AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 25th November 2021
Time 9.30 to 12.30
Venue Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/20-21/66	1.	Welcome, Introductions & Apologies		Verbal	Chair	9.30
TB/20-21/67	2.	Declaration of Interests		Verbal	Chair	
PERSONAL STORY						
TB/20-21/68	3.	Sexual Safety Collaborative Quality Improvement Project	FN	Verbal	MF/ AQ	9.35
STANDING ITEMS						
TB/20-21/69	4.	Minutes of the previous meeting – 30/09/2021	FA	Paper	Chair	9.45
TB/20-21/70	5.	Action Log & Matters Arising	FN	Paper	Chair	
TB/20-21/71	6.	Chair's Report • Board Action Plan	FN	Paper	JC	9.50
TB/20-21/72	7.	Chief Executive's Report	FN	Paper	HG	
TB/20-21/73	8.	Board Assurance Framework	FA	Paper	MM	10.05
STRATEGY AND DEVELOPMENT						
TB/20-21/74	9.	MHLDA Improvement Board Update	FD	Paper	HG	10.15
TB/20-21/75	10.	Strategic Delivery Plan Priorities Update	FD	Paper	VB2	10.30
TB/20-21/76	11.	Provider Collaborative Update	FD	Paper	SS	10.50
TB/20-21/77	12.	Eradicating dormitory wards in mental health facilities in Kent and Medway	FD	Paper	VB2	11.00
OPERATIONAL ASSURANCE						
TB/20-21/78	13.	Integrated Quality and Performance Report – Month 7	FD	Paper	HG	11.10
TB/20-21/79	14.	Finance Report: Month 7	FD	Paper	SS	11.35
TB/20-21/80	15.	Workforce Report	FD	Paper	SG	11.45
TB/20-21/81	16.	Quality Improvement	FD	Paper	AQ	11.55
GOVERNANCE						
TB/20-21/82	17.	Standing Orders and Standard Financial Instructions	FA	Paper	TS	12.05
TB/20-21/83	18.	Development, Approval and Management of Formal Trust Documents - Policy and Procedures	FA	Paper	TS	
TB/20-21/84	19.	Use of Trust Seal	FN	Verbal	TS	12.10
CONSENT ITEMS						
TB/20-21/85	20.	Mental Health Act Committee Chair Report	FN	Paper	KL	
TB/20-21/86	21.	Quality Committee Chair Report & Mortality Report Q2	FN	Paper	FC	

TB/20-21/87	22.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/20-21/88	23.	Finance and Performance Committee Chair Report	FN	Paper	MW	
CLOSING ITEMS						
TB/20-21/89	24.	Any Other Business			Chair	12.20
TB/20-21/90	25.	Questions from Public			Chair	12.25
	Date of Next Meeting: 27th January 2021					

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

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Fiona Carragher	FC	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Sean Bone-Knell	SB-K	Non-Executive Director
Mickola Wilson	MW	Non-Executive Director
Martin Carpenter	MC	Associate Non-Executive (NExT Director Scheme)
Helen Greatorex	CE	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Executive Medical Director
Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
Mary Mumvuri	MM	Executive Director of Nursing & Quality
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Organisational Development
In attendance:		
Tony Saroy	TS	Trust Secretary (Minutes)
Hannah Puttock	HP	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications
Mudasir Firdosi	MF	Clinical Director for Quality Improvement
Apologies:		

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Board Meeting held at 1000 to 1200hrs on Thursday 30th September 2021
At the Orchards Event Centre and via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Sean Bone-Knell	SB-K	Associate Non-Executive Director
	Fiona Carragher	FC	Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Associate Non-Executive Director
	Anne-Marie Dean	A-MD	Non-Executive Director
	Helen Greatorex	HG	Chief Executive (CE)
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
	Mary Mumvuri	MM	Executive Director of Nursing and Quality
	Dr Afifa Qazi	AQ	Executive Medical Director
	Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
	Sandra Goatley	SG	Director of Workforce and Communications
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
Observers:			
	Georgie Grassom	GG	Communications Manager
	Sara Casado	SC	Consultant Forensic Psychologist & CAT Psychotherapist & Supervisor
	Michelle Streatfield	MS	Lead Nurse, Physical Health
	Philippa Macdonald	PM	Service Manager, CRHT
	Teresa Barker	TB	Head of Service, Older Adults Care Group
	Dan Lagadu	DL	Head of Quality Improvement
	Gemma McSweeney	GM	Matron, Older Adults & ECT
	Ola Yemi-Sofumade	OY-S	Corporate Performance & Quality Manager
Apologies			

Item	Subject	Action
TB/21-22/47	**Welcome, Introduction and Apologies** The Chair welcomed all to the in-person Board meeting, with PC, A-MD, KL, MW and JMG joining virtually. The Board meeting was livestreamed to allow members of the public to join. Several senior members of staff attended the meeting virtually. No apologies were received.	

Item	Subject	Action
TB/21-22/48	**Declarations of Interest** There were no declarations of interest.	
TB/21-22/49	**Personal Story: Engagement from a Service User Perspective** The Board watched a pre-recorded video from CS, which set out the Trust's Engagement from a service user perspective. CS set out how the Trust is working with service users to co-produce its mental health services. This has allowed service users to work with the Trust as equal partners, and sometimes to take a lead. The Board reflected on the video: • The foundation of KMPT's services remain the Trust's staff and the relationships they form with service users; • The Trust's Engagement Team is a small but influential team, which has reached out service users to receive the feedback that is important for the development of services. • The Trust's ambition is for service users to be leaders in help setting the Trust's ambitions. Their learning and knowledge will help shape the Trust's services in a coproduction manner. The Board **noted** the Personal Story and expressed its thanks to CS.	
TB/21-22/50	**Minutes of the previous meeting – 30/09/2021** The Board **approved** the minutes of the meeting subject to an amendment: • TB/21-22/31- Chief Executive's Report – the additional word 'as' to be removed from the first sentence within the minuted item.	
TB/21-22/51	**Action Log & Matters Arising** The Board **approved** the Action Log, subject to correction to a typographical error for the action due in January 2022. The Board received an update on the following action: • TB/21-22/43 – Mental Health Act Committee Chair Report – query re additional finance for staff to deal with backlog: An increased capacity has been created to deal with the backlog, with matters to be resolved in the coming months. Action to be closed.	
TB/21-22/52	**Chair's Report** The Board received and **noted** the Chair's Report.	
TB/21-22/53	**Chief Executive's Report** The Chief Executive's Report was received by the Board, which was taken as read.	

Item	Subject	Action
	The Chief Executive highlighted: • The Trust's focus on staff wellbeing continues, with this being a key discussion at the Trust's Big Conversation. The Trust is embedding remote working and continues to increase clinical capacity by the use of virtual appointments. • The Chief Executive has re-commenced her "Working With" days and spent a day this month with the Trust's Facilities Team. • The Trust is looking forward to the installation of the 'Garden of Hope' at the Trust's Mother and Baby Unit at Rosewood. The Board's discussions focussed on: • The Garden of Hope – The Trust is ensuring that there is publicity regarding the installation of the prize garden. The Trust will be improving the standards of its estate – including its gardens - across the county, working with the third-sector and service users. This will help establish the Trust as being an employer of choice. • Staff Survey – The Trust is ensuring staff have the time and space to complete the Staff Survey. The response target is 68%, but the Trust is looking to exceed that by way of regular communications; teams that exceed a 60% response rate will be placed in the Trust's draw for £500 that will be spent on that Team's Health and Wellbeing. • Petrol issues – The Trust continues to monitor the situation but as of yet, the Trust's tactical group does not consider that there is a need to instigate the Trust's Business Continuity Plan. • Rest Areas for staff – The Trust Board noted that progress on the re-development of staff rest areas has faltered and is looking to increase capacity within its Estates team to be able to tackle a number of estate matters, including staff rest areas. The Trust has set itself a target of March 2022 for the completion of its staff Rest Areas works. The Board **noted** the Chief Executive's Report.	
TB/21-22/54	**KMPT's Engagement Council** The Board received KMPT's Engagement Council paper. VB2 opened this item by highlighting that the Trust has made significant progress over the last year regarding engagement. To date, over 100 people have signed up to the Trust's Engagement Pool. The request to the Board is for permission to create an Engagement Council, to recruit to that Engagement Council and for the Board to meet the Engagement Council twice a year. The first meeting is proposed for February 2022. The Board reflected on the paper, with discussions centring on the following: • The Trust will be focussed on ensuring that people's voices are being heard.	

Item	Subject	Action
	• There is a need for a flexible approach, so the Trust will be working with a number of established forums – including the third sector - to reach out to different demographics. • The reporting recommendation for the Engagement Council is yet to be finalised, but it may report in directly to the Trust's Quality Committee. • The establishment of an Engagement Pool is central to registering service user and carer interests in working with the Trust, but will not restrict methods of engagement or interfere with current areas of participation. • The Board recommended that front line staff should be attending the Engagement Council meetings as members, with senior staff being attendees (contrary to the proposal). The Board **approved** the proposal for the Board to meet the Engagement Council twice a year. **Action: TS to schedule a Board-Engagement Council meeting for February 2022. Confirmation to be provided at November Board.**	**TS**
TB/21-22/55	**Integrated Quality and Performance Report (IQPR) – Month 3** The Board received the IQPR for Month 5 and complimented the Executive Management Team for the clear narrative contained within it. The paper was taken as read, with Board discussions focussed on each of the matters raised on the IQPR coversheet. <u>Unplanned readmissions within 30 days</u> The data regarding this metric is not statistically concerning at this stage as there is generally an improving picture. There has been a pressure on inpatient beds due in part to an increase in the use of section 136 of the Mental Health Act 1983. However, this is lower than this time last year. The situation will be clearer in two months' time. <u>The Orchards</u> Delays to the refurbishment project has been due to Covid-19 and its impact on material and labour. The Trust is anticipating a November opening with a new Project Manager in post. <u>4-week wait for assessment</u> Memory Assessment is challenging remains challenging locally, reflecting the national picture. The Trust has been increasing capacity, including by way of weekend working; this has allowed the creation of 50 additional slots per month. The increased pressure is not solely due to the Memory Assessment Service, but is reflective of the number of referrals generally, with a paper on this being taken to the Quality Committee. That paper should address what support the Older Adults Care Group needs to tackle the low figures for the 4-week wait for assessment. The Board received assurance that imaging is not a delaying factor for complex dementia services.	

Item	Subject	Action
	Action: On behalf of the Board, FC as Quality Committee Chair is to seek assurance on the Trust's work to tackle the '4-week wait for assessment' issues. The Board shall receive an update on the matter through the Quality Committee Chair Report in November 2021. The Board noted that the Trust was involved in system-wide work to deal with the delays in the 4-week wait assessment. Assurance was given that in the longer term, an improved dementia pathway with new crisis services would be in place; therefore the areas of concern were focused on the short term reparation of the situation. <u>Urgent referrals in 72-hours</u> A detailed review regarding this metric was undertaken and the Clinical Director for Community Recovery Care Group is taking the lead on delivering improvements. The target date for those improvements to be delivered is November 2021. <u>Workforce</u> The Board noted that the Trust is struggling to meet a number of Workforce key performance indicators, with staff sickness currently standing at 4.2% (with Covid as a reason removed), and the Trust unlikely to meet its 4% target given that winter is still to come. HR Business Partners are working with Care Groups to improve staff retention and to tackle long-term sickness. The Board reflected on the staff Covid-19 vaccination rates noting: • All staff: first vaccination - 77%, second vaccination – 66%; • Front-line staff: first vaccination - 81%, second vaccination – 61%. The lower results on the second vaccination is due to a timing issue. **Action: The Executive Management Team is to provide an update on Agile Working as part of an update to the Trust's Strategic Priorities Delivery Plan. Update to be provided in November 2021, with TS to ensure sufficient time is available for discussion.** <u>Average Length of Stay</u> The Board noted that the Trust captures delayed transfer of care data, which is monitored by the Trust's Patient Flow Team. Matters are escalated to Executive Management as deemed necessary. Discussions occur at a system-wide level given that there may be issues regarding social care. <u>Responsive</u> The Board noted that work is ongoing regarding the 'Did Not Attends – 1st Appointments' as this metric has increased since April 2021. The Board **noted** the IQPR.	**FC** **HG/TS**

Item	Subject	Action
TB/21-22/56	**Board Assurance Framework** The Board received the new-format Board Assurance Framework ('the BAF'). The Board was informed that there were no new risks placed on the BAF. Five risks were recommended for removal, one risk had increased in risk score and two risks had been reduced in risk score. The Board noted that three of the risks to be removed were linked to workforce. This is because those risks were being reformulated and once finalised, new workforce risks are likely to be added. The Board focussed its discussions on: • The Audit and Risk Committee could only provide Partial Assurance for the BAF, as the enhancement of processes and formats remain work-in-progress. PC, as Chair of the Audit and Risk Committee, considered the Trust's risk profile to be greater than currently reflected in the BAF; • There was a need for Committees to have a better understanding of which risks fall within their remit, particularly those risks that sit across Committees. The Chairs of all the Committees will be meeting soon and will take responsibility for agreeing an approach to the risk register. • The Board considered that there needs to be more 'creative thinking' around risk. The Board were pleased with the work done to reformulate the presentation of the BAF and **noted** the Board Assurance Framework.	
TB/21-22/57	**Finance Report: Month 5** The Board received the Finance Report (Month 5), with the following matters highlighted: • The Trust delivered a Break-Even position at the end of August 2021 and is currently awaiting H2 guidance. Headline dates have been received, with H2 planning likely to be mid-November. • **Income and Expenditure:** Within the breakeven position reported, there are several key drivers. There is continued pressures in temporary staffing and private placements above budget. Year To Date agency spend at the end of August was £3.2m, £329k lower than the same period last financial year. Any overspend is being mitigated currently by vacancies due to challenges recruiting into substantive roles • **Cost Improvement Plan:** So far of the £7m target, £3.1m has been developed, leaving a gap of £3.9m to be found. There are ideas coming forward via the pillars to be costed over the coming months to close this gap. As sub-pillars and schemes are developing, it is expected that further savings will be identified as the year progresses • **Capital Programme:** The YTD position is underspent by £3.9m. The main reasons for the underspend are delays on the Closed Protocol, Comms Room schemes and Orchards Ward, new year estates schemes in the planning stage, VAT reclaims, retention adjustments, and Strategic IT schemes not yet proceeding. The full programme is forecast	

