6.4 monitoring of management action to correct variances; and

18.6.5 arrangements for the authorisation of budget transfers/virements.

18.7 Each Budget Holder is responsible for ensuring that:

18.7.1 any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Executive and should be reported to the following Board meeting;

18.7.2 the amount provided in the approved Budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

18.7.3 no permanent Officers are appointed other than those provided for within the available resources and manpower establishment as approved by the Board.

18.8 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced Budget.

18.9 **Capital Expenditure -** The general rules applying to budgetary delegation, budgetary control and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained below.)

18.10 **Monitoring Returns -** The Director of Finance on behalf of the Chief Executive is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisation.

19 ANNUAL ACCOUNTS AND REPORTS

19.1 The Director of Finance, on behalf of the Trust, will:

19.1.1 prepare financial returns in accordance with the accounting policies and guidance given by the Department of Health and Social Care and the Treasury, the Trust's accounting policies, and generally accepted accounting practice;

19.1.2 prepare and submit annual financial reports to the Secretary of State certified in accordance with current guidelines; and

19.1.3 submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Secretary of State

19.1.4 submit periodic monitoring and financial returns to external organisations, such as NHSI, in accordance with the timetables set by those organisations.

19.2 The Trust's annual accounts must be audited by an auditor appointed by the Integrated Audit and Risk Committee. The Trust's audited accounts shall be presented to a public meeting and made available to the public, within the timescales set by the Secretary of State.

19.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care's Group Accounting Manual.

20 BANK AND GBS ACCOUNTS

20.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health and Social Care.

20.2 The Board shall approve the banking arrangements.

20.2.1 Bank and GBS Accounts

20.2.2 The Director of Finance is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds if held;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; and

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

20.3 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

20.3.1 the conditions under which each bank and GBS account is to be operated;

20.3.2 the limit to be applied to any overdraft; and

20.3.3 those authorised to sign cheques or other orders drawn on the Trust's accounts.

20.4 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

21 TENDERING AND REVIEW

21.1 The Director of Finance will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

21.2 Benchmarking for commercial accounts should be undertaken at least every 5 years. The results of the benchmarking should be reported to the Board. Where benchmarking indicates the Trust is not achieving best value, alternative banking arrangements should be sought in line with Procurement requirements.

22 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

22.1 **Income Systems**

22.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

22.1.2 The Director of Finance is also responsible for ensuring a procedure is in place for the prompt banking of all monies received.

22.2 **Fees and Charges**

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22.2.1 The Trust shall follow the DHSC's advice in the costing manual in setting prices for NHS service agreements.

22.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by statutory regulation. Independent professional advice on matters of valuation shall be taken as necessary.

22.2.3 All Officers must not commit the Trust but inform the Director of Finance promptly of money due to the Trust from transactions which they initiate/deal with including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

22.2.4 The Director of Finance shall approve all property leases, property rentals and tenancy agreements. The Director of Estates and Capital Projects shall advise on these arrangements.

22.3 **Debt Recovery**

22.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

22.3.2 Income invoiced but not received should be treated as a bad debt and dealt with in accordance with the losses procedures. Disputed NHS transactions are not treated as bad debts but cleared via a credit note.

22.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

22.3.4 In the event an external party is engaged to seek the recovery of monies due, this must be undertaken in accordance with the Concession Contract Regulations (2016).

22.4 **Security of Cash, Cheques and Other Negotiable Instruments**

22.4.1 The Director of Finance is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for Officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

22.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

22.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

22.4.4 Holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the Trust or individuals absolving the Trust from responsibility for any loss.

23 NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

23.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable Contracts or Service Level Agreements (SLAs) with service commissioners for the provision of NHS services to patients. The Chief Executive should take into account:

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23.1.1 the standards of service quality expected;

23.1.2 National Operating Framework

23.1.3 the relevant National Service Framework (if any);

23.1.4 the provision of reliable information on cost and volume of services;

23.1.5 the NHS Long Term Plan;

23.1.6 the NHS National Performance Assessment Framework;

23.1.7 that SLAs build where appropriate on existing Joint Investment Plans;

23.1.8 that SLAs are based on integrated care pathways.

23.2 A good contract or SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and commissioning of the service required. In this way the Trust can jointly manage risk with all interested parties.

23.3 The Director of Finance on behalf of the Chief Executive, as the accountable officer, will produce monthly reports to the Board detailing actual and forecast income from activity contracts and SLAs.

23.4 The approval limits as stipulated in the Trust's Business Case policy are as follows:

23.4.1 Director of Finance or nominated officer will approve services up to £75,000;

23.4.2 The Executive Assurance Committee will approve all services from £75,001 to £250,000;

23.4.3 The Finance and Performance Committee will approve services from £250,001 to £750,000;

23.4.4 The Board shall approve all services over £750,000.

23.5 The Director of Finance shall provide up to date advice on:

23.5.1 Standard NHS contractual terms and conditions, issued by the Department of Health and Social Care;

23.5.2 Costing and pricing of services;

23.5.3 Payment terms and conditions;

23.5.4 Amendments to contracts, SLAs and extra-contractual arrangements.

23.6 The Director of Finance shall ensure that all SLAs are other contractual and extra contractual arrangements:

23.6.1 Are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income;

23.6.2 Are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the Director of Finance and reported to the Board.

23.6.3 The Director of Finance is responsible for ensuring that systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreement for the provision of healthcare services.

23.7 The Director of Finance shall produce regular reports, to the Board or its Committees detailing the Trust's forecast financial performance.

23.8 Budget holders with responsibilities for managing delivery against service agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

24 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS

24.1 Remuneration and Appointments

24.1.1 In accordance with SO 8 the Board shall establish a Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (Remuneration and Terms of Service Committee).

24.1.2 The Remuneration and Terms of Service Committee will:

(a) determine appropriate remuneration and allowances, and the other terms and conditions of office of the Chief Executive;

(b) approve the appropriate remuneration and allowances and the other terms and conditions of service for other Executive Directors and the Senior Management Team to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate

24.1.3 The above to include:

- all aspects of salary (including any performance-related elements/ bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms.

24.1.4 The Remuneration and Terms of Service Committee shall report in writing to the Board the basis for its decisions. Minutes of the Board's meetings should record such decisions.

24.1.5 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those Officers not covered by the Remuneration and Terms of Service Committee.

24.1.6 The Trust will remunerate the Chairperson and Non-Executive Directors in accordance with instructions issued by the DHSC.

24.2 Funded Establishment

24.2.1 The manpower plans incorporated within the annual Budget will form the funded establishment.

24.2.2 The funded establishment of any service may not be varied in excess of its financial envelope.

24.2.3 The approval limits for posts in excess of the agreed funded establishment either permanent or temporary as stipulated by the business case policy are as follows:

(a) Executive Management Team will approve requests up to £75,000;

(b) The Executive Assurance Committee will approve requests from £75,001 to £250,000;

(c) The Finance and Performance Committee will approve requests from £250,001 to £750,000; and

(d) The Board will approve all requests over £750,000.

24.3 **Staff Appointments**

24.3.1 No Director or Officer may re-grade Officers, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration unless authorised to do so by the Director of Workforce and Organisational Development and Director of Finance; and within the limit of the approved Budget and funded establishment.

24.3.2 No Director or Officer may engage, re-engage, either on a permanent or temporary nature, or hire agency staff, unless within the limit of the approved budget and funded establishment.

24.3.3 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc., for Officers.

24.4 **Processing of Payroll**

24.4.1 The Director of Finance is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances save for those determined by the Remuneration Committee;

(c) making payment on agreed dates;

(d) agreeing method of payment.; and

(e) Specifying and agreeing the contractual arrangements for the provision of payroll services.

24.4.2 The Director of Finance will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of Officers and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act 1998;

(g) methods of payment available to various categories of Officers;

(h) procedures for payment by cheque, bank credit, or cash to Officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash; and

(m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

24.4.3 Appropriately nominated Officers and the Senior Management Team have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement. Where an Officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

24.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

24.5 **Contracts of Employment**

24.5.1 The Board shall delegate responsibility to the Director of Workforce and Communications for:

(a) ensuring that all Officers and Executive Directors are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

(b) dealing with variations to, or termination of, contracts of employment.

25 NON-PAY EXPENDITURE

25.1 **Delegation of Authority**

25.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Holders.

25.1.2 The Chief Executive will set out:

(a) the list of Officers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

25.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services. In the first instance this will ordinarily be the Procurement Department.

25.1.4 The approval limits funding requests in excess of current delegated levels as stipulated in the Business Case policy are as follows:

(a) Executive Management Team can approve all requests to £75,000;

(b) Executive Assurance Committee or Business Case Review Group with delegated authority from Executive Assurance Committee can approve all requests from £75,001 to £250,000;

(c) The Finance and Performance Committee can approve all requests from £250,001 to £750,000;

(d) The Board can approve all requests over £750,000.

25.2 **Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services**

25.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought.

25.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

25.2.3 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in these SFIs and the Scheme of Delegation (as appropriate) and regularly reviewed;

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- A list of Directors, Senior Management Team and Officers with an authorisation limit authorised to certify invoices.
- Certification that:

  A goods have been duly received, examined and are in accordance with specification and the prices are correct;

  B work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

  C in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

  D where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

  E the account is arithmetically correct;

  F the account is in order for payment.

- A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early accounts subject to cash discounts or otherwise requiring early payment.
- Instructions to Officers regarding the handling and payment of accounts within the Trust's Finance Department.
- be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).
- Prepare and issue procedures regarding Value Added Tax.

25.1 **Prepayments**

25.1.1 Prepayments are only permitted where exceptional circumstances apply (for the avoidance of doubt, this includes pre-payments made via Escrow and other similar functions). In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to NPV) and the intention is not to circumvent cash limits;

(b) the appropriate Director or member of the Senior Management Team must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments and the contractual provisions to be put in place which will safeguard the Trust's financial position. This will ordinarily include an appraisal of the supplier's financial position;

(c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the relevant provisions of these SFIs, the Public Contract Regulations and other provisions including with regard to State Aid where the contract is above a stipulated financial threshold); and

(d) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

25.2 **Official Orders**

25.2.1 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade, including the provision to access the prevailing document referred to; and

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

25.2.2 Officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with relevant legislation on public procurement;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with these SFIs and any relevant guidance issued by the DHSC and NHSI;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or Officers, other than:

(e) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(f) conventional hospitality, such as lunches in the course of working visits.

(g) no requisition and/or order is placed for any item or items for which there is no Budget provision, unless authorised in advance and in writing by the Director of Finance on behalf of the Chief Executive;

(h) all goods, services, or works are ordered on an official order except as approved on the exception list and purchases from petty cash;

(i) verbal orders must only be issued very exceptionally. These must be confirmed at the earliest possible time by an official order and clearly marked "Confirmation Order" and approved by a Budget Holder.

(j) orders are not disaggregated, split or otherwise placed in a manner devised so as to avoid the financial thresholds set out in these SFIs, the Scheme of Delegation or any relevant statute;

(k) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase in breach of these SFIs and that all trials or loans are supported by a contract for the term proposed;

(l) changes to the list of Directors, members of the Senior Management Team and Officers authorised to certify invoices are notified to the Director of Finance;

(m) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

(n) petty cash records are maintained in a form as determined by the Director of Finance.

25.2.3 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the 'Estate Code' guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

25.3 **Tendering and Contract Procedure**

25.3.1 All tendering must be carried out via the authorised e-tendering platform and be compliant with the Trust policies and procedures. Issue of all tender documentation will be undertaken electronically through a secure website with controlled access using secure login, authentication, audit and viewing rules. All tenders will be received into a secure electronic vault so that they cannot be accessed until the published closing time and date. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

25.3.2 UK and EU Directives governing public procurement

25.3.3 Where relevant, United Kingdom and European Union directives on public sector purchasing procedures for awarding contracts shall have effect as if incorporated in these SFIs.

25.4 **Formal Competitive Tendering**

25.4.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials, works and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

25.4.2 The Associate Director of Procurement must be consulted on any formal tendering procedures that may be waived, in accordance with the Single Tender Waiver process. The Chief Executive (and any persons whom powers have been delegated to) can choose to waive a formal tendering procedure where:

(a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income

would not warrant formal tendering procedures and the circumstances are detailed in the appropriate Trust record; or

(b) where the timescale genuinely precludes competitive tendering, do note that failure to plan is not regarded a justification ; or

(c) where specialist expertise is required and is genuinely available from only one source. This would include specialist Original manufacturer (OEM) parts, maintenance and repairs; or

(d) there is a clear benefit to be gained from maintaining continuity with an existing Contract. The benefits of continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

(e) where the market has been tested and/or an opportunity has been published and an insufficient number of bids has been received; or

(f) for the provision of legal advice and services that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England & Wales for the conduct of their business (or by the Bar council for England and Wales in relation to the obtaining of counsel's opinion) and are generally recognised as having sufficient expertise in the area of working for which they are commissioned

25.4.3 The waiver can be granted without reference to the Chief Executive where:

(a) the estimated expenditure does not, or is not reasonably expected to, exceed £49,999; or

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with; or

(c) specialist expertise is required and is available from only one source; or

(d) in exceptional circumstances, the Associate Director of Procurement has granted approval, in consultation with an Executive Director and the urgency genuinely outweighs the consulting of the Chief Executive. In such instances the Chief Executive shall be informed immediately at the earliest opportunity

25.4.4 The limited application of the single tender waiver process should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure including via a framework.

