AGENDA

Title of Meeting	Trust Board Meeting (Public)
Date	30th November 2023
Time	09.30 – 12.00
Venue	Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/23-24/84	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/23-24/85	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/23-24/86	3.	Personal Story – Acute Directorate – Admission Experience	FN	Verbal	DHS	09.35
TB/23-24/87	4.	Quality Improvement - Zonal Observations as an alternative to Enhanced Observations for Managing Sexual Risk in a Low Secure Learning Disability Service	FN	Verbal	AQ	09.45
STANDING ITEMS						
TB/23-24/88	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/23-24/89	6.	Action Log & Matters Arising	FA	Paper	Chair	10.00
TB/23-24/90	7.	Chair's Report	FN	Paper	JC	10.05
TB/23-24/91	8.	Chief Executive's Report	FN	Paper	SS	10.10
TB/23-24/92	9.	Board Assurance Framework	FA	Paper	AC	10.15
TB/23-24/93	10.	Trust Risk Register	FD	Paper	AC	10.25
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/23-24/94	11.	MHLDA Provider Collaborative Board Progress Report	FN	Paper	AR	10.35
OPERATIONAL ASSURANCE						
TB/23-24/95	12.	Integrated Quality and Performance Review	FD	Paper	SS	10.40
TB/23-24/96	13.	Finance Report	FD	Paper	NB	11.00
TB/23-24/97	14.	Workforce Deep Dive – Medical Recruitment	FD	Paper	AQ	11.10
TB/23-24/98	15.	Medical Revalidation Report	FA	Paper	AQ	11.25
TB/23-24/99	16.	Community Mental Health Transformation Update	FD	Paper	DHS	11.35
TB/23-24/100	17.	Standing Orders and Standing Financial Instructions	FA	Paper	TS	11.40
TB/23-24/101	18.	Committee Terms of Reference	FA	Paper	TS	11.45
CONSENT ITEMS						
TB/23-24/102	19.	Report from Quality Committee (incl Mortality Report)	FN	Paper	SW	11.50
TB/23-24/103	20.	Report from Workforce and Organisation Development Committee	FN	Paper	VB	
TB/23-24/104	21.	Report from Mental Health Act Committee	FN	Paper	KL	
TB/23-24/105	22.	Report from Audit and Risk Committee	FN	Paper	PC	
TB/23-24/106	23.	Report from Finance and Performance Committee	FN	Paper	MW	
CLOSING ITEMS						
TB/23-24/107	24.	Any Other Business			Chair	11.55

TB/23-24/108	25.	Questions from Public			Chair	
	Date of Next Meeting: 25th January 2024					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Sean Bone-Knell	SB-K	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Stephen Waring	SW	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Associate Non-Executive Director
Dr Asif Bachlani	AB	Associate Non-Executive Director
Shelia Stenson	SS	Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer/ Deputy Chief Executive
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnership and Transformation
In attendance:		
Tony Saroy	TS	Trust Secretary
Kindra Hyttner	KH	Director of Communications and Engagement
Hannah Puttock	HP	Deputy Trust Secretary
In attendance (External Well Led Review):		
John Murray	JM	Engagement Director, Deloitte
Amy White	AW	Senior Manager, Deloitte
Apologies:		

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

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 10.00 to 12.10 hrs on Thursday 28th Sept 2023
At the Orchards Event Centre

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director
	Dr Asif Bachlani	AB	Associate Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Associate Non-Executive Director
	Helen Greatorex	HG	Chief Executive
	Sheila Stenson	SS	Chief Finance and Resources Officer/Deputy Chief Executive
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	Chief People Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
	Kindra Hyttner	KH	Director of Communications and Engagement
	Paul Roberts	PR	Clinical Lead
	Sonja Munday	SM	Nursing Student
	Amy W	AW	Service User
	Gemma R	GR	Service User
	Brenda Allerton	BA	Team Leader (East Kent, Thanet)
	Heidi Dutton	HD	Senior Occupational Therapist
Apologies:			
Observers:			
	Members of the Public		List available

Item	Subject	Action
TB/23-24/59	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/23-24/60	**Declarations of Interest** There were no declarations of interest.	

Item	Subject	Action
TB/23-24/61	**Personal Story – Open Dialogue** The Board heard from two service users, AW and GR, and two members of the Open Dialogue Team, SM and PR. AW and GR set out their experiences of the Open Dialogue method of counselling. They described how they benefited from the reflective aspects of the intervention and their increased ability to express themselves in a less pressured format. The Board recognised the pioneering technique of Open Dialogue and how the Open Dialogue Team have gone from strength-to-strength in embedding the technique within KMPT's wider operating model. The Board thanked AW, GR, SM, and PR for attending and **noted** the Personal Story – Open Dialogue.	
TB/23-24/62	**Quality Improvement (QI) – Long term/work related sickness reduction project in Thanet Older Adults Community Mental Health Team (OACMHT)** The Board heard from BA and HD, who informed the Board about the QI project within the Thanet OACMHT to improve staff attendance at wellbeing meetings and reduce staff sickness. The outcomes sought were an improvement in staff morale, associated with a reduction in staff turnover. The team had noted that between April to August 2022, 170 staff days were lost due to staff sickness. The team created a wellbeing notice board, with different activities offered by staff. Such activities included exercises in the garden, painting, writing poetry, and mindfulness. Attendance at these wellbeing meetings doubled. The staff vacancy rate has reduced and staff sickness between April to August 2023 was 54 days. This has led to the appointment cancellation rate reducing from 20% to 12%, with more appointments being effective. The Board congratulated the team on their success, noting that local leadership remains a key element in the Trust delivering its Strategy. The Board thanked BA and HD for attending, and **noted** the Quality Improvement –. Long term/work related sickness reduction project in Thanet OACMHT.	
TB/23-24/63	**Minutes of the previous meeting** The Board **approved** the minutes of the previous meeting without amendment.	
TB/23-24/64	**Action Log & Matters Arising** The Board **approved** the Action Log with the following amendments: • The Board will receive the Bed Strategy paper in January 2024 and will be renamed. Current working title: Patient Flow Plan. There were no matters arising.	

Item	Subject	Action
TB/23-24/65	**Chair's Report** The Board received and **noted** the Chair's Report. The Board reflected on the NED visit to the perinatal team, with the Trust confirming that there is a postholder dealing with those under-18 who are transitioning to KMPT's services. The Board **approved** the Board's self-assessment action plan.	
TB/23-24/66	**Chief Executive's Report** The Board received the Chief Executive's Report and discussions focussed on: • The Executive Management Team has visited the new Ruby Ward build. The building will be opened in Spring 2024. • The Trust has carried out an audit of its estate and has confirmed there are no issues with its concrete (RAAC) in Trust buildings. The Board **noted** the Chief Executive's Report.	
TB/23-24/67	**Board Assurance Framework (BAF)** The Board received the BAF and reflected on the following matters: • The waiting lists for psychological intervention continue to be a significant problem. The Board sought assurance as it appeared no progress has been made since 2016. Some of the work depends on the rollout of the digital work, as it will allow for some therapeutic intervention at an earlier stage in the patient's journey. The Board requested that rigorous oversight of psychology waiting lists be carried out by Quality Committee (in terms of safety), and the Finance and Performance Committee (in terms of performance). • The Community Mental Health Framework rollout will have a positive impact on psychology waiting lists, but will not resolve all the issues. Funding for the Community Mental Health Framework is due to be received imminently. • The Trust's agency usage remains a significant risk, although the Board noted that it is a much wider impact than just financial risk. The Board sought assurance that issues such as recruitment and retention of medical staff are being addressed in order to mitigate that risk. **Action: The Workforce Deep Dive for November to be focussed on Medical Recruitment. Report to be produced by AQ.** The Board **approved** the Board Assurance Framework.	**AQ**
TB/23-24/68	**Strategic Delivery Plan Priorities Progress Report** The Board received the Strategy Delivery Plan Priorities Progress Report. The Board discussed: • There had been an improvement in the memory assessment service, but there an inconsistency in the way that the new model of service was rolled	

Item	Subject	Action
	out. There is a triage system that is being used and further analysis of that triage system is taking place to assess its effectiveness. • There was a request that future iterations of the report be clearer as to the detailed outcomes against the activity plan. • The Committees remain sighted on the progress of the strategic delivery plan and will receive further reports with more granular detail. The Board **noted** the Strategy Delivery Plan Priorities Progress Report.	
TB/23-24/69	**MHLDA Provider Collaborative Report** The Board reflected on the MHLDA Provider Collaborative Report and the various risks as detailed in the report. The Board requested that future iterations of the Report includes a risk register that makes those areas of concern clearer. There were five risks recorded under the Urgent and Emergency Care Programme, but it was unclear as to matters the Board should be concerned about. **Action: Future iterations of the Provider Collaborative Board Progress Report to reflect the discussions that are to be held between AR and PC.** The Board **noted** the MHLDA Provider Collaborative Report.	**AR**
TB/23-24/70	**Integrated Quality and Performance Report (IQPR)** The Board received the IQPR with the Board discussion focussed on the following: • There was an increase in patient violence and aggression across all services in the summer. The Trust monitors its use of restrictive practices and the Trust is dealing with long term segregation as an area of concern. Quality Committee remains well sighted on the use of restrictive practices. • The Trust is still seeing an increase in the number of patients with a Delayed Transfer of Care (DToC). It remains a challenge for the Trust, but there has been progress regarding length of stay, which is now 31/32 days compared with 80 days previously. • There is a need for a system solution to the issue of DToC, especially over the winter period. For those with housing needs, the Trust is working with housing associations to ensure they have appropriate accommodation for discharge. The Trust has also had some success with psychiatrists visiting care homes, which has reduced the need for admission. • The Board noted an increase in the number of readmissions with the Trust confirming that the Crisis Resolution and Home Treatment Team is being strengthened to ensure there is appropriate follow-up within 72 hours of a patient’s discharge. • Agency staff costs need to be reduced by 42% within seven months. The Board recognised that this may not be achievable given that safety and quality for patients are staff being key priorities for the Board. The Board **noted** the IQPR.	

Item	Subject	Action
TB/23-24/71	**Finance Report** The Board received the Finance Report and highlighted the following: • The Procurement Team will be involved in the negotiations of agency rates, as there has been some success in reducing some agency rates by £40 per hour. The key to tackling the agency issue may not be in reducing the volume of agency usage but rather the rates at which agency staff are contracted. • Although the Trust has been affected by the various strikes, the real impact on patient flow has been due to the acuity in the patients' conditions when they become detained. The Board **noted** the Finance Report.	
TB/23-24/72	**Workforce Deep Dive – Anti-Racism Plan** The Board received the Workforce Deep Dive paper regarding the Anti-Racism Plan. The Board reflected on, and noted, the following matters: • Racist incidents continue to occur in the Trust and are not limited to patient on staff, but also staff on staff. • The Trust acknowledged that there was an inconsistency in the delivery of the Trust's policies and that there are occasions when a robust sanction needs to be given, with good communication to staff regarding these outcomes. The Board stated that it required an improved delivery of the Trust's anti-racism plan. The Board were assured that AC or his deputies contact the victims of racist incidents personally. The Board **noted** the Workforce Deep Dive paper regarding Anti-Racism Plan.	
TB/23-24/73	**Community Mental Health Framework Progress Report** The Board received the Community Mental Health Framework (CMHF) Progress Report with discussions focussed on the following: • A review of the financial arrangements for the CMHF, • The results of the caseload review in the Thanet Community Mental Health Team. This has led to primary care working with KMPT on a shared caseload. The caseload review is now being carried out in Dartford. • Finance and Performance Committee received a paper on the occupancy rates within the Trust's estate to identify future space for clinical use. The Trust's Estate's plan will be informed by the Trust's Clinical plan. The Board **noted** the Community Mental Health Framework Progress Report.	
TB/23-24/74	**Business Continuity and Emergency planning Report** The Board **noted** the Business Continuity and Emergency planning Report**.**	
TB/23-24/75	**Standing Orders**	

Item	Subject	Action
	The Board **approved** the proposed amendments to the Trust's Standing Orders.	
TB/23-24/76	**Register of Interests** The Board **noted** the Register of Interests.	
TB/23-24/77	**Use of Trust Seal** The Board **noted** the Use of Trust Seal Report	
TB/23-24/78	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/23-24/79	**Report from Audit and Risk Committee** The Board received and **noted** the Audit and Risk Committee's Chair Report.	
TB/23-24/80	**Report from Workforce and Organizational Development Committee** The Board received and **noted** the Workforce and Organisational Development Committee Chair's report.	
TB/23-24/81	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/23-24/82	**Any Other Business** None.	
TB/23-24/83	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 28th September 2023.	

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

Date …………………………………………………………..

NHS Kent and Medway NHS and Social Care Partnership Trust

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/11/2023

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN NOVEMBER 2023								
28.09.2023	TB/23-24/67	Board Assurance Framework	The Workforce Deep dive is to be focussed on Medical Recruitment	AQ	November 2023		This is on the agenda for discussion.	CLOSED
28.09.2023	TB/23-24/69	MHLDA Provider Collaborative Board Progress Report	Provider Collaborative Board Progress Report to reflect the discussions that are to be held between AR and PC.	AR	November 2023		This has been included within the report.	CLOSED
ACTIONS NOT DUE OR IN PROGRESS								
27.07.2023	TB/23-24/44	Operation Cavell Annual Progress Report	AR to bring an Operation Cavell Progress Report to the Board in January 2024.	AR	January 2024			NOT DUE
27.07.2023	TB/23-24/46	Bed Strategy	AQ to present the Purposeful Admissions Programme (previously Bed Strategy) progress report in July 2024.	AQ	January 2024		Date adjusted at September Board. Item to be renamed as 'Purposeful Admissions Programme'.	NOT DUE
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.05.2023	TB/23-24/10	MHLDA Provider Collaborative Report	AR to include a Risk Register in future iterations of MHLDA Provider Collaborative updates.	AR	July 2023	September 2023	This is included within the MHLDA Report.	COMPLETE
27.07.2023	TB/23-24/47	Integrated Quality and Performance Report (IQPR)	Future iterations of the IQPR should address any concerns raised by the CQC regarding restrictive practices.	HG	September 2023		This is included within the IQPR	COMPLETE

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 30th November 2023**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

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

- Chief Executive
- Kent & Medway System
- Renewal of tenures for Non-Executive Directors
- Board Seminar Day
- Launch of the Trust's Equality, Diversity, and Inclusion (EDI) work plan
- Trust Chair and Non-Executive Director visits

2. Chief Executive

At the end of October, Helen Greatorex retired from her role as Chief Executive of the Trust. On 1st November, Sheila Stenson took up the post and the Board welcomes her to the role. The Board looks forward to supporting Sheila and in helping the Trust deliver on its strategy.

I would like to take this opportunity to congratulate Sheila on her new appointment as the Trust's Chief Executive, but also to celebrate her receipt of the Healthcare Financial Management Association (HFMA) Honorary Fellowship Award for 2023 in recognition of her dedication to the NHS and HFMA.

3. Kent & Medway system

There is considerable financial pressure across the Kent and Medway system, and KMPT continue to play their role in striving for a break-even position at the end of the year. Progress with Health and Care Partnerships, and with Provider Collaboratives is slow, but moving in a positive direction. I chaired our Mental Health Learning Disability and Autism Provider Collaborative board workshop, and the working relationship and motivation to collaborate between the partners remains strong.

4. Renewal of tenures for Non-Executive Directors

I am pleased to inform the Board that in October NHS England renewed the tenure of Kim Lowe. Kim will sit on the Board until October 2026.

5. Board Seminar Day

On 26th October, the Board met for a development day. These days are an important way for the Board to meet more informally to discuss important topics. On this occasion, the Board had a Quality Improvement Workshop and a seminar on the Trust's Data, Digital, and Technology Plan.

The Board also met with the KMPT Engagement Council and was updated on its key areas of work. We were pleased to see that the Council is establishing itself, and working with

Trust leaders increasingly to hold us to account. In particular, there was some learning raised by the Council in relation to the catering procurement process.

6. Launch of the Trust's Equality, Diversity, and Inclusion (EDI)

I joined the Trust's Leaders Event on 31st October and spent the morning working on 'cultural competence' with senior leaders within the Trust. This was a challenging but extremely energising session with our external facilitator. This was followed by a further session with the Board.

The Trust and the Board have committed itself to changing the culture of KMPT into an anti-discrimination organisation and the Trust has been supported in that work by Sylvia Stevenson. The work is ongoing, and the Board will be updated on progress over the next six months.

7. Trust Chair and NED visits

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

Where	Who
September 2023	
Peter Conway	West Kent Early Intervention in Psychosis (EIP) Team
Jackie Craissati	Directorate leadership teams x 5
	Quality & Performance meetings for support services
October 2023	
Kim Lowe	Littlebrook Hospital inpatient wards
Jackie Craissati	Allied Health Professionals
	Quality & Performance meetings for N. Kent directorate

Chair visits

Over the past two months, I have spent time meeting the leaders across the Trust. In October, the Chief Executive and I met with each of the new Directorate leadership teams, as a follow up to our meeting in May 2023. It was immensely encouraging to hear the consistent feedback that the new structures were beginning to evidence the advantages that come with closer working across small teams, and there was a strong sense that leaders felt empowered to make positive changes that were within their gift. Nevertheless, intransigent issues remain in terms of estates, business analytics and the electronic patient record.

It was delightful to catch up again with our Occupational Therapist leads across the Trust. This is an ambitious team, and I fully support their aspirations to continue to develop new roles (such as the carer leads, sport and exercise instructors, Advanced Clinical Practitioners and Non-medical Responsible Clinicians). Some of these developments have been slow, particularly the non-medical RC role, and there appears to be some nervousness on the part of clinical directors and a lack of role planning in the Trust.

Peter Conway, West Kent EIP Team

I visited the West Kent EIP Team at Coxheath on 24.9. It was very buzzy. Lots of people around attending training, team meetings or doing their day jobs. Smiles and friendly. Clean and bright location. Good discussion regarding the service and I came away feeling assured that they were on top of supply/demand challenges in their particular area

Kim Lowe, Littlebrook Hospital inpatient wards

I received a warm welcome from the team and had a tour of the site. The wards were clean and bar a few issues, well maintained. I was told that food quality and choice had improved and the team were very excited to hear that the Food Hosts would be starting in February to remove the preparation and serving task from the clinical staff's workload. OTs were all holding a range of classes and the recreation and art rooms were well equipped and in use.

We discussed a number of topics, including compassionate care training, reducing violence and aggression, smarter use of mobile technology and step-down beds. My thanks to the teams for hosting the visit and giving up their time.

Chief Executive's Board Report

Date of Meeting: 30 November 2023

Introduction

In this my first report to the Board as Chief Executive, I cannot express enough what a privilege it is to be leading Kent & Medway NHS and Social Care Partnership Trust (KMPT). Firstly, I would like to formally record my thanks to Helen Greatorex for leading the organisation for the past 7 years and taking the organisation to a Good rated Trust by the Care Quality Commission (CQC). We wish Helen all the best in her well-deserved retirement.

The Board will have seen my 100-day plan and my vision for KMPT to make every day a better day for our patients. Today marks day 22 for me and it has been an incredible few weeks meeting many staff and patients as I carry out service visits. I have also met with all the Non-Executive Directors and had many introduction meetings with external stakeholders. I have set out 6 clear priorities in my 100-day plan which are below, I have had very positive feedback from staff regarding the priorities.

My 6 Priorities are:

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

NATIONAL UPDATE

You will have seen the national news regarding the financial pressures that the NHS is under. NHS England wrote to all Chief Executives and Chief Finance Officers addressing the financial pressures and setting out expectations for the next six months to ensure that the NHS delivers its financial plan, whilst protecting patient safety and prioritising emergency performance and capacity, protecting urgent care, elective and cancer care. The NHS will receive £800m provided to systems which will be sourced from a combination of reprioritisation of national budgets and new funding. Systems are being asked to agree plans by the 22nd November. The Kent and Medway system is currently working through the impact of the additional funds. KMPT is planning on delivering break-even and is on course to do so.

INTERNAL UPDATE

The Executive Team

From 1st November two changes came into place in the Executive Team. I would like to welcome Nick Brown to his new role as Chief Finance & Resources Officer, I wish Nick every success in his role.

Donna Hayward-Sussex, started as Deputy Chief Executive. I also wish Donna well in her new role and know she will be a success.

Visits to MerseyCare and Tees, Esk and Weir

Last month I visited the above two Trusts before I took up my new role as it was very important for me to see other Mental Health Trusts and start to share learning for KMPT. I met with their Chief Executives, members of their Executive teams, and also clinical and non-clinical staff from the two organisations who wanted to showcase what they are doing and how they have made transformational improvements to patient services on a sustainable basis. I would like to express my sincere thanks to Joe Rafferty Chief Executive from MerseyCare and Brent Kilmurray Chief Executive from Tees Esk and Weir and their teams for being so accommodating and making my visits very informative and extremely beneficial as I start my journey of leading KMPT to the next level.

November Chief Executive Visits

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

1st November - Priority House wards walk-about
3rd November – Opening/Introduction the Psychiatry/Clinical Directors Away Day
10th November – TGU wards walk-about and Clincal and admin teams visit
23rd November – Britton House
24th November – Opening Nurses Away Day
24th November – Visit to PALS team, Gregory House and Canterbury Wards with Dr Kirsten Lawson
27th November – Visit to the Research Team and Safeguarding Team

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

System Provider Collaborative

I attended by first Integrated Care Board (ICB) this month. I presented a paper to the ICB on the progress we have made over the Summer with establishing the Provider Collaboratives (PC) for the system. The paper set out the PC governance structure and the programmes of work that will be delivered through this new structure. I am pleased to say that the ICB was supportive of the direction of travel. All the system PC meetings are now in the diary for next calendar year. Where programmes of work are not yet started these will be launched by January 2024.

I am delighted to say that I have also recruited to the PC System Programme Director role who will report into me. It was a popular role with 32 applications received and a strong field for final interview. The successful candidate will start in the new calendar year and comes with a lot of experience for leading transformational change across clinical services.

ICB

I joined my first ICB meeting on 7th November it was a highly informative meeting. I think it is extremely beneficial that I have a seat at the ICB representing community and mental health providers to ensure that our voices are heard in the system. The winter plan for the system was presented and approved by the ICB, KMPT has a role to play in this to support delivery of the urgent care pathways for our patients. We have included this month in our Integrated Quality and Performance report (IQPR) our performance of our liaison teams who are supporting the acute trusts on a daily basis to manage patients safely in

emergency departments. The ICB also approved a high-level interim estates strategy. It will be important that in the next draft the community and mental health requirements are included.

Equality Diversity Inclusion (EDI) Seminar

On 31 October, we held our first in-person leaders' event since the start of the pandemic, with 71 senior leaders in attendance. The event focused on KMPTs identity and how it looks and feels to work for the organisation, a top priority for me in my new role. Two programmes of work were launched during the event, one on EDI and the other on shaping KMPT's brand and values.

The session on EDI was led by Sylvia Stevenson, an external EDI expert, and provided valuable insights into the importance of allyship in creating an inclusive work environment. Leaders were encouraged to actively advocate for marginalised and underrepresented groups, fostering a culture of diversity and equality. The Executive Team took part in a Question & Answer panel which allowed for an open dialogue. The discussions further emphasised the need for personal, team, and organisational commitment to EDI principles, highlighting its positive impact on overall productivity, employee satisfaction and patient care.

The session on brand was led by our communications and engagement team. This explored our leaders' current perceptions of KMPT and how we do things. This will inform work we are doing to reshape KMPT's identity, including our brand and values. Wider staff are being interviewed next, followed by our external stakeholders and then the wider public across Kent and Medway.

On Monday 13 November, we launched an EDI survey to staff, which 313 people have completed already, and our 'Listening into Action' sessions which will be running with staff at all levels to hear their thoughts and concerns. All of this work will inform KMPT's new plan on EDI which we will launch in 2024.

Summary and Conclusion

It has been a brilliant first month for me in my new role. I look forward to continuing with my 100-day plan and meeting as many staff, patients and partners as possible. I will keep the Board sighted on progress of my six priorities as I move forward.

Sheila Stenson
Chief Executive

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

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

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in September 2023, and ARC on 13th November

- No risks have been added to the BAF since September.
- Three risks have changed their risk score since September
  - Risk ID 00119 – Capital Projects – Availability of Capital (Decreased to 12 (High) from 16 (Extreme))
  - Risk ID 04232 – Management of Environmental Ligatures (Increased to 12 (High) from 8 (High))
  - Risk ID 07442 – Module reporting via Datix and InPhase (Decreased to 4 (moderate) from 12 (High))
- One risk is recommended for removal
  - Risk ID 04682 – Organisational Risk- Industrial Action (Rating of 6 (Moderate))

Governance

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

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 28th September 2023. It was updated for presentation to the Audit and Risk Committee on 13th November and has since been updated.

The Top Risks are

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

Risk Movement

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

- **Risk ID 00119 – Capital Projects – Availability of Capital (Decreased to 12 (High) from 16 (Extreme))**
  Funding for most of the identified estates programme is secured. Project management and design processes are in place. Initial signs are that funding for the major new build at Maidstone, initial PICU phase, has been allocated.
  The Capital Programme funding is allocated on an annual basis and therefore this risk should be reviewed annually. The new Estates structure should ensure that projects are delivered as required by the Capital Programme

- **Risk ID 04232 – Management of Environmental Ligatures (Increased to 12 (High) from 8 (High))**
  This risk has increased in score to 12 due to the increased focus on ligature and anchor points across the Trust. KMPT has seen an increase in Ligature incidents on female wards following the move to gender segregation. This is not always directly related to the environment. There is focus on identifying priority areas for capital spend to address last years identified anchor points and ligature risk areas from the annual ligature audit. The Ligature Audits are due to be completed again in November. These will give a baseline for looking at how to further reduce ligature incidents and anchor points.

- **Risk ID 07442 – Module reporting via Datix and InPhase (Decreased to 4 (moderate) from 12 (High))**
  This risk has reduced in risk score to 4. Data migration is complete, and has been checked with governance leads. InPhase are continuing to ensure all legacy actions are brought across in a format required by the Trust. The Trust retains all Datix records, but these are not held in a user-friendly format. If progress continues to be made on this, this risk will be recommended for closure in the new year.

Version Control: 01

Risks Recommended for Removal

1 risk is being recommended for removal at this time:

- **Risk ID 04682 – Organisational Risk- Industrial Action (Rating of 6 (Moderate))**
  This risk was updated to recognise that continued periods of Industrial Action may create a backlog for work to catch up. However, this risk is being recommended for removal from the BAF as the Trust has not received any notification of future periods of industrial action. This risk will be kept open and managed at a lower level.

New Risks

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

Emerging Risks

No new emerging risks have been identified for this report.

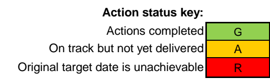
Recommendations

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: 21 November 2023



Board Assurance Framework

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

Definitions:
Initial Rating = The risk rating at the time of identification

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

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

Action status key:

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

1 - We deliver outstanding, person centred care that is safe, high quality and easy to access

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened — The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021.

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

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

31/10/2022 — Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target.