Item	Subject	Action
	to deliver £15.5m this financial year. A capital forecast is being compiled based on the estates planning information • **Cash:** The cash position increased by £0.5m in month to £15.3m. The actual is £2.5m higher than the original plan, with receipts £1m below plan and payments £3.5m below plan. Whilst cash has been received from Health Education England quarterly rather than bi-annually, this has been offset by the August Provider Collaborative SLA not being paid until 1st Sept and the NHS England block payments to date being lower than planned. Payments have been lower, largely due to slippage on the capital programme and reduced creditor payments. There continue to be four areas of concern which could adversely affect the delivery of a breakeven position by year-end. These are Temporary Staffing Spend: Agency, Private Placement Spend, Planned and Reactive maintenance, and Patient Travel spend. The Trust is mitigating these issues by: 1. Temporary staffing – recruitment initiatives continue to be mobilised and developed further such as on-boarding a large cohort of newly-qualified nurses and mobilising the International Nurse recruitment programme. There has been a small reduction in the Temporary Staffing cost. 2. Private Placement Spend – further focus has been spent on this internally to understand the position, the Trust are in discussions with the CCG regarding potential discharge funding being made available as part of the Spending Review funding which will continue investment in post-discharge support and potentially alleviate the pressure on placements spend. 3. Planned and Reactive maintenance – TIAA the Trust internal auditors have finalised their report, the Trust are currently drafting their action plan to be taken forward at pace in response to the audit findings. there is a review of the Maintenance schedule which will assist with managing spend and identifying further financial risks. 4. Patient Travel Spend – relates to the use of patient transport. A task and finish group has been set up to review our processes and standardise processes across the Trust. The first meeting has taken place and agreed the actions required. The Board reflected on the national expression of interest bids for capital projects in mental health. The Trust submitted bids in respect of female psychiatric intensive care Unit and high support units. Due to the number of bids that were received, there will now be a second round for consideration early next year, with the outcome announced in Spring 2022. The Trust is planning to bring in additional project support to re-map the planned capital projects and their delivery. The Board also noted that with respect to the Trevor Gibbens Unit, a focus group has been set up to better understand the Forensics and Specialist Care Group's strategy for service delivery in order to build a robust case for capital. The Board **noted** the Finance Report: Month 5.	

Item	Subject	Action
TB/21-22/58	**Medical Revalidation Report** The Board received the Medical Revalidation Report, noting: • The Trust had completed 93% of all doctor appraisals, with there being just five doctors who needed to have their appraisals completed. Those appraisals were due to be completed soon. • All doctors continue to be practising within GMC Guidelines and receive four hours-per-week for Continuous Professional Development ('CPD'). The Board considered that it was an appropriate aspiration to offer a similar level of CPD opportunity for all staff, in the interests of fairness, and in the Trust's ambition to be an employer of choice. The Board **noted** the Medical Revalidation Report.	
TB/21-22/59	**Managing Conflicts Policy** TS provided a verbal update to the Board regarding the Managing Conflicts Policy. The Policy was due to expire at the end of September 2021 and a re-drafted version of the Policy had been submitted to the Audit and Risk Committee on 22nd September. Following that Committee's recommendation to make the Policy an easier read for front-line staff, it was necessary to request a six-month extension to the current version of the Policy. The Board **approved** a six-month extension to the Managing Conflicts Policy.	
TB/21-22/60	**Committee Terms of Refence** The Board received and **approved** the amended Terms of Reference for all Committees as submitted within the Paper.	
TB/21-22/61	**Quality Committee Chair Report** The Board received and **noted** the Quality Committee Chair Report as well as: • Director of Infection Prevention and Control Annual Report.	
TB/21-22/62	**Workforce and Organisational Development Committee Chair Report** The Board received and **noted** the Workforce and Organisational Development Committee Chair Report including: • Annual Equality and Diversity Report.	
TB/21-22/63	**Audit and Risk Committee Chair Report** The Board received and **noted** the Audit and Risk Committee Chair Report.	
TB/21-22/64	**Any Other Business** There was no other business.	

Item	Subject	Action
TB/21-22/65	**Questions from Public** Following questions and comments from the Public and Observers, the Board stated: • The views of staff and service users regarding the Trust's risks do need to be considered when reviewing the BAF and will be taken into consideration via the Engagement Council; • Office space in the new builds will be predominantly for clinical staff but the office space may also be used occasionally by the Executive Management Team when visiting front-line staff. • The Trust has made progress on recording the outcome of assaults on KMPT staff where a crime has been reported to the police: since May 2021, seven people had been prosecuted. SG receives Datix reports whenever an attack on staff members occurs and support is provided to staff members.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 25th November 2021.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/11/2021

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 2021								
30.09.2021	TB/21-22/54	KMPT's Engagement Council	TS to schedule a Board-Engagement Council meeting for February 2022. Confirmation to be provided at November Board.	TS	November 2021		Item has been scheduled for February 2022 and agreed by Trust Chair and Chief Executive	COMPLETE
30.09.2021	TB/21-22/55	Integrated Quality and Performance Report (IQPR) – Month 3	On behalf of the Board, FC as Quality Committee Chair is to seek assurance on the Trust's work to tackle the '4-week wait for assessment' issues. The Board shall receive an update on the matter through the Quality Committee Chair Report in November 2021.	FC	November 2021		A report was presented to Quality Committee at their meeting on 16 November 2021. QC Chair has provided an update attached to her report	COMPLETE
30.09.2021	TB/21-22/55	Integrated Quality and Performance Report (IQPR) – Month 3	The Executive Management Team is to provide an update on Agile Working as part of an update to the Trust's Strategic Priorities Delivery Plan. Update to be provided in November 2021, with TS to ensure sufficient time is available for discussion.	EMT & TS	November 2021		Item on public board agenda	COMPLETE
ACTIONS NOT DUE OR IN PROGRESS								
29.07.2021	TB/21-22/36	Progress on Turning the Tide; Tackling Racism	CEO to produce an update paper regarding progress against the Tackling Racism workplan. Paper to be received by the Board in January 2021.	CEO	January 2021			Not due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
27.05.2021	TB/21-22/08	Integrated Quality and Performance Report (IQPR) – Month 1	JMG to produce a paper setting out the Trust's plans for the Memory Assessment Service for the short term. Paper to be presented to the Board by September 2021.	JMG	September 2021		This item is to be taken to the Quality Committee in November 2021	CLOSED
29.07.2021	TB/21-22/40	Quality Committee Chair Report	CEO and Trust Chair to discuss the issue of the Trust's underspending on capital projects and the overspending on reactive maintenance and ensure a focus on this area in a future Board meeting. Meeting to occur by end of September 2021.	CEO	September 2021		Board seminar on Capital Projects to be scheduled for February 2022	CLOSED

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/11/2021

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
29.07.2021	TB/21-22/43	Mental Health Act Committee Chair Report	CEO and AQ to consider if additional finance could be provided to recruit a member of staff to deal with this backlog and revert to KL by the end of September 2021	CEO	September 2021		An increased capacity has been created to deal with the backlog, with matters to be resolved in the coming months. Action to be closed.	CLOSED

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 25th November 2021**
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 4 matters:

- Board action plan
- System wide meetings
  - Board-to-Board meeting
  - Stroke services in Kent and Medway
- NED visits
- Congratulations

2. Board action plan

As part of its well-led work, Board members recently carried out a self-assessment exercise by way of a survey. I have reviewed the results of that survey and consulted with Board members on the action plan formed.

The Board will commit to the action plan at its November Board meeting. A paper setting out the survey results and action plan is attached to this Chair's report.

I would like to take this opportunity to remind everyone that the Board meetings will continue to be held virtually into the new year. It is important that we do everything we can to keep everyone safe as we go through a difficult winter period. It is a matter of sadness to me that we cannot invite our public to join us in person at the moment, but I hope that the live streaming and recording of the board allows for some wider participation.

The Trust has an established Board Development Programme, with the next session being in December. This will be externally facilitated and focused on honing our performance as a unitary board.

3. System Wide Meetings

I continue to attend the monthly ICS partnership board meetings, and to liaise regularly with my fellow chairs. In October I attended my third Population Health Management Programme for system leaders in the county.

Board to Board meeting

On 12th October, KMPT and Kent Community Health Foundation Trust (KCHFT) held a Board-to-Board meeting.

It was a great opportunity for the two Boards to reflect on the joint working that has taken place since agreeing our Memorandum of Understanding a year ago. It was pleasing to note the significant progress on two of the three workstreams: annual health checks for people

with a learning disability; and assessment and post diagnostic support for adults with autism and/or ADHD. Further work is needed in the crisis care of people with dementia.

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

The two trust boards will meet again in Spring 2022 for further joint working at Board level.

Stroke services and neuropsychological rehabilitation in Kent and Medway

In November 2021, the Secretary of State for Health and Social Care decided to change the way stroke services are delivered across Kent and Medway. Three new 'hyper acute stroke units' will be established to give very specialist care to stroke patients in the immediate days after a stroke.

There will also be a Kent and Medway CCG investment of £100,000 to support neuropsychological rehabilitation for people in Medway.

4. Trust Chair and NED visits

My NED colleagues and I were able to carry out some virtual and in person visits over the months of October and November 2021. These are listed within the table, with further details of the visits below the table.

Where	Who
October 2021	
Workforce and Organisation Development Team	Catherine Walker
Ashford CMHT	Catherine Walker
Trust Secretariat	Catherine Walker
Priority House	Peter Conway
111 Call Centre, Ashford	Jackie Craissati
Orchards ward (new unit)	Jackie Craissati
November 2021	
Tarantfort & Allington	Jackie Craissati
Rosewood mother and baby unit	Jackie Craissati
KMPT Innovation Awards panel	Catherine Walker

Chair visits

SECAM made every effort to ensure that my visit to their 111 call centre was a really informative and interesting time, and I am very grateful to the team who were so attentive. I was enthused by the obvious potential for much greater collaboration between us going forwards: this is a very difficult time for the ambulance service but as we come through the winter, I hope to see greater integration between our two crisis lines.

My visits to Allington, Tarenfort and Rosewood were all delightful, and all characterised by passionately committed and high performing teams. Given our frustrations over the past few

months with the task of maintaining our estate to a good standard, I was struck on these visits by the ways in which modest but creative touches to the environment could have a significant impact on the quality of the surroundings for patients and staff.

Catherine Walker's visit to Workforce and Organisation Development Team

I attended the Workforce and Organisation Development Team October meeting. It was a structured meeting and I learned a lot about planning and new initiatives around the Trust. It was helpful to triangulate themes of discussion at Board with insight from the front lines via this team's lens. I was interested to hear about work on widening career paths and new roles. I noted the work that is being done on identifying and resolving closed cultures. The team uses the QUEST tool in services which is an overview snapshot - I commend it to colleagues visiting services to get an idea of the current state of play.

Catherine Walker's visit to Ashford CMHT

I was warmly welcomed by Ashford CMHT colleagues when I spent the morning there on 6th October. Staffing and large caseloads remain an issue, but I was told that the culture of the team is now very positive and supportive, and colleagues are striving collectively to do their best to care for those in their care. Estates is a problem with lack of prompt and reasonably costed maintenance and minor works a bugbear.

Catherine Walker's visit to Trust Secretariat

I visited the Trust Secretariat team on 11.10.21 and joined their planning meeting as an observer. It is apparent that much careful thought and preparation goes into working behind the scenes to ensure that board and committees can perform effectively. I would like to record my thanks for their work and to note that the Trust Secretariat's recent work has contributed to the further development of Governance standards at KMPT.

Catherine Walker's participation in KMPT Innovation Awards

I chaired the first Panel considering shortlisted entries for the first round of KMPT Innovations Awards. It was a real pleasure to listen to the presentations covering the diverse ideas/ pitches for funding from the 7 shortlisted entries from across the Trust. There are some great ideas out there.

5 Congratulations

National award success for KMPT

I am delighted to note that KMPT has been successfully shortlisted for a number of awards recently.

In October, we received news that we were recognised as part of the Mental Health Positive Practice Awards; scooping top spots in two categories and a highly commended in a third.

- Our Specialist Low Secure Services took first place in the Forensic/Secure Mental Health Services category followed by our Community Mental Health Perinatal Services in the Perinatal Mental Health Services category
- The Trust was also delighted to be part of the of the multi-agency work in the Kent and Medway Suicide Programme which picked up the top spot in Suicide Prevention services category.

More recently, Sheila Stenson, Executive Director of Finance, has been recognised as a finalist in this year's HFMA National Healthcare Finance Awards in the category of Finance Director of the Year; this is a fantastic achievement. In addition, the Finance team has also been shortlisted for the Costing Award. All HFMA winners will be announced on Thursday 9 December 2021 at the London Hilton Metropole and the awards ceremony will be streamed online.

And finally, we are thrilled to announce that the Digital Services team was announced this week a finalist for the second year running for the Best Service Desk in the Service Desk Institute Awards. Announcements should take place on 17 March 2022.

Well done to everyone involved and the Board looks forward to hearing the final results.