25.4.5 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the single tender waiver process, the reasons should be documented and reported by the Director of Finance to the Integrated Audit and Risk Committee.

25.4.6 It is not possible to legally waiver any requirement in excess of the published OJEU Threshold applicable and in effect, as varied from time to time

25.4.7 Tendering procedures are set out in Appendix A of this policy.

25.5 **Spending the Trust's Money**

25.5.1 All spend must be in accordance with Spending The Trust's Money (STTM) and advice must be sought from the Procurement Team where necessary.

25.5.2 At least one written quotation must be obtained where the total estimated contract value is below £10,000.

25.5.3 At least three written quotations, with at least one quote from a Kent and/or Medway based business, must be obtained where the total estimated contract value is between £10,000 and £49,999. Where the lowest priced supplier is not chosen, the relative benefits of the chosen supplier must be formally logged demonstrating the achievement of value for money.

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25.5.4 A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above. This must include a published award criteria.

25.5.5 A full competitive OJEU procedure must be conducted where the total estimated contract value exceeds the relevant OJEU threshold in force as varied from time to time.

25.5.6 Quotations and Tenders must be evaluated in accordance with the published award criteria.

25.5.7 Any award must utilise the Trust's standard Contract.

25.6 **Where tendering or competitive quotation is not required** the Trust should adopt one of the following alternatives:

25.6.1 The Trust shall use NHS Supply Chain for procurement of all goods and services (and will not be required to obtain competitive quotations) unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

25.6.2 If the Trust does not use NHS Supply Chain (where tenders or quotations are not required, as set out in this policy), the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

25.7 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

25.8 **In-house services**

25.9 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided by the Trust on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering or benchmarking.

25.10 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

25.10.1 "specification group", comprising the Chief Executive or Nominated Officer(s) and specialist(s);

25.10.2 "in-house tender group", comprising representatives of the in-house team, a nominee of the Chief Executive and appropriate technical support; and

25.10.3 "evaluation group", comprising a specialist Officer, a Procurement Officer and a representative of the Director of Finance. For services having a likely annual expenditure exceeding £500,000, a Non-Executive Director shall be a member of the evaluation group.

25.11 All groups referred to above shall work independently of each other but individual Officers may be a member of more than one group. No member of the "in-house tender group" may, however, participate in the evaluation of tenders.

25.12 In all cases the approval of tenders shall be governed in accordance with the Scheme of Delegation. The "evaluation group" shall make recommendations to the Board.

25.13 The Chief Executive shall nominate an Officer to oversee and manage the in-house service.

25.14 Personnel and Agency or Temporary Staff Contract

25.14.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers and enter into contracts for the engagement of agency staff or temporary staff, or others under service contracts. The appointment of staff via an agency or other such intermediary falls within the scope of procurement requirements, and so advice should be sought as appropriate.

25.15 Compliance requirements for all contracts

25.15.1 The Trust may only enter into contracts within its statutory powers and shall comply with:

(a) the SOs;

(b) these SFIs;

(c) UK and EU Directives and other statutory provisions; and

(d) any relevant guidance or directions issued by the Secretary of State.

25.15.2 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. Any significant deviation should consider the legal risk of alteration.

25.15.3 For the purposes of these SFIs, 'contracts' shall include all agreements, leases, licences and hire purchase contracts to which the Trust is a party.

25.15.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

25.16 **Prevention of corruption**

25.16.1 Except where specific provision is made in model Forms of Contracts or standard schedules of conditions approved for use within the National Health Service, there shall be inserted in every written contract entered into by the Trust, a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

(a) the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

(b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor), or

(c) in relation to any contract with the Trust, the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts or any other appropriate legislation.

25.16.2 Determination of contracts for failure to deliver goods or material

(a) The Trust's standard Contract must be utilised. This ensures the supply of goods or materials entered into by the Trust contains a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may (without prejudice to any other rights under the contract) determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

26 TREASURY MANAGEMENT

26.1 The Director of Finance will ensure that the principles of the Treasury Management policy are followed, particularly in relation to:

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26.1.1 achieving the most competitive return on surplus cash within the agreed risk profile'

26.1.2 ensuring the availability of flexible, competitively priced funding at all times within the constraints of the Prudential Borrowing Code;

26.1.3 identifying and managing the financial risks, including interest rates, arising from operational activities;

26.1.4 ensuring compliance with all banking covenants;

26.1.5 maintaining appropriate cash headroom to meet anticipated requirements; and

26.1.6 managing the Trust's liabilities and investment assets prudently ensuring commitments can be made as they fall due.

27 EXTERNAL BORROWING AND INVESTMENTS

27.1 External Borrowing

27.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the DHSC and/or NHSI and the Trust's Treasury Management Policy. The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

27.1.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an Officer so delegated by him.

27.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

27.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.

27.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan and within the Trust's authorised Prudential Borrowing Limits.

27.2 Investments

27.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and/or NHSI and authorised by the Board.

27.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

27.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

28 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

28.1 Capital Investment

28.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

28.1.2 For every material capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance provided by DHSC) is produced setting out:

i an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

ii appropriate project management and control arrangements; and

iii the involvement of appropriate Trust personnel and third parties;

(b) that the Director of Finance has certified professionally the costs and revenue consequences detailed in all business case proposals, and the relevant thresholds to determine the approval route.

28.1.3 The approval limits for capital investments as stipulated in the Business Case Policy are as follows:

(a) The Trust Capital Group will approve schemes up to £75,000;

(b) Executive Assurance Committee or Business Case Review Group with delegated authority from Executive Assurance Committee will approve all schemes from £75,001 to £250,000;

(c) The Finance and Performance Committee will approve all schemes from £250,001 to £750,000; and

(d) The Board will approve all schemes over £750,000.

28.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations in the 'Estate Code' guidance. The Director of Finance shall assess on an annual basis the requirement for the operation of the 'Construction Industry Scheme' in accordance with any guidance issued by HM Revenue and Customs.

28.1.5 The approval of a capital programme shall not constitute approval for expenditure against that scheme.

28.1.6 The Chief Executive shall issue to the manager responsible for any approved capital scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender;

(c) approval to accept a successful tender.

28.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the "Estate Code" guidance and the SOs.

28.1.8 The Finance Director shall:

(a) issue procedures for the regular reporting of expenditure and commitment against authorised expenditure;

(b) issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account any guidance or best practice advice issued by the DHSC or NHSI regarding investment decisions by NHS Trusts.

28.2 Private Finance

28.2.1 The Trust should normally test for 'Private Finance Initiative' funding when considering material capital procurement. When the Trust proposes to use private finance which is to be provided by the private sector the following procedures shall apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the NHSI for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Trust in light of such professional advice as should reasonably be sought in particular with regard to vires.

(d) The selection of a contractor and/or finance company must be on the basis of competitive tendering or quotations

28.3 Asset Registers

28.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

28.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Chapter as issued in the DHSC's Group Accounting Manual.

28.3.3 Additions to the fixed asset register must be clearly identified to an appropriate Budget Holder and be validated by reference to:

(a) Notification of project completion by the relevant project manager who is responsible for ensuring properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) Purchase and installation of equipment;

(c) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

(d) Lease agreements in respect of assets held under a finance lease and capitalised.

28.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Where assets are disposed of, best value must be achieved in consideration of the same principles as when procuring them.

28.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

28.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the DHSC's Group Accounting Manual.

28.3.7 The value of each asset shall be depreciated using methods and rates as specified in the DHSC's Group Accounting Manual.

28.3.8 The Director of Finance shall calculate and pay capital charges as specified in the DHSC's Group Accounting Manual.

28.4 Security of Assets

28.5 The overall control of fixed assets is the responsibility of the Chief Executive.

28.6 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

28.6.1 recording managerial responsibility for each asset;

28.6.2 identification of additions and disposals;

28.6.3 identification of all repairs and maintenance expenses;

28.6.4 physical security of assets;

28.6.5 periodic verification of the existence of, condition of, and title to, assets recorded;

28.6.6 identification and reporting of all costs associated with the retention of an asset; and

28.6.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

28.7 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

28.8 Whilst each Officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors, Senior Management Team members and senior Officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

28.9 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Officers in accordance with the procedure for reporting losses.

28.10 Where practical, assets should be marked as the property of the Trust.

28.11 The Trust's property must not be used by Officers for private purposes nor removed from the normal workplace except as specifically authorised by senior management/ Officers.

29 STORES AND RECEIPT OF GOODS

29.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be kept to a minimum.

29.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stocks and stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers and stores managers and/or keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel, oil, coal, gas etc. shall be the responsibility of the designated Estates Manager.

29.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as 'Health Service Property'.

29.4 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

29.5 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those Officers authorised to requisition and accept goods from the store. The authorised Officers shall check receipt against the delivery note before accepting the charge. All discrepancies must be reported within 24 hours of receiving goods.

30 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

30.1 Disposals and Condemnations

30.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to Directors and relevant Officers.

30.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

30.2 Disposals Generally

30.2.1 All disposals shall be in accordance with these SFIs and the Scheme of Delegation.

30.2.2 Competitive tendering or quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his Nominated Officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000 (this figure to be reviewed annually by the Director of Finance); or

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

30.2.3 Disposals of Businesses, Business Units, etc. must be determined by the Board and subject to a recommendation from the Chief Executive supported by a statement from the Director of Finance setting out the financial implications.

30.2.4 Disposal of serviceable assets, mainly land, buildings and equipment, will be subject to the Trust's Capital Procedure and subject to the limits set out in the Scheme of Delegation. All material transactions will be determined by the Board and subject to a recommendation from the Chief Executive supported by a statement from the Director of Finance setting out the financial implications.

30.3 Disposal of Unserviceable Articles

30.3.1 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an Officer authorised for that purpose by the Director of Finance;

(b) recorded by the condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise

disposed of. All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Director of Finance.

30.3.2 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action. Even where an item has nil or negligible value, such items are to be disposed of in accordance with these SFI's and Officers of the Trust are not permitted to obtain such items without the prior written authorisation of a Senior Manager.

30.4 Losses and Special Payments

30.4.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

30.4.2 Any Director or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an Officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This Officer will then appropriately inform the Director of Finance and/or Chief Executive. .

30.4.3 The Board shall delegate its responsibility to approve the writing-off of losses and to authorise special payments in accordance with the Scheme of Delegation.

30.4.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

30.4.5 For any loss, the Director of Finance should consider whether any risk pooling or insurance claim can be made.

30.4.6 The Director of Finance shall maintain a 'Losses and Special Payments Register' in which write-off action is recorded.

30.4.7 No special payments exceeding delegated limits shall be made without the prior approval of the Board, or contrary to any guidance or best practice advice issued by the DHSC.

30.4.8 The Director of Finance must report all losses and special payments to the Integrated Audit and Risk Committee.

31 FRAUD AND CORRUPTION

31.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with any relevant guidance issued by DHSC or NHS Counter Fraud Authority on fraud and corruption in the NHS.

31.2 The Director of Finance is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, he will ensure that the Trust co-operates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

31.3 The Trust will appoint at least one person (who may be either an Officer or a person whose services are supplied to the Trust by an outside organisation) as a Local Counter Fraud Specialist, in accordance with any guidance issued by DHSC or the NHS Counter Fraud Authority on the suitability criteria for such appointees.

31.4 The Director of Finance will ensure that the Trust's Local Counter Fraud Specialist receives appropriate training in connection with counter fraud measures and that they are accredited by the Counter Fraud Professional Accreditation Board.

31.5 Where the Trust appoints a Local Counter Fraud Specialist whose services are provided to the Trust by an outside organisation, the Director of Finance must be satisfied that the terms on which those services

are provided are such to enable the Local Counter Fraud Specialist to carry out his functions effectively and efficiently and, in particular, that he will be able to devote sufficient time to the Trust.

31.6 The Local Counter Fraud Specialist shall report directly to the Director of Finance and shall work with NHS Counter Fraud Authority.