10/02/2023 — **The system wide Dementia SIG has begun to meet again, chaired by KCC. There remains a question around the system wide clinical lead role for Dementia, but it is positive the SIG is meeting again. A draft strategy has been completed and is in the process of being shared with stakeholders**

ID	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)
ID 00580	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	"MAS recovery programme " started in Aug 2023 to work on a number of initiatives to address capacity and demand and diversifying diagnostic skill-mix. Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form. EMAIS roll out for one step diagnosis as opposed to previously used two step model. Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by March 2023. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16	↔	Chief Medical Officer		3	3	9	31/03/2024

Actions to reduce risk	Owner	Target Completion (end)	Status
MAS Recovery programme setup meeting twice a week	Chief Medical Officer	31/03/2024	A
Dementia Strategy Development	Chair of K&M Dementia Service Improvement Group	31/03/2024	A
Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment	Chief Medical Officer	31/03/2024	A

30/08/2023 — BAF Risk Opened

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)
ID 05075	Aug 2023	Chief Operating Officer	**Community Psychological Services Therapy Waiting Times** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1.Active Review is in place in each CMHT locality. This involves an understanding and review of risk on a regular basis for all patients who are waiting some form of intervention. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3. Psychological Services to maintain spreadsheet database to track patients in pathway. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO. 6. Hybrid working in place as requested by patients needs 7. Expansion of psychological practice workforce use of Mental Health Wellbeing Practitioners, Clinical Associate Psychologists, Recruit to Train staff and Assistant Psychologists continues to grow. 8. Ongoing group interventions to reduce waiting times and parity of offer at place.	Assurances from dashboard data	4	4	16	↔	Chief Operating Officer		1	2	2	30/08/2024

Actions to reduce risk	Owner	Target Completion (end)	Status
Waiting list review for mental health together	Director of Psychological Therapies	31/08/2024	A
Psychological Practice Strategy	Director of Psychological Therapies	31/10/2023	A

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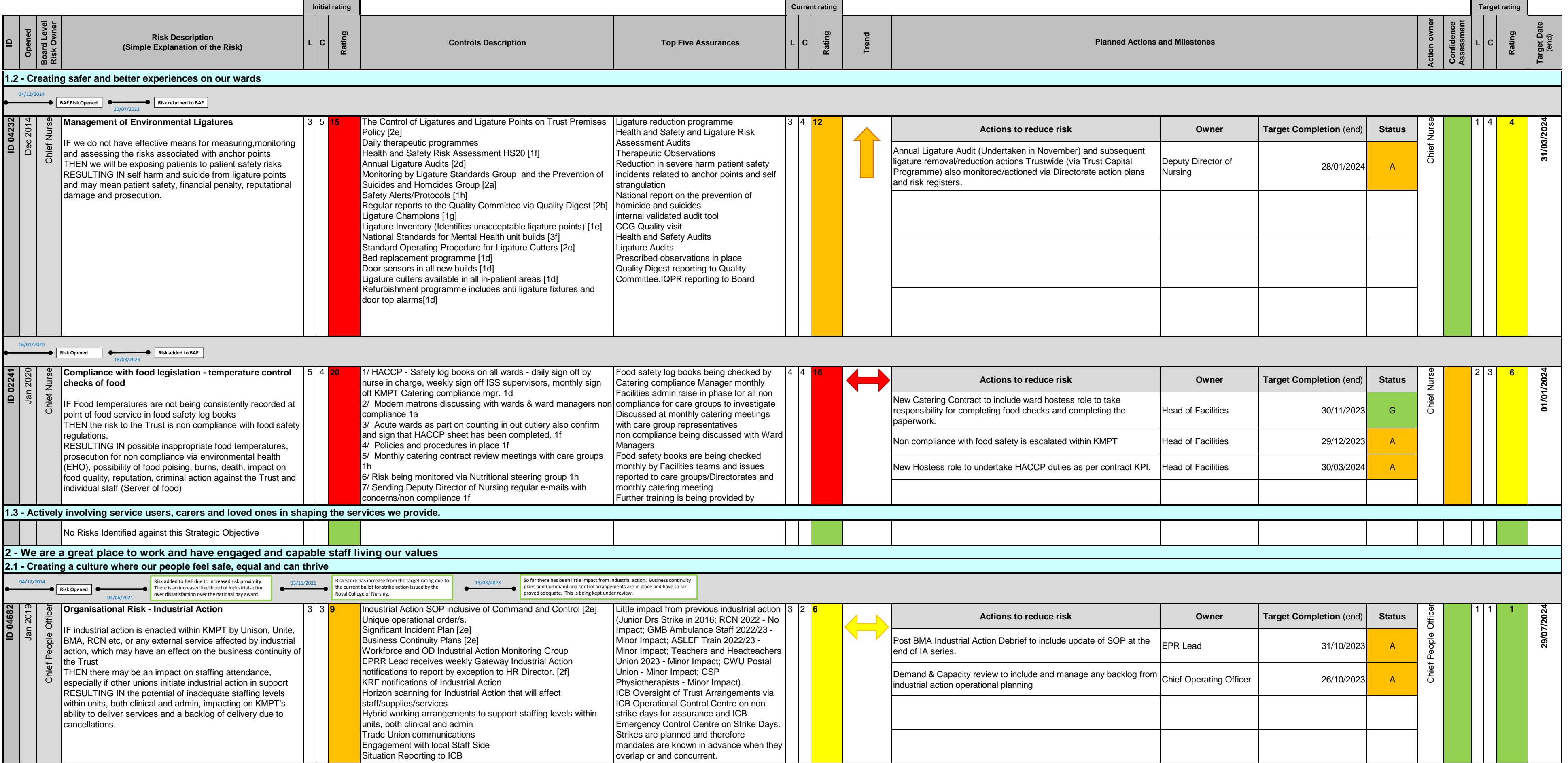
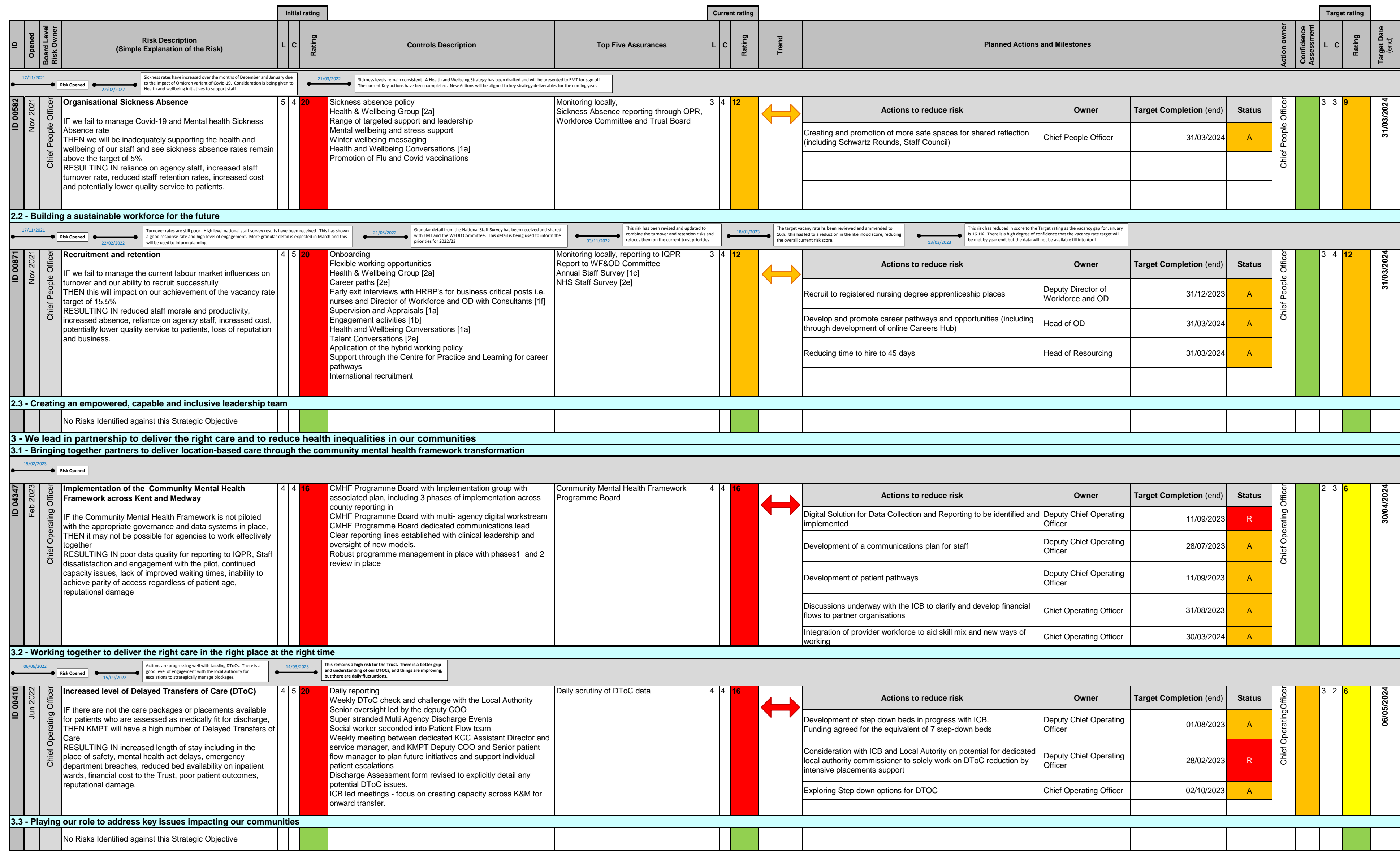


ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones: Actions to reduce risk	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
1.2 - Creating safer and better experiences on our wards																						
	04/12/2014		BAF Risk Opened — 20/07/2023 Risk returned to BAF																			
ID 04232	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	3	4	12		Annual Ligature Audit (Undertaken in November) and subsequent ligature removal/reduction actions Trustwide (via Trust Capital Programme) also monitored/actioned via Directorate action plans and risk registers.	Deputy Director of Nursing	28/01/2024	A	Chief Nurse		1	4	4	31/03/2024
	16/01/2020		Risk Opened — 18/08/2023 Risk added to BAF																			
ID 02241	Jan 2020	Chief Nurse	**Compliance with food legislation - temperature control checks of food** IF Food temperatures are not being consistently recorded at point of food service in food safety log books THEN the risk to the Trust is non compliance with food safety regulations. RESULTING IN possible inappropriate food temperatures, prosecution for non compliance via environmental health (EHO), possibility of food poising, burns, death, impact on food quality, reputation, criminal action against the Trust and individual staff (Server of food)	5	4	20	1/ HACCP - Safety log books on all wards - daily sign off by nurse in charge, weekly sign off ISS supervisors, monthly sign off KMPT Catering compliance mgr. 1d 2/ Modern matrons discussing with wards & ward managers non compliance 1a 3/ Acute wards as part on counting in out cutlery also confirm and sign that HACCP sheet has been completed. 1f 4/ Policies and procedures in place 1f 5/ Monthly catering contract review meetings with care groups 1h 6/ Risk being monitored via Nutritional steering group 1h 7/ Sending Deputy Director of Nursing regular e-mails with concerns/non compliance 1f	Food safety log books being checked by Catering compliance Manager monthly Facilities admin raise in phase for all non compliance for care groups to investigate Discussed at monthly catering meetings with care group representatives non compliance being discussed with Ward Managers Food safety books are being checked monthly by Facilities teams and issues reported to care groups/Directorates and monthly catering meeting Further training is being provided by	4	4	16		New Catering Contract to include ward hostess role to take responsibility for completing food checks and completing the paperwork. Non compliance with food safety is escalated within KMPT New Hostess role to undertake HACCP duties as per contract KPI.	Head of Facilities Head of Facilities Head of Facilities	30/11/2023 29/12/2023 30/03/2024	G A A	Chief Nurse		2	3	6	01/01/2024
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																						
			No Risks Identified against this Strategic Objective																			
2 - We are a great place to work and have engaged and capable staff living our values																						
2.1 - Creating a culture where our people feel safe, equal and can thrive																						
	04/12/2014		Risk Opened — 04/06/2021 Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award — 03/11/2021 Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing. — 13/03/2023 So far there has been little impact from Industrial action. Business continuity plans and Command and control arrangements are in place and have so far proved adequate. This is being kept under review.																			
ID 04682	Jan 2019	Chief People Officer	**Organisational Risk - Industrial Action** IF industrial action is enacted within KMPT by Unison, Unite, BMA, RCN etc, or any external service affected by industrial action, which may have an effect on the business continuity of the Trust THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services and a backlog of delivery due to cancellations.	3	3	9	Industrial Action SOP inclusive of Command and Control [2e] Unique operational order/s. Significant Incident Plan [2e] Business Continuity Plans [2e] Workforce and OD Industrial Action Monitoring Group EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side Situation Reporting to ICB	Little impact from previous industrial action (Junior Drs Strike in 2016; RCN 2022 - No Impact; GMB Ambulance Staff 2022/23 - Minor Impact; ASLEF Train 2022/23 - Minor Impact; Teachers and Headteachers Union 2023 - Minor Impact; CWU Postal Union - Minor Impact; CSP Physiotherapists - Minor Impact). ICB Oversight of Trust Arrangements via ICB Operational Control Centre on non strike days for assurance and ICB Emergency Control Centre on Strike Days. Strikes are planned and therefore mandates are known in advance when they overlap or and concurrent.	3	2	6		Post BMA Industrial Action Debrief to include update of SOP at the end of IA series. Demand & Capacity review to include and manage any backlog from industrial action operational planning	EPR Lead Chief Operating Officer	31/10/2023 26/10/2023	A A	Chief People Officer		1	1	1	29/07/2024



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
17/11/2021 Risk Opened — 22/02/2022: Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff. — 21/03/2022: Sickness levels remain consistent. A Health and Welbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year.																		
ID 00582	Nov 2021	Chief People Officer	**Organisational Sickness Absence** IF we fail to manage Covid-19 and Mental health Sickness Absence rate THEN we will be inadequately supporting the health and wellbeing of our staff and see sickness absence rates remain above the target of 5% RESULTING IN reliance on agency staff, increased staff turnover rate, reduced staff retention rates, increased cost and potentially lower quality service to patients.	5	4	20	Sickness absence policy Health & Wellbeing Group [2a] Range of targeted support and leadership Mental wellbeing and stress support Winter wellbeing messaging Health and Wellbeing Conversations [1a] Promotion of Flu and Covid vaccinations	Monitoring locally, Sickness Absence reporting through QPR, Workforce Committee and Trust Board	3	4	12		Chief People Officer		3	3	9	31/03/2024
2.2 - Building a sustainable workforce for the future																		
17/11/2021 Risk Opened — 22/02/2022: Turnover rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning. — 21/03/2022: Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23 — 03/11/2022: This risk has been revised and updated to combine the turnover and retention risks and refocus them on the current trust priorities. — 18/01/2023: The target vacany rate hs been reviewed and ammended to 16%. this has led to a reduction in the likelihood score, reducing the overall current risk score. — 13/03/2023: This risk has reduced in score to the Target rating as the vacancy gap for January is 16.1%. There is a high degree of confidence that the vacancy rate target will be met by year end, but the data will not be available till into April.																		
ID 00871	Nov 2021	Chief People Officer	**Recruitment and retention** IF we fail to manage the current labour market influences on turnover and our ability to recruit successfully THEN this will impact on our achievement of the vacancy rate target of 15.5% RESULTING IN reduced staff morale and productivity, increased absence, reliance on agency staff, increased cost, potentially lower quality service to patients, loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Health & Wellbeing Group [2a] Career paths [2e] Early exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e] Application of the hybrid working policy Support through the Centre for Practice and Learning for career pathways International recruitment	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c] NHS Staff Survey [2e]	3	4	12		Chief People Officer		3	4	12	31/03/2024
2.3 - Creating an empowered, capable and inclusive leadership team																		
			No Risks Identified against this Strategic Objective															
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																		
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																		
15/02/2023 Risk Opened																		
ID 04347	Feb 2023	Chief Operating Officer	**Implementation of the Community Mental Health Framework across Kent and Medway** IF the Community Mental Health Framework is not piloted with the appropriate governance and data systems in place, THEN it may not be possible for agencies to work effectively together RESULTING IN poor data quality for reporting to IQPR, Staff dissatisfaction and engagement with the pilot, continued capacity issues, lack of improved waiting times, inability to achieve parity of access regardless of patient age, reputational damage	4	4	16	CMHF Programme Board with Implementation group with associated plan, including 3 phases of implementation across county reporting in CMHF Programme Board with multi- agency digital workstream CMHF Programme Board dedicated communications lead Clear reporting lines established with clinical leadership and oversight of new models. Robust programme management in place with phases1 and 2 review in place	Community Mental Health Framework Programme Board	4	4	16		Chief Operating Officer		2	3	6	30/04/2024
3.2 - Working together to deliver the right care in the right place at the right time																		
06/06/2022 Risk Opened — 15/09/2022: Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages. — 14/03/2023: This remains a high risk for the Trust. There is a better grip and understanding of our DTOCs, and things are improving, but there are daily fluctuations.																		
ID 00410	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly DToC check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events Social worker seconded into Patient Flow team Weekly meeting between dedicated KCC Assistant Director and service manager, and KMPT Deputy COO and Senior patient flow manager to plan future initiatives and support individual patient escalations Discharge Assessment form revised to explicitly detail any potential DToC issues. ICB led meetings - focus on creating capacity across K&M for onward transfer.	Daily scrutiny of DToC data	4	4	16		Chief OperatingOfficer		3	2	6	06/05/2024
3.3 - Playing our role to address key issues impacting our communities																		
			No Risks Identified against this Strategic Objective															

Planned Actions and Milestones

ID 00582

Actions to reduce risk	Owner	Target Completion (end)	Status
Creating and promotion of more safe spaces for shared reflection (including Schwartz Rounds, Staff Council)	Chief People Officer	31/03/2024	A

ID 00871

Actions to reduce risk	Owner	Target Completion (end)	Status
Recruit to registered nursing degree apprenticeship places	Deputy Director of Workforce and OD	31/12/2023	A
Develop and promote career pathways and opportunities (including through development of online Careers Hub)	Head of OD	31/03/2024	A
Reducing time to hire to 45 days	Head of Resourcing	31/03/2024	A

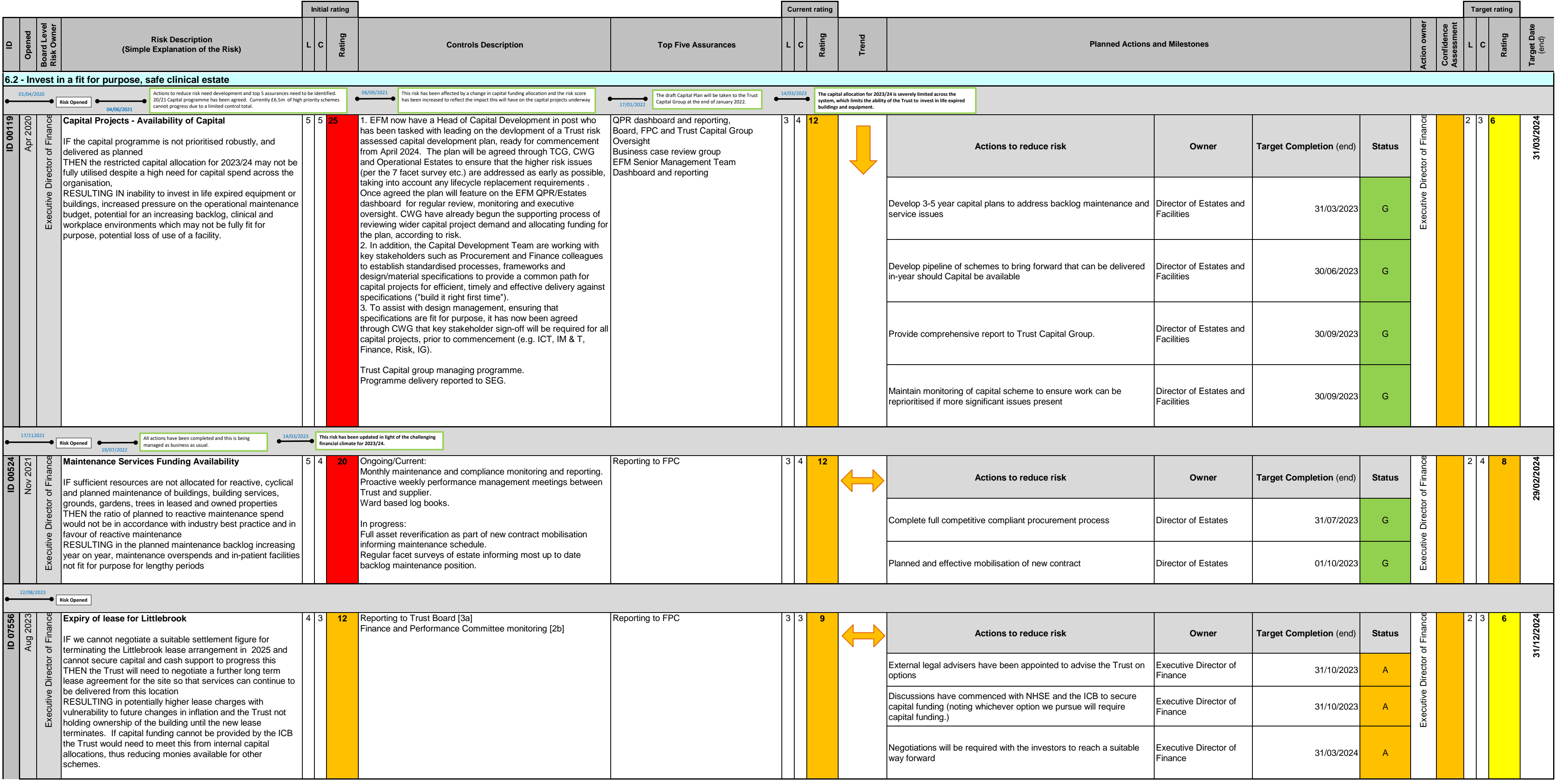
ID 04347

Actions to reduce risk	Owner	Target Completion (end)	Status
Digital Solution for Data Collection and Reporting to be identified and implemented	Deputy Chief Operating Officer	11/09/2023	R
Development of a communications plan for staff	Deputy Chief Operating Officer	28/07/2023	A
Development of patient pathways	Deputy Chief Operating Officer	11/09/2023	A
Discussions underway with the ICB to clarify and develop financial flows to partner organisations	Chief Operating Officer	31/08/2023	A
Integration of provider workforce to aid skill mix and new ways of working	Chief Operating Officer	30/03/2024	A

ID 00410

Actions to reduce risk	Owner	Target Completion (end)	Status
Development of step down beds in progress with ICB. Funding agreed for the equivalent of 7 step-down beds	Deputy Chief Operating Officer	01/08/2023	A
Consideration with ICB and Local Autority on potential for dedicated local authority commissioner to solely work on DToC reduction by intensive placements support	Deputy Chief Operating Officer	28/02/2023	R
Exploring Step down options for DTOC	Chief Operating Officer	02/10/2023	A

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	C	Rating	Controls Description	Top Five Assurances	Current rating L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	C	Rating	Target Date (end)
4 - We use technology, data and knowledge to transform patient care and our productivity																			
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																			
13/03/2023 Risk Opened																			
ID 07442	Mar 2023	Executive Director of Finance	**Module Reporting via DATIX and InPhase** IF DATIX abruptly ceases access by KMPT to the archive data sets available prior to 13 March 2023 THEN KMPT will be reliant only on the new InPhase modules in so far as they have been migrated and reports built. RESULTING IN inability to present complete data in a recognised format against requests for assurance and compliance on statutory and contractual obligations.	5	4	20	InPhase Project Board Access to the licence key for Datix until Aug 23 Most data has been migrated to InPhase Database access to Datix.	Data Migration Audit	2	2	4		Data Migration – Director of Digital and Performance – 31/08/2023 – G	Executive Director of Finance		2	2	4	**01/01/2024**
4.2 - Enhance our use of IT and digital systems to free up staff time																			
			No Risks Identified against this Strategic Objective																
4.3 - Effective digital tools are in place to support joined-up, personalised care																			
			No Risks Identified against this Strategic Objective																
5 - We are efficient, sustainable, transformational and make the most of every resource																			
5.1 Achieve financial sustainability																			
10/03/2021 Risk Opened; 06/09/2021 As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.; 14/03/2023 This risk has been reviewed and updated for the coming financial year.																			
ID 00256	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not continue to focus on cost savings, productivity and efficiency initiatives to ensure services are financially sustainable THEN it may move back into an underlying deficit position, RESULTING IN increased scrutiny from NHSE/I, potential for financial sanctions to be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. Monthly reporting is taking place through QPRs and Finance Reports, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs. Service Line reporting (SLR) data has been utilitised to inform of services with underlying deficits and update papers provided to FPC and Trust Board. SLR data being reviewed routinely to ensure Directorates clear on actual and underlying SLR position.	3	4	12		**Actions to reduce risk – Owner – Target Completion (end) – Status** Delivery of multiyear efficiency programme – Deputy Director of Finance – 31/07/2023 – A Review of six identified loss making services to identify drivers to the position – Deputy Director of Finance – 30/09/2023 – A Review activity and service data to identify any unwarranted variation within the loss making services – Deputy Director of Finance – 30/09/2023 – A Clear workplan and detailed approach to unwarranted variation work – Deputy Director of Finance – 30/09/2023 – A Review of underlying deficit position for 2024/25 planning – Deputy Director of Finance – 30/09/2023 – A Monthly reporting is taking place through QPRs and Finance Reports – Deputy Director of Finance – 30/09/2023 – A Review pricing and contracting for services prior to 2024/25 planning round – Deputy Director of Finance – 30/09/2023 – A	Executive Director of Finance		3	3	9	**31/03/2024**
22/08/2023 Risk Opened																			
ID 07557	Aug 2023	Executive Director of Finance	**Trust agency usage** IF the Trust fails to contain agency spend within the 2023/24 spend cap THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend	Monitoring of agency usage and compliance with usage and rate limits is an NHSE expectation of all systems and providers with established governance processes in place to oversee agency staffing.	4	5	20		**Actions to reduce risk – Owner – Target Completion (end) – Status** Executive led agency control meetings – Deputy Director of Finance – 30/09/2023 – A Implementation of No agency admin being progressed, policy being implemented with no new agency being agreed – Deputy Director of Finance – 30/09/2023 – A Present agency establishment being review to identify the impact of removing the staff and opportunities for permanent recruitment. – Deputy Director of Finance – 30/09/2023 – A Position statement for EMT review provided monthly – Deputy Director of Finance – 30/09/2023 – A Any exceptions to be discussed with ICB before requesting regional approval – Deputy Director of Finance – 30/09/2023 – A	Executive Director of Finance		3	3	9	**31/03/2024**
5.2 Exceed the ambitions of the NHS Greener programme																			
			No Risks Identified against this Strategic Objective																
5.3 Transform the way we work																			
			No Risks Identified against this Strategic Objective																
6 - We create environments that benefit our service users and people																			
6.1 - Maximise our use of office spaces and clinical estate																			
			No Risks Identified against this Strategic Objective																



6.2 - Invest in a fit for purpose, safe clinical estate

Timeline (ID 00119):
- 01/04/2020 Risk Opened
- 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total.
- 06/09/2021 This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway
- 17/01/2022 The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.
- 14/03/2023 **The capital allocation for 2023/24 is severely limited across the system, which limits the ability of the Trust to invest in life expired buildings and equipment.**

Timeline (ID 00524):
- 17/112021 Risk Opened
- 19/07/2022 All actions have been completed and this is being managed as business as usual.
- 14/03/2023 **This risk has been updated in light of the challenging financial climate for 2023/24.**

Timeline (ID 07556):
- 22/08/2023 Risk Opened

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)
ID 00119	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not prioritised robustly, and delivered as planned THEN the restricted capital allocation for 2023/24 may not be fully utilised despite a high need for capital spend across the organisation, RESULTING IN inability to invest in life expired equipment or buildings, increased pressure on the operational maintenance budget, potential for an increasing backlog, clinical and workplace environments which may not be fully fit for purpose, potential loss of use of a facility.	5	5	25	1. EFM now have a Head of Capital Development in post who has been tasked with leading on the devlopment of a Trust risk assessed capital development plan, ready for commencement from April 2024. The plan will be agreed through TCG, CWG and Operational Estates to ensure that the higher risk issues (per the 7 facet survey etc.) are addressed as early as possible, taking into account any lifecycle replacement requirements . Once agreed the plan will feature on the EFM QPR/Estates dashboard for regular review, monitoring and executive oversight. CWG have already begun the supporting process of reviewing wider capital project demand and allocating funding for the plan, according to risk. 2. In addition, the Capital Development Team are working with key stakeholders such as Procurement and Finance colleagues to establish standardised processes, frameworks and design/material specifications to provide a common path for capital projects for efficient, timely and effective delivery against specifications ("build it right first time"). 3. To assist with design management, ensuring that specifications are fit for purpose, it has now been agreed through CWG that key stakeholder sign-off will be required for all capital projects, prior to commencement (e.g. ICT, IM & T, Finance, Risk, IG). Trust Capital group managing programme. Programme delivery reported to SEG.	QPR dashboard and reporting, Board, FPC and Trust Capital Group Oversight Business case review group EFM Senior Management Team Dashboard and reporting	3	4	12	(down arrow)	Executive Director of Finance		2	3	6	31/03/2024
ID 00524	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Ongoing/Current: Monthly maintenance and compliance monitoring and reporting. Proactive weekly performance management meetings between Trust and supplier. Ward based log books. In progress: Full asset reverification as part of new contract mobilisation informing maintenance schedule. Regular facet surveys of estate informing most up to date backlog maintenance position.	Reporting to FPC	3	4	12	(left-right arrow)	Executive Director of Finance		2	4	8	29/02/2024
ID 07556	Aug 2023	Executive Director of Finance	**Expiry of lease for Littlebrook** IF we cannot negotiate a suitable settlement figure for terminating the Littlebrook lease arrangement in 2025 and cannot secure capital and cash support to progress this THEN the Trust will need to negotiate a further long term lease agreement for the site so that services can continue to be delivered from this location RESULTING in potentially higher lease charges with vulnerability to future changes in inflation and the Trust not holding ownership of the building until the new lease terminates. If capital funding cannot be provided by the ICB the Trust would need to meet this from internal capital allocations, thus reducing monies available for other schemes.	4	3	12	Reporting to Trust Board [3a] Finance and Performance Committee monitoring [2b]	Reporting to FPC	3	3	9	(left-right arrow)	Executive Director of Finance		2	3	6	31/12/2024

Planned Actions and Milestones – ID 00119

Actions to reduce risk	Owner	Target Completion (end)	Status
Develop 3-5 year capital plans to address backlog maintenance and service issues	Director of Estates and Facilities	31/03/2023	G
Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available	Director of Estates and Facilities	30/06/2023	G
Provide comprehensive report to Trust Capital Group.	Director of Estates and Facilities	30/09/2023	G
Maintain monitoring of capital scheme to ensure work can be reprioritised if more significant issues present	Director of Estates and Facilities	30/09/2023	G

Planned Actions and Milestones – ID 00524

Actions to reduce risk	Owner	Target Completion (end)	Status
Complete full competitive compliant procurement process	Director of Estates	31/07/2023	G
Planned and effective mobilisation of new contract	Director of Estates	01/10/2023	G

Planned Actions and Milestones – ID 07556

Actions to reduce risk	Owner	Target Completion (end)	Status
External legal advisers have been appointed to advise the Trust on options	Executive Director of Finance	31/10/2023	A
Discussions have commenced with NHSE and the ICB to secure capital funding (noting whichever option we pursue will require capital funding.)	Executive Director of Finance	31/10/2023	A
Negotiations will be required with the investors to reach a suitable way forward	Executive Director of Finance	31/03/2024	A

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 30 November 2023

Title of Paper: Trust Risk Register

Author: Louisa Mace, Risk Manager

Executive Director: Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose: For Discussion and Noting

Submission to Board: Committee Requested

Overview of Paper

The Board are asked to receive and note the Trust Risk Register (TRR).

Issues to bring to the Board's attention

The Trust Risk Register was presented to the Audit and Risk Committee on 13th November, and requested to be presented to Board for awareness of the extreme rated risks held across the Trust following an increase in the number of risks scoring 15 and over from 7 risks to 14 risks in total.

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

Trust Risk Register

The Trust Risk Register was presented to the Audit and Risk Committee on 13th November, and requested to be presented to Board for awareness of the extreme rated risks held across the Trust following an increase in the number of risks scoring 15 and over.

Since the TRR was presented to ARC, 2 risks have reduced in risk score:

- Risk ID 07489 – East Kent Liaison Psychiatry Services - delays in accessing inpatient beds (Risk Rating 10)
  This risk reduced in risk score following a review of the controls. Additional controls have been added and there is an action relating to Safe Haven's that is being taken forward by KMPT and Mental Health Matters in Thanet which supports the reduction in risk score.