Kent and Medway
NHS and Social Care Partnership Trust

Board Self-Assessment Results Report 2021

1. Introduction

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

The well-led framework is structured around eight key lines of enquiry (KLOEs) and Board members have been asked to undertake a self-assessment around these KLOE. A separate section has also been included that focuses on the Board's response to the Covid-19 pandemic. As Board members will see, recommendations have been made to continue to improve the Board's effectiveness and performance.

2. Summary of Board Responses

Board members were asked to provide a rating between strongly disagree to strongly agree for each question (1 = strongly disagree, 5 = strongly agree). The results have been analysed by averaging the scores for each KLOE and cross referenced with the NHSI well led rating framework. Overall, the rating and comments received from Board members demonstrated a positive response to the Board's function and performance.

All Board members agreed that the Board works well as a cohesive group and the Chairman encourages a range of views and constructive challenge. Furthermore, Board decision-making includes active participation and members views are considered. There was widespread agreement that Board members, both individually and collectively understand what is expected of them. Board members felt that the current Board composition has suitable and skilled representatives and this has improved in the last year with the addition of new Non-Executive Directors. There was agreement that the new Non-Executive Directors received an appropriate induction programme.

Regarding Board operation, in April 2021, it was agreed at a Board Development session that the Trust Board would trial bi-monthly Board meetings for a year, with a Board development session taking place between each Board meeting. Some Board members reflected that they felt that the new frequency and length of the Board meetings could be improved, and in some cases Board members felt there was not enough time allocated for each agenda item. However, members agreed that Board agendas and related papers are circulated in a timely manner in order for Board members to prepare for the meeting. Some Board members agreed that more work needs to be carried out to ensure there is adequate board development plans in place. Feedback was also given that Board members do not feel adequately briefed on the business of the Board Sub-Committees, although the role of each of the Board Sub-Committees is fully understood.

One of the highest scoring areas of the Board Self-Assessment was the Trust's response to the Covid-19 pandemic. There was widespread agreement amongst the Board that members felt well informed and continued to receive regular updates throughout the various peaks of the pandemic. Board members felt that the Board had adapted well to the virtual meetings and that the Trust has continued to encourage service users, the public and staff to attend public Board meetings. The recent 12 months has been astonishingly difficult and Board members felt that the support from each other has been phenomenal.

Regarding having an established strategy for the Trust, Board members felt more focus could be given on the Trust's vision and strategy at Board meetings. Members of the Board were particularly interested in hearing how the Trust engages staff when developing key documents such as the Trust's objectives and strategy. Board members agreed that the Trust's Strategy is clearly aligned with, and updated to reflect changes to, local and national NHS Policy. However, although the vision for the Trust is clear, the NHS landscape is changing due to the introduction of the Integrated Care Systems (ICS) and impending legislation and the strategy and ambitions of the Trust may need to be reviewed as these develop. A Board seminar took place recently with the Accountable Officer of the ICS to discuss and understand the Trust's role in the ICS and what the Board of the new ICS may look like. There was widespread agreement amongst all Board members that there is effective communication with patients, staff, commissioners and regulators and there is positive and collaborative working relationships with the relevant external organisations.

Board members agreed that the Trust has robust and effective governance systems in place and the Board is made aware and kept up to date with this. However, one area where Board members felt improvements could be made is with further reporting on the arrangements in place to ensure there are appropriate interactions with key partners and the reporting on progress of partnerships. Board members recognised that they know that this takes place, but commented that more feedback to the Board formally would be welcomed. The Trust is currently planning on holding its first joint seminar with the Kent Community Health NHS Foundation Trust Board in October, and this will provide further feedback to the Board on how the two Trusts are working together since the Memorandum of Understanding was signed.

Board members strongly believe that there is a strong culture of high quality and sustainable care. With regards to Risk and Performance Management, the Board acknowledged that there is a sound risk-based approach underpinning most of the work of the Trust. The Board recognised that high level risks that could impact the Trust are monitored well, as this will be further improved by the new look Board Assurance Framework that will come to the Board in September 2021. There was agreement that the existing range of performance measures and financial information are broad enough to enable the Board to monitor operational management performance. However, Board members felt that more work could be done to understand the performance of the Trusts against other relative healthcare providers where appropriate, to identify when the Trust is an outlier.

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

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3. Average Scores

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

Key Line of Enquiry (KLOE)		Board's View (Average scoring)	Risk Rating
KLOE 1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	4.0	
KLOE 2	Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	3.8	
KLOE 3	Is there a culture of high quality, sustainable care?	4.1	
KLOE 4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	4.1	
KLOE 5	Are there clear and effective processes for managing risks, issues and performance	3.8	
KLOE 6	Is appropriate and accurate information being effectively processed, challenged and acted on?	3.9	
KLOE 7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	3.9	
KLOE 8	Are there robust systems and processes for learning, continuous improvement and innovation:	3.9	
Additional question	Board operation/administration/governance	3.8	
Additional question	Covid-19 Response	4.4	

Key:

4-5 score – Green

3-4 score - Amber Green

2-3 score - Amber Red

1-2 score - Red

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

4. Proposed Action Plan

The following action plan has been developed based on the feedback provided by Board members. The Trust Board is asked to approve the following action plan.

KLOE	Action
Board Operation	• To review the length and frequency of the Trust Board meetings at the December development day, and ensure there is enough time dedicated on the Trust Board agendas to relevant items. (Chairman & Trust Secretary) • Review how the Board can be better briefed on the work of its Sub-Committees. (Chairman & Trust Secretary)
KLOE 1: Leadership, capacity and capability	• To ensure the biannual Board development days – commencing in December 2021 – are planned in advance and in collaboration with the Board (Chairman & Trust Secretary). • To ensure the mix of skills, experience, knowledge and diversity within the Board is considered in November 2021 with a view to making decisions regarding Associate NED recruitment in January 2022 (Trust Secretary & Director of Workforce).
KLOE 2: Vision & Strategy	• The Trust's Strategy and overall vision to be given more exposure at Trust Board Meetings and Board Seminars, as coordinated by the Chair, Trust Secretary and Chief Executive at their bimonthly Board agenda meetings. (Chairman & Trust Secretary).
KLOE 3: Culture	• The Board to continue to receive biannual updates on the Trust's Equality and Diversity position (Chief Executive & Director of Workforce). • The Board to receive a bi-annual report on Freedom to Speak Up, with the Trust Secretary amending the Board's Forward Plan. The Board to have an annual Freedom to Speak Up seminar with the FTSU Guardian and Ambassadors in attendance. • Board front sheets have been amended to make it clear which staff groups have been involved in the work stream/strategic work.
KLOE 4: Clear responsibilities/accountability	• Interactions with key partners and any progress of new partnerships to be considered over the next 18 months in the Partnership & Innovation Task & Finish Group and reported to Board via updated reports (Chief Executive & Executive Directors).

KLOE 5: Risk and Performance Management	• The Board Assurance Framework to be improved, as from September 2021, to provide further assurance to the Trust Board when monitoring high level risks which could impact the Trust (Executive Director of Nursing – action already in hand)
KLOE 6: Quality of information	• The new training on Board and Committee report writing – led by the Chair and Chief Executive – includes reference to the importance of benchmarking KMPT against other organisations, where appropriate.
KLOE 7: Stakeholder awareness and engagement	• Effective forms of communication with patients, staff, commissioners & regulators to be included in all reporting (Executive Directors). • The newly formed Engagement Council will meet with the Board biannually.
KLOE 8: Robust systems, processes and continuous improvement and learning	• Included in and covered by the first action related to KLOE 1: Leadership, capacity and capability.

Chief Executive's Board Report

Date of Meeting: 25 November 2021

Introduction

Brilliant Care through Brilliant People remains our simply stated mission. Set against a backdrop of sustained increased demand for our services and the impact of a global pandemic, it has never been more important that every one of us in KMPT holds fast to our mission.

Creative thinking from our clinical leaders and senior managers is helping to make additional capacity available through new ways of working and in particular, using digital technology to extend access to services. This is not straightforward work and for some of our services, especially those supporting people whose needs are complex, it can be challenging.

What remains apparent and consistent throughout the organisation, is that however pressed people are, they put those we serve, first. They are impressively focused on providing brilliant care and putting people at the heart of what they do.

The board will I know want to join the Chair and I in formally recording our thanks to every single one of our three and half thousand KMPT colleagues who go above and beyond, every day.

In this month's board papers, the Integrated Quality and Performance Report (IQPR) sets out in detail, the areas of pressure that are of most concern along with a description of the steps that my team and I are taking to address areas where a performance target is not met.

In the midst of an extremely busy Winter, there is light, one example of which is our Garden of Hope. We were delighted to welcome to our Mother and Baby Unit, garden designer Arit Anderson. Arit and her team spent several days, personally installing the Chelsea Flower Show garden that the Trust won long before the pandemic in 2019. The garden was officially opened in October and has already made an enormously positive impact on our patients, their families and the unit's staff. The inspiration provided by the garden is being used to drive our new programme of garden and outdoor space renovation, with 2022 officially named KMPT's Year of the Great Outdoors.

Update: Internal

Covid-19 and Seasonal Influenza

Our Infection Prevention and Control (IPC) measures remain in place and robust with 2-meter social distancing and mask wearing a requirement on all trust sites. The annual 'flu vaccination programme has started with a revised approach this year making it as quick and easy as possible for staff to receive their vaccination whilst at work.

Community Mental Health Teams (CMHTs) and GPs

Through the work of our CMHT Clinical Director, Dr Kirsten Lawson we continue to build on the close working of GPs and CMHTs. Designed at improving both the patient and GP experience of our services a range of activities are being offered. Shadowing days, educational meetings and more transparent lines of communication for advice for GPs all feature. A Quality Improvement project is underway in

Medway & Swale linking in with the Community Mental Health Transformation Framework processes to show improved referral management which will in turn improve the quality of experience for those we serve.

Annual Staff Survey

Launched in October, this year's survey closes at the end of November. At the time of writing, the Trust is just behind the response rate of the highest performing trust in its group. The Trust's overall target for completed, returned surveys this year is 68%.

Five, £500 staff well-being prizes have been awarded to teams who have achieved a sixty percent response rate. The winning teams are able to choose from a list of wellbeing prizes. A second prize draw will be held in December, with a further five £500 prizes to be won.

Chief Nurse Recruitment and Chief Operating Recruitment

We will be sad to say goodbye to Executive Director of Nursing Mary Mumvuri when she leaves us for a new role in Coventry in December. The Board will I know want to join me in formally recording thanks to Mary for her work across KMPT and the wider system since she joined us in 2016.

Andy Cruickshank, currently a Director of Nursing at East London Foundation Trust has been appointed as Mary's successor and will take up post on March 1st. Robust interim cover arrangements are in place.

Since the last board meeting, Chief Operating Officer Jacquie Mowbray-Gould has been appointed to a role in her home county of Devon. We congratulate Jacquie and are pleased that she will be with us until the end of February.

The process to select Jacquie's successor is well underway with interviews scheduled for December 17th.

Big Conversation and Leaders Events

These regular events continue to be well attended and held virtually. A focus of both has been the well-being of staff and service innovation. Consideration is being given to the programme for 2022 some of which will be held in person.

Visit to KMPT by Positive Practice

Tony and Angie Russell, the founders of Positive Practice in Mental Health visited the trust in October. Their mission as an organisation is to locate and connect best practice nationally. The Chair and Chief Executive were pleased to jointly host a Positive Practice dinner and along with a wide range of colleagues from across KMPT, spent the evening reflecting on national best practice and the opportunities for KMPT to share more widely, the very best of our work.

Update: External

Integrated Care System

A substantive appointment has been made to the Integrated Care System Chair, and Cedi Frederick took over from Interim Chair John Goulston on November 1st. Interviews for the Accountable Officer took place at the end of October with both KMPT's Chair and Chief Executive participating in the selection

focus groups. Paul Bentley (currently Chief Executive of Kent Community Partnership Trust) has been appointed and was congratulated on behalf of our board.

Planning Guidance H2

Since the last board meeting planning guidance for the second half of the financial year (now referred to nationally as H2) has been issued. Today's board papers include an update on the Trust's response and our intention to end the year at breakeven.

Secretary of State's Statement on Covid Vaccination of NHS Staff

Since the last board meeting, a national announcement has been made that all 'patient facing' NHS staff will be required to be fully vaccinated against Covid-19 by Spring 2022. The Workforce and Organisational Development Committee were briefed on the Trust's approach to this new instruction at their November meeting and the board will be updated in detail at its January meeting.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Mary Mumvuri, Executive Director of Nursing, Quality and Allied Health Professionals

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

- Four risks have been added to the BAF since the last report
  - Risk ID 6847 – Sickness (Rating of 16 – Extreme)
  - Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
  - Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
  - Risk ID 6850 – H2 Planning (Rating of 6 – Moderate)
- No risks have increased in risk score
- No risks have reduced in risk score

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 is presented in the new template format. It was last reviewed by the Audit and Risk Committee on 22 September, but has since been updated.

The Top Risks are

- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6573 - Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 – Extreme)
- Risk ID 6628 - Financial Sustainability (Rating of 16 - Extreme)

Supplementary assurance information has been provided with this paper relating to the key controls for each risk. The purpose is to demonstrate that evidence can be provided for each key control and that the control is being monitored and assessed for quality and impact.

Risk Movement

There have been no changes to risk scores since the Board Assurance Framework presented in September.

Risks Recommended for Removal

No risks are recommended for removal

New Risks

Four new risks have been added to the BAF:

- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 6850 – H2 Planning (Rating of 6 – Moderate)

Workforce Risks (Risk IDs 6847,6848, 6849)
The three workforce risks have been added to refocus the previous workforce risks. The current risk score remains extreme while these risks are newly stated and work is being undertaken to evaluate the effectiveness of the controls and assurances in place.