31.7 The Local Counter Fraud Specialist and the Director of Finance will, at the beginning of each Financial Year, prepare a written work plan outlining the Local Counter Fraud Specialist's projected work for that Financial Year.

31.8 The Local Counter Fraud Specialist shall be afforded the opportunity to attend Integrated Audit and Risk Committee meetings and other meetings of the Board, or its committees, as required.

31.9 The Director of Finance will ensure that the Local Counter Fraud Specialist:

31.9.1 keeps full and accurate records of any instances of fraud and suspected fraud;

31.9.2 reports to the Board any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;

31.9.3 has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;

31.9.4 receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and

31.9.5 participates in activities which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

31.10 The Director of Finance must, subject to any contractual or legal constraints, require all Trust Officers to co-operate with the Local Counter Fraud Specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

31.11 The Director of Finance must also prepare a “fraud response plan” that sets out the action to be taken both by persons detecting a suspected fraud and the Local Counter Fraud Specialist, who is responsible for investigating it.

31.12 Any Officer discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Director of Finance or the Local Counter Fraud Specialist, who will then inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the Local Counter Fraud Specialist.

31.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

31.13.1 the Board of Directors; and

31.13.2 the Auditor.

32 INFORMATION TECHNOLOGY RELATING TO FINANCIAL RECORDS AND INFORMATION

32.1 Responsibilities and duties of the Finance Director

32.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, together with the Director of IT, who is responsible for wider procedures in respect of information governance, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1984 and any other relevant legislation;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

32.1.2 The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, the Director of Finance must obtain from that organisation assurance of adequacy prior to implementation.

32.1.3 The Director of Finance will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Trust's information technology strategy.

32.1.4 The Director of Finance will ensure that separate control procedures are put in place for computer systems. This procedure will include:

(a) The acquisition and disposal of information technology, systems and equipment; and

(b) The decommissioning of systems containing confidential data in accordance with any relevant guidance issued by DHSC, or as required under statute.

32.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

32.2.1 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Health Service Bodes in the region wish to sponsor jointly) all responsible Directors and Officer will send to the Director of Finance:

32.2.2 details of the outline design of the system;

32.2.3 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

32.3 Contracts for computer services with other Health Service Bodies or outside agencies

32.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another Health Service Body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

32.3.2 Where another Health Service Body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

32.4 **Risk Assessment**

32.4.1 The Director of Finance shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

32.5 **Requirements for computer systems which have an impact on the Trust's corporate financial systems**

32.5.1 Where computer systems have an impact on the Trust's corporate financial systems the Director of Finance shall satisfy himself that:

(a) systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's Clinical Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) staff have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

33 PATIENTS' PROPERTY

33.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

33.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

33.2.1 notices and information booklets,

33.2.2 hospital admission documentation and property records,

33.2.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

33.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

33.4 Where any guidance by the DHSC requires the opening of separate accounts for patients' monies, these accounts shall be opened and operated under arrangements agreed by the Director of Finance.

33.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

33.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

33.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

34 ACCEPTANCE OF GIFTS BY OFFICERS

34.1 The Chief Executive shall ensure that all Officers are aware of the Trust's policy on acceptance of gifts or benefits in kind by Officers.

34.2 All Officers are subject to the provisions of section 7 of the Staff Code of Conduct which sets out clearly the rules which apply to the acceptance of gifts and hospitality. Nothing may be accepted by Officers which would constitute a breach of the provisions of the Bribery Act 2010.

35 RECORDS MANAGEMENT

35.1 The Chief Executive shall be responsible for the management of all NHS records by the Trust, regardless of the media on which they are held.

35.2 The Chief Executive shall ensure that the Trust adopts information governance arrangements which comply with the principles and guidelines contained in the DHSC's Records Management: NHS Code of Practice as may be varied from time to time.

35.3 The documents held in archives shall be capable of retrieval by authorised persons in accordance with the provisions of the Records Management Code.

35.4 Records held by the Trust under the Records Management Code shall only be destroyed at the express instigation of the Chief Executive. The Chief Executive shall ensure that records are maintained of documents so destroyed.

36 RISK MANAGEMENT & INSURANCE

36.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS guidelines, which must be approved and monitored by the Board.

36.2 The programme of risk management shall include:

36.2.1 a process for identifying and quantifying risks and potential liabilities;

36.2.2 engendering among all levels of Officers a positive attitude towards the control of risk;

36.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

36.2.4 contingency plans to offset the impact of adverse events;

36.2.5 audit arrangements including; Internal Audit, clinical audit, health and safety review;

36.2.6 decisions on which risks shall be included in the NHSLA risk pooling schemes;

36.2.7 arrangements to review the Trust's risk management programme

36.3 The Chief Executive will be responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control as required by the DHSC guidance from time to time.

36.4 The Board shall decide if the Trust will insure via the risk pooling schemes administered by the NHS Litigation Authority under Section 71 (Schemes for meeting losses and liabilities, etc. of certain health service bodies) of the NHS Act 2006) or 'self insure' for some or all of the risks covered by the schemes for any risk area (clinical, property, and non-clinical third party liability) covered by the scheme. This decision shall be reviewed annually.

36.5 Subject to the following exceptions, the Trust may not enter into insurance arrangements with commercial insurers:

36.5.1 insuring motor vehicles owned or leased by the Trust including third party liability arising from their use; and

36.5.2 where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into. In case of doubt the Finance Director should consult with NHSI.

36.6 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that the documented procedures that cover these arrangements.

36.7 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance will draw up a formal documented procedure for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

36.8 All risk pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure that documented procedures also cover the management of claims and payments below the deductible in each case.

37 SECURITY MANAGEMENT

37.1 The Chief Executive is responsible for the security of Officers and people engaged in activities for the purposes of the functions of the Trust.

37.2 The Chief Executive is responsible for within the Trust:

37.2.1 security management matters; and

37.2.2 the promotion of security management measures.

37.3 The Trust will appoint at least one person as a Local Security Management Specialist, in accordance with any guidance issued by DHSC or Secretary of State (Home Office). on suitability criteria for such appointees.

37.4 The Chief Executive will ensure that the Trust's Local Security Management Specialist receives appropriate training in connection with security management measures in order to meet the requirements and objectives set out by DHSC or Secretary of State (Home Office).

37.5 The Local Security Management Specialist shall report directly to the Chief Executive.

37.6 The Chief Executive will ensure that the Trust co-operates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the security of people and property across the NHS.

37.7 The Chief Executive will ensure that the Trust has effective arrangements in place to ensure that:

37.7.1 breaches of security and weakness in security-related systems are reported as soon as practicable to the

(a) Local Security Management Specialist;

(b) Integrated Audit and Risk Committee; and

(c) Auditor,

37.7.2 any confidentiality of information relevant to the investigation of breaches of security is protected; and

37.7.3 where possible, the Trust recovers money lost through breaches of security.

37.8 The Local Security Management Specialist and the Chief Executive will, at the beginning of each financial year, prepare a written work plan outlining the Local Security Management Specialist's projected work for that financial year.

37.9 The Local Security Management Specialist shall be afforded the opportunity to attend Integrated Audit and Risk Committee meetings and other meetings of the Board of Directors, or its Committees, as required.

38 FREEDOM OF INFROMATION AND INFORMATION DATA REQUESTS

38.1 The Chief Executive shall publish and maintain a 'freedom of information publication scheme' or adopt a model publication scheme approved by the Information Commissioner. A publication scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information that the Trust makes publicly available.

RESERVATION OF POWERS TO THE BOARD – DETAILED SCHEME OF DELEGATION

39 RESERVATION OF POWERS TO THE BOARD

39.1 Standing Orders (SOs) and Standing Financial Instructions (SFIs) set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other directors. These responsibilities are summarised below in section 39.5.

39.2 Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	**Overall responsibility**
Data Protection Act Requirements	Caldicott Guardian
Health and Safety Arrangements	Chief Executive

39.3 This scheme of delegation covers only matters delegated by the Board to Directors and nominated officers.

39.4 Throughout the Scheme of Delegation reference to a “Nominated Deputy” will mean the person advised in writing by the lead delegated officer.

39.5 **Detailed list of reservation of powers to the Board**

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
INTRODUCTION					
4.1	Final authority in interpretation of SOs.				
MEETINGS OF THE TRUST					
6.1	Calling meetings of the Trust Board at any time				
6.46	Chair all Board meetings and associated responsibilities				
DECLARATION OF INTERESTS					
9.7				Maintain register of interests	Trust Secretary
CUSTODY OF SEAL AND SEALING OF DOCUMENTS					
12.1		Keep seal in safe place			
12.3				Approve and sign all building, engineering, property or capital documents that require to be sealed.	2 members of the Board
12.5				Maintain register of sealing	Trust Secretary
SIGNATURE OF DOCUMENTS					
13.1		Approve and sign all documents which are a necessary step in legal proceedings involving the Trust (or Board approved officer)			
13.2		Sign on behalf of the Trust any agreement or document not required to be executed as a deed (or nominated officer)			
RESPONSIBILITIES AND DELEGATION					
16.4.4		To ensure all employees and directors are notified of and understand SFIs.			

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
16.7			Implement the Trust's financial policies and co-ordinating corrective action. Ensuring detailed financial procedures and systems are prepared, documented and maintained.		
16.8				Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, SFIs, financial procedures and the Scheme of Delegation.	All Directors and Employees:
16.10			Form and manner of discharge of financial functions		
AUDIT					
17.2.1		Ensure compliance with counter fraud and the DHSC directions on Fraud, Bribery and corruption	Ensure compliance with counter fraud and the DHSC directions on Fraud, Bribery and corruption		
17.3			Liaise with LCFS and internal audit. Ensure annual internal audit report is prepared and presented to Integrated Audit and Risk Committee and Board. Ensure police are informed at the right time in cases not involving fraud or corruption		
BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING					
18.1		Submit Annual Business Plan to Board Submit 5 year Integrated Business Plan	Submit annual budgets to Board for approval. Monitor performance against budget, submit to Board financial estimates and forecasts.		
18.2		Delegate budget to budget holders and submit monitoring returns.	Devise and maintain systems of budgetary control.	Sign up to their allocated budget at the commencement of each financial year	All budget holders

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
ANNUAL ACCOUNTS AND REPORTS					
19.1			Prepare, submit and present Annual Accounts		
19.3	Prepare, submit and publish an Annual Report				
BANK AND GBS ACCOUNTS					
20.1.1			Managing the Trust's Banking arrangements.	Managed via Deputy Director of Finance, requires one requisitioner and one approver.	Deputy Director of Finance
INCOME FEES AND CHARGES					
22.1.1			Systems for recording and collecting Income		
NHS SERVICE AGREEMENTS FOR PROVISON OF SERVICES					
23		Negotiating and signing contracts for provision of patient services.	Monthly reports of actual and forecast income contract receipts.		
TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS					
24.3.1			Re-grading or changing terms of employment of existing employee	Re-grading or changing terms of employment of existing employee	Director of Workforce and Communications
24.3.2				Must not engage staff permanent or temporary above establishment.	All staff
24.4				Ensure all employees are issued with a Contract of Employment and dealing with variations to, or termination of, contracts of employment	Director of Workforce and Communications
NON PAY EXPENDITURE					
25.1		Determine, and set out, level of delegation of non pay expenditure to budget managers.			

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
25.2		Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current departmental guidance.	Prompt payment of accounts. Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current departmental guidance.		
25.5		Formal tendering waived when notified in writing. Best value for money is demonstrated for all services provided under contract or in house.	Formal tendering waived when notified in writing.		
TREASURY MANAGEMENT					
26			Ensure that the principles of the Treasury Management Policy are followed.		
EXTERNAL BORROWING AND INVESTMENTS					
27			Application for Loans and Short term borrowing- in accordance with Standing Orders, Standing Financial Instructions and Treasury Management Policy		
CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTER AND SECURITY OF ASSETS					
28.1		Determine priorities for capital expenditure.	Certify professionally the cost and revenue consequences.		
28.2		Overall responsibility for fixed assets.	Maintenance of asset registers	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.	All Senior Staff
STORES AND RECEIPT OF GOODS					
29		Identify persons authorised to requisition and accept goods from NHS Supply Chain.	Responsible for systems of control over stores and receipt of goods.		

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
DISPOSALS AND CONDEMNATIONS					
30.1			Prepare detailed procedures for the disposal of assets including condemnations		
30.2			Prepare procedures for recording and accounting for losses and special payments and informing NHS Executive of all frauds and informing Police in cases of suspected arson or theft.		
INFORMATION TECHNOLOGY IN RELATION TO FINANCIAL RECORDS AND INFORMATION					
31.1		.	Responsible for accuracy and security of computerised financial data		
PATIENT PROPERTY					
32.1		Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.			
ACCEPTANCE OF GIFTS BY STAFF					
33		All staff are aware of Trust policy			
RECORDS MANAGEMENT					
34		Retention of document procedures. Management of all NHS records			
RISK MANAGEMENT AND INSURANCE					
35		Risk management programme. Insurance arrangements.	Risk pooling arrangements and procedure.		
SECURITY MANAGEMENT					
36		Security management and the promotion of security management measures.			

