AGENDA

Title of Meeting	Trust Board Meeting (Public)
Date	28th July 2022
Time	9.30 to 12.00
Venue	Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/22-23/36	1.	Welcome, Introductions & Apologies		Verbal	Chair	9.30
TB/22-23/37	2.	Declaration of Interests		Verbal	Chair	
		BOARD REFLECTION ITEMS				
TB/22-23/38	3.	Personal Story – Dementia Services		Verbal	AQ	9.35
TB/22-23/39	4.	Quality Improvement – Medway CMHSOP		Verbal	AQ	9.45
		STANDING ITEMS				
TB/22-23/40	5.	Minutes of the previous meeting	FA	Paper	Chair	9.55
TB/22-23/41	6.	Action Log & Matters Arising	FN	Paper	Chair	10.00
TB/22-23/42	7.	Chair's Report	FN	Paper	JC	10.05
TB/22-23/43	8.	Chief Executive's Report	FN	Paper	HG	10.10
TB/22-23/44	9.	Board Assurance Framework	FA	Paper	AC	10.20
		STRATEGY, DEVELOPMENT AND PARTNERSHIP				
TB/22-23/45	10.	ICB Mental Health Update	FD	Paper	HG	10.30
TB/22-23/46	11.	Operational Cavell Annual Progress Report	FD	Paper	VB2	10.40
		OPERATIONAL ASSURANCE				
TB/22-23/47	12.	Integrated Quality and Performance Report – Month 3	FD	Paper	HG	10.50
TB/22-23/48	13.	Finance Report: Month 3	FD	Paper	SS	11.00
TB/22-23/49	14.	HR Deep dive: Equality, Diversity and Inclusion	FD	Verbal	SG	11.10
TB/22-23/50	15.	Delayed Transfers of Care IQPR Deep Dive	FD	Paper	DHS	11.20
TB/22-23/51	16.	Safer Staffing Action Plan	FD	Paper	AC	11.30
TB/22-23/52	17.	Self-Certification Declaration for NHSI	FD	Paper	TS	11.40
		CONSENT ITEMS				
TB/22-23/53	18.	Quality Committee Chair Report (incl Mortality Report Q1)	FN	Paper	CW	11.50
TB/22-23/54	19.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/22-23/55	20.	Mental Health Act Committee Chair Report	FN	Paper	KL	
TB/22-23/56	21.	Finance and Performance Committee Chair Report	FN	Paper	MW	
		CLOSING ITEMS				
TB/22-23/57	22.	Any Other Business			Chair	11.55
TB/22-23/58	23.	Questions from Public			Chair	
	Date of Next Meeting: 29th September 2022					

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

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Board Meeting held at 09.30 to 12.15hrs on Thursday 26 May 2022
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Martin Carpenter	MC	NExT Director Scheme
	Helen Greatorex	HG	Chief Executive
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Andy Cruickshank	AC	Chief Nurse
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Sandra Goatley	SG	Director of Workforce and Organisational Development
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Sheila Wilkinson	SW	Trust Secretariat Locum (minute taker)
	Kindra Hyttner	KH	Director of Communications
	Dan Lagadu	DL	Head of Quality Improvement
	Geoffrey Lawrence	GL	Financial Planning Manager (item TB/22-23/3)
	Alice Sigfrid	AS	Senior Nurse (item TB/22-23/3)
	Jacquelyn Dee'ath	JD	Promoting Safer Services Training Manager (item TB/22-23/4)
	Portia Aveling	PA	Head of Nursing – OACG (item TB/22-23/4)
Apologies:			
	Fiona Carragher	FC	Non-Executive Director
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
Observers:			

Item	Subject	Action
TB/22-23/01	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, noting the apologies of FC, TS and HP.	
TB/22-23/02	**Declarations of Interest** There were no declarations of interest.	
TB/22-23/03	**Personal Story: Recovery and Resettlement Team**	

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Item	Subject	Action
	The Board was joined by Geoffrey Lawrence, Financial Planning Manager and Alice Sigfrid, Senior Nurse RRT. GL and AS described the journey of the RRT over the last couple of years. They outlined how it had started as a diligence exercise looking at out of area specialist placements. They had overcome many challenges to arrive at one version of the truth and a single database was created. By scrutinising and monitoring placement the case load had been halved and £2.4m of expenditure had been saved. The Board commended the team on their excellent work and commented on how powerful the RRT story was in demonstrating the benefits of system-based solutions. The Board discussed the ongoing scrutiny and were informed that it was planned to propose to the Collaborative Board that KMPT become the Lead Provider and retain full control of the funds. The Board **noted** the Recovery and Resettlement Team story.	
TB/22-23/04	**Quality Improvement Story – Safety Pod Project** The Board was joined by Jackie Dee'ath, Promoting Safer Services Training Manager and Portia Aveling, Head of Nursing – Older Adults Care Group. JD and PA described how the Safety Pod Project had begun in the Mother and Baby Unit. The applicability of the pods in other environments was quickly recognised and the roll out of safety pods across the Trust commenced. The initial motivation was to reduce restraints and violence and aggression on wards however the therapeutic use of the pods has been significant. Feedback from service users, staff and families has been extremely positive. Benefits had exceeded expectations in areas such as sleep support, pain relief and self-care. The challenges of Covid have been overcome by staff enthusiasm and willingness to use the pods and they are now on all inpatient units. Board members commented on how good it was to hear such an uplifting story. The links to other QI projects were noted and the partnership aspect of using pods in third sector situations. JA and PA were thanked for their presentation and encouraged to write up and publish their work nationally. The Board **noted** the Quality Improvement story.	
TB/22-23/05	**Minutes of the previous meeting – 31/03/2022** The Board **approved** the previous minutes subject to wording amendments provide by AQ as below: • TB/21-22/121 – capitalisation of "Good" and "Requires Improvement" • TB/21-22/122 – amend wording from "There may be an issue regarding junior doctors due to a number going on maternity leave whilst with the Trust. A number of junior doctors also leave the Trust quite quickly" to	

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Item	Subject	Action
	"The large number of trainee doctors on Maternity leave and impact of this on service delivery was noted" • TB/21-22/122 – amend wording from "The Trust will also investigate any underlying reasons for why junior doctors are leaving the Trust. To date, junior doctor feedback to the General Medical Council has been predominantly positive." to "To date, junior doctor feedback around training at KMPT to the General Medical Council has been predominantly positive." • TB/21-22/124 – amend wording from "with there now being ten dementia coordinators." to "including appointment of 42 dementia coordinators, to help people with dementia and their carers to access services and support in a timely manner."	
TB/22-23/06	**Action Log & Matters Arising** The Board received the Action Log. In relation to action TB/21-22/74, the Board was asked for their views on the best way to ensure they were fully sighted on the work of the Collaborative. It was suggested that a separate Board item on Provider Collaboratives generally with an emphasis on local work may be a way forward. JC would follow up with colleagues after this meeting. The Board **approved** the Action Log.	
TB/22-23/07	**Chair's Report** The Board received and **noted** the Chair's Report. The Board **approved** the change of name of the Executive Assurance Group to the Transformation Board to reflect the merger of the two groups. The Board **approved** the additional wording requested by the Trust Secretary in the Policy on Policies.	
TB/22-23/08	**Chief Executive's Report** The Chief Executive's Report was received by the Board. The Chief Executive highlighted: • The inaugural meeting of the Provider Collaborative which had been positive and well attended by high level organisational representatives. Referring to the earlier item on the RRT, the Provider Collaborative would provide a vehicle for whole system solutions. • The financial deficit was the biggest challenge for the Trust and the different perspective provided by new colleagues was welcome. The Board discussed the issue of providing care for individuals who were not entirely appropriate for KMPT but for whom there was no alternative provision. This was an example of a system and regional problem which was being tracked at regional level to create the right environments. Senior posts had been created in the system to drive this work forward but it was acknowledged there was no quick solution. Learning from recent experience, the Trust position was that the	

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Item	Subject	Action
	Board supported its clinical leaders in making difficult clinical decisions in difficult circumstances. The issue of evaluation of hybrid working and sustainability more generally was raised. Metrics were being developed and there would be follow up reports for the Board. **Action:** TS to agree with JC and HG an appropriate time and occasion for Board follow up on sustainability. The Board **noted** the Chief Executive's report.	**TS/JC & HG**

TB/22-23/09	**Board Assurance Framework**
	
	The Board received the Board Assurance Framework (BAF). Since the last iteration:
	• No new risks have been added to the BAF since March
	• No risks have changed their risk score since March
	• 4 risks are recommended for removal
	  ○ Risk ID 6420 – COVID 19 Personal Protective Equipment (Rating of 4 (Moderate))
	  ○ Risk ID 5989 - Emerging Infectious Diseases (including response to covid-19 and subsequent variants) (Rating of 8 (High))
	  ○ Risk ID 6623 - Easing of Lockdown National Roadmap - Hybrid working (Rating of 8 (High))
	  ○ Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services (Rating of 4 (Moderate))
	
	PC highlighted 3 issues discussed at Audit and Risk Committee (ARC)
	• Potential need for process improvement to avoid differences of opinion on removal or reinstatement of risks
	• Focus on red HR risks
	• Concern over whether the emerging risk at Colman House in Dover was an isolated case or indicative of others
	
	Assurance was offered over Colman House. Longer term strategic decisions were required which would be brought back to ARC for consideration.
	
	DToC issues were raised as a risk for the Board to be sighted on. **Action**: DH-S agreed to provide an IQPR deep dive on the topic for the July Board.
	
	DH-S gave an overview update for the Board confirming that a system wide approach to DToC was being worked on in partnership with Social Services. A Social Worker had been seconded to the Trust looking at joint working solutions involving changes to the social care system and focus on prevention of placement breakdowns.
	
	The Board **approved** the Board Assurance Framework.
		DH-S

TB/22-23/10	**Low and Medium Secure Provider Collaborative – Year End performance summary 2021-22**	

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Item	Subject	Action
	The Board received the Low and Medium Secure Provider Collaborative – Year End performance summary 2021-22. It had been a successful year for the Collaborative in both performance and financial terms. The service was moving forward in the right direction and further work was underway on flows into the community and women's pathway. The Board reflected on how this work triangulated with other issues such as patient acuity and HR issues. The Board **noted** the Low and Medium Secure Provider Collaborative – Year End performance summary 2021-22.	
TB/22-23/11	**Strategic Delivery Plan Priorities 2021/22 Review** The Board received the Strategic Delivery Plan Priorities 2021/22 Review noting that the tabular format was useful and commending the openness of the report where targets had not been achieved. VB2 reminded the members that Board Committees had been looking at the detail throughout the year. The key components of the Trust Strategy last year had been Quality, Integration, Leading and Partnership and Capabilities to Deliver Quality Improvement. All of these areas had been built on during the year despite the impact of the Pandemic. There was more work to be done and teams were aware of the focus on Estates and Finance. The Board noted that the current long-term strategy ended in 2023 and consultations would begin shortly on its replacement. Discussion followed covering whether some targets were too ambitious, estates focus and hybrid working, the need for a K&M wide strategy, new ways of working and governance route for introduction and removal of roles and clarity in reporting of when priorities were within KMPT control and where there were interdependencies. The new Priorities for this year had been communicated to the organisation and the executive team were asked for a table for the 3 priorities for this year. **Action**; VB2 and HG to provide tabular format for 2022-23 Strategic priorities delivery In summary, significant progress had been made in some areas while others felt too slow to gain traction. A rigorous approach needed to be taken to ensure delivery of prioritised actions and removal of less impactful initiatives. The Board **noted** the Strategy Delivery Plan Priorities 2021-22 Review.	**VB2/HG**
TB/22-23/12	**Research Strategy** The Board received the Research Strategy. AQ introduced the Strategy saying that it was in line with Trust Strategy and that research benefits in terms of quality and staffing were well documented. The	

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Item	Subject	Action
	new Director of Research had set the ambition to become a Teaching Trust and this was a direction supported by the Executive Team and QC. A full Business Case would follow later but the agreement was that there would be a breakeven position by 2025. Discussion centred on the need for investment until 2025 and Board appetite for pump priming money in the current year in light of the need to reduce the underlying deficit. The Board noted that the return on investment from research projects was proven however there was a need for robust monitoring of the financial impact and clarity about what could not be afforded because of the investment in research. The FBC should include a table of ambitions which would then be monitored by QC and FPC in parallel. The Board requested that the Full Business Case including income targets be available for all members in the Reading Room. Further discussion covered QC's robust conversation on the Strategy which had covered the financial implications and the benefits of highlighting research in recruitment and branding. The Board **approved** the Research Strategy subject to editing of wording to better reflect the strength and positivity of the ambition.	
TB/22-23/13	**Integrated Quality and Performance Report (IQPR) – Month 01** The Board received the IQPR for month 01. The Chair noted that discussion on key areas such as DTOC had taken place elsewhere on the agenda and asked if there were other matters members wished to raise. Matters raised were: • The potential need to recalibrate some of the targets which were consistently underachieved. Further discussion on the subject would take place outside of this meeting. • Limited assurance on Crisis Performance and potential data issues • Data cleansing exercise on Waiting Lists to establish where to concentrate and weighting issues according to patient safety. **Action**; results of Waiting times work to be brought back to Board in September The **Board** noted the IQPR.	**DH-S/AC**
TB/22-23/14	**Finance Report: Month 01** The Board received the Finance Report (Month 01), with the following matters highlighted: • **Income and Expenditure:** Within the breakeven position reported, there are several key factors. There is continued use of temporary staffing due to vacancies and staff absence, but the spend on agency in April was lower than that seen in 2021/22 - £533k in April 2022 compared to £699k in April 2021, a 24% reduction.	

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NHS
Kent and Medway
NHS and Social Care Partnership Trust

Item	Subject	Action
	• **Capital Programme:** In April, the Trust spent £0.6m against the plan of £0.5m. The overspend in month was largely as a result of schemes brought forward from 2021/22 proceeding quicker than anticipated and progress being made on the Improving Mental Health Services Programme. • **Cash:** The cash position has increased by £2.1m to £22.2m in comparison to March and is £1.8m higher than plan This is mainly due to funds received for prior year invoices. The high-level cash plan for March 2023 has been reported at £10.6m. • **Cost improvement programme:** The Long Term Sustainability Programme (CIPs) for 22/23 has commenced and plans already identified need to start delivering as expected. Where progress is interrupted alternative initiatives need to be identified to mitigate any gaps in delivery. Further work is being undertaken to identify CIP schemes for the unidentified CIP balance - this work is imperative to support the eradication of the underlying deficit by March 2023. A further planning submission was required by the 20th June 2022 and national agency targets and caps were expected to be imposed. The Board was pleased to note that the finance report included a one-page briefing on the Trust's work to deal with the financial deficit. The Board **noted** the finance report for month 01.	
TB/22-23/15	**Workforce Deep Dive – Equality, Diversity and Inclusion** The Board received the Workforce Deep Dive into Equality, Diversity and Inclusion. The Board was informed that the paper gave an overview of WRES 2021-22 results at a local level and comparisons with Trust nationally. The breakdown of data to a comparator group would become available at a later stage. The following points were highlighted: • KMPT representation of black, Asian and minority ethnic staff continues to above that of the South East and nationally, this is also demonstrated within the make-up of our Board. • National data shows that white staff continue to be shortlisted for interview over black, Asian and minority ethnic staff – we have improved our overall position year on year, to above the national average • There have been some significant improvements in the areas of bullying and harassment faced by black, Asian and minority ethnic staff taken from scores within the most recent NHS staff survey. • The key concern for our most recent data is that there is an increase in the likelihood of black, Asian and minority ethnic staff being taken through a formal disciplinary process. We are one of the ten poorest performing Trust's in the country. • We need to continue to develop career pathways and the talent pool to ensure black, Asian and minority ethnic staff have opportunities for progression from band 3 and band 7.	

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Item	Subject	Action
	Board discussion covered concern over numbers of BME employees in the disciplinary process, good progress on reducing bullying and harassment and higher engagement score for BME than white staff. A request was made for further Board training in this area and it was suggested that there should be time allocated to focus on this topic at the Board Development session at the end of June. The WFODC was asked to consider what should be monitored to create an EDI Dashboard. The Board **noted** the Workforce Deep Dive into Equality, Diversity and Inclusion.	
TB/22-23/16	**Staff Survey** The Board received and **noted** the Staff Survey. The Board noted the success achieved in response rates this year. The response was the best KMPT had achieved and out of 50 comparable Trusts the highest was 67.9% KMPT's was 67.8%. The Board expressed it thanks to all staff who had taken the time to respond to the survey.	
TB/22-23/17	**Safer Staffing Report** The Board received the Safer Staffing Report and expressed their thanks to Tumi Banda for the helpful and interesting paper. The following matters were highlighted; • The review had used the Mental Health Optimal Staffing Tool (MHOST) which is designed to reflect staff available and acuity of patients. • There was adequate staffing for the acuity on the wards during review period • The staffing levels have been adversely affected by increased number of delays of transfers of care • The services are accepting patients outside the care pathways which is contributing to high usage of observations and posing challenges meeting the needs of those patients not on the appropriate pathway • The PICU data from this review has been advisedly affected by the need to respond to a county wide challenge and it is not reflective of the care pathway • The care groups since the last establishment review report to board in 2021 have worked on various initiatives that have seen reduction in acuity across all the care groups. • The Care Groups have submitted plans to meet the financial efficiencies for the year 2022/23 Discussion focussed on areas where staffing levels appeared to be above requirements, the need to understand the reasons behind the apparent anomalies and what opportunities might be available as a consequence. Transformation in its wider sense involving leadership and management of nurses relating outcomes and KPIs to people, processes and technology.	

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Item	Subject	Action
	Action: The Board requested a high-level plan of action with timescales be shared in July. The Board **noted** the Safer Staffing Report.	**AC**
TB/22-23/18	**Quality Committee Chair Report** The Board **received** and **noted** the Quality Committee Chair Report. The Board **noted** the Mortality Report.	
TB/22-23/19	**Workforce and Organisational Development Committee Chair Report** The Board **received** and **noted** the Workforce and Organisational Development Committee Chair Report.	
TB/22-23/20	**Audit and Risk Committee Chair Report** The Board **received** and **noted** the Audit and Risk Committee Chair Report	
TB/22-23/21	**Finance and Performance Committee Chair Report** The Board **received** and **noted** the Finance and Performance Committee Chair Report.	
TB/22-23/22	**Mental Health Act Committee Chair Report** The Board **received** and **noted** the Mental Health Act Committee Chair Report.	
TB/22-23/23	**Any Other Business** There were no matters of any other business.	
TB/22-23/24	**Questions from Public** There were no questions received from the Public.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 28th July 2022	

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

Date …………………………………………………………..

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Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Extraordinary Board Meeting held at 08.30 to 08.50hrs on Wednesday 15th June 2022
Via Videoconferencing

Members:			
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Martin Carpenter	MC	NExT Director Scheme
	Helen Greatorex	HG	Chief Executive
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Andy Cruickshank	AC	Chief Nurse
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Sandra Goatley	SG	Director of Workforce and Organisational Development
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
Apologies:			
	Dr Jackie Craissati	JC	Trust Chair
	Fiona Carragher	FC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
Observers:			

Item	Subject	Action
TB/22-23/25	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, noting the apologies as above.	
TB/22-23/26	**Declarations of Interest** CW declared that she has become Chair of the Members' Panel of National Employment Savings Trust (NEST). Some of the Trust's employees might be part of that pension scheme.	
TB/22-23/27	**Annual Report** The Board received the Annual Report for approval. The Board complimented the various teams that had worked on the report, and in particular Kindra Hyttner, Director of Communications and Engagement, for making the report an enjoyable read.	

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Item	Subject	Action
	The Board noted that there had been an administrative error, which had caused different payment rates to be applied to the Non-Executive Directors. CW had discussed with TS the issue and felt assured that the issue had been discovered and the Trust was dealing with it. The Board considered that the check-and-balance system in place had worked well. The Board **approved** the Annual Report.	
TB/22-23/28	**Annual Accounts** The Board received the Annual Accounts. The Trust delivered a breakeven position however, the Trust has had to o make a prior-period of adjustment. This relates to a 25-year agreement, of which KMPT is now in year 23. The agreement had been treated as a PFI, but it should have been treated as a financial lease. That adjustment has led to the Trust reporting a £4.6m deficit position in the financial year. The Board were informed that the Trust has still managed to deliver its three-year breakeven performance including this adjustment. As the agreement will be ending in 2025, the Trust will be working on a range of options for the Board to consider. The Board will be updated in due course. The Board **approved** the Annual Accounts.	
TB/22-23/29	**External Audit Report** The Board **noted** the External Audit Report.	
TB/22-23/30	**Letter of Representation** The Board **approved** the Letter of Representation.	
TB/22-23/31	**Audit and Risk Committee Chair's Report** The Board received and **noted** the Audit and Risk Committee Chair's Report.	
TB/22-23/32	**Any Other Business** There were no matters of any other business.	
TB/22-23/33	**Questions from Public** There were no questions received from the Public.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 28th July 2022	

Kent and Medway
NHS and Social Care Partnership Trust

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

Date …………………………………………………………..

NHS Kent and Medway NHS and Social Care Partnership Trust

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 26/05/22

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JULY 2022								
25.11.2021	TB/21-22/75	Strategic Delivery Plan Priorities Update	HG to give a year-end progress report on Operation Cavell in May 2022.	HG	May 2022	July 2022	This is on the agenda for discussion.	Closed
31.03.2022	TB/21-22/133	Workforce and Organisational Development Committee Chair Report	By July 2022, TS to support the Trust Chair in advising NEDs about the different assurance levels contained within the Committee Chair Reports.	TS	July 2022		Guidance on assurance levels sent to NEDs.	Complete
26.05.2022	TB/22-23/08	Chief Executive's Report	TS to agree with JC and HG an appropriate time and occasion for Board follow up on Sustainability.	TS/JC/HG	July 2022		Item to come back in January 2023	Complete
26.05.2022	TB/22-23/09	Board Assurance Framework	DH-S agreed to provide an IQPR deep dive on the DTOC topic for the July Board.	DH-S	July 2022		This is on the agenda for discussion.	Closed
26.05.2022	TB/22-23/11	Strategic Delivery Plan Priorities 2021/22 Review	VB2 and HG to provide tabular format for 2022-23 Strategic Priorities delivery	VB2	July 2022		Verbal update to be provided at the Board meeting	In progress
26.05.2022	TB/22-23/17	Safer Staffing Report	The Board requested a high level plan of action in response to the finding of the Establishment Review with timescales be shared in July.	AC	July 2022		This is on the agenda for discussion.	Closed
ACTIONS NOT DUE OR IN PROGRESS								
26.05.2022	TB/22-23/13	IQPR	Results of Waiting times work to be brought back to Board in September	DH-S/AC	September 2022			

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 26/05/22

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
26.05.2022	TB/22-23/15	Workforce Deep Dive into Equality, Diversity and Inclusion	The WFODC was asked to consider what should be monitored to create an EDI Dashboard.	SG	September 2022			
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.11.2021	TB/21-22/74	Mental Health, Learning Disability and Autism (MHLDA) Improvement Board Update	In May 2022, HG to produce a year-end MHLDA Improvement Board report detailing what the position was last year, what the position is now, what are the future trajectories and how is learning shared.	HG	May 2022		This action has now been superseded by events, with the MHLDA Improvement Board moving to the next stage in its development. It will work as a provider collaborative, and the improvement board will become more strategic in its remit, providing vision as well as assurance to the system. KMPT Trust Board last received an update on the MHLDA Improvement Board's work in March 2022.	Complete
25.11.2021	TB/21-22/76	Kent, Surrey and Sussex Provider Collaborative Update	SS to provide further update on the Kent, Surrey and Sussex Provider Collaborative by May 2022.	SS	May 2022		This is on the agenda for discussion.	Complete

Action Log v2

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 28th July 2022**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

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

- Kent & Medway system
- KCHFT & KMPT Board to Board Meeting
- Board Seminar Day
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

This month marks the formal start of the Integrated Care Systems (ICS), and in Kent & Medway, this entails building on the considerable activity that has been undertaken by all providers in the county over the past two years. KMPT holds a number of roles within the system: I am now Chair of the Dartford, Gravesham & Swanley Health & Care Partnership board which meets bimonthly, and as chair, I am also a member of the Integrated Care Partnership, responsible for setting the strategy that is then delivered by the Integrated Care Board. Inaugural meetings have taken place and are scheduled for the rest of the year.

3. KCHFT & KMPT Board to Board Meeting

On 21st June, KMPT and Kent Community Health Foundation Trust (KCHFT) held a Board-to-Board meeting.

It was another great opportunity for the two Boards to reflect on the joint working that has continued to take place since agreeing our Memorandum of Understanding in 2020. It was pleasing to note the progress on three workstreams: annual health checks for people with a learning disability; assessment and post diagnostic support for adults with autism and/or ADHD; and crisis care of people with dementia.

Further collaborative work is occurring in the areas of stroke services, inpatient physical health, and the estates function.

The two Boards have a shared ambition to work closer together for the benefit of patients in Kent and Medway. The Chief Executives of KMPT and KCHFT will meet with their respective teams to reflect on the Board-to-Board.

The two trust boards will meet again for further joint working at Board level.

4. Board Development Day

On 30th June, the Board met for its Development Day.

In the morning, the Board was joined by an external speaker as part of the Trust's drive to become an anti-racist organisation. The presentation stimulated Board's discussion on how to create an inclusive and anti-racist culture and will continue to be a focus of the Board development over the next few months.

The rest of the development day was externally facilitated and focussed on honing our performance as a unitary board.

5. Approval of business cases

In accordance with the Trust's Standing Orders and Standing Financial Instructions, the Board has approved three business cases since its last Board meeting. Those business cases were considered and approved by the Trust's Finance and Performance Committee before submission to the Board.

6. Trust Chair and NED visits

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

Where	Who
June 2022	
Thanet community mental health team	Jackie Craissati
Thanet Early Intervention in Psychosis (EIP) team	Jackie Craissati
Wingman Bus and Talking Wellbeing service	Jackie Craissati
Folkestone CMHT & CMHSOP	Peter Conway
Innovation Panel	Catherine Walker
July 2022	
Gregory House community older adults service	Jackie Craissati
New staff room at Little Brook Hospital	Jackie Craissati

Chair Visits

I spend an excellent morning with two Thanet community teams. The CMHT impressed me with their efficient management of the caseload, and I was interested to explore their new approach to team – rather than individual – caseloads. Morale seemed to be good, and they anticipate that the new structure may relieve some of the pressure of the work from individual staff. As always with EIP, their knowledge of and commitment to their service users is impressive, and we spend time reflecting on their learning from past incidents, and some occasional obstacles to their liaison with the wards. The following month, at Gregory House, I was able to have a detailed discussion about developments in the approach to memory assessment; hearing about service user needs and the challenge to service delivery from staff on the ground really helped me to understand the reality behind the performance figures that we worry about at the Board.

There are some shared issues which the visits raised, and which I have asked the Chief Executive to address. These include ongoing inefficiencies in the way we use our electronic clinical record system, thereby taking staff time away from clinical care, and opportunities for greater partnership working that haven't been fully realised.

My visit to the Wingman bus and Talking Wellbeing service was delightful and the service is being presented to the Board after our board meeting this month. This is an initiative for

NHS staff across all Kent and Medway Trusts, hosted by KMPT, and supported by Project Wingman who provide the adapted double decker bus. The service is being used well by staff and is a particularly important initiative given the impact of the pandemic and subsequently the cost of living pressures on staff.