Risk ID 6850 – H2 Planning
This risk has been added as the Trust must deliver breakeven for H2. A plan has been submitted to NHSI/E which is challenging. There are a number of risks identified within this plan which have mitigations in place to manage these risks. A robust forecast will be produced on a monthly basis to ensure the Trust is on track for delivery.

Version Control: 01

Emerging Risks

Two emerging risks have been identified through discussions at recent committees:

- **Memory Assessment Services**
  Following discussion at Quality Committee in November it has been agreed to separate out the Memory Assessment Service risk from Risk ID 6573 (Demand and Capacity for Adult and Older Adult CMHTs as impacted by the covid-19 pandemic). This will be drafted for inclusion on the Trust Risk Register to be presented at the Audit and Risk Committee in December.

- **Winter Pressures**
  National indicators state winter will be challenging for Health and care providers across the health and social care system. A risk will be drafted for the Trust Risk Register to reflect the planning for expected pressures and assess where there may be any gaps.

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: 17 November 2021

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Board Assurance Framework

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

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

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

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

Action status key:

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

1 - Consistently deliver an outstanding quality of care

17/11/2020 — Risk Opened — 04/06/2021 — The top 5 assurances need to be identified for this risk — 15/11/2021 — Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered.

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	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs as impacted by the covid-19 pandemic** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment. Older Adult Care group awarded additional funding to improve memory assessment standards.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	4	16	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer	To be confirmed	3	3	9	**30/04/2022**
													Skill Mix of Workforce (CMHTs)	Head of Service	30/09/2021	G						
													Increasing initial interventions capacity - CMHTs	Lead for Psychological Practice	30/08/2021	G						
													Skill Mix of Workforce (CMHSOPs)	Head of Service	2/28/2022	A						
													Dementia Strategy Development	Deputy COO	31/03/2022	A						

14/12/2020 — Risk Opened — 04/06/2021 — Mitigating actions are progressing. Awaiting confirmation of national KPIs which has delayed completion of local action. — 06/09/2021 — All actions progressing positively. Initial quality and safety concerns are being managed appropriately. Confident the risk will be mitigated to target level by Sept target date. Further Service development required after October 2021. — 15/11/2021 — The new SPoA SOP has been agreed and approved by the Trust Wide Patient Safety Group. The service is working to locally defined KPIs which are giving good oversight of an agreed set of metrics. Nationally defined KPIs are still awaited, but there is no timescale for these to be received. There is a high level of confidence that this risk is well managed.

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	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6626	Dec 2020	Chief Operating Officer	**Development of a Crisis line** IF the SPoA is unable to respond to additional demand and requirements as it moves to become a Kent-wide Crisis Line as required by NHSE in response to the Covid pandemic in addition to its existing functions THEN there will be people who do not have their calls answered and/or clinical decision making may be compromised. Response to urgent referrals may also be compromised by an increase of crisis line calls RESULTING IN poor patient and referrer experience, patient safety issues, increased staff stress and reputational damage as a result of not delivering a nationally required service.	4	4	16	Urgent Access Lead role in place (1a) Oversight by COO and EMT (1a) MHIS funding invested in year and recruitment underway (1g) Delivery group in place with all relevant stakeholders - chaired by DCOO and supported by CCG (2a) Revision of Standard Operating Procedures (2e)	Development of a revised governance structure, including dedicated QPR (1b/1h) Governance Meetings / QPR (1a) CliQ Checks and local quality audits (1c) Open Access Crisis Programme Board (2a)	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer		3	3	9	**14/03/2022**
													Revision of SOP, including development of local standards (no national KPI's for Mental health Crisis line)	Urgent access lead	30/11/2021	A						
													Workforce Development based on new service requirements	Urgent access lead	31/08/2021	G						
													Ongoing recruitment to vacancies to ensure safe operational staffing levels	Urgent access lead	09/08/2021	G						
													Implement new telephony system	Urgent access lead	07/02/2022	A						

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.

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	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6052	Mar 2019	Executive Director of Nursing, AHPs and Quality	**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.	3	4	12	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 Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock inspections)	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Nursing, AHPs and Quality		1	3	3	**31/12/2021**
													Cliq checks and Deep dives	Executive Director of Nursing, AHPs and Quality	Ongoing	A						
													Quality Summits	Executive Director of Nursing, AHPs and Quality	Ongoing	A						
													Learning from each other - Peer reviews	Executive Director of Nursing, AHPs and Quality	Ongoing	A						

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
	04/12/2014 Risk Opened 04/06/2021	Actions to reduce risk need development	15/11/2021 The Annual Ligature Audit Wondow will be undertaken thorugh November. There is a high level of confidence this risk is well manged as evidenced through the Quality Digest and IQPR data.																
4083	Dec 2014	Executive Director of Nursing, AHPs and Quality	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Refreshed Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool. — Deputy Director of Nursing — 30/11/2021 — A Annual Ligature Audit (Undertaken in November) — Deputy Director of Nursing — 18/01/2022 — A	Executive Director of Nursing, AHPs and Quality		1	4	4	31/03/2022
	28/04/2020 Risk Opened 04/06/2021	Performance Metric: Met Risk is well controlled but continues to be actively monitored and managed while we are in response to the Pandemic.	15/11/2021 Risk continues to be well controlled. It will remain actively monitored and managed while we are in response to the Pandemic.																
6420	Apr 2020	Executive Director of Nursing, AHPs and Quality	**COVID 19 Personal Protective Equipment** IF there are not adequate national stocks of COVID-19 PPE provided through the National Supply chain to NHS organisations THEN there is a risk that Trust Staff (including contractors, partners and volunteers on trust sites) will not have access to appropriate PPE RESULTING IN a failure of the Trust to comply with Health and Safety regulations which may lead to increased staff sickness and unions instructing staff to withdraw from the working environment which in turn will impact on the health and safety of patients.	3	4	12	National: National Stockpile of PPE National Daily Situation Reporting from Trusts to DoH National Exception reporting for PPE National/Regional Mutual Aid Agreement Regional: Kent and Medway Strategic Co-ordinating Group Kent and Medway Tactical Incident Control Centre Regional Distribution centre within Kent and Medway for COVID-19 PPE Mutual Aid between Partners in Kent and Medway Trust: Central Procurement strategy for COVID-19 related PPE, Managed by a Trust Director Link between Business intelligence and procurement to identify new suspected and confirmed cases by location Dedicated procurement contact email address Centralised stock and buffer store Trust tactical control meetings held three times a week (and assessment prior to any bank holiday period) Dedicated drivers for PPE logistics (department of Transport contact details should further logistical support be required) Policies, procedures, real time circulation of new/updated guidance via tactical control Product reviews prior to acceptance of product into the organisation. Dedicated tactical control contact details with ICC open 08:00-20:00 daily. Fit testing, Donning and Doffing and Hand Hygiene Training	Stock management system that is reported nationally. Local review of buffer stock annually from October 2021 with stock rotation as appropriate	1	4	4	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** No further actions identified	Executive Director of Nursing, AHPs and Quality		1	4	4	23/05/2022
2 - Recruit, retain and develop the best staff making KMPT a great place to work																			
	17/11/2021 Risk Opened																		
6847	Nov 2021	Director of Workforce and Communications	**Sickness** IF we fail to support the health and wellbeing of our staff THEN this will impact on the sickness absence rate RESULTING IN reliance on agency staff, increased cost and potentially lower quality service to patients	5	4	20	Health & Wellbeing Group [2a] Range of targetted support and leadership Musculosketal health and screening Mental wellbeing and stress support Tobacco control Physical activity and active travel Healthy eating and healthy weight Alcohol and substance misuse support Winter wellbeing messaging Health and Wellbeing Conversations [1a]	Monitoring locally, reporting to IQPR Report to WF&OD Committee	4	4	16	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Targetting communications — H&WB lead — 3/31/2022 — A Supporting managers through absence management cases — Deputy Director of Workforce and OD — 3/31/2022 — A Flu vaccination programme — Director of Workforce and OD — 2/28/2022 — A Covid vaccination programme — Deputy Director of Workforce and OD — 3/31/2022 — A	Director of Workforce and Communications	To be confirmed	4	4	16	31/03/2022

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
			17/11/2021 Risk Opened																
6848	Nov 2021	Director of Workforce and Communications	**Staff Turnover** IF we have high turnover in Additional Clinical Services and Allied Health Professionals THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e] Buddy Approach [1f]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways — OD Specialist — 31/03/2022 — A Quarterly People Pulse — Director of Workforce and Communications — 31/03/2022 — A National Staff Survey — Director of Workforce and Communications — 31/12/2021 — A Recruitment and Retention group have workstreams to support retention — HR Business Partners — 31/03/2022 — A	Director of Workforce and Communications	To be confirmed	4	5	20	31/03/2022
			17/11/2021 Risk Opened																
6849	Nov 2021	Director of Workforce and Communications	**Retention of Employees** IF we do not retain our employees in additional professional scientific and technical group and allied health professionals group THEN this would impact on staff morale, recruitment, turnover, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1e] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e] Buddy Approach [1f]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways — OD Specialist — 31/03/2022 — A Quarterly People Pulse — Director of Workforce and Communications — 31/03/2022 — A National Staff Survey — Director of Workforce and Communications — 31/12/2021 — A Recruitment and Retention group have workstreams to support retention — HR Business Partners — 31/03/2022 — A	Director of Workforce and Communications	To be confirmed	4	5	20	31/03/2022
3 - Put continuous improvement at the heart of what we do																			
			25/01/2019 Risk Opened — 04/06/2021: This risk is required as part of the EPRR assurance process. Risk actions require development to evidence the ongoing monitoring and update of response plans and will reflect any learning from the covid -19 pandemic. Surge testing is in place to track spread in areas seeing increasing rate of infection — 06/09/2021: Rolling tactical control rota for the Trust is being maintained aligned to NHS command and control arrangements for monitoring and response functions. — 15/11/2021: **NHS command and control arrangements continue, Trust monitoring and response functions continue to align. Staff encouraged to have their Covid booster vaccinations in addition to seasonal Flu vaccination, and uptake is monitored.**																
5989	Jan 2019	Executive Director of Nursing, AHPs and Quality	**Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK and national command and control arrangements THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical and mental health of clients	3	4	12	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Significant Incident Plan [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g] Timely Trust adoption of new centrally provided guidance relating to the specific disease [3b] Engagement with Vaccination Programme Engagement with Surge testing requirements	Significant incident plan which provides Trust Command and Control linking into the system Command and Control, regional and national Physical Health Nurses in place Access to Cloud now widely available to staff Business Continuity Plans in place Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance	3	3	9	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Continued compliance with national IPC guidance — Infection prevention and control — ongoing — A Screening Programmes (lateral flow testing and PCR testing for both staff and patients) — Infection prevention and control — ongoing — A Fit testing and use of PPE — Infection prevention and control — ongoing — A Maintain a rolling tactical rota aligned to NHSE response — EPRR Lead — ongoing — A	Executive Director of Nursing, AHPs and Quality		2	3	6	29/07/2023
			02/03/2021 Risk Opened — 04/06/2021: Actions to reduce risk and top 5 Assurances need development — 06/09/2021: **The risk description has been updated to reflect where the government roadmap is with relation to easing of lockdown. The Trust continues to have work from home direction in place and infection prevention and control measures in place on all trust sites.**																
6623	Mar 2021	Executive Director of Finance	**Easing of Lockdown National Roadmap - Agile working** IF the national roadmap for easing of lockdown leads to staff returning to pre pandemic working practices THEN staff may conclude that they can return to work in Trust buildings RESULTING IN the Trust not maintaining the new ways of working (agile working) that have been developed during the national pandemic and not delivering on the Trust estates strategy to use our buildings more efficiently and effectively.	3	4	12	Agile working group Communications re continuation of work from home Covid secure SOP Restriction on number of staff in rooms against risk assessment Use of face masks on trust sites	Reporting through Agile Working Group EAC oversight	2	4	8	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop Agile Working Policy — Executive Director Partnerships and Strategy — 31/01/2022 — A	Executive Director of Finance	To be confirmed	2	2	4	27/02/2022
4 - Develop and extend our research and innovation work																			
			10/08/2017 Risk Opened — 04/06/2021: Recruitment to Research and Innovation Director post was successful. Candidate due to start in September. Further sources of assurance need to be identified. — 06/09/2021: Research and Innovation Director due to start mid October. Actions identified are currently on hold and will be picked up under their leadership. Some research activity/ participation in drug trials has been paused due to team capacity. — 15/11/2021: **Research and Innovation Director is now in post. The research and Innovation strategy is on track for ratification ahead of March 2022**																
5345	Aug 2017	Executive Medical Director	**Participation in international research & innovation** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment and tendering and patient choice.	3	2	6	R&D links across the organisation in line with the Research & Development Strategy [2e] Research & Development SoP [2e] Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b] Annual report to the Board [3a] Report CRN clinical research network [3e]	National Clinical Research governanace arrangements Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee minutes	3	2	6	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recruitment to Research and Innovation Director post — Afifa Qazi — 29/10/2021 — G Increase in funding for research and innovation team — Sarah Dickens — 29/06/2022 — A Ratification of research and Innovation Strategy — Afifa Qazi — 19/03/2022 — A	Executive Medical Director	To be confirmed	1	1	1	17/10/2022