40 DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
MANAGEMENT OF BUDGETS (SFI section 18)						
Responsibility of keeping expenditure within budgets	At individual budget level (pay and non pay)	For Care Group	For the totality of Responsibility	For all other areas		
Approving expenditure higher than tender/ contracted price			up to 10% or £15k (in the aggregate) whichever is the higher	up to 10% or £15k (in the aggregate) whichever is the higher	> 10% or > £15k. Up to £25k.	
NON PAY REVENUE AND CAPITAL – REQUISITION AND APPROVAL OF GOODS AND SERVICES (SFIs section 25)						
Each purchase/ non Pharmacy expenditure	To £1,000	From £1,001 to £10,000	From £10,001 to £50,000	To £249,999 in conjunction with Director	From £250,000 to £499,999	Above £500,000: Finance and Performance Committee
Each Pharmacy order	Up to £74,999 Head of Pharmacy				£75,000 to £250,000 Each requisition and order exceeding 12 month period	£250,001 to £750,000 CE and Chairperson for reporting to next Board meeting
Business cases					EMT to £75,000. Executive Assurance Committee from £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee Above £750,000 Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Independent Legal and/or Professional Advice						Integrated Audit and Risk Committee has authority to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary
MANAGEMENT OF CAPITAL SCHEMES (SFIs section 28 and SO section 12)						
Selection or architects, quantity surveyors, engineers and other professional advisors within EU regulations			Director of Capital Planning and Estates			Following approval as set out in Business case policy
Financial monitoring and reporting on all capital scheme expenditure			DoF & Director of capital planning & estates	Deputy DoF		
Granting, extension and termination of leases with annual rent up to :				To £249,999 with Director	From £250,000 to £499,999	From £500,000: Finance and Performance Committee
Business cases per scheme		Trust Capital Group to £75,000			Executive Assurance Committee or Business Case Review Group from £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee Above £750,000 Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	Associate Director/ Head of Service	Director/Deputy Chief Operating Officer	Deputy Director of Finance	Chief Executive, Director of Finance or nominated Deputy	Committee of the Board
QUOTATION, TENDERING AND CONTRACT PROCEDURES (SFI section 25, SO section 12)						
At least one written quotation	Below £10,000 (or delegated manager e.g, Estates)					
At least 3 written quotations	From £10,000 to £49,999 (Undertaken by Procurement and budget holder)					
Full Competitive Tender Process	From £50,000 to OJEU tendering undertaken (Undertaken by Procurement and budget holder)					
Full Competitive Tender Process	In excess of OJEU Threshold tendering undertaken (Undertaken by Procurement and budget holder)					
Waiving of quotations and tenders subject to Standing Orders (SO 10.5)					CE if over £50k. All to be considered by Procurement	
SETTING OF FEES AND CHARGES (SFI section 22)						
Private patient, overseas visitors, Income Generation and other patient related services				DoF or Deputy Director of Finance	DoF or Deputy Director of Finance	
Price of NHS contracts				To £75,000	DoF above £75,000	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
ENGAGEMENT OF STAFF AND CONSULTANTS NOT ON THE ESTABLISHMENT (SFI section 24)						
Non medical Consultancy staff		Where aggregate commitment in any one year (or total commitment) is less than £75,000			Executive Assurance Committee where aggregate commitment in one year is over £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee
Engagement of Trust's Solicitors other than for litigation	Head of Legal Services to £5,000		Head of Legal Services with relevant Director/ Head of Service to £20,000		Head of Legal Services with CE to £75,000	Head of Legal Services with CE (or DOF) and with Audit Committee NED over £75k
Booking of Bank or Agency staff	Budget Holder if costs are within budget of vacant posts.	Costs beyond budget of vacant posts but within total Care Group budget	Costs beyond Care Group budget			
AGREEMENTS/LICENCES (SFI Section 25)						
Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff			Director of Capital Planning and Estates			
Extension to existing licenses/agreements not exceeding one year						
Letting of premises to outside organisations						
Approval of rent based on professional assessment			Director of Capital Planning and Estates with DoF			
Terminating agreements/licences			Director of Capital Planning and Estates			

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
DISPOSALS CONDEMNING AND DISPOSAL OF ASSETS/EQUIPMENT (SFIs section 30)						
Minor current replacement price;-	price less than £50		Above £50 Director of Capital Planning and Estates			
Disposal of mechanical engineering plant		Less than £1,000 per sale; Head of Estates	Above £1,000 per sale; Director of Capital Planning and Estates			
Disposal of Land, Building and Equipment				Up to £19,999 - Equipment only	£20,000 - £74,999; CE or DOF £75,000 - £249,000; CE or DoF and Director of Capital planning and Estates	From £250,001 to £400,000; CE and Chairperson reporting to next Board meeting. From £400,000 to £749,999 Finance and Performance Committee. Board over £750,000
LOSSES, WRITE-OFF AND COMPENSATION (SFIs section 30.2)						
Losses and cash due to theft, fraud, overpayment.					CE and DoF ; up to £50,000	Report to Integrated Audit & Risk Committee under Losses and Compensation procedures.
Fruitless payments (including abandoned Capital Schemes).					CE and DoF ; up to £250,000	
Bad debts and claims abandoned. Private patients, overseas visitors and others.					CE and Director of Operations ; up to £50,000	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)			Director of Capital planning & Estates - up to £50,000		Chief Executive - up to £50,000	
Compensation payments made under legal obligation.					Up to £99,999	
Extra Contractual payments to contractors					Up to £50,000	
Ex Gratia payments to service users and staff for loss of personal effects					Chief Executive and Director of Finacne	
Clinical negligence (negotiated settlements) based on legal advice					Up to £1,000,000	
For personal injury claims involving negligence where legal advice has been obtained and guidance applied	Where settled within 'insurance excess';-	Head of Legal Services and DOF			Including plaintiff's costs, up to £1,000,000	
Other uninsured settlements, except cases of mal-administration where there was no financial loss by claimant,					Up to £50,000	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
REPORTING OF INCIDENTS TO THE POLICE (SFIs sections 17 and 31)						
Where a criminal offence is suspected	Criminal offence of a violent nature;- Duty Manager		Director of Workforce and Communications			
Where a criminal offence is suspected where a fraud is involved;	LCFS					
PETTY CASH DISBURSEMENTS (SFIs section 25.4)						
Approval of Petty cash vouchers	Expenditure up to £50 per item (Limited to 125 claims per week)	In excess of £50;- Director/ Head of Service (Limited to 125 claims per week)				
RECEIVING HOSPITALITY (SOs section 11 and SFIs section 34)						
Applies to both individual and collective hospitality receipt items in excess of £25 per item received	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	
IMPLEMENTATION OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS (SFIs section 17)						
Maintenance and update of Trust Financial Procedures.					Present up to date procedures	Approved by Finance and performance Committee
HUMAN RESOURCES AND PAY (SFIs section 24)	Fill funded post on the establishment with permanent staff				All requests for re-banding	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
	Additional staff to the establishment with specifically allocated finance			Additional staff to the establishment without specifically allocated finance	Additional staff to the establishment without specifically allocated finance	
	Complete standing data forms					
	Authorise overtime					
	Authorise travel and subsistence expenses					
	Approval of annual leave					
	Compassionate leave up to 4 days	Over 4 days				
	Special leave arrangements incl paternity leave etc.	Leave without pay				
	Time off in lieu – paid and unpaid					
	Maternity leave – paid and unpaid Automatic approval (with guidance HR final approval)					
	Sick Leave		Extension of sick leave			
	Study leave		Medical Staff - Medical Director		Study Leave outside the UK	
Removal Expenses, Excess Rent etc.			Up to £8k Director		Over £8k Director of Workforce and Communications	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Renewal of Fixed Term Contract up to a maximum of one year	Budget Holder in conjunction with HR					
Redundancy, Health retirement, Dismissal (as set out in the Policy)					Redundancy, Health retirement, Dismissal (as set out in the Policy)	
AUTHORISATION OF NEW DRUGS						
Estimated total additional cost		Annual cost below £25k; Drugs and Therapeutic Committee, Medical Director and Chief Pharmacist			Annual cost above £25k; Drugs and Therapeutic Committee, in accordance with NICE guidelines; Medical Director and CE	
Sponsorship deals	Up to £5k				CE, Medical Director, Chairperson of Research Committee, DoF	
RESEARCH PROJECTS						
Research projects (Approval)					Up to £50k per year, Medical Director, Chairperson of Ethics committee, DoF.	
Clinical Trials (Approval)					Up to £50k per year, Medical Director, Chairperson of Ethics committee, DoF.	
PATIENTS AND RELATIVES COMPLAINTS						
Ensuring that all complaints are dealt with effectively		Investigation; - Director/ Head of Service	Overall responsibility; DCOO			

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Medico-Legal Complaints Co-ordination of their management		Director of Nursing and Quality or Head of Legal Services				
INTRODUCTION OR DISCONTINUANCE OF ANY SIGNIFICANT ACTIVITY OR OPERATION OTHER THAN BY TENDER						
Introduction or Discontinuance of any significant activity or operation other than by tender		Up to £250,000 Head of Service and DoF or with DCOO			£250,000 - £750,000 Executive Assurance Committee	Above £750,000 Trust Board
FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE						
Professional recognition, Honorary contracts and insurance of Medical staff			Medical Director			
Work experience students		Head of Workforce and Communications / Director/ Head of Service				

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Trust Board (Public)	**Date**	26 November 2020
Title of Paper	Register of Board Members Interests – October 2020		
Author	Tony Saroy, Trust Secretary		
Executive Director			

Purpose: the paper is for:	• **Delete as applicable**
• **Noting:**	

Recommendation:
The Board is asked to note the Register of Board members' Interests. The Board members' Declarations of Interests will be published on the Trust website.

Summary of Key Issues:	• **No more than five bullet points**

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

It is the Trust's practice to formally update the Register of Interests twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board was updated as at 22 October 2020 and is attached.

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

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

Report History:
Reviewed by IARC November 2020

Strategic Objectives:	• **Select as applicable**
☒ Consistently deliver an outstanding quality of care ☒ Recruit retain and develop the best staff making KMPT a great place to work ☐ Put continuous improvement at the heart of what we do ☐ Develop and extend our research and innovation work ☐ Maximise the use of digital technology ☐ Meet or exceed requirements set out in the Five Year Forward View ☒ Deliver financial balance and organisational sustainability ☐ Develop our core business and enter new markets through increased partnership working ☐ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership	

Implications / Impact:
Patient Safety: *None*
Identified Risks and Risk Management Action:
Resource and Financial Implications:
Legal/ Regulatory: Code of Accountability and NHSE/I requirement
Engagement and Consultation: *None*
Equality: *None*
Quality Impact Assessment Form Completed: ~~**Yes/ No**~~ **N/A**

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

Interests fall into the following categories:

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

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

REGISTER OF BOARD MEMBERS INTERESTS
OCTOBER 2020

Director	Position	Interest declared
Jackie Craissati	**Interim Chairman**	Jackie's current company, Psychological Approaches is on the NHS England framework for Independent Serous Incident Investigations but does not undertake investigations relating to KMPT. Jackie is Trustee on the Board of Samaritans and Independent Governor on the Board of the University of East London
Anne-Marie Dean	**Non-Executive Director**	None declared
Mark Bryant	**Non-Executive Director**	Mark's daughter, Laura, is a midwife (Band 7) at Pembury Hospital. This is part of Maidstone and Tonbridge Wells Trust. MB declared this for full transparency.
Rod Ashurst	**Non-Executive Director**	None declared
Tom Phillips	**Non-Executive Director**	Tom is a Non Executive Director – Barking, Havering and Redbridge NHS Trust Tom is also Chairman of Racecourse Technical Services Ltd appointed 1 July 2015 after serving since Feb 2006 as a Non Executive Director
Venu Branch	**Non-Executive Director**	None declared