Peter Conway – Folkestone Community Mental Health Team (CMHT) & Community Mental Health Service for Older People (CMSHOP)

1.CMHT

Excellent visit. Positive in many areas - staff, feedback, atmosphere and premises. Top risks include demand, staffing levels, a leaking roof and Coleman House in Dover (risk transferred to Estates). Spent some time discussing (1) digital enablement (and how RiO is more of a hindrance than an enabler); and (2) recruitment (and the merits/challenges of working in a CMHT vs CMHSOP)

2.CMHSOP

Co-located on a site considered expensive and in the wrong place. Most staff were out or working from home and so lots of unused space and empty desks. Service is stable but demand pressures and juggling staff numbers exacerbated by sickness/holidays are the biggest challenge. Current GP pressures impact on OPs which in turn affects demands and expectations of the CMHSOP service

Catherine Walker – Innovation Panel

I attended the Innovation Panel on 28th June. It was a real pleasure to see such a varied range of ideas from colleagues. Today's winning bids included super ideas such as QR codes for medicine information leaflets to be given to patients and carers via their smart phones and enhancing therapeutic gardening facilities.

Chief Executive's Board Report

Date of Meeting: 28 July 2022

Introduction

Since the board last met in public, a number of significant changes at both national and local level have occurred. At a national level the Health and Care Act enabled the merger of NHS Improvement and NHS England. It also gave NHS England powers to bring together Health Education England and NHS Digital; one new combined organisation; NHS England.

NHS England's Chief Executive Amanda Pritchard set out on July 7th a plan to reduce by up to forty percent, the workforce of the new organisation. This she shared would be delivered by the end of the financial year 203/4. At almost the same time, a new Secretary of State for Health and Social Care, Steve Barclay was appointed by Prime Minister Boris Johnson. Whilst these are changes at a national level they do of course affect health and social care organisations at a local level.

In Kent, on July 1st the Clinical Commissioning Group was dismantled and in its place at midnight on the same day, a new organisation NHS Kent and Medway, the county's Integrated Care Board was authorised. Today's board agenda includes an update on the new organisation, its priorities and plans.

Against these significant national changes, in KMPT, we continue to focus on delivering high quality services and driving the delivery of our three overarching strategic aims, addressing our workforce, quality improvement and partnerships. Today's agenda includes examples of where this work is starting to make a difference and improving the quality of care we offer those we serve.

Hybrid Working, Saving Money and Not Going Back

The executive and the board set a clear example of how thinking and working differently is possible in these post pandemic times when we closed for ever our Trust Headquarters. The building that in the past was used for board meetings amongst other things and which provided the executive team with individual offices was emptied and handed over to the construction firm who are building the new Ruby ward on our Maidstone site. Giving the building to Kier to use resulted in the Trust saving around £80k as the one-off cost of hiring a portacabin was avoided. In addition, a recurrent saving of around £75k a year has been achieved by not operating an HQ.

Perhaps more importantly than the cost saving, the executive team and I are now working in a truly hybrid way, and gaining the benefits from so doing. Our presence across the organisation has increased, we are meeting colleagues who we may not have met before and people are commenting that they can see our individual and team commitment to not going back. An evaluation of the effect of Hybrid Working will be shared later in the year along with stories from colleagues about their personal experience. In the meantime, reducing both one off and recurrent spend at the same time as improving the quality of what we do is a strong theme of our conversations across KMPT.

Leaders Event

On July 7th we held our Summer leaders' event. The two-hour event was held on Lifesize with the agenda structured to link back to our three overarching strategic aims. This event also included an update from the Trust's newly launched independent, 24/7 Freedom to Speak Up service. Delegates heard how in the first month, nine concerns had been raised four of which were speedily resolved. The remaining five have required further work which is underway. The board will receive in future, updates on the work of this service, the themes it identifies and importantly actions taken in response to concerns raised.

Delayed Transfers of Care

The board monitors Delayed Transfers of Care in a number of ways and is always mindful that for any of our patients ready to move on and out of a KMPT bed, being held up for whatever reason can be disappointing and frustrating. Working in partnership with Kent County Council, we have in recent weeks welcomed a Social Worker seconded to KMPT to work specifically on tackling delayed transfers of care. Early indicators are that progress can be achieved for patients requiring a specific package of care to enable them to return home. The challenge remains however for patients requiring a care home or specialist placement. Multi Agency Discharge Events are planned for July.

Green Spaces

Many of KMPT's wards and buildings have outside spaces. We made a commitment earlier this year to ensure that these are well-maintained and pleasant to use. To that end, our contractors are prioritising the maintenance and upkeep of courtyards and gardens that are on our sites where we have wards. In addition, the Trust's Sustainability and Environment Manager, Sirina Blankson is leading a multidisciplinary group who are volunteers and Occupational Therapists in looking after some of the courtyards and gardens in partnership with people who use our services as part of the therapeutic day.

Carers Conference

The carers and loved ones of our service users are extremely important partners and I was delighted to be asked to join the first ever jointly held conference for carers. Our partners in the event were Kent Community Health Foundation Trust. It was an extremely well attended event with carers from across the county meeting in person to hear presentations, shared experiences and aspirations. Many of those who addressed delegates were carers and the day was both inspiring and action focused.

Appraisal window

Some years ago, KMPT took the decision to implement an all employee appraisal window. The window opens in May and closes at the end of September by which time nearly 100% of employees will have had both their reflective appraisal meeting and agreed their objectives for the forthcoming year. The starting point for these conversations is always 'How are you?' and in these times of a cost of living crisis and mounting pressure on the NHS, it has been especially important for this appraisal window that we not only ask the question with genuine interest in the answer, but think about what as an employer, KMPT could do to improve things for colleagues. One decision that we hope will help, is the increase by ten pence per mile on the travel reimbursement rate. This came in to effect on July 1st and has been welcomed as an indication that the Trust is aware of the challenges facing the country.

Integrated Care Board

Today's board agenda includes an update on the work of the newly authorised Integrated Care Board (ICB). It is important to record here in the Chief Executive's report however, that there is one allocated place for KMPT and Kent Community Health Foundation Trust (KCHFT). The chairs of the respective organisations agreed that for the first two years, the KMPT Chief Executive would represent both organisations. The KCHFT Chief Executive will take over once the first term is completed.

Annual report and accounts (Extraordinary board 15th June)

These were received and approved by an extraordinary meeting of the board on June 15th.

Board to Board

On 21st June KMPT's board met member of Kent Community Foundation Trust's (KCHFT) board to reflect on progress since the two organisations signed a Memorandum of Understanding (MoU) in May 2021.

Presentations were received on the work jointly undertaken to deliver an improved service across a number of areas including dementia and autism. The Chief Executives were asked to think with their respective teams about potential areas for further joint work in addition to reviewing the original MoU and updating it as necessary. To that end, a paper by the Chief Executives will be shared with the September board.

Engagement Council

Our newly formed engagement council has, since its first meeting with the board earlier this year agreed a lived experience chair and co-chair who will take on their roles from August 2022. The Council has also agreed to

- provide the leadership on the implementation of Shared Decision Making (NICE Guideline 197) in KMPT
- Provide oversight of the co-production training rollout
- Provide oversight from a lived experience perspective of CQC Improvement Plans Establish links with local patient groups to understand their issues and influence the Trust's improvement work

The council will meet the board again in seminar in September.

Helen Greatorex
Chief Executive

Non- Executive Director visits to Trust services

Background

The Trust has benefited from Non-Executive Director (NED) visits to Trust services for a number of years. They are an established way of helping the Trust in fulfilling the Care Quality Commission's Well-Led framework, but of equal value, KMPT staff members have always welcomed NED visits as a way of expressing their pleasure and concerns. As testimony to the Trust's values, staff members have felt that they can be open with NEDs and that they are being listened to when they speak.

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

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

Arrangement of NED visits

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

Since the last NED Visit update, in June 2022 a new process for organising NED visits has been introduced, to make the organisation of visits more streamlined and to ensure services are not repeatedly visited in a short space of time. All visits are now co-ordinated by the Trust Secretariat with the support of the Deputy Chief Operating Officer. All feedback from visits is now provided directly to the Executive Management Team for comment or feedback to the relevant NED.

Themed outcomes of NED visits

Since January 2022, there have been 21 NED visits, across the Trust's geographical area. Services that have been visited include:

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

Feedback

A great deal of feedback received remains positive of the work the Trust is doing. All feedback provided praised staff and the hard work they are doing every day. There were some issues that

were raised and as a result of the NED visits, a number of themes were identified from the feedback given. These themes were:

- Issues with the quality of the environment for patients and staff, including unused space where staff are now hybrid working.
- Maintenance of sites and the timeliness in getting issues fixed.
- Workforce including the retention of staff and juggling staff due to sickness and annual leave
- Digital, including how this can sometimes be a burden due to the duplication of data entry.
- Concerns regarding the choice of food for special diets such as vegans.

Helping to shape our services

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

Those identified themes have helped the Trust to shape its services and the Trust has:

- Through its Trust Capital Investment Programme set up 31 projects valued at £9.5m, all based on a recent seven facet survey and planned to improve the health, safety and environment within the Trust. The Estates Department has also engaged 3 x Mobile Maintenance Assistants who provide speedy responses to low level reactive maintenance. This has been a very successful initiative which has reduced the time and costs of carrying out minor maintenance tasks and has contributed to improving the quality of patient and staff environment. Changes to the way the Trust works with ICOM / BDR on a 5-year contract has also led to improved performance and response times.
- The RiO review has been in progress for the last 6 months with a list of co-produced recommendations due to be presented at the Digital Strategy Board in September.
- A Catering Compliance Manager has been employed who is working with the Trust's catering food provider (ISS) to introduce a more varied menu, which has now been rolled out and initial feedback has been positive.
- The Hybrid Working Policy came into effect in April 2022 and since then the estates team has transformed the "unused space" in Priority House and Magnitude. These spaces now included a number of bookable desks and meeting rooms. The Trust is currently rolling out a hybrid way of working throughout the organisation with a building by building approach.

Conclusion

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

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

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 28 July 2022

Title of Paper: Board Assurance Framework

Author: Louisa Mace, Risk Manager

Executive Director: Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose: Approval

Submission to Board: Regulatory Requirement

Overview of Paper

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

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in May 2022.

- 2 new risks have been added to the BAF since May
    - Risk ID 7038 – IT Infrastructure Refresh Funding (Rating of 16 (Extreme))
    - Risk ID 7050 – Increased level of Delayed Transfers of Care (DToC) (Rating of 12 (High))

  1 risk has returned to the BAF after being agreed for removal in May.
    - Risk ID 5989 – Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)

- 5 risks have changed their risk score since May
    - Risk ID 6862 - Contract Management of Outsourced Services (reduced from 12 (High) to 6 (Moderate))
    - Risk ID 6861 – Estates and Facilities Resources (reduced from 16 (Extreme) to 12 (High))
    - Risk ID 3164 – Capital Projects – Availability of Capital (reduced from 16 (Extreme) to 12 (High))
    - Risk ID 6858 – External Market Forces (reduced from 12 (High) to 6 (Moderate))
    - Risk ID 6857 – Maintenance Services Funding Availability (reduced from 20 (Extreme) to 12 (High))

- 2 risks are recommended for removal
    - Risk ID 6862 – Contract management of outsourced services
    - Risk ID 6858 - External Market Forces

Version Control: 01

Governance

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

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 26 May 2022.

The Top Risks are

- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 6628 - Financial Sustainability (Rating of 16 - Extreme)
- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6881 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID 7038 – IT Infrastructure Refresh Funding (Rating of 16 – Extreme)

Risk Movement

5 risks are considered to have reduced in risk score since the Board Assurance Framework presented to Board on 26 May

- **Risk ID 6862 - Contract Management of Outsourced Services** (reduced from 12 (High) to 6 (Moderate))
  This is due to all actions having been completed. The risk is now at its target risk score. Risk will remain open to ensure sustained improvement.
- **Risk ID 6861 – Estates and Facilities Resources** (reduced from 16 (Extreme) to 12 (High))
  Identified actions have now been completed, and individual development programmes are being identified through the staff appraisal processes. There is still work to be done to fully resource the service.
- **Risk ID 3164 – Capital Projects – Availability of Capital** (reduced from 16 (Extreme) to 12 (High))
  Identified actions have been completed, with a new Trust Capital Group in place to monitor delivery of the agreed capital projects in year.
- **Risk ID 6858 – External Market Forces** (reduced from 12 (High) to 6 (Moderate))
  All identified actions have been completed, allowing risk score to reduce. It is now at its target risk score.
- **Risk ID 6857 – Maintenance Services Funding Availability** (reduced from 20 (Extreme) to 12 (High))
  Identified actions have been completed allowing risk score to reduce to its target rating. Re-audit assurances are pending

Risks Recommended for Removal

Two risks are recommended for removal

- **Risk ID 6862 - Contract Management of Outsourced Services** (reduced from 12 (High) to 6 (Moderate))
  This risk is being recommended for removal to the Board. This is due to all actions having been completed and the risk meeting its target risk score. Risk will remain open to ensure sustained improvement, but will be managed at a service level.

- **Risk ID 6858 – External Market Forces** (reduced from 12 (High) to 6 (Moderate))
  This risk is being recommended for removal to the Board. All identified actions have been completed, allowing risk score to reduce to its target risk score. This will now be managed through business as usual processes.

New Risks

Two new risks have been added to the BAF this time.

- **Risk ID 7050 – Increased number of Delayed Transfers of Care (DToC)**
  This risk has been added to reflect the high number of Delayed Transfers of Care currently being experienced, and the system wide work that is being undertaken to address this. A paper is being presented to the July Board Meeting regarding this.

- **Risk ID 7035 – IT Infrastructure Refresh Funding**
  This risk has been added to reflect the risk to the IT infrastructure following withdrawal of central funding. A plan was in place to replace the infrastructure in a timely way, but 2 years on limited, tactical procurement has taken place for the areas of greatest risk. The BAF risk has been added to reflect the impact of continued delay to the infrastructure refresh programme.

One risk has returned to the BAF after being agreed for removal in May.

- **Risk ID 5989 – Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)**
  This risk was agreed for removed from the BAF in May, however due to the potential impact of the current increased levels of infection to disrupt service provision this remains as part of the BAF. The current increase in sub-variant of Omicron has led to sustained community transmission affecting staffing and a small number of inpatients. Internal IPC guidance has been issued to ensure staff within clinical areas are wearing face masks in addition to standard IPC guidance.

Emerging Risks

No Emerging risks have been identified this time.

Other Notable Updates

- The actions for the following risks have been reviewed and updated. Work is underway to sense check these risks and see if they need to be refreshed and refocussed. Following this, the confidence assessment will also be updated.
  - Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
  - Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
  - Risk ID 6847 – Sickness (Rating of 16 – Extreme)

- Confidence assessments are being used more broadly across the risks. This will continue to be reviewed and updated as actions are completed

Version Control: 01

Recommendations

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

Version Control: 01

Updated: 20 July 2022

NHS Kent and Medway NHS and Social Care Partnership Trust

Board Assurance Framework

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

Definitions:

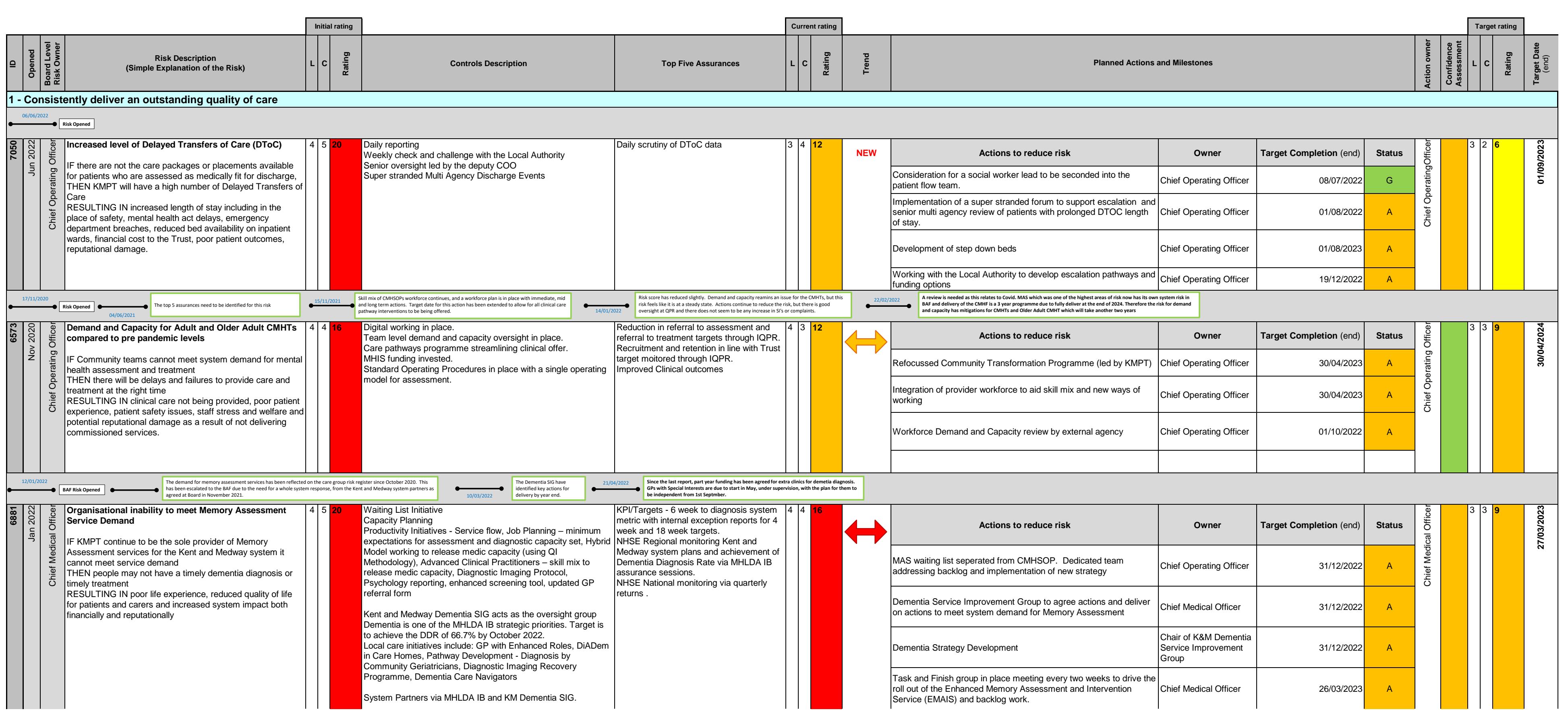
Initial Rating = The risk rating at the time of identification

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

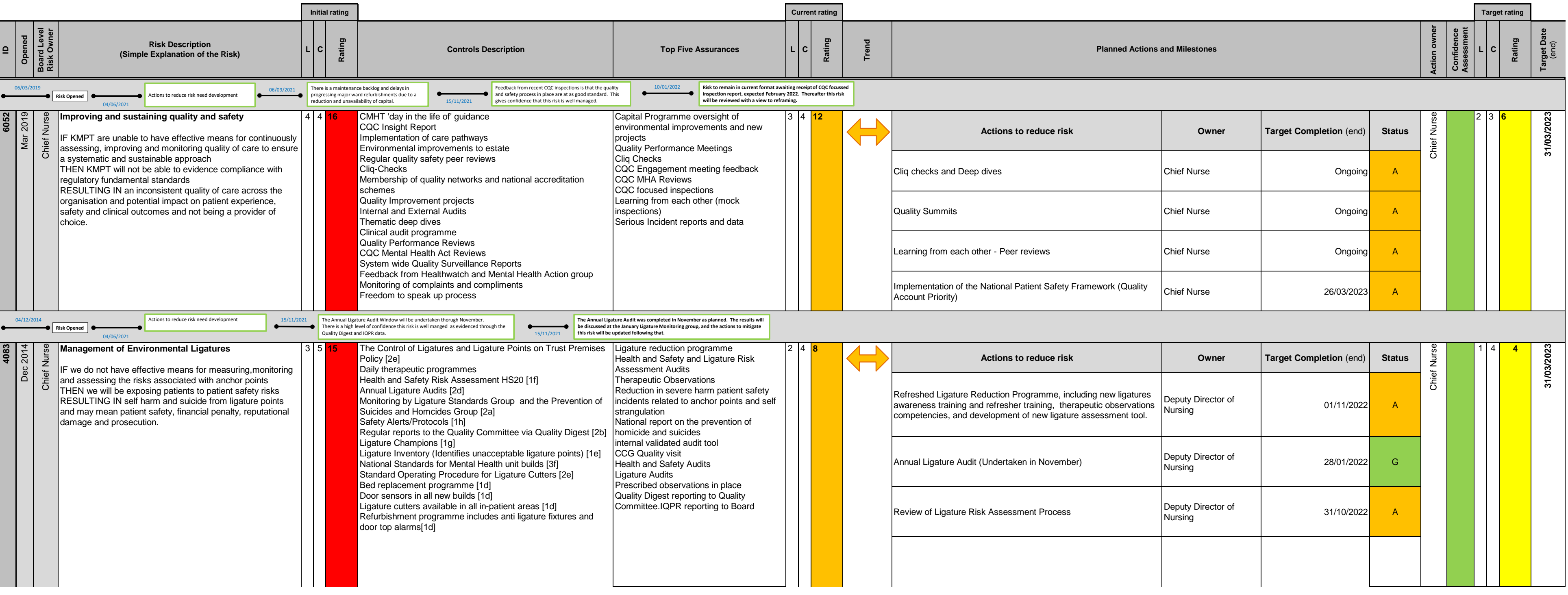
Target Rating = Risk rating Month end by which all actions should be completed

Action status key:

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



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target Rating	Target Date (end)
1 - Consistently deliver an outstanding quality of care																			
06/06/2022 Risk Opened																			
7050	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events	Daily scrutiny of DToC data	3	4	12	NEW	**Actions to reduce risk / Owner / Target Completion (end) / Status** Consideration for a social worker lead to be seconded into the patient flow team. / Chief Operating Officer / 08/07/2022 / G Implementation of a super stranded forum to support escalation and senior multi agency review of patients with prolonged DTOC length of stay. / Chief Operating Officer / 01/08/2022 / A Development of step down beds / Chief Operating Officer / 01/08/2023 / A Working with the Local Authority to develop escalation pathways and funding options / Chief Operating Officer / 19/12/2022 / A	Chief OperatingOfficer		3	2	6	**01/09/2023**
17/11/2020 Risk Opened — 04/06/2021: The top 5 assurances need to be identified for this risk — 15/11/2021: Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered. — 14/01/2022: Risk score has reduced slightly. Demand and capacity reamins an issue for the CMHTs, but this risk feels like it is at a steady state. Actions continue to reduce the risk, but there is good oversight at QPR and there does not seem to be any increase in SI's or complaints. — 22/02/2022: **A review is needed as this relates to Covid. MAS which was one of the highest areas of risk now has its own system risk in BAF and delivery of the CMHF is a 3 year programme due to fully deliver at the end of 2024. Therefore the risk for demand and capacity has mitigations for CMHTs and Older Adult CMHT which will take another two years**																			
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs compared to pre pandemic levels** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	3	12		**Actions to reduce risk / Owner / Target Completion (end) / Status** Refocussed Community Transformation Programme (led by KMPT) / Chief Operating Officer / 30/04/2023 / A Integration of provider workforce to aid skill mix and new ways of working / Chief Operating Officer / 30/04/2023 / A Workforce Demand and Capacity review by external agency / Chief Operating Officer / 01/10/2022 / A	Chief Operating Officer		3	3	9	**30/04/2024**
12/01/2022 BAF Risk Opened — The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021. — 10/03/2022: The Dementia SIG have identified key actions for delivery by year end. — 21/04/2022: **Since the last report, part year funding has been agreed for extra clinics for demetia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st Septmber.**																			
6881	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by October 2022. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG.	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16		**Actions to reduce risk / Owner / Target Completion (end) / Status** MAS waiting list seperated from CMHSOP. Dedicated team addressing backlog and implementation of new strategy / Chief Operating Officer / 31/12/2022 / A Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment / Chief Medical Officer / 31/12/2022 / A Dementia Strategy Development / Chair of K&M Dementia Service Improvement Group / 31/12/2022 / A Task and Finish group in place meeting every two weeks to drive the roll out of the Enhanced Memory Assessment and Intervention Service (EMAIS) and backlog work. / Chief Medical Officer / 26/03/2023 / A	Chief Medical Officer		3	3	9	**27/03/2023**



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current Rating	Trend	Action owner	Confidence Assessment	Target rating L	Target rating C	Target Rating	Target Date (end)
6052	Mar 2019	Chief Nurse	**Improving and sustaining quality and safety** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice.	4	4	16	CMHT 'day in the life of' guidance CQC Insight Report Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Membership of quality networks and national accreditation schemes Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CQC Mental Health Act Reviews System wide Quality Surveillance Reports Feedback from Healthwatch and Mental Health Action group Monitoring of complaints and compliments Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock inspections) Serious Incident reports and data	3	4	12	↔	Chief Nurse		2	3	6	31/03/2023
4083	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8	↔	Chief Nurse		1	4	4	31/03/2023

Risk 6052 timeline: 06/03/2019 Risk Opened — 04/06/2021 Actions to reduce risk need development — 06/09/2021 There is a maintenance backlog and delays in progressing major ward refurbishments due to a reduction and unavailability of capital. — 15/11/2021 Feedback from recent CQC inspections is that the quality and safety process in place are at as good standard. This gives confidence that this risk is well managed. — 10/01/2022 **Risk to remain in current format awaiting receipt of CQC focussed inspection report, expected February 2022. Thereafter this risk will be reviewed with a view to reframing.**

Planned Actions and Milestones (6052):

Actions to reduce risk	Owner	Target Completion (end)	Status
Cliq checks and Deep dives	Chief Nurse	Ongoing	A
Quality Summits	Chief Nurse	Ongoing	A
Learning from each other - Peer reviews	Chief Nurse	Ongoing	A
Implementation of the National Patient Safety Framework (Quality Account Priority)	Chief Nurse	26/03/2023	A

Risk 4083 timeline: 04/12/2014 Risk Opened — 04/06/2021 Actions to reduce risk need development — 15/11/2021 The Annual Ligature Audit Window will be undertaken thorugh November. There is a high level of confidence this risk is well manged as evidenced through the Quality Digest and IQPR data. — 15/11/2021 **The Annual Ligature Audit was completed in November as planned. The results will be discussed at the January Ligature Monitoring group, and the actions to mitigate this risk will be updated following that.**

Planned Actions and Milestones (4083):

Actions to reduce risk	Owner	Target Completion (end)	Status
Refreshed Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool.	Deputy Director of Nursing	01/11/2022	A
Annual Ligature Audit (Undertaken in November)	Deputy Director of Nursing	28/01/2022	G
Review of Ligature Risk Assessment Process	Deputy Director of Nursing	31/10/2022	A