				Initial rating				Current rating						Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
5 - Maximise the use of digital technology																			
23/07/2020 Risk Opened 04/06/2021 — Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 — Digital Business partners are attednig clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this. 15/11/2021 — Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy.																			
6495	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	3	2	6	Trust board commitment and approval (3a) Digital business partners allocated (1g) reviewed at ICTSMT monthly (1a)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	2	1	2	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Digital Business Partners to attend clinical meetings — Head of ICT — 29/03/2024 — G Recruitment of Change Leads — Head of ICT — 31/01/2022 — A	Executive Director of Finance	To be confirmed	1	1	1	31/03/2023
6 - Meet or exceed requirements set out in the Five Year Forward View																			
			No Risks Identified against this Strategic Objective																
7 - Deliver financial balance and organisational sustainability																			
01/04/2020 Risk Opened 04/06/2021 — Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. 06/09/2021 — This risk has been affected by a change in capital funding allocation and the risk score has been increased to refelct the impact this will have on the capital projects underway																			
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose and a potential for an increasing backlog.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Ensure Capital Plan reflects backlog maintenance and services priorities, as well as implementing standing orders and SFI's for robust financial management — Director of Estates and Facilities — To be Advised Provide comprehesive report to Trust Capital Group. — Director of Estates and Facilities — To be Advised	Executive Director of Finance	To be confirmed	2	3	6	31/12/2021
10/03/2021 Risk Opened 06/09/2021 — As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.																			
6628	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. A 4 % efficiency target has ben set to start to tackle the underlying deficit.	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deep dive into Acute Care Group Service line reporting. This has been discussed at the check challenge and support meetings with the DOF and COO. — Head of Service — 29/10/2021 — G Establish new CIP Programme. This is being embedded in the organisation — Deputy Director of Finance — 30/06/2021 — G Complete full budget setting — Deputy Director of Finance — 30/07/2021 — G Corporate benchmarking into Governanace and Risk. This will support a more up to date benchmarking in the Autumn — Deputy Director Quality and Safety — 30/07/2021 — G	Executive Director of Finance	To be confirmed	3	3	9	31/03/2022
17/11/2021 Risk Opened																			
6850	Nov 2021	Executive Director of Finance	**H2 Planning** IF the Trust fails to deliver on the H2 financial plan THEN the Trust could fail to deliver the Trust control total of a break even position in the current financial year. RESULTING IN an increased risk that the Trust doesn't break even. This will also have an impact on the Trust ability to deliver long term financial sustainability	4	3	12	CIP Process [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 Care group efficiency targets	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] QPR Meetings [2a]	3	2	6	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Introduction of new agency controls to reduce care group agency spend — Deputy Director of Finance — 06/12/2021 — A Agency use reporting via new weekly meeting — Executive Director of Finance — 21/01/2022 — A	Executive Director of Finance	To be confirmed	2	2	4	31/03/2022

				Initial rating					Current rating					Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
8 - Develop our core business and enter new markets through increased partnership working																			
			01/10/2017 — Risk Opened — 04/06/2021 — Actions to reduce risk need development — 06/09/2021 — The Trust continues to work with Sussex Partnership Trust to ensure that the five workstreams are effective and allow the provider collaborative to be sustainable on a long term basis.															
5456	Oct 2017	Executive Director of Finance	**Provider Collaberative (New Care Models) - Secure Services** If we do not deliver on the objectives of the Provider Collaborative for KSS, for example achieving repatriation and reducing Length of Stay THEN the forensic services may not be able to sustain the investment in the community services and the overall provider collaborative may not be sustainable on a longer term basis. RESULTING in a risk to the sustainablity of the Provider Collaborative	3	5	15	Clear governance process established for the New Care Models (NCM) [1f] The DoF is the Executive Lead and attends the NCM Board and sub group [2f] The Trust are also part of the activity modelling group [2f] Financial governance (1g) Quality assurance processes (1f) Strategic Partnership with Surrey/Sussex Partnership (2f) Partnership working with 3rd party providers (2f) On-going service evaluation & audits (2d) Board oversight (3a) Peer network and other 3rd party assurance (3e)	Numerous quality audits are carried out within the service Regular inspections by CQC take place NHSE evaluation of performance	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deliver care pathway within financial envelope and to required quality standards / Head of Forensic Psychological Services / 31/03/2022 / A	Executive Director of Finance	To be confirmed	1	4	4	31/03/2022
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																			
			10/03/2021 — Risk Opened — 04/06/2021 — Actions to reduce risk need development and top 5 assurances need to be identified. — 06/09/2021 — Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide support for the delivery of identified priorities.															
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2024** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2024 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	9	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	3	2	6	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans / Lead Executive Director and Trust Secretariate / End September / A Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021 / Executive Director Partnerships and Strategy / November 2021 / A Review of strategy delivery plan trajectories to final quarter 2021/22 / Executive Director Partnerships and Strategy / January 2022 / A	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	10/03/2022

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	Mental Health Learning Disabilities and Autism Improvement Board Update
Author:	Catronia Toms – (Assistant Director of ICP Development)
Executive Director:	Vincent Badu (Executive Director Strategy and Partnerships / Deputy Chief Executive)

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview update for Board on:

a) Current headline improvement plan for each of the key priority areas identified by the Mental Health Learning Disability and Autism Improvement Board (MHLDA IB), with the actions and timescale.
b) Updates on additional areas overseen by the MHLDA IB in the last quarter

Issues to bring to the Board's attention

The MHLDA IB and associated governance has been commended by the Integrated Care Partnership and the NHSE/I Regional Director as a model for the delivery of system improvements across Kent and Medway. A revised governance and supporting structure is in development in line with the transformation of the integrated care system aligned to the Department of Health and Social Care White Paper: Integration and innovation: working together to improve health and social care for all. This will be taken forward in Q4 2021/22.

The MHLDA Improvement Board has received an update on the activity of and the re-procurement process for Live Well Kent and Medway, integrated commissioned mental health and wellbeing service, which will take place during 2022 and remain a key interface with the Community Mental Health Framework Transformation. Agreement on the value and contribution of the service to the mental health and wellbeing of people in Kent and Medway was recognised with the total number of individuals supported in 2019/20 reported as 6241.

Work has been completed in partnership with Provider Collective to assist the MHLDA Improvement Board with establishing a positive and proactive engagement framework with voluntary and third sector partners.

Governance

Version Control: 01

Implications/Impact:	Impact on patient care and partnership working
Assurance:	Reasonable
Oversight:	Oversight by MHLDA Improvement Board and ICS Partnership Board

Version Control: 01

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Mental Health Learning Disability and Autism Improvement Board Update

The Mental Health Learning Disability and Autism Improvement Board (MHLDA IB) was established in October 2020 to provide leadership, oversight and partnership working to improve the mental health and mental wellbeing outcomes of the population of Kent and Medway.

The board brings together senior representatives from across the integrated care system (ICS), to work collaboratively to drive delivery of Mental Health Learning Disabilities and Autism Improvement priorities at scale across Kent & Medway. There is currently a governance review of ICS structures which will see the MHLDA IB evolve with a new reporting framework proposed in 2022.

Operating as a strategic board, the MLDA IB supports the development of the vision, outcomes, purpose and scope of Kent and Medway Mental Health Strategy, and alignment with the NHS Long Term Plan priorities.

The current Board structure now includes a quarterly assurance meeting with NHSE/I regional colleagues focussed on areas of concern in Kent and Medway with respect to national targets.

The work to improve rates of annual health checks for people with learning disabilities was commended by NHS region in July 2021 – for 2020/21 this exceeded the nation target of 70% at 72%.

Work continues on the key workstreams with current system improvement priorities focused on Dementia Diagnosis Rates, Children and Young People's services, Community Mental Health Framework place/system transformation and Physical Health Checks for Serious Mental Illness (SMI).

During the past quarter the MHLDA Improvement Board has also provided strategic oversight for the Kent and Medway Better Mental Health Programme which includes the development and implementation of the Pledge aligned to the National Prevention Concordat and the Kent and Medway Listens programme which is integral to the trust strategic plan to improve the health of our communities.

Version Control: 01

MHLDA IB - Improvement Priorities Overview

During this quarter the MHLDA Improvement Board has focused its strategic influence, support and assurance activity on the following key priorities which were identified via the overview dashboard as requiring specific improvement plans to achieve national and local targets. Work to develop the dashboard to report at a placed based partnership level in additional to system level is in development.

Priority Area	Kent & Medway System Target / Performance Q1-2	RAG Rating	Comments
Dementia Diagnosis Rate (DDR)	National Target - 66.7% Q2 Sept 2021 - 57.3%		Improvement plan in place to increase delivery capacity Trajectory evidencing ongoing improvements
Children and Young People's Services (CYP)	17,703 CYP accessing services by March 2022 Q1 June 2021 - 16,915		Recognition of increasing demand – Improvement plans in place to address going forwards
Community Mental Health Framework Transformation	National KPIs are established for post implementation delivery only Programme implementation is progressing to planned milestones. Financial spend is below projections		• Delivery groups established • Programme Business and Finance group to be established to progress spend – currently funding stream returned to CCG to support governance • Local service delivery model to be finalised November 2021
Physical Health Checks for Serious Mental Illness	National 60% Target Q2 Sept 2021 - 18.3%		Improvement plan in place to address key issues of: • capacity • system interoperability
Out of Area Placements	Inappropriate OoAPs (general overspill bed days) to be eliminated by 2020/21 Trajectory in place to achieve by 2021/22 September 2021 was at 205 bed days against a trajectory of 97		Improvement plan in place to address • Delayed Transfers of Care (DTOC) • improve patient flow • service availability i.e. for Psychiatric Intensive care beds

1 Dementia

1.1 Dementia Diagnosis Rate (DDR):

Kent and Medway agreed target is 66.7% by March 2023 with a monthly improvement trajectory agreed – September 2021 figure is 57.3%.

DDR Improvement Plan:

- **Diagnosing Advanced Dementia Mandate (DiADem)**: Dr Katie Collier and Mark Kitchingham, trainee Advanced Clinical Practitioner (ACP) and Non-medical Prescriber (NMP) have hosted recorded evening education session on diagnosing dementia in local care using DiADem to support local care diagnosis.
- **GP with Enhanced Role Pilots**: 10 GPs have been recruited to undertake training with Bradford University and mentoring from Memory Assessment Service to increase diagnostic capacity and peer support in Primary Care.

Version Control: 01

- **Memory Assessment Service**: Short term weekend initiatives to increase capacity in 2021/22. Long term initiatives include: QI projects that focus on improving productivity and advanced clinical practitioner development. Kent and Medway ICPs are being asked to consider co-locating MAS clinics delivered by primary and secondary care in the Community Diagnostic Hubs to reduce stigma and provide one-stop clinics where appropriate and requested by patient.

2 Children and Young People's Services

2.1 **Service Access:** The Kent and Medway target is 17,703 CYP accessing services in the 12 months up to March 2022 - currently on plan to achieve the target at 16,915 rolling 12-month target (June 2021).

Access Improvement Plan:

- **Recruitment** of joint strategic transition lead, lived experience lead and participation workers.
- **Clinical Lead role** to be identified and provided by AMHS.
- **NHSE/I CYP Event for CCGs, LAs, Public Health and VCSE Leaders**- Exploring opportunities for rapid expansion with VCSE
- **Pilot outreach projects** to support particularly vulnerable young adults
- **Care Leaver service engagement** to build up the offer for this cohort
- Engagement with **Student Wellbeing programme**, **Community Transformation** and **Suicide and Self-harm Prevention programme** to align work plans
- Contribution to the HEE peer-support mapping programme to mitigate future workforce risk
- Continued collaboration with partnership organisations to map services/community assets within ICP geographical areas and aligned to the Thrive framework
- Specialist Bereavement Service contract will commence (accepting referrals from September 2021), supporting people aged up to 25 years old.
- LTP refresh to include Young Adults (transition, capacity and innovation)
- Final consultation and engagement with young people/families/clinicians regarding the offer of a comprehensive service for 16-25-year olds report is due.
- NELFT, KMPT and CCG have agreed initial integrated approach to developing and delivering 16 to 25 work stream
- Trauma-informed approaches training for the 18-25 workforce is underway in Kent and Medway.
- Collaboration with strategic vision and opportunities within the VCSE commissioning system.
- Thrive framework for system change presented at series of cross sector engagement events
- Dedicated data analyst support in place to support providers of services for people aged 18 and above to submit data to NHS Digital's Mental Health Services Dataset.

2.2 **NHS LTP target:** By 2020/21, 35% coverage of 24/7 crisis provision for CYP which combine crisis assessment, brief response and intensive home treatment functions rising to 57% during 2021/22, 79% during 2022/23 and 100% during 2023/24.

LTP Improvement Plan:

- KMPT and NELFT have secured funding from CCG for a joint transition post pilot (12 months) to support transition from CAMHS to Adult MH services – post holder to start 22.11.2021
- Implement a collaborative and system-approach to the crisis pathway development work
- The Crisis service provide assessment in a variety of settings
- Deliver comprehensive planning phase to test, pilot and develop an implementation plan (including trajectories) to meet targets.
- Ensure that there is a provision of support, advice and triage to CYP and families/ carers during an episode of crisis.
- The recommendations identified within the liaison mental health service audit (November 2019) are actioned
- Review the capacity of the local VCS partners to work on crisis services & associated services including design, development and delivery of the commissioned services.
- Access available funding streams to secure additional finances to compliment the CYP Crisis offer.

3 Community Mental Health Framework Transformation

The programme is well established, with a large number of organisations and people engaged in the work. Whilst a large programme it is encouraging small tests of change to progress to begin testing new ways of working and will build positive changes into the overarching Kent wide system changes.

There are key risks to be noted mostly in terms of available workforce, ensuring transformation occurs with little or no residual overspend alongside an ability to spend the available funds in a timely manner. NHSE/I is sighted on some of the concerns across the country in terms of ability to spend in year however continue to push hard for the service redesign to occur as quickly as possible**.**

3.1 Eating Disorder Services

- Working group established
- Regular meetings with NHSE/I
- Business Case presented to the CMHF Oversight Group on 26th August for feedback and now awaiting approval.