- Risk ID 07490 - East Kent CRHT & RR - delays in accessing inpatient beds (Risk Rating 10)
  This risk reduced in risk score following a review of the controls. Additional controls have been added and there is an action relating to Safe Haven's that is being taken forward by KMPT and Mental Health Matters in Thanet which supports the reduction in risk score.

There are now a total of 12 risks on the Trust Risk Register 7 of which also form part of the Board Assurance Framework.

- Risk ID 00119 – Capital Projects Availability of Capital (Risk Rating 16)
- Risk ID 00410 - Increased level of Delayed Transfers of Care (DToC) (Risk Rating 16)
- Risk ID 00580 – Organisational Inability to meet Memory Assessment Service Demand (Risk Rating 16)
- Risk ID 02241 – Compliance with Food legislation – Temperature control checks of food (Risk Rating 16)
- Risk ID 03563 – Improving and Sustaining Quality and Safety (Risk Rating 16)
- Risk ID 4347 - Implementation of the Community Mental Health Framework across Kent and Medway (Risk Rating 16)
- Risk ID 05075 – Community Psychological Services Therapy Waiting Times (Risk Rating 16)
- Risk ID 07449 – Risk Assessing for Suicide (Risk Rating 15)
- Risk ID 07455 - WK CMHSOPs - Dementia assessment waiting times (Risk Rating 15)
- Risk ID 07496 - East Kent Directorate registered nursing workforce shortfalls (Risk Rating 16)
- Risk ID 07557 – Trust Agency Usage (Risk Rating 20)
- Risk ID 07655 - Implementation of PSIRF (Patient Safety Incident Response Framework) (Risk Rating 16)

The risks which were newly presented to ARC in November (and haven't reduced in risk score) were:

- ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (Risk Rating 16)
  This risk is included on the BAF and increased in risk score for reporting to the September Board

- ID 05075 – Community Psychological Services Therapy Waiting Times (Risk Rating 16)
  This risk is included on the BAF and increased in risk score for reporting to the September Board

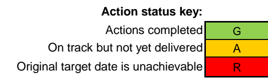
- ID 07455 – WK CMHSOPs - Dementia assessment waiting times (Risk Rating 15)
  Following discussion at the Directorate QPR meeting on 10 October, and at the advice of the Trust Chief Nurse, this risk rating has been increased from 12 (high) to 15 (extreme) in line with Trust wide concern and directorate impact.

- Risk ID 07496 - East Kent Directorate registered nursing workforce shortfalls (Risk Rating 16)
  This risk increased in risk score following the last report of the Trust Risk Register to ARC. There have been improvements noted in the November iQPR report in relation to vacancy gaps and agency staffing. The rating will remain at this level until recruited staff have started in teams (due from January 2024). A further recruitment plan is being drawn up for Thant to coincide with the wider recruitment drive for Mental Health together.

- Risk ID 07557 – Trust Agency Usage (Risk Rating 20)
  This risk was a new risk included on the BAF for reporting to the September Board.

- Risk ID 07655 - Implementation of PSIRF (Patient Safety Incident Response Framework) (Risk Rating 16)
  This is a new risk which has been added to ensure that the risks associated with the move to the new nationally directed PSIRF for responding to patient safety incidents are adequately planned for and mitigated. This will be a fundamental change to investigation processes and there needs to be time for robust training provision to ensure all staff understand the processes.

Updated: 21 November 2023



Trust Risk Register

Risks with a current risk score of 15 or over

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	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)
01/04/2020 Risk Opened — 04/06/2021: Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. — 06/09/2021: This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway — 17/01/2022: The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022. — 14/03/2023: **The capital allocation for 2023/24 is severely limited across the system, which limits the ability of the Trust to invest in life expired buildings and equipment.**																		
InPhase ID 00119	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital (Included on the BAF)** IF the capital programme is not prioritised robustly, and delivered as planned THEN the restricted capital allocation for 2023/24 may not be fully utilised despite a high need for capital spend across the organisation, RESULTING IN inability to invest in life expired equipment or buildings, increased pressure on the operational maintenance budget, potential for an increasing backlog, clinical and workplace environments which may not be fully fit for purpose, potential loss of use of a facility	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16		Executive Director of Finance		2	3	6	31/03/2024
06/06/2022 Risk Opened — 15/09/2022: Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages. — 14/03/2023: **This remains a high risk for the Trust. There is a better grip and understanding of our DTOCs, and things are improving, but there are daily fluctuations.**																		
ID 00410	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC) (Included on the BAF)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly DToC check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events Social worker seconded into Patient Flow team Weekly meeting between dedicated KCC Assistant Director and service manager, and KMPT Deputy COO and Senior patient flow manager to plan future initiatives and support individual patient escalations Discharge Assessment form revised to explicitly detail any potential DToC issues. ICB led meetings - focus on creating capacity across K&M for onward transfer.	Daily scrutiny of DToC data	4	4	16		Chief OperatingOfficer		3	2	6	06/05/2024
12/01/2022 BAF Risk Opened — 10/03/2022: 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. — The Dementia SIG have identified key actions for delivery by year end. — 21/04/2022: Since the last report, part year funding has been agreed for extra clinics for demetia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st Septmber. — 31/10/2022: Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target. — 10/02/2023: **The system wide Dementia SIG has begun to meet again, chaired by KCC. There remains a question around the system wide clinical lead role for Dementia, but it is positive the SIG is meeting again. A draft strategy has been completed and is in the process of being shared with stakeholders**																		
ID 00580	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand (Included on the BAF)** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form. EMAIS roll out for one step diagnosis as opposed to previously used two step model. Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by March 2023. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery	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		Chief Medical Officer		3	3	9	31/03/2024
16/01/2020 Risk Opened — 18/08/2023 Risk added to BAF																		
ID 02241	Jan 2020	Chief Nurse	**Compliance with food legislation - temperature control checks of food (Included on the BAF)** IF Food temperatures are not being consistently recorded at point of food service in food safety log books THEN the risk to the Trust is non compliance with food safety regulations. RESULTING IN possible inappropriate food temperatures, prosecution for non compliance via environmental health (EHO), possibility of food poising, burns, death, impact on food quality, reputation, criminal action against the Trust and individual staff (Server of food)	5	4	20	1/ HACCP - Safety log books on all wards - daily sign off by nurse in charge, weekly sign off ISS supervisors, monthly sign off KMPT Catering compliance mgr. 1d 2/ Modern matrons discussing with wards & ward managers non compliance 1a 3/ Acute wards as part on counting in out cutlery also confirm and sign that HACCP sheet has been completed. 1f 4/ Policies and procedures in place 1f 5/ Monthly catering contract review meetings with care groups 1h 6/ Risk being monitored via Nutritional steering group 1h 7/ Sending Deputy Director of Nursing regular e-mails with concerns/non compliance 1f	Food safety log books being checked by Catering compliance Manager monthly Facilities admin raise in phase for all non compliance for care groups to investigate Discussed at monthly catering meetings with care group representatives non compliance being discussed with Ward Managers Food safety books are being checked monthly by Facilities teams and issues reported to care groups/Directorates and monthly catering meeting Further training is being provided by	4	4	16		Chief Nurse		2	3	6	01/01/2024
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

ID	Actions to reduce risk	Owner	Target Completion (end)	Status
InPhase ID 00119	Develop 3-5 year capital plans to address backlog maintenance and service issues	Director of Estates and Facilities	31/03/2023	G
InPhase ID 00119	Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available	Director of Estates and Facilities	30/06/2023	A
InPhase ID 00119	Provide comprehensive report to Trust Capital Group.	Director of Estates and Facilities	30/09/2023	A
InPhase ID 00119	Maintain monitoring of capital scheme to ensure work can be reprioritised if more significant issues present	Director of Estates and Facilities	30/09/2023	A
ID 00410	Development of step down beds in progress with ICB. Funding agreed for the equivalent of 7 step-down beds	Deputy Chief Operating Officer	01/08/2023	A
ID 00410	Consideration with ICB and Local Autority on potential for dedicated local authority commissioner to solely work on DToC reduction by intensive placements support	Deputy Chief Operating Officer	28/02/2023	R
ID 00410	Exploring Step down options for DTOC	Chief Operating Officer	02/10/2023	A
ID 00580	MAS Recovery programme setup meeting twice a week	Chief Medical Officer	31/03/2024	A
ID 00580	Dementia Strategy Development	Chair of K&M Dementia Service Improvement Group	31/03/2024	A
ID 00580	Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment	Chief Medical Officer	31/03/2024	A
ID 02241	New Catering Contract to include ward hostess role to take responsibility for completing food checks and completing the paperwork.	Head of Facilities	30/11/2023	G
ID 02241	Non compliance with food safety is escalated within KMPT	Head of Facilities	29/12/2023	A
ID 02241	New Hostess role to undertake HACCP duties as per contract KPI.	Head of Facilities	30/03/2024	A

ID	Opened	Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones (Actions to reduce risk; Owner; Target Completion (end); Status)	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
ID 03563	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 Reviews CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Self assessment and peer review Serious Incident reports and data	4	4	16		Cliq checks and Deep dives; Chief Nurse; Ongoing; A CQC Oversight Meetings; Chief Nurse; Ongoing; A Inpatient Improvement Forums; Chief Nurse; Ongoing; A Implementation of the National Patient Safety Framework; Chief Nurse; 26/03/2024; A	Chief Nurse		2	3	6	31/03/2024
15/02/2023 Risk Opened																			
ID 04347	Feb 2023	Chief Operating Officer	**Implementation of the Community Mental Health Framework across Kent and Medway (Included on the BAF)** IF the Community Mental Health Framework is not piloted with the appropriate governance and data systems in place, THEN it may not be possible for agencies to work effectively together RESULTING IN poor data quality for reporting to IQPR, Staff dissatisfaction and engagement with the pilot, continued capacity issues, lack of improved waiting times, inability to achieve parity of access regardless of patient age, reputational damage	4	4	16	CMHF Programme Board with Implementation group with associated plan, including 3 phases of implementation across county reporting in CMHF Programme Board with multi- agency digital workstream CMHF Programme Board dedicated communications lead Clear reporting lines established with clinical leadership and oversight of new models. Robust programme management in place with phases1 and 2 review in place	Community Mental Health Framework Programme Board	4	4	16		Digital Solution for Data Collection and Reporting to be identified and implemented; Deputy Chief Operating Officer; 11/09/2023; R Development of a communications plan for staff; Deputy Chief Operating Officer; 28/07/2023; A Development of patient pathways; Deputy Chief Operating Officer; 11/09/2023; A Discussions underway with the ICB to clarify and develop financial flows to partner organisations; Chief Operating Officer; 31/08/2023; A Integration of provider workforce to aid skill mix and new ways of working; Chief Operating Officer; 30/03/2024; A	Chief Operating Officer		2	3	6	30/04/2024
30/08/2023 BAF Risk Opened																			
ID 05075	Aug 2023	Chief Operating Officer	**Community Psychological Services Therapy Waiting Times (Included on the BAF)** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1.Active Review is in place in each CMHT locality. This involves an understanding and review of risk on a regular basis for all patients who are waiting some form of intervention. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3. Psychological Services to maintain spreadsheet database to track patients in pathway. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO.	Assurances from dashboard data	4	4	16		Waiting list review for mental health together; Director of Psychological Therapies; 31/08/2024; A Psychological Practice Strategy; Director of Psychological Therapies; 31/10/2023; A	Chief Operating Officer		1	2	2	30/08/2024
09/05/2023 Risk Opened																			
ID 07449	May 2023	Chief Nurse	**Risk assessing for suicide** If the trust does not improve risk and safety planning management in line with NICE guidance (NG225), then this can impact on patient outcomes, resulting in possible suicides and reputational damage.	3	5	15	Current training is in line with policy as it is. Management oversight.	Learning and development training figures. Reliability of new processes - KPIs. Suicide data.	3	5	15		Development of Collaborative Assessment and Management of Suicidality: Training and implementation; Chief Nurse; 31/10/2023; A	Chief Nurse		3	3	9	12/06/2024
18/05/2023 Risk Opened																			
ID 07455	May 2023	Service Director	**WK CMHSOPs - Dementia assessment waiting times** IF there continues to be substantial waiting times from referral to routine dementia assessment THEN patients will be delayed in receiving appropriate treatment and support RESULTING IN delayed initiation of suitable treatment and care; declining presentation and poor health of the patients; stress on carers, potential increase in complaints; breaching commissioned service agreements; reputational damage.	3	5	15	- recruitment to staffing vacancies - processes and policies, and dedicated recruitment programme with HR Business partner [1a,2a,2e,1g] - skill mix of existing staff to cover dementia assessments as far as possible [1d,1f,2a] - medical oversight an management of service options [2s] - CQC inspection/oversight [3e] - patients and their family / carers kept informed of waiting list situation [1d,1f]. - business continuity plan for core tasks [1g,2e,2a] - signposting of patients and their families to third sector providers of suitable interventions [1d,1f,2f] - NHSP staff sought [1a,1d,1f,1g,2a,2e] - financial management of locum staff use[1a,2a,2e]	-Management oversight of incidents related to this risk -Management oversight of impact of this risk on Performance, quality and patient safety -CQC oversight	3	5	15		Dedicated locum nursing post working solely on dementia initial assessments forming part of the backlog. Work to continue until the end of the financial year 2023-24; SWK CMHSOP General Manager; 31/03/2024; G Implementation programme for the merging of the currently separate SWK CMHSOP and Tunbridge Wells CMHSOP to be working together from one base ensuring increased flexibility in staffing depolyment. Focus on dementia assessment waiting list; SWK CMHSOP General Manager; 31/03/2024; A	Service Director		3	3	9	12/06/2024

ID	Opened	Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones: Actions to reduce risk	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
							- incident reporting of all incidents associated with this risk [1h] - escalation of incident themes by governance team, of related incidents [1a,2a,1f,2e]															
29/08/2019 Risk Opened																						
ID 07496	Aug 2019	Interim Head of Nursing	**East Kent Directorate registered nursing workforce shortfalls** IF we are unable to recruit and retain nursing staff within the East Kent Directorate THEN there will be a high impact on individual teams achieving the required standards of quality and safety within service delivery as they will either be working with inadequate staff levels or reliant on bank/agency staff RESULTING IN poor patient experience, increased workloads, breaching of regulatory standards, increased levels of staff sickness absence, poor staff retention, negative impact on quality, poor morale and damage to care group reputation.	4	4	16	•Recruitment policy and process •Escalation of areas of concern •Use of agency staff where applicable and approved •Staff supervision and support •Staff Resilience training, and coaching and mentoring available •Workforce profiling and skill mixing •Trust wide Workforce Planning Group including international recruitment •Cross Directorate rotational posts		4	4	16	↑	KMPT Recruitment Plan for Thanet (to address 4x band 6 vacancies in the CMHT)	Interim head of Nursing, Quality and Patient Safety	30/04/2024	A	Interim Head of Nursing		2	3	6	31/03/2024
22/08/2023 Risk Opened																						
ID 07557	Aug 2023	Executive Director of Finance	**Trust agency usage** **(Included on the BAF)** IF the Trust fails to contain agency spend within the 2023/24 spend cap THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend	Monitoring of agency usage and compliance with usage and rate limits is an NHSE expectation of all systems and providers with established governance processes in place to oversee agency staffing.	4	5	20	↔	Executive led agency control meetings	Deputy Director of Finance	30/09/2023	A	Executive Director of Finance		3	3	9	31/03/2024
													Implementation of No agency admin being progressed, policy being implemented with no new agency being agreed	Deputy Director of Finance	30/09/2023	A						
													Present agency establishment being review to identify the impact of removing the staff and opportunities for permanent recruitment.	Deputy Director of Finance	30/09/2023	A						
													Position statement for EMT review provided monthly	Deputy Director of Finance	30/09/2023	A						
													Any exceptions to be discussed with ICB before requesting regional approval	Deputy Director of Finance	30/09/2023	A						
13/10/2023 Risk Opened																						
ID 07655	Oct 2023	Deputy Director of Quality and Safety	**Implementation of PSIRF (Patient Safety Incident Response Framework)** IF KMPT do not implement the new PSIRF effectively THEN we will be in breach of the new national patient safety strategy RESULTING IN Reputational risk to the organisation, potential sanctions through ICB from national team, inability to demonstrate the learning from patient safety events	4	4	16	Project in place to progress PSIRF. Monthly meetings with the ICB.	Working groups are working towards the implementation of PSIRF.	4	4	16	NEW	PSIRF plan regarding categories of investigating incidents	Head of Patient Safety	31/01/2024	A	Deputy Director of Quality and Safety		2	3	6	31/03/2024
													Training of CIT team in regards to patient safety incident investigation	Head of Patient Safety	31/03/2024	A						
													Training Trust-wide in PSIRF processes including after action review (AAR) and swarm huddles.	Head of Patient Safety	31/07/2024	A						

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update
Author:	Adrian Richardson, Director of Partnerships & Transformation
Executive Director:	Adrian Richardson, Director of Partnerships & Transformation

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview update for the Mental Health, Learning Disability and Autism Provider Collaborative Development session on the 2nd October 2023 including discussions on the wider Provider Collaborative developments for Kent and Medway and future workstreams. It also outlines the risks that have been identified within a number of the current workstreams.

Issues to bring to the Board’s attention

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

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

Governance

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

Version Control: 01

October Provider Collaborative Development Session

The development session received a number of briefings:

Strategic Direction of Provider Collaborative Boards

An overview of the strategic direction of Provider Collaboratives was received. It has been developed across the system. The proposed structure is for five Provider Collaboratives:

- MHLDA Provider Collaborative
- Community, Social and Primary Care Provider Collaborative
- Acute Provider Collaborative
- Diagnostics Provider Collaborative
- Pathology Provider Collaborative

Each of the Collaboratives will report into a Provider Collaborative Board which will include membership from Chairs and Chief Executives of providers.

Workstreams within each Collaborative are being finalised, at the October meeting there were eight proposed workstreams for the MHLDA PC:

1. Community Mental Health Framework
2. Children Young Persons transitions and Out of Area placements
3. Suicide Prevention
4. Frequent attenders
5. Mental Health Urgent and Emergency Care
6. Learning Disability and Autism Out of Area placements
7. Mental Health Digital Strategy delivery
8. Neurodiversity (ADHD/ASD)

It was noted that the workstreams are still being finalised. It was also noted that there was potential overlap of some workstreams for example suicide prevention and that there would be a need when workstreams have been finalised to map these interdependencies.

Lived Experience within Provider Collaborative

The meeting discussed the benefit of Lived Experience representation as part of the Provider Collaborative Board. There is currently representation from the Voluntary, Community and Social Enterprise Sector and it was proposed that a similar model for Lived Experience could be adopted. A formal paper will be bought to the December Provider Collaborative Board.

Dementia

An update on the Dementia Programme was reviewed along with a discussion on the proposed movement of the programme to the Ageing Well Programme which will report into the Community, Social and Primary Care Collaborative. It was agreed that a joint outline proposal for consideration and sign off would be drafted and reviewed at the December meeting of the MHLDA Provider Collaborative, Ageing Well Board and the Community Provider Collaborative.

Version Control: 01

Children and Young Persons Strategy

The meeting received an overview on a collaborative improvement that is underway between NELFT, KCHFT, Kent and Medway ICB and KMPT. This was followed by a discussion if the work that is underway could report into the MHLDA Provider Collaborative.
The discussion expanded on the overview and the need for a wider agenda for a CYP workstream within the MHLDA and agreed that a proposal would go to the December Provider Collaborative Board.

How do we incorporate the 5-year strategy and action plan for suicide prevention into the PCB activity?

The meeting received a presentation supporting the theme. It was recognised Suicide Prevention as a comprehensive programme would not necessarily benefit from being a workstream under the Provider Collaborative. Instead that it is important for the Provider Collaborative to understand the totality of the work and to support the work as required. The meeting recommended that a metric be identified to monitor transformation over the year and that an annual report will be delivered to the Provider Collaborative.

Risk Register

A summary risk register associated with the current workstreams of the PC is attached as appendix A. There are four workstreams reporting risks in the appendix, there are 21 risks with a post mitigation risk score of 12 or above.
Following on from previous discussions at Board, the register has been enhanced to show mitigations and work is now underway to ensure the workstreams are confident in their identification of risks. This will form a key component to the new format of the Provider Collaborative in 2024.

Version Control: 01

TRANSFORMATION RISK REGISTER

Risk No.	Programme	Organisation	Date Raised	Type	There is a risk: IF xxx	Risk Description: THEN xxx	Risk Consequence: RESULTING IN xxx	Pre-Mitigation Risk Score	Mitigating Action	Post Mitigation Risk Score
5	Dementia	KMPT	15/11/2023	Operational	*IF* the new model is rolled out alongside the existing waiting list	*THEN* there is a risk that patients already waiting may be seen after newly referred patients	*RESULTING IN* concerns from clinical staff, increased complaints, and disengagement from the change process	20	Waiting list methodology to be developed that ensures patients are clinically prioritised and seen in order of waiting time.	16
6	Dementia	KMPT	15/11/2023	Reputational	*IF* the project does not progress with sufficient pace	THEN local provider or system diagnostic target will not be met	*RESULTING IN* national scrutiny, delays to people accessing care, diagnosis and treatment.	16	This is a Trust operational priority. The standalone service being developed will focus on standardising service offering and expanding scope of workforce to combat resource/capacity constraints. Risk to be reduced once model approved.	25
7	Dementia	KMPT	15/11/2023	Dependency	*IF* the dependency between CMHF and MAS is not managed	*THEN* the project and locality teams will not be able to effectively plan for the transition	*RESULTING IN* further impacts to waiting lists, staff resource etc.	12	CMHF front door to be launched from Nov23 to Feb24. The process for triaging patients (dependent on available staffing) and subsequent booking to be confirmed. Action: John Lavelle and Victoria Stevens (Nov23)	16
8	Dementia	KMPT	15/11/2023	Operational	*IF* we cannot realise short term extra resource post model go live	*THEN* KMPT will not be able to catch up on the diagnostic backlog	*RESULTING IN* not being able to reduce the waiting list	20	Between Jul-Oct23, 1377 additional appointments were delivered via Locums, GPwER, and overtime. It is anticipated that additional capacity will be required post the stand-alone service going live to support waiting list reductions.	20
9	Dementia	KMPT	15/11/2023	Operational	*IF* data management system do not accurately reflect the patient flow for the memory service	*THEN* it will not be possible to ascertain what is driving demand and to appropriately allocate resources	*RESULTING IN* duplication, inefficient use of resources and poor patient experience	15	Amendments to RIO and the supporting operational processes to differentiate those referred for a memory assessment vs. those re-referred for treatment plan reviews or advice/guidance. Post mitigation to be reduced when dates set.	15
10	CMHF	KMPT	15/11/2023	Operational	*IF* we fail to manage the current labour market influences on turnover and our ability to recruit successfully	*THEN* this will impact on our achievement of the vacancy rate	*RESULTING IN* reduced staff morale and productivity, increased absence, reliance on agency staff, increased cost, potentially lower quality service to patients, loss of reputation and business.	20	Onboarding, Flexible working opportunities, Health & Wellbeing Group, Career paths, Early exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants, Supervision and Appraisals, Engagement activities, Health and Wellbeing Conversations, Talent Conversations, Application of the hybrid working policy, Support through the Centre for Practice, and Learning for career pathways International recruitment **Risk to be closed if vacancy rate remains below 14% in December**	12
11	CMHF	KMPT	15/11/2023	Legal	*IF* we cannot establish the right contracting mechanism	*THEN* we will not be able to fulfil the role as Lead Provider and subcontract with partners	*RESULTING IN* delays to the trailblazers and wider rollout of MHT.	15	Clarify with the ICB the lead provider contract scope and the contracting mechanisms with the third parties. Finance and Contracting Workstream review membership. Establish what can be implemented without contracts in place. Establish what can be implemented within the existing contracts with additional funds to the third parties, and what will need new contracts.	15
12	CMHF	KMPT	15/11/2023	Resources	*IF* staff do not engage with the new PROMs mandated by NHSE	*THEN* the take up will be low	*RESULTING IN* a small number of clinical outcome measures, which will not be sufficient enough to evaluate the trailblazer.	16	Engage with staff in all three providers via the implementation groups. The SoP has clear instructions around PROMs. Develop a PROM sequencing implementation plan that staff will be able to achieve during the trailblazer. A comms strategy to support the culture shift, and a clear training model. Seamless digital solution to push out and pull back in for the agreed PROMs. Live feedback loop so patients can see the benefit. Understand who in CMHTs need an iPad to deliver PROMs to engage with patients. Deliver DIALOG+ training	12
14	CMHF	KMPT	15/11/2023	Resources	*IF* the programme has difficulty recruiting to new roles due to known workforce issues for the Kent and Medway system	*THEN* MHT might be able to deliver all of the interventions or a small number of the interventions,	*RESULTING IN* patient's not receiving a mental health service within 4 weeks that suits their presenting needs.	12	A system wide recruitment drive to promote job roles to be flexible and attractive to candidates. Working closely with stakeholders to establish and utilise existing staff to avoid unnecessary recruitment. Skill-mix interventions model, which includes Lived Experience roles.	12
15	CMHF	KMPT	17/11/2023	Operational	IF we cannot resolve the issues with admin staff refusing to work in the new model's regional hubs	*THEN* we will not be able to fulfil the admin requirements of the new service.	*RESULTING IN* delays to the trailblazers and wider rollout of MHT.	16	A reengineering process is underway to ensure the new staff are in a position to move to the new regional hub within the MHT model.	6
16	Suicide Risk Reduction	KCC	17-Nov	Resources	*IF* the cost of living increases	*THEN* this could lead to increased mental distress	*RESULTING IN* an increased number of suicides	16	Money and Mental Health Service commissioned from Citizens Advice. The service has received confirmed ICB continued funding of which can be rolled over to next financial year 2024/25 – providing financial security for the service and enabling the service to continue until the outcomes of the NIHR evaluation are known.	16
17	Suicide Risk Reduction	KCC	17-Nov	Operational	*IF* national changes to Children and Young People Gender Incongruence Services	*THEN* this could lead to increased mental distress	*RESULTING IN* an increased number of suicides	16	NHS Kent and Medway Children's Mental Health team are developing comms strategy to raise awareness within the local system and they are working with NHS England to manage this transition	16
18	Suicide Risk Reduction	KCC	17-Nov	Operational	*IF* national Right Care, Right Person (RCRP) which aims to ensure vulnerable people get the right support from the right emergency services (and as such from 2024 Kent Police will only be reacting to calls where there is a threat to life of the Kings peace); reduces responsiveness to people in crisis	*THEN* this could lead to increased mental distress	*RESULTING IN* an increased number of suicides	16	NHS Kent and Medway ICB ongoing work – holding an rolling implementation group and 2x duplicate workshops where issues anticipated from the implementation of RCRP will be discussed	16
19	Bereavement Support Service	KCC	17-Nov	Operational	*IF* funding is not available to continue existing services	*THEN* support to people bereaved by suicide may be withdrawn	*RESULTING IN* an increased risk of mental illness and possible suicide	12	ICB confirmed that they are happy KCC prepares paperwork in relation to contract extension of this service for 24/25. Paper work has now been drafted and approved at SMT pending written confirmation and completion of the schedule variation to contract.	12

20	Dementia	K&M ICB	10/04/2023	Resources	*IF* the programme is not appropriately resourced within the ICB	*THEN* it will not be possible to deliver all of the initiatives proposed	*RESULTING IN* delays to implementation, scope change, and reputation damage	16	Consultation on ICB restructure underway to inform the resource required to deliver the dementia programme going forward. Dementia Programme substantive resource 0.6WTE B7. Dementia programme resource will be decided on the outcome of the consultation. Risk to be escalated within ICB by clinical leads.	16
21	Dementia	K&M ICB	10/06/2022	Operational	*IF* the waiting list is not reduced	*THEN* the 6 week to diagnosis ambition will not be met and appropriate patients will not receive cholinesterase inhibitors to delay the progression of dementia	*RESULTING IN* lack of effective management of symptoms, not maintaining independence in own homes and a rise in crisis situations leading to avoidable hospital/care home placements.	20	KMPT have prioritised within Trust Strategy. KMPT BI to produce trajectory to understand backlog and recovery plan. Residual risk will be reduced once we have assurance via a trajectory KMPT committed to reducing the waiting list by Mar 24, including addressing any patients referred prior to 1st Apr23 by Sep23 Updates: Jul23 – Trajectory still awaited, will now form part of action plan following KMPT operational workshop, due Oct 23. GPwERs undertaking additional sessions to diagnose between Sept23 – Apr24. Trajectory was expected by end of October 23 but not received, update from KMPT awaited	20
22	Dementia	K&M ICB	17/11/2023	Resources	*IF* recurrent funding is not approved THEN a co	*THEN* a community-based MAS will not be possible	*RESULTING IN* insufficient diagnostic capacity in K&M, loss of skills developed in primary care and reputational risk	12		12
23	Dementia	K&M ICB	10/06/2022	Strategic	*IF* the national DDR target of 67.7% is not achie	*THEN* people living with an undiagnosed dementia will have a lack of access to information, guidance and appropriate support	*RESULTING IN* delays to people accessing care, diagnosis and treatment, increase in crisis situations, reduction in appropriate and timely end of life planning, national scrutiny and damage to the systems reputation.	12	NOTE System have agreed a 23/24 DDR local target of 61.25%. This was based on the national revised data that was inaccurate as didn't include deaths for the previous quarter and therefore the local targets remain challenging 9 GPwER supporting additional diagnoses in KMPT DiADeM embedded in frailty pathway in DGS. DiADeM pilot in Medway and Swale active Expand the use of Diadem to diagnose advanced dementia in care homes in EK and WK. Medway pilot for community MAS commences 6 November for 3 months, expecting to diagnose extra 10 patients per week	12
24	Urgent and Emergency Care	K&M ICB	01/10/2023	Operational	*IF* an increased number of people are clinically ready for discharge and long lengths of stay exist	*THEN* a number of people will be waiting for admission in environments that are clinically unsafe	RESULTING IN potential major injury of those waiting and those medically fit for discharge potentially deconditioning and relapsing.	16	Use of out or area beds Increase in home treatment intervention/supervision Liaison Psychiatry advice to Acute Trusts Multi-Agency plan for reduction in CRFD Multi agency check and challenge event Safe haven and Crisis House procurement	16
25	Urgent and Emergency Care	K&M ICB	01/10/2023	Operational	*IF* the 72 hour referral pathway sits within the NHSE 111 Select 2 / Urgent Crisis Line (in the absence of alternative repository)	*THEN* capacity to respond to urgent crisis calls is reduced	*RESULTING IN* poor service user experience and non-compliance with NHSE requirements.	16	Use of Temporary Staff Development of a revised operational model in partnership with Mental Health Matters	16
26	Urgent and Emergency Care	K&M ICB	17/11/2023	Operational	*IF* the Urgent Ambulance Response / Blue light Triage is delayed	*THEN* there will be a continued demand for unnecessary conveyance of individuals with primary mental health presentation to the emergency departments	*RESULTING IN* continued pressure upon emergency services, poor patient experience and inability to realise a further reduction in incidents of S136.	12	Planning meeting on 24th November 2023	12
27	Workforce	K&M ICB	27/10/2021	Operational	IF the Mental Health Programmes do not meet the additional workforce growth required in the Long Term Plan Ambitions	*THEN* this could lead to a reduction in capacity and activity	*RESULTING IN* an increase in waiting times for assessment and treatment, poor outcomes for patients, and increased demand for secondary and emergency services	12	Collaborative partnership signed by 3 providers. Lead provider gathering momentum working up resources required for next 2 years to expand in line with LTC expectations Shaw trust have recruited some posts, and they're confident in their ability to fill the remaining.	12

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**30th November 2023**
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

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

The following represents a strategic view of the areas of greatest focus across the trust:

Days lost to those **Clinically Ready for Discharge** continues to impact the trusts performance negatively. The majority of patients currently delayed are older adults which are also impacting on the average length of stay. Colleagues in the ICB have agreed a piece of work to support KMPT in helping to secure the most appropriate onward provision for those delayed. In addition, an ICB expert on patient flow has been asked to support KMPT to undertake a diagnostic process and analysis of the issues, both process and system wide. This work will commence 27th November 2023. Executive responsibility is the Chief Operating Officer.