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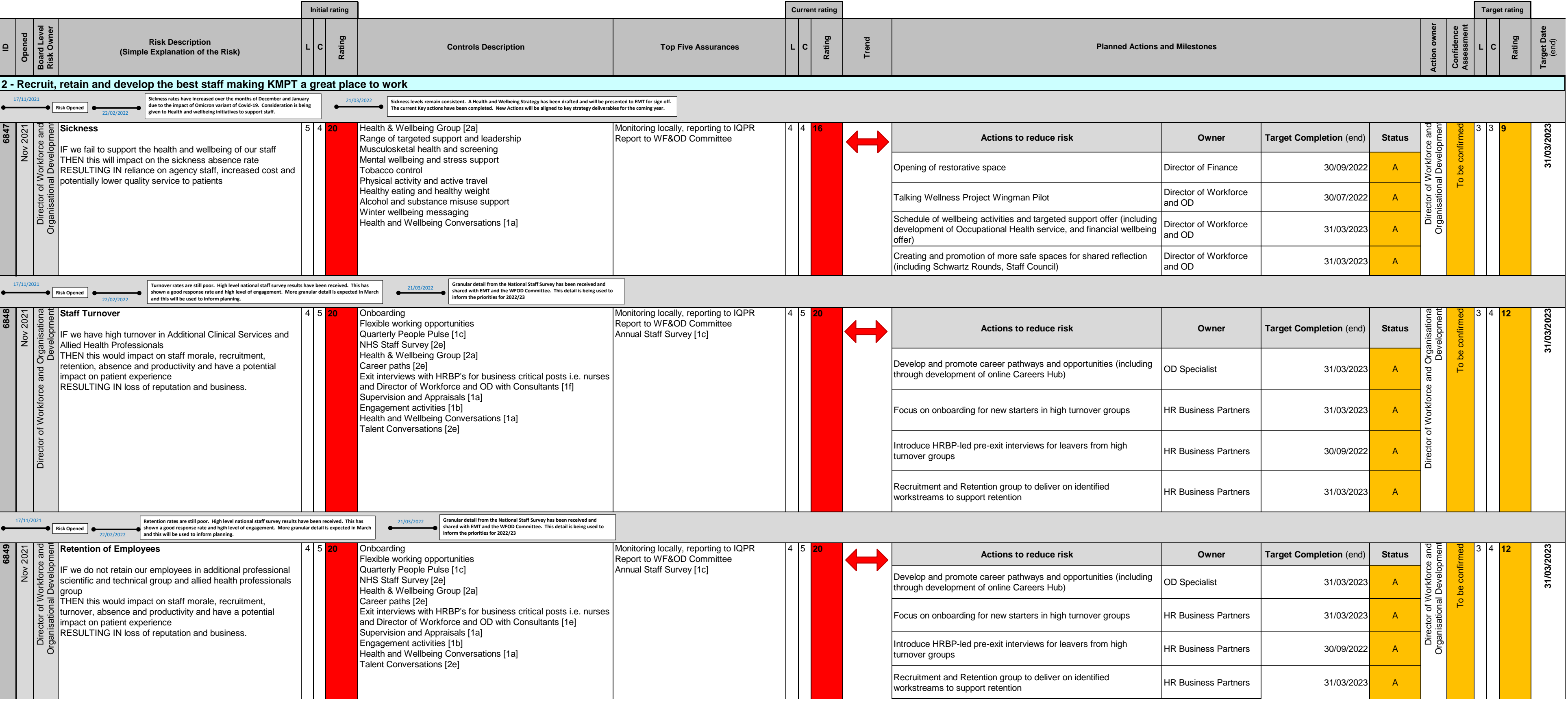

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2 - Recruit, retain and develop the best staff making KMPT a great place to work																		
6847	Nov 2021	Director of Workforce and Organisational Development	**Sickness** IF we fail to support the health and wellbeing of our staff THEN this will impact on the sickness absence rate RESULTING IN reliance on agency staff, increased cost and potentially lower quality service to patients	5	4	20	Health & Wellbeing Group [2a] Range of targeted support and leadership Musculosketal health and screening Mental wellbeing and stress support Tobacco control Physical activity and active travel Healthy eating and healthy weight Alcohol and substance misuse support Winter wellbeing messaging Health and Wellbeing Conversations [1a]	Monitoring locally, reporting to IQPR Report to WF&OD Committee	4	4	16	↔	Director of Workforce and Organisational Development	To be confirmed	3	3	9	31/03/2023
6848	Nov 2021	Director of Workforce and Organisational Development	**Staff Turnover** IF we have high turnover in Additional Clinical Services and Allied Health Professionals THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	↔	Director of Workforce and Organisational Development	To be confirmed	3	4	12	31/03/2023
6849	Nov 2021	Director of Workforce and Organisational Development	**Retention of Employees** IF we do not retain our employees in additional professional scientific and technical group and allied health professionals group THEN this would impact on staff morale, recruitment, turnover, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1e] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	↔	Director of Workforce and Organisational Development	To be confirmed	3	4	12	31/03/2023

6847 – Sickness: timeline

17/11/2021 Risk Opened

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

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

6847 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Opening of restorative space	Director of Finance	30/09/2022	A
Talking Wellness Project Wingman Pilot	Director of Workforce and OD	30/07/2022	A
Schedule of wellbeing activities and targeted support offer (including development of Occupational Health service, and financial wellbeing offer)	Director of Workforce and OD	31/03/2023	A
Creating and promotion of more safe spaces for shared reflection (including Schwartz Rounds, Staff Council)	Director of Workforce and OD	31/03/2023	A

6848 – Staff Turnover: timeline

17/11/2021 Risk Opened

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

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

6848 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Develop and promote career pathways and opportunities (including through development of online Careers Hub)	OD Specialist	31/03/2023	A
Focus on onboarding for new starters in high turnover groups	HR Business Partners	31/03/2023	A
Introduce HRBP-led pre-exit interviews for leavers from high turnover groups	HR Business Partners	30/09/2022	A
Recruitment and Retention group to deliver on identified workstreams to support retention	HR Business Partners	31/03/2023	A

6849 – Retention of Employees: timeline

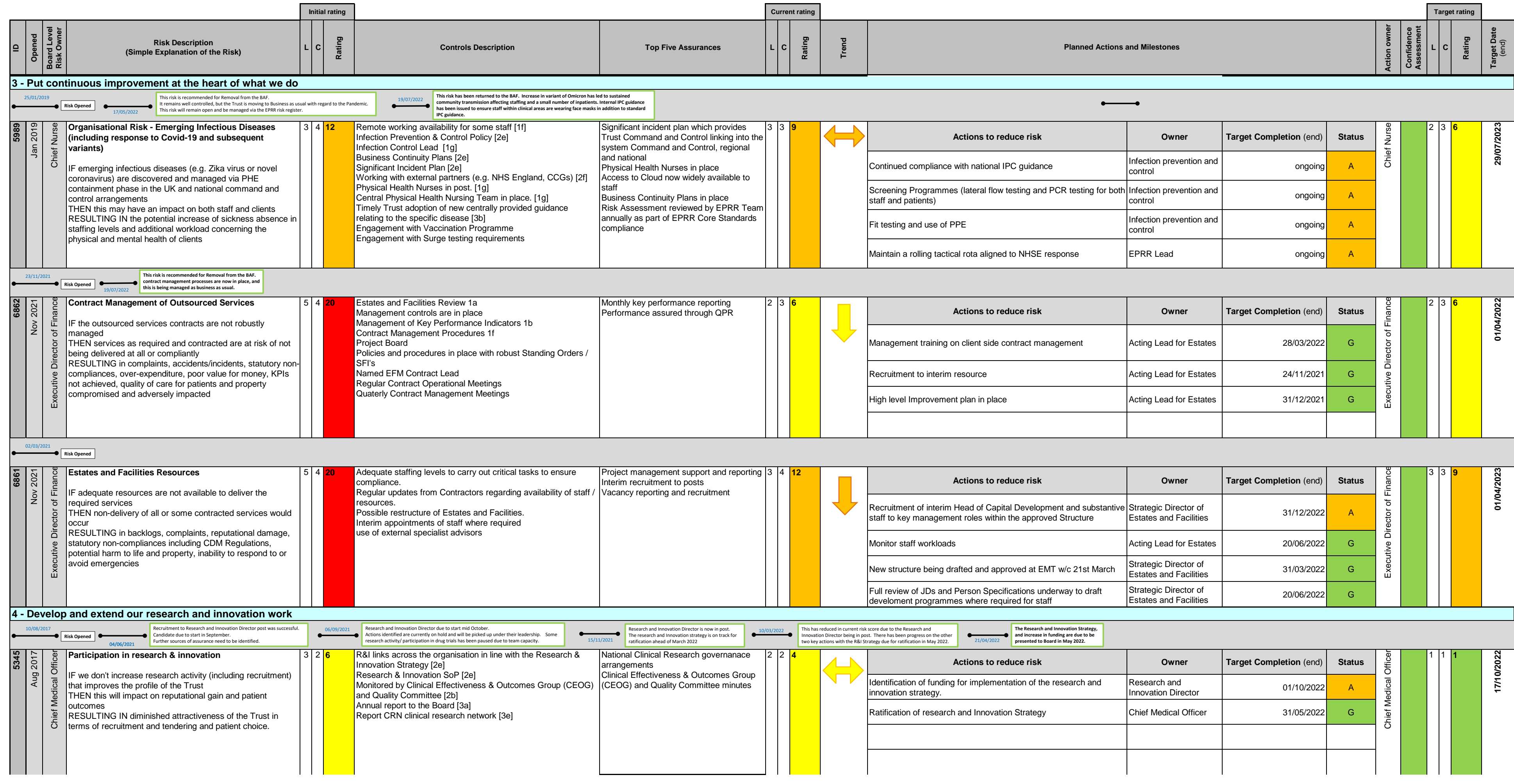
17/11/2021 Risk Opened

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

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

6849 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Develop and promote career pathways and opportunities (including through development of online Careers Hub)	OD Specialist	31/03/2023	A
Focus on onboarding for new starters in high turnover groups	HR Business Partners	31/03/2023	A
Introduce HRBP-led pre-exit interviews for leavers from high turnover groups	HR Business Partners	30/09/2022	A
Recruitment and Retention group to deliver on identified workstreams to support retention	HR Business Partners	31/03/2023	A



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3 - Put continuous improvement at the heart of what we do																			
25/01/2019 Risk Opened; 17/05/2022: This risk is recommended for Removal from the BAF. It remains well controlled, but the Trust is moving to Business as usual with regard to the Pandemic. This risk will remain open and be managed via the EPRR risk register.; 19/07/2022: **This risk has been returned to the BAF. Increase in variant of Omicron has led to sustained community transmission affecting staffing and a small number of inpatients. Internal IPC guidance has been issued to ensure staff within clinical areas are wearing face masks in addition to standard IPC guidance.**																			
5989	Jan 2019	Chief Nurse	**Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK and national command and control arrangements THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical and mental health of clients	3	4	12	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Significant Incident Plan [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g] Timely Trust adoption of new centrally provided guidance relating to the specific disease [3b] Engagement with Vaccination Programme Engagement with Surge testing requirements	Significant incident plan which provides Trust Command and Control linking into the system Command and Control, regional and national Physical Health Nurses in place Access to Cloud now widely available to staff Business Continuity Plans in place Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance	3	3	9		**Actions to reduce risk / Owner / Target Completion (end) / Status** Continued compliance with national IPC guidance / Infection prevention and control / ongoing / A Screening Programmes (lateral flow testing and PCR testing for both staff and patients) / Infection prevention and control / ongoing / A Fit testing and use of PPE / Infection prevention and control / ongoing / A Maintain a rolling tactical rota aligned to NHSE response / EPRR Lead / ongoing / A	Chief Nurse		2	3	6	**29/07/2023**
23/11/2021 Risk Opened; 19/07/2022: **This risk is recommended for Removal from the BAF. contract management processes are now in place, and this is being managed as business as usual.**																			
6862	Nov 2021	Executive Director of Finance	**Contract Management of Outsourced Services** IF the outsourced services contracts are not robustly managed THEN services as required and contracted are at risk of not being delivered at all or compliantly RESULTING in complaints, accidents/incidents, statutory non-compliances, over-expenditure, poor value for money, KPIs not achieved, quality of care for patients and property compromised and adversely impacted	5	4	20	Estates and Facilities Review 1a Management controls are in place Management of Key Performance Indicators 1b Contract Management Procedures 1f Project Board Policies and procedures in place with robust Standing Orders / SFI's Named EFM Contract Lead Regular Contract Operational Meetings Quaterly Contract Management Meetings	Monthly key performance reporting Performance assured through QPR	2	3	6		**Actions to reduce risk / Owner / Target Completion (end) / Status** Management training on client side contract management / Acting Lead for Estates / 28/03/2022 / G Recruitment to interim resource / Acting Lead for Estates / 24/11/2021 / G High level Improvement plan in place / Acting Lead for Estates / 31/12/2021 / G	Executive Director of Finance		2	3	6	**01/04/2022**
02/03/2021 Risk Opened																			
6861	Nov 2021	Executive Director of Finance	**Estates and Facilities Resources** IF adequate resources are not available to deliver the required services THEN non-delivery of all or some contracted services would occur RESULTING in backlogs, complaints, reputational damage, statutory non-compliances including CDM Regulations, potential harm to life and property, inability to respond to or avoid emergencies	5	4	20	Adequate staffing levels to carry out critical tasks to ensure compliance. Regular updates from Contractors regarding availability of staff / resources. Possible restructure of Estates and Facilities. Interim appointments of staff where required use of external specialist advisors	Project management support and reporting Interim recruitment to posts Vacancy reporting and recruitment	3	4	12		**Actions to reduce risk / Owner / Target Completion (end) / Status** Recruitment of interim Head of Capital Development and substantive staff to key management roles within the approved Structure / Strategic Director of Estates and Facilities / 31/12/2022 / A Monitor staff workloads / Acting Lead for Estates / 20/06/2022 / G New structure being drafted and approved at EMT w/c 21st March / Strategic Director of Estates and Facilities / 31/03/2022 / G Full review of JDs and Person Specifications underway to draft develoment programmes where required for staff / Strategic Director of Estates and Facilities / 20/06/2022 / G	Executive Director of Finance		3	3	9	**01/04/2023**
4 - Develop and extend our research and innovation work																			
10/08/2017 Risk Opened; 04/06/2021: Recruitment to Research and Innovation Director post was successful. Candidate due to start in September. Further sources of assurance need to be identified.; 06/09/2021: Research and Innovation Director due to start mid October. Actions identified are currently on hold and will be picked up under their leadership. Some research activity/ participation in drug trials has been paused due to team capacity.; 15/11/2021: Research and Innovation Director is now in post. The research and Innovation strategy is on track for ratification ahead of March 2022; 10/03/2022: This has reduced in current risk score due to the Research and Innovation Director being in post. There has been progress on the other two key actions with the R&I Strategy due for ratification in May 2022.; 21/04/2022: **The Research and Innovation Strategy, and increase in funding are due to be presented to Board in May 2022.**																			
5345	Aug 2017	Chief Medical Officer	**Participation in research & innovation** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment and tendering and patient choice.	3	2	6	R&I links across the organisation in line with the Research & Innovation Strategy [2e] Research & Innovation SoP [2e] Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b] Annual report to the Board [3a] Report CRN clinical research network [3e]	National Clinical Research governanace arrangements Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee minutes	2	2	4		**Actions to reduce risk / Owner / Target Completion (end) / Status** Identification of funding for implementation of the research and innovation strategy. / Research and Innovation Director / 01/10/2022 / A Ratification of research and Innovation Strategy / Chief Medical Officer / 31/05/2022 / G	Chief Medical Officer		1	1	1	**17/10/2022**

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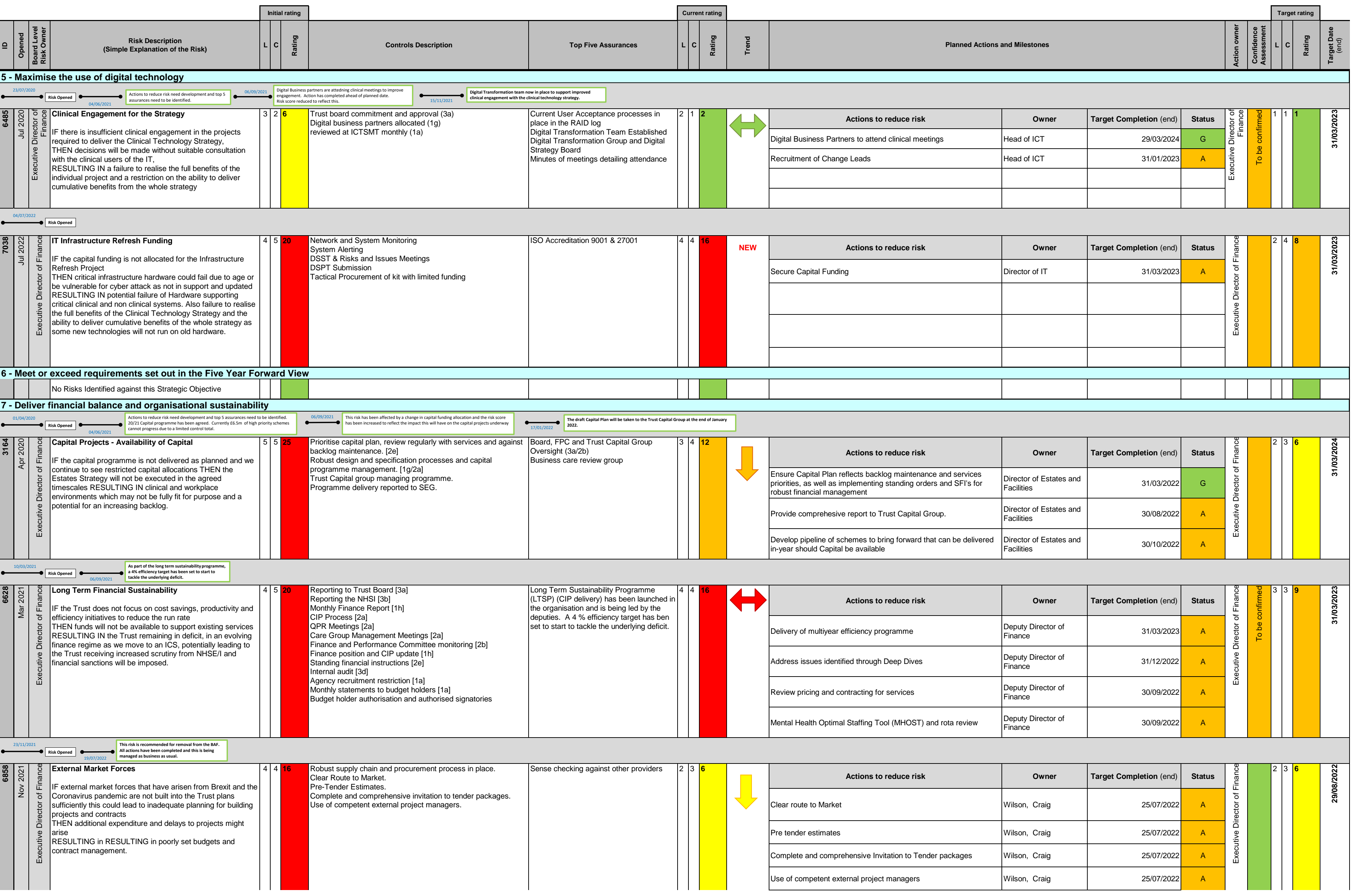

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5 - Maximise the use of digital technology																			
			23/07/2020 Risk Opened; 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified.; 06/09/2021 Digital Business partners are attedning clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this.; 15/11/2021 Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy.																
6485	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	3	2	6	Trust board commitment and approval (3a) Digital business partners allocated (1g) reviewed at ICTSMT monthly (1a)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	2	1	2		**Actions to reduce risk / Owner / Target Completion (end) / Status** Digital Business Partners to attend clinical meetings / Head of ICT / 29/03/2024 / G Recruitment of Change Leads / Head of ICT / 31/01/2023 / A	Executive Director of Finance	To be confirmed	1	1	1	31/03/2023
			04/07/2022 Risk Opened																
7038	Jul 2022	Executive Director of Finance	**IT Infrastructure Refresh Funding** IF the capital funding is not allocated for the Infrastructure Refresh Project THEN critical infrastructure hardware could fail due to age or be vulnerable for cyber attack as not in support and updated RESULTING IN potential failure of Hardware supporting critical clinical and non clinical systems. Also failure to realise the full benefits of the Clinical Technology Strategy and the ability to deliver cumulative benefits of the whole strategy as some new technologies will not run on old hardware.	4	5	20	Network and System Monitoring System Alerting DSST & Risks and Issues Meetings DSPT Submission Tactical Procurement of kit with limited funding	ISO Accreditation 9001 & 27001	4	4	16	NEW	**Actions to reduce risk / Owner / Target Completion (end) / Status** Secure Capital Funding / Director of IT / 31/03/2023 / A	Executive Director of Finance		2	4	8	31/03/2023
6 - Meet or exceed requirements set out in the Five Year Forward View																			
			No Risks Identified against this Strategic Objective																
7 - Deliver financial balance and organisational sustainability																			
			01/04/2020 Risk Opened; 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total.; 06/09/2021 This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway; 17/01/2022 The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.																
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose and a potential for an increasing backlog.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	3	4	12		**Actions to reduce risk / Owner / Target Completion (end) / Status** Ensure Capital Plan reflects backlog maintenance and services priorities, as well as implementing standing orders and SFI's for robust financial management / Director of Estates and Facilities / 31/03/2022 / G Provide comprehesive report to Trust Capital Group. / Director of Estates and Facilities / 30/08/2022 / A Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available / Director of Estates and Facilities / 30/10/2022 / A	Executive Director of Finance		2	3	6	31/03/2024
			10/03/2021 Risk Opened; 06/09/2021 As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.																
6628	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. A 4 % efficiency target has ben set to start to tackle the underlying deficit.	4	4	16		**Actions to reduce risk / Owner / Target Completion (end) / Status** Delivery of multiyear efficiency programme / Deputy Director of Finance / 31/03/2023 / A Address issues identified through Deep Dives / Deputy Director of Finance / 31/12/2022 / A Review pricing and contracting for services / Deputy Director of Finance / 30/09/2022 / A Mental Health Optimal Staffing Tool (MHOST) and rota review / Deputy Director of Finance / 30/09/2022 / A	Executive Director of Finance	To be confirmed	3	3	9	31/03/2023
			23/11/2021 Risk Opened; 19/07/2022 This risk is recommended for removal from the BAF. All actions have been completed and this is being managed as business as usual.																
6858	Nov 2021	Executive Director of Finance	**External Market Forces** IF external market forces that have arisen from Brexit and the Coronavirus pandemic are not built into the Trust plans sufficiently this could lead to inadequate planning for building projects and contracts THEN additional expenditure and delays to projects might arise RESULTING in RESULTING in poorly set budgets and contract management.	4	4	16	Robust supply chain and procurement process in place. Clear Route to Market. Pre-Tender Estimates. Complete and comprehensive invitation to tender packages. Use of competent external project managers.	Sense checking against other providers	2	3	6		**Actions to reduce risk / Owner / Target Completion (end) / Status** Clear route to Market / Wilson, Craig / 25/07/2022 / A Pre tender estimates / Wilson, Craig / 25/07/2022 / A Complete and comprehensive Invitation to Tender packages / Wilson, Craig / 25/07/2022 / A Use of competent external project managers / Wilson, Craig / 25/07/2022 / A	Executive Director of Finance		2	3	6	29/08/2022

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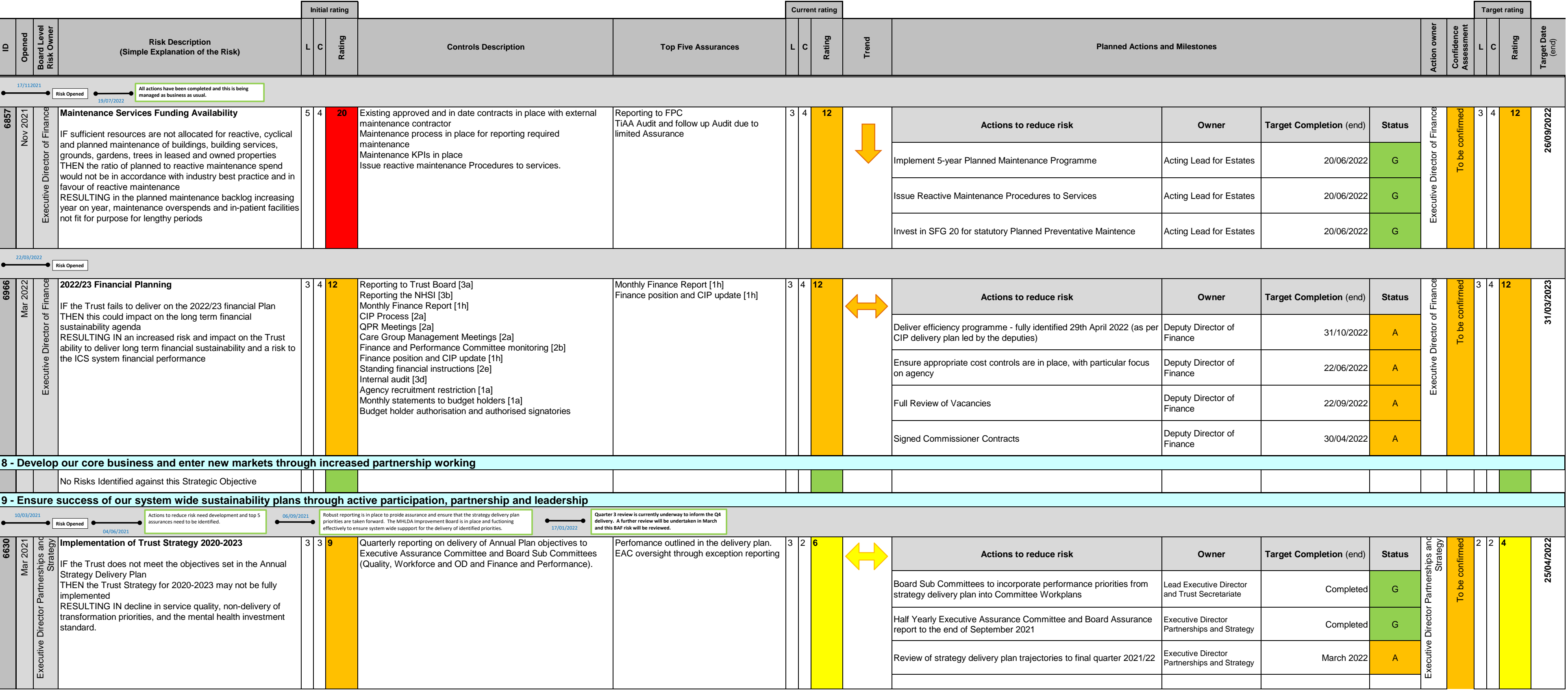

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			17/112021 Risk Opened; 19/07/2022 All actions have been completed and this is being managed as business as usual.															
6857	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Existing approved and in date contracts in place with external maintenance contractor Maintenance process in place for reporting required maintenance Maintenance KPIs in place Issue reactive maintenance Procedures to services.	Reporting to FPC TiAA Audit and follow up Audit due to limited Assurance	3	4	12	↓	Executive Director of Finance	To be confirmed	3	4	12	26/09/2022
			22/03/2022 Risk Opened															
6966	Mar 2022	Executive Director of Finance	**2022/23 Financial Planning** IF the Trust fails to deliver on the 2022/23 financial Plan THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance	3	4	12	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Monthly Finance Report [1h] Finance position and CIP update [1h]	3	4	12	↔	Executive Director of Finance	To be confirmed	3	4	12	31/03/2023
8 - Develop our core business and enter new markets through increased partnership working																		
			No Risks Identified against this Strategic Objective															
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																		
			10/03/2021 Risk Opened; 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified.; 06/09/2021 Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide suppport for the delivery of identified priorities.; 17/01/2022 Quarter 3 review is currently underway to inform the Q4 delivery. A further review will be undertaken in March and this BAF risk will be reviewed.															
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2023** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2023 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	9	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	3	2	6	↔	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	25/04/2022

Planned Actions and Milestones – Risk 6857

Actions to reduce risk	Owner	Target Completion (end)	Status
Implement 5-year Planned Maintenance Programme	Acting Lead for Estates	20/06/2022	G
Issue Reactive Maintenance Procedures to Services	Acting Lead for Estates	20/06/2022	G
Invest in SFG 20 for statutory Planned Preventative Maintence	Acting Lead for Estates	20/06/2022	G

Planned Actions and Milestones – Risk 6966

Actions to reduce risk	Owner	Target Completion (end)	Status
Deliver efficiency programme - fully identified 29th April 2022 (as per CIP delivery plan led by the deputies)	Deputy Director of Finance	31/10/2022	A
Ensure appropriate cost controls are in place, with particular focus on agency	Deputy Director of Finance	22/06/2022	A
Full Review of Vacancies	Deputy Director of Finance	22/09/2022	A
Signed Commissioner Contracts	Deputy Director of Finance	30/04/2022	A

Planned Actions and Milestones – Risk 6630

Actions to reduce risk	Owner	Target Completion (end)	Status
Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans	Lead Executive Director and Trust Secretariate	Completed	G
Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021	Executive Director Partnerships and Strategy	Completed	G
Review of strategy delivery plan trajectories to final quarter 2021/22	Executive Director Partnerships and Strategy	March 2022	A

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**28 July 2022**
Title of Paper:	Integrated Care Board and Integrated Care Partnership Update
Author:	**Helen Greatorex**
Executive Director:	N/A

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

The paper briefly sets out the background to the formation of NHS Kent and Medway, the county's new Integrated Care Board (ICB) and shares the overarching aims that it is working to.