3.2 Community Rehabilitation Services

- Working group established to include the VCSE and Social Care/Local Authorities
- West Kent identified as the first area to transform Community Rehabilitation services – WK Health and Care Partnership (previously ICP) JPMO engaged
- Reviewing other providers' contributions to the delivery of Community Rehabilitation services and exploring the voluntary sector and how they can support in the delivery of services in the new model.

3.3 18 to 25 Services

- 18-25 years working group established with lead from the CCG
- Lived experience role has been recruited specifically for the young adult's cohort
- Joint role between KMPT and CCG has been recruited for transition across CAMHs and Adult services

- Developing the pathways between KMPT and NELFT to support the transition process for example by the use of a “buddying scheme”

3.4 Additional roles reimbursement scheme (ARRS) Mental Health Practitioners in PCN

- Recruitment in place jointly with trailblazer PCNs funded through Mental Health Investment Standard in Year 1 (2021/22)
- Business case for sustainment and growth in development for 2022/23 and 2023/24
- Roles will act as bridge between PCNs and CMHF

3.5 Medway and Swale Core Services Community offer

The PMO is working closely with the Medway and Swale ICP (now called Health and Care Partnership)

Key highlights:

- Established local group with engagement from VCSE, local authority and GPs
- Identification of task and finish groups: mapping services, pathways, workforce and data and digital
- Draft model created
- Care connector roles are being explored to be piloted in Medway and Swale
- Business case for care connector roles presented at the Oversight group on 7th Oct and awaiting approval subject to refining of delivery model
- Kent and Medway Care Record (KMCR) identified as the best system to drive forward collaborative working and to hold the shared care plan
- The CMHT and CMHSOP leadership engaging proactively with the programme to deliver change
- Medway CMHT has begun a small test of change with Livewell Kent completing joint assessments to reduce “bounce back” of referrals
- Initial meetings with Recovery College and Individual Placement Support programmes to discuss integration into the delivery model
- Workshop on 6th Oct with over 35 attendees to develop the high-level delivery model
- Focus groups to review model/pathways have been set up for the first two weeks of November with the new Clinical Director to fully describe an end to end delivery pathway across providers

3.6 Programme KPIs:

The following outcome measures will be used nationally and locally applied to measure performance of our new ways of working – this are being embedded in the delivery planning and will develop existing performance:

- 4 week wait from referral to first ‘meaningful intervention’ (***clock starts***- First contact for mental health need in primary care, ***clock stops***)
- A comprehensive biopsychosocial assessment, **and**
- Co-produced personalised care and support plan, **and**
  - Have received meaningful intervention (e.g. Course of psychological therapy), **and**
  - The recording of first outcome measure (e.g. Via DIALOG+)

4 Physical Health Checks for Serious Mental Illness

In Kent and Medway there are 12,143 people with SMI – 60% of people on GP SMI registers should have a comprehensive physical health check in any setting at least once a year. This is a minimum of 8,393 people with serious mental illness receiving the 6 core physical health checks in 2021/22.

In Q1 2021/22 the improvement trajectory is 15% with a performance of 13.3% reported. Note: Data reported is 2 months behind and therefore does not represent the current % for Q1 which is at 16.8% and 24.3% with KMPT data from secondary care - this is being addressed through the interoperability project.

Improvement Plan:

- Providers agreement for a collaborative way of working and to focus on achieving and supporting the improvement trajectories and milestones across K&M.
- Funding of £630K for interoperability for PH-SMI across the South East as currently the data does not flow into primary care electronically. This work began end of June 2021 and is supported by SE Digital team and NHSX.
- Business Case from KMPT approved for additional support roles in CMHT to undertake physical health checks.
- All Providers asked to identify increased funding requirements by July 2021.
- A programme digital lead has been recruited to address the interoperability issues, this project commenced 20/09/21 and will run to March 2022. All stakeholders have been identified. The PM has put together the action plan and milestones/timeline for improvements. Technical solutions testing will be completed by Nov 21 and it is expected that refined technical configuration based on results of testing will go live in Dec 2021.

5 Out of Area Placements

5.1 Reduction to zero trajectory: Deliver and maintain the ambition to eliminate all inappropriate adult and older adult acute admissions out of area by end of 2021/22 (noting ambition to eliminate by end of 2020/21 was not met)

Improvement Plan:

- **Delayed Transfer of Care** (DTOC) – the CCG and KCC have jointly funded a project manager role for 6 months to focus on a defined cohort of DTOCs to identify specific actions. In addition, utilise Spending Review Discharge Funding to develop posts to support timely discharge and reduce risk of readmission.
- **Acuity** – check and challenge need for admission vs alternative to admission
- **Psychiatric Intensive Care Unit (PICU)** – consider expanding the contract for some male beds and additional female – will require funding. Awaiting decision from NHSEI re Winter Monies
- **Bi weekly oversight** by the CCG with KMPT Patient Flow to support delivery plan
- The weekly OPEL and DETOC reports will inform progress for DETOC and PICU and as such are indicators of the pressures on the K&M acute beds

Additional areas of focus

6 Prevention Concordat (Kent and Medway Better Mental Health)

In Dec 2020, the MHLDA Improvement Board agreed that Kent County Council's Public Health team should work with KMPT and other partners to lead work to ensure that the Kent and Medway ICS becomes a signatory to the national Prevention Concordat programme.

The aim of the Prevention Concordat is to provide a structure for cross-sector action to deliver an increase in the adoption of public mental health approaches across local authorities, NHS, private and voluntary sector organisations, education and employers.

Prevention Concordat Network was established in Feb 2021 and over 40 organisations have joined the Network to date. Quarterly meetings have been held since and a Chair has been recruited from a VCS organisation to ensure that the Network is not dominated by statutory partners.

Three key areas are being taken forwards:

- Engagement with, and listening to, seldom heard communities across Kent and Medway
- The Kent and Medway Better Mental Health Pledge
- Ensure that the Kent and Medway ICS becomes a signatory of the national Prevention Concordat

7 Recommissioning of the Community Mental Health and Wellbeing Service (Commonly known as Live Well Kent)

In line with national guidance and the NHS Five Year Forward View, KCC and Kent CCGs jointly commissioned an integrated offer of community mental health and wellbeing support, which came to be known as Live Well Kent (LWK). The vision for LWK is to keep people well and provide a holistic offer of support for individuals living with and without a mental health diagnosis. The service commenced on 1 April 2016 and will run to 31 March 2023. 5+2 years Contract term.

Although this is a jointly funded service between KCC and K&M CCG, KCC hold the Contracts with the Strategic Partners and are responsible for the performance management and pay 77.78% of the contract. The money is part from Kent Adult Social Services and Kent Public Health.

A comprehensive service review was conducted in 2019 and confirmed the value of continuance of the service. KCC commissioners responsible for the management of the Contract completed a comprehensive market analysis which aimed to provide the evidence base to inform decision making around any consideration of future Contract arrangement post March 2023.

Service		2019-20
Community Mental Health and Wellbeing Service	Live Well Kent	4860 Referrals 3709 Sign-Ups Total number of individuals supported = 6241 19/20 average weekly caseload = 2499
	Mental Health Housing Related Support	Reporting began in Q3 2019/20 – the total number of individuals supported in Q3 an Q4 19/20 was 284 256 Units
	24-7 Telephone and Online Support Service for Kent and Medway	25,979 Answered calls
	Debt Counselling	105 individuals supported
	Charlton Athletic early Intervention and Psychosis Support for Young People for Kent.	179 individuals supported

The market analysis concluded that considering the evidenced need for community mental health and wellbeing services in Kent, it is recommended KCC continue to fund and commission a service which meets current and future demand.

The market analysis also recommended that KCC continue to work in collaboration with K&M CCG to jointly commission the service. Future commissioning needs to be informed and aligned to the Community Mental Health Transformation Programme and wider Wellbeing commissioning and delivery in Kent and Medway.

Version Control: 01

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	KMPT Strategy Delivery Plan 2021/22- half year report
Author:	Martine Mccahon (Assistant Director Transformation and Improvement)
Executive Director:	Vincent Badu (Executive Director Strategy and Partnerships / Deputy Chief Executive)

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

The agreed framework is for individual sub committees to have oversight of delivery of the KMPT's 2021/22 Strategy Delivery Plan. This Board report provides a summary of this oversight against quarters 1 and 2. It notes good progress, challenges and the key areas of focus for coming year.

Issues to bring to the Board's attention

Items of excellence – quality improvement awareness target year achieved; zero staff with a disability went through the disciplinary process, 71% annual health checks (AHC) for people with learning disability and autism, peer support workers increase from 40 to 80; specialised services as part of the NHS-led Provider Collaborative Occupied bed days in year performance remains positive for Kent patients

Items of concern and hot spots;

- performance of percentage of ward staff trained in Broset Checklist tool to improve patient safety – 25% achieved against trajectory of 50% resulting in variance due to pressures of Promoting Safe Services (PSS) team; safety pod Trust-wide implementation and Restraint Reduction Network training standards. Oversight and monitoring of risks and performance is undertaken by Quality Committee
- performance for Clinician Reported Outcome Measure (CROM) Health of the Nation Outcomes Scales (HoNOS) and Patient Recorded Outcome Measures (PROM) Recovering Quality of Life (ReQoL). Variance to trajectory includes technical issues with collecting feedback from patients. Oversight and monitoring of risks and performance is undertaken by Quality Committee
- there is negative variance to trajectory for turnover and sickness. We will not meet the year end sickness target and there is a risk turnover may not meet the end of year target. Although there is variance to trajectory for sickness this is an improvement year on year with the exception of last year. Turnover is an improving picture year on year and turnover performance has improved compared to last year. Oversight and monitoring of risks and performance is undertaken by Workforce and Organisational Development Committee

Version Control: 01

Governance

Implications/Impact:	Ability to deliver Trust Strategy.
Assurance:	Reasonable
Oversight:	Oversight by Quality Committee, Finance and Performance Committee, Workforce and Organisational Development Committee and Board

Version Control: 01

NHS
Kent and Medway
NHS and Social Care Partnership Trust

STRATEGIC DELIVERY PLAN (REVIEW QUARTER TWO 2021/22)

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
1a. Embedding quality improvement	Executive Medical Director Quality Committee	• 25 QI projects completed with learning shared across the organisation • 350 staff trained in bitesize QI modules • 800 staff attended QI awareness events	• 5 completed QI projects ○ 83 multi professional staff trained in bitesize QI modules. Clinical Director for QI recruited and in post • Relaunched I Connect web pages and with QI tools live • Review of active QI projects and measurable outcomes		• Complete further 20 QI projects • Scale up projects across the trust • QI annual celebration and learning event • Submission of QI work for publication • Further engage with research and audit department to streamline approaches
1b. Successfully deliver our 3 Quality Account priorities	Executive Director of Nursing, AHPs & Quality Quality Committee	Patient Safety • 95% of ward staff trained in Broset Checklist tool Patient Experience • 95% of patients have a copy of their crisis plan and care plan • Patient Recorded Experience Measure (PREM) score 8/10 and above Clinical Effectiveness • Improved clinical outcomes across care groups from 41% to 75% CROM (HONOS) from 2.7% to 50% PROM (REQOL)	Patient Safety • 25% of staff have been trained on participating wards Patient Experience • 89.5% of Care Programme Approach (CPA) patients had received a care plan. Clinical Effectiveness • Clinician Reported Outcome Measure (CROM) Health of the Nation Outcomes Scales (HoNOS) 43% for community and 35.8% for inpatient, Acute care group community is the highest at 71.2%. Patient Recorded Outcome Measures (PROM) Recovering Quality of Life (ReQoL) 7.7% for community and 9.3% for inpatient.		• Roll out of Safety Pods throughout the Trust • Enhance e learning training offer • Safe Care champions facilitating team-based training • Improve capturing and recording risks • Peer support worker champions • Share learning across the Trust • New Clinical lead focus on PROM completion

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
2a. Collaborate to deliver sustainable services and improved care for service users, carers and families	Executive Director Partnerships and Strategy Trust Board	Alignment of pathways to reduce disjointedness and reduce health inequalities in line with NHS Long Term Plan	• Physical health checks 18.3% Q2 2021/22 against an improvement trajectory of 18% • Annual health checks achieved 71% against a target of 67% for year end 2020/21 • Current dementia diagnosis rate position in September 2021 is 57.2% which is above NHSI/E agreed improvement trajectory • Open Access Crisis Project is now a partnership across Kent and Sussex for delivery of crisis support, alignment with NHS 111 agreed across all partners for October 2022		• Physical health checks; address interoperability issues and deliver additional resource • Dementia; deliver improvement plans
2b. Delivering improvements to population health and outcomes through innovation and transformation	Executive Director Partnerships and Strategy Trust Board	Strong community engagement on Prevention Concordat for public health and mental wellbeing. • 5000 people across Kent & Medway engaged in listening events • Community Mental Health Framework-redesign milestones delivered • 43 Primary Mental Health Care Practitioners new roles developed in partnership with	• Prevention Concordat network has schedule of quarterly meetings with multi-agency partnership. Kent and Medway Listens for better mental health launched. 4 Integrated Care Partnership (ICP) level community providers commenced delivery and targeting seldom heard populations across Kent and Medway. • CMH Transformation Programme established, recruitment complete and Clinical lead in post. Memorandum of Understanding approved with partners in lead ICP area. Medway and Swale ICP delivery workstream and task and finish groups established. Positive feedback on Kent Medway implementation		Additional ARRS recruitment to support Primary Care & PCNs CMH Framework governance and aligned lead provider model in place to support redesign