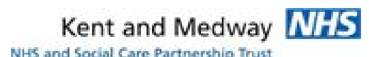
CMHSOPs are not meeting the 6 **weeks to initial assessment and 18 weeks to second appointment performance target for dementia**. This has resulted in 2,700 patients awaiting for an initial assessment with a further 800 awaiting a second appointment. A Memory Services Improvement

Programme, made up of six task and finish groups, has been launched to implement the changes to the service model in order to achieve the 6 weeks to diagnosis target with agreed timelines monitored via the transformation programme (one of the six priorities) and via the monthly Quality Performance Reviews. Executive responsibility is the Director of Partnerships and Transformation.

It is positive to note that eight out of nine workforce metrics are within target, **Vacancy Rates** and **Turnover** are both at their lowest positions for the last 12 months. This means that the Trust will enter the winter months with a more stabilised workforce supported by initiatives including the roll out of the flu vaccination for staff.

Governance

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



Chief Executive Overview

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

Looking at all measures addressed within this report as well as those routinely reviewed at monthly Directorate Quality Performance Review meetings, as at the end of October 2023 there are:

- 15 measures of concern due to their trend of performance
- 7 measures of an improving nature
- 40 common cause or movement which is not significant at this stage

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

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

Section	Measure Name	Area Level	Area Name	Month	Target	Actual	V	A	LCL	Mean	UCL
Caring	002.C: Mental Health Scores From Friends And Family Test – % Positive	Trust Wide	TrustTOTAL	Oct-23	93.0%	87.1%			80.6%	85.8%	91.1%
Caring	006.C: Complaints responded to within 25 days	Trust Wide	TrustTOTAL	Oct-23	100.0%	65.0%			83.2%	90.9%	98.5%
Effective	006.E: Clinically Ready for Discharge	Trust Wide	TrustTOTAL	Oct-23	7.5%	13.9%			9.6%	12.1%	14.5%
Effective	015.E: %Patients with a CPA Care Plan	Trust Wide	TrustTOTAL	Oct-23	95.0%	83.2%			84.9%	87.6%	90.3%
Effective	017.E: Non CPA Care Plans & PSP	Trust Wide	TrustTOTAL	Oct-23	80.0%	71.2%			67.6%	70.3%	73.0%
Responsive	016b.R: Care spell start to Assessment within 6 weeks (MAS only)	Trust Wide	TrustTOTAL	Oct-23	75.0%	36.6%			30.7%	45.9%	61.1%
Responsive	017.R: Care spell start to Treatment within 18 weeks	Trust Wide	TrustTOTAL	Oct-23	95.0%	73.5%			69.9%	75.5%	81.2%
Safe	002.S: CPA Patients Receiving Formal 12 Month Review	Trust Wide	TrustTOTAL	Oct-23	95.0%	85.5%			88.6%	91.1%	93.7%
Well Led (Finance)	010.W-F: Agency Spend Against Cap YTD (%)	Trust Wide	TrustTOTAL	Oct-23	0.0%	25.0%			9.9%	18.5%	27.1%

Community Teams

Performance in CMHTs and CMHSOPs is not where we would want it to be. There are capacity issues and a high degree of variability between teams. All community services continue to review caseloads in line with the implementation of the Community Mental Health Framework (CMHF). The

variability of performance across teams will be addressed through the unwarranted variation work that has started as part of the Trusts strategy and standardisation through CMHF.

Clinically Ready for Discharge

Patients that are Clinically Ready for Discharge are placing pressure on the Trusts bed base. The effective section of this report sets out the actions we are taking working with the system to ensure our patients are cared for in an appropriate setting. The table below sets out the latest benchmarking information regarding how KMPT is performing within its current bed base, compared nationally to our peers. This highlights the focus required for the Trust on bed occupancy which is part of the Purposeful Admission Programme (previously called the Bed strategy), Average LOS for Older Adults and clinically ready for discharge work with the wider health and social care system.
Despite these pressures it is positive to note that KMPT was the highest performing trust nationally for Inappropriate adult acute mental health out of area placement bed days in the most recent provider oversight data.

	Metric	KMPT 2022/23	National Mean	National Quartile	KMPT: 12 months to Oct 2023
YA Acute	Beds per 100,000 resident population	15	23	0-25	Unchanged
	Bed Occupancy (excluding leave)	96%	93%	51-75	94.7%
	Average Length of Stay	36	38	26-50	33.9
	Clinically Ready for Discharge	13%	7%	76-100	16.1%
OP Acute	Beds per 100,000 resident population	23	43	0-25	Unchanged
	Bed Occupancy (excluding leave)	96%	87%	76-100	95.8%
	Average Length of Stay	95	86	51-75	97.3
	Clinically Ready for Discharge	27%	12%	76-100	24.0%

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

Liaison

Our liaison teams play a key role in supporting the local acute trusts on a daily basis to manage patients safely in emergency departments. This month we have included two metrics within the IQPR that measures our team’s performance against a one hour and two-hour standard. In the next few months we will add further metrics for the Board to be sighted on.

Conclusion

My role in the next 4 months will be to work with the Executive team to review what actions can be taken to improve performance for specific metrics. As stated above sadly performance in a number of areas is not where we would want it to be, my objective working with the Executives and within

existing resources will be to set out for the Board where we can make improvements at pace and where others may take longer, set out a timescale for improvements and start to implement trajectories for performance that can be monitored proactively over time.

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

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

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

Restrictive Practice

Restraints:

- 105 reported incidents of restraint needing to be used in October 2023, an increase of 32 from the previous month. Acute Directorate reported 102 and Forensic & Specialist reported three incidents.
- It is often the case that many restraints are ascribable to a minority of patients. Of the total 105 restraints, 40 (38%) of these involved just five patients; three who can be tracked through their admissions via the Place of Safety units and subsequent transfer to inpatient wards and an additional two who are currently receiving care.
- One incident reported moderate harm.
- There were six reported **Prone** restraints, all occurring within the Acute Directorate and involving 5 patients.

Seclusions:

- There were 22 reported episodes of seclusion in October, an increase of five from the previous month.
- Nineteen episodes occurred within the Acute Directorate and involved 17 patients with three episodes taking place within the Forensic and Specialist Directorate and involving two patients.
- Eight of the total seclusions were under 24 hours in duration, with five episodes lasting over seven days. These five episodes all occurred within the Acute Directorate with four taking place within Willow Suite.

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
011.S	Restrictive Practice - All Restraints		-	-	67	74	83	80	69	66	73	82	94	120	77	105
020.S	Unplanned Readmissions within 30 days		8.8%	L	5.0%	8.4%	4.1%	6.2%	8.2%	3.6%	3.8%	7.6%	9.4%	7.0%	4.3%	2.0%

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

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

Issues of Concern

Bed pressures

The trust retains a strong focus to enable the management of beds within capacity to minimise the impact on patients and carers by reducing inappropriate out of area patients. The table above in the CEO section of this report highlights how the Trust is performing nationally against peers for managing beds. Our LOS for Younger Adults is below the national average. There is more work to do with regards to our Older Adults LOS. Further work is required for Clinically Ready for Discharge patients with the local system. Actions being taken are set out in this paper. Our PAP clearly sets out our ambition to reduce bed occupancy to 92% by the end of March. This year across acute beds, this has consistently been in excess of 95% for the last 12 months, however reduced to 92.1% in October. Work will continue to maintain occupancy at this level.

There is a continued need to use external PICU beds due to the local provision being insufficient to meet the needs of the population with Willow Suite being a male only 12 bedded unit. These beds achieve a Length of Stay below the national mean. The Trust is forecasting to use 6-8 beds with external providers (5 ideally within area) for the foreseeable future until a long-term solution is found for a female unit locally.

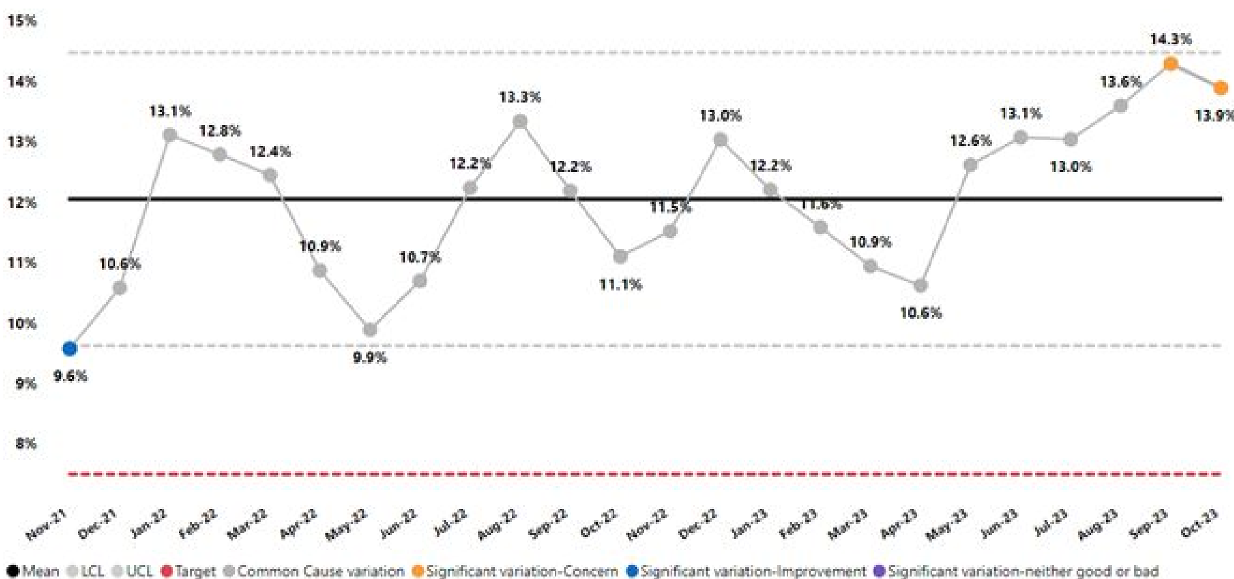
Care Planning

Care planning continues to be an area of challenge, ongoing monitoring within directorates ensures a focus is retained. DIALOG + training has commenced, starting in the Thanet locality, with county wide training to be completed by March 2024. The DIALOG+ form is embedded on RiO and is ready to use. Following full implementation indicators around care planning will need to be reviewed.

Executive Commentary

Clinically Ready for Discharge (006.E)

- Days lost to those Clinically Ready for Discharge decreased by 0.4% to 13.9% in October from an annual high of 14.3% in September. The majority of patients currently delayed are older adults which also impact on length of stay. This is now an area of concern due to a run of six points above the mean.

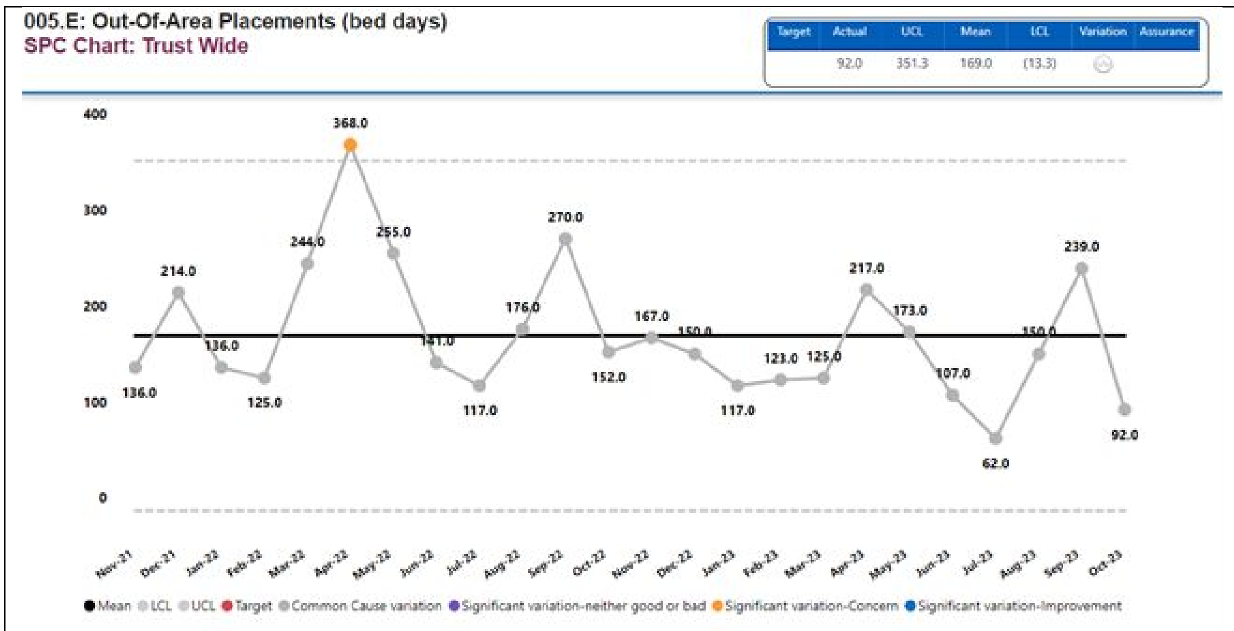


- Colleagues in the ICB are now supporting KMPT in helping to secure the most appropriate onward provision for those delayed, as outlined above through a diagnostic process.

	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			49.0	0.0	-7.6	76.3	34.3
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			190.0	0.0	3.9	247.1	125.5
4	Trust Total			239.0	0.0	10.9	308.8	159.8

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**
Narrative	
• 92 bed days were used in October (0 YA Acute and 92 PICU), compared to 239 bed days used in September (49 YA Acute and 190 PICU).	

Kent and Medway NHS
NHS and Social Care Partnership Trust



- The chart highlights continued variation in the use of external beds across Acute and PICU in excess of the 5 pre-contracted female PICU beds. The graph shows ongoing common cause variation with no significant trends identified over the previous 24 months. Always use some until long term solution.
- A revised process for monitoring external placements is in place to ensure external placements are constantly reviewed.

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			68.2%	95.0%	75.8%	94.6%	85.2%
2	Forensic and Specialist			87.8%	95.0%	88.9%	97.3%	93.1%
3	East Kent			86.8%	95.0%	87.8%	95.9%	91.8%
4	North Kent			78.2%	95.0%	78.2%	90.6%	84.4%
5	West Kent			74.1%	95.0%	79.4%	88.5%	83.9%
6	Trust Total			81.6%	95.0%	85.0%	90.6%	87.8%

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
2	Forensic and Specialist			82.8%	80.0%	63.7%	78.3%	71.0%
3	East Kent			78.2%	80.0%	73.7%	82.0%	77.8%
4	North Kent			63.5%	80.0%	61.8%	70.7%	66.2%
5	West Kent			58.3%	80.0%	54.4%	65.0%	59.7%
6	Trust Total			70.9%	80.0%	67.7%	73.1%	70.4%

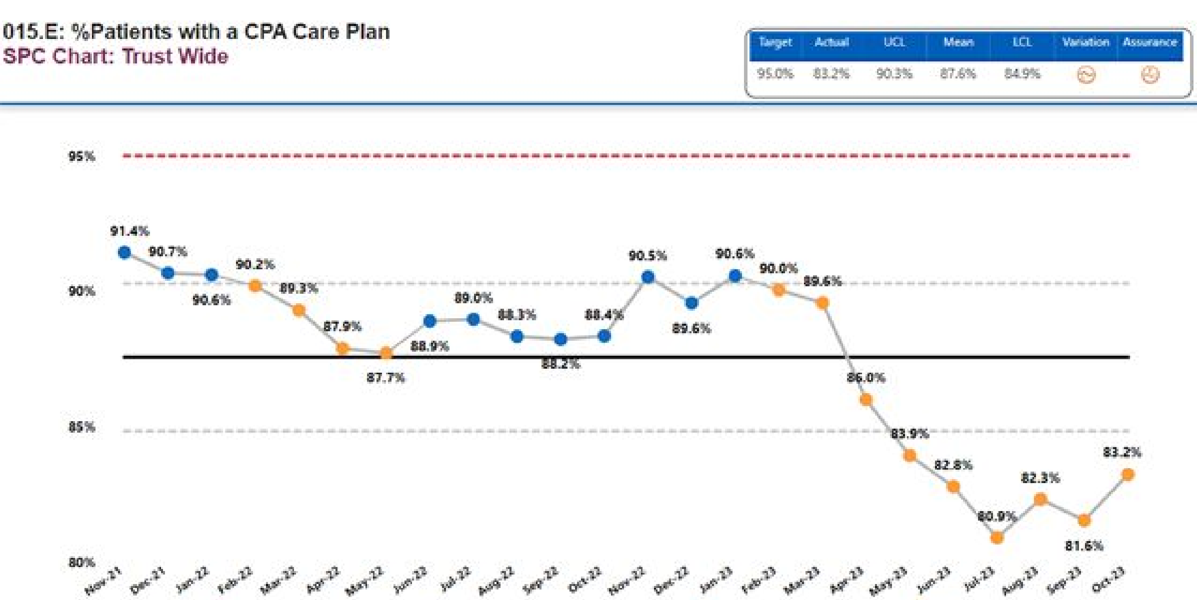
Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Special Cause Variation of a **Concerning nature** *Non CPA PSP & Care Plans:* Special Cause Variation of a **Concerning nature**

Assurance	Variation indicates consistently **failing short of target**

Narrative

CPA Care Planning

- Across the locality Directorates CMHTs, CMHSOPs and EIP teams contribute to over 80% of this indicator. The trust wide position represents an increase in month of 1.6%, the highest percentage of the last 5 months.



- In North Kent, where compliance is at the lowest, it is recognised that the significant number of people on the caseload attributes to poor performance. Additional working has been approved to improve the position. The deputy Service Director and Allied Health Professional lead are also expediating the roll out of DIALOG+ across north Kent, which will support the formation of the care plan, pulling across from the assessment, therefore supporting long-term improved compliance.
- FSS and East Kent Directorates continue to exceed 85%, the Acute Care Group Figure reflects a low number of patients (12).

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

- Trust wide performance remains above the mean of the last 24 months despite a decrease of 0.5% in September to 71.2%.
- The West Kent and North Kent Directorates are outliers having achieved 60.2% & 63.6% respectively at the end of September.

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
001b.E	CPA patients receiving follow-up within 72hours of discharge				78.7%	79.7%	84.6%	83.2%	84.5%	84.3%	76.4%	79.0%	78.1%	73.0%	80.6%	80.5%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.3%	95.4%	95.1%	95.4%	95.3%	95.5%	95.3%	95.4%	95.4%	95.5%	95.6%	95.3%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	169	150	117	123	125	217	173	107	62	150	239	92
006.E	Clinically Ready for Discharge		7.5%	L	11.5%	13.0%	12.2%	11.6%	10.9%	10.6%	12.6%	13.1%	13.0%	13.6%	14.3%	13.9%
012.E	Average Length Of Stay(Younger Adults)		34	L	36.33	34.49	36.48	37.94	36.24	30.31	28.11	34.81	35.61	36.38	29.90	33.36
013a.E	Average Length Of Stay(Older Adults - Acute)		77	L	89.65	125.16	113.50	76.24	106.36	70.80	97.59	121.03	109.81	83.58	60.17	94.81
015.E	%Patients with a CPA Care Plan		95%	L	90.5%	89.6%	90.6%	90.0%	89.6%	86.0%	83.9%	82.8%	80.9%	82.3%	81.6%	83.2%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	74.4%	74.9%	74.4%	73.7%	72.3%	69.9%	68.9%	72.7%	73.8%	75.6%	77.6%	79.1%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		80%	L	68.5%	69.0%	71.1%	71.0%	70.4%	68.6%	68.2%	69.2%	68.8%	71.4%	70.9%	71.2%
018.E	Bed Occupancy (Net)				96.2%	94.9%	95.3%	95.6%	94.4%	95.5%	97.0%	95.8%	95.0%	95.2%	94.1%	92.1%
019.E	Ave LoS for Clinically Ready for Discharge (at discharge)				77.8	34.9	64.3	37.8	51.9	18.5	58.0	53.3	81.8	31.5	38.0	68.6
020.E	% of Acute (YA & OPMH) discharges at weekends				7.6%	8.9%	4.7%	8.0%	4.8%	18.1%	23.2%	8.2%	15.0%	11.1%	9.0%	9.7%

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

Executive Lead(s): Chief People Officer
Lead Board Committee: Workforce Committee

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

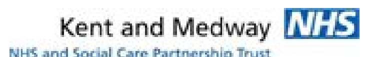
Executive Commentary

- Targets were achieved for all key performance indicators in October, with the exception of appraisal. It should be noted however, that the appraisal target has since been reached following the close of the window.
- Vacancy rates and safer staffing fill rates saw a further significant improvement in October owing to larger than usual numbers of new starters and lower levels of turnover than over the previous 12 months.
- Although continuing to achieve target, there was an increase in sickness absence in October compared with the previous 4 months. This is considered to reflect usual seasonal trends.

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
020.W-W	Establishment (Overall)									4088.5	4088.5	4088.5	4088.5	4088.5	4088.5	4088.5
001.W-W	Staff Sickness - Overall	✓	5.30%	L	5.7%	6.7%	5.4%	4.6%	4.5%	4.4%	4.9%	4.8%	4.7%	4.6%	4.4%	4.9%
005.W-W	Appraisals And Personal Development Plans		95%	L	94.7%		95.8%	95.8%	95.8%					17.1%	42.2%	86.6%
006.W-W	Vacancy Gap - Overall		15.50%	L	16.3%	16.2%	16.1%	16.2%	14.3%	14.0%	14.0%	13.7%	13.6%	12.9%	12.9%	11.8%
012.W-W	Essential Training For Role		90%	L	93.1%	93.6%	93.8%	93.5%	93.9%	93.6%	92.8%	92.9%	93.6%	93.8%	93.4%	93.4%
015.W-W	Staff Stability (Overall)		85%	L	84.2%	84.2%	83.9%	84.1%	85.0%	84.5%	86.0%	85.3%	85.3%	85.3%	86.2%	85.4%
019.W-W	Staff Turnover (Overall)		16.50%	L						16.9%	16.9%	16.4%	15.9%	15.8%	15.7%	15.2%
019a.W-W	Staff Voluntary Turnover (Overall)		15.00%	L	14.6%	14.8%	14.7%	14.7%	14.3%	14.2%	14.2%	13.8%	13.1%	13.0%	13.4%	11.4%
023.W-W	Safer staffing fill rates		80.00%	L	100.4%	99.1%	100.2%	99.6%	100.5%	102.3%	103.7%	105.8%	108.7%	108.7%	105.5%	108.8%

- *New targets were introduced April 2023; historic data RAG rated against the new targets however may have previously been compliant against old targets.*



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

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

Issues of Concern
The Trust is forecasting to deliver its financial position in year, with the Trust's CIP programme identified in full, and in year delivery sitting at 86% of the planned position. Work is on-going to recover this slippage. The Trust's agency run rate remains high, with the pressure sitting within the medical staff group. The Trust is presently forecasting to overspend its agency cap by £1.56m (£8.58m vs £7.02m).

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
004.W-F	In Month Budget (£000)		0.0	N	(12,712)	(12,524)	(12,526)	(12,659)	(12,571)	(13,296)	(13,279)	(14,931)	(13,739)	(13,651)	(14,390)	(13,607)
005.W-F	In Month Actual (£000)		-	-	(13,242)	(12,746)	(12,843)	(12,873)	(13,873)	(13,391)	(12,909)	(14,708)	(13,669)	(14,063)	(14,108)	(13,362)
006.W-F	In Month Variance (£000)		-	-	(530)	(223)	(317)	(214)	(1,302)	(95)	370	224	71	(411)	283	245
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	4.17%	1.78%	2.53%	1.69%	10.36%	0.71%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	565	565	565	565	565	549	545	566	633	559	645	612
008.W-F	Agency - In Month Actual (£000)		-	-	766	728	739	580	930	740	748	717	684	726	638	648
009.W-F	Agency - In Month Variance from budget (£000)		-	-	201	163	173	15	365	191	172	186	131	181	95	71
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	11.82%	13.72%	15.41%	14.25%	18.44%	34.77%	33.20%	33.06%	29.64%	30.16%	27.30%	24.96%

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

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

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

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

Executive Commentary

- **Complaints responded to within 25 days (or agreed timeframe)** (006.C) This reduction in performance is the change in accountability for the directorate structure and a more robust accountability for not extending the timeframe for complaint responses to improve patient experience.

IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	87.1%	88.1%	84.9%	85.1%	87.5%	87.5%	84.2%	85.8%	86.4%	83.4%	88.3%	87.1%
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	98.0%	98.0%	99.0%	99.0%	98.0%		82.0%	83.0%	86.0%	96.0%	96.0%	98.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	97.0%	98.0%	97.0%	97.0%	97.0%		87.0%	84.0%	84.0%	87.0%	73.0%	65.0%
007.C	Compliments - actuals		-	-	120	143	114	101	106	78	114	97	115	112	117	106
008.C	Compliments - per 10,000 contacts		-	-	33.34	48.20	31.52	31.09	29.36	24.03	31.07	26.71	36.04	34.62	35.67	30.87
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	681	522	703	584	553	375	685	709	675	512	460	510
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	4.6	4.1	4.8	4.2	3.8	2.7	4.8	4.9	4.7	3.6	3.2	3.4
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.3	8.4	8.4	8.4	8.3	8.1	8.3	8.3	8.3	8.4	8.4	8.1

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

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

Issues of Concern

Community Services

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. All community services continue to review caseloads in line with the implementation of the Community Mental Health Framework. The reduction of caseloads which can only be achieved with support from all agencies providing a suitable step-down model for patients whose mental state is stable. Implementation of Mental Health Together has an ambition to have services live across all Kent and Medway by the end of March 2023. This is dependent on contracting arrangements with partners. The Thanet locality will be first to go live (in partnership), followed by the remainder of east Kent, Medway/ Swale and lastly west Kent and DGS. The infrastructure to support, such as DIALOG+; SNOWMED coding and workforce realignment are well underway and in place. Once final contracting has been agreed system recruitment for new posts will commence.

Waiting Lists

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

CMHSOPs are not meeting the 6 weeks to initial assessment and 18 weeks to diagnosis performance target for dementia. This is largely driven by the previous backlog, increasing demand (over the last 2 years when compared to pre-pandemic levels), variation in clinical practice, difficulty in recruiting to roles within CMHSOPs, and a mixed caseload of both older adults who require support for an organic need and those who have a functional mental health need.

Positive work has been made in tackling the backlog of referrals waiting for their second appointment, prior to a cut-off point of 1 April 2023. This list has been reduced from 785 as at 31st March to 2 as at 13th November with plans in place for the remaining 2 patients.

A Memory Services Improvement Programme has been launched to implement the changes to the service model needed to achieve the 6 weeks to diagnosis target with agreed timelines monitored via transformation programme and via the monthly Quality Performance Reviews. Capacity planning

is currently being completed with an initial trajectory expected in early Q4 for review and refinement with operational and clinical leads.

Demand remains high and despite demonstrating throughput of patients receiving assessments the list size remains high, the first appointment waiting list has reduced slightly from 2,700 patients in September to 2,580 in mid-November. A further 800 organic patients continue to wait for their 2nd appointment. These waits reflect the high number of referrals received by the teams, over 900 per month on average for memory assessment and complex dementia.

Executive Commentary

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

- The % of those commencing treatment within two weeks reduced to 76.9% in month, monthly values are subject to variation as the denominator for any given month is low. This indicator is under review following new national guidance being published which will likely result in a larger denominator with the inclusion of At-Risk Mental State (ARMS) team's data.
- The cumulative position of the last 12 months is 68.9%, which is above the national target.