In addition, the paper notes that the one shared place allocated on the ICB for a community and mental health services representative, is taken by KMPT's Chief Executive for the first eighteen months of a three year tenure.

Attached as an appendix are three slides showing the architecture and governance of the ICB.

Issues to bring to the Board's attention

It is early days in the development of the Integrated Care Board and its ability to deliver is as yet untested. Significant ambition to work and think differently is evident from the ICB's discussions to date and there is a commitment to enabling the county's providers and partners to deliver improvements both in health and social care.

Governance

Implications/Impact:	[identification of any risks/impact on legal/patient safety/resource and finance/engagement and consultation]
Assurance:	[significant/reasonable/limited/not applicable/to be assigned]
Oversight:	[Oversight by XYZ Committee/Board]

Background and Introduction

The Health and Care Act received Royal Assent in April 2022. At the heart of the changes brought about by the Act is the formalisation of integrated care systems (ICSs). The Kent and Medway ICS was created in 2015 to be a cross-county partnership whose aim was to bring together both providers and commissioners along with local authorities. Through that joining together it was hoped that they could collectively plan health and care services to better meet the needs of their local population. That approach was reliant on all parties willingly playing their part and working to the greater good.

What the Health and Care Act did, was to recognise the importance of the integrated system in which KMPT works, and formalise the requirements to cooperate. Our revised system now has two parts; an Integrated Care Board (ICB) and an Integrated Care Partnership (ICP). The ICB is tasked with the commissioning and oversight of most NHS services and will be accountable to NHS England for NHS spending and performance. The ICP will bring together a wider range of partners, not just the NHS, to develop a plan to address the broader health, public health and social care needs of the population.

The ICB Accountable Officer is Paul Bentley and the ICB Chair is Cedi Frederick. The board comprises executive and non-executive members as well as partner members.

There is one place allocated for a partner member to represent the four acute trusts in the county and one place for a partner member to represent mental health and community services. The Chief Executive for KMPT is the partner member in this role for the first eighteen months of the three-year tenure. The Chief Executive for the community trust (Kent Community Health Foundation Trust) will then take the role for the second part.

The ICB replaces the Clinical Commissioning Group.

As one of the forty-two ICBs across England, NHS Kent and Medway it has to achieve four, overarching aims;

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The board is also charged with agreeing an Integrated Care Strategy aligned to the four priorities.

At this early stage in its development, the ICB has established interim priorities;

Priority 1 - Operational recovery (elective care, cancer, diagnostics)

Priority 2 - Improvement of East Kent and Medway Hospital trusts

Priority 3 - Implementation of K&M general practice strategy

Priority 4 – Build and grow social care sector

Priority 5 - Establish a high-performing ICB and transitioning well from CCG

Priority 6 – Setting ICS strategy and ICB delivery plan

Priority 7 - Development of our ICS (place, PC, partnership working)

Each of the priorities is designed to make progress against the overarching four aims of the ICB and address the county's most pressing challenges.

The ICB has shared what it believes will be different as a result of its existence

- A material change in emphasis towards **tackling health inequalities, improving population well-being and the prevention of ill health**
- **Integrated decision making** with a focus on patient and population groups and a particular emphasis of subsidiarity with decisions being made at local partnership level, recognising that local priorities will need to be addressed as well as system and national priorities
- The framework and system architecture that facilitates the development of a **whole-population Integrated Care Strategy** and delivery plans, based on local need, developed and owned by all system partners, with a focus on care and well-being outcomes rather than operational outputs
- Increased **clinical, professional, voluntary and community sector involvement** and influence in decision making at both system and local partnership levels
- Greater **system ownership in addressing clinical and corporate challenges**, rather than leaving this to individual organisations
- **Improved collaboration** and integration between health, local authority and third sector partners, bound in legislation
- **Reduced bureaucracy / improved efficiency**, particularly in terms of finance, contract management and decision making
- **Inclusivity** rather than exclusivity

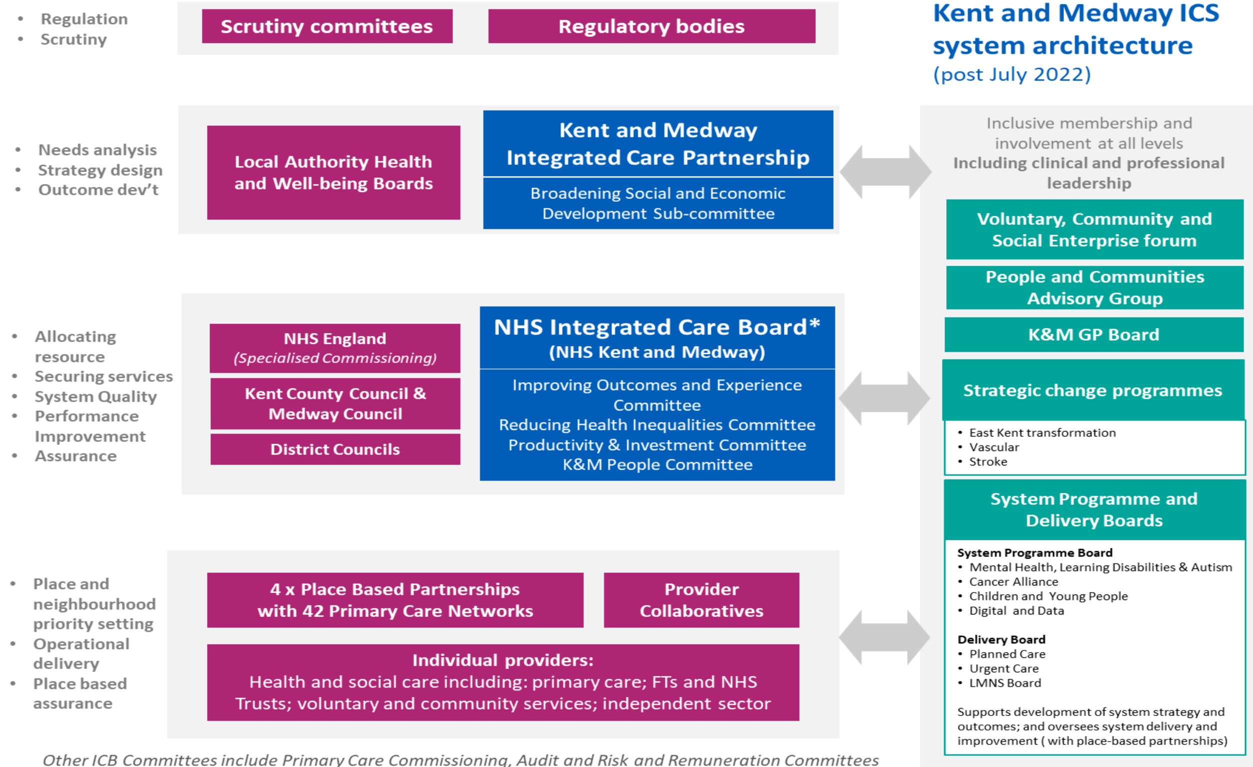
Summary and Conclusion

The newly formed ICB is in its very early stages of development. It has met once in public and its ambition to think and work differently in the interests of the population of Kent and Medway was clearly stated.

KMPT's Chief Executive will continue to represent the community and mental health on the board and will share regular updates on progress with both the KMPT board and the Chief Executive of KCHFT.

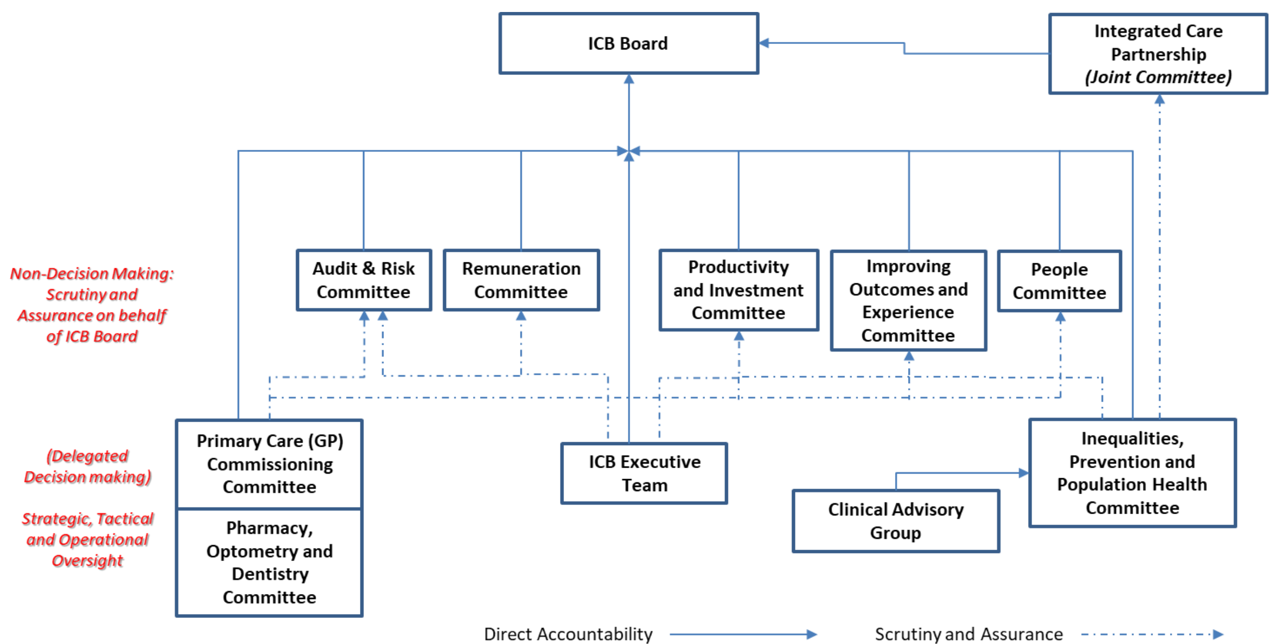
APPENDIX 1

ICS Architecture – High Level Overview



Appendix 2

Integrated Care Board



Integrated Care Partnership (ICP)

- A **Joint Committee** of the Local Authorities and the new NHS Integrated Care Board (ICB)
- **Membership inclusive** of all health and well-being stakeholders. Predominantly elected member, NED and clinical and professional membership
- Place-based **Health and Care Partnerships** will be important members, including primary care and district councils
- Specific responsibility to develop an **'Integrated Care Strategy'** for the whole population using the best available evidence and data covering health and social care and addressing health inequalities and the wider determinants which drive these inequalities.
- Also responsible for **setting system outcomes linked to the integrated care strategy**, plus oversight of delivery of the strategy and these outcomes, with partners holding each other to account
- Whilst the four purposes of an ICS will run through the entirety of the Kent and Medway system, the Partnership will have a particular responsibility for ensuring effective strategies are in place for **supporting wellbeing and broader social and economic issues**. This is because this purpose cannot be achieved by health and care services alone

Appendix 3

ICS Governance Framework – High Level

1) Kent and Medway Integrated Care System (ICS)

- The name for the whole system, formed of our Integrated Care Board, four Health and Care Partnerships, Integrated Care Partnership, Provider Collaboratives, and system Programme Boards

2) NHS England (NHSE)

- NHS regulator and commissioner of national specialist healthcare services

3) Kent and Medway Integrated Care Board (ICB)

- Develops plans to meet the health needs of the population and delivery the wider integrated care strategy and national plans.
- Allocates resources to deliver the plan across the system (revenue and capital)
- Establishes joint working and governance arrangements between partners
- Arranges for the provision of health services including through contracts and agreements with providers, and major service transformation programmes across the ICS
- People Plan implementation with employers
- Leads system-wide action on digital and data
- Joint work on estates, procurement, community development, etc

4) Kent and Medway Integrated Care Partnership (ICP)

- Joint Committee of the ICB, Kent County Council and Medway Council
- Responsible for the development and oversight of an 'integrated care strategy' for the whole population (covering all ages).
- Includes addressing health inequalities and the wider determinants of health and well-being, including social and economic development
- Champions inclusion and transparency and will challenge the ICS to demonstrate progress in reducing inequalities and improving outcomes

5) KCC and Medway Council Health and Wellbeing Boards (H&WBBs)

- Responsible for setting the vision and high-level health and well-being outcomes and priorities for the totality of their population
- Provides Joint Strategic Needs Assessments (JSNAs) for their areas
- Determines the strategic priorities and outcomes through Health and Wellbeing strategies

6) 4 x Kent and Medway Health and Care Partnerships

a – Dartford, Gravesham and Swanley
b - East Kent
c - Medway and Swale
d - West Kent)

- Develops and oversees local (place based) delivery strategies and plans that:
  - support delivery of Kent and Medway system and national priorities health, care and well-being priorities
  - enable delivery of local health and well-being needs/priorities
- Responsible for the integration of community, primary and social care services at a local level
- Reducing health inequalities and delivery of public health management strategy
- Primary Care Network development and integration with other local services
- Delivery of acute physical and mental health services
- Potential / expectation of increasing delegated responsibility for self-assurance and management of resources at a local level

7) System Programme Boards

- System programmes boards with responsibility for developing and overseeing delivery of 'at scale' strategies and implementation plans. Potential for delegated authority from ICB Board for specific programmes of work:

8) Service Programme Boards

- Mental Health, Learning Disabilities and Autism
- Cancer Alliance
- Children and Young People Services

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th July 2022
Title of Paper:	Operation Cavell Progress Update
Author:	Paul Squire, Local Security Manager Specialist
Executive Director:	Vincent Badu, Executive Director Partnerships & Strategy

Purpose of Paper

Purpose:	**For discussion**
Submission to Board:	Board requested

Overview of Paper

Operation Cavell was formed as a joint working agreement between the National Police Chiefs' Council, the Crown Prosecution Service and NHS Protect to pledge to work together to tackle violence and anti-social behaviour against NHS staff from both service users and carers.

KMPT partnered with Kent Police and launched Operation Cavell on February 14 2021.

The paper details an update on progress, learning and outcomes from Operation Cavell and next steps in development of this improvement project to support achievement of a reduction in violence and aggression experienced by NHS staff.

Issues to bring to the Board's attention

The Board is asked to note there has been a small reduction in the number of offences recorded since Operation Cavell was introduced across all locations.

Significant improvements in matters that were previously an area of concern

Although there is some awareness about the campaign across KMPT, there is a lack of trust in the due to the perception from staff that there is little point in reporting due to labour intensive reporting processes, timeframes for outcomes or failure to report or follow the full process as it is considered to be part of working in mental health. In order to address these issues further work is being undertaken in partnership with staff networks and partners in the criminal justice system. A range of next steps have been identified from the early learning and analysis of data and outcomes and will be taken forward. A further relaunch of the initiative has been proposed which will highlight the benefits from early joint work to staff and include hearing about successful prosecutions and staff stories to encourage them to come forward and remain engage with the process.

Governance

Implications/Impact:	Focus on reduce violence and aggression experience by NHS staff remains a key indicator and part of our quality account and people plan priorities.

Assurance:	Reasonable
Oversight:	Oversight by Executive Management Team

Operation Cavell Progress Update

Background

Operation Cavell was formed as a joint working agreement between the National Police Chiefs' Council, the Crown Prosecution Service and NHS Protect to pledge to work together to tackle violence and anti-social behaviour against NHS staff from both service users and carers.

It is named after the British Nurse Edith Louisa Cavell and was launched to undertake a closer working relationship between Sussex Partnership NHS Foundation Trust and Sussex Police in order to improve response to assaults.

Sussex Police Service launched the scheme with Sussex Partnership NHS Foundation Trust in 2016 with a PACT signed by the Chief Constable and Chief executive to illustrate that both organisations agreed to work together to tackle violence and anti-social behaviour against NHS Staff.

1. KMPT and Operation Cavell

KMPT partnered with Kent Police and launched Operation Cavell on February 14 2021.

Both organisations worked closely to produce a comprehensive suite of campaign material to promote and raise awareness of the agreement/PACT between Kent Police and KMPT.

The initiative was launched with a video pledge by KMPT's Chief Executive Helen Greatorex and Chief Constable of Kent Police, Alan Pughsley and media release distributed to local media outlets across Kent and Medway.

Appendix A: Examples of joint marketing material to promote Operation Cavell.

2. The PACT

The PACT is a pledge or series of guiding principles for Kent Police officers to uphold and implement when investigating any incident that involves violence and antisocial behaviour against KMPT staff.

The PACT stands for:

- Putting the victim first
- Assume capacity
- Consider all the options
- Take positive action

In practice PACT offers:

- KMPT staff restorative justice, warnings and cautions over court action.
- Dissuades police officers from making assumptions about the mental capacity of service users until capacity or lack of it is proven.
- Supports officers to assume that prosecution of a crime committed against a public servant is in the public interest.

3. Partnership working

KMPT's Promoting Safe Services (PSS) team has been working with Kent Police's Staff Safety Training team to better understand each other's training programs and working practices. This has involved exploring the different legislations and regulatory governance in place.

Training undertaken to date:

Two police officers attended the PSS team's basic training and gave feedback that they found it valuable. KMPT PSS staff have also attended police training. The PACT forms part of the induction and training materials provided to Police Officers as part of induction and essential training programme delivered by Kent Police.

The next piece of collaborative work will involve understanding how the new legislation (Mental Health Units Use of Force Act 2018) will impact on both services with the aim of developing training aspects and 'mutual expectations' for both public sector bodies. This will then be reflected in the 'involving police in inpatient services policy' which will need to be reviewed and updated.

4. Kent Police data 2019 and 2022 - pre and post Operation Cavell

This table shows data for all three mental health policing team based across three KMPT facilities (Littlebrook, Priority House and St Martins Hospital) for a six-month period pre-Operation Cavell and the first 6 months for 2022 (January – June).

Table 1

	Littlebrook Hospital & associated units/wards		Priority House		St Martins Hospital	
	Offences 2019	Offences 2022	Offences 2019	Offences 2022	Offences 2019	Offences 2022
Jan	22	16	13	8	34	20
Feb	14	8	21	17	17	12
Mar	11	7	23	12	25	7
Apr	14	1	16	20	17	16
May	13	3	19	10	26	32
June	14	3	6	8	18	6
Total crimes in 6 months	**88**	**38**	**98**	**75**	**137**	**93**

Kent Police has reviewed two of the three sites to date (Littlebrook Hospital and Priority House). There has been a small reduction in the number of offences recorded since Operation Cavell was introduced across all locations as shown in Table 1.

A detailed breakdown of how the offences have been categorised is given below.

Littlebrook Hospital and associated units/wards

(January 2019 – March 2019)

- 47 crimes were reported of which 10 related to members of staff being assaulted by patients.
- 7 related to hate crime/POA (Prosecution of Offences Act 1985), offences by patients towards staff.
- 2 were miscellaneous offences.

Jan 2022 - Mar 2022

- 31 crimes reported with 9 relating to members of staff being assaulted by patients.
- 8 related to hate crime/POA offences.

Priority House

Jan 2019 - Mar 2019

- 57 crimes reported with 10 relating to members of staff being assaulted by patients.
- 4 relating to hate crime/POA offences by patients towards staff.

Jan 2022 - Mar 2022

- 37 crimes reported with 6 relating to members of staff being assaulted by patients.
- 3 relating to hate Crime/POA offences by patients towards staff.

Hate crimes

There is no real difference in the number of hate crimes being reported currently as per table 1. This is attributed to complications arising around the public order act dwelling legislation which impacts on the criminal justice process at present. Currently Kent Police are working on a piece of work around community resolution that looks to an impact on reducing this type of behaviour.

5. Outcomes data January - September 2021

KMPT and Kent Police are working together to ensure that information on outcomes of offences and crimes reported can be shared with victims and our staff networks to support improvement in experience and learning. A snap shot of outcomes data available for the period January – September 2021 provided the following information.

- 90 crimes reported by KMPT staff to Kent Police

- 16 cautions issued
- 4 community resolutions/ restorative justice outcomes
- 6 charges going through court process
- In a significant proportion of crimes reported victims (our staff), have declined to support further action being taken
- Information sharing and information governance requirements

6. Communicating to staff about Operation Cavell

Since Operation Cavell's launch, KMPT has communicated with staff using a range of channels including offline and online methods. These include: posters, flyers, screensavers, i-connect (intranet), Big Conversations, Leaders' event, case studies, news articles, team meetings and video.

Kent Police adopted a similar approach to rolling out the initiative across their internal channels.

There is some awareness about the campaign across KMPT; however, anecdotally, there is a lack of trust in the initiative due to the perception from staff that there is little point in reporting due to labour intensive reporting processes, unsatisfactory outcomes or failure to report as it is considered to be part of working in mental health.

A relaunch of the initiative has been proposed around ensuring staff understand:

- What constitutes a crime
- How to report it and what details are required to take further action
- What they can expect from the process including timelines and realistic outcomes
- Working with the police
- Legislation guidance
- Access to support.

7. Learning from Operation Cavell since launch and next steps

Victim expectations and experience

Any KMPT staff who are victim of a crime must be supported and be made aware of expectations relating to the process, what is involved and what they can reasonably expect for Kent Police to do as a result of the reported incident.

Victims should receive updates from the investigation police offers which will be further supported by the Victims' charter which will be endorsed by forces.

A joint webinar /Q&A session presented by Kent Police and KMPT. His would include real case studies, reflections from people with lived experience and an opportunity to learn more about how we can improve the reporting and rate of successful outcomes.

Staff would have the opportunity to ask questions to improve their understanding and feedback to Kent Police around concerns, points of learning.

Post Incident debrief should be a part of the process to help support the victim better. Psychology is a valuable area of support, long-term; especially with trauma, counselling services must be promoted.

Feedback on success
Limited feedback about successful prosecutions, restorative justice and positive outcomes has been available due to confidentiality.

Staff need to hear about successful prosecutions/ staff stories to encourage them to come forward and engage with the process. Early follow up discussion with our staff networks has generated ideas about how this could be approached differently, for example through the use of ted talks with staff and officers describing both experiences and handling responses.

We must work more closely to release the information where we can and showcase outcomes.

Encouraging line managers of any victim within KMPT to support the process will also dispel the myth that 'nothing ever happens.' The improved visibility and support from Police Officers based locally on KMPT sites and joint working with KMPT newly appointed Local Security Manager is supporting continued improvement work to be taken forward.

Reporting processes and technology

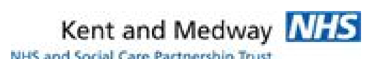
Reporting processes need to be simple and easy for staff to report crime using Datix simply and more effectively.

Better use of technology may help to report crime quicker and easier and prevent staff having to recount their experience of a crime

Body worn video technology has been used to manage hate crime previously and often provides clear evidence needed by police officers to bring about successful prosecutions or other forms of restorative justice

Better partnership working and promotion

The partnership working is positive with Kent Police and this should be continued to be supported by KMPT Executive team and Kent Police's Senior Command team.



TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**28th July 2022**
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

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

The Board's attention will naturally focus on those areas below target, seeking assurance that measures are in place to rectify the situation. The report shows continued pressure in some of our key workforce metrics along with examples of the work in train to improve the situation. Sickness Absence remains at 4.5% compared to the 4% target and the Vacancy Gap has increased by 1.3% in month to 16.6% which is the highest position within the last 12 months. Recruitment and retention remain a strong focus and is a priority area included in the trust's strategic priorities for 2022-23.

Bed pressures is an area of focus for the Executive Team, this is partially driven by high levels of Delayed Transfers of Care. It is positive to note a continued reduction in Bed days lost to delayed transfers of care to 10.7% following three months in excess of 12.4% during the spring. The Chief Operating Officer continues to oversee a detailed piece of work which is outlined in the Board Paper.

It is positive to note that bed days used in Out of Area placement which exceed contracted beds was 114 days lower than in May 2022 and the lowest position (141) since February 2022. The improved position has been maintained into July at time of writing this report.

It has previously been highlighted that our community teams require an increased focus, this includes; care planning and waiting times for assessment and treatment. Despite ongoing challenges, it is positive to note that care planning indicators improved in month and the target compliance (75%) for the distribution of care plans for those on CPA was exceeded for the first time. Further improvement is being managed at a team level supported by exception reporting, the impact of factors such as vacancy rates, sickness and referral rates continue to result in variation across teams.

The Trust will need to focus on the delivery of recurrent efficiencies as we move into the new financial year to ensure deliver of a break-even position. KMPT's spend on temporary staffing has reduced slightly in 2022/23 Q1 compared to the final quarter of the previous year. This will continue to be an area of focus during the year and it is likely we will see national agency caps/controls introduced shortly. Proposals for developing a locum bank and sharing the learning from opportunities to use existing resource and locum resource more effectively are underway and will be implemented during this financial year.

Governance

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

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

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

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

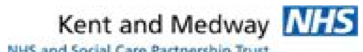
Executive Commentary

Restrictive Practice - No. Of Prone Incidents (012.S)

In May 2022, there were two prone restraints but none reported in June 2022. Both prone restraints occurred in the acute care group and involved two different patients. In both cases, the prone position was used for under two minutes. The Promoting Safe Services (PSS) team have implemented the use of safety pods over the last 12 months which is contributing to the reduction of the use of prone restraint within services. It is worthy to note, June 2022 is the first month of reporting zero prone restraints since April 2015.

IQPR Dashboard: Safe

Ref	Measure	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
001.S	Occurrence Of Any Never Event	0	N	0	0	0	0	0	0	0	0	1	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review	95%	N	94.2%	93.2%	92.8%	92.3%	92.9%	93.0%	93.2%	93.5%	93.8%	93.4%	92.7%	93.0%
006.S	Serious Incidents Declared To STEIS	-	-	11	13	21	20	23	20	18	26	27	24	18	21
011.S	Restrictive Practice - All Restraints	-	-	151	96	82	62	72	71	88	83	105	82	121	97
012.S	Restrictive Practice - No. Of Prone Incidents	0	L	6	5	11	4	2	2	2	4	2	4	2	0
013.S	Restrictive Practice - No. Of Seclusions	-	-	26	19	17	12	17	19	17	8	11	9	15	6
017.S	RIDDOR Incidents	-	-	2	2	3	3	2	5	3	1	4	3	2	2
020.S	Unplanned Readmissions within 30 days	8.8%	L	7.8%	11.0%	5.6%	8.5%	5.8%	7.2%	5.3%	4.5%	7.7%	6.7%	6.4%	6.3%



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

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

Issues of Concern
• Care planning continues to be an area of concern and increased focus, although it is positive to note the increased performance in month • Delayed transfers of care (DToC) continue to have an impact on bed availability, it is positive to note the reduction in external placements despite the ongoing DToC pressure

Executive Commentary

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. Two key approaches have been agreed with the aim of identifying and resolving underlying issues:

- A secondment commenced 4th July to review the quality of care delivery and the robustness of the mechanisms in place to monitor and act upon findings.
- A focussed piece of work with Executive sponsorship to review the Memory Assessment caseload and apply the new operating model has commenced within CMHSOPs.