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
		Primary Care Networks.	plan and stage of progress received from NHS England National Team • Additional Roles Reimbursement Scheme (ARRS) - 11 mental health practitioners recruited with target to have 42 practitioners in place by end 2022/23. • ARRs contract developed and in sign off with all relevant PCNs – KMPT lead provider. • KMPT fully engaged in the Population Health Management Action Learning Sets across the system. Influence has enabled inclusion of mental health criteria to the majority of selected cohorts at ICP place and PCN neighbourhood levels		
3a. Looking After Our People by creating the Perfect Day and delivering the People Recovery Plan	Director of Workforce & Communications Workforce and OD Committee	• Reduced sickness absence from 4.22% to 4% • Reduce turnover from 10.5% to 9% overall • Improved retention rate from 86% to 90% • 20 more Mental Health First Aiders • Improved staff survey result	• Sickness absence overall year to date (excluding Covid), 4.37%. • Turnover overall year to date, 8% against a target of 9% comprising additional clinical services (ACS) 11.6% against 10% target; nursing 6.2% against target of 9%, and medical 8.7% against target of 8%. • Retention rate overall year to date, 89.3% comprising ACS 87.9% against 90% target; nursing 91.5% against target of 91%, and medical 88.8% against target of 92%. • Mental Health First Aiders: 44		A number of initiatives to reduce sickness absence, turnover and improve retention rates are underway, through the Vacancy Challenge work

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
			• Staff survey: data not available until January 2022		
3b. Encourage Belonging by becoming a fully diverse and inclusive organisation with anti-discriminatory behaviour	Director of Workforce & Communications Workforce and OD Committee	Workforce race equality standards (WRES) performance improved by 31/8/22 • Indicator 5: from 44.3% to 34.4% • Indicator 6: from 25.5% to 17.5%	• Workforce race equality standards (WRES) indicator 5: 42.9%, Indicator 6: 23.4% • Workforce disability standards (WDES) Metric 3 - zero staff with a disability went through the disciplinary process		• 'Being an anti-racist organisation' virtual events • Staff Network event
3c. New ways of Working and Delivering Care by creating innovative Workforce Modelling for the future, delivering Brilliant Care	Director of Workforce & Communications Workforce and OD Committee	Leadership and implementation of structured plan for workforce remodelling • New workforce model • Expenditure on use of locum/agency staff reduced by £2M • Test for change extended hours in Community Mental Health Teams • Tests for change – peripatetic model	• Non-medical consultant practitioners (NMCP) 3; non-medical responsive clinicians (NMRC) 0; qualified advanced clinical practitioners (ACP) 4; ACP trainees 6, peer support workers (PSW) 63; nurse consultants (NC) 1 • Agency spend 21/22: data will only be available in April 2022 at year end. monthly agency control groups being set up with Director of Finance, Director of Workforce and OD, Medical Director and Heads of Service, with additional weekly medical agency meetings to include Clinical Directors • Extended community mental health team hours: proposal has now been approved and implementation is being designed.		• Care Groups developing trajectories for these roles and as part of workforce planning • Community strategies in place for hours and role redesigns

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
			• Specialist community nurse posts: 6 teams have them in post with 2 more being appointed • Peripatetic model: Tackling the Vacancy Challenge group assessing other options for workforce modelling innovations		
4a. Continue to implement the Clinical Technology Strategy	Executive Director Finance & Performance Finance & Performance Committee	Improved delivery of digitally enabled care • Video consultations • Roll out of E-Meds (Interface between Civica and RIO (paper processes ceased) • Real time bed management information (FLOW) • Mobilising RIO	• Emeds Project behind based on original timeline but has now restarted following finding an interface solution between Rio and EMeds and subsequently an in-house solution is being developed. The UAT sessions will start on the 15th of November, with a go-live date set for March/April 2022. The EMeds Steering Group was held 14th October, with comms discussed for the next edition of the Technology News. • FLOW Progressing smoothly. All wards will be completed in October. Delay to RiO 21.1 upgrade until March 2022 will mean additional functionality will not be available, which may require additional funding and a Business Case to support it. • Mobilising RiO and Speech recognition progressing slowly. Service met with to understand requirements and testing started with staff.		• Ratify Data Protection Impact Assessment for Cortana (Windows speech to text application) • Business Case ratification for Speech Recognition Test for Change

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
			• ICS Procurement for Replacement of (Centrally Funded for Two Years) Attend Anywhere.		
4b. Simpler and lighter expectations for patient recording, focusing on the core issues with exception report around performance	Executive Director Finance & Performance Finance and Performance committee	Increased focus on clinical outcomes and engagement on clinically lead measures • Agreed KPIs for focused exception reporting at Care Group Level • Reduction in time spent inputting to RiO up to a maximum of 10%	• New exception reporting templates launched in September 2021 • Power business intelligence (BI) software procured to allow establishment of new reporting platform. Draft project plan in place to define key workstreams. Recruitment to Information Management Team completed to enhance capacity for delivery. • Workplan being developed for rationalising RIO		• Roll out of exception reporting across all area of QPR • Proof of concept dashboards to be produced to meet areas of highest need
4c. Improved data ensuring ability to quickly identify and correct performance	Executive Director Finance & Performance Finance and Performance committee	• Relaunch of Performance Framework for 21/22. • Care Group IQPR indicators agreed including exception reporting • Board triangulation of QPR data (workforce, performance, quality and finance)	• See above regarding development of new dashboards, linked to Power BI roll out • Data Quality Committee in place and meets monthly		Draft high-level dashboards developed by the end of March 2022
5a. Support the delivery of breakeven and an organisational	Executive Director of Finance and Performance	• KMPT to achieve break even position during H1 • Deliver year end position as per the	• At the end of month 6 (Sept21) KMPT is reporting breakeven, and is forecasting to deliver breakeven for H1 as planned. Guidance for H2 has been received. Trusts are being asked to breakeven. A detailed forecast for		The Trust needs to remain focused on reducing its underlying deficit during H2. Key areas for delivery this year include reduction in Support Services running costs, reduction in agency, procurement savings and improvements in private bed use.

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
and system trajectory	Finance & Performance	control total set for KMPT by NHS I/E • Deliver 4% efficiency programme	the full year has been shared with the Finance and Performance committee highlighting the key risks for H2 with proposed mitigations. • Efficiencies: year to date savings are £2.4m, which is in line with the phased plan set for 2021-22. This includes £1.5m recurrent savings, and £0.9m non-recurrent savings relating to vacancies. Identified savings now total £4.6m for the full year, with an unidentified gap of £2.4m. This is an improvement of £1.5m since the last report to Trust Board in September. There is still a significant gap to be closed. The new schemes that have recently been identified are non-recurrent.		
5b. Lead the Kent and Medway one public estate initiative	Executive Director of Finance and Performance Finance & Performance	• Optimised estate running costs and occupancy levels (aim to reduce running costs by a maximum of 4%) • Reduce backlog maintenance costs by up to a maximum of 10% (this will be within a reduced capital allocation)	• Continued focus on working with ICOM to improve the lead time for maintenance work		• Agree a new space utilisation policy and set up a monthly space utilisation group • Deliver rest rooms for our staff on the three main hot sites • Plan the long-term ambition for estates maintenance (jointly with KCHFT)
5c. Deliver specialised services as part of the NHS-led	Executive Director of Finance and Performance	• 4 % reduction in Occupied Bed day of patients within the	• Kent Surrey and Sussex Collaborative went live 1st April 2021 • As at end of September the collaborative has 289 patients within		• Ongoing collaborative working to improve patient pathways and also a focus on the transfer of the learning disability element

Goal	Executive Lead / Board committee	Outcomes to be achieved	Completed Activity to date Q1 2 2021/22	Action oversight (RAG)	Ongoing activity *completing by April 2022*
Provider Collaborative	Finance & Performance	Provider Collaborative Baseline • Net reduction of 6 patients (1,816 bed days)	its footprint which is 1 less than the forecast position.		of Forensic services into the Provider Collaborative. • Learning disability and autism Provider Collaborative to go-live during Q4 of 21/22

Trust Board Meeting - Public

Date of Meeting:	25th November 2021
Title of Paper:	Kent, Surrey & Sussex (KSS) Provider Collaborative Joint update paper
Author:	Phil Lawrence – Director of Contracting, IG and Business Development (KMPT) Suzy Dobson **-** Programme Director - Secure Care Provider Collaborative - Kent Surrey Sussex
Executive Director:	Sheila Stenson – Executive Director of Finance (KMPT)

Purpose of Paper

Purpose:	Discussion / update
Submission to Board:	Request from Chairs of both provider organisations for a half yearly update on progress

Overview of Paper

The paper is presented to provide an update on the Kent, Surrey & Sussex Provider Collaborative performance to date this financial year. The paper will provide a summary of the business plan established at the start of the year and the latest activity and financial performance. The paper will also provide a summary of the workstreams ongoing within the collaborative.

Items of focus

- Activity and financial performance to month 6 is in excess of plan with a surplus being forecast for year end.
- Capacity issues and the pandemic have impacted the four workstreams within the original business case, progress has been made recently with project leads identified and focus groups established. Project plans are being developed by the collaborative leads.
- An increase in the positive performance is required next year to support the ongoing financial aims of the collaborative and sustainability, planning has commenced alongside the NHS Planning timetable.

Governance

Implications/Impact:	No forecast financial risk in 2021/22
Assurance:	Provided by the KSS Provider Collaborative Executive Board
Oversight:	Joint ownership from the three NHS Risk share partner and their respective governance structures

1. Executive Summary

This paper is presented to the Trust Boards of Sussex Partnership NHS Foundation Trust and Kent and Medway NHS & Social Care Partnership Trust as a position statement on the progress, performance and future next steps of the Kent, Surrey & Sussex (KSS) Provider Collaborative. The paper was requested by the Chairs of both organisations following a meeting earlier in the financial year, it was felt that closer working and a joint understanding of the position of the collaborative was imperative for both organisations, with Sussex hosting the collaborative and Kent being the largest NHS partner and therefore the largest risk share partner.

The paper outlines the current position for the collaborative, the performance to date against the proposed trajectory, the current financial year end forecast, and provides an update on the workstreams that were established to support the delivery and aims of the collaborative.

2. Recap – The KSS Provider Collaborative

Three NHS providers along with 6 independent providers established the Kent, Surrey and Sussex Adult Secure Collaborative, the three NHS providers are: -

- Sussex Partnership NHS Foundation Trust (SPFT) (The lead/host)
- Kent and Medway NHS & Social Care Partnership Trust (KMPT)
- Surrey and Borders Partnership NHS Trust (SaBP)

Initially the collaborative came together in shadow form in July 2018 following extensive negotiation with NHS England and Sussex Partnership Foundation Trust who become the host and “responsible” for commissioning and providing care for c330 patients. Kent and Surrey are part of the provider collaborative for Kent, Surrey and Sussex (KSS). The services are provided within existing NHS services alongside a cohort of patients placed privately in secure hospitals across the UK with the intention of:

- Returning all users of secure services to their home region
- Reducing unwarranted variation
- Reducing length of stay and delays
- Improving patient satisfaction
- Reducing clinical escalation avoidance and prevention
- Providing interactive seamless care to improve flow

The KSS Collaborative officially went 'live' from the 1st April 2021 at which point the clinical and financial responsibility for the service provision transferred from NHS England South to the KSS Provider Collaborative, with Sussex as the host. This equated to 299 patients (132 Kent patients, 39 Surrey patients and 128 Sussex patients) and a budget of £62m, a summary of which is illustrated in the table below.

		2020/21	Growth @ 2%	2021/22 Budget
		£	£	£
Kent And Medway NHS And Social Care Partnership Trust	NHS	13,533,209	270,664	13,803,873
Sussex Partnership NHS Foundation Trust	NHS	19,091,266	381,825	19,473,091
Surrey and Borders Partnership NHS Foundation Trust	NHS	158,184	3,164	161,348
Total NHS Partners - KSS Collaborative		**32,782,659**	**655,653**	**33,438,312**
Total activity placed outside KSS footprint		**28,388,900**	**567,778**	**28,956,678**
Grand Total		**61,171,559**	**1,223,431**	**62,394,990**

Changes to CCG configuration

In April 2021 Surrey Heath CCG merged with another CCG to form Frimley CCG. This CCG sits outside the KSS Provider Collaborative and is now within the Thames Valley and Wessex Adult Secure Provider Collaborative. Surrey Health CCG had until that time been part of the KSS Provider Collaborative.

A decision was made to retain commissioning responsibility for this small group of patients (totalling no more than 2% of the entire KSS inpatient population) and to develop cross charge arrangements with Thames Valley and Wessex Adult Secure PC for this activity.

2021/22 Performance

The latest activity forecast is below.

In Patient Activity year to date and forecast year end Forecast to Year End

	April 21	Sept 21	*Movement*	March 22 Target	March 22 (Forecast)
Kent	132	129	*3*	127	123 (-4)
Surrey	39	38	*1*	37	38 (+1)
Sussex	128	122	*6*	124	122 (-2)
Total	**299**	**289**	***9***	**288**	**283**

- As of end of September the collaborative has 289 patients within its footprint, this is 1 less than the forecast position against which the original business plan was developed.
- The target year end position is 288 inpatients. However, the current forecast position is 283 inpatients.

The KSS Provider Collaborative have increased the focus on patient flow from point of referrals, through to discharge planning and repatriations since April 2021, with a growth in the number of Forensic Outreach Liaison Service (FOLS) community patients and reduction in those placed outside of Natural Clinical Flow. The table below shows improved performance with increase in FOLS caseloads since April 2021.

Forensic Outreach and Liaison Service (FOLS) Caseloads

Team	April 21	Sep 21	Increase/ Decrease
Kent FOLS	79	89	+10
Surrey FOLS	45	46	+1
Sussex FOLS	101	108	+7
Total	**225**	**243**	**+18**

The KSS provider collaboratives initial focus was on reviewing approaches and increasing the throughput within the FOLS Services, coupled with a reduction in inpatient activity. The approach has been successfully delivered with inpatient numbers reducing, and the FOLS teams supporting more patients in the community during the year.