Catherine Walker	**Non-Executive Director**	Catherine is Lay Chair of the Consultant Appointments Committee at Kings College Hospital NHS Foundation Trust, London Catherine works for Walkers Solicitors of which her husband, Ivan Walker, is the Principal. Walkers is an Employment law practice specialising in Pensions. Walkers acts for the majority of UK Trade Unions including a number of Trade Unions active in the Health sector. Walkers' Health sector Union clients are The Chartered Society of Physiotherapy, The Royal College of Midwives and the Prison Officers Association. (Walkers Solicitors do not act for the NHS but clients do negotiate with the NHS – declared to ensure full transparency) Member of an advisory and scrutiny Panel of the National Employment Savings Trust (' NEST') Corporation. NEST is the pension auto enrolment vehicle used by KMPT for workers who are not members of the NHS pension scheme.
Fiona Carragher	**Non-Executive Director**	Fiona is an Executive Director – Alzheimer's Society and a Trustee of the UK Dementia Research Institute
Kim Lowe	**Non-Executive Director**	Kim is a Non Executive Director – Central Surrey Health Lay member – University of Kent
Mikola Wilson	**Non-Executive Director**	None declared
Sean Bone-Knell	**Non-Executive Director**	None declared
Peter Conway	**Non-Executive Director**	Non Executive Director – Kent Community Health NHS Foundation Trust
Helen Greatorex	**Chief Executive Officer**	Helen's husband is Director of Talking Therapies and may compete for business in the Trust's area. From 1 April 2019 Helen's husband commenced job with Priory
Vincent Badu	**Executive Director of Partnerships and Strategy**	None declared
Jacquie Mowbray-Gould	**Chief Operating Officer**	None declared
Sheila Stenson	**Executive Director of Finance**	Sheila is the Chair HFMA Kent, Surrey and Sussex
Afifa Qazi	**Executive Medical Director**	None declared
Mary Mumvuri	**Executive Director of Nursing and Quality**	Mary is Vice chair- Mental Health Nurse Director Forum
Sandra Goatley	**Director of Workforce and OD**	None declared

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Front Sheet

Title of Meeting	Trust Board Meeting	**Date**	26th November 2020
Title of Paper	Board Assurance Framework		
Author	Louisa Mace, Risk Manager		
Executive Director	Mary Mumvuri, Executive Director of Nursing, AHPs and Quality		

Purpose: the paper is for:	• **Delete as applicable**
• **Approval**:	

Recommendation:

The Board are asked to receive and review the Board Assurance Framework confirming the current process for gathering assurance, ensuring that appropriate assurance is provided and that any new risks are included under the correct Strategic Objective.

Summary of Key Issues: • **No more than five bullet points**

The Board Assurance Framework provides assurance to the Trust Board that any risks which may impact on achieving the strategic objectives have been identified and actions put in place to mitigate them. A summary of key controls and evidence is added as appendix 1.

- The four top risks rated as Extreme are:
  - Risk ID 6098 Long Term Financial Sustainability (Rating 20)
  - Risk ID 6428 2020/21 CIP Programme (Rating 16)
  - Risk ID 6570 New Finance Regime (Rating 16)
  - Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating 16)
- The next three risks rated as 12 (High) are:
  - Risk ID 6274 Lack of access to specialist learning disability and autism beds
  - Risk ID 6052 Improving and sustaining quality and safety
  - Risk ID 3808 Recruitment
- Four Risks have reduced their risk score:
  - Risk ID 6428 2020/21 CIP Improvement Programme (Reduced to 16 – Extreme from 20 - Extreme)
  - Risk ID 6274 Lack of access to specialist learning disability and autism beds (Reduced to 12 – High from 20 - Extreme)
  - Risk ID 5920 Financial Risk to KMPT due to out of area PICU bed use

(Reduced to 9 – High from 12 - High)
    - Risk ID 3164 Capital Projects - Availability of Capital (Reduced to 8 – High from 9 - High)
- Two risks are recommended for removal:
    - Risk ID 4996 Integrated Care System Process (3 Low)
    - Risk ID 6192 Clinical Technology Strategy Funding (6 Moderate)
- Two New Risks have been added
    - Risk ID 6570 New Finance Regime 2020/21 (Rating of 16 - Extreme)
    - Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 - Extreme)

Report History:
Reviewed by Executive Directors prior to submission to Trust Board.

Strategic Objectives:	• **Select as applicable**
☒ Consistently deliver an outstanding quality of care	
☒ Recruit retain and develop the best staff making KMPT a great place to work	
☒ Put continuous improvement at the heart of what we do	
☒ Develop and extend our research and innovation work	
☒ Maximise the use of digital technology	
☒ Meet or exceed requirements set out in the Five Year Forward View	
☒ Deliver financial balance and organisational sustainability	
☒ Develop our core business and enter new markets through increased partnership working	
☒ Ensure success of our system-wide sustainability plans through active participation, partnership and leadership	

Implications / Impact:
Patient Safety: Risks relating to Patient Safety are covered under the first three Strategic Objectives
Identified Risks and Risk Management Action: Not applicable
Resource and Financial Implications: As set out in the risk descriptions and mitigations
Legal/ Regulatory: Compliance with Annual Governance Statement disclosure requirement Accountable Officer memorandum

Engagement and Consultation: Reviewed by Executive Directors prior to submission to Trust Board
Equality: Not applicable
Quality Impact Assessment Form Completed: ~~Yes/~~ No

The Top Risks are

- Risk ID 6098 Long Term Financial Sustainability (Rating of 20 – Extreme)
- Risk ID 6428 2020/21 CIP Programme (Rating of 16 – Extreme)
- Risk ID 6570 New Finance Regime 2020/21 (Rating of 16 – Extreme)
- Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 – Extreme)

Supplementary assurance information has been provided with this paper relating to the key controls for each risk. The purpose is to demonstrate that evidence can be provided for each key control and that the control is being monitored and assessed for quality and impact.

Risk Movement

There have been 4 risks which have reduced their scores.

Risk ID 6428 2020/21 CIP Improvement Programme (Rating of 16 – Extreme)
This risk has reduced from 20 (Extreme) due to the ongoing work to close the gap and plan for 2021/22 efficiencies.

Risk ID 6274 Lack of access to specialist learning disability and autism beds (Rating of 12 – High)
This risk has reduced from 20 (Extreme) as there are system discussions in place to resolve this gap in service provision.

Risk ID 5920 Financial Risk to KMPT due to out of area PICU bed use (Rating of 9 – Moderate)
This risk has reduced from 12 (High) in response to mitigations in place operating to provide a Kent based service, with a monthly quality and performance contract meeting in place, good clinical relationships in place and reduction in out of area bed use

Risk ID 3164 Capital Projects - Availability of Capital (rating of 8 – Moderate)
This risk has reduced from 9 as funding for most of the identified estates programme is secured. The capital resource for this financial year is being managed on a system basis.

Risks recommended for Removal

Risk ID 4996 Integrated Care System Process
It is recommended that this risk is closed as we have now transitioned to Kent & Medway Integrated Care System and partnership arrangements for Mental Health have been established at an ICS and ICP level with the new single CCG. It is proposed that a new risk is opened to focus on the implementation of the Trust Strategy and 2020-2024 and meeting the objectives set in the annual strategy delivery plan.

Risk ID 6192 Clinical Technology Strategy Funding
It is recommended this risk is closed as the final business case for resource was approved by the finance and performance committee.

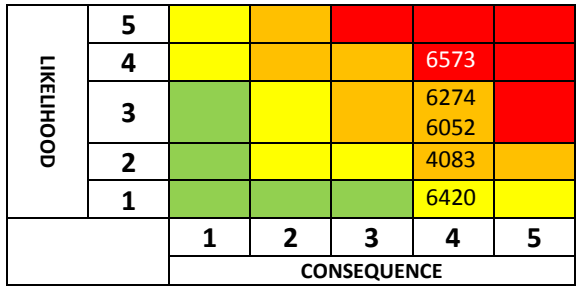
New Risks

Risk ID 6570 New Finance Regime 2020/21 (Rating of 16 - Extreme)
This risk has been added in response to the new finance regime notified to the trust for the remaining months of the financial year. This is rated extreme due to the calculation used to determine the baseline, which is being queried with NHSE/I.

Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 - Extreme)
This risk has been added to reflect the demand and capacity issues affecting the Community Mental Health Teams. It replaces risk ID 5875 and reflects the issues across the Adult and Older Adult care groups.

Recommendations

- The Board to receive the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.

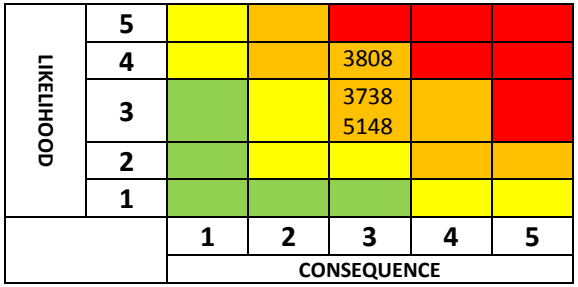
Strategic Objective 1	Consistently deliver outstanding quality of care	
Risk Report  	**NEW** Opened: 17/11/2020 Target rating: 9 Target Date: 30/06/2021	**Risk ID 6573:** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services. **Performance Metric:** Improvement in the 4 and 18 week wait trajectory. **Performance Metric Status: Not Met** **BAF Owner: Chief Operating Officer** Directors Comment: Demand and capacity continue to be an area of risk however not solely in terms of the CMHTs. Whilst much has been done to ensure steady state there needs to be continued development of services both adult and older adult over the next 12 months. This will be addressed via the community mental health framework delivery and the risk has been revised in month accordingly. The COO has closed risk item 5875 and completed this risk incorporating both younger and older adult CMHTs.
	 Opened: 06/03/2019 Target: 3 Target Date: 31/06/2021	**Risk ID 6052:** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice. **Performance Metric:** CQC Well Led ratings; Enforcement Actions **Performance Metric Status: Met** **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: We continue to monitor the quality and safety of care through defined formal and informal processes already established in the Trust with performance scrutinised at all levels. We continue to have regular meetings with Care Quality Commission (CQC) to discuss any areas of risk to quality of care

		as part of the provider assurance process. Clinical audits including Cliq Checks and themed deep dives continue to be used to assure quality.
	 Opened: 04/12/2014 Target rating: 4 Target Date: 30/06/2021	**Risk ID 4083:** 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 safety risks RESULTING IN self-harm and or death from suspension from anchor points and may mean patient safety, financial penalty, reputational damage and prosecution **Performance Metric:** Reduced number of moderate to severe harm incidents involving anchor points **Performance Metric Status: Met** **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: Ligature risks are mitigated operationally through individual patient risk assessments, environmental checks, use of formal observations and therapeutic interventions. We continue to modernise our Estates as part of the Trust Capital programme. Trends and themes relating to ligature incidents are reviewed by the Prevention of Suicide Group, Trust Wide Health Safety and Risk Group and the Patient Safety Group. The IQPR report includes numbers of any such incidents where harm has been caused and there have been no reported incidents. An annual audit on management of ligatures across all wards is underway throughout November 2020.

	 Opened: 28/04/2020 Target rating: 4 Target Date: 31/03/2021	**Risk ID 6420:** IF there are not adequate national stocks of COVID-19 PPE provided through the national supply chain to NHS Organisations THEN there is a risk that Trust Staff (including contractors, partners and volunteers on Trust sites) will not have access to appropriate PPE RESULTING IN a failure of the Trust to comply with Health and Safety regulations which may lead to increased staff sickness and unions instructing staff to withdraw from the working environment which in turn will impact on the health and safety of patients. **Performance Metric:** Stock control and Sitrep data **Performance Metric Status:** **Met** **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: The Trust has good stock levels of all PPE, including emergency contingencies held in the East of the County in the event of road disruptions related to e.g. adverse weather or EU Exit. Across all core lines there is a minimum of 21 days stock held and for non-core items there is an ongoing locally sourced supply ordered on a weekly basis. Regular updates are given by the Trust's Associate Director of Procurement via Tactical group and elsewhere as appropriate with escalations and resolutions made as suitable.
	 Opened: 28/01/2020 Target rating: 9 Target Date: 25/03/2021	**Risk ID 6274:** IF people in the community require crisis support for and/or access to specialist care and treatment due to their learning disability or autism, in the absence of a treatable mental health need, and there is no specialist placement or service available THEN they may be admitted to an inappropriate care setting such as a younger adult inpatient setting where the persons care needs cannot be fully met RESULTING IN increase risk of harm to self/others, poor patient experience and outcomes; lack of treatment options for specialist needs such as autism, reduced staff morale, increased carer stress and possibility of complaints, financial implications due to high level of needs requiring additional resources with a possible risk to the Trust reputation **Performance Metric:** People with learning disability and autism have their care needs met at the right time in the right care setting provided by staff who have the right clinical expertise **Performance Metric Status**: **Not Met**