	005.E: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			0.0	0.0	-44.5	111.3	33.4
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			141.0	0.0	23.6	267.4	145.5
4	Trust Total			141.0	0.0	4.6	353.3	178.9

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**
Narrative	
June 2022 saw a further decrease in the use of out of area beds not procured in advance by KMPT, 141 bed days were used (all PICU), a reduction from the 255 used in May. Ongoing restrictions on capacity exist on the Trust's PICU ward, Willow Suite, due to the admission of a patient with complex needs. 71 of the 141 beds days used have been as a direct result of the capacity challenges on Willow Suite requiring male patients to be placed externally. It is positive to note that	

as of 12th July no male PICU patients remain placed externally, three female placements were in place.

015.E: % Of Patients on CPA With Valid Care Plan		Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			73.1%	95.0%	59.9%	90.9%	75.4%
2	CRCG			87.5%	95.0%	86.5%	92.3%	89.4%
3	FSCG			92.7%	95.0%	91.3%	98.0%	94.6%
4	OPMH			95.2%	95.0%	93.6%	99.1%	96.3%
5	Trust Total			88.9%	95.0%	88.4%	93.0%	90.7%

017.E: % Non CPA Patients with a Care Plan or PSP		Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			66.9%	95.0%	64.4%	71.2%	67.8%
2	FSCG			69.1%	95.0%	66.2%	76.3%	71.2%
3	OPMH			76.2%	95.0%	69.9%	82.8%	76.3%
4	Trust Total			71.1%	95.0%	68.9%	74.7%	71.8%

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

Narrative

CPA Care Planning

The percentage of patients on CPA with a valid Care Plan is showing as special cause variation of a concerning nature, despite this the overall trust position has improved in month overall by 1.2%. CRCG remains the biggest contributor to this indicator and has increased 2.3% in month to 87.5%. These improvements follow seven successive months of reduced performance.

OPMH are exceeding target with FSS at 92.7% (19 of 261 non-compliant), the Acute Care Group Figure reflects a low number of patients (26).

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

There has been an improvement in the trust position of 2.4% following five successive months of reduction. The increase was across all care groups.

Despite the improved CMHSOPs position of 2.7% in month five CMHSOPs are showing special cause variation, a reduction from seven teams in April.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			83.2%	95.0%	71.3%	87.1%	79.2%
2	Canterbury CMHSOP			82.4%	95.0%	63.4%	86.2%	74.8%
3	DGS CMHSOP			80.8%	95.0%	72.1%	90.1%	81.1%
4	Dover & Deal CMHSOP			88.9%	95.0%	80.3%	90.1%	85.2%
5	Maidstone CMHSOP			55.2%	95.0%	67.7%	89.0%	78.4%
6	Medway CMHSOP			82.5%	95.0%	69.5%	84.7%	77.1%
7	Sevenoaks CMHSOP			56.5%	95.0%	63.4%	83.5%	73.5%
8	Shepway CMHSOP			75.9%	95.0%	78.9%	89.2%	84.1%
9	Swale CMHSOP			81.0%	95.0%	64.8%	81.8%	73.3%
10	Thanet CMHSOP			82.1%	95.0%	72.7%	86.8%	79.8%
11	Tunbridge Wells CMHSOP			51.5%	95.0%	56.1%	73.7%	64.9%
12	**CMHSOP Total**			76.2%	95.0%	73.9%	82.5%	78.2%

Actions in place within the OPMH care group include a Personal Support Plan (PSP) Brief Guide developed for use by staff to enable PSP to be embedded in practice. Locality Managers are prioritising supporting Team Leaders and staff in using PSP. This is being addressed and monitored through the Senior Management Team (SMT) governance structure and has been added to the CLIQ check audit process. This will be monitored via the Quality Performance Review (QPR) meetings.

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	97.8%	96.4%	96.3%	95.2%	95.3%	96.2%	98.5%	98.6%	93.8%	95.6%	95.8%	95.2%
001b.E	CPA patients receiving follow-up within 72hours of discharge				86.5%	86.6%	81.7%	87.5%	88.0%	80.0%	78.6%	85.0%	84.4%	84.1%	83.9%	85.7%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.7%	95.7%	95.9%	96.2%	96.1%	96.1%	96.1%	95.9%	95.7%	95.7%	95.7%	95.6%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	201	103	205	175	142	108	120	69	168	253	255	141
006.E	Delayed Transfers Of Care		7.5%	L	8.8%	9.0%	10.6%	11.9%	9.6%	10.6%	13.1%	12.8%	12.4%	10.9%	9.9%	10.7%
012.E	Average Length Of Stay(Younger Adults)		25	L	28.23	27.68	29.78	36.63	33.96	26.85	35.99	33.63	36.23	38.84	37.11	36.38
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	53.24	56.90	72.25	80.22	85.18	85.90	53.88	57.41	72.63	81.88	85.15	69.11
015.E	%Patients with a CPA Care Plan		95%	L	90.7%	91.3%	89.5%	88.7%	91.4%	90.7%	90.6%	90.2%	89.3%	87.9%	87.7%	88.9%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	63.5%	64.4%	65.4%	66.3%	67.9%	71.7%	74.2%	73.3%	72.5%	71.5%	72.2%	75.3%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	74.4%	74.2%	73.2%	74.0%	73.7%	72.6%	73.5%	73.4%	70.9%	69.2%	68.7%	71.1%
018.E	Bed Occupancy (Net)				91.1%	94.9%	96.8%	96.1%	95.5%	90.7%	95.0%	93.7%	94.4%	94.4%	96.1%	96.5%

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

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

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

Executive Commentary
KMPT continues to operate in a challenging staffing context, with a very competitive employment market and heightened levels of sickness absence nationally stemming from the Covid-19 pandemic.

Of particular concern for KMPT are increasing vacancy levels, with around c500 WTE of vacancies across the Trust although there is an extant recruitment pipeline (offers to successful candidates) for around 400 WTE of those vacancies. KMPT continues to recruit proactively, and saw 69 new starters in June. There were 53 leavers in the same period.

This level of turnover is slightly reduced from the previous two months, but remains considerably higher than at the same time last year, with particularly high rates of turnover amongst HCA and Nursing Associates. Work is underway to address frequently cited reasons for leaving, with the most prevalent being work-life balance.

Work is ongoing around enhancing opportunities for flexible working, and a significant emphasis is being placed currently on physical, psychological, social and financial wellbeing.

KMPT has recently developed a broad schedule of well received wellbeing activities for KMPT staff, including outdoor activities, craft and art sessions and theatre trips. The Trust has also delivered its second Schwartz Round, with good engagement, and the Talking Wellness service has now seen over 1000 visitors. In support of financial wellbeing, mileage allowances have been increased by KMPT by 10p per mile, and a further range of financial wellbeing benefits are being explored.

Additionally, we continue to focus on getting recruitment right first time, and on ensuring a supportive onboarding process.

Levels of sickness absence remain broadly consistent from month to month and are comparable with levels at the same time last year.

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
001.W-W	Staff Sickness - Overall	✓	4.00%	L	4.6%	4.2%	4.6%	5.0%	4.9%	4.7%	4.3%	4.3%	4.3%	4.3%	4.5%	4.5%
005.W-W	Appraisals And Personal Development Plans		95%	L					98.8%	99.0%	99.0%	99.0%	99.0%	99.0%		
006.W-W	Vacancy Gap - Overall		10.00%	L				15.0%	14.9%	14.9%	15.1%	15.2%	15.7%	15.1%	15.3%	16.6%
012.W-W	Essential Training For Role		90%	L	90.4%	90.5%	92.6%	91.5%	92.7%	93.1%	92.5%	93.0%	92.0%	91.9%	92.5%	92.6%
015.W-W	Staff Retention (overall)		87%		82.7%	84.3%	81.8%	81.8%	81.0%	83.2%	85.9%	85.4%	83.2%	83.4%	84.0%	83.3%
019.W-W	Staff Turnover (Overall)		9.00%		10.9%	11.3%	12.2%	12.6%	12.8%	13.6%	13.1%	13.4%	12.7%	13.0%	13.1%	12.6%
023.W-W	Safer staffing fill rates		80.00%	L	110.5%	110.5%	110.5%	110.3%	110.2%	100.6%	102.5%	101.3%	101.5%	103.5%	103.6%	101.9%

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

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

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

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

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
004.W-F	In Month Budget (£000)	0.0	N	(0)	(0)	(0)	0	0	0	0	0	0	0	0	0
005.W-F	In Month Actual (£000)	-	-	0	0	(0)	0	0	0	0	0	0	0	0	0
006.W-F	In Month Variance (£000)	-	-	0	0	(0)	0	0		0		0	(0)	0	0
006a.W-F	Distance From Financial Plan YTD (%)	0.0%	N	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.32%	-2.92%	21.21%
007.W-F	Agency - In Month Budget (£000)	-	N	427	427	427	427	427	427	427	427	427	427	427	427
008.W-F	Agency - In Month Actual (£000)	-	-	664	658	687	562	536	741	595	516	698	533	572	612
009.W-F	Agency - In Month Variance from budget (£000)	-	-	237	231	260	135	109	314	168	89	271	106	145	185
010.W-F	Agency Spend Against Cap YTD (%)	0.0%	N	60.85%	59.31%	51.76%	48.88%	45.97%	49.04%	48.08%	45.60%	47.08%	43.84%	29.37%	34.03%

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

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

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

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

Executive Commentary

Friends and Family Test (002.C)

In terms of how we compare nationally and regionally for the quantity of NHS FFT submitted, the analysis is positive. We are exceeding the national response rate. Nationally 2.2% were submitted in April 2022 and KMPT submitted 3.6% (note: there is no formal NHS national target). We are exceeding a regional comparison - Sussex Partnership NHS Foundation Trust submitted 1.1%.

In terms of how we compare nationally and regionally for performance, analysis observes a rise in performance since December 2021. We are 1% below the national ‘positive percentage’ in April 2022. Nationally patients are 86% positive about their experience. For KMPT, patients are 85% positive about their experience. This is in the range where overall, the experience of our service is ‘very good’. We are exceeding a regional comparison - Sussex Partnership NHS Foundation Trust patients were 74% positive. Patients who rated their overall experience as ‘poor’ or ‘very poor’ often comment on how their experience could have be improved. In both months, being seen often enough and wait times were the main themes that contributed to their ‘poor’ or ‘very poor’ experience. Staffing, streamlining and specialism work is progressing.

Patient Reported Experience Measures (PREM) (013-015.C)

The response rate has been improving over the year. This is a result of the embedding of the PREM which has extended its reach and uptake. Currently, performance can be expected to vary in the range between 4% and 4.8%. The highest response rate since the new PREM launched has been achieved in May 2022. This was 4.8%. The acute care group is in a good position at the end of June 2022 with the response rate being markedly above the target of 10%. They achieved 12.8% in May 2022 and 16.7% in June 2022. They have exceeded the target every month since December 2020. The other care groups are rebuilding the opportunities to give feedback into their interactions. The community recovery care group has improved the most and their response rate increased to 5% in

May 2022. Maintaining the profile of the PREM as our tool for seeking views on the quality of care is a primary driver. The CQC monitors, through the national Community mental health survey, whether trusts are seeking the views of patients. It is positive to note that the trust patient experience indicator is above 8 out of 10 which is in the top range where patients 'strongly agree' that they experience our services positively. In May 2022 the patient experience indicator was 8.1 out of 10 and in June 2022 the patient experience indicator was 8.3 out of 10.

IQPR Dashboard: Caring

Ref	Measure	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
002.C	Mental Health Scores From Friends And Family Test – % Positive	93%	N	87.2%	85.1%	82.5%	85.6%	87.8%	81.3%	84.5%	84.9%	84.5%	84.5%	79.5%	84.9%
003.C	Complaints - actuals	-	-	28	47	36	46	34	33	26	37	36	35	32	21
004.C	Complaints - per 10,000 contacts	-	-	7.19	13.36	9.83	12.94	8.78	10.15	7.25	10.99	9.71	10.81	8.57	6.06
005.C	Complaints acknowledged within 3 days (or agreed timeframe)	100%	L	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	98.0%	98.0%	97.0%	98.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)	100%	L	98.0%	98.0%	100.0%	96.0%	98.0%	100.0%	98.0%	98.0%	97.0%	98.0%	98.0%	98.0%
007.C	Compliments - actuals	-	-	141	121	106	106	195	148	187	131	162	113	115	89
008.C	Compliments - per 10,000 contacts	-	-	36.20	34.39	28.93	29.83	50.38	45.53	52.16	38.93	43.68	34.90	30.79	25.70
010.C	PALS acknowledged within 3 days (or agreed timeframe)	-	-	100%	100%	100%	100%	100%	100%	100%	100%	99%	99%	99%	99%
011.C	PALS responded to within 25 days (or agreed timeframe)	-	-	100%	100%	100%	100%	100%	99%	99%	98%	97%	98%	99%	99%
012.C	PALS - actuals	-	-	83	62	70	85	95	57	78	70	88	79	69	58
013.C	Patient Reported Experience Measures (PREM): Response count	-	-	611	541	526	585	641	653	651	634	698	511	738	691
014.C	Patient Reported Experience Measure (PREM): Response rate	-	-	3.8	3.6	3.3	3.8	4.0	4.6	4.2	4.1	4.6	3.6	4.8	4.7
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %	-	-	8.4	8.3	8.2	8.2	8.4	8.0	8.1	8.2	8.3	8.2	8.0	8.3

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

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

Issues of Concern
Memory Assessment Services, demand continues to outstrip capacity. Actions include the role out of a new model *(see below)* **CMHT waiting times for assessment and treatment impacted by staff sickness levels leading to high levels of variability across teams.**

Executive Commentary

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. Two key approaches have been agreed with the aim of identifying and resolving underlying issues:

- A secondment commenced on the 4th July to review the quality of care delivery and the robustness of the mechanisms in place to monitor and act upon findings.
- A focussed piece of work with Executive sponsorship to review the Memory Assessment caseload and apply the new operating model has commenced within CMHSOPs.

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG		F	66.3%	95.0%	52.2%	85.4%	68.8%
2	OPMH		F	68.8%	95.0%	46.8%	84.0%	65.4%
3	Trust Total		F	67.2%	95.0%	53.7%	81.1%	67.4%

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

This indicator has been amended for 2022/23: Older activity related to Routine Memory Assessments is now reported within a separate measure against a 6-week target (reported below). The activity reported against CMHSOPs for the 4 week target reflects Functional and Complex Dementia presentations. This will be split on RiO in July, following which referrals triaged as complex dementia will also be reported against the 6-week target combined with Routine Memory Assessments. The reporting methodology for CRCG activity remains unchanged.

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

now subject to common cause variation. Referrals to CMHTs and CMHSOPs in June 2022 remained above the average of the last 6 months.

CMHTs continue to show common cause variation overall, however three CMHT's continues to show special cause variation of a concerning nature with a significant reduction in performance in 2022 to date. It is important to note that the percentage noted (66.3%) above was for routine assessments and does not include the urgent assessments completed by the teams within this period. In addition to note, is client cancellations and DNAs affect the teams' ability to reach the target as the 'clock' starts at the point the referral is opened to KMPT.

Medway CMHT is showing special cause variation having achieved 35.1% for assessment completed within 4 weeks. This was an increase from 15% in May and the team has reduced their total waiting list by 20 to 140, however total list size remains high and the % waiting over 28 days increased by 35.6% to 37.9% in month. Recruitment of new staff has resulted in 1st appointments being booked well within the 4 weeks.

It is positive to note that Dover and Deal increased performance for assessments in 4 weeks (69.2) as well as reducing the percentage of their waiting list waiting over 28 days at the end of June from 3.8% from 18.5% in May. This suggests that the reduced performance in recent months was a result of clearing the backlog and it is therefore it is expected that performance against the 4 week wait will continue to increase subject to no significant changes in demand or capacity within the team.

Similarly, Shepway has seen a reduction from 34.4% to 19% in the percentage of their waiting list waiting over 28 days, as at the end of June had a waiting list of 42 patients (a reduction in month of 19).

Whilst not showing special cause variation Maidstone CMHT achieved 25.8% of assessments completed within 4 weeks, despite this they were also able to reduce their waiting list and percentage waiting over 28 days in month.

Routine Referral to assessment in 4 weeks		Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford & Canterbury CMHT			89.0%	95.0%	54.0%	103.9%	78.9%
2	DGS CMHT			83.0%	95.0%	70.5%	98.9%	84.7%
3	Dover & Deal CMHT			69.2%	95.0%	57.1%	112.7%	84.9%
4	Maidstone CMHT			25.8%	95.0%	-8.1%	109.1%	50.5%
5	Medway CMHT			35.1%	95.0%	37.1%	86.9%	62.0%
6	Shepway CMHT			34.6%	95.0%	18.7%	112.9%	65.8%
7	Swale CMHT			83.3%	95.0%	33.1%	105.2%	69.1%
8	SWK CMHT			83.3%	95.0%	34.2%	93.8%	64.0%
9	Thanet CMHT			91.2%	95.0%	57.8%	109.6%	83.7%
10	CMHT Total			66.2%	95.0%	53.5%	87.0%	70.3%

**Note: CMHT team mergers has resulted in limited historic analysis in Ashford & Canterbury CMHT*

Older Adult performance against the 4 week wait for functional and complex dementia referrals remains stable at around 70% for the fourth successive month and remains subject to common cause variation. The total waiting list as at the end of June had increased to 312 from 279 at the end of May and the percentage of CMHSOP referral waiting over 28 days had also increased by 3.9%. The focused piece of work which commenced recently indicates that reduction in wait lists is possible with improvements expected in the coming months.

The following table shows the performance of CMHSOP teams against the 6 week target for Routine Memory Assessments, highlighting 3 teams showing special cause variation: Canterbury, Medway and Swale CMHSOPs. Encouragingly three teams (Dover & Deal, Maidstone and Thanet) are also showing special cause variation of an improving nature. Overall there is a large variance across teams in performance against the 6 week to assessment measure with a range in month of 8.6% to 100%.

It is positive to note that 511 assessments were completed in June. The highest number since November 2021 and 120 more than in May 2022. The biggest increase in assessments delivered were within two teams showing special cause variation of a concerning nature (Canterbury and Medway) and therefore the decreased performance may be a result of reducing the backlog.

	016.R: Care Spell start to Memory Assessment (Routine) Assessment Within 6 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			96.0%	95.0%	71.5%	114.7%	93.1%
2	Canterbury CMHSOP			8.6%	95.0%	6.0%	68.5%	37.3%
3	DGS CMHSOP			47.1%	95.0%	29.0%	110.7%	69.9%
4	Dover & Deal CMHSOP			90.3%	95.0%	9.7%	83.9%	46.8%
5	Maidstone CMHSOP			87.3%	95.0%	43.7%	102.4%	73.0%
6	Medway CMHSOP			24.7%	95.0%	8.4%	60.9%	34.7%
7	Sevenoaks CMHSOP			9.1%	95.0%	-17.3%	68.2%	25.5%
8	Shepway CMHSOP			44.2%	95.0%	66.9%	95.0%	81.0%
9	Swale CMHSOP			100.0%	95.0%	61.2%	103.5%	82.4%
10	Thanet CMHSOP			97.5%	95.0%	15.4%	90.1%	52.7%
11	Tunbridge Wells CMHSOP			11.4%	95.0%	-11.7%	44.9%	16.6%
12	CMHSOP Total			52.6%	95.0%	36.8%	78.4%	57.6%

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**CRCG**			91.2%	95.0%	85.1%	97.8%	91.4%
2	**OPMH**			65.3%	95.0%	56.4%	78.7%	67.6%
3	**Trust Total**			76.5%	95.0%	71.5%	84.5%	78.0%

Interpretation of results (Trust wide)

Variation	Common Cause - no significant change in month
Assurance	Variation indicates consistently **failing short of target**

Narrative

Overall performance (76.4%) remains stable having been 75-80% for 7 months, following previous reductions from August 2021 when performance was in excess of 89% and increasing monthly. The overall position remains common cause variation.

CMHTs are within 4% of the target in May, however CMHSOPs remain a distance from target. This is in part a result of the increased referrals received in the latter half of 2021 as well as issues of capacity not matching demand.

The table below highlights two CMHSOPs (Canterbury and Shepway) showing special cause variation as well as DGS CMHSOP who were able to achieve 85.2% and are now subject to special cause variation of an improving nature.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			82.1%	95.0%	70.8%	107.0%	88.9%
2	Canterbury CMHSOP			56.0%	95.0%	52.2%	90.0%	71.1%
3	DGS CMHSOP			85.2%	95.0%	61.0%	101.8%	81.4%
4	Dover & Deal CMHSOP			55.9%	95.0%	46.4%	96.4%	71.4%
5	Maidstone CMHSOP			66.1%	95.0%	32.7%	89.6%	61.1%
6	Medway CMHSOP			63.0%	95.0%	51.6%	94.0%	72.8%
7	Sevenoaks CMHSOP			47.1%	95.0%	39.6%	87.4%	63.5%
8	Shepway CMHSOP			64.0%	95.0%	67.6%	104.0%	85.8%
9	Swale CMHSOP			75.0%	95.0%	62.6%	105.7%	84.1%
10	Thanet CMHSOP			70.2%	95.0%	50.5%	94.7%	72.6%
11	Tunbridge Wells CMHSOP			47.1%	95.0%	23.1%	79.6%	51.3%
12	**CMHSOP Total**			65.3%	95.0%	62.6%	83.2%	72.9%

IQPR Dashboard: Responsive

Ref	Measure	Target	Local / National Target	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	N	87.5%	78.6%	85.2%	82.8%	75.0%	89.5%	81.3%	86.4%	75.0%	76.5%	77.4%	75.0%
007.R	DNAs - 1st Appointments	-	-	11.0%	11.2%	11.5%	11.2%	10.3%	9.6%	10.0%	10.7%	10.7%	11.0%	12.4%	11.4%
008.R	DNAs - Follow Up Appointments	-	-	12.4%	9.8%	8.7%	8.5%	8.4%	7.8%	8.5%	7.8%	7.9%	8.4%	8.3%	8.4%
009.R	Patient cancellations- 1st Appointments	-	-	1.9%	2.0%	2.5%	1.9%	2.1%	2.7%	2.2%	1.9%	2.7%	2.3%	2.3%	2.5%
010.R	Patient cancellations- Follow Up Appointments	-	-	4.2%	4.5%	4.5%	4.5%	4.9%	5.0%	4.7%	4.9%	5.2%	5.4%	5.4%	5.2%
011.R	Trust cancellations- 1st Appointments	-	-	4.3%	3.9%	4.6%	4.9%	5.2%	5.4%	4.0%	3.9%	4.5%	4.9%	5.0%	4.2%
012.R	Trust cancellations- Follow Up Appointments	-	-	8.5%	9.7%	10.2%	10.4%	10.0%	10.8%	10.4%	11.4%	12.0%	11.6%	9.9%	11.4%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)	95%	-	75.0%	68.7%	60.8%	68.9%	70.0%	68.1%	57.2%	70.8%	68.3%	67.0%	63.8%	67.2%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)	95%	-	72.1%	62.2%	35.5%	49.4%	54.3%	58.0%	53.1%	59.9%	55.6%	58.2%	61.1%	52.6%
017.R	Care spell start to Treatment within 18 weeks	95%	-	88.8%	89.1%	83.3%	83.5%	83.4%	80.2%	76.8%	81.7%	78.3%	77.5%	76.1%	76.5%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)	-	-	32.5%	37.7%	36.7%	34.4%	31.4%	39.1%	37.2%	30.3%	32.2%	36.5%	26.5%	26.1%
019.R	Urgent referrals seen within 72 Hours	95%	-	59.2%	62.6%	59.8%	60.4%	61.3%	65.1%	62.3%	60.2%	58.4%	62.6%	63.4%	61.5%

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

Appendix A: Single Oversight Framework

Overview

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

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

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

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

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

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

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	May-22	Jun-22	Trend (Last 12 months where available, left to right)
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	95.8%	95.2%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		83.9%	85.7%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		255	141	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	77.4%	75.0%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.7%	95.6%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	4.5%	4.5%	
002.C	Mental Health Scores From Friends And Family Test – % Positive		79.5%	84.9%	

**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*

Appendix B: IQPR Overview and Guides

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

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

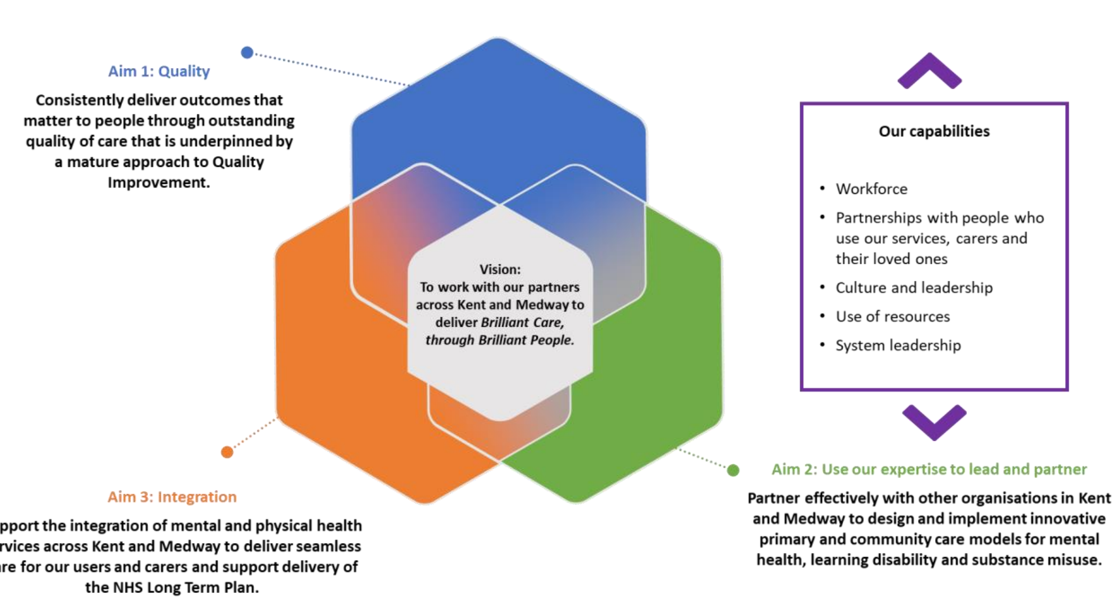
The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally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

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

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

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

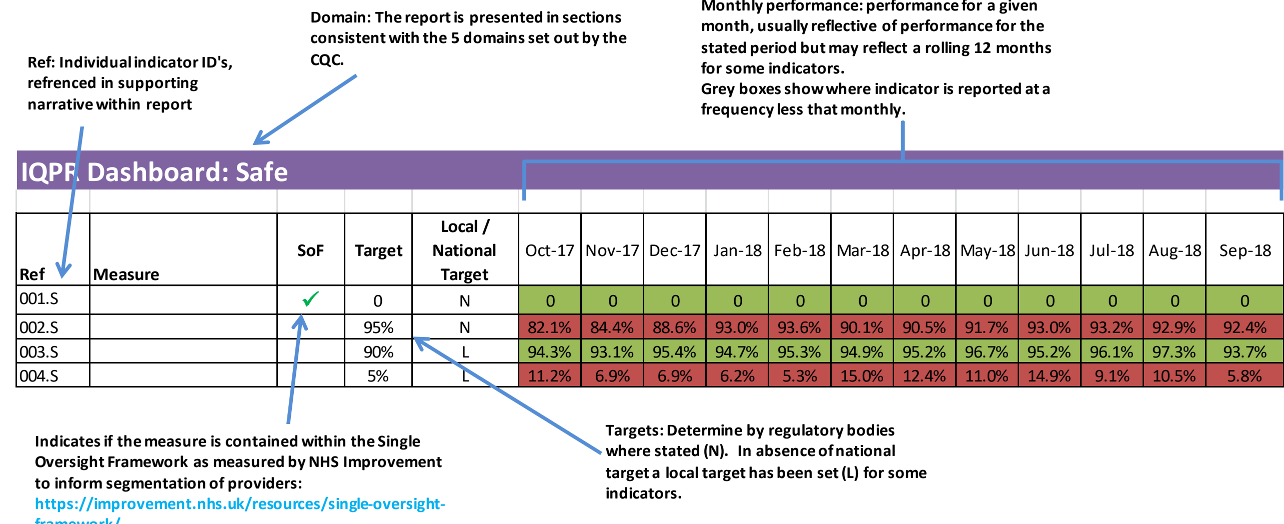
NHS
Kent and Medway
NHS and Social Care Partnership Trust


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

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%

IQPR Exception Reporting

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

SPC Key:

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

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

IQPR Change Tracker

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

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

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th July 2022
Title of Paper:	Finance Report for month 3 (June 2022)
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director of Finance

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for Month 3 (June 2022). As at the end of June 2022, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with the annual plan.