This work has been achieved through the following key points in relation to the function of the FOLS services:

- Weekly (Kent), bi-weekly (Sussex) and monthly (Surrey) Discharge Tracker meetings are held with FOLS and community representatives to assist with the regional discharge pathways
- Estimated Discharge Dates are used to clarify patient pathways and hold teams to account
- Escalation processes are in place to ensure resolution with delayed discharges
- The Discharge Tracker meetings work in conjunction with the Fragile Pathways Project and the Single Point of Access Referral process
- In April 2021 a Single Point of Access for all KSS admissions was introduced allowing for greater scrutiny of referrals and allocations
- Repatriation plans are in place for patients placed out of area and are reviewed monthly, and patients are actively referred to the gate-keeping Trust for consideration for admission when vacancies occur

2021/22 Financial position

The financial position and associated forecast is built upon the patient activity and the number of inpatients being supported by the collaborative across all of its providers. Financially the latest reported position is as follows:

- The Provider Collaborative reported a surplus in M6 (September 2021) of £89k and the Year to date surplus (April – September 2021) of £173k.
- Forecasts for the 2021/22 Financial Year have been developed based upon Best/Mid/Worst case scenarios
- **BEST** - The Best Case forecast surplus, supported by current predictions of patient numbers and flow, is a surplus of £1.582m. This is a fall of £130k from the £1.712m forecast provided in August 2021
- **MID** - The Mid case scenario is a forecast surplus of £1.169m
- **WORST** - The worst-case scenario based on target patient trajectories is a surplus of £730k.
- The drivers for this reduction are an increase in forecast patient numbers, particularly in Sussex (£562k additional cost), offset by a reduction in anticipated block contract adjustments, particularly at Sussex Partnership Foundation Trust (SPFT) where forecast occupancy levels for April – September 2021, reduced from 14% to 10%.

The forecast is based on a number of assumptions, primarily:

- The surplus for September was £89k and the year-to-date surplus is £173k. This is reflective of a fall in 'month-end' patients (292 in August to 289 in September) and an improvement in occupancy rates in SPFT beds (86% in August to 90% in September).
- Income – per 21/22 Financial Allocation (including Surrey Heath) plus KMPT FOLS non-recurrent income.
- Bed costs – derived from the KSS Activity plans and the provider organisation occupied bed day prices.
- Commissioning Commitments – Extra Packages of Care (EPC) are included alongside, SPFT FOLS and SABP Gateway Assessments
- Commissioning Commitments – KSS Adult Infrastructure and SABP FOLS in line with monthly spend shown in April – August 2021

- Income and costs, where appropriate, are shown on a pro-rata basis with reference to days in the month.

The forecast position is positive noting the caveats above, additional improvements however will be required in 2022/23 to ensure that the collaborative can continue to meet its financial obligations and start to repay the pump priming loan of £2m provided by NHSE in 2019/20. The first repayment of this will be due in 2022/23 with the timing and size of repayment being discussed with NHS England.

3. Update on the areas of focus

The KSS provider collaborative is designed to improve patient flow, thereby reducing reliance on inpatient provision. Alongside these aims there is a need to ensure that there are sufficient suitable beds within the KSS footprint to meet the needs of the local population that require inpatient care. This will ensure that care is delivered close to home wherever possible. To support this ambition the provider collaborative outlined key workstreams to be focussed upon to deliver the overarching ambition of the provider collaborative.

The following updates for each workstream should be noted:

Review of FOLS operating models

The FOLS review is now near completion. Operating models across the footprint have been reviewed alongside a review of workforce and financial arrangements. An update paper describing the proposed changes to the model is scheduled for the Collaborative Executive Board meeting in December with recommendations and next steps. The updated model proposed by the Provider Collaborative, is designed to increase both the support to patients within the cohort alongside the pace of repatriation where clinically appropriate to do so. The three NHS Trusts will be asked to review the models internally as part of their governance processes before any changes are implemented.

Reconfiguration of KSS available bed stock (Women's Pathway)

The Bed Reconfiguration Project focusses on the women's secure care pathway. It is understood that women's inpatient services present the greatest challenges in terms of suitable, sufficient capacity which is affordable. The workstream aims to provide high quality service provision and reduce the reliance on out of area placements. A lead has been appointed with KMPT providing executive sponsorship for this workstream. It is anticipated that the review will be concluded in March 2022 with proposals for the future model to be agreed by partners in April following scrutiny by the three NHS provider organisations governance processes.

Prison and Criminal Justice Pathways review

The Prison and Criminal Justice aims to deliver on the following:

- Identify gaps or current service needs within the KSS Collaborative footprint.
- Develop a regional network across Kent, Surrey and Sussex for collaborative working with Prison Services, PICU and Criminal Justice Liaison and Diversion Services.
- Develop a clear clinical pathway protocol for admission from Prison and remission to Prison, in line with MOJ MH Transfer Remissions Protocol Guidance.

A workstream group has now been established and work has commenced outlining the scope and pace of the project

Fragile Pathways

The workstream was established to review a cohort of patients within the KSS footprint with longer then anticipated lengths of stay to identify the causes behind any delays to discharge and support their transition from inpatient units into a community setting. The workstream has identified a cohort of 20 patients who meet the initial scope of the workstream. To date 3 patients have been discharged but progress has been hampered by competing work pressures within the collaborative members. The collaborative team are reviewing the delivery of this workstream and will be confirming a refocussed approach to the three NHS partners once they have been developed.

4. Recommendations and next steps

The Trust Board are asked to note the position of the KSS provider collaborative, the current activity and financial position.

The initial focus of leadership and management resources within the provider collaborative has focussed on mobilising the contracts and maintaining operational grip within the financial envelope transferred from NHS England. As set out in section 3 these efforts have been successful. The focus has now shifted to delivering the transformation programmes required to secure the long-term future of the collaborative. A review of the provider collaborative team infrastructure is underway to ensure that there is sufficient capacity to successfully deliver the agreed workstreams.

The KSS provider collaborative acknowledge there are challenges ahead and significant work is required to drive forward the workstreams, to ensure the long-term sustainability of the KSS provider collaborative. The pump priming loan will need to be paid back in part to NHSE next financial year. The timings will be agreed as part of the planning round for 2022/23.

The Executive Board of the provider collaborative will be responsible for ensuing that the pace and change required in year is delivered, with updates on progress provided to future meetings on a regular basis to the Boards of both SPFT & KMPT.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	Eradicating dormitory wards in mental health facilities in Kent and Medway
Author:	Vincent Badu, Executive Director of Partnership & Strategy
Executive Director:	Vincent Badu, Executive Director of Partnership & Strategy

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper outlines the findings from the formal public consultation on a proposal to relocate Ruby Ward (a dormitory style ward for older adults with functional mental illness) from its current location at Medway Maritime Hospital in Gillingham to the KMPT Hermitage Lane site in Maidstone. It also describes the activity undertaken during formal public consultation to elicit views and responses from a wide range of audiences and stakeholders.

Issues to bring to the Board's attention

The results of the consultation, including feedback and responses elicited from stakeholders, groups and individuals have been analysed by an independent research agency to highlight themes and issues.

There is clear support for, and an understanding of, the Ruby Ward case for change and the proposal to relocate the current service to a new purpose-built facility. Many respondents believe that mental health patients should be treated in facilities where their safety, dignity and privacy can be maintained.

However, it is also clear that people have concerns about travel and transport and have made suggestions about how the impact of a potentially longer journey to a new facility for both staff and patients might be mitigated. The consultation responses are clear that people would like more information and clarity about the implementation process, should the decision to relocate Ruby Ward go ahead, especially around the relocation of patients and staff.

Governance

Implications/Impact:	Financial implications regarding NHSE/I and DHSC funding
Assurance:	Reasonable
Oversight:	Oversight by KMPT Improving Mental Health Services Capital Project Board, Finance and Performance Committee and Trust Board

Version Control: 01

In March 2021, Medway HASC determined the proposal is 'substantial variation' and therefore warranted consultation. A seven-week formal public consultation was held between 3 August and 21 September 2021 on the preferred, recommended option. The consultation findings and feedback will inform the development of the decision-making business case (DMBC) that KMCCG's Governing Body will review and make its decision in November 2021.

Analysis shows that there is clear support for, and an understanding of, the Ruby Ward case for change and the proposal to relocate the current service to a new purpose-built facility. Many respondents understood the important role that environment plays in the therapeutic process for this cohort of patients and are firmly of the belief that mental health patients should be treated in facilities where their safety, dignity and privacy can be maintained. However, it is also clear that people have concerns about travel and transport and have made suggestions about how the impact of a potentially longer journey to a new facility for both staff and patients might be mitigated. It is evident that the people of Medway value local mental health services and they have expressed reservations about any perceived loss of service within the area if Ruby Ward relocates to Maidstone. It is important to note that Ruby Ward is an inpatient facility for older female adults (currently) and admits patients from across Kent and Medway. Between 2016 and 2021 40.8% of Ruby Ward patients were from Medway and Swale, 15% from North Kent, 23.7% from West Kent and 20.4% from East Kent or outside of Kent and Medway. The consultation responses are clear that people would like more information and clarity about the implementation process, should the decision to relocate Ruby Ward go ahead, especially around the relocation of patients and staff.

Board members are asked to review and consider the findings set out in this paper and make any suggestions and recommendations about how these mitigations might be developed.

Financial implications

Kent and Medway NHS and Social Care Trust submitted a business case for funding to NHSE/I and DHSC under the eradicating dormitory wards scheme. An allocation of £12.65 million has been confirmed. More detail on the financial implications was received by the Board at its July meeting and published as part of the pre-consultation business case.

There is a programme risk in tight timeline the programme needs to adhere to through the decision-making processes to draw down the allocated funding in the financial year 2021/22 as KMPT has agreed with DHSC.

If the recommendation is not adopted there is a risk of loss of this significant funding allocation and a missed opportunity for a purpose-built new facility to improve the safety, privacy, dignity and outcomes of mental health patients in Kent and Medway.

Decision-making

This paper is coming to KMPT's Board for information and noting as the decision-making rests with KMCCG as the commissioner of the Ruby Ward service and the consultor for the proposal to relocate Ruby Ward. The CCG's decision-making business case will be shared with KMPT's Board for information at the time of publication.

Assurance

Previous updates to the Board have assured members that the pre-consultation business case has been legally reviewed and assured. The proposal has been progressed in line with published guidance from

NHSE/I and HM Treasury and legal duties relating to the requirement to consult with the general public and Medway Council via the HASC.

The proposal, business case, appendices and plans have been approved through stage one and stage two assurance gateways with NHSE/I South East in June and July 2021 as part of their service change process, including review from the chair of the South East Clinical Senate.

Oversight

The proposal to relocate Ruby Ward has been overseen by the KMPT Improving Mental Health Services Capital Project Board (which has CCG membership); and in turn has been presented to the system-wide Kent and Medway Mental Health, Learning Disability and Autism Improvement Board in June 2021. It has been reviewed by the Clinical and Professional Board that operates as a sub-committee of the MHLDA IB.

The KMCCG Governing Body reviewed and agreed the pre-consultation business case and made the decision to move to formal public consultation on the proposal in July 2021. KMPT's Board has been kept abreast of developments, the publication of the pre-consultation business case and the decision to consult, through briefings and updates at Board meetings.

Externally, Medway HASC and Kent HOSC have considered and scrutinised the proposals in public committee in March and June and August 2021. Both committees received updates and information on the consultation at their meetings in September and October 2021.

Recommendations

Board members are asked to:

- Note the headline feedback and analysis from the formal public consultation provided in this report.
- Note the overview of consultation activity outlined within this report and the appendices.
- Note and discuss any mitigations that KMPT and the KMCCG Governing Body should consider in light of the feedback from consultation when the CCG decides the future shape and location of Ruby Ward services.

Version Control: 01

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Eradicating dormitory wards in mental health facilities in Kent and Medway

Draft report of formal public consultation on the proposal to relocate Ruby Ward to a new purpose-built facility

Summary

This report outlines the headline results from the formal public consultation on the proposal to relocate Ruby Ward from Medway Maritime Hospital to a new purpose-built facility in Maidstone. Full, detailed reports and analysis of the responses to the consultation and the activity undertaken to deliver the consultation are available electronically in the Board reading room.

1. Background

1.1. Ruby Ward is an inpatient mental health ward for older adults (65 and over) with functional mental illness (for example, severe depression, schizophrenia, or bi-polar conditions). Ruby Ward is currently based at Medway Maritime Hospital on the first floor of a building. It is in a ward space originally designed for physical rather than mental health patients and has little space for therapeutic activity, and limited access to outside space and gardens. It is Kent and Medway's last remaining dormitory ward for mental health patients. It has 14 beds but only 10 can be used because of the layout of the ward. Due to its dormitory style accommodation and shared bathroom facilities, only female patients are cared for at the moment on Ruby Ward.

1.2. It is Government policy to eradicate dormitory wards for mental health patients as they do not provide the privacy, dignity, and safety mental health patients expect and deserve. Kent and Medway Clinical Commissioning Group (KMCCG), working in partnership with Kent and Medway NHS and Social Care Partnership Trust (KMPT), is therefore proposing to replace Ruby Ward with a purpose-built new facility with single ensuite rooms, dedicated therapeutic areas and garden space at KMPT's main Hermitage Lane, Maidstone site.

1.3. KMPT has been allocated £12.65m of Government funding to build the new facility that would be able to accommodate male and transgender patients as well as female patients within national same sex accommodation guidelines. While inpatient care accounts for a small proportion of all mental health services, it is important that when people need to go into hospital the environment supports their recovery.

1.4. The Ruby Ward programme is overseen via the Improving Mental Health Services Capital Project Board