Liaison Psychiatry

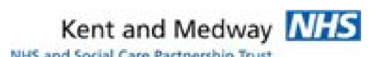
Our liaison teams play a key role in supporting the local acute trusts on a daily basis to manage patients safely in emergency departments. KMPT liaison teams receive approximately 900 urgent referrals a month. Work is ongoing to better understand factors impacting all those that present at an emergency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

Current KMPT measures focus on those that present at an emergency department who have an onward referral to KMPT liaison services. Currently there is mix of response times measured dependant on historic funding, the following tables show the compliance against the targets.

<u>Urgent Referrals seen within 1 hour</u>

Directorate	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
East Kent		86.1%	85.7%	81.6%	80.8%	76.8%	83.4%	72.1%	76.1%	84.7%	86.7%	84.2%	86.0%
North Kent		87.4%	92.7%	92.7%	95.7%	94.0%	90.9%	95.3%	94.9%	85.3%	91.7%	88.4%	89.2%

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



Urgent referrals seen within 2 hours

Directorate	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
East Kent		76.1%	89.5%	82.1%	89.2%	92.8%	81.6%	76.5%	74.0%	73.6%	69.5%	67.3%	72.9%
North Kent		92.6%	78.9%	92.5%	94.7%	91.7%	87.5%	96.1%	93.2%	94.5%	95.8%	94.4%	94.8%
West Kent		95.4%	95.6%	95.8%	97.4%	93.3%	93.3%	93.8%	95.6%	94.4%	93.6%	96.3%	96.5%

Whilst not routinely reported within the IQPR these metrics are reviewed monthly within the directorate QPR meetings. Work is underway to move to the 1-hour target for all teams as well as embed an enhanced triage function. Additionally, data collection is being implemented to allow a measure of admissions to KMPT within 12 hours for those patients who subsequently require an admission. This will provide assurance that time spent in the emergency department is minimised for this patient group.

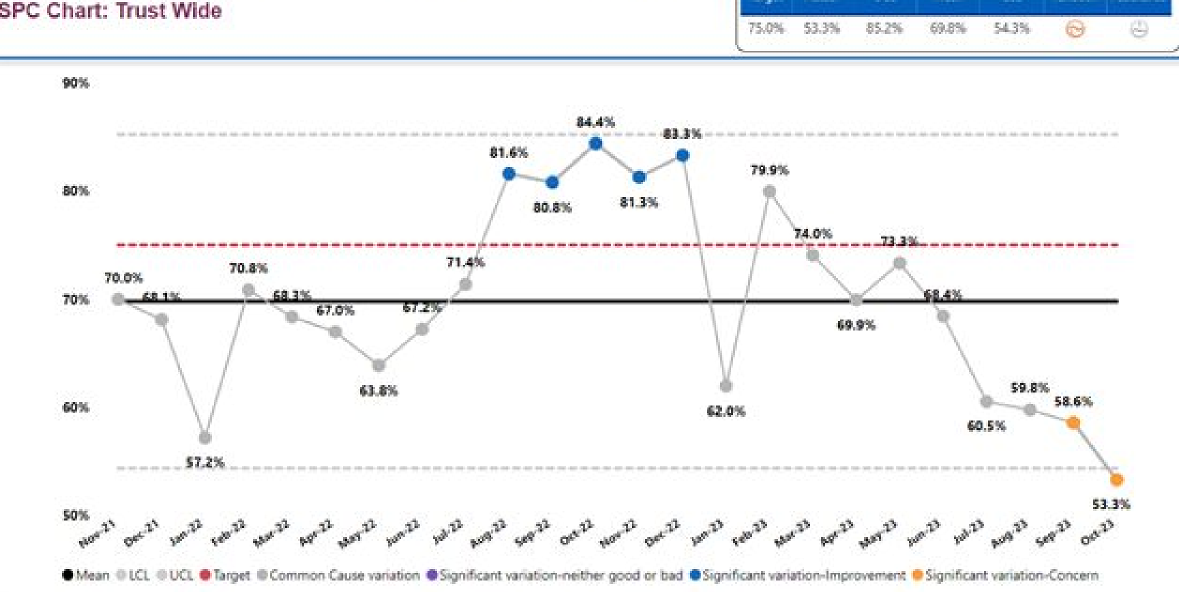
We will be reviewing all metrics reported to Board for month 1 reporting in the new financial year. It is highly likely that we will include metrics for liaison within the IQPR as these demonstrate KMPTs role in the system for managing the urgent care pathways.

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	East Kent			73.2%	75.0%	62.7%	93.9%	78.3%
2	North Kent			42.6%	75.0%	38.6%	86.2%	62.4%
3	West Kent			74.0%	75.0%	49.4%	91.2%	70.3%
4	**Trust Total**			58.6%	75.0%	55.5%	85.4%	70.4%

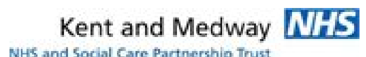
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	Variation indicates **inconsistently hitting or failing target**
Narrative	

- Overall trust performance decreased for the sixth successive month to 58.6% in October. This is the lowest monthly figure since January 2022.

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



- Numbers on the waiting list remains static at approx. 1,200 although the percentage of which who had already breached decreased by 5.6% to 36.5%.
- The North Kent Directorate continues to see the largest challenge in achieving this target, the performance across CMHTs was under 40% for the third time in four months. Stepping up the full Mental Health Together (MHT) model in this area is crucial as evidenced by the review of cases reported in the previous Board report. Data quality, such as not outcoming appointments is a significant factor for the 4 week wait and as such it has been agreed to support the team with additional admin resource to enable data cleansing. Workshops for all staff are being provided to upskill in the use of data and management of wait lists. In Medway CMHT the MHT



pathway into services has been implemented and has seen an improvement in performance, thus demonstrating the need to implement the full MHT model with provider partners.

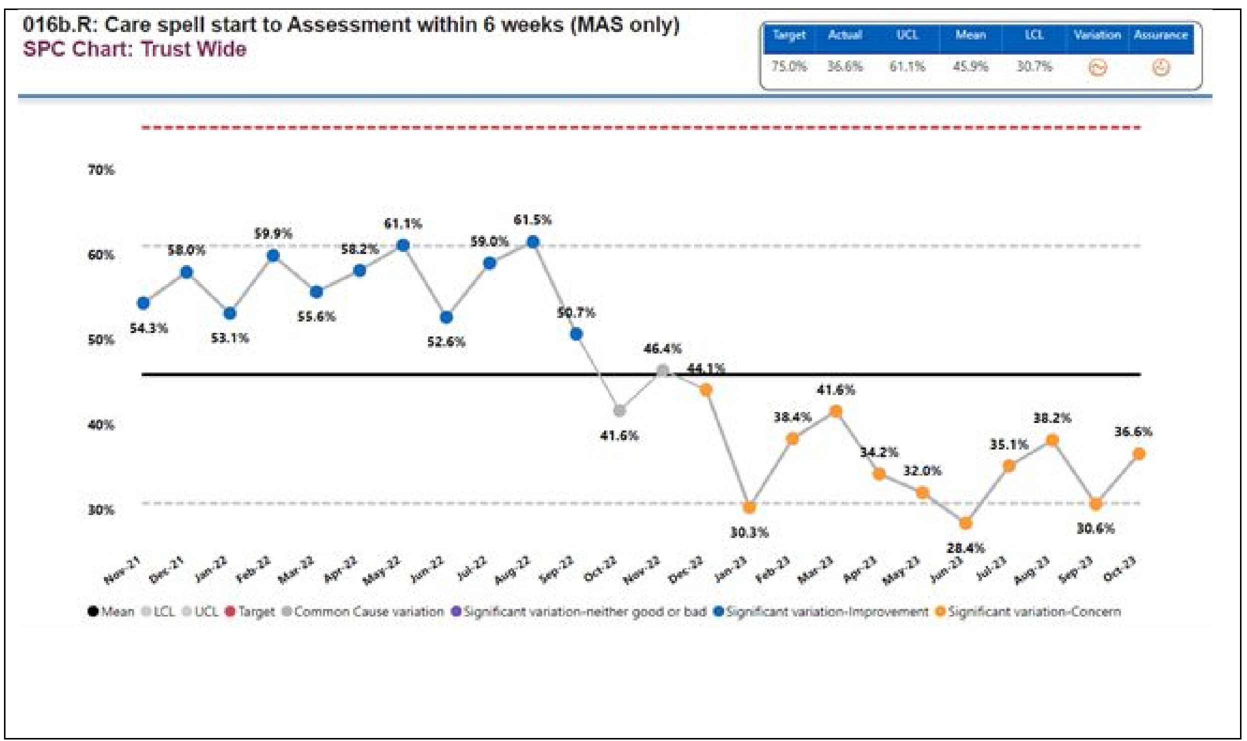
- The Mental Health Together model, as part of the Community Mental Health Framework, is planned to commence in East Kent in November starting with Thanet CMHT. Whilst this will not demonstrate a sudden impact on the 4 week wait, the new model of care will provide a streamlined pathway and allow people to be allocated directly into a clinical intervention.
- Work is ongoing to transition to a system wide target in line with previously highlighted national waiting time metrics for this patient group over the next 6- 9 months.

	016.R: Care Spell start to Memory Assessment (Routine) Assessment Within 6 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	East Kent			33.1%	75.0%	33.6%	69.9%	51.7%
2	North Kent			27.2%	75.0%	22.0%	49.9%	36.0%
3	West Kent			29.6%	75.0%	28.6%	70.3%	49.5%
4	Trust Total			30.6%	75.0%	31.4%	61.5%	46.4%

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

Narrative

- CMHSOPs are addressing three waiting lists: 4 weeks wait for functional presentations; 6 weeks wait to assessment & diagnosis for organic presentations and 18 weeks to treatment for all referrals. The vast majority of the activity sits within organic presentations.
- Immediate actions are being taken to address the issues experienced in ongoing waits, which includes the teams continuing to review caseloads to ensure accuracy of waiting lists and understanding capacity available to deliver each aspect of the pathway. Actions are overseen by the Director of Partnerships and Transformation.
- A longer-term plan to address the delivery of the memory assessment and diagnosis service provision has been formulated and is broken down into six key task and finish groups.
- There remains a large variance across teams in performance. It is recognised that Sevenoaks and Tunbridge Wells have significant workforce challenges, there is an improved position with regards to recruitment to nursing posts. Vacancies do however remain in the team and new recruits are currently going through the onboarding process with expected start dates in December 23. The service has negotiated an increase in GPwERs time, the team is exploring the development of evening and weekend clinics to support the assessment and diagnosis process.


Kent and Medway NHS
NHS and Social Care Partnership Trust
016b.R: Care spell start to Assessment within 6 weeks (MAS only)
SPC Chart: Trust Wide
Target Actual UCL Mean LCL Variation Assurance
75.0% 36.6% 61.1% 45.9% 30.7%
70%
60%
50%
40%
30%
54.3% 58.0% 53.1% 59.9% 55.6% 58.2% 61.1% 52.6% 59.0% 61.5% 50.7% 41.6% 46.4% 44.1% 30.3% 38.4% 41.6% 34.2% 32.0% 28.4% 35.1% 38.2% 30.6% 36.6%
Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23
Mean LCL UCL Target Common Cause variation Significant variation-neither good or bad Significant variation-Improvement Significant variation-Concern

IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	87.5%	69.2%	68.2%	61.1%	52.4%	68.8%	88.2%	60.7%	52.2%	88.2%	65.2%	76.9%
007.R	DNAs - 1st Appointments		-	-	14.3%	13.8%	11.5%	11.7%	11.8%	12.0%	11.9%	11.1%	11.8%	10.5%	10.7%	11.5%
008.R	DNAs - Follow Up Appointments		-	-	8.6%	8.4%	8.0%	7.9%	7.9%	8.9%	8.5%	8.7%	8.9%	8.7%	8.8%	9.0%
009.R	Patient cancellations- 1st Appointments		-	-	2.4%	2.4%	1.9%	2.5%	2.6%	2.3%	2.3%	3.1%	2.6%	2.6%	1.8%	2.0%
010.R	Patient cancellations- Follow Up Appointments		-	-	6.2%	6.3%	5.5%	5.9%	6.1%	5.5%	5.5%	6.2%	6.7%	6.5%	5.2%	5.2%
011.R	Trust cancellations- 1st Appointments		-	-	4.3%	4.7%	4.4%	4.0%	4.4%	4.4%	3.6%	3.9%	4.7%	3.8%	1.9%	2.2%
012.R	Trust cancellations- Follow Up Appointments		-	-	10.3%	11.2%	10.2%	10.6%	9.8%	8.9%	9.0%	8.6%	10.0%	10.4%	9.1%	9.3%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)		75%	L	81.3%	83.3%	62.0%	79.9%	74.0%	69.9%	73.3%	68.4%	60.5%	59.8%	58.6%	53.3%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)		75%	L	46.4%	44.1%	30.3%	38.4%	41.6%	34.2%	32.0%	28.4%	35.1%	38.2%	30.6%	36.6%
017.R	Care spell start to Treatment within 18 weeks		95%	L	73.3%	75.4%	74.6%	72.9%	69.0%	69.0%	68.4%	74.0%	76.6%	75.4%	71.9%	73.5%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)		-	-	28.8%	44.7%	30.2%	32.4%	33.8%	34.9%	45.5%	35.0%	38.7%	44.6%	42.2%	36.5%
022.R	Referrals to Rapid response assessed within 4 hours		-	-					50.0%	62.8%	62.7%	62.0%	70.8%	67.8%	53.0%	63.7%
023.R	Open Access Crisis Line: Calls received		-	-	2,526	2,403	2,603	2,552	3,984	5,172	5,016	5,433	5,245	4,910	5,248	5,249
024.R	Open Access Crisis Line: Abandonment Rate (%)		-	-	26.7%	30.3%	26.1%	36.2%	35.1%	37.1%	31.7%	38.1%	35.2%	38.6%	45.4%	41.4%
025.R	Open Access Crisis Line: Ave time to answer			-	*00:09:28*	*00:09:19*	*00:08:40*	*00:10:33*	*00:09:39*	*00:07:29*	*00:06:01*	*00:09:52*	*00:07:12*	*00:07:31*	*00:09:58*	*00:07:46*
026.R	Open Access Crisis Line: Ave call length		-	-	*00:11:42*	*00:13:31*	*00:11:19*	*00:12:25*	*00:11:57*	*00:12:24*	*00:12:39*	*00:12:23*	*00:10:48*	*00:12:02*	*00:12:53*	*00:12:00*

Appendix A: Single Oversight Framework

Overview

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

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

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

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

NHSI monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs. KMPT's current segmentation is 2 as highlighted below, this is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met:

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

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Sep-23	Oct-23	Trend (Last 12 months where available, left to right)
001b.E	CPA patients receiving follow-up within 72hours of discharge		80.6%	80.5%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		239	92	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	65.2%	76.9%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.6%	95.3%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	5.3%	4.4%	4.9%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93.0%	88.3%	87.1%	
006a.W-F	Distance From Financial Plan YTD (%)		0.0%	0.0%	

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

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Finance Report for Month 7 (October 2023)
Author:	Nicola George, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 7 (October 2023).

Items to bring to the Board's attention

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

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

1. The Trust has an agency cap of £7.02m (c3.7% of its total pay bill). At Month 7, the Trust is forecasting to exceed this cap by £1.56m. The main driver to this position is vacancies within medical staffing.

2. The Trust is presently forecasting to deliver its £4.76 efficiency programme in full; with non-recurrent savings supporting recurrent full year delivery in the later part of the year. The full year effect of these plans will offset the non-recurrent impact.

3. At Month 7, the capital programme spend is £1.48m under plan, this is predominantly due to slippage in the completion of the new Ruby Ward, and the benefit of VAT reclaims

4. The cash position remains strong at £17.16m at the end of October 2023.

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
October 2023

Trust Board

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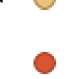

Executive Summary

Key Messages

For the period ending 31 October 2023, the Trust has reported a break even position; and this is expected to continue, with the Trust forecasting to deliver a break even position in year.

The key financial challenges for the Trust continue to be:

- High Agency use, with a continued pressure in the Medical Staff group. This area is subject to external scrutiny through the use of an agency cap. Based on present run rate the Trust is forecasting to exceed the cap by £1.56m
- There is a continued usage of external beds, which includes the use of female PICU beds above contracted levels.
- The capital programme is £1.48m behind plan. £0.58m due to slippage on the Ruby Ward scheme, £0.69m relating to VAT reclaims, £0.21m on other estates schemes. Plans have been developed to utilise this position in year.
- The Trust is presently forecasting to deliver its £4.76 efficiency programme in full; with non recurrent savings supporting recurrent full year delivery in the later part of the year. The full year effect of these plans will offset the non-recurrent impact.
- 2024/25 planning has been launched internally, with national planning guidance expected to be released in December 2023.

Income and Expenditure

Key pressures for October included the following:

- Agency spend remains high in month; with the Trust exceeding cap by £0.96m year to date. Pressure continues to be seen within medical staffing with a high number of agency medics covering vacancies and sickness. If the current spend levels continue the Trust will exceed the annual agency cap by £1.56m (£8.58m Forecast vs £7.02m cap).
- The Trust's run rate on bank staff remains consistent with spend in September. With the Trust utilising 477 bank wte in month, 40 wte (9%) higher than the level used in Quarter 1. This position has improved over the last couple of months, however further work is on-going to continue progress in this area.
- In October, the Trust utilised 4.6 external beds in addition to the 5 contracted female PICU beds, with minimal other external beds used.
- There is a year to date overspend on drugs of £0.26m. Nationally a price variance has been identified around drugs expenditure. Work is underway to identify the local drivers and potential mitigations.

At a Glance - Year to Date

Area	Status
Income and Expenditure	Green
Efficiency Programme	Amber
Agency Spend	Red
Underlying deficit	Amber
Capital Programme	Red
Cash	Green

Underlying Deficit

The Trust delivered a balance financial position in 2022/23, however to ensure the trust remains financially sustainable the Trust is shifting its focus to individual services; with a review of loss making services and unwarranted variation within its services being undertaken as part of the Trust CIP programme

Capital Programme

In October the overall capital position overspent by £0.66m reflecting the progress made on capital schemes and brings spend closer to plan. The year to date underspend has reduced to £1.48m.

In month schemes with spend levels above plan were the Ruby Ward scheme and Frontline Digitisation Programme due to the new contract for E-Meds.

The other main area of underspend relates to £0.69m VAT reclaims from prior year schemes.

Cash

The cash position increased by £2.75m, in month, to £17.16m; £3.83m over plan. The main driver of the increase was additional funding received from the ICB relating to anticipated adjustments to the Trust's block contract.

The key reasons for the YTD position against plan relate to the higher opening cash position, the capital position and additional funding being agreed with the ICB for issues such as external beds relating to a PICU patient.

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Income and Expenditure

Statement of Comprehensive Income

	Annual Budget £000	Current Month Budget £000	Current Month Actual £000	Current Month Variance £000	Year to date Plan £000	Year to date Actual £000	Year to date Variance £000
Income	(259,881)	(23,245)	(22,556)	689	(150,973)	(151,011)	(38)
Employee Expenses	195,987	16,780	16,513	(267)	115,361	114,801	(560)
Operating Expenses	58,347	6,002	5,584	(418)	32,376	33,072	697
Operating (Surplus) / Deficit	(5,548)	(462)	(458)	4	(3,236)	(3,137)	99
Finance Costs	5,548	462	458	(4)	3,236	3,137	(99)
(Surplus) / Deficit	0	0	(0)	(0)	0	0	(0)

Commentary

To month 7, there is an favourable pay variance to budget of £0.56m. This includes a significant underspend on substantive pay of £13.06m. This is due to the level of vacancies and is partly offset by agency and bank usage.

Agency spend was in line with previous month's run rates with no reduction seen; particular pressure continues to be seen within medical, accounting for 48% of the year to date agency spend. The main pressure can be seen in the East Kent directorate with spend equating to nearly half of all medical agency spend.

If current spend levels continue the Trust will exceed the annual agency cap (of £7.02m) by £1.56m. There has been a small decrease in this position in month, reflecting a reduction in agency usage within Support Services.

In Month bank spend was consistent with levels reported in September. The run rate remains high Trust wide, with this partially due to vacancy and absence cover from annual leave and sickness.

The Trust utilised 477 bank wte in month, 40 wte (9%) higher than usage in Quarter 1. October saw a further run rate reduction within the Acute Inpatient wards; wte has now reduced 35% since the high seen earlier this year; and wte usage is in line with that seen in February 23.

For the same period there has been an increase in bank spend within the Forensics Inpatient wards due the extra packages of care required for complex patients; additional funding for this has been agreed with our Commissioners.

Other non pay includes a high level of spend on External placements compared to budget, with additional Female PICU beds utilised. In month the external bed usage exceeded contracted levels by 4.6 beds, with 9.6 female PICU beds being utilised.

There was the equivalent of 0.4 male PICU beds and zero acute beds were used in month.

Long Term Sustainability Programme

Pillar	Plan £000	Identified £000	CIP scheme Risk Rating: Red £000	Amber £000	Green £000
Back Office	1,567	1,309	-	-	1,309
Commercial Development	1,804	-	-	-	-
Procurement and Purchasing	400	75	75	-	-
Productivity	437	2,829	108	600	2,121
Workforce	550	550	550	-	-
Unidentified	6	-	-	-	-
Trust CIP	4,764	4,763	733	600	3,430
		100%	*15%*	*13%*	*72%*

Commentary

The Trust submitted a financial plan for 2023/24 predicated on the basis of delivery of a £4.76m CIP target.

As at the end of October, schemes have been identified to meet the full £4,76m CIP target; 86% of the year to date plan has been achieved with some slippage in Estates and Workforce Schemes.

Focus remains on ensuring that any schemes currently rated amber or red progress to green and that the green rated schemes continue to deliver savings as expected. Where there is slippage work is on-going to ensure plans are delivered on a recurrent basis. In year positions are being supported by non-recurrent delivery.

Work continues in relation to loss making services with the focus on Forensic and MHLD services.

Planning has now launched and part of which work will commence to identify future efficiency opportunities.

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Exception report

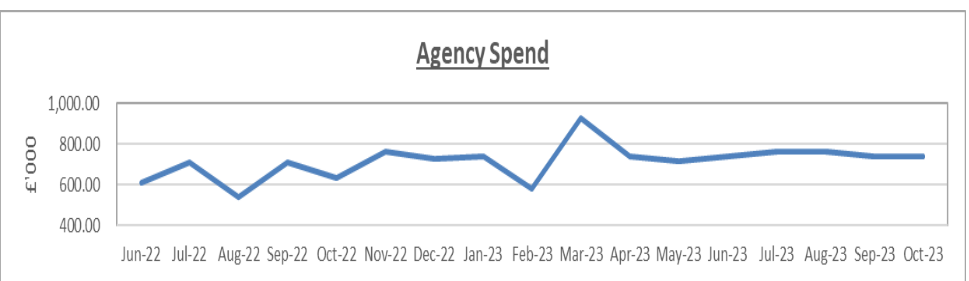
Temporary Staffing Spend

As at the end of October, the Trust reports a year to date underspend on pay of £0.56m. This consists of an underspend on substantive pay of £13.06m, offset by overspends on temporary staffing which totals £12.50m; £7.36m on bank staff and £5.14m of agency spend.

Agency

Agency spend to month 7 totalled £5.14m and this is forecast to continue due to both vacancies and operational pressures. The highest level of spend is seen within the East Kent Directorate with high levels of spend on both medical and nursing agency.

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



Bank

The Trust holds a budget for bank spend predominantly to cover the headroom in the rota. This is used to cover sickness absence, training and annual leave cover.

Currently due to the level of vacancies and operational pressures there is a higher level of bank cover utilised than planned.

Trust Wide Bank spend (£'000) — Actual

	22/23 Qtr 2	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	23/24 Qtr 2	Oct-23
Nursing	1,892	1,766	2,097	1,885	2,159	720
HCAs	2,720	2,685	2,768	2,760	3,342	1,017
Other	454	416	450	383	433	129
Total	**5,066**	**4,867**	**5,316**	**5,028**	**5,934**	**1,866**

Trust Wide Bank Usage (WTEs) — Average

	22/23 Qtr 2	22/23 Qtr 3	22/23 Qtr 4	23/24 Qtr 1	23/24 Qtr 2	Oct-23
Nursing	131	125	153	125	145	144
HCAs	298	280	309	277	321	144
Other	45	40	43	34	38	189
Total	**474**	**445**	**506**	**437**	**505**	**477**

Bank (continued)

There has been high levels of spend on HCA bank reported this financial year within the Acute Directorate; due to the clinical requirements and the high level of observations.

There is an on-going QI project to identify any systemic issues. However initial work has identified a number of mitigations which are starting to be implemented, these include:-

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

Work is ongoing and the downward trajectory in wte, seen in September, was continued in month 7.

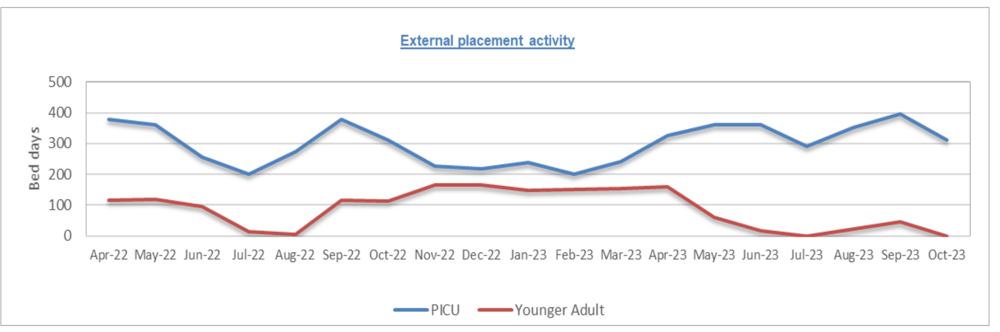
Acute Inpatient HCA Bank Usage (WTEs)

Inpatient area	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Older Adult wards	47.15	45.59	45.61	38.82	36.77	47.58	37.88	41.92	36.12
PICU	15.74	30.12	23.46	28.32	32.09	34.14	37.36	35.75	27.2
Younger Adult wards	73.32	90.69	84.84	85.49	78.97	97.28	89.78	70.34	75.59
Grand Total	**136.21**	**166.4**	**153.91**	**152.63**	**147.83**	**179.00**	**165.02**	**148.01**	**138.91**

External placements

October saw an improved position on placement spend; female PICU bed usage exceeded contracted levels with 9.6 beds being utilised; 4.6 over contracted levels. Of which 2 beds related to an extended package of care for a patient with complex needs.

However external Acute bed utilisation was minimal with the equivalent of 0.4 male PICU beds and zero acute beds utilised in month.



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Appendices

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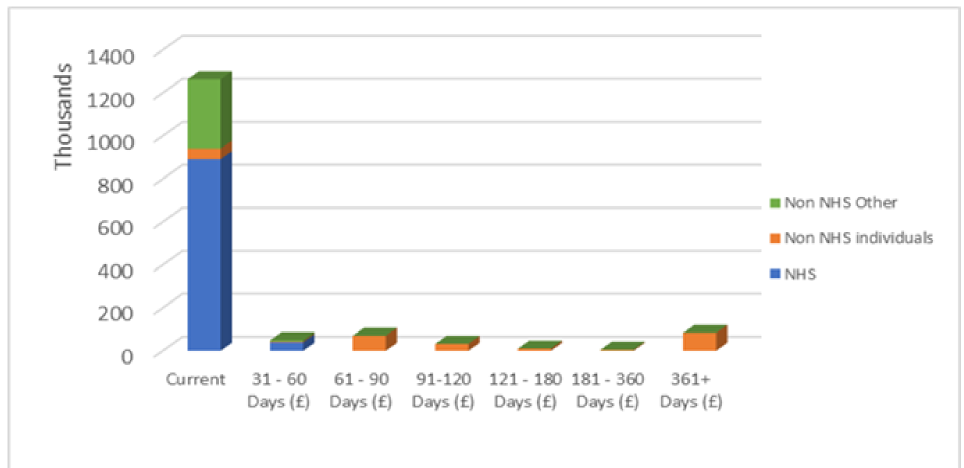
Balance Sheet

Statement of Financial Position

	Opening	Prior Month	Current Month
	31st March 2023	30th September 2023	31st October 2023
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	172,052	172,890	173,531
Current assets	31,132	21,834	23,940
Current liabilities	(37,727)	(30,784)	(33,668)
Non current liabilities	(35,945)	(34,428)	(34,291)
Net Assets Employed	129,512	129,512	129,512
Total Taxpayers Equity	129,512	129,512	129,512

Aged Debt

Our total invoiced debt is £2.40m, of which £2.11m is within 30 days.



Commentary

Non-current assets

Non current assets have increased by £0.64m in month, reflecting capital expenditure of £1.43m being offset by depreciation of £0.89m and £0.06m increase in right of use assets for remeasurements.

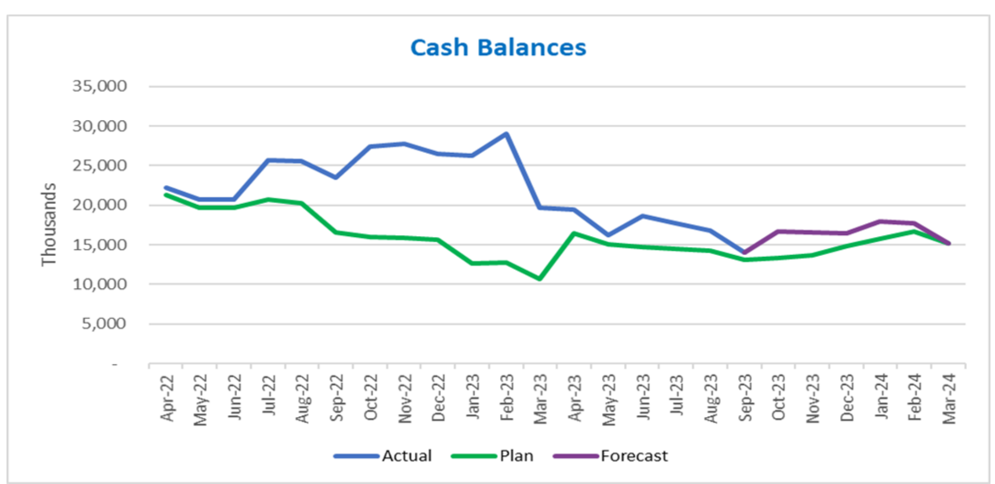
Current Assets

Within current assets the cash position increased by £3.12m and remains strong at £17.16m.