		BAF Owner: Chief Operating Officer Director's Comment: This is key risk for organisation. As a system Kent is lacking any service provision for people with autism who go into crisis. The impact is people are admitted to a KMPT acute in-patient bed which is the wrong clinical environment for many of these people. The system is aware of the gap and discussions in place to resolve.
Linked Risks (Current Rating)**:** **Risk ID 5875:** 4248 Community Flow, High Caseloads & Unallocated Cases (4 Mod); 5623 Referral to assessment within 4 weeks (9 High); 6031 – 6040 CMHTs Demand & Capacity (16 Extreme) 6149 High levels of referrals into the organisation **Risk ID 4083:** 2667: H&S Compliance (9 High) **Risk ID 6274:** 6268 Increase in Violence & Aggression incidents (patient to patient/patient to staff) due to temporary reduced seclusion/ECA capacity (12 High)	**Assurances:** • **Risk ID 5875:** Investment via the MH investment standards, revised Standard Operating Procedures, weekly performance information to team level, improved CPA performance • **Risk ID 6052 –** Capital Programme oversight of environmental improvements and new projects; Quality Performance Meetings; CQC Well Led Inspection report February 2019; CQC Engagement meeting feedback; MHA reviews; QPR Performance and Quality report; patient safety incidents. • **Risk ID 4083:** Monitored by NHS England via STEIS; Datix incident reports, therapeutic observations and engagement; Health & Safety ligature Audits; Refurbishment programme is reducing anchor points; *National Standards for Mental Health unit builds* • **Risk ID 6420:** PHE Outbreak overview spreadsheet available to Trust IPC. Pre-planned requirement for PPE to service Seasonal Flu campaign mapped via IPC/Trust Procurement. Products are being assured via IPC/Procurement to assure of HSE compliance for new national stockpile/product 'push' receipts. • **Risk ID 6274:** Mental Health and Learning Disability board have a defined workstream to provide oversight to strategic programme for LDA
Performance Report 	**Key Controls:** • **Risk ID 5875:** Care Group management overview; QPR oversight; Recruitment policy; CliQ Checks; Caseload Management tool • **Risk ID 6052 –** Achievement of good/outstanding regulatory standards; Implementation of care pathways; Environmental improvements to estate; CliQ-Checks; CCG Quality Visits; CQC Mental Health Act Reviews; Thematic deep dives • **Risk ID 4083:** Health & Safety Risk Assessment (HS20); Annual Ligature Audits; Ligature inventory; Oversight by Prevention of Suicides and Homicide Group and Trust Wide Health Safety and Risk Group; Ligature Champions; Refurbishment programme includes anti-ligature fittings and door top alarms; standardised ligature cutters • **Risk ID 6420:** Local and national sitrep reporting, central procurement strategy, mutual aid between partners in Kent and Medway • **Risk ID 6274:** Segregation of individuals in low stimulus environments; Increased Staffing Levels; reporting of all incidents; Business cases for upgrading nursing staff, and increase in total staffing establishment led by KMPT Deputy Head of Nursing and Head of Nursing for ACG; Executive lead for LDA identified; Specialist

	LDA Clinical Lead in post to lead KMPT and system improvements to address commissioned gaps and improve pathways. CQC/NHSE/I knowledge of local challenges and supporting improvement planning.

Strategic Objective 2	Recruit retain and develop the best staff making KMPT a great place to work	
Risk Report  	 Opened: 12/05/2014 Target Rating: 9 Target Date: 31/03/2021	**Risk ID 3808:** IF we fail to recruit appropriate numbers of healthcare professionals THEN this will impact on the ability to meet safe staffing requirements RESULTING IN continued reliance on agency staff, increased cost and potentially lower quality service to patients. **Performance Metric**: Reporting to CCGs, Vacancy rate, reduced use of agency/bank/NHSP staff, over performance on Agency Cap (national target) **Performance Metric Status: Not Met** **BAF Owner: Director of Workforce & Communications** Directors Comment: The Medical Improvement Plan is in place, with Medical Staffing Programme Board chaired by the Executive Medical Director and The Director of Workforce and Communications. The development of the recruitment strategy for all staff is part of 2020/21 People Plan. There are new social media developments in place and specific staff group initiatives with some video being produced. There is also further work on culture and employer branding planned.
	 Opened: 01/04/2014 Target Rating: 6 Target Date: 31/03/2021	**Risk ID 3738:** IF we do not have engaged employees THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business **Performance Metric:** Response rate and staff engagement indicator from annual staff survey **Performance Metric Status: Not Met** **BAF Owner: Director of Workforce & Communications** Directors Comment: Staff Survey plans are in place for 2020 survey. Leadership and management development, including career development work. Talent management and succession planning. Freedom to Speak Up Guardian is in post. There is preventative work on sickness absence underway through a pilot in the Acute Care group. Further improvements to appraisal and supervision are planned, with 2020/21 window about to officially close. Talent Conversation approach revised and remains open until end of November 2020.

<table>
<tr>
<td></td>
<td>Opened:
05/03/2017
Target Rating: 6
Target Date:
31/03/2021</td>
<td>Risk ID 5148: IF we do not retain our employees THEN this would impact on staff morale, absence and productivity and have a potential impact on patient experience RESULTING IN impact on Turnover, Absence etc.
Performance Metric: Turnover rate
Performance Metric Status: Not Met
BAF Owner: Director of Workforce & Communications
Directors Comment: Embedding new approach to supervision processes and recording, including Talent management discussions. Business case being amended following feedback in relation to band 5 nurses to band 6 once they have reached certain competencies – this will also aid recruitment as more attractive for Band 5 nurses.
Career pathways to improve staff retention.
Leadership and management development.</td>
</tr>
<tr>
<td>Linked Risks (Current Rating):
3954: Recruiting an effective workforce (16 Extreme)
4617: Revalidation of Nurses (2 Low)
4540: Recruitment & retention of medical staff (6 Moderate)
5073: Appraisals (8 High)</td>
<td colspan="2">Assurances:
• Risk ID 3808: Monitoring of recruitment and retention; Monitored by WFOD Committee bi Monthly
• Risk ID 3738: Workforce Committee oversight; Green Button activity; Leadership and management development; Report to Trust Board – Staff Survey and appraisals
• Risk ID 5148: External monitoring – various bodies; NHSI Cohort 2 retention project;
(Text in italics denotes a 3rd line control)</td>
</tr>
<tr>
<td>Performance Report
 
</td>
<td colspan="2">Key Controls:
• Risk ID 3808: Review of Roster templates; Escalation policy; Medical Staffing Programme Board; Consultant mentoring in place; Recommend a Friend; Review of end to end recruitment process; SafeCare Pilot.
• Risk ID 3738: Quarterly Staff Friends & Family Test Survey; NHS Staff Survey; Care Group and Staff Awards; Green Button on i-connect; Freedom to Speak Up Guardian; Big Conversation events; ‘Just learning’ approach review of culture; EMT Working With Days
Risk ID 5148: Exit Interviews; Supervision and Appraisals; NHSI retention programme cohort 2</td>
</tr>
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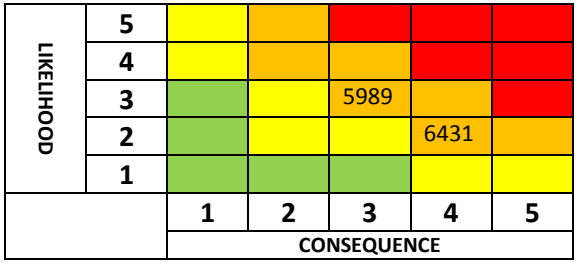
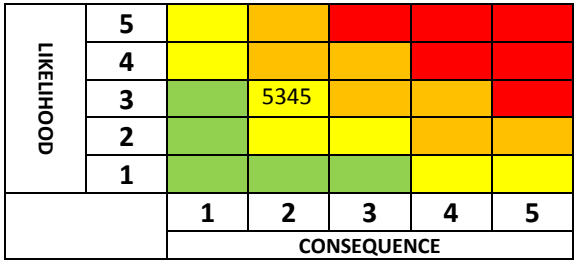
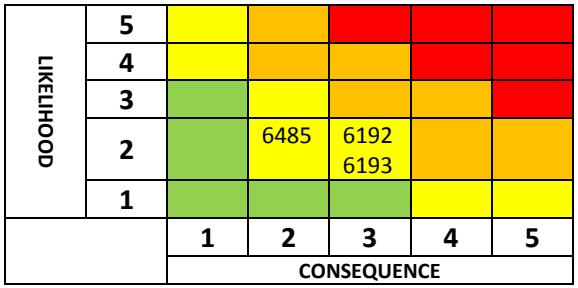
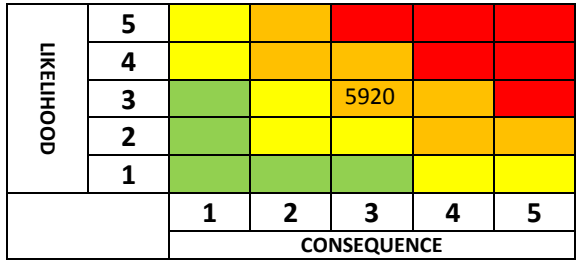
Strategic Objective 3	Put continuous improvement at the heart of what we do	
Risk Report  	 Opened: 25/01/2019 Target rating: 6 Target Date: 31/03/2021	**Risk ID 5989:** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical health of clients **Performance Metric:** No impact on service delivery **Performance Metric Status:** Unknown **BAF Owner: Executive Director of Nursing and Quality** Director's comment: The trust's response mirrors the guidance from Public Health England, NHSE/I and Department of Health and Social care. The trust is aligned to the national command and control structure for a level 4 Major Incident response. The Trust command and control arrangements were enhanced on 10/11/2020 to run as per the national requirement of 08:00 to 20:00 7 days per week. There is currently no approved antiviral mitigation for this emerging disease. A second and variant strain of COVID has been identified in Denmark. Notification was noted by the Trust 09/11/2020.
	 Opened: 20/05/2020 Target Rating: 4 Target Date: 30/09/2020	**Risk ID 6431:** IF the Trust does not establish Covid-19 secure workplaces THEN there is a risk that staff, patients and contractors will be at greater risk of transmission of Covid-19 RESULTING IN local outbreaks, operational impact, regulatory sanctions, financial and reputational damage, removal of Covid secure status assigned to workplaces **Performance Metric:** Covid-19 related staff absence to be less than peak rate of 1.29% inclusive of shielding; no team based outbreak incidents **Performance Metric Status: Met** **BAF Owner: Executive Director of Finance** Directors Comment: The work stream under recovery and transformation to establish Better Safer Buildings has allowed Trust buildings to be certified Covid-19 secure, under the government's guidance on certification. These

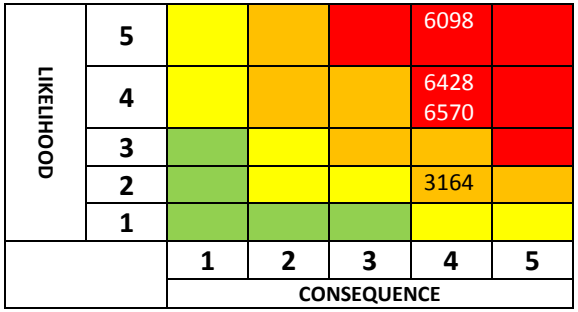
		arrangements are under constant review, and responsive to changes in policy or risk levels. Currently the measures taken appear effective. Another work stream is now focussed on embedding the new ways of working established during Covid-19 where they add value. There have been no Covid outbreaks declared in reporting period.
Linked Risks (Current Rating)**:**	**Assurances:** • **Risk ID 5989:** Physical Health Nurses in place, Access to Cloud now widely available to staff, Business Continuity Plans in place, EPRR Core Standards compliance • **Risk ID 6431:** Sickness Absence monitoring, Covid secure risk assessments completed, Rio, PHE and NHSE/I reporting of outbreaks. *(Text in italics denotes a 3rd line control)*	
Performance Report 	**Key Controls:** • **Risk ID 5989:** Remote working availability for some staff, Infection Prevention & Control Policy, Infection Control Lead, Business Continuity Plans, Physical Health Nurses in post • **Risk ID 6431:** Standard Operating Procedure Working Safely During COVID-19 Social Distancing; Site based action plans agreed between building occupants and estates, Home/Remote Working SOP; Shielding and Self Isolation arrangements; Outbreak Plan.	