This is consistent with the position submitted to NHS Improvement in the Month 3 Financial Performance Return.

Items of focus

As at the end of June 2022 Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with plan.

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

1. The 22/23 efficiency target has an unidentified balance and it is essential that focus must be on identifying recurrent and sustainable efficiencies for the financial year. Whilst efficiency programmes have been identified it is vital that delivery plans are operationalised swiftly in order for the savings to materialise this financial year.

2. Focus needs to remain on minimalising agency spend as much as possible. It has been confirmed that Agency caps will be reintroduced this financial year so the Trust's agency spend will be under external scrutiny as per the pre-Covid regime.

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

4. In June, the Trust spent £0.4m against the capital plan of £1.4m. The year to date position is underspent by £0.8m. The underspend in month and year to date is largely due to the delay in

schemes starting such as the Fern Ward refurbishment and Improving Mental Health Services Programme.

5. The cash position remains strong at £20.7m at the end of June 22.

Governance

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

Finance Report

Trust Board

June 2022

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Executive Summary

Key Messages for June 2022

The Trust has reported a break even position for the period ending 30 June 2022. This is in line with the annual plan submission and expectation in the Kent and Medway ICS.

CCGs cease operations as of 30th June with the introduction of Integrated Care Boards (ICBs) on 1st July. ICBs are part of a fundamental shift in the way the health and care system is organised – away from competition and organisational autonomy and towards collaboration, with health and care organisations working together to integrate services and improve population health. This will not impact the Financial plan moving forward but will introduce more integrated, system based reporting, building on measures that have been introduced over the last few years that KMPT have played a key role in around capital, financial monitoring and productivity.

There are emerging opportunities around capital funding for KMPT to bid for that could make a significant difference to our patients and staff. Support Services functions are working with national teams to ensure that all opportunities are assessed, and bids are completed to a high standard to ensure the best chance of securing funding. Currently there are a number of capital funding opportunities from national funding sources for digital and estates. This funding is in addition to our existing capital programme and will likely impact in future years.

Income and Expenditure

KMPT is continuing to use temporary staffing due to vacancies and staff absence, but the spend on agency in June was lower than that seen in 2021/22 - £555k in 2022 compared to £661k in 2021, a 16% reduction. Most of the continued reduction is due to the on-going medical agency reviews being undertaken by the Executive Director of Finance, the Executive Director of Workforce and OD and Medical Director. This successful impact of stronger controls has reduced our underlying deficit, as shown on the underlying deficit reporting tab and will continue to improve financial sustainability.

In other expenditure areas, there is still significant spend on external placements for PICU - patients numbers remain high due to complexities regarding how the Trust's PICU can be utilised at present. This is expected to improve in August, but in the meantime is being supported by commissioner income.

	Year to date		
	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(58,066)	(57,400)	666
Employee Expenses	45,214	43,460	(1,755)
Operating Expenses	11,406	12,525	1,119
Operating (Surplus) / Deficit	**(1,446)**	**(1,415)**	**30**
Finance Costs	1,446	1,415	(30)
(Surplus) / Deficit	**0**	**0**	**0**

At a Glance - Year to Date

Area	Status
Income and Expenditure	Green (On or above target)
Efficiency Programme	Amber (Below target, between 0 and 10%)
Agency Spend	Green (On or above target)
Capital Programme	Amber (Below target, between 0 and 10%)
Cash	Green (On or above target)

Key

- On or above target (green)
- Below target, between 0 and 10% (amber)
- More than 10% below target (red)

Capital Programme

In June, the Trust spent £0.4m against the plan of £1.4m. Due to overspends in April and May the year to date position is underspent by £0.8m.

The underspend is largely due to delayed start and completion dates for the following schemes - Fern Ward refurbishment £0.2m, Emmetts and Walmer Porch £0.1m, Priority House & St Martins Closed Protocol Systems £0.1m, and TMHU Lift £0.1m. There has also been a delay in the Improving Mental Health Services Programme of £0.2m due to groundworks.

The capital plan for the year is £22.1m, this includes £10.5m relating to the Improving Mental Health Services programme. This is being carefully monitored and managed in year with both executive and non executive oversight.

Cash

The cash position has decreased by £0.1m in month to £20.7m. The actual cash position is £1m higher than plan, with receipts £2m lower, due to invoices to the Provider Collaborative being paid later than expected, offset by payments £3m lower than plan.

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

Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to date		
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(19,355)	(18,988)	367	(58,066)	(57,400)	666
Employee Expenses	15,115	14,390	(725)	45,214	43,460	(1,755)
Operating Expenses	3,759	4,121	362	11,406	12,525	1,119
Operating (Surplus) / Deficit	**(481)**	**(477)**	**4**	**(1,446)**	**(1,415)**	**30**
Finance Costs	481	477	(4)	1,446	1,415	(30)
(Surplus) / Deficit	**0**	**0**	**0**	**0**	**0**	**0**

Commentary

Pay is underspent at the end of June by £1.8m. Within this, substantive pay is £2.0m underspent against plan, partly offset by bank and agency spend. This is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives. For these areas, corresponding income has also been deferred to match and performance is being closely monitored between the Trust and ICS colleagues.

Other non pay at month end includes a high level of spend on external placements when compared the run rates in 21/22. The average number of patients in June was 12 including 3 acute beds and 9 female PICU.- a decrease on April and May with both seeing an average of 17 per day.

Long Term Sustainability Programme (Efficiency Programme)

	Annual	Current Month			Year to Date		
	Plan	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
Pillar	£000	£000	£000	£000	£000	£000	£000
Back Office	(816)	(27)	(64)	(37)	(84)	(192)	(108)
Workforce	(938)	(21)	(8)	13	(68)	(30)	38
Service Line Reporting	(2,905)	(95)	(76)	19	(296)	(246)	49
Patient Pathways	(905)	(31)	(84)	(52)	(97)	(255)	(159)
Procurement and Purchasing	(300)	(15)	0	15	(45)	0	45
Commercial Development	(1,130)	(93)	(63)	30	(239)	(156)	84
Non-recurrent slippage	0	0	0	0	0	0	0
Total	**(6,995)**	**(282)**	**(295)**	**(13)**	**(829)**	**(880)**	**(51)**

Commentary

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

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

Agency spend is being monitored throughout the financial year and it is anticipated that Agency caps will return naitonally to be monitored against. Controls include senior level approval for agency use, negotiation with agencies on rates offered for CVs on doctors, and work across the system on collaborative measures including the introduction of a collaborative bank model that is expected to bring about positive benefits on agency use.

Exception Report

Top Variances

	Year to date Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last report
Agency	1,871	1,701	(170)	**(9%)**	**(14%)**
Bank	4,183	4,647	464	**11%**	**15%**
External Placements	796	1,423	627	**79%**	**67%**

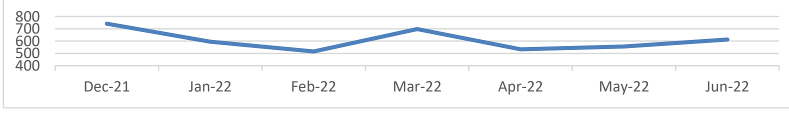
1. Temporary Staffing Spend: Agency (£170k)

Agency spend remains below plan although spend in month 3 has increased and is now only £12k below plan. There were some small increases in month across the majority of staff groups with the largest increases within medical and nursing.

There will be continued focus and scrutiny on all agency spend as the new financial year progresses to ensure spend remains within budget. No agency caps have been set nationally this year but are anticipated to return so it is vital to have clear plans in place to enable the reduction in spend.

ANNUAL	2018/19	2019/20	2020/21	2021/22	2022/23
Agency	6,459	6,395	8,740	7,537	1,701

MONTHLY TREND



2. Temporary Staffing Spend: Bank £464k

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

Month 3 continues the increase in run rate - of the £100k increase in monthly spend since the beginning of the year £30k per month is due to the anticipated pay award. The remainder of the increase will be predominantly due to covering vacancies and higher sickness across the Trust.

The Acute Care Group has needed to use higher levels of bank due to the clinical requirements and the high level of observations of a specialist patient. These additional costs are being recharged to Kent & Medway CCG and the Integrated Care Board.

MONTHLY TREND	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Nursing	567	548	643	577	595	625
Healthcare Assistants	733	984	813	752	814	757
Other	64	172	46	101	123	150
Total	**1,364**	**1,705**	**1,502**	**1,430**	**1,532**	**1,532**

3. External placements £627k

For month 3 the year to date spend remains high but in month 3 the run rate decreased to £318k from £531k and £484k in month 1 and 2 respectively.
The average number of patients in June reduced to 12 including 3 acute beds and 9 female PICU.- a decrease on April and May with both months having reported an average of 17 per day.
The run rate has increased from that seen earlier in the calendar year due to a patient being admitted to PICU with complex care requirements. It is anticipated this will reduce in the coming months when the discharge plan is actioned. In the intervening period additional costs incurred will be recharged to the CCG and ICB.

Structural Deficit

Current Annual Underlying Deficit	£6.4m

Key Drivers

Forensic Community Service	£0.8m
Forensic Inpatients	£0.4m
External placements	£1.2m
Brookfield	£0.7m
Mental Health Learning Disability Services	£1.1m
Neurology Services	£0.3m
Bridge House Detox Service	£0.3m
Agency Spend (premium element)	£1.5m
Total	**£6.4m**
Last reported deficit	**£7.7m**
Movement	***(£1.3m)***

Key Actions currently being implemented

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

Psychology review*	£0.4m
Agency controls	£0.6m
Bridge House price increases	£0.3m
Forensic service establishment review	£0.7m
MHOST (Mental Health Optimal Staffing Tool) and ward establishment reviews	£0.3m
Brookfield price increase	£0.1m
Total	**£2.4m**
Residual Annual Underlying Deficit	**£4.0m**
Target position for 31st March 2023	**£0m**
Remaining Gap	**£4.0m**

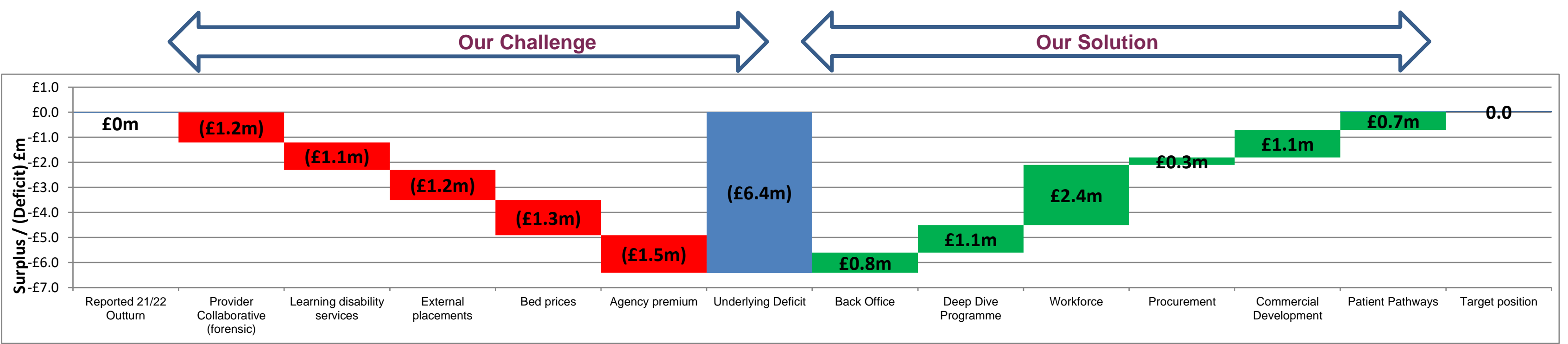
*this is the recurrent value, £0.7m will be realised in 22/23, of which £0.3m is non recurrent

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

72 %

27 %

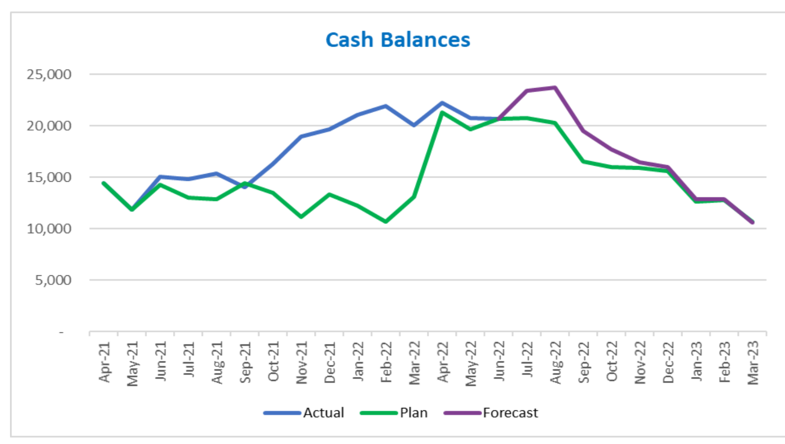
Bridging the Gap



Appendices

Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2022 *Actual* £000	Prior Month 31st May 2022 *Actual* £000	Current Month 30th June 2022 *Actual* £000
Non-current assets	139,701	157,849	157,531
Current assets	26,599	27,292	30,005
Current liabilities	(25,907)	(28,775)	(30,740)
Non current liabilities	(17,502)	(33,475)	(33,198)
Net Assets Employed	**122,891**	**122,891**	**123,599**
Total Taxpayers Equity	**122,891**	**122,891**	**123,599**



Commentary

Non-current assets

Non current assets has decreased by £0.3m in month, reflecting depreciation exceeding YTD capital expenditure.

Current Assets

The cash position remains strong with a slight decrease of £0.1m.

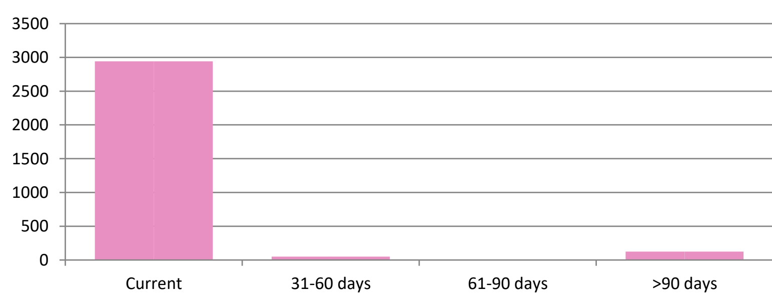
Receivables have increased by £2.8m mainly due to an increase in trade receivables of £2.4m (predominantly due to receipts from Sussex Partnership Trust relating to Provider Collaborative not being received until July). There has also been an increase of £0.2m in VAT receivables and increase in prepayment of £0.1m.

Current Liabilities

Trade and other payables have increased by £1.9m mainly due to increases in trade creditors and accruals of £1.3m and deferred income of £1.3m (relating to CCG and NHS England). The increases have been partially offset by decrease in capital creditors of £0.6m.

Aged Debt

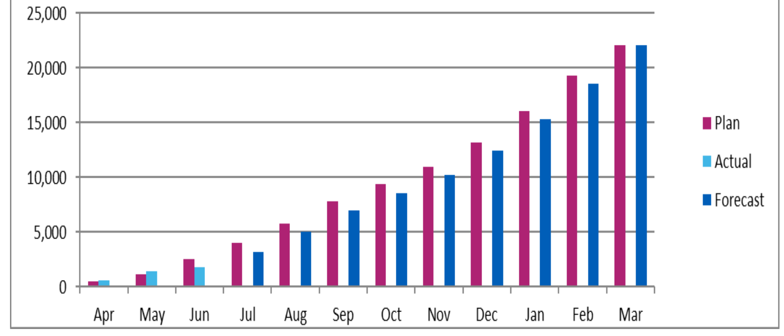
Our total invoiced debt is £3.1m, of which £2.9m is within 30 days. Debt over 90 days stands at £0.1m.



Capital Expenditure

	Current Month			Year to Date			Full Year
	Plan **£000**	*Actual* **£000**	*Variance* **£000**	*Plan* **£000**	*Actual* **£000**	*Variance* **£000**	*Plan* **£000**
Information Management and Technology	139	76	(63)	332	334	2	2,350
Capital Maintenance & Minor Schemes 2022/23	(25)	0	25	(23)	0	23	3,742
Capital Maintenance & Minor Schemes from 2021/22	813	122	(691)	1,127	583	(544)	3,412
Capital Maintenance & Minor Schemes Prior Year Adj	0	0	0	0	0	0	0
Strategic Schemes - Ward Refurbishment	0	0	0	0	0	0	2,000
Improving Mental Health Services (Maidstone)	447	184	(263)	1,087	846	(241)	10,545
PFI 2021/22	3	3	0	9	10	1	41
Total Capital Expenditure	**1,377**	**386**	**(991)**	**2,532**	**1,774**	**(758)**	**22,090**

Cumulative Performance against Plan



Commentary

In June, the Trust spent £0.4m against the plan of £1.4m. Due to the overspends in April and May the year to date position is underspent by £0.8m.

The underspend is largely due to delayed start and completion dates for the following schemes - Fern Ward refurbishment £0.2m, Emmetts and Walmer Porch £0.1m, Priority House & St Martins Closed Protocol Systems £0.1m, and TMHU Lift £0.1m. There has also been a delay in the Improving Mental Health Services Programme of £0.2m due to groundworks.

The Estates team have been supporting the CCG in refurbishing the Cedar Bungalow for 1:1 care. This is now complete and they will be focusing on completing brought forward schemes and preparing for tenders to be issued for the 2022/23 agreed schemes.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th July 2022
Title of Paper:	Delayed Transfer of Care
Author:	Victoria Stevens – Deputy Chief Operating Officer
Executive Director:	Donna Hayward- Sussex, Chief Operating Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper outlines the current position of delayed transfer of care within the older and younger adult care groups. Actions are described to address the challenges experienced.

Issues to bring to the Board's attention

There are a large number of patients who are medically fit to be discharged but due to delays in their ongoing care remain on an acute psychiatric ward. The impact on both quality and safety is of concern. This includes mental health act delays, extended length of stay in our Places of Safety and emergency department breaches.

It is recognised that KMPT will need the appropriate support from system partners to address the challenges of delayed transfers of care whilst in addition seeking creative solutions within the organisation to aid flow.

Governance

Implications/Impact:	Delays in patient receiving the right care and the right time.
Risks Recorded on:	Currently recorded on the BAF **-** Risk ID 7050 – Increased level of Delayed Transfers of Care (DToC)
Oversight:	Executive Management Team

Delayed Transfer of Care

Introduction

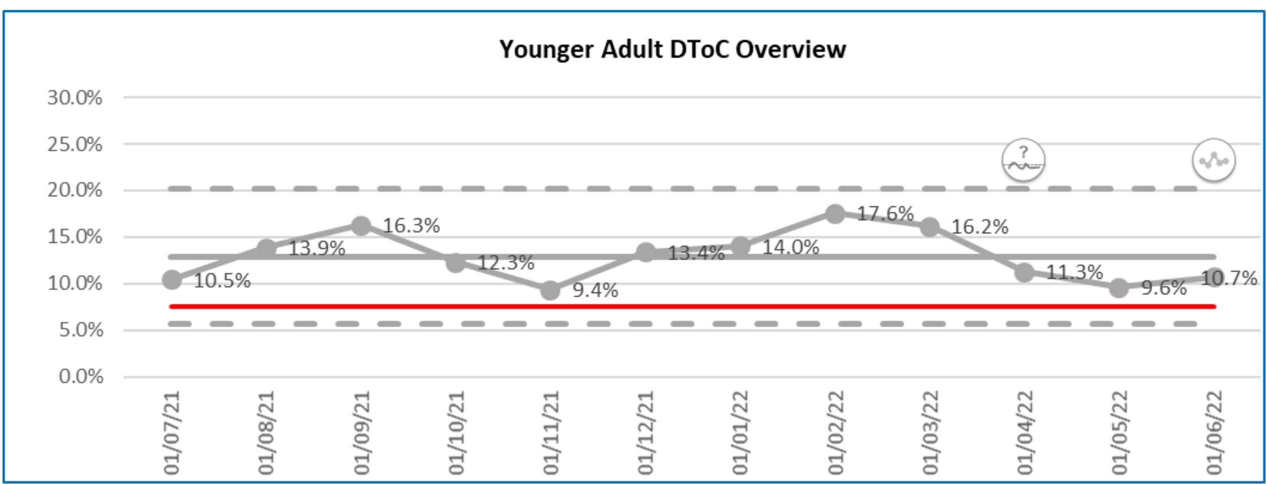
It is widely acknowledged that the NHS, as a system is facing extreme bed pressures in all specialities with an increase in referrals along with complexity as a result of the pandemic. Mental Health along with Acute Trusts are experiencing similar challenges and within KMPT this pressure is exacerbated by the number of patients who waiting for a suitable next step in their care. This includes care packages and supportive living accommodation as well as nursing and residential placements.

This paper outlines the current position and the impact on patient safety, quality and flow across the system. In addition, the immediate actions are described along with further recommendations for consideration.

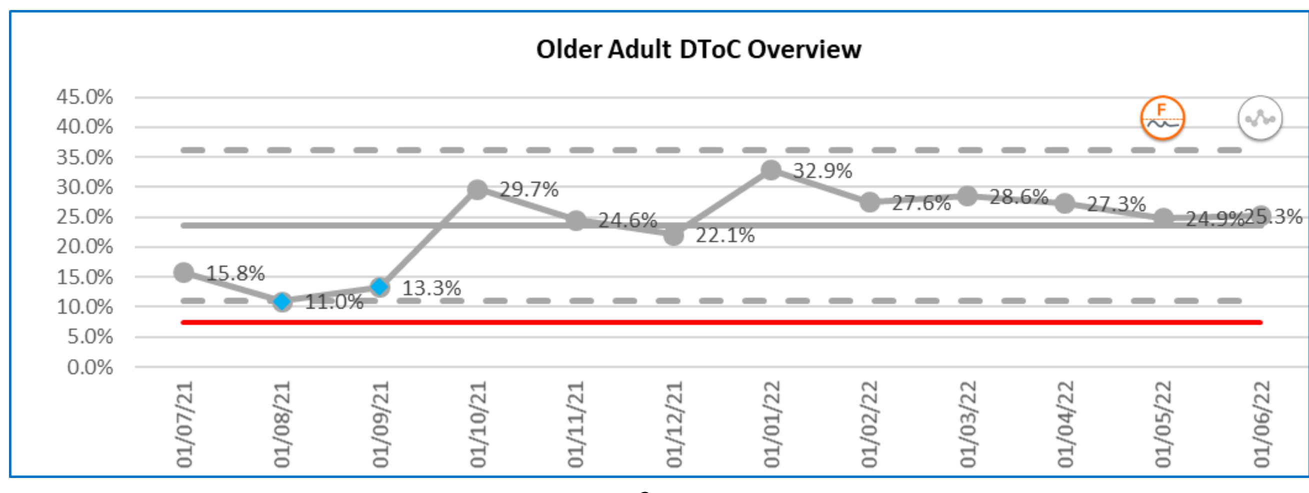
Current Position

There is a delayed transfer of care (DToC) target of 7.5% across all care groups. The data below outlines the trust position from July 2021 to June 2022 demonstrating an ongoing challenge in meeting this target.

Graph 1- DToC Younger Adults



Graph 2- DToC Older Adults



The current DToC position stands at 44 patients across both Care Groups (16 Younger Adult, 28 Older Adults). This is the equivalent of KMPT having over 2 wards closed to admissions and as a result is seriously impacting on patients accessing acute care in a timely manner.

A recent analysis undertaken showed 57% of delayed transfers are attributed to Social Care including funding delays. The remaining 43% are attributed to patients requiring a jointly funded placement, CCG funded placement or housing delays although housing delays are minimal.

In addition to the above, delays are attributed to the Kent County Council (KCC) contracted versus non-contracted position leading to significant delay in funding agreements.

Impact on Patient Flow Quality and Safety

On average there are 8-10 people waiting each day to be admitted to an acute psychiatric bed from the community, many of whom need a Mental Health Act assessment (MHAA) which includes seeking a warrant under section 135 (1), which cannot take place if a bed has not been identified. This poses a significant clinical risk for the individual person who is awaiting admission and therefore the commencement of their treatment plan.

In the month of June 2022, a total of 3 MHAAs were delayed due to no bed availability with the position worsening in July 2022 with 4 MHAAs delayed as of 20th of the month. KMPT and KCC are currently working in partnership to monitor this position with formal recording.

Additionally, there are protracted lengths of stay within the Health Based Places of Safety which has a direct impact on patient care. Specifically, the police will divert patients to Emergency Departments who are subject to a section 136. This adds to increasing pressure within emergency departments and moreover an increase in mental health breaches.

The information below suggests that on average 23.2% of patients occupy the Place of Safety for over 24hours. A further indication of pressure across the urgent pathway.

Table 1- Overview of Place of Safety Length of Stay

PoS LoS/Month	2021-07	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	2022-02	2022-03	2022-04	2022-05	2022-06	Total
0 - 4 Hours	9.70%	4.30%	3.80%	10.80%	3.00%	12.70%	8.60%	3.90%	2.10%	4.30%	2.80%	1.80%	5.80%
5 - 8 Hours	16.10%	14.00%	11.40%	16.20%	13.40%	10.90%	17.20%	9.80%	6.40%	20.30%	15.30%	15.80%	14.20%
9 - 12 Hours	14.00%	14.00%	15.20%	10.80%	11.90%	18.20%	13.80%	17.60%	12.80%	13.00%	12.50%	19.30%	14.20%
13 - 16 Hours	18.30%	21.50%	13.90%	24.30%	26.90%	14.50%	12.10%	13.70%	17.00%	8.70%	13.90%	8.80%	16.60%
17 - 20 Hours	8.60%	8.60%	12.70%	12.20%	10.40%	12.70%	12.10%	19.60%	21.30%	8.70%	15.30%	8.80%	12.00%
21 - 24 Hours	16.10%	11.80%	15.20%	4.10%	14.90%	9.10%	10.30%	11.80%	14.90%	14.50%	26.40%	17.50%	14.00%
Over 24 Hrs	**17.20%**	**25.80%**	**27.80%**	**21.60%**	**19.40%**	**21.80%**	**25.90%**	**23.50%**	**25.50%**	**30.40%**	**13.90%**	**28.10%**	**23.20%**

A further impact on operating within a reduced number of beds due to delayed transfers of care is the trusts ability to provide single sex wards and over the last twelve months period a total of 13,209 bed days have been occupied by patients who are unable to be discharged.