Trade and other receivables reduced by £1.02m. Invoiced debt fell by £0.87m and accrued income reduced by £0.32m, these decreases were partially offset by an increase in prepayments.

Current Liabilities

Overall Trade and other payables increased by £3.06m. Key drivers were a £2.00m increase in deferred income, a £0.58m increase in accruals and a £0.32m rise in the value of the PDC dividend payable. This increase in trade and other payables was partially offset by a decrease of £0.18m due to the release of a dilapidation provision



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Capital Position

Trust Capital Position

Scheme	Full Year Plan £000	Full Year Forecast £000	Full Year Variance £000	Current Month Plan £000	Current Month Actual £000	Current Month Variance £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
Information Management and Technology	584	(121)	(705)	42	14	(28)	297	(150)	(447)
Capital Maintenance and Minor Schemes	1,806	2,821	1,015	173	191	18	1,134	355	(779)
Ruby Ward and Improving Mental Health Services Infrastructure	7,386	7,075	(311)	317	587	270	7,324	6,748	(576)
Section 136 development	1,077	1,077	0	25	0	(25)	75	3	(72)
Frontline Digitisation Programme	1,890	1,890	0	200	629	429	640	1,031	391
PFI 2023/24	49	49	0	4	4	0	29	29	0
Total Capital Expenditure	**12,792**	**12,792**	**(0)**	**762**	**1,426**	**664**	**9,499**	**8,016**	**(1,483)**

Capital Resource Limit summary

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

Commentary

As at 31 October the overall capital position of £1.48m underspent.

The Ruby Ward scheme overspent in month by £0.27m, reducing the year to date underspend to £0.58m but still remains a key driver for the underspend position.

Another significant reason for the underspend is the VAT reclaims from the prior year, these total £0.69m with £0.40m for estates and the remainder for IT.

Other estates schemes which are underspent due to delays in commencement are:

- TGU Access Control and Pinpoint, £0.31m
- Coleman House Windows, £0.22m
- Allington and Tarentfort Windows, £0.04m
- Trustwide Anti Ligature, £0.12m

Collectively these schemes are £0.69m underspent, it is expected that these schemes will progress over the coming months and deliver to plan.

The Frontline Digitisation Programme is now overspent by £0.39m due to the new contract for EMeds, this is a phasing issue and spend will be managed within the funded value.

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

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Workforce Deep Dive - Medical agency spend and plans to address recruitment and retention
Author:	Dr Afifa Qazi, Chief Medical Officer
Executive Director:	Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose:	Discussion
Submission to Committee:	Board Requested

Overview of Paper

This paper has been prepared to provide the following:

- Spend on medical agency
- Recruitment and Retention Programme
- Work in progress to mitigate risks

Issues to Bring to the Board's Attention

Consultant and SAS Doctor vacancies have been a longstanding concern in KMPT. A large programme of work was started in 2022 to address the vacancies which has enabled us to get to a position of nil agency use for SAS Doctors and 12% use of agency locums for consultant posts against 70% substantive recruitment to consultant posts.

12% of consultant posts are filled by agency doctors which remains an area of concern hence increased focus on recruitment and retention remains a priority.

Currently of note is the full complement of substantive consultants in all crisis teams and all in-patient wards (apart from 4 out of 25 wards).

Governance

Implications/Impact:	Recruitment and retention; quality and safety
Assurance:	Reasonable
Oversight:	Workforce and Organisational Development Committee

Dr Afifa Qazi
Chief Medical Officer

Workforce Deep Dive – Medical Agency spend and plans to address Recruitment and Retention

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Purpose

To update the Board on;

- Current Medical Establishment
- Spend on Medical Agency
- Risks
- Work in progress to mitigate the risks
- Achievements

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Budgeted Establishment

- KMPT has 114 consultant and 49 speciality doctor posts
- 70% of the consultant posts are filled substantively (n=80) against the national average of 76% (Royal College of Psychiatrists census 2021)
- 12% are filled by agency locums, 9% are covered by acting-up consultants, 3% by NHS locums and 6% of posts are vacant. The vacant consultant posts are currently covered internally by extra work delivered by substantive consultants. No consultant posts are left without cover
- We currently have 14 agency consultant psychiatrists

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Consultant Vacancy Risks

- Quality & Safety of services
- Patient Experience
- Staff morale
- Medical Staff Retention
- Financial Risk

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Financial Risk 2023/2024

KMPT overall financial position

- The agency forecast has been included in KMPT's overall Financial forecast and KMPT is on track to deliver a break even position as planned

KMPT Agency Spend

- KMPT agency NHS England Cap – £7.02millon
- KMPT Agency Forecast spend - £8.47million
- KMPT Forecast breach of Cap - £1.455million

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Medical Agency Spend 2023/2024

- Forecast spend - £4.093million
- Medical Agency spend is forecast to be 48.29% of the total agency spend
- The estimated cost of substantive posts that agency is filling is £3m
- Therefore the cost to KMPT to mitigate the risks to quality and safety of service and patient experience is £1.023million

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South East Region Mental Health Agency spend comparison (September 2023)

Trust	Agency spend as a % of total pay bill
Berkshire Healthcare	3.8%
KMPT	4.4%
Oxford Health	4.9%
Solent	7.4%
Southern Health	10%
SPFT	10.5%
SABP	12.1%

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Agency Use

- Recruitment Issues into certain posts
    - SAS Doctors
- Recruitment Issues for East of the County and Medway
    - Location
- National picture
- Agency Rate Increase

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Recruitment Initiatives

SAS posts

- Conversion to Trainee posts with expansion in Trainee numbers
- Pilot site for Medical Support Worker (MSW) Programme with NHS England.
- Accreditation from GMC for International Medical Fellowship (IMF) Scheme in Psychiatry.
- Royal College of Psychiatrist Medical Training Initiative (MTI) scheme.
- Conversion of SAS posts to Non-Medical Prescribers and Advanced Clinical Practitioners (ACP)

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Recruitment Initiatives

Consultants

- Acting up opportunities for higher trainees.
- Strengthening of CESR Programme (Certificate of Eligibility for Specialist Registration)
- Working on development of specialist grade doctors (new enhanced grade to replace SAS grade).
- Developing creative consultant roles (flexible working, academic posts, job share)
- Offering leadership roles with new consultant roles in Community Mental Health Teams
- Continuing to offer recruitment premium to new consultants
- Retirement forecasting in train

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Retention Initiatives

- Robust links with Kent and Medway Medical School (KMMS)
- Strengthening of the appraisal process with enhanced training to appraisers
- Introduction of the Lead Psychiatrist role with improved supervision and support
- Individually tailored job plans offered to support flexibility and development in areas of specialist interest
- Developing mentorship for new consultants
- Reviewing our internal bank rates for out-of-hours work for all grades of doctors

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Retention Initiatives

- Robust Continuing Professional Development programmes for consultants and SAS grade doctors and also increased support to consultants for attending conferences
- Reviewed current model, recruited differently to SAS roles, reducing the burden on substantives consultants
- Introduction to Peer support plan to support and strengthen the peer support structure for consultants and specialty doctors
- Raising the profile of Research and Innovation
- Improved medical engagement as evidenced by the staff survey 2022

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Medical Staff Survey Results 2022/2023

	KMPT medical staff group 2021	KMPT medical staff group 2022	National MH average for medical staff
Believing patient care is the organisation's top priority	73.6%	83.9%	73.3%
Feeling valued for good work	42.2%	59.1%	49.7%
Feeling recognised for good work	55%	64.8%	57.5%
Organisation takes positive action on HWB	60.4	72.9%	56.8%
Believe their manager takes a positive interest in their wellbeing	72.7%	85.2%	69.8%
Not feeling pressure from their manager to attend work unwell	72.5%	94.1%	
Feeling able to discuss flexible working with their manager	67.0%	79.3%	68.3%
Feeling like their manager asks for their opinion before making decisions affecting their work	68.2%	79.5%	65.8%

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Actions to address Recruitment Issues in East of the County and Medway

- Caseload Review
- Change of Job Descriptions and adding a leadership element to consultant roles
- Offering flexible working and job shares
- Incentivising medical staff with a recruitment bonus
- Exploring options to cover elements of the consultant role by other professions

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Actions taken to Reduce Agency Spend

- Substantive overtime
- Weekly Executive Management Team (EMT) sign off process for all medical agency consultants
- Monthly support and review meetings with Service Leads and EMT on all agency roles
- Developing and promoting the internal medical bank
- Changing procedure in Procurement

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Achievements

- No agency usage for SAS Doctor posts
- Substantive Consultants in all Crisis Teams and Inpatient Wards (apart from 4 out of 25 wards)
- Trainee expansion (doubling of trainee numbers)
- KMMS – Collective working with medical school to retain a pipeline for the future

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Conclusion

- Agency usage creates a financial risk. The current agency spend is required to ensure that we provide safe and high quality services to our patients
- A robust programme of work has started to improve Medical recruitment and retention.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Designated Body Annual Board Report and Statement of Compliance (2022/23)
Author:	Dr Mohan Bhat, Deputy Chief Medical Officer for Workforce
Chief Medical Officer:	Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose:	Approval for Submission to NHS England
Submission to Board:	Regulatory (Responsible Officer Regs 2010 (as amended 2013)

Overview of Paper

Annual Organisation Audit Report and Statement of Compliance to Board for approval prior to submission to NHS England (2022/23).

Report is submitted to Board to provide assurance on appraisal and revalidation of doctors employed by the organisation and following approval will be submitted to NHSE as a statutory requirement.

Issues to bring to the Board's attention

1) The majority of KMPT doctors (131/145 (90.34%)) completed their appraisals within the appraisal year or within the first quarter of the next year. There were 14 exemptions for the appraisal year, 1 on a career break, 6 new starters and 7 on long term sick.
2) In line with GMC requirement and Responsible Officer Protocol, KMPT has a robust process in place to ensure recommendations to the GMC are timely and our doctors are revalidated in line with GMC requirements.
3) All actions raised from 2021/2022 Annual Board Report have been completed.

Governance

Implications/Impact:	KMPT meets the regulatory requirement for designated bodies (Responsible Officer Regs 2010 (as amended 2013)) to ensure all Doctors employed by the organisation are fit to practice. There are no Resource and Financial Implications.
Assurance:	The paper is to provide assurance on compliance with the Responsible Officer (RO) regulations submission of the Annual Organisation Audit Report to NHS England.
Oversight:	Chief Medical Officer

Version Control: 01

Briefing Note:

Revalidation and appraisals are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop, so care continuously improves. All Responsible Officers, who are the people responsible for helping doctors with revalidation, are required to complete the Annual Organisational Audit (AOA) on behalf of their organisations or 'designated bodies'. The collective results from the exercise provides a level of assurance about the consistency of the appraisal process supporting medical revalidation to patients and the public; and to doctors, Responsible Officers and the organisations in which they work; to higher level Responsible Officers in NHS England's regional teams, the General Medical Council and Ministers on the value that medical revalidation brings.

Our Annual Organisational Audit (AOA) for 2022/23 has concluded that as an organisation we have fit for purpose processes in place to ensure our doctors are appraised and revalidated in a timely manner in line with RO Regulation. We are assured that all our doctors are fully engaged with the appraisal and revalidation process.

Version Control: 01

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2022

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board/executive management team –of Kent & Medway NHS and Social Care Partnership Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Comments: Yes. Dr Afifa Qazi, Chief Medical Officer is the Revalidation Officer (R.O.) Dr Mohan Bhat, Deputy Chief Medical Officer is the named Revalidation Lead/Deputy R.O Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes. There is adequate capacity and resources. Deputy RO is supported by an appraisal and revalidation team to deliver this function Action from last year: None Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: KMPT (Online platform for conducting and recording appraisals) SARD contract expired March 2023. Following a meeting with a comparison provider, the SARD contract has been renewed as the software system it well established and is a reliable system to ensure accurate records are maintained Comment: The SARD contract has been renewed for a further period of 3 years Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Policies are reviewed and updated. The Revalidation and Medical Appraisal Policy is presently being updated. Comment: The Revalidation and Medical Appraisal Policy has been reviewed and will be submitted to LNC for ratification. Action for next year: Policy to be submitted to LNC for ratification.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

The Deputy Chief Medical Officer is delivering appraiser refresher training on a quarterly basis for all KMPT trained appraisers, to ensure the consistency of quality. The Deputy Chief Medical Officer will deliver appraisal training for appraisees in September 2023. Areas to be covered will include the following: a) uploading of documents to SARD b) recording each section relevant to appraisal c) how to use different sections on SARD d) Q&A session. A TIAA appraisal audit was carried out in December 2022. The two recommendations following this audit have been implemented. Comment: 1) The policy has been reviewed and updated to highlight that multi-source feedback is now to be completed once in every 5-year revalidation cycle in line with GMC guidance. 2) All doctors will be expected to complete an annual appraisal and all 5 annual appraisals will be reviewed by the R.O before making the recommendation for revalidation to the GMC (this is required after every 5 years) . For doctors where 5 appraisals are unavailable, an explanation for a missed appraisal will be provided to the R.O which will be considered before the recommendation is made to the GMC. Action for next year: None

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locum/short term placement doctors have 1 PA (4 hours) allocated in their weekly job plan to accommodate CPD activities.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. KMPT has continued to adopt the Appraisal 2020, and all doctors are using this version with emphasis in appraisal on verbal reflection, health and well-being. Comment: As from 1 August 2023 KMPT has adopted version 7 of the MAG form however, there will be a transition period in the 2023/24 appraisal year cycle for those doctors who have already commenced using version 6 of the MAG. Action for next year: To ensure all doctors are aware of the changeover to version 7 MAG form.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Actions from last Year: The Trust is sighted on reasons for appraisals not completed. Comment: There are agreed process, to record the missed appraisals and plans/timelines for completion of outstanding appraisals for those doctors who are not on sabbatical, long term sick leave, maternity leave or unpaid leave for long periods. Action for next year: None

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None Comment: The Revalidation and Medical Appraisal policy is reviewed every two years and is presently being finalised. Action for next year: Policy to be ratified at the LNC

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Quarterly Appraiser Refresher training is being delivered in-house. Annual New Appraiser training is planned for early from external provider.
Comments: Courses for in-house Refresher training have been provided by Deputy Chief Medical Officer on a quarterly basis with positive feedback. The organisation has an adequate number of trained appraisers.
Action for next year: Continue the annual refresher training for appraisers.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: Going forward the appraiser peer group meetings are to be included in the quarterly Appraiser Refresher training.
Comment: Peer group structure will be finalised and implemented in Q4 2023
Action for next year: None

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Continuation of reporting to the Trust Board.
Action for next year: None

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Kent and Medway NHS and Social Care Partnership Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	**145**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**125**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**6**
Total number of agreed exceptions	**14**

Long term sickness 7
New starters 6
Career break 1

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: This process is to be continued. Comments: KMPT has a process in place to ensure timely recommendations are submitted to the GMC. The R.O. is supported by the Deputy Chief Medical Officer/Deputy Revalidation Officer and the Revalidation Team. Action for next year: to continue this process

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Is to continue support mechanisms are in place. Comments: Prior to the revalidation date there is discussion with doctors where deferment/non-engagement may be an issue. Support is offered to facilitate any outstanding actions. In line with GMC recommendations, correspondence is sent to all relevant doctors when a recommendation has been submitted to the GMC or indeed a deferment is made. Action for next year: to continue this process

Section 4 – Medical Governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: To continue to review effectiveness of the systems and processes already in place. Comments: The Trust has established good systems and processes in place to ensure effective clinical governance of doctors. The Heads of Psychiatry ensure robust medical management structures have been created in the organisation. Clinical Directors offer senior clinical leadership to all services in the organisation. Action for next year: to continue this process

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Continuation of the above. Comments: Effective systems are in place and information is easily accessible to all doctors via their Revalidation Lead/Revalidation Team and Medical Staffing. Action for next year: to continue this process

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Continue as above. Comments: A Trust policy is in place which is in line with the MHPS policy (Maintaining High Professional Standards). Action for next year: to continue this process

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be

Action from last year: Continue as above. Comments: Monthly Decision-Making Unit (DMU) meetings are established which are overseen by the R.O. or Deputy R.O./Revalidation Lead with the input from the Chief Peoples Officer. The Deputy R.O./Revalidation Lead meets with the Revalidation Team on a weekly basis. Action for next year: to continue this process

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: None. Comments: There is a process in place for timely R.O. to R.O. sharing information. Action for next year: to continue this process

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: None. Comments: There is a regular review of processes at the Decision Making Unit (DMU) meetings. Discussion of individual cases with high level South East Region R.O. and quarterly discussions with GMC Liaison Officer are in place. Action for next year: to continue this process

requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None. Comments: Recruitment checks are carried out in line with GMC guidance. Action for next year: to continue this process

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

At KMPT in the last year we had a total of 131 doctors had their appraisals. The 14 doctors who did not have the appraisal had agreed exceptions.

We have started an annual refresher training for all the appraisers in the trust to standardise the quality of appraisals.

General review of actions since last Board report

There have been no actions outstanding from the last board report.

Current Issues

In light of the TIAA audit findings which we received in August 2023 we have already updated the medical revalidation policy taking into account the recommendations of the Audit. This policy is being presented to the LNC for ratification.

New Actions:

To update the current medical revalidation policy

To produce a reassurance to the board about the action plan following on from the TIAA audit recommendations which we just received in August 2023.

Overall conclusion:

We have had another successful year with regard to Doctors having their annual appraisals completed. We have also taken steps to support the doctors in this process and also ensured that the current appraisers are trained to improve the quality of appraisal experience of our doctors. We are committed to improve this overall process and will be implementing few actions arising from the annual audit into the process.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England
Skipton House
80 London Road
London
SE1 6LH

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Community Mental Health Framework – Quarterly Update
Author:	Neil West – CMHF Programme Director
Executive Director:	Donna Hayward-Sussex, Chief Operating Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

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

Issues to bring to the Board's attention

While funding has now been confirmed for the remainder of 23/24 and 24/25, the scope of KMPT's role as lead provider still needs to be clarified by the ICB. The detail of KMPT's lead provider role will inform contractual arrangements across providers.

Governance

Implications/Impact:	Without clarification of KMPT's lead provider role, contractual arrangements with partners cannot be confirmed. It is important that these arrangements are confirmed to support the county-wide rollout of Mental Health Together. Further delays put at risk the ambition to go live across county by April 2024.
Assurance:	Reasonable
Oversight:	Executive Management Team

Mental Health
Together
NHS
Community
Mental Health
Framework
Quarterly Update – November 2023

Establishing the MHT Workforce

Below, outlines the approach taken to establish the future workforce for MHT.

Demand & Capability Modelling

Using information from caseload reviews, learnings from other trusts, and existing data points the team have built out a model to establish:

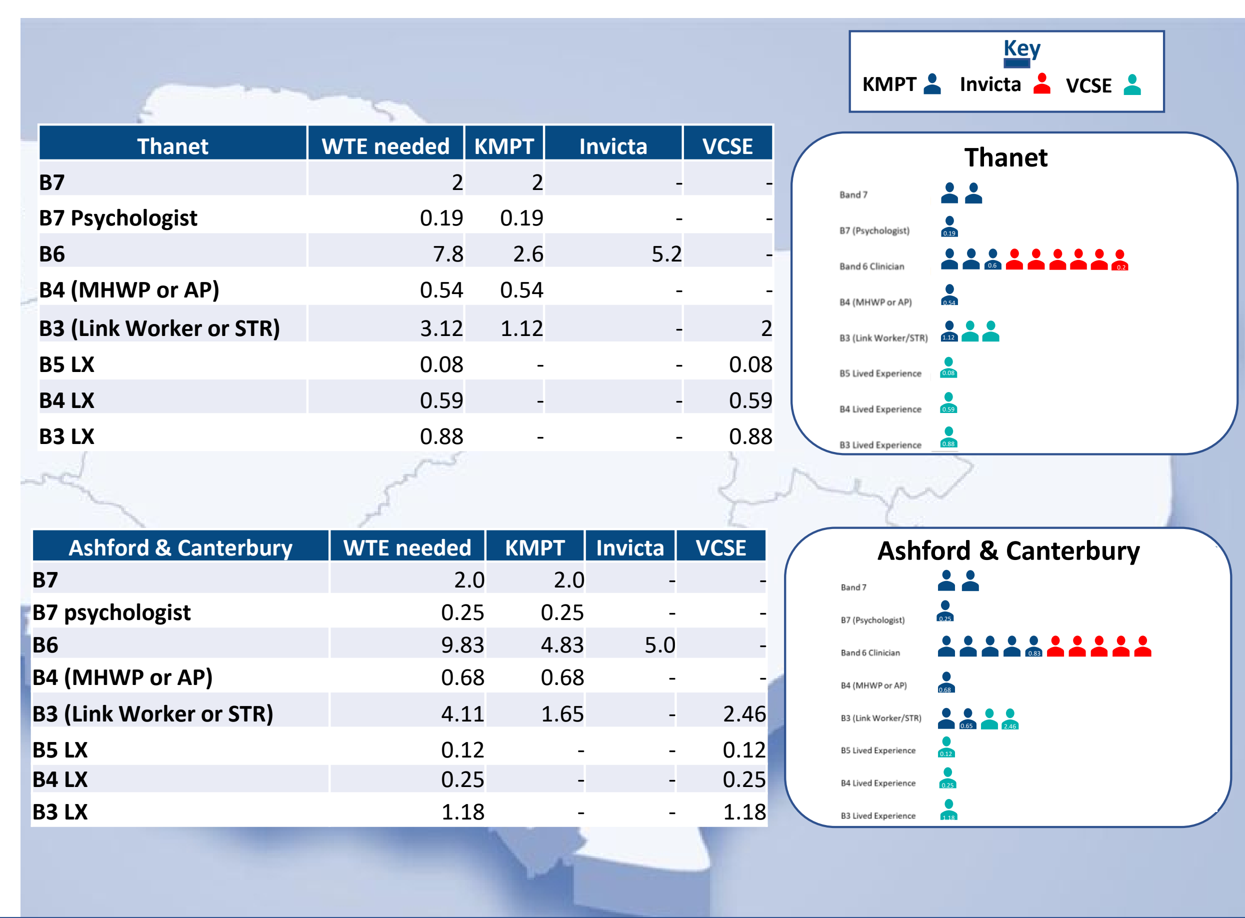
1. The extra resource required for the new MHT model.
2. What resource is currently in the system.
3. The gap required for recruitment processes.

Agreeing a Budget for Workforce

- The work has been done in collaboration with the finance team to ensure there is a scalable model pan-county
- This has been signed off by the ICB with £2.64million allocated for the remainder of 23/24 and £8.38million for 24/25

Challenges still to work through

- Invicta's contract requires revision to move to new MHT model
- A new governance structure will need to be established for KMPT and our partners to recruit
- Staff skills gap analysis in new model will be ongoing



Thanet	WTE needed	KMPT	Invicta	VCSE
B7	2	2	-	-
B7 Psychologist	0.19	0.19	-	-
B6	7.8	2.6	5.2	-
B4 (MHWP or AP)	0.54	0.54	-	-
B3 (Link Worker or STR)	3.12	1.12	-	2
B5 LX	0.08	-	-	0.08
B4 LX	0.59	-	-	0.59
B3 LX	0.88	-	-	0.88

Ashford & Canterbury	WTE needed	KMPT	Invicta	VCSE
B7	2.0	2.0	-	-
B7 psychologist	0.25	0.25	-	-
B6	9.83	4.83	5.0	-
B4 (MHWP or AP)	0.68	0.68	-	-
B3 (Link Worker or STR)	4.11	1.65	-	2.46
B5 LX	0.12	-	-	0.12
B4 LX	0.25	-	-	0.25
B3 LX	1.18	-	-	1.18

Key Risks

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

Risk Description	Consequence	Rating Initial	Rating Target	Controls/ Mitigation
IF we cannot establish the right contracting mechanism THEN we will not be able to subcontract with partners.	RESUTLING IN delays to the trailblazers and wider rollout of MHT.	20	4	• Scope of KMPT's Lead Provider responsibilities being clarified • Director of Contracting working closely with ICB • New governance structure for contracting being established
IF the D&D Workstream does not move with pace THEN digital and IG solutions will hold up the Go Live date for the trailblazers.	RESULTING IN Inability to effectively monitor and evaluate the trailblazer	15	4	• Digital Design Workshop has given the workstream a clearer direction and the activity needed to implement • A detailed programme plan has been developed along with a critical pathway • SoP outlining 4 week wait process for data capture and recording is complete
IF staff do not engage with the new PROMs THEN the take up will be low with patients.	RESULTING IN there not being enough paired clinical outcome measures to evaluate the trailblazer.	16	9	• The SoP has clear instructions around PROMs • Develop a simple PROM sequencing implementation plan that staff will be able to complete during the trailblazer • A comms strategy to support the culture shift and a clear training model

Progress across Workstreams

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

Model of Care & Outcomes

- **Eating Disorders** – *Beat* contract in close to signature with service mobilisation expected by end of 2023, business case for enhanced care pathway and to introduce a pathway for ARFID has been approved.
- **SUN Model** – Clinical lead is now in post and contract to procure four VCSE Lived Experience roles is close to signature
- **Outcome Measures** – Collection of outcome measures to be phased with initial focus on four-week-wait and embedding DIALOG+ PROM in RiO

Workforce

- **Demand and Capacity Modelling –** Is now complete across all of Kent & Medway with new roles being phased into the system across 23/24 and 24/25
- **Band 7 Mapping** – Work established the potential need to restructure Band 7 workforce. Paper going to JNF in December with restructure, if taken forward to begin in January

Data and Digital

- **Recording data** – To enable the recording of new MHT interventions new SNOMED codes are being added to RiO. The new methods of recording the 4ww wait and patient PROM DIALOG+ are now clearly defined in the new SOP
- **Website development –** Agreement has now been reached on an approach for an MHT website skin which will be a single point of truth for MHT services users

Finance & Contracting

- **SUN Model**– Collaborative work between KMPT and the ICB has enabled a contracting mechanism for the SUN model contract
- **Release of funds** – The ICB has signed off the allocation of £2.64million for the remainder of 23/24 and £8.38million for 24/25
- **Governance structure –** The team is developing a governance structure to ensure due diligence is followed in the recruitment of workforce

Comms & Engagement

- **Manager Toolkit** – A first draft of a toolkit has been developed to help support managers in their conversations with teams about what the changes will mean to day-to-day roles
- **Thanet kick-off event** – A kick-off event was held in Thanet with over 100 of KMPT, Porchlight and Invicta's staff attending to discuss the new ways of working in the model

Estates

- **Estate Planning –** Is underway in across all partners and localities for all MHT interventions
- **Workstream Mobilisation –** Service Directors are adopting a focused approach locally to estates which includes MHT's core model as well as Community Rehabilitation.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Changes to Standing Orders and Standing Financial Instructions
Author:	Tony Saroy, Trust Secretary Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Chief Executive, and Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

A paper setting out proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation.

Items to bring to the Board's attention

A full annual review has been undertaken of the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation, with proposed changes to update to reflect current practices and to assist readers with a better understanding of the policy. A copy of the full document, with tracked changes, has been uploaded to the Board Reading Room within Diligent.

Changes include revisions to executive titles, the addition of a leases section in line with changes in accounting standards (IFRS16), updates to procurement legislation and requirements for tendering and amendments to delegated authority to provide more clarity for budget holders and managers

The Scheme of Delegation has been amended to reflect the new hierarchies in place across the Trust as a result of the Fit for the Future programme. It also streamlines the document for ease of understanding and moves away from specific job titles to levels of authority across the organisation.

Governance

Implications/Impact:	This policy is a statutory requirement for all NHS Organisations, and it is important that this document is up to date, hence annual reviews have been scheduled.
Assurance:	Significant
Oversight:	Oversight by Audit and Risk Committee, approval by the Board.