Strategic Objective 4	**Develop and extend our research and innovation work**	
Risk Report  	 Opened: 10/08/2017 Target Rating: 1 Target Date: 31/03/2021	**Risk ID 5345:** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment, tendering and patient choice **Performance Metric:** Increase in research recruits; Increase in bid submissions; **Performance Metric Status: Met** **BAF Owner: Executive Medical Director** Directors Comment: We have developed a refreshed Research Strategy which is going to Board for Ratification in January 2021. We are also taking forward the role of the R&I Director and seeking a high calibre academic post holder via a national advert to help deliver this strategy. The advert is going out in Nov 2020. The Performance metric has been paused externally by Clinical Research Network. All other activity was affected by COVID, some of this has been restarted.
Linked Risks (Current Rating)**:** 3808: Recruitment (12 High)		**Assurances:** • **Risk ID 5345 –** National research governance arrangements; *Annual report to Board; Performance Metrics monitored by CRN, KSS and NIHR* *(Text in italics denotes a 3rd line control)*
Performance Report  		**Key Controls:** • **Risk ID 5345 –** Increasing principle investigators and R&D links across the organisation in line with the R&D Strategy; R&D SoP; Statistical analytical software available on the Cloud; Monitored by CEOG and Quality Committee; Annual report to the Board; Report ERN comprehensive research network.

Strategic Objective 5	Maximise the use of digital technology	
Risk Report  	 Opened: 19/09/2019 Target Rating: 2 Target Date: 31/03/2021	**Risk ID 6192**: IF sufficient capital funds are not released to implement the current IT strategy THEN it will not meet staff expectations around what technology can do for them, and will affect efficiency RESULTING IN longer waits for patients, poor morale, inability to meet specifications in our contracted services and planned contracted services **Performance Metric:** 90% of users to have technology that is less than 3 years old **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: The Trust Board approved the Clinical Technology Strategy and invested 5 year funding to deliver it. The business case for Clinical Technology Strategy project resources has been approved and capital allocated for 2020/21. The final business case for resource has been to the Finance and Performance Committee and was also approved. It is therefore recommended this risk can be closed.
	 Opened: 19/09/2019 Target Rating: 2 Target Date: 31/03/2021	**Risk ID 6193**: IF we are unable to establish a Mobile RiO solution and get approval and funding THEN staff would not realise the benefits to utilising mobile devices to access clinical records RESULTING IN the inability to improve services and realise improved productivity and improve patient experience. **Performance Metric:** Effective mobile RiO solution to be in place and used by mobile staff **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: The Trust Board approved the Clinical Technology Strategy and invested 5 year funding to deliver it. Capital funding has been allocated for Mobile RIO in 2020/21. Solution testing is underway in Crisis Resolution and Home Treatment teams. The Trust is currently drafting a specification and will be going out to procurement by the start of the financial year.

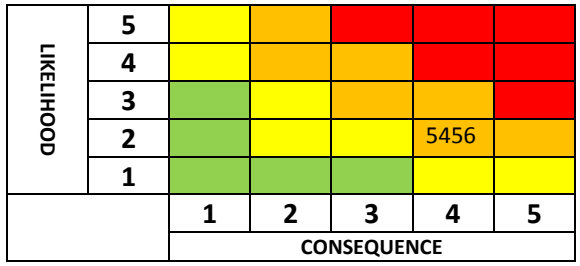
	 Opened: 23/07/2020 Target Rating: 1 Target Date: 31/03/2021	**Risk ID 6485**: IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy **Performance Metric:** Completed 'Project on a Page' reports for each project to communicate progress specifically with regards to communications and engagement with users and risks and issues. The Governance structures are ultimately responsible ensuring representation, resources and the success of the Clinical Technology Strategy **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: This risk is part of the rationale for changes to our digital governance structure (approved at EAC) and can be closed when the revised governance arrangements are seen to be working effectively. The first of the new governance meetings is planned for November.
Linked Risks (Current Rating)**:**	**Assurances:** • **Risk ID 6192** – Trust Board Minutes, BCRG minutes, Capital plan for IM&T • **Risk ID 6193** - Trust Board Minutes, Capital plan for IM&T., Project update sheets for mobile RIO Project. • **Risk ID 6485** – Governance meetings in operation with clear ToR and outcomes	
Performance Report 	**Key Controls:** • **Risk ID 6192** Oversight at digital delivery board, Reduced delivery strategy, Managing down staff expectations by having a process for all IT requests, IT amnesties to recover unused equipment • **Risk ID 6193** Progress monitored via digital delivery board, Engagement with vendors for hardware, software and mobile networks, Engagement work with clinical teams, Benchmarking with other NHS trusts, Evaluation of potential solutions and suitability • **Risk ID 6485** Trust board commitment and approval, Digital business partners allocated, reviewed at ICTSMT monthly	

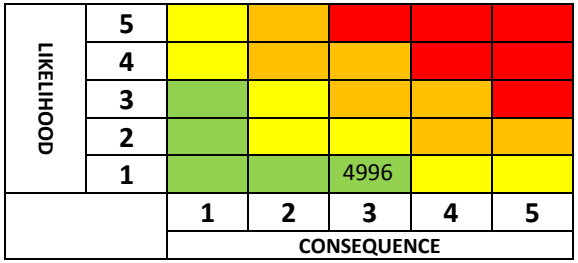
Strategic Objective 6	**Meet or exceed requirements set out in the Five Year Forward View**	
Risk Report  	 Opened: 11/12/2018 Target: 9 Target Date: 31/03/2021	**Risk ID 5920:** IF KMPT continues with under commissioned PICU bed numbers THEN this patient group will not receive the appropriate care within KMPT services and patients being placed in private &/or out of area beds RESULTING IN increased cost pressures, poor patient experience, patient flow issues where step down placements required, stress for families and carers having to visit relatives out of area, and a negative impact on KMPT reputation as a provider of choice. **Performance Metric:** Number of female PICU beds reduced to 6 or less in 2019/20 and cease from 2020/21 **Performance Metric Status: Not Met** **BAF Owner: Chief Operating Officer** Directors Comment: The female PICU contract has been in operation for four months with around 5 to 6 beds of the 5 block and 2 C&V beds used in month. There remains a small number of people in month (mostly men) requiring out of area PICU (non contracted). Male PICU OOA is unusual and likely related to the impact of the Covid pandemic as acuity levels have increased CQC highlighted some concerns about the current contracted provider for female PICU beds (Cygnet) re: Castle Ward. In response the Dep Dir of Nursing completed a site visit and provided a positive response. The COO has updated board with findings in the Nov board report Overall risk has reduced in response to mitigations in place operating to provide a Kent based service, with a monthly quality and performance contract meeting in place, good clinical relationships in place and reduction in out of area bed use
Linked Risks: 6268: Increase in Violence & Aggression incidents (patient to patient/patient to staff) due to temporary reduced seclusion/ECA capacity (16 Extreme)	**Assurances:** • **Risk ID 5920** – SDIP to be developed by December 2019	
Performance Report  	**Key Controls:** • **Risk ID 5920** – Budget monitoring; Patients presenting with high risk are placed on 1:1 obs; Blue light meetings; Regular interface with Finance; Proposed risk summit facilitation by the Medical Director	

Strategic Objective 7	Deliver financial balance and organisational sustainability	
Risk Report  	 Opened: 10/04/2019 Target Rating: 12 Target Date: 31/03/2021	**Risk ID 6098:** IF the Trust fails to reduce the underlying financial deficit THEN the Trust could fail to deliver the long term financial sustainability RESULTING IN the Trust being unable to develop a robust financial strategy during 2020/21 that will demonstrate how the Trust will return to break even or generate a surplus by March 2021 on a recurrent basis. The financial strategy will set out a three year financial plan. **Performance Metric:** New Performance Management Framework in place with monthly Quality Performance Reviews (QPRs) **Performance Metric Status: Unknown** **BAF Owner: Executive Director of Finance** Director's Comment: The Trust has received trajectories from NHS England and NHS Improvement outlining the expected improvement in financial performance over the next 5 years. A final Long Term Plan (LTP) for KMPT has been agreed and signed off by Trust Board in October 19. The Board are committed to delivering the LTP and the expected performance, if not better than plan. A draft plan submission for 2020/21 was submitted on 5th March. Due to covid-19 all NHS Trusts are operating under a different financial architecture. The current payment structure that allows all Trusts to breakeven each month will be in place all financial year. A phase 3 planning submission has been made to NHSE/I as part of the Kent and Medway system planning. Work continues internally to address the underlying deficit.
		**Risk ID 3164:** IF the capital programme is not delivered in full THEN the Estates Strategy agreed at Board may not be executed in the timescales set out RESULTING IN clinical and workplace environments which may not be full fit for purpose. **Performance Metric:** Delivery of completed schemes as per revised 2020-21

	Opened: 01/04/2020 Target Rating: 6 Target Date: 30/09/2020	capital programme **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: The Trust has agreed a capital programme for 2020-21 as part of the in-year planning process. This has been agreed with the Kent and Medway system. Funding for most of the identified estates programme is secured. Project management and design processes are in place. The capital resource for this financial year is being managed on a system basis. Any slippage that Trusts are forecasting will need to be signalled to the system and offered to the system.
	 Opened: 19/05/2020 Target Rating: 8 Target Date: 30/03/2021	**Risk ID 6428:** IF the Trust fails to deliver the annual cost improvement programme recurrently THEN the Trust could fail to deliver the Trust control total of a break even position in the current financial year. RESULTING IN an increased risk that the Trust misses its use of resources target. this will also have an impact on the Trust ability to deliver long term financial sustainability **Performance Metric: Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: This risk has been added to reflect the 2020/21 CIP. This risk will need to be managed in a different financial architecture due to the COVID-19 Pandemic. The Trust has set a Cost improvement programme (CIP) of £5.9m for the year. There is currently an unidentified value of £1.3m at the end of October. Work is ongoing in the Trust to close this gap and to plan for 21/22 efficiencies.
	NEW Opened: 17/11/2020 Target Rating : 12 Target Date: 31/03/2021	**Risk ID 6570:** IF the national team do not acknowledge the financial pressure for KMPT created as a result of the calculation for control totals THEN KMPT will need to rely on expenditure controls and contingency to deliver its breakeven position RESULTING IN a higher chance of not achieving breakeven this financial year and will have an impact on future financial years if the funding regime remains the same. **Performance Metric:** delivery of financial position in line with breakeven control total

		Performance Metric Status: Met **BAF Owner: Executive Director of Finance** **Directors Comment:** This is a new risk that covers the new finance regime and how the baseline has been set. The regime has based the expenditure plans for the last six months of this year on month's 8-10 actual expenditure during 2019/20. This has therefore led to a financial pressure for KMPT as the Trust moved their forecast favourably in month 10 last financial year, The risk is £5m per annum. This has been raised with NHSI/E and put forward to the national team, The Trust are awaiting advice as to whether this will be treated as an exceptional case and the baseline adjusted. Consideration needs to be made as to the impact this will have on the Trusts baseline for next year if the regime is kept the same and the baseline adjustment is not made
Linked Risks:	**Assurances:** • **Risk ID 6098 -** Audit; CCG monitoring; NHSI; EAC, FPC and Board review of performance; Quality Committee monthly review of key KPIs; Clinical audit implementation and review; QPR meetings with Care Groups • **Risk ID 3164 –** Board, FPC and Trust Capital Group oversight; Business Case Review Group • **Risk ID 6428 –** QPR meetings with care groups; Quality Committee monthly review of key QPIs	
Performance Report X	**Key Controls:** • **Risk ID 6098 –** Monthly Finance Report; New CIP Process; QPR meetings; Care Group Management meetings; Standing Financial Instructions; Internal Audit; Monthly statements to budget holders; Monthly feedback forms completed by manages and sent to Finance • **Risk ID 3164 –** Clear prioritised capital plan, reviewed regularly with services; Tight design and specification processes and capital programme management • **Risk ID 6428 -**Care Group Management Meetings; Finance and Performance Committee monitoring; Finance position and CIP update; Standing financial instructions; Internal audit; Agency recruitment restriction; Monthly statements to budget holders	

Strategic Objective 8	**Develop our core business and enter new markets through increased partnership working**	
Risk Report  	 Opened: 01/10/2017 Target Rating: 4 Target Date: 31/03/2021	**Risk ID 5456:** IF we do not achieve repatriation and Length of Stay targets THEN the forensic services may cost more to run than the budget devolved from NHSE to New Care Models RESULTING in a gap between cost of forensic services and available funds. **Performance Metric:** No unbudgeted expenditures **Performance Metric Status:** **Unknown** **BAF Owner: Executive Director of Finance** Directors Comment: KMPT continue to be actively engaged in the Provider Collaborative (formerly known as the New Care Model Programme). Negotiations for the 20/21 planning have concluded with NHSE and the Provider Collaborative. The Provider Collaborative was due to go-live on the 1st April; due to Covid-19 the go-live date has currently been delayed to 1st April 2021. The mid-year performance of the provider collaborative demonstrates savings have been delivered to support the investment in the community teams against the budget agreed with NHSE.
Linked Risks:		**Assurances:** • **Risk ID 5456:** Numerous quality audits are carried out within the service; Regular inspections by CQC take place; NHSE evaluation of performance; *Board oversight; Peer network and other 3rd party assurance* *(Text in italics denotes a 3rd line control)*
Performance Report  		**Key Controls:** • **Risk ID 5456:** Regular updates provided to the Trust Finance & Performance Committee; Clear governance process established for the NCM; The DoF is the Executive Lead and attends the NCM Board and sub group; The Trust is also part of the activity modelling group; Strategic partnership with Surrey/Sussex Partnership; Partnership working with 3rd party providers; On-going service evaluation & audits; Quality Assurance process