The table below demonstrates the impact of delays across the Younger and Older Adult Care Groups and the reason for delay, culminating in 36.1 unavailable beds per day.

Table 2- Rationale for DToC *Overview of Delayed Bed Days (July 21 - June 22)*

Responsible Provider/Care Group	Acute Service	Older Adult	Grand Total
Social Care	3760	3789	7549
Health & Social Care	1928	1910	3838
Health	1064	556	1620
Housing	202	0	202
Grand Total	**6954**	**6255**	**13209**

The financial impact on the Trust is an additional consideration. In June 2022 the occupied bed days for DToC in younger adults equates to £303,094 and older adults £362,994. Whilst it is acknowledged that the aim of the actions being taken is not to reduce the KMPT bed stock and thus release savings, it does clearly evidence that putting more beds into the system would not be helpful in solving the challenges related to flow.

Actions

The Deputy Chief Operating Officer is leading a focused piece of work to address both immediate and longer-term actions to ensure oversight and ownership of the plans. A weekly highlight report is provided to the Chief Operating Officer outlining any areas for escalation along with providing the most up to date DToC position.

Summary of Actions:

1. On 5th July 2022 a social worker seconded from Kent County Council (KCC) joined KMPT to support the interface between the two organisations and gain traction on the DToC position for Younger Adults. This role commenced with a focus on East Kent where 6 DToC cases contribute to 393 delayed days. The secondee will explore each case in depth and work to decrease the barriers for onward care.

2. A seconded social work place has recently been agreed to work specifically with Older Adult delays.

3. Revise the role and function of Social Care Early Discharge Planning Team (EDPT). It is recommended that the revised model has a dedicated Senior Social Work Lead to be responsible for the DToC within KCC.

4. Patient Flow manager is leading a weekly DToC meeting with a clear escalation process agreed across the Kent and Medway system.

5. Super stranded forum implemented to gather themes and identify gaps in commissioning and review funding pathways.

6. The Patient Flow Team to ensure potential Social Care barriers are identified upon admission.

7. Multi Agency Discharge Events scheduled for the week commencing 18th July.

Longer Term Actions

1. Explore the potential for multi-disciplinary Patient Flow Team, including Social Workers to work across wards to expediate discharge.

2. Development of step-down beds and improved offer of community rehabilitation in line with the rehabilitation change programme.

3. Development of the Complex Emotional Difficulties pathway as part of the Community Transformation thus preventing admission for people with personality disorders.

4. Reduce variance regarding Length of Stay across Younger and Older Adults' wards. Current data suggests that there are opportunities to improve the length of stay position by reducing variance in practice.

Summary

On average 40 patients a day are delayed in their onward care. This has an impact on patient flow and therefore a significant concentration is required across system partners to aid KMPT's ability to provide the standard of care we expect to deliver.

Funding delays along with issues related to closures of residential and nursing homes is evident in addition to pressures regarding the organisation of social care packages for people requiring support at home is reported as being under considerable strain.

All actions are being closely monitored to measure impact whilst recognising that the challenges as outlined require system collaboration and moreover collective solutions.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28 July 2022
Title of Paper:	Safer Staffing Update
Author:	Tumi Banda: Deputy Director of Nursing and Practice
Executive Director:	Andy Cruickshank: Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This is an update on the plans that are in place as next steps set out in the MHOST Review from May 2022. The work on shift reviews is progressing and the milestones have been reached and set to be completed by the end of the year. Staff feedback has been sort on shift working, staff have been engaged by Weekly Roundup, emails, focus groups, Team Managers and survey.

The check and challenge meetings are now set up in the care groups with established terms of reference.

Covid19 continues to disrupt safe staffing and there is an increase in case in July which is yet to peak. Plans are in place supported by the Tactical Meeting to respond to the staffing challenges.

Issues to bring to the Board's attention

The projects set up to ensure safer staffing have been established which are Roster Management, Therapeutic Observation Quality Improvement and Shift Patterns are underway since the update to Board in May 2022.

Governance

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

Version Control: 01

The Board was last presented with an establishment review in May 2021 using the Mental Health Optimal Staffing Tool (MHOST). The review fully considered multi professional contributions to inpatient care settings across all care groups. The Board was informed of the next steps in May 2022. This paper is a summary to appraise the Board on progress to ensure safer staffing in the inpatient units.

1. Shift Review

The MOST showed inefficiencies in the rosters and rosters did not promote staff wellbeing. A Shift Review project was commissioned by the Trust led by the Deputy Director of Nursing and Practice supported by the Transformation Team with all care groups represented. Below is the summary of the project plan and progress to-date. The project has a risk register which the group monitors and ensures all identified risks are mitigated.

ID	Task	Lead	Start Date	Target End Date	RAG	Updates
1	**Collate feedback from staff**					
1.1	Formulation of Focus Groups	Amanda Newman/OD	23/05/2022	15/07/2022	Completed	6 focus groups completed with varying attendance
1.11	Comms to advise staff of Focus Groups	Georgie Grassom	23/05/2022	17/06/2022	Completed	Weekly Round and email utilised
1.2	Creation of a Staff Survey	Maria Field/Whole Project Group	25/05/2022	17/06/2022	Completed	Completed survey is now open closing end of July 202223/05/22
1.3	Creation of a shared email for staff feedback	Maria Field	23/05/2022	23/05/2022	Completed	Email available to staff
1.4	Development of an iConnect Page	TBC	23/05/2022	17/06/2022	Not Started	Under construction
1.5	Updates to JNF	Tumi Banda	23/05/22	31/12/2022	In progress	In progress, Verbal update given in May, and a paper submitted in July
2	**Analysis of Data**					
2.1	Agree staff to be involved in data analysis	Data Sub group	23/05/2022	16/06/2022	In Progress	Feedback from focus group received and analysed, awaiting survey to close.

Version Control: 01

2.2	Completion of data analysis	Data Sub Group	15/07/2022	05/08/2022	Not Started	In progress
3	**Shift Pattern Development**					Currently 6 weeks to complete (to confirm timeline with JNF/SS)
3.1	Development of Shift Pattern Options	TBC			Not Started	
3.2	Options Appraisal	TBC			Not Started	
3.3	Costing of Options	Finance Team (Nicola George)			Not Started	
3.4	Proposal for Trust Shift Patterns	TBC			Not Started	
4	**Consultation**					
4.1	Detail to be confirmed with JNF/HR	TBC	01/09/2022	25/11/2022	Not Started	NB: rough dates implemented to support project development. 2/05/2022: Discussion with SS, agreed that a shorter consultation may be possible
5	**EMT approval**					
5.1	Confirm EMT approval of the outcome	TBC		31/12/2022	Not Started	

2. Check and Challenge

The roster concerns highlighted in the MHOST review are being addressed in Check and Challenge meetings. Terms of reference have been agreed with the care groups. The meetings have been set up to be chaired by the Heads of Nursing supported by Human Resources and Finance Business Partners. Meetings are held monthly. The objectives and key performance indicators are as below:

- Review of rosters using the Rostering Dashboard from the eRoster Team
- Review of roster from the Health Rosters that are finalised from the most recent roster period.
- Rosters to be published 6 weeks in advance, roster efficiency will be reviewed using the Roster Dashboard.
- Annual leave to be planned throughout the year, staff to have planned as per Roster Management Policy
- Hours owed to staff or the Trust to be under 7.5hrs per week.

The rosters to be reviewed against the following Matrixes:

Safe care fill rate will be between 80%-130%

Name	Matrix	Unit	Yellow Alert	Red Alert	Description
Safety	Unfilled Duty Count %	Percentage	20%	30%	Number of Unfilled Mandatory Duties
Safety	Shifts Without Charge Cover %	Count	0	5	Number of Shifts Without Charge Cover
Safety	Registered Skill Mix	Percentage	40%	50%	Percentage of all assigned hours filled by registered staff

Version Control: 01

Effectiveness	Additional Duties	Count	0	3	Number of assigned duties that are in addition to the agreed establishment
Effectiveness	Bank / Agency Use %	Percentage	10%	20%	Bank and Agency hours as a percentage of total assigned hours
Unavailability	Annual Leave %	Percentage	18%	22%	% of time from substantive staff that is marked as Annual Leave, leave should be between 11% and 17%
Unavailability	Sickness %	Percentage	5%	10%	% of staff time marked as Sick, Rosters to aim for Trust Target
Unavailability	Study Day %	Percentage	5%	10%	% of staff time marked as Study Day
Unavailability	Maternity / Paternity %	Percentage	3%	8%	% of staff time marked as Parenting (e.g. maternity)
Fairness	Roster Complete	-	-	✘	Shows if more than 80% of staff on the roster have shifts assigned. 20% allowance added for new starters etc.
Unavailability	Supernumerary	%	2%	4%	% of staff time marked as Supernumerary (i.e. performing non-clinical work)
Fairness	Partial Approval Lead Time	Days	84	77	Roster period publishing date (Ward Manager)
Fairness	Full Approval Lead Time	Days	84	77	Roster period publishing date (Matron/Service Manager)
Temp Staffing	NHSP Shifts Sent	Weeks	3	2	Number of weeks of shifts on the roster that have been requested to NHSP via the NHSP interface. This will only shows if the roster is fully approved

The roster publishing period has been reduced from 12 to 6 weeks as recommended, this has been welcomed by staff.

The care groups have conducted their initial meetings in June 2022. The findings so far have revealed that there are a number of roster practices which were as concluded in the MHOST findings and the Heads of Nursing are addressing these. Some of these practices included disproportionate utilisation of supernumerary shifts, rosters constructed by untrained junior staff, flexible working agreements that are not being reviewed and poor long-term sickness absence management. The check and challenge meetings are ensuring that vacancies are put on Trac and recruitment is done in a timely manner.

3. Therapeutic Observation and Engagement Project QI

The project has been set up to be a pilot on the following wards with support from the QI and Transformation Team:

- Boughton
- Foxglove
- Pinewood
- Willow Suite
- Walmer
- Penhurst
- Tarentfort Centre
- Mother and baby unit
- Ruby
- Woodchurch

The QI group is meeting regularly as a multi-disciplinary team.
The data is being pulled and shared weekly (Sunday- Monday) to the individual pilot wards and copied to the QI team. The data is being obtained from Care. The data is summary of all the levels of observations. The other measures are staff booked which is also from eRoster. The pilot

teams being aware the importance of placing the data into the E-Roster system and the ward managers are monitoring that census periods are completed

The pilot wards are to ensure that on admission the observations are being checked with a senior medic to avoid blanket observations prescriptions on admission.

There is further work to understand and reduce the reliance on multiple observations (2/3:1 for example). These are the most restrictive and the most costly forms of observation and are where some of the biggest gains are to be made in terms of improving clinical care and reducing costs.

There is learning that patient flow is key in managing observations as some wards are directed to take more acutely unwell patients because they are closer to a seclusion.

Covid19 Pandemic

There has been an increase in Covid19 cases in July 2022, 12 outbreaks have been reported so far. This has promoted a re-introduction of some Infection and Prevention Control measures such as mask wearing in clinical areas. Tactical Meeting have been re-instated to monitor how the pandemic is affecting staffing and service delivery. The Trust is monitoring the increase along with the Kent and Medway System using local and national guidance.

4. Senior Management Teams (SMT) MHOST plans

All the SMTs have plans to respond to the findings of the MHOST review as highlighted in the paper to the Board in May 2022. The plans are multi-disciplinary and there have been task and finish groups set up in Forensic and Specialist Care Group to deliver the plans. The care groups have been discussing their plans in Quality and Performance Reviews.

5. Conclusion

The plans set out in the review in May 2022 to the Board are being followed up and progress is being made to ensure that the services are safely staffed.

Version Control: 01

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	28th July 2022
Title of Paper:	NHSE/I Board Self-Certification Declaration
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

A paper setting out assurance to the Board that the Trust is in a position to self-certify that it can meet the obligations set out in the NHS provider licence and that it has complied with governance requirements.

Issues to bring to the Board's attention

On an annual basis, the NHS Provider Licence regime requires two declarations:

- Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution.
- Providers must certify compliance with required governance standards and objectives.

The Trust has a robust governance structure which supports the Trust's position that it is able to self-certify against those two declarations. The governance structure itself is subject to a number of checks and balances by way of regular oversight externally by the Trust's External and Internal Auditors, and internally by way of the Audit & Risk Committee and the Board itself.

Current assurances include year-end documentation, together with the Annual Governance Statement, which was audited by Grant Thornton in June 2022 and approved by the Trust Board in the same month.

Governance

Implications/Impact:	Impact on legal compliance - NHS trusts are subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.
Assurance:	Significant
Oversight:	Oversight by Trust Board

Version Control: 01

NHSE/I Board Self-Certification Declaration

Introduction

This is the sixth year NHS Trusts must self-certify. NHS Trusts are exempt from needing a provider licence however, directions from the Secretary of State requires NHSE/I to ensure that all NHS Trusts comply with specific conditions that are equivalent to the provider licence.

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. The self-certification requirement set out in CoS7 (3) does not apply to NHS Trusts and therefore we are not required to comply with this condition. The Trust has to self-certify that it is compliant with the following conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)).
- The provider had complied with required governance arrangements (Condition FT4(8)).

KMPT Approach and Assurance

The aim of self-certification is for providers to be assured that they are compliant with the relevant conditions. The templates supplied by NHSE/I have been completed to prove compliance, with the necessary and recommend governance processes followed which are summarised below.

- Internal and External Audit Assurance.
- Externally audited year end documentation including the Annual Governance Statement.
- Standing Financial Instructions.
- Standing Orders for the Board of Directors.
- Annual Decelerations of Interests, Fit and Proper Person Test and Corporate Governance queries.
- Managing Conflicts – Interests, Gifts, Hospitality and Sponsorship Policy and Procedure.
- Terms of Reference and Workplans for each of the Board Sub-Committees.
- Board and Board Sub-Committee Self-Assessments.
- Regular review of the IQPR, Finance Performance Report and Financial Plan by Board and its Sub-Committees.
- Regulatory inspection compliance.
- Board Assurance Framework.
- Non-Executive and Executive visits to services.

Recommendation

It is recommended that the Trust Board approves the compliant self-certification declaration for 2021-22 as per the NHSE/I requirement.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**28 July 2022**
Title	**Quality Committee Report**
Author	**Siobhan Shardlow-Wrest, Executive Assistant**
Presenter	**Catherine Walker, Senior Independent Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention
• The Committee were informed of the positive news that there were no prone restraints in June 2022, which is the first nil return since April 2015 and which is a reflection of both training and staff efforts in this domain. • The Committee noted that the KMPT Safeguarding Team have received the following feedback from system partners: KMPT are currently performing above CCG KPI delivery, referral evidence is embedded and thoughtful, safeguarding both for early intervention and children. Front line staff are asking and responding to challenging subjects to safeguarding. The assurance captured from this is that during a pandemic, KMPT was able to maintain and exceed CCG KPI training compliance and is significantly above health partner agencies. This is a significant achievement for the trust, reflecting the competing demands and impact on staffing resource during a pandemic; and demonstrates the hard work and commitment the safeguarding team, staff, and managers have in ensuring patients are protected from abuse. The CCG have recognised this achievement and have commended KMPT on this performance. The statutory duty placed on health (KMPT) is to ensure staff have the skills, tool and support to identify and respond to abuse, as defined in the Care Act 2014 and Children Act 2004, the referral rate for adult safeguarding and child safeguarding reflects that the systems in place are meeting this duty and staff are able to have these difficult conversations. • The Trust Chair and Chair of FPC joined the meeting as part of an ongoing Board conversation about assurance across Committees. The Executive are conducting a review of KPIs which will further inform that conversation.

Items referred to other Committees (incl. reasons why)
• No items to note

The Quality Committee was held on 19 July 2022. The following items were discussed and scrutinised as part of the meeting:

1. Quality Impact Assessments
2. Quality Risk Register
3. Quality Digest
4. CQC Report
5. Quality Account Priorities
6. Autism Awareness Training

7. Waiting Lists Update
8. Mortality Review
9. Operational Hot Spots and verbal Waiting List update
10. Promoting Safer Services Strategy – Progress Report
11. Patient Safety Partners
12. Patient Safety Syllabus
13. Annual Complaints Report
14. Safeguarding Annual Report
15. Safeguarding: Allegations Against Staff Deep Dive
16. Annual Controlled Drugs Report
17. Forensic Essential Training

The Board is asked to:

1) Note the content of this report.

KMPT Mortality Report – Q1

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

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

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

3 ANALYSIS OF INFORMATION

3.1 In Q1, a total of 321 mortality incidents were reported on Datix. The graph (1) below shows the figures relating to mortality that have been reported since April 2021. This includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality have decreased in Q1. When data is compared to the Q4 2021/22 Mortality Report, there has been a 31% decrease in mortality reported incidents (471 reported in Q4 2021/22). The number of Datix Death notifications reported (as part of the data reconciliation work) have decreased in Q1 2022/23, with a total of 81, compared to 167 in Q4 2021/22. This could have contributed to the reduction in mortality incidents we have seen in this quarter.

3.2 The number of COVID–19 deaths has again remained low in Q1, with a total of eight reported. The number of STEIS reported mortality incidents in Q1 was 13. This compares to 14 in Q4 2021/22. Older Adult and Acute services have seen a reduction in STEIS reported mortality incidents, whereas the number of Community Recovery STEIS reported mortality incidents has increased.

3.3 As previously highlighted to the Board, the figures will continue to fluctuate depending on the timing of updating patients' records on the national spine by General Practitioners. The vast majority of these incidents were reported by Older Adults' community teams and would have been people who had previous contact with community teams and from areas in the county with a high proportion of older people and also with more nursing or residential homes. As shown in graph 6, the number of mortalities in older adult patients is consistently higher than any other service.

3.4 Whilst the cases are reported as a death of the patient, it does not mean that the death was attributable to the organisation or that there were care or service delivery concerns. They are reported to enable a review by the Serious Incident and Mortality Panel to assure the organisation and external bodies, including families as necessary, that there

were no contributory factors relating to the death of the patient. In the event that any additional learning points are identified, the individual incidents are reviewed and action is taken to prevent reoccurrence. This can include further review in the form of a Structured Judgement Review or a Root Cause Analysis/Learning Review.

Graph 1 Mortality reported cases

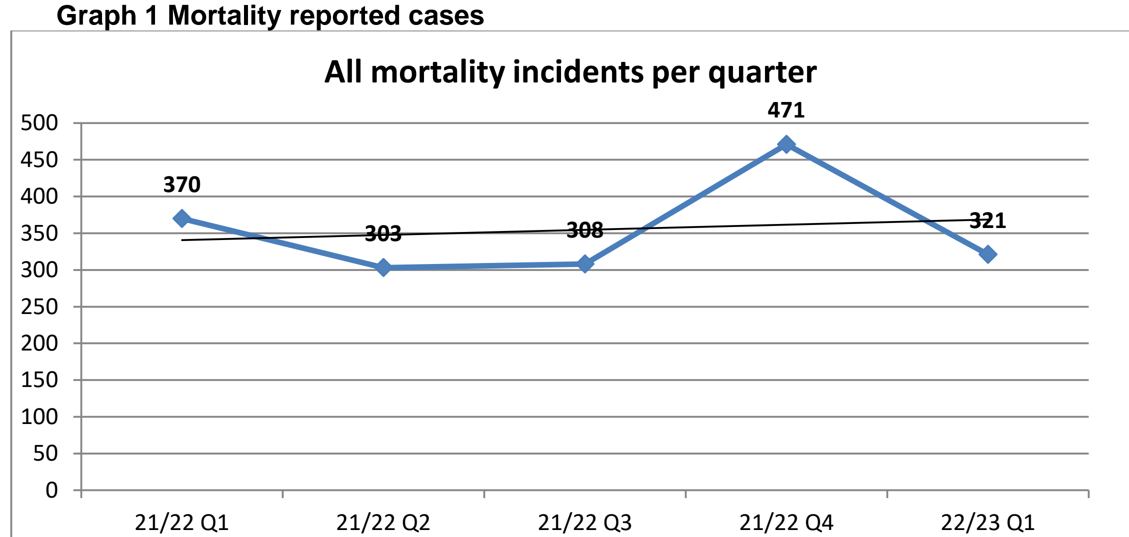


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Total
Suicide (actual)	5	2	3	2	2	3	0	1	3	2	4	0	1	28
All Deaths reported on Datix	155	75	122	107	91	97	120	174	152	144	123	107	91	1549

3.5 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q1, 1.5% of deaths of patients are suicide or suspected suicide related. This compares to 1.8% reported in the previous quarter. The average number of deaths for the 13 months above was 119 per month. For this quarter (Q1), there was an average of 107 per month. This is a decrease of 50 compared to the previous quarter, where there was an average of 157 per month in Q4 2021/22.

3.6 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services were the highest reporters. In Q1 2021/22, the number of suspected suicide incidents has marginally decreased, with a total of five, compared to six in Q4. Table 1 shows that the number of suspected/confirmed suicides has shown little change each quarter, with the numbers sitting between 5 and 7 in the last 12 months. There are still no suspected suicides reported by Forensic and Specialist Services over the course of the financial year.

3.7 Of the five suspected or confirmed suicide incidents reported in Q1 2022/23, all were for patients under Community Recovery services at the time of their death. This is different to the previous quarter, where although Community Recovery were the highest

reporters, three suspected suicide incidents were for Older Adult and Acute services. In Q1, all five suspected suicides have been reported on STEIS as a serious incident.

3.8 Analysis by age and gender

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

Age Band	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	Total
100+	5	2	1	1	1	**10**
90-99	61	47	42	72	53	**275**
80-89	121	102	103	179	112	**617**
70 to 79	74	58	62	101	62	**357**
60 to 69	33	28	26	30	23	**140**
50 to 59	31	28	30	28	26	**143**
40 to 49	20	21	23	31	21	**116**
30 to 39	17	8	13	15	18	**71**
20 to 29	8	9	5	13	4	**39**
10 to 19	0	0	3	1	1	**5**
Unknown	0	0	0	0	0	**0**
Total	**370**	**303**	**308**	**471**	**321**	**1773**

Table 3 Deaths reported on Datix by gender and age

	100+	90-99	80-89	70-79	60-69	50-59	40-49	30-39	20-29	10-19	Total
Male	0	21	59	34	12	15	16	15	3	0	175
Female	1	32	53	28	11	11	5	3	1	1	146

Table 4 COVID-19 deaths by gender

	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Total
Female	1	0	0	0	2	2	2	5	2	1	3	2	1	21
Male	0	0	2	3	3	1	1	1	1	4	1	1	0	21
Total	1	0	2	3	5	3	3	6	3	5	4	3	1	42

3.8.1 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age, residing in residential or nursing homes and presenting with co-morbidities. In Q1 there have been eight incidents where the criteria for Structured Judgement Review (SJR) was met. Five for the Older Adult Care Group and three for Community Recovery Services. Five cases met the criteria due to patient diagnosis. Two cases have been identified for SJR as an ad-hoc review and for one case it was agreed to undertake an SJR due to family raising concerns about the care provided. All are in the process of review and will be shared with the treating teams and patient safety leads once complete.

3.8.2 We continue to see low numbers of mortality from COVID-19. A total of eight COVID-19 deaths occurred in Q1 2022/23. These either relate to patients who died in the community or in an acute hospital. There have been no mental health inpatient deaths reported in Q1.

3.8.3 When data is analysed for reported deaths within KMPT according to gender, indications are that figures of mortality in men are usually higher than in women. The number

of deaths of males was higher in Q1, with a total of 175, compared to 145 of females. The Q1 2022/23 data shows that the vast majority of patient deaths was due to natural causes, including deaths of patients living in a care home or nursing home, and of patients who died in an acute hospital, unrelated to their mental health condition. The overall figures of mortality are higher in older adults, with 75% of the total mortality incidents reported in Q1 2022/23 relating to patients over the age of 65.

3.8.4 In Q1 there was one mortality incident that related to a patient under the age of 20 years old. This also compares to one reported in Q4 2021/22 also. The data suggests that we there has not been an increase in mortality of patients under the age of 20. The case in Q1 related to a 19-year-old female, who was appropriately discharged from the Liaison Psychiatry service in July 2020, almost two years prior to their death, with no other contact with mental health services in the interim. As the death was over 12 months after discharge, no further investigation was required.

3.8.5 The overall figures of mortality have decreased in Q1 2022/23. As demonstrated in Table 2, there has been a reduction of mortality incidents for each age category, with the exception of age categories 10 to 19 and 30 to 39. As previously mentioned, the number of mortality incidents relating to patients under the age of 20 have not changed in Q1, compared to Q4. Mortality incidents relating to patients aged between 30 to 39 have slightly increased (18 in Q1 compared to 15 in Q4 2021/22). This is the highest amount seen over the 13 months, as shown in Table 2. Where the numbers have not significantly increased, a brief review has been undertaken to understand the figures.

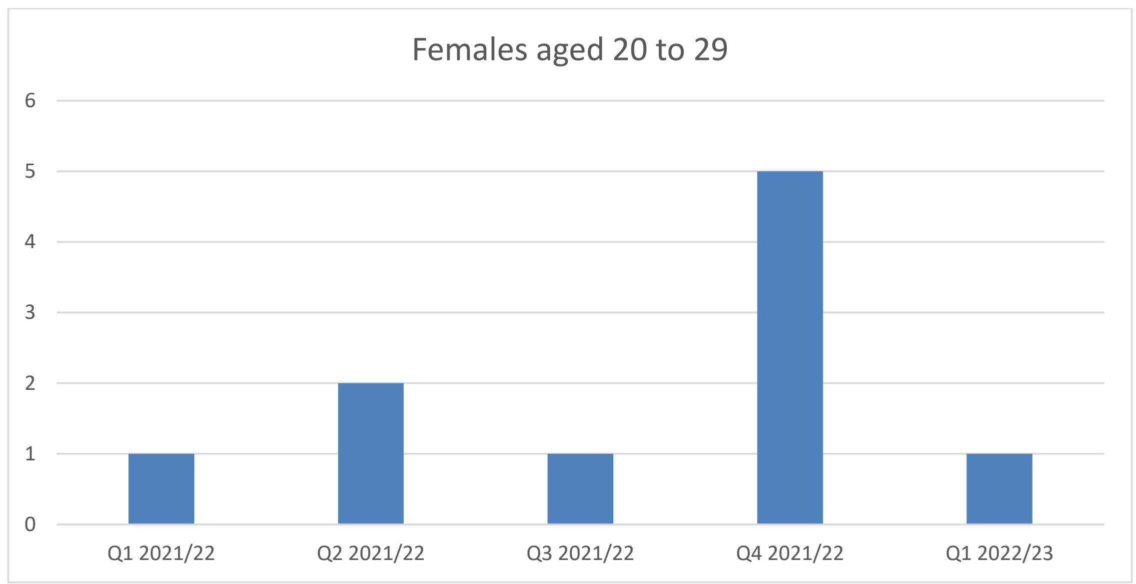
3.8.6 A review of the 18 mortality incidents relating to patients between the ages of 30 to 39 has shown the following:

- All patients died unexpectedly
- 12 cases were reported to KMPT Legal Services by HM Coroner.
- One incident is recorded as suspected suicide. An additional case has been reported as a suicide attempt, where the patient has sadly died. No care or service delivery issues were noted following review of the case in the SI and Mortality Panel.
- 11 patients were discharged from services at the time of their death. Six of these patients were discharged from services over 12 months before their death.
- One patient is believed to have died from natural causes

3.8.7 Where there seems to be an increase in deaths of patients within this age category, the numbers are not significant, and as shown above, most relate to patients who were not open to KMPT services at the time of their death. 16 of the 18 cases have been downgraded in the SI and Mortality Panel, as no care or service delivery problems have been identified.