Key Changes Requested for Approval

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

SO/SFI number	Current wording	New wording	Reason
Throughout	Business Case **Policy**	Business Case **Production Procedure**	Document is categorised as a procedure not a policy
Throughout	NHS England and Improvement	NHS England	Name change nationally
SO 5.8	5.8.4 Chief Finance and Resources Officer **(Deputy Chief Executive)** 5.8.5 Director of Partnerships and Strategy (non-voting); and 5.8.6 Chief People Officer 5.8.7 Chief Operating Officer (non-voting)	5.8.4 Chief Finance and Resources Officer 5.8.5 Director of Partnerships and Strategy (non-voting) 5.8.6 Chief People Officer **(non-voting)**; and 5.8.7 Chief Operating Officer **(Deputy Chief Executive)**	Previously approved by the Trust Board in September 2023, to go live on 01.11.2023.
SO 7.7	N/A	7.7 Out of Cycle Business Case and Contract Approval – In circumstances where business efficacy dictates and the Trust's Business Case Procedure cannot be followed due to time constraints, the Trust Chair and Chief Executive may jointly approve a business case or contract on behalf of the Trust if either of the following has occurred: 7.7.1 At a Board meeting (whether or not the public has been excluded), the Board has been notified of the proposed business case or contract, and the Board has given approval to the Trust Chair and Chief Executive to approve the business case or contract once it is finalised, or 7.7.2 The Trust Chair and Chief Executive have consulted with the members of the Finance and	New section to account for changes in frequency of Board meetings

SO/SFI number	Current wording	New wording	Reason
		Performance Committee, and the Chief Finance and Resources Officer (or their nominated Officer) has provided written assurance that the business case or contract provides value for money. For the avoidance of doubt, this provision does not affect any duty placed on any Officer pertaining to value for money as contained below within the Standing Orders or the Standing Financial Instructions.	
SO 8	8.12.3 Workforce and Organisational Development Committee	8.12.3 People Committee	Name change
SO 8.12.3	Primary Role: To provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff. To assure the Board **through consultation with the Audit and Risk Committee**, that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services. To assure the Board that where there are workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives that these are being managed in a controlled and timely way.	Primary Role: To provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff. To assure the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services. To assure the Board that where there are workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives that these are being managed in a controlled and timely way.	Remove the words "through consultation with the Audit and Risk Committee", to reflect the Committee's own Terms of Reference.
SO 8.12.4	Primary Role: To provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. To assure the Board **through consultation with the Audit and Risk Committee** that the structures,	Primary Role: To provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. To assure the Board that the structures, systems and processes are in place and functioning to support an	Remove the words "through consultation with the Audit and Risk Committee", to reflect the Committee's own Terms of Reference

SO/SFI number	Current wording	New wording	Reason
	systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services. To assure the Board that where there are risks and issues that may jeopardise the Trust ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.	environment for the provision and delivery of excellent quality health and social care services. To assure the Board that where there are risks and issues that may jeopardise the Trust ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.	
SO 8.12.5	Primary Role: To provide the Board with assurance concerning all aspects of finance and performance relating to the provision of care and services in support of getting the best value for money and use of resources. To assure the Board, **through consultation with the Audit and Risk Committee** that structures, systems and processes are in place and functioning to support broad and long term Financial, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively, To assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets, that these are being managed in a controlled and timely way.	Primary Role: To provide the Board with assurance concerning all aspects of finance and performance relating to the provision of care and services in support of getting the best value for money and use of resources. To assure the Board that structures, systems and processes are in place and functioning to support broad and long term Financial, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively, To assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets, that these are being managed in a controlled and timely way	Remove the words "through consultation with the Audit and Risk Committee", to reflect the Committee's own Terms of Reference
SFI 17.5	NHS Internal Audit Manual	Public Sector Internal Audit Standards	Name change
SFI 18.2	N/A	18.2 **Changes to Annual Plan and Forecast** – The Chief Finance and Resources Officer shall compile any formal changes to annual plan and/or forecast and communicate accordingly for approval in line with the delegated authorities as follows:	Addition of new subsection to cover situations where a formal reforecast or plan resubmission is required to external bodies (i.e. ICB or NHS England)

SO/SFI number	Current wording	New wording	Reason
		18.2.1 Changes below £500,000 – approved by the Chief Finance and Resources Officer and Chief Executive jointly 18.2.2 Changes between £500,000 and £999,999 – approved by the Finance and Performance Committee 18.2.3 Changes above £1,000,000 – approved by Trust Board, either at a formal meeting or extraordinary meeting if national time restrictions are in place This section is applicable for formal, externally communicated changes as opposed to internal modelling for executive or management level discussion.	
SFI 22	22.2.4 The Chief Finance and Resources Officer shall approve all property leases, property rentals and tenancy agreements. The Director of Estates and Capital Projects shall advise on these arrangements	REMOVE	New section on leases which covers this
SFI 23	23.4 The approval limits **as stipulated in the Trust's Business Case policy** are as follows:	23.4 The approval limits are as follows:	Removal of reference to Business Case policy as governing authority – authority comes from SFIs Reference also removed from sections 24.2.3, 25.1.4, and 28.1.3
SFI 23	23.4.2 The **Transformation Board** will approve all services from £75,001 to £500,000;	23.4.2 The **Executive Management Team** will approve all services from £75,001 to £500,000;	

SO/SFI number	Current wording	New wording	Reason
SFI 24	a) **Executive Management Team** will approve requests up to £75,000; b) The Transformation Board will approve requests from £75,001 to £250,000; c) The Finance and Performance Committee will approve requests from £250,001 to £750,000; and d) The Board will approve all requests over £750,000.	a) **Chief Finance and Resources Officer or nominated officer** will approve requests up to £74,999; b) The **Executive Management Team** will approve requests from £75,000 to **£499,999**; c) The Finance and Performance Committee will approve requests from **£500,000 to £999,999**; d) The Board shall approve requests over **£1,000,000.**	Amended in line with new Business Case Production Procedure
SFI 25	a) Executive Management Team will approve requests up to £75,000; b) The Transformation Board will approve requests from £75,001 to £250,000; c) The Finance and Performance Committee will approve requests from £250,001 to £750,000; and d) The Board will approve all requests over £750,000.	a) **Chief Finance and Resources Officer or nominated officer** will approve requests up to £74,999; b) The **Executive Management Team** will approve requests from £75,000 to **£499,999**; c) The Finance and Performance Committee will approve requests from **£500,000 to £999,999**; d) The Board shall approve requests over **£1,000,000.**	Amended in line with new Business Case Production Procedure
SFI 25	25.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought.	25.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always **seek** the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought **in advance of selecting any items or services.**	There may be situations where value for money is not obtained, but this should always be sought. The procurement team should always be contacted in advance of product selection.
SFI 25	25.5.1 The Public Contract Regulations 2015 and The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020 which govern public procurement along with supporting legislation must be followed.	25.5.1 **The Public Procurement (International Trade Agreements) (Amendment) Regulations 2023,** The Public Contract Regulations 2015 and The Public Procurement (Amendment etc.) (EU Exit) Regulations	New legislation published in May 2023 for procurement

SO/SFI number	Current wording	New wording	Reason
		2020 which govern public procurement along with supporting legislation must be followed.	
SFI 25	25.5.3 Prior to commencing a competitive tender process or entering into a formal contract or SLA, relevant budget approval must be sought. If the requirement is new and/or additional budget needs to be allocated, a business case must be prepared for any expenditure see para 23.4.	25.5.3 Prior to commencing a competitive tender process or entering into a formal contract or SLA, **over a total contract value of £250,000**, relevant approval must be sought **via a procurement project control form submitted to the Deputy Directors Group**. If the requirement is new and/or additional budget needs to be allocated, a business case must be prepared first for any expenditure **to be approved in advance of a procurement process** (see para 23.4). **25.5.4 The budget holder or service lead shall be responsible for specifying, in sufficient detail, the goods or services being requested so as to ensure a robust procurement process can be undertaken.**	New project control form to improve procurement governance and ensure relevant awareness of tenders
SFI 25	N/A	25.6.8 An exemption list of suppliers for whom a waiver is not required and are not covered by the full provision of the Public Contract Regulations will be held by the Procurement Team and reported annually for approval to the Audit and Risk Committee. This list will only include suppliers for whom there are no reasonable substitutes such as universities, other NHS Trusts or professional bodies.	New provision to cover the exemption list that has been developed
SFI 25	25.6.6 A single tender waiver will be required in circumstances where the cumulative total of expenditure with an individual supplier in any financial year is more than **£25,000** (excluding VAT). For example, if goods or services are procured totalling £14k and then a further purchase of £5k is made with the same supplier then an STW **will not be required**	25.6.6 A single tender waiver will be required in circumstances where the cumulative total of expenditure with an individual supplier in any financial year is more than **£15,000** (excluding VAT). For example, if goods or services are procured totalling £14k and then a further purchase of £5k is made with the same supplier then an STW **will be required** for the additional purchase. It	Value misstated in current version – amend to correct threshold of £15,000

SO/SFI number	Current wording	New wording	Reason
	for the additional purchase. However, it should be noted that requirements cannot be knowingly split in order to avoid a quotation process.	should be noted that requirements cannot be knowingly split in order to avoid a quotation process.	
SFI 25	25.7.1 All purchasing must be done in accordance with Spending the Trust's Money (STTM) guidance document. Advice must be sought from the Procurement Team where necessary and for any procurement above the value of £50,000. **At least one written quotation must be obtained where the total estimated contract value is below £10,000.** 25.7.2 At least one written quotation must be obtained where the total estimated contract value is below £15,000. **A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above. This must include a published award criteria.** 25.8 For expenditure below the value of **£10,000** where tendering or competitive quotation is not required	25.7.1 All purchasing must be done in accordance with Spending the Trust's Money (STTM) guidance document. Advice must be sought from the Procurement Team where necessary and for any procurement above the value of £50,000. 25.7.2 At least one written quotation must be obtained where the total estimated contract value is below £15,000. 25.7.6 Before any contract is awarded approval must be sought as set out in the Scheme of Delegation. Following approval suppliers can be notified of the outcome. 25.8 For expenditure below the value of **£15,000** where tendering or competitive quotation is not required	Remove last sentence - the threshold for 1 quote is now £15,000 Remove last two sentences – no longer applicable New instruction for clarity Change to value to align to procurement regulations
SFI 28	28.1.3 The approval limits for capital investments is as stipulated in the Business Case Policy	28.1.3 The approval limits for capital investments is as stipulated **in the Scheme of Delegation and in line with** the Business Case Procedure.	Change focus of paragraph – primary authority for approval is the Scheme of Delegation
SFI 28	28.1.5 The approval of the annual capital programme by the Trust Board shall constitute approval for expenditure against that scheme	28.1.5 The approval of the annual capital programme by the Trust Board shall constitute approval for expenditure against that scheme, **to the value authorised.**	Section 28.1.6 is already included within SFI 25 on tendering processes – removed to avoid confusion

SO/SFI number	Current wording	New wording	Reason
	28.1.6 The Chief Executive shall issue to the manager responsible for any approved capital scheme: specific authority to commit expenditure; authority to proceed to tender; approval to accept a successful tender.		
SFI 28	N/A	**28.3 Leases** 28.3.1 Due to the introduction of IFRS 16, new or renewed leases of over 12 months in length should sit within the process for capital expenditure. A more detailed procedure note is included within the Capital Policy. 28.3.2 The acquisition of any new lease or renewal of existing leases must be supported by a property report. The content should be determined by the materiality of the consideration or lease payments and any contentious issues, but must contain: • Details of the consideration or lease payments; • Details of the period of the lease; • Details of the required accounting treatment; • Annual running costs of the property; • Funding sources within the Trust of both capital and revenue aspects of the acquisition; • The results of property and ground surveys; • Professional advice taken and the resultant cost; • Details of any legal agreement entered into; • Any restrictive covenants that exist on the property; and • Planning permission.	Insert additional provision for leases following changes to accounting standards

SO/SFI number	Current wording	New wording		Reason
		28.3.3 Any property acquisition under lease should be in accord with Department of Health and Social Care guidance. 28.3.4 Approval to undertake a new lease contract or renewal should be obtained from the Trust Board. 28.3.5 All leases must be reviewed by the Legal Department 28.3.6 All leases should be supported by a Lease signing sheet which provides assurance that due diligence has been conducted and the contract is fit for purpose. This Lease signing sheet must be signed by the Director of Estates and Facilities and the Chief Finance and Resources Officer. 28.3.7 The final lease contract to acquire the property must be signed by the Chief Executive Officer and Chairperson.		
Scheme of Delegation	Changes to delegated limits for purchasing and signing contracts. Currently: Under £1,000 – Budget Holder £1,001 - £10,000 – Service Director £10,001 – £50,000 – Directors/Deputy Chief Operating Officer £50,001 - £249,999 – Deputy Director of Finance £250,000 - £499,999 – Chief Executive and Chief Finance and Resources Officer	Up to £2,500	Level 1	Introduction of levels within the organisation to mirror reporting hierarchies and responsibilities as a result of the new Fit for Future structure. Increase lower level to £2,500 due to rising prices and inflation to give more of a relevant limit to ward managers and lower level budget holders
		£2,500 - £14,999	Level 2	
		£15,000 - £49,999	Level 3	
		£50,000 - £74,999	Level 4	
		£75,000 - £249,999	Level 5	
		£249,999 - £999,999	Level 6	

SO/SFI number	Current wording	New wording		Reason
	£500,000 - £999,999 – Finance and Performance Committee £1,000,000+ - Trust Board	£1,000,000 +	Level 8	

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th November 2023
Title of Paper:	Committee Terms of Reference (ToRs)
Author:	Tony Saroy, Trust Secretary
Executive Director:	n/a

Purpose of Paper

Purpose:	Approval
Submission to Board:	Standing Order/Regulatory Requirement

Overview of Paper

The Board is asked to approve the changes to Committee Terms of Reference proposed by the Committees.

Issues to bring to the Board's attention

The Board Committees have completed their annual Terms of Reference reviews and as a result of these reviews are proposing some changes to their Terms of Reference for Board approval. All Terms of Reference have been updated to reflect new job titles.

Where Committees have requested changes, these are highlighted in the attached paper.

Copies of the Committee Terms of Reference are available on the Board Reading Room on Diligent for Board members.

Governance

Implications/Impact:	Maintenance of sound governance systems
Assurance:	Significant
Oversight:	Trust Board

Committee Terms of Reference

1 Context

In order to fulfil its statutory duties and responsibilities, the Trust Board has established Committees. The Board Committees are an essential part of the overall governance structure and provide the Board with assurance and scrutiny in the areas delegated to them by the Board. These responsibilities are defined in the Committees' Terms of Reference and only the Trust Board can approve any changes to these.

The Board Committees carry out an annual review of their effectiveness against their Terms of Reference. Changes as a result of these reviews are presented to the Board for approval. The Board Committees have completed their reviews for 2023-24 and the following changes are proposed.

Clean copies of the new Terms of References have been uploaded to Diligent, with the exception of the Workforce and Organisational Development Committee's Terms of Reference, which is tracked changes.

2 Proposed Changes for Approval

1 Quality Committee

The Quality Committee is proposing an amendment to its membership to include the Clinical Director of Quality Improvement and the Director of Digital and Performance.

2 Workforce and Organisational Development Committee (WFODC)

The Committee will be renamed as the People Committee. That is addressed within another Board item. At the time of writing, it is still known as Workforce and Organisational Development Committee.

The WFODC has reviewed its Terms of Reference and is proposing changes to its membership, which should now include either the Deputy Director of Nursing of the Chief Nurse to attend, and either the Deputy Medical Director of Chief Medical Officer to attend.

It was suggested that a member of the Communications Team should be invited to attend when relevant.

The Committee is also proposing updates to reflect the current process for policies and procedures to reflect the Development, Approval and Management of Formal Trust Documents Policy.

Other suggested changes include removing groups that no longer exist, and updating the relevant strategic objective within the Terms of Reference to reflect the new Trust Strategy.

3 Mental Health Act Committee

The Mental Health Act Committee is proposing changes to its administrative arrangements only. It is proposing the addition of a reference to virtual meetings being acceptable and noting the availability of Committee minutes to Board members.

4 Audit and Risk Committee and Mental Health Act Committee

Both committees have concluded their reviews against their Terms of Reference and concluded no changes are required to previously Board approved versions.

5 Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee shall meet on 28.02.2024 and consider if any changes are required.

6 Finance and Performance Committee

The Finance and Performance Committee shall meet on 28.11.2023 and consider if any changes are required.

7 Conclusion and Recommendation

It is recommended that the Board approve the changes proposed by the individual committees following their annual reviews.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**14th November 2023**
Title	**Quality Committee Report**
Author	**Simone Frisby, Executive Assistant**
Presenter	**Stephen Waring, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- The committee discussed and agreed improvements to refine the Quality Risk Register to ensure the purpose of the paper is clear and timescales are included for each risk to allow for better oversight of outcomes.

- The committee received a report on Low Intensity Support Team Cases and acknowledged the significant learning identified from this with a recommendation to improve working relations with primary care to better the quality of care for service users.

- The committee noted the Mortality Report and Suicide Thematic Report, the work undertaken on the review of historic deaths and the impending changes to clinical practice around risk assessment.

- The committee acknowledged the improvements made on the overall Trust's Child Protection Conference attendance figures however noted that significant improvements are still required. This will be reviewed at the May 2024 Quality Committee.

- The committee commended the work underpinning the Research and Innovation Strategy ten-month update with a recommendation to demonstrate service user participation and engagement.

Items referred to other Committees (incl. reasons why)

No items were referred to other Committees.

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

1. CQC Updates
2. Quality Risk Register
3. Low Intensity Support Team Case for Change
4. Shared Team Caseloads
5. Mortality Report
6. Suicide Thematic Report
7. Child Protection Conference Attendance
8. Research and Innovation Strategy Update
9. Quality Digest
10. Quality Impact Assessments

The Board is asked to:

1) Note the content of this report.

Mortality Report Q2 2023/24

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

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

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

3 ANALYSIS OF INFORMATION

3.1 In Q2, a total of 774 mortality incidents were reported on InPhase. The graph (1) below shows the figures relating to mortality that have been reported since June 2022. This includes natural causes, expected, and unexpected deaths of patients. When data is compared to the previous quarterly mortality report, there has been a 69% increase in mortality reported incidents (242 reported in Q1 2023/24). The number of InPhase historical deaths has contributed to this increase. According to InPhase data, 460 death records are part of the historical death project.

3.2 A number of historic deaths noted by West Kent, prompted a trust wide review of the patient deaths reported to InPhase (and where the patient was marked as deceased on RiO). The review found that there are approximately 600 deaths across the trust that were not recorded. In light of this, the directorates have been working tirelessly to report and review each death. The number of mortality incidents reported in Q2 has drastically increased as a result of the historical deaths project. Up until 30/09/2023, there were no historic deaths that were declared as a serious incident. (This has since changed, with one STEIS reported incident in Q3 2023/24, which will be represented in the next quarterly report).

3.3 The number of STEIS reported mortality incidents in Q2 was 12. This compares to 21 in Q1 2023/24. The majority were for East Kent.

3.4 As previously highlighted to the Board, the figures will continue to fluctuate depending on the timing of updating patients' records on the national spine by General Practitioners. The vast majority of these incidents were reported by Older Adults' community teams and would have been people who had previous contact with community teams and from areas in the county with a high proportion of older people and also with more nursing or residential homes. As shown in graph 7, the number of mortality in older adult patients is consistently higher than any other service.

3.5 Whilst the cases are reported as a death of the patient, it does not mean that the death was attributable to the organisation or that there were care or service delivery concerns. They are reported to enable a review by the Serious Incident and Mortality Panel and governance leads, to assure the organisation and external bodies, including families as necessary, that there were no contributory factors relating to the death of the patient. In the event that any additional learning points are identified, the individual incidents are reviewed and action is taken to prevent reoccurrence. This can include further review in the form of a Structured Judgement Review or a Root Cause Analysis/Learning Review.

Graph 1 Mortality reported cases

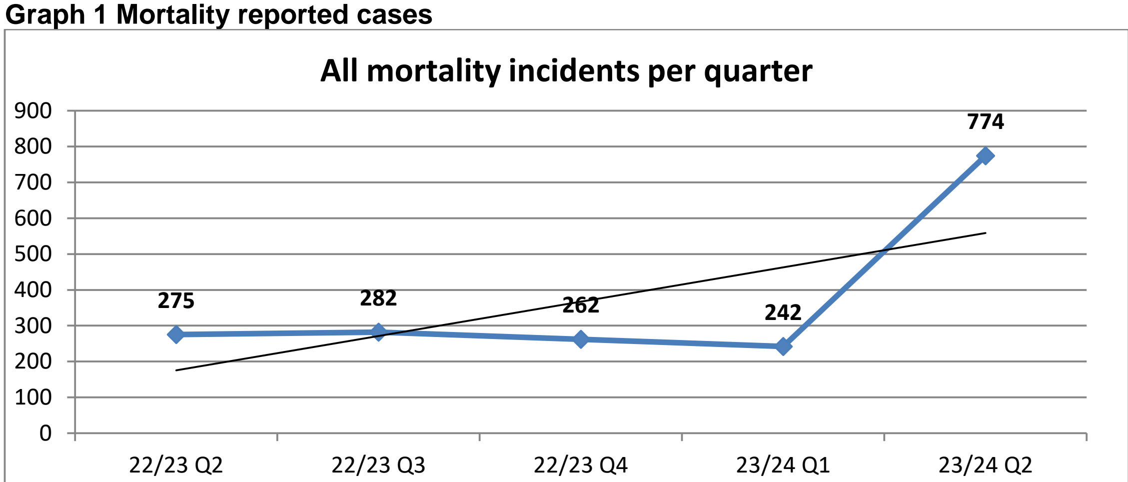


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Total
Suspected or actual suicide	3	4	4	2	3	4	1	4	7	10	6	3	5	56
All Deaths reported on Datix / InPhase	97	99	93	90	125	78	59	75	78	89	87	132	555	1657

3.6 Graph (1) shows all mortality incidents reported on InPhase while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q2 2023/24, 1.8% of deaths of patients are suicide or suspected suicide related. This compares to 8.6% reported in Q1 2023/24. It is expected that due to the high number of historic deaths represented in this report, the percentages would too have changed.

3.7 As previously stated, the Trust now has the ability to capture suicide data more effectively, by recording whether or not the death was likely due to gaps in care and attributable to the Trust. This is a more effective and accurate way of capturing deaths relating to suspected or confirmed suicide. With this in mind, it may appear that suicide deaths within KMPT in Q1 and Q2 2023/24 have increased. The number of suspected/ confirmed suicides STEIS reported on Q2 was seven, compared to eight in Q1 2023/24, a slight decrease.

3.8 The average number of deaths for the 13 months above was 127 per month. For this quarter (Q2), there was an average of 258 per month, compared to 81 in Q1 2023/24. Numbers have drastically increased due to the historical death notifications.

3.9 On review of the suspected suicide incidents over the 13 months, North Kent, East Kent and West Kent reported an equal amount of suspected/confirmed suicides in Q1 2023/24, each with a total of six. In Q2, East Kent saw higher numbers, with a total of six.

4 Analysis by age and gender

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

Age Band	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	Total
100+	2	1	1	0	0	**4**
90-99	46	40	46	33	154	**319**
80-89	68	81	81	76	312	**618**
70 to 79	65	61	61	39	162	**388**
60 to 69	32	27	24	26	52	**161**
50 to 59	19	31	14	29	45	**138**
40 to 49	20	14	14	15	24	**87**
30 to 39	15	18	16	15	16	**80**
20 to 29	8	7	5	9	7	**36**
10 to 19	0	2	0	0	2	**4**
Unknown	0	0	0	0	0	**0**
Total	**275**	**282**	**262**	**242**	**774**	**1835**

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	65	155	91	26	29	20	8	3	1	398
Female	0	89	157	71	26	16	4	8	4	1	376

4.1 As stated 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.

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, which is reflected in the Q2 figures.

4.2 Three female deaths were reported on STEIS and are subject to a Root Cause Analysis investigation, one of which is a suspected suicide. The circumstances around the death are unknown for two patients. Two patients were under the age of 25 when they died.

4.3 Nine male deaths have been STEIS reported and are subject to a Root Cause Analysis investigation, six of which are suspected suicides. The most common age category for STEIS reported male deaths was 50 to 59, the same as the previous mortality report.

4.4 Much like previous reports, the vast majority of patient deaths were 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 80% of the total mortality incidents reported in Q2 2023/24 relating to natural causes deaths of patients over the age of 65.

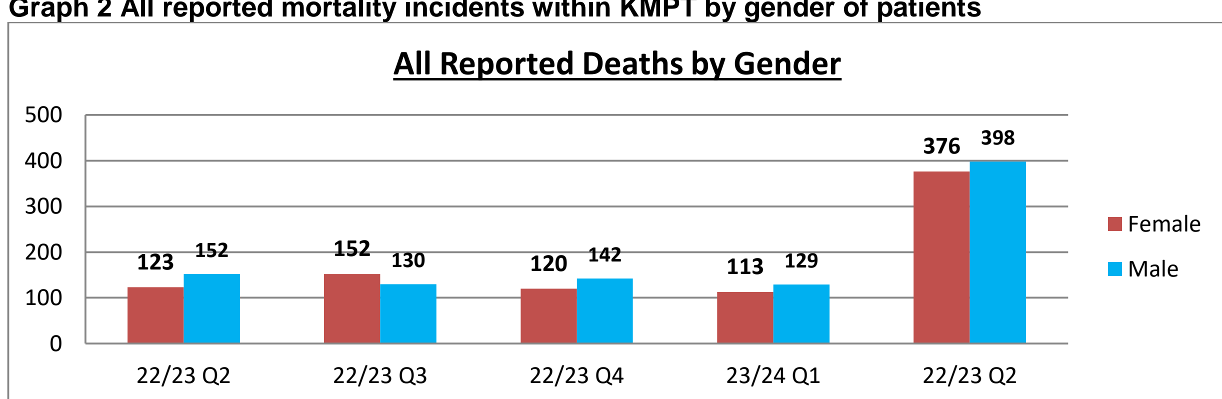
4.5 The number of deaths of patients under the age of 20 seems to fluctuate each quarter. In Q2, two patients under the age of 20 died unexpectedly, one from suspected suicide. Both patients were open to the South West Kent CMHT at the time of their death

4.6 Two male patients in their fifties who were autistic, died unexpectedly. One patient died in November 2022 (death was identified as part of the historical death work). Both patients were not open to services at the time of their death. No care or service delivery issues were highlighted following a review of their care.

4.7 There were 13 unexpected deaths for female patients under the age of 40 reported in Q2 2023/24. Although cause and circumstances of death was unknown for most patients, no gaps in care were identified during the course of the review for 11 cases. One incident, relating to a 23 year old female was declared as a serious incident, due to concerns regarding handover from CRHT to CMHT and documentation of contacts with the patient. Another female patient died at the age of 18. This incident is also subject to a Root Cause Analysis investigation.

4.8 There were 45 incidents relating to patients in their fifties. 16 of which were reported as historical deaths. Seven deaths (not historic deaths) have been declared as a serious in incident and reported on STEIS.

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



4.9 In Q2, the 14 cases of suspected suicide by age and gender were as follows in table 5.

Table 4 Suspected suicides by age and gender

Age	Male	Female
10 – 19 years	0	1
20 – 29 years	1	0
30 – 39 years	2	0
40 – 49 years	4	0
50 – 59 years	3	0
60 – 69 years	1	1
70 – 79 years	0	0
80 – 89 years	1	0
90 – 99 years	0	0
Total	**12**	**2**

4.9.1 14 suspected suicides were reported in Q2 2023/24, compared to 21 in the previous quarter. Middle-aged males between 40- 54 were an outlier.

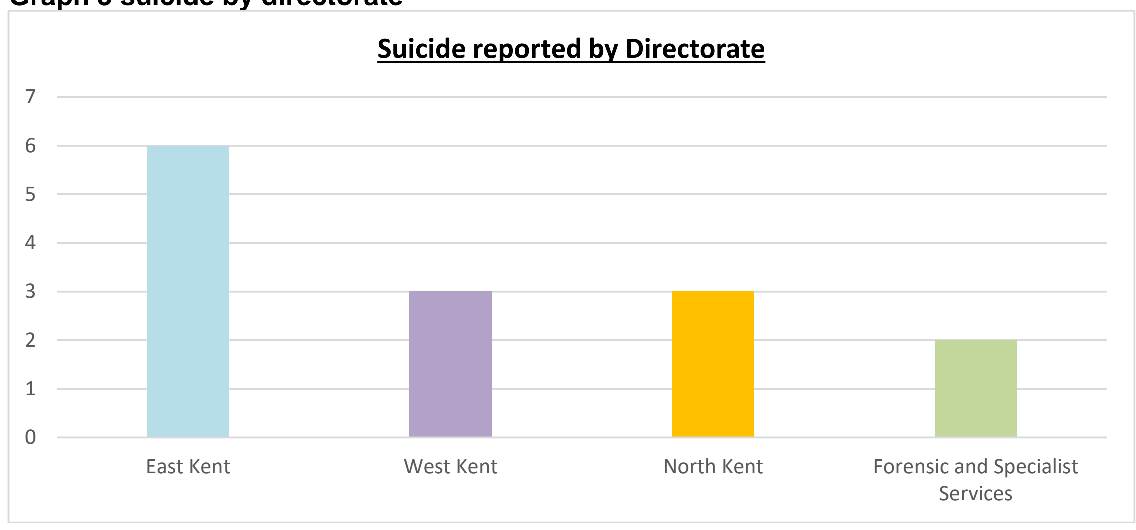
4.9.2 Looking at the suicide deaths reported this quarter, seven have been STEIS reported, due to concerns raised at initial review. East Kent were the highest reporters with a total of four.

Table 5 common ages for suicide by quarter

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

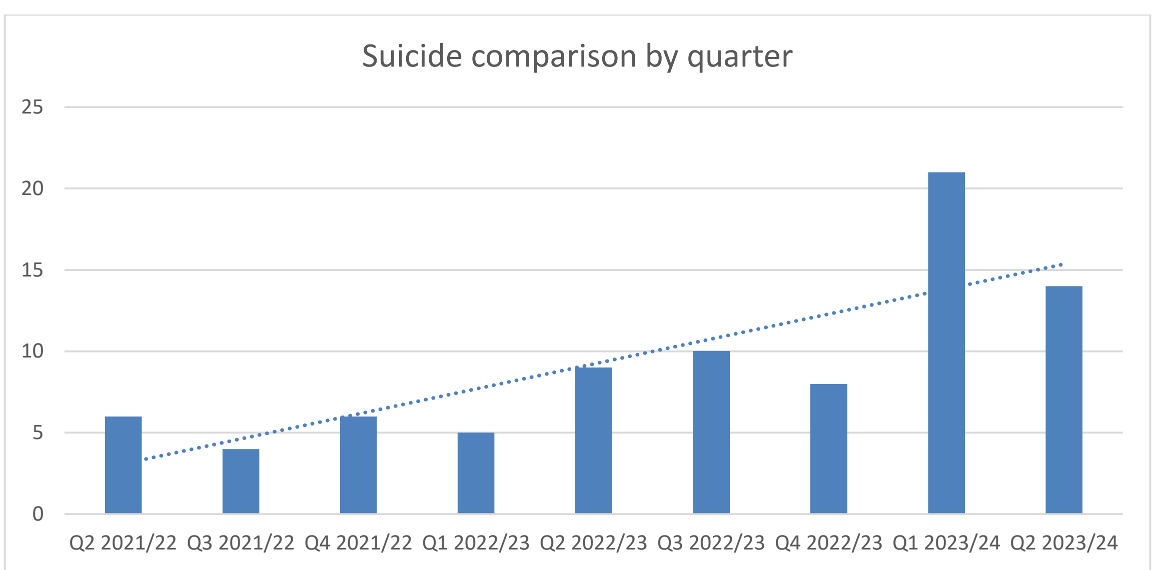
NB. Where N/A is stated, this either means that there were no suicides or there was no outlier for age in that particular quarter.