Strategic Objective 9	Ensure success of our system-wide sustainability plans through active participation, partnership and leadership	
Risk Report  	 Opened: 03/11/2016 Target Rating: 3 Target Date: 31/03/2021	**Risk ID 4996:** If KMPT is not actively involved in the Kent and Medway system transformation and development of the new Integrated Care System (ICS) and Integrated Care Partnerships (ICPs), then aspects of the NHS Long Term Plan may not be dealt with in sufficient depth leaving the trust at risk of decline in service quality, non-delivery of trust strategy, transformation priorities, and the mental health investment standard. **Performance Metric:** The Board has an agreed strategy delivery plan for 2020/21 with clear objectives focussing on using our expertise to lead and partner **Performance Metric Status:** Met **BAF Owner: Executive Director Partnerships and Strategy** Directors Comment: We have now transitioned to Kent & Medway Integrated Care System and partnership arrangements for Mental Health have been established at an ICS and ICP level with the new single CCG. Therefore it is recommended that this risk is closed. It is proposed that a new risk is opened to focus on the implementation of the Trust Strategy and 2020-2024 and meeting the objectives set in the annual strategy delivery plan.
Linked Risks	**Assurances:** • **Risk ID 4996:** KMPT taking a leading role in the ICS process; *Wilf Williams AO of the ICS chairs the system transformation Executive Board which maintains oversight and strategic leadership of all system level transformations;* *(Text in italics denotes a 3rd line control)*	
Performance Report  	**Key Controls:** • **Risk ID 4996:** ICS AO; KMPT CEO and deputy CEO members of the Mental Health Improvement Board at ICS level. Additional capacity is in place to ensure our engagement in ICPs and development of partnerships.	

Appendix 1 – Summary of key controls and evidence for mitigation

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
Strategic Objective 1: Consistently deliver an outstanding quality of care								
6573	Demand and Capacity for Adult and Older Adult CMHTs	Trust Board (3a)	None identified	None Identified	Team level demand and capacity information available, Trajectories for improvement set, Funding requirements known and built into contracting	None identified	Lack of triangulation of data (workforce, performance and quality) Gaps in staffing and inability to recruit into certain teams – primarily due to location No agreement at a system level (CCG) to progress changes needed to address memory assessment service challenges	
6052	Improving and sustaining quality and safety	Trust Board (3a)	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks	CCG Quality Visits to be re-established	Achievement of good/ outstanding regulatory standards	Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks	Clinical care pathways because they are still in implementation	Y

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
			CQC Well Led Inspection Report February 2019 CQC Engagement meeting feedback MHA Reviews QPR Performance and Quality Report			Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CCG Quality visits	phase Cliq Checks have yet to be extended to non CQC Core Services	
4083	Management of Environmental Ligatures	3e - Third party assurance (CQC / NHSI/E	Monitored by NHS England via STEIS [3b] CCG Quality Visit	anti lig fixture testing not done consistently during vacation cleans	Program for removing anchor points and restricting access to staff only areas	Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by the Prevention of Suicides and Homicides Group and Trust Wide Health Safety and Risk Group [2a]	Anchor points identified on Forensic wards Wards Some wards have yet to be fitted with the door top alarms	Y
6420	COVID-19 Personal Protective Equipment	Trust Board (3a)	Situation reporting locally and nationally Exception reporting	None Identified	Procurement Management Processes	Central procurement strategy Centralised stock and buffer store Internal and External Situation reporting Kent and Medway Incident control and mutual aid arrangements.	None Identified	
6274	Lack of access to specialist LD, AD and medium secure beds	Trust Board (3a)	None Identified	None Identified	Long Term Segregation and Therapeutic Observations	Reporting of all incidents Increased Staffing Levels	None identified	
Strategic Objective 2: Recruit retain and develop the best staff making KMPT a great place to work								
3808	Recruitment	3e - Third party assurance (CQC /	Establishment review Monitoring of recruitment and retention Monitored by CCG and CQC	None identified	System controls in place	Review of Roster Templates in line with agreed safe staffing levels. (1a) Medical Recruitment and Retention Group [2a]	Establishment review Recruitment and Retention	Y

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
		NHSI/E	Shift by Shift Analysis reported to WODC Incident rates and monitoring compliance with tool Report to WF&OD Committee			Recommend a Friend (1a) New Hire Bonus nurse and Consultant (1a) Consultant mentoring in place (1a) SafeCare Pilot [O]	Strategy	
3738	Staff engagement, acting on feedback and cultural change	Trust Board (3a)	Staff FFT surveys run quarterly [1c] Monthly service line performance monitoring [2b] Workforce Committee oversees reporting against various different HR policies and other methods of reporting [2b] Stress Management Tool used by Workforce Advisors as a team approach to Stress Management Green Button & FTSU activity reports to Workforce Committee and EMT [2b] Cultural audit tender specification	None identified	2e - Policies / Constitution / Strategy / Plan People Strategy	Quarterly Staff Friends & Family Test (FFT) Survey [1c] NHS Staff Survey [2e] Engagement with staff through Intranet, staff forum, local and KMPT wide leadership groups. [1h] Freedom to Speak Up and Safe Working Guardians, with Green Button option [1g] Health & Wellbeing Group [2a] Big Conversation [1b] EMT Working With Days [2a] Report to Trust Board - Staff Survey and appraisals [3a]	None identified	Y
5148	Retention of employees	3b - NHS England / PHE / DoH / Government property unit	Monitoring of retention External monitoring - various bodies (3e) NHSI Cohort 2 retention project [O]	No gaps in assurances	3b - NHSI Programme	Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants (1e) Supervision and Appraisals (1a) Health & Wellbeing Group [2a] Medical Recruitment and Retention workgroup - 8 point plan, including on-call rota (1a) Engagement activities (1b) EU exit implications reported and actions in place (1a)	National shortages in Consultants and Registered Nurses	Y

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
						NHSI retention programme cohort 2 [O]		
Strategic Objective 3: Put continuous improvement at the heart of what we do								
5989	Organisational Risk - Emerging Infectious Diseases	3b - NHS England / PHE / DoH / Government property unit	Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance Internal and external SITREPs Completed Business Continuity Plans Staffing fill rates	Limited number of Physical Health Nurses available in in-patient areas only	1g - Project/operation management	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g]	Quality of BCPs	N
6431	Covid-19 Secure Workplaces	3b NHS England / PHE / DoH / Government property unit	NHS England IIMARCH return completed if there is an outbreak PHE Reporting outbreaks template RIO reporting actual and suspected COVID cases Sickness Absence monitoring Covid secure risk assessments completed by building managers as part of the Safer working policy	None identified	HSE Regulatory Compliance	Standard Operating Procedure Working Safely During COVID-19 Social Distancing. Site based action plans agreed between building occupants and estates. Home/Remote Working SOP	Individual compliance with policy versus individual behaviour	
Strategic Objective 4: Develop and extend our research and innovation work								
5345	Participation in international research & development	None Identified	National clinical research governance arrangements	None Identified	CEOG report & QC oversight	Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b]	No clinical lead to oversee clinical risk or to drive research forward from a clinical	N

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
							perspective.	
Strategic Objective 5: Maximise the use of digital technology								
6192	Clinical Technology Strategy Funding	3a – Trust Board	Trust Board Minutes, BCRG minutes, Capital plan for IM&T	None Identified	3a - Trust Board Escalation to Board level	Oversight at digital delivery board Reduced delivery strategy Managing down staff expectations by having a process for all IT requests IT amnesties to recover unused equipment	None identified	N
6193	Mobile RiO Approval & Funding	3a – Trust Board	Trust Board Minutes, Capital Plan for IM&T, Project update sheets for Mobile RIO project.	None Identified	3a - Trust Board Awaiting Board Approval	Progress monitored via digital delivery board Engagement with vendors for hardware, software and mobile networks Engagement work with clinical teams Benchmarking with other NHS trusts Evaluation of potential solutions and suitability	Disarticulation of strategic planning Lack of coherent strategic direction in requirements No established timeline as it is too early in the process	N
6485	Clinical Engagement for the Strategy	None identified	None identified	None identified	ICT SMT	None identified	None identified	
Strategic Objective 6: Meet or exceed requirements set out in the Five Year Forward View								
5920	Financial risk to KMPT due to out-of-area PICU bed use.	Trust Board (3a)	Tender complete Medical Director holds clinical teams to account for robust review of OOA PICU patients	None	Budget monitoring	-Regular interface with finance regarding budgets - Tendering process underway for direct provision for KMPT female PICU placement (7 Beds as close to	Community engagement work is ongoing and not complete	Y

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
						Kent as possible.)		
Strategic Objective 7: Deliver financial balance and organisational sustainability								
6098	Long term financial sustainability	Trust Board (3a)	EAC, FPC and Board review of performance [2b/3a]	None Identified	Long term financial sustainability	Monthly Finance Report [1h] New CIP process (2a) QPR Meetings [2a] Care Group management Meetings [2a] Standing Financial Instructions [2e] Internal Audit [3d] Monthly statements to budget holders [1a] Monthly feedback forms completed by managers and sent to Finance [1b]	Appropriate budgeting Reviewing services that cost more than income Drive efficiency programme utilising Care Group reporting	Y
3164	Capital Projects - Availability of Capital	Trust Board (3a)	Business Case Review Group Board, FPC and Trust Capital Group oversight [3a/2b]	None identified	1g - Project/operation management	Clear prioritised capital plan, reviewed regularly with services. [2e] Tight design and specification processes and capital programme management. [1g/2a] Newly formed Estates Operational Group adjunct to the Estates Strategy and Capital Planning Group [2a]	None identified	N
6428	2020/21 CIP Programme	Trust Board (3a)	EAC, FPC and Board Review of performance [2b/3a]	None Identified	CIP Programme	CIP Process [2a] Finance Position and CIP update [1h] PMO oversight and COP Track in place [O] Regular CQUIN tracking to ensure	Appropriate budgeting Reviewing services that cost more than	Y

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
						full delivery [1c] Monthly statements to budget holders [1a]	income Drive efficiency programme utilising care group reporting	
6570	New Finance Regime 2020/21	3a - Trust Board	None identified	None identified	Escalation from the executive team to NHSE/I	None identified	Adjustment to baseline requested from NHSE/I due to a repositioning of forecast expenditure in month 10 of the last financial year. This will impact the baseline next year if the regime is kept the same.	
Strategic Objective 8: Develop our core business and enter new markets through increased partnership working								
5456	New Care Models - Secure Services	3e - Third party assurance (CQC / NHSI/E	Numerous quality audits are carried out within the service Regular inspections by CQC take place NHSE evaluation of performance	No gaps identified	2b - Committee of the Board Trust is a member of the NCM Board	Clear governance process established for the NCM [1f] The DoF is the Executive Lead and attends the NCM Board and sub group [2f] The Trust are also part of the activity modelling group [2f] Financial governance (1g) Quality assurance processes (1f)	No gaps in quality controls identified No gaps in financial controls identified	N

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
						Strategic Partnership with Surrey/Sussex Partnership (2f) Partnership working with 3rd party providers (2f) On-going service evaluation & audits (2d) Board oversight (3a) Peer network and other 3rd party assurance (3e)		
Strategic Objective 9: Ensure success of our system-wide sustainability plans through active participation, partnership and leadership								
4996	Kent and Medway System Transformation	3b NHS England / PHE / DoH / Government property unit	KMPT taking a leading role in the ICS process; Wilf Williams AO of the ICS chairs the system transformation Executive Board which maintains oversight and strategic leadership of all system level transformations;	None identified	Check and Challenge Process	ICS AO; KMPT CEO and deputy CEO members of the Mental Health Improvement Board at ICS level. Additional capacity is in place to ensure our engagement in ICPs and development of partnerships.	None identified	N

Appendix 2 – Table of target risk values

Inherent (starting) score	Target (without performance measure)	Target (with performance measure)
25	16	12
20	12	9
16	9	6
15	8	6
12	6	4
10	4	3
9	4	2
8	3	2
6	2	1
5	3	2
4	1	N/A
3	1	N/A
2	1	N/A
1	N/A	N/A

The above table shows the Target Ratings as calculated using the Control Calibration Tool.