3.8.8 It was identified in the Q4 2021/22 mortality report that there appeared to be an increase in deaths of female patients aged 20 to 29. For the purpose of monitoring, the numbers have been reviewed in this report to evidence that the figures have not continued to increase, but have in fact decreased in Q1 2022/23, as shown in Graph 2

Graph 2 Mortality in females ages 20 to 29



As shown in Graph 2, there was a spike in mortality of female patients aged 20 to 29, with a total of five reported in Q4. When we compare this to the data pulled for Q1 2022/23, the figures have again decreased to what we would consider usual numbers for this age and gender category.

Graph 3 All reported mortality incidents within KMPT by gender of patients

All Reported Deaths by Gender

250
200
150
100
50
0

21/22 Q1: Female 173, Male 197
21/22 Q2: Female 131, Male 172
21/22 Q3: Female 145, Male 163
21/22 Q4: Female 238, Male 232
22/23 Q1: Female 146, Male 175

Female
Male

3.8.9 In Q1, the six cases of suspected suicide by age and gender were as follows in table 5.

Table 5 Suspected suicides by age and gender

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

90 – 99 years	-	-

3.8.10 With the National data indicating that suicide in middle-aged males (between the ages of 40 to 54 years) is typically higher than other ages, the Q1 2022/23 KMPT data for suspected suicides has been reviewed and compared to that of the data provided by the NCiSH. As shown in Table 5, there were five suspected suicides reported in Q1 2022/23, a slight decrease from the Q4 figures. For the 11 suicide deaths reported over the past two quarters (Q4 and Q1), only one male patient was between the ages of 40 and 54 years.

Common ages identified in the Q4 mortality reported were:

- 20-29 (male)
- 40-49 (female)
- 60-69 (male)

This compares to the following, identified in Q1:

- 50-59 (female)

3.8.11 Suicide in males does tend to be higher than females, however the age categories vary quarter by quarter. This again represents a different picture to that of the national data, as shown in Table 5. As there were two suicides reported in Q1 relating to females between the ages of 50 and 59, a brief review has been undertaken.

3.8.12 For the two female patients who died from suspected suicide in their fifties in Q1, one female died from hanging and one is believed to have died from a fatal overdose. Both cases have been STEIS reported and are in the stages of investigation.

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

3.9 Mortality review by ethnicity

Table 6 Deaths by ethnicity

	21/22 Q1	21/22 Q2	21/22 Q3	21/22 Q4	22/23 Q1	Total
Bangladeshi	0	0	0	0	1	1
Black African	2	0	0	1	1	4
Black Caribbean	0	0	0	1	0	1
Chinese	1	0	0	0	0	1
Indian	1	0	1	2	1	5
Mixed white and Asian	0	1	1	1	1	4
Mixed white and black African	0	0	0	0	1	1
Mixed white and black Caribbean	2	0	0	1	1	4
Not stated	33	24	42	50	32	181
Other Asian	1	1	4	1	2	9
Other Mixed	0	1	0	1	2	4
Other ethnic category	0	1	2	1	2	6
Pakistani	0	0	0	0	0	0
White - British	324	269	248	404	271	1516

White - Irish	1	1	0	2	2	6
White - other white	5	5	10	6	4	30
Unknown	0	0	0	0	0	0
Total	370	303	308	471	321	1773

3.9.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British. On reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were eight in Q1 2022/23, compared to seven in Q4 2021/22. Of the BAME deaths in Q1 2022/23, two incidents were reported to KMPT Legal Services by the Coroner. One incident was retrospectively reported as part of the data reconciliation work. Six of the eight incidents have been downgraded in the Serious Incident and Mortality Panel, following a review of the care provided.

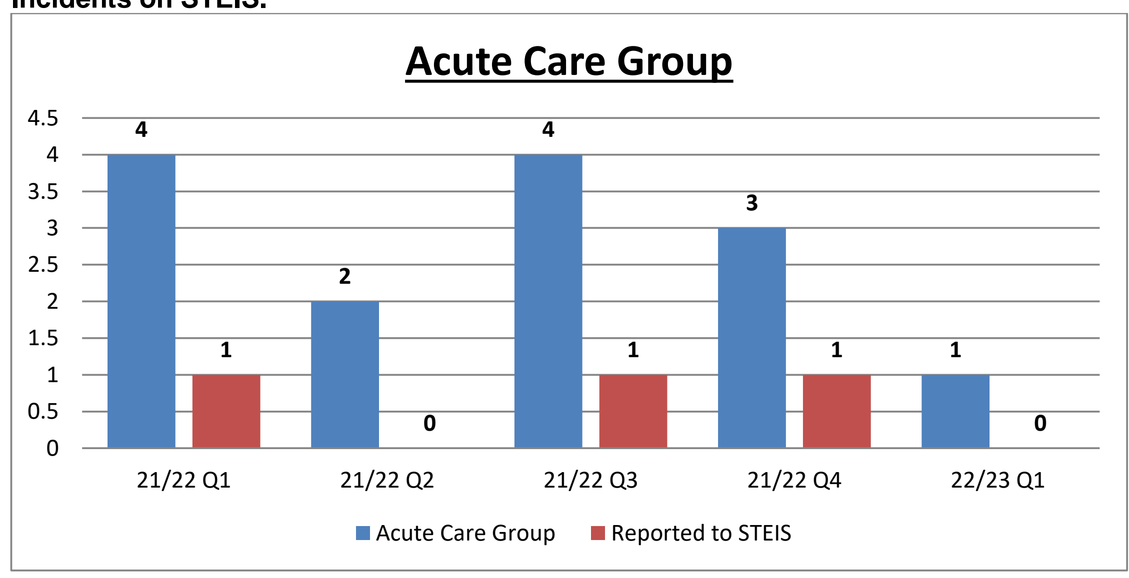
3.9.2 One of the BAME deaths has been STEIS reported. This is currently in the stages of investigation.

3.9.3 Of the 321 incidents reported on Datix during Q1 2022/23, 10% had no ethnicity recorded compared to 9.6% in Q4. It is recognised that there is room for improvement when recording ethnicity in patient records, although this could be for a number of reasons, including the patient not consenting to the information being shared or recorded.

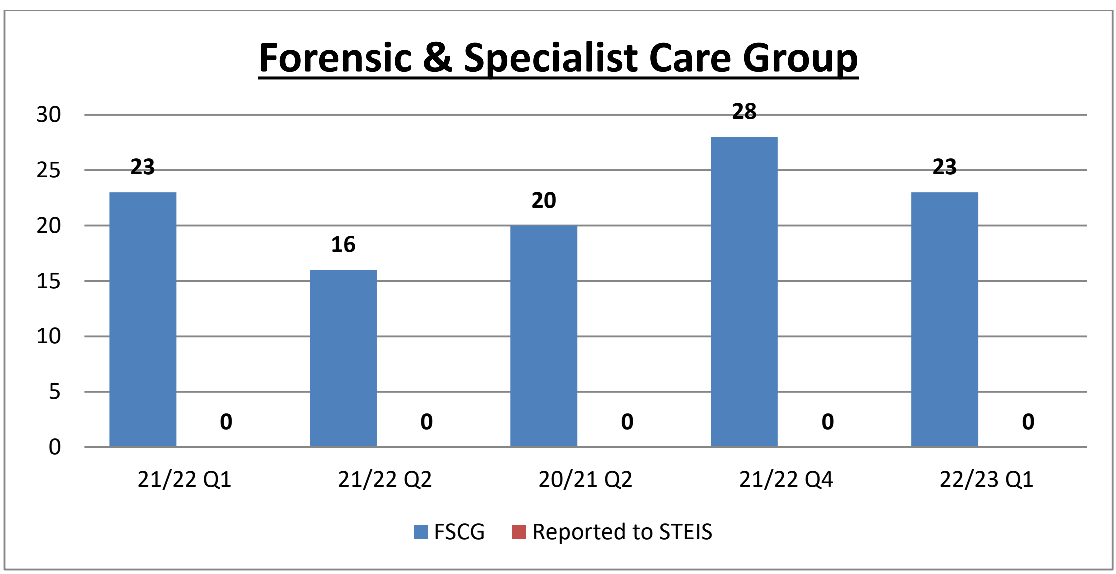
4 Serious Incidents and LeDeR cases

4.1 The following graphs (4 to 7) show the mortality incidents reported for the period 01/04/2021 to 30/06/2022 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

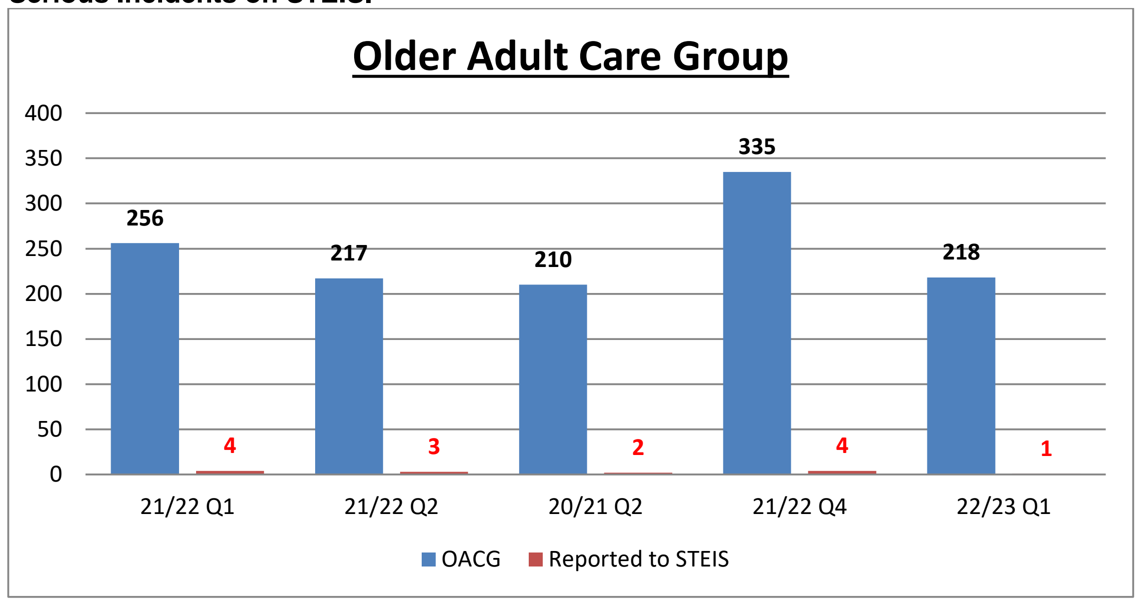
Graph 4 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.



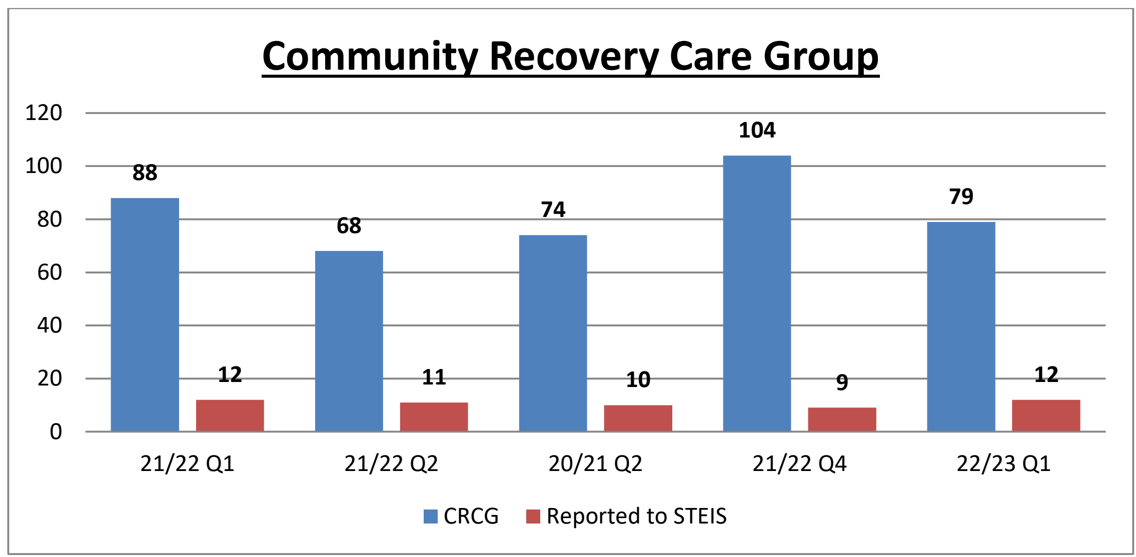
Graph 5 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.



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



Graph 7 Mortality by Community Recovery Care Group and numbers of those reported as Serious Incidents on STEIS.



4.2 A total of 13 mortality serious incidents were reported in Q1, compared to 14 in Q4. The percentage of serious incidents compared to overall mortality in Q1 is 4%, this compares to 3% in Q4. Acute and Older Adult STEIS reported mortality incidents has decreased in Q1, whereas Community Recovery STEIS incidents has increased, as shown in the graphs above.

4.3 When we compare the overall mortality figures for Community Recovery services over the 13 months, the number of incidents reported in Q1 are not too dissimilar in quantity, however the number of STEIS reported mortality incidents have slightly increased, when measured against the previous quarters.

4.4 On review of the 13 Serious Incidents relating to mortality that were reported on STEIS in Q1, five relate to suspected suicide and are in the stages of investigation. Some of the remaining serious incidents relate to mortality where cause of death may not be known but where care and service delivery problems have been identified that may have contributed to the patient's death.

4.5 Initial learning from the STEIS reported cases are as follows:

- Lack of exploration of risk of self-harm and suicide. (4)
- Risk assessment was not complete (4)
- Incomplete care plan (4)
- Long gaps between contact with the patient/ lost to follow up (3)
- Safeguarding not raised (2)
- Transfer of care did not take place (2)
- 72 hour follow up was not face to face or in time (2)
- Documentation standards not adhered to (2)
- Lack of communication between KMPT services (2)
- Carer views not gained/ support not offered (2)
- ECG and electrolyte monitoring was lacking
- DNA policy not followed
- Some concerns around physical health monitoring
- Patient was not seen face to face
- Unclear care pathway
- Patients referral not treated as emergency
- Concerns around decision to discharge a patient from services

- Lack of joint working with external agencies
- Unclear why patient was removed from the Red Board
- No evidence that crisis team was considered when risk increased

4.6 As shown, the most common areas of concern identified in four individual cases, are a lack of exploration of the patients' risk at the last contact, and risk assessment and care plans either not being created or completed. The initial concerns will be reviewed and analysed in more detail through the root cause analysis process.

4.7 In Q1, there were four mortality incidents where the patient had a diagnosis of a learning disability or autism, all of which have been reported to LeDeR, as per national guidance. Two patients were of white-British ethnicity, one of other-white ethnicity and one is unspecified. All patients were male. All four incidents have been downgraded following review of the care in the SI and Mortality Review Panel. Three patients were in their fifties at the time of their death, and one patient was in his seventies.

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

5. STRUCTURED JUDGEMENT REVIEW LEARNING

5.1 There have been no Serious Incidents to come from SJRs in Q1 2022/23. However some learning, not previously highlighted during initial review has been identified. This has been further discussed in the SI and Mortality Panel and shared with the care groups.

5.2 Themes from SJR's will be pulled to understand the common areas of good and poor care. This will contribute to learning and continued improvement of patient care. The Mortality Review Manager has worked with the Trusts Datix team to create learning fields on the Datix incident form. Once populated, this will enable an easy pull of themes relating to the different phases of a patients care that have been reviewed.

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

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

5.4 Some common areas of learning identified in Structured Judgement Reviews are so far are:

Good care:

- Evidence of comprehensive assessments and follow up by the community teams
- Evidence of joint working with external agencies
- Evidence of mental capacity being considered
- Smooth transition into services and transfer of care
- Evidence of consideration of the need for alcohol support services and encouragement provided to patients
- Good physical health monitoring on a mental health ward

Areas for improvement:

- A group of cases identified missed opportunities to complete physical health checks in the community. This included requesting an ECG for patients on an antipsychotic medication
- Lack of joint working with external agencies (e.g social care)
- Inconsistent documentation in health care records

- Lack of documented plan for patients, including a gap in contact (response to staff sickness/changes)
- Other incidents not always logged onto Datix

6. THE MEDICAL EXAMINER

6.1 KMPT are preparing for the implementation of the Medical Examiner in Mental Health. In June 2022, the government announced in Parliament its intention to work towards commencing the statuary medical examiner system from April 2023, recognising the need for all relevant government departments to be ready and aligned to enable successful implementation.

6.2 In March 2021, NHS England and NHS Improvement submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2022 ('section 251 to support') to process confidential information without consent. The approved application can be found on the Health Research Authority's website. When the statutory medical examiner systems commences, it is expected that organisations will add medical examiners to the list of persons with a right to access to patient records in the Access to Health Records Act 1990. We understand that for KMPT the numbers will be small in comparison to the deaths reported.

6.3 The Mortality Review Manager is taking steps to prepare for this and is working with the Medway ME office in organising a county-wide meeting. The aim of this is to ensure that KMPT have a streamlined process with the different Medical Examiner offices. The Mortality Review Manager will update the Board with any developments via relevant Trust-wide meetings.

7. CONCLUSION AND NEXT STEPS

7.1 Mortality incidents recorded on Datix have decreased in Q1 2022/23, compared to Q4 2021/22. This could be due to a reduction in Datix Death notifications as part of the data reconciliation work, with a total of 81 retrospective deaths reported in Q1, compared to 167 in Q4 2021/22. That being said, the Q1 figures are not too dissimilar to those in Q3, Q2 and Q1 2021/22, with the numbers sitting between 300 to 370.

7.2 The mortality data indicates that suspected suicides have not risen in this quarter, with a total of five reported in Q1, compared to six in Q4.

7.3 Where it was thought the numbers of mortality in age categories 20 to 29, 30 to 39 and 40 to 49 had increased in Q4, the Q1 figures have shown a reduction. There was an initial concern that deaths in younger females, aged 20 to 29 was increasing, however this does not appear to be the case when we compare to the Q1 data. Five females within this age category died in Q4 2021/22, compared to the one in Q1 2022/23. This will continue to be monitored.

7.4 The Mortality Review Manager will continue to work with the Medical Examiners in Kent, in preparation for the roll out of the Medical Examiner process in Mental Health.

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

Title of Meeting	Workforce and Organisational Development Committee (WFODC)
Meeting Date	19th July 2022
Title	Workforce & OD Committee (WFODC) Report
Author	Venu Branch, Chair of WFODC
Presenter	Venu Branch, Chair of WFODC
Executive Director Sponsor	Sandra Goatley, Director of Workforce & OD
Purpose	Assurance

Matters to be brought to the Board's attention

Positive Assurance:

- Community Recovery Care Group Presentation: Presented a good report on their challenges and achievements. In the high-level summary provided from the Staff Survey Results, it was reported the Community Recovery Care Service achieved the biggest improvement in response rates of all the care groups. They achieved an engagement score of 6.9. They are the only care group to have seen their engagement score increase each year for the last 4 years.
- The care group outlined some Business Developments/Service changes which include:
  - A rehabilitation transformation
  - Looking to become a fully core 24/7 in all Liaison Services

- Staff Health and Wellbeing Strategy: This was approved. This strategy has been reviewed and in October 2021 KMPT was selected by NHS England as one of the 14 national trailblazers who were tasked as early adopters of the updated version of the NHS Health and Wellbeing Framework. A key commitment as part of KMPT's participation in the pilot was to develop a Health and Wellbeing Strategy which aligns with the 7 elements of the framework. This strategy is focused with the emphasis on prevention.

- Social Work Workforce Development Strategy: Social work is one of the 8 key roles in mental health delivery and a key to achieving the ambitions of the NHS long term plan. The strategy presented outlines the development of the Social Work workforce in KMPT and assurance that the strategic direction for developing social work as one of the core professions within our multi-disciplinary structure for delivering front-line support and care services.

Issues of Concerns:

- HR Risk Register: There are ongoing challenges with workforce and the risks remain red. We recognise these are ongoing issues and are also a national issue. A new risk was added relating to the increase in elective surgery which might put additional strain on retention and staff absence. The risks are reviewed on a monthly basis with the Risk Support Team.

Approvals

- The items detailed below were approved by the Committee:
  - KMPT Staff and Wellbeing Strategy - APPROVED

Items referred to other Committees (incl. reasons why)
• None • This Committee is chasing a report back from a referral to the Quality Committee.

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

Matters to be brought to the Board's attention
• CQC Actions from the Rivendell Rehabilitation Unit MHA Monitoring Visit – A Non-Executive Director visit took place at the Rivendell Rehabilitation Unit 2 years ago were some questions and issues were raised and assurance was provided that these issues were being dealt with. A recent MHA Monitoring visit took place at the same service and the same issues were identified. How do we capture these issues. • Staff engagement in estates projects – a common theme that came out of MHA monitoring visits was staff wellbeing and estates. There was a concern around staff consultation before estates projects take place and considering how staff are affected when these projects take place. Engagement with the end user must be a fundamental principle going forward. Can the Committee be assured that this will be baked in going forward? • The White Paper – there are several proposed changes to the Mental Health Act, which are due to proceed through parliament to receive royal assent in 2023/24 with full implementation by 2030. An impact assessment has been prepared for the draft bill which outlines the cost implications for bodies and organisations. alongside the proposed changes to the Mental Health Act. • MHAC Terms of Reference (for approval) – The Board are asked to approve the MHAC Terms of Reference. The only changes made were grammatical changes and changes to job titles.

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

MHAC met on 11th July 2022 to consider:

Significant assurance:

- Chief Medical Officer's Report
- MHLOG Report
- Report from Associate Hospital Managers
- Legislation Update

Reasonable assurance:

- Mental Health Act Activity Data Quarterly Report
- Mental Health Act Monitoring Visits Actions

MHLOG Report

MHLOG discussed an operational concern that staff deal with daily following the expiry of the Section 136. A task and finish group has been formed who are currently reviewing the process and recommendations will be made to MHLOG. MHLOG was also cited with a new initiative that was designed to support patients in terms of debt. The Section 132 Rights Policy was also approved.

MHA Activity Data Quarterly Report

This was the second time the Committee received the new Mental Health Act dashboard, which is moving in the right direction but more work to do changes to and these have been requested. It was highlighted that the Trust has sustained its reduction in section 136 assessments and there has also been a reduction in section 2 retentions.

CQC Actions & QIP Actions Arising from MHA Monitoring Visits

It was noted that the key themes that came out of the recent MHA Monitoring Visits was staff wellbeing and environment.

Chief Medical Officer's Report

There has been a sustained reduction in the backlog of manager's hearings in Maidstone which has reduced from 54 to 22. The Trust continues to provide Health Act training to Maidstone and Tunbridge Wells NHS Trust (MTW) and the positive response being received from MTW staff. The number of the questions to the Mental Health Act team has also reduced as a result. the Mental Health Act draft bill has now being signed and the pre-implementation scrutiny phase will now begin.

Report from Associate Hospital Managers

The Associate Hospital Managers (AHMs) now meet 3 times a year with one meeting in person. All AHMs have now received trust laptops and are due to discuss hybrid working and patient choice in in-person or virtual hearings.

Legislation Update

Following the consultation of the white paper to reform the Mental Health Act, there are a several proposed changes to the Mental Health Act. It is hoped that the changes will proceed through Parliament to receive royal assent in 2023/2024, will full implementation taking place in 2030. An impact assessment has been prepared for the draft bill which outlines the cost implications for bodies and organisations. alongside the proposed changes to the Mental Health Act, there are also legislative changes currently for LPS and the Diagnostic Coding Manual.

Terms of Reference

Minor changes were made to the terms of reference including grammatical changes and job title updates. The Board are asked to approve the minor amendments.

	Title of Meeting	**Board of Directors**
	Meeting Date	**28th July 2022**
	Title	**Finance and Performance Committee (FPC) Report**
	Author	**Mickola Wilson (Chair of the Committee)**
	Presenter	**Mickola Wilson**
	Executive Director Sponsor	**N/A**
	Purpose	**Assurance**

FPC met on 28 June to consider the following:

- IQPR
- Financial Report (Month 2)
- Financial Forecast
- Underlying Deficit/CIPs update
- BAF Risk Register
- Operational Maintenance Contract
- SLR Report
- Dormitory Eradication (Ruby Ward) Update
- Business Cases x 4
- New Risks identified
- Annual review of Terms of Reference and Committee Workplan

Area	**Assurance**	**Items for Board's Consideration and/or Next Steps**
IQPR	*Limited Assurance*	Committee requested report re the financial implications of the demand and capacity work for the Memory Assessment Service (MAS). A review of current capacity for MAS to be conducted and if there is a need to increase capacity to cope with demand, this should be costed for the Committee's reference. Concern regarding data quality and ability to hit 95% targets. SS/DHS to look at possibility of short term/interim targets. SS/DHS to draft proposal stating what can be delivered in the short term, for consideration by the Board
Underlying Deficit/CIPs Update	*Limited Assurance*	Of the £7m target, £2m is now fully developed and £4.5m of savings is in progress Committee requested an updated underlying deficit slide which incorporates the impact the NHSE contract has had, which has impacted particularly in the Forensics Care Group. VF outlined key steps being taken. With the Corporate cost return due on 13th July, all up to date information will be available for report to Board in September 2022.

Financial (month 2)	*Reasonable Assurance*	Month 2 outcome in line with expectations and breakeven reported. Required re-submission of Annual Plan was completed on 20th June 22, with minimal changes to Plan submitted in April 22. Good work around medical agency has resulted in positive position. More to be done in terms of nursing agency. High level spend on PICU is result of one LDA patient as previously reported but CCG have pledged support.
Risk Register	*Reasonable Assurance*	There are currently five financial risks appearing on the Board Assurance Framework. Of these, three have been identified as extreme - The lack of availability of capital funds, the long-term financial sustainability of the Trust and the availability of funding for maintenance services There are two high rated financial risks on the Board Assurance Framework associated with the planning cycle for 22/23 and delivery of the CIP programme and the impact of external market forces. Committee requested review of target completion dates. VF to speak to Risk Manager
Business Cases	*n/a*	Committee reviewed 4 Business cases: • **At Risk Mental States (ARMS)** – developing service, funded by CCG. Possible impact on EIP service/ confident roles will be attractive. **Business Case APPROVED** • **Functional ACPs** – Also funded by CCG. Service happy not going to lose staff from existing service. Will give staff opportunity to move around the patch **Business Case APPROVED** • **Estates Capital Development Team** – Business Case for substantive staff rather than relying on external agency staff. Will see capital benefits over time in terms of delivering programme. **Business Case APPROVED** • **Quality Improvement** - to be funded initially from repurposed funding from Care Group budgets and identified contingency with the intention that it will be self-funded next year from efficiencies delivered by QI projects **Business Case APPROVED**
Terms of Reference/ Committee Workplan	*n/a*	ToR to be updated to include indication of items raised by exception. VF to prepare update TOR for virtual approval by Committee. Committee workplan to contain items raised by other sub committees as an exception and for escalation to FPC