Graph 3 suicide by directorate



4.9.3 The number of suspected and confirmed suicides were higher for East Kent. This compares to equal numbers being reported for East, West and North in Q1. Unlike previous reports, suspected or confirmed suicide incidents within the Forensic directorate seem to have increased. This is due to the changes to the way we report suicide incidents across the trust. Both suspected suicide incidents for Forensic services did not identify any care or service delivery issues and did not warrant further investigation. One patient was known to the CJLDS service (discharged before death), and one patient was open to neuropsychology services, on the waiting list for assessment before they died. Both patients were male.

Graph 4 suicide reported by quarter



4.9.4 The number of suspected or confirmed suicide incidents has reduced in Q2, although as expected, with the new ways of reporting suicides, the numbers are higher in Q1 and Q2 compared to previous quarters.

5.0 Mortality review by ethnicity
Table 6 Deaths by ethnicity

	22/23 Q2	22/23 Q3	22/23 Q4	23/24 Q1	23/24 Q2	Total
Bangladeshi	0	0	0	0	2	2
Black, African, Caribbean or Black British – African	1	3	1	2	1	8
Indian	0	0	1	1	0	2
Mixed white and Asian	0	2	2	0	0	4
Mixed white and black African	0	0	1	1	1	3
Not stated / Unknown	31	22	30	28	185	296
Other Asian	1	2	0	1	0	4
Other Black, African or Caribbean background	0	0	0	0	1	1
Other mixed or multiple ethnic background	0	0	4	0	1	5
Other ethnic category	0	1	0	1	2	4
Pakistani	0	0	0	0	1	1
White - British	238	249	253	207	572	1519
White - Irish	0	2	2	0	0	4
White - other white	4	1	5	0	8	18
Total	275	282	299	241	774	1382

5.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British. On reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were seven in Q2 2023/24, compared to four in Q4 2022/23. Of the ethnic minority deaths in Q2 2023/23, four

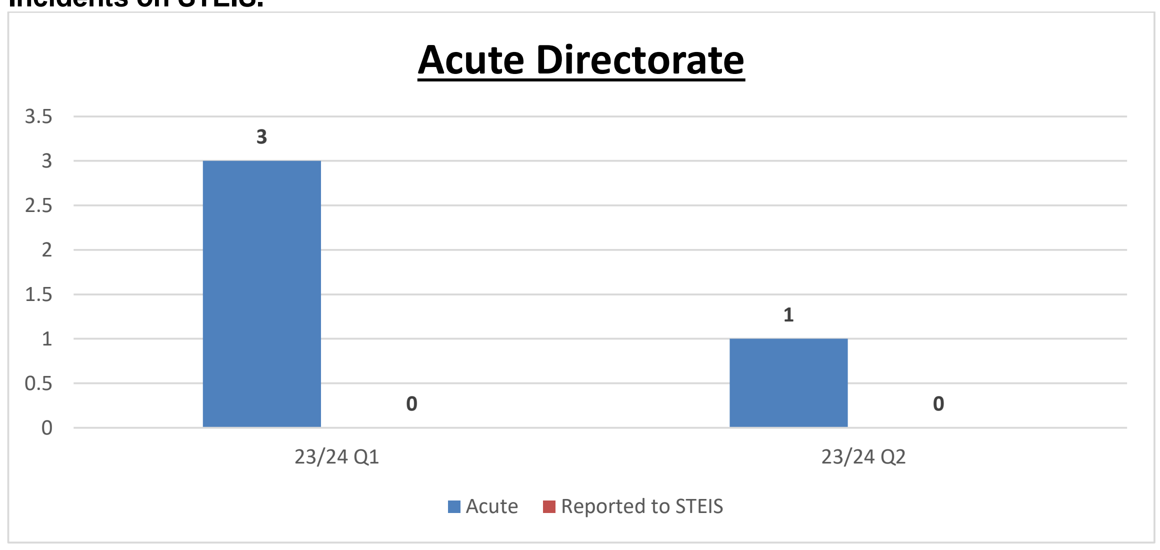
patients died unexpectedly, one by suspected suicide. Two incidents have been STEIS reported, and are subject to a Root Cause Analysis investigation. One patient was in their twenties when they died. Three incidents are historic death records, all of which were downgraded to a low level incident, due to gaps in care being identified.

5.2 Of the mortality incidents reported on InPhase, during Q2 2023/24, 24% had no ethnicity recorded compared to 12% in Q1 2023/24.

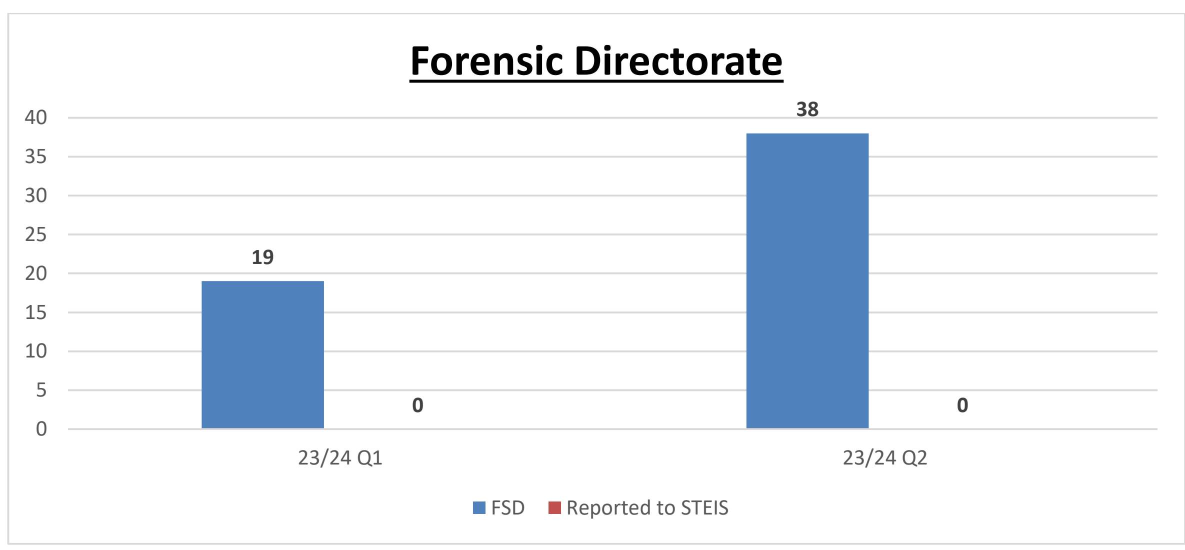
6 Serious Incidents and LeDeR cases

6.1 The following graphs (4 to 8) show the mortality incidents reported for the period 01/04/2023 to 30/09/2023 by Directorate. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

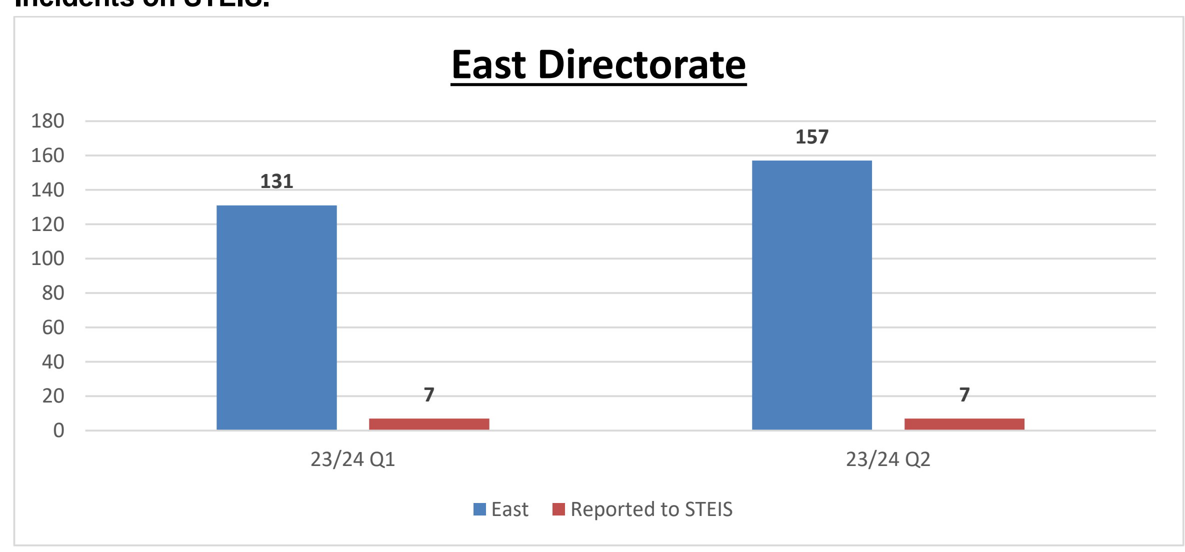
Graph 5 Mortality by Acute Directorate and numbers of those reported as Serious Incidents on STEIS.



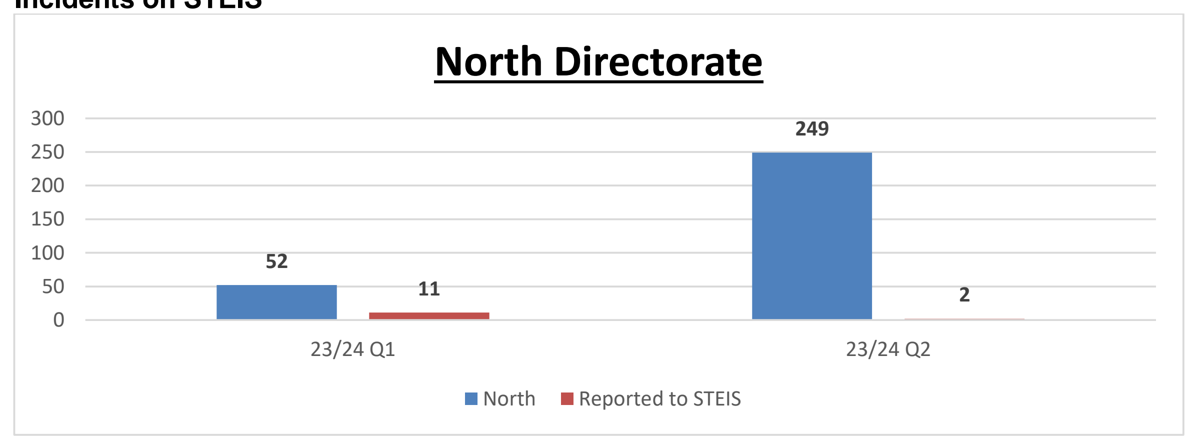
Graph 6 Mortality by Forensic and Specialist Directorate and numbers of those reported as Serious Incidents on STEIS.



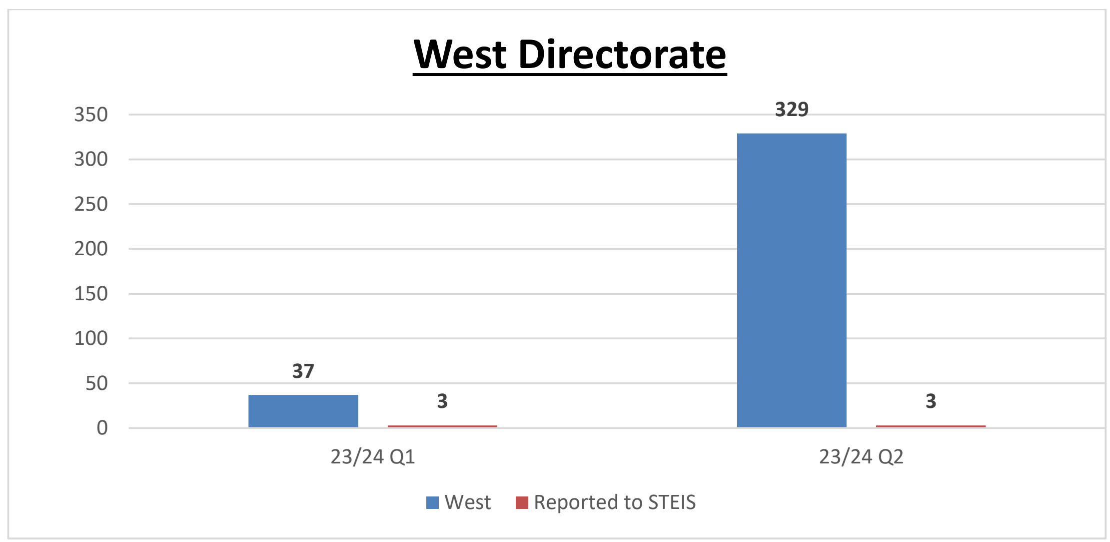
Graph 7 Mortality by East Directorate and numbers of those reported as Serious Incidents on STEIS.



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



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



6.2 A total of 12 mortality serious incidents were reported in Q2 2023/24, compared to 21 in Q1 2023/24. The percentage of serious incidents compared to the overall mortality in Q2 is 1.5%. This compares to 8.7% in Q4 2022/23. Where it is expected that the percentage differences will change this quarter, given the number of historical deaths reported, it is noted that the number of STEIS reported mortality incidents has decreased.

Graph 10, Quarterly mortality/STEIS percentage

Quarterly mortality/ STEIS percentage

4.70% 4.20% 3.00% 4.00% 8.00% 9.80% 6.80% 8.70% 1.50%

Q2 2021/22 Q3 2021/22 Q4 2021/22 Q1 2022/23 Q2 2022/23 Q3 2022/23 Q4 2022/23 Q1 2023/24 Q2 2023/24

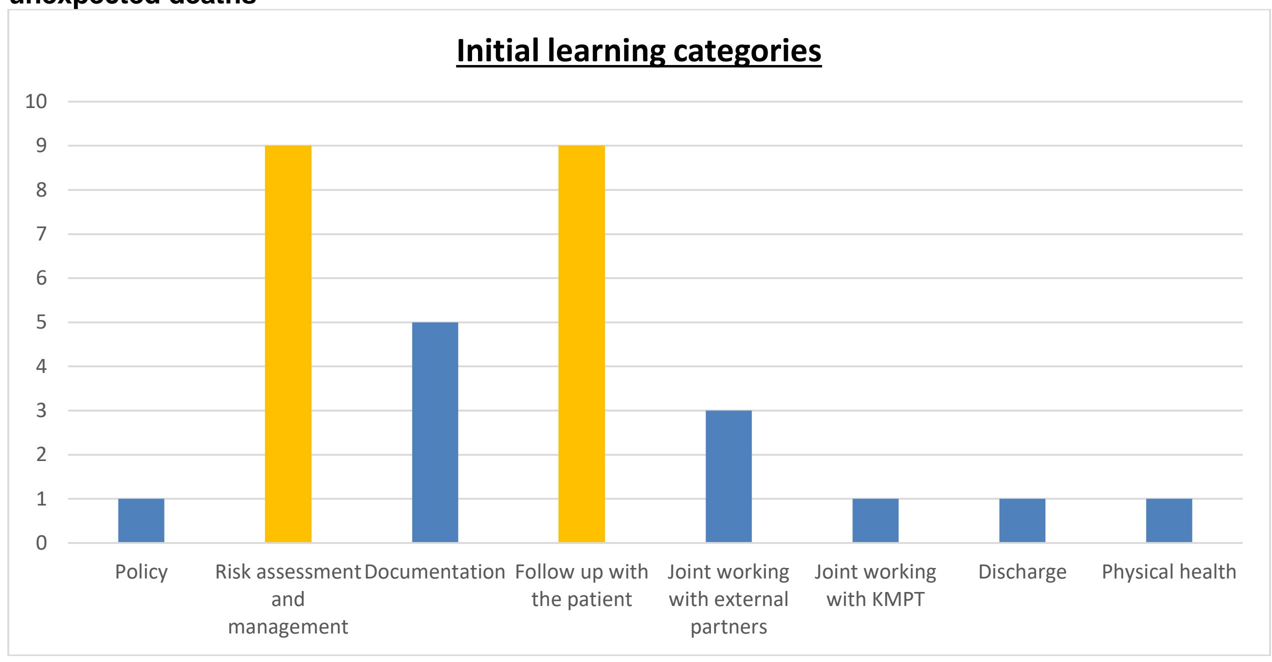
6.3 Graph 9 shows the percentage of STEIS reported mortality incidents each quarter. Due to the higher number of overall mortality incidents reported this quarter (historical deaths) the percentage is expected to have decreased.

6.4 On review of the 12 Serious Incidents relating to mortality that were reported on STEIS in Q2, seven are suspected/confirmed suicides, similar to the previous quarter figures.

6.5 The remaining STEIS reported incidents relate to patients who have died unexpectedly, where the cause of death may not have been confirmed, but gaps in care meet the criteria for investigation. Three cases were reported to KMPT Legal services by the Coroner.

6.6 Initial learning from the STEIS reported cases

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



6.6.1 A review of the initial learning points that have led to STEIS reporting has been undertaken to draw from common areas, prior to the completion of the Root Cause Analysis investigations. When we compare the findings in this quarter, compared to Q1, there are some similarities in the common areas of learning. These are:

- Contact/follow up with the patient and
- Risk management

Documentation is a theme commonly identified in both incidents and RCA's. This was more prevalent in the Q2 incidents, than in the previous quarters.

6.6.2 Contact/follow up with the patient

In Q2, common areas were found to be that patients were lost to follow up or not contacted within the expected timeframes (identified in the Q1 report also). Issues were linked to there being delays in triaging referrals, a patient not being seen face to face, and there being missed opportunities to have followed up with the patient sooner. Initial findings (pending analysis within the RCA) is that low staffing and increased demand may have contributed to this finding.

6.6.3 Risk assessment and management

Much like the findings in the Q1 mortality report, there were common themes relating to risk assessment and management of the patient's risk. The areas of learning included, there being no safety plan for a patient, risks not escalated, and assessment documentation not being updated following a change in risk. Another common theme was around exploration of the patient's risk, and consideration of a patient's social stressors within the risk assessment. There have been many incidents where the patient's life events and life circumstances may

not have been considered at the risk assessment. This has at times led to an incorrect determination of risk.

The trust is currently working on redesigning the risk assessment tool, which will improve the way we review and determine risk.

6.6.4 Documentation
Learning relating to documentation was common theme this quarter. Findings included care plans and risk assessments being out of date, triage forms not being completed, calls not being documented in healthcare records, and referrals not being uploaded to patient records. These issues will be further explored within the analysis of the RCA investigations.

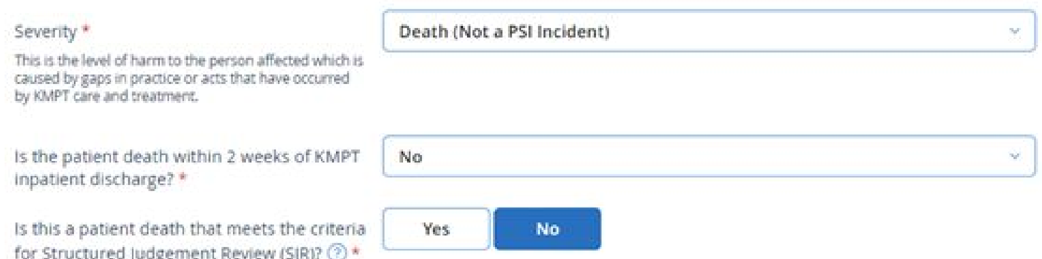
6.7 In Q2, nine patients had a diagnosis of a learning disability and or autism. These were reported to LeDeR as per the national guidelines for reporting learning disability and autism deaths. Data shows that two patients were autistic. Each incident was reviewed by the directorate and identified no care or delivery issues, therefore further investigation or review was not required.

7. STRUCTURED JUDGEMENT REVIEW LEARNING

7.1 The Structured Judgement Review process needs to be improved within the Trust. Trained staff do not have the capacity to undertake reviews, and therefore more staff need to be recruited and trained to support this important and national process.

7.2 A job plan has been developed by the Mortality Review Manager, which is currently under review with the Chief Medical Officer. Once in place, and posts are successfully recruited to, reviews will be allocated and completed in a timelier manner.

7.3 The InPhase incident reporting form has been adapted in Q2, to enable the incident reporter or reviewer, to identify the cases that meet the structured judgment review criteria. Changes to the form can be seen below:


Severity *
This is the level of harm to the person affected which is caused by gaps in practice or acts that have occurred by KMPT care and treatment.
Death (Not a PSI Incident)
Is the patient death within 2 weeks of KMPT inpatient discharge? *
No
Is this a patient death that meets the criteria for Structured Judgement Review (SJR)? *
Yes
No

7.4 In Q2 2023/24, an SJR undertaken for a patient in his sixties, who died on the end of life care pathway. The reason for SJR was due to the patient's diagnosis of schizophrenia. Concerns were raised by the reviewing psychiatrist relating to the physical health monitoring and escalation within the depot clinic/CMHT. The reviewer found the following problems relating to physical health monitoring:

- ECGs not completed
- Lack of escalation when concerning ECG recording was received
- Lack of communication with GP and other physical health clinicians

- Acute hospital and GP did not seem to be aware that the patient was administered a 3 monthly depot
- Other physical health observations were not recorded

A second opinion was sought from another consultant psychiatrist and the Chief Pharmacist. Although there was learning concerning physical health monitoring and communication, it was felt that it was unlikely the patient's death would have been prevented, given the cardiovascular and other physical health concerns present for this gentleman.

Learning has been shared with the clinical team, patient safety and physical health teams, with request that a physical health trust-wide action is considered.

Diagnosis remains the most common criteria for SJR.

Although learning identified in SJRs, there have been no cases where the serious incident criteria was met.

Title of Meeting	Workforce and Organisational Development Committee (WFODC)
Meeting Date	14th November 2023
Title	Workforce & OD Committee (WFODC) Report
Author	Venu Branch, Chair of WFODC
Presenter	Venu Branch, Chair of WFODC
Executive Director Sponsor	Sandra Goatley, Chief People Officer
Purpose	Noting

Matters to be brought to the Board's attention

HR Policies

- There were nine Policies brought to the Committee for Ratification
  Appraisal, Absence Policy, Allegations against Staff, Annual Leave, Recruitment, Shared Parental Leave, Retirement, Work Experience & Supporting Staff. These were ratified.

Communications & Engagement Plan

- The paper was brought to the Committee to provide an update of the Communications and Engagement Plan for 2023-26. The Committee was also updated on two priority pieces of work within that plan which directly impact WFOD's strategic objectives – refreshing KPMT brand identify and the new staff intranet.
- Internally this means a strategic focus on improving staff engagement, culture and enabling change.
- Externally, there is also a strategic focus on improving KMPT's reputation with its staff, partners and communities.
- There was a suggestion to enhance the profile of patient care within the strategy.

East Kent Directorate

- The East Kent Directorate provided the Committee with a fully comprehensive presentation. Targets are steadily improving and reported further successful recruitment over the last few months. This is down to the improvements of Job adverts and the revamping of the Job Descriptions, making them more attractive to potential candidates.
- The Committee was informed there has been improvement around staff morale, there is an appetite for all the changes which are taking place right now. There is a sense of positive engagement, especially within the new Dementia Strategy and how it fits into the new model areas. There is on-going commitment to engage the workforce in significant change programmes, such as (CMHF, Dementia Strategy & Crisis Pathway as an example)
- The Directorate have successful partnership working and new provisions with Invicta and Porchlight within the Community and Mental Health Matter in crisis.
- It was reported there are new governance structures embedded at Team, Service and Senior Management levels ensuring the safe delivery of service and adequate workforce whilst transitioning to new models of care.

Medical Revalidation and Clinical Supervision

- The paper was brought to the Committee as NOTED to provide an Assurance Review of the Medical Revalidation and Clinical Supervision. This was referred to the Committee by the Audit and Risk Committee.
- It was reported there are no clinical supervision contracts between the Consultants and the Clinical Leads and this needs to be reflected if we were to be audited by TIAA.

○ The report outlined limited assurance, with the main issues being identified as the Trust Policy not being followed and low compliance with clinical supervision. The Committee was assured the Policy has since been updated. ○ There will be a review of the process of supervision for Senior Medics and the process will be monitored closely. This will be linked in with the changes made to the Medical structure as part of the Fit for Future changes. ○ The Committee thought it necessary that as a number of items that come to WFOD relate to medical staff, it would be useful for the Executive Medical Director to attend the Committee at least twice a year or if there is a relevant agenda item.
Items referred to other Committees (incl. reasons why)
• None

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

1. Workforce & Organisational Development Main report
2. HR Risk Register Report
3. Employee Relations Cases Update
4. Review of Terms of Reference
5. Items to be reported to the Trust Board
6. Committee Workplan
7. AOB

Following the main WFOD there was a closed session attended by the Chair of WFOD Venu Branch, Kim Lowe (Non-Executive Director, Sandra Goatley, the Chief People Officer, Rebecca Stroud Matthews, Deputy Director of People, Resourcing and Organisational Development and Trina Laws, Executive Assistant. There was an appropriate declaration of interest. This session was to receive an update on an outstanding complex employment issue. It was thought important for the lessons learned from such issues to be shared.

Title of Meeting	Board of Directors (Public)
Meeting Date	30th November 2023
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
• Estates Flowchart • Service Level Agreement (SLA) • Doctors Planned Leave • CQC Actions arising from MHA Monitoring Visits

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

MHAC met on 9th October 2023 to consider:

Significant assurance:

- MHLOG Report
- Mental Health Act Compliance and Monitoring Report
- Chief Medical Officer's Report
- Associate Hospital Managers Report

Reasonable assurance:

- None

Limited assurance:

- CQC actions progress arising from MHA Monitoring Visits

Estates Flowchart

An estates flowchart has been put in place to support the estate process when working on wards where patients are present. This is to ensure that the impacts are recognised and mitigated to improve patient and staff wellbeing during work.

Service Level Agreement

A Service Level Agreement (SLA) has been agreed with the East Kent Hospitals University NHS Foundation Trust which is the second one in place, following the success of the SLA agreement with Maidstone and Tunbridge Wells NHS Trust. Further discussion will to be held with Dartford and Gravesham NHS Trust and Medway NHS Foundation Trust with the hope that these two Trusts will sign up to the agreement in the future. This agreement provides huge benefit for patients being treated for a physical condition whilst they are detained under the Mental Health Act and a financial benefit to the Trust as a revenue is received for this work.

Planned Leave

Assurance was given that the processes are being reviewed and there will be clear guidance put in place regarding planned leave to ensure that there are adequate doctors on site during holiday periods. The newly appointed Clinical Directors and Heads of Psychiatry have a team away day in early November and this item will be under discussion and a plan implemented.

CQC Actions arising from MHA Monitoring Visits

There is limited assurance regarding the CQC actions arising from MHA monitoring visits and that the required progress was being made eg section 132 rights. It was agreed that the Mental Health Act Manager and the Compliance and Assurance Manager will meet and compile a timeline for MHA actions, including dates and owners, to support assurance of actions linked to MHAC.

Note to: KMPT Board
From: Peter Conway
Date: 14.11.2023

Subject: Audit & Risk Committee (ARC) meeting 13 November 2023

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Management, BAF and TRR	*Reasonable Assurance*	Process: Processes continue to improve with better quality risk conversations and management generally as evidenced by 8 new high risks on the TRR (Trust Risk Register). ARC recommended a number of improvements -removal of all low current risks on the BAF -greater focus on actions, timelines, confidence and appetites (ie. the right hand side of the registers) -changes to the layout of the BAF -improved line of sight of high risks to other Board committees plus consideration of a ''lead committee model'' assigning each risk > (say) 16 to a specific committee to provide assurance to the Board Outputs: The 8 new high risks on the TRR (making a total of 14 for the Trust as a whole) changes the perceived risk profile of KMPT *It is recommended that the Board consider their risk appetite for this level of risk and suggest treatment/tolerance/transfer/termination for individual risks if the Trust position is considered too high* Assurance: (1)Benchmarking of risk and governance costs offered limited assurance. ARC suggested a re-focussing of work and re-submission in 3 months. (2)Quality Risk Registers - transparency and join-up with the BAF and TRR could be better. Peter and Stephen to address
Financial Reporting	*Reasonable Assurance*	Final y/e report received from Grant Thornton (no changes from earlier version which was waiting on the CQC findings before final issue)
Financial Controls	*Substantial Assurance*	Substantial assurance received regarding Losses and Special Payments plus Single Tender Waivers
(1) Internal Controls - Auditors	*Limited Assurance*	TIAA Progress Report: (1)Limited assurance report for ''Compliance with Job Plans'' (to review the effectiveness of processes to ensure individuals are working and being paid in accordance with approved plans and contracts''). Following on from the recent limited assurance ''Medical Revalidation and Clinical Supervision'' audit, this report

		will also be referred to People Committee with the suggestion that the remediation dates are too far in the future -ARC was uncomfortable with 8 overdue audit recommendations being delayed for a second time. Internal Audit and ARC to tighten up here Anti-Crime Progress Report: Substantial assurance
(2) Internal Controls - Trust	*Limited Assurance*	Information Governance and GDPR compliance: ARC not comfortable with the assurance provided and an updated and more focussed report requested addressing the committee's concerns: (1)number of outstanding/on hold Data Protections, (2)systemic implications of 8x8 service data retention where 30 days implemented rather than the mandatory 6 years (3)clear line of sight to key issues (4)benchmarked data (5)AI being used in the Trust being reported to the Information Commissioner's Office (ICO) as a reportable information breach (ICO responded that staff should be reminded of Trust AI policy) Review of Standing Orders, Delegation of Powers and Standing Financial Instructions: ARC agreed with the general direction of the proposed changes but there were too many errors and gaps plus opaque wording for it to be agreed and recommended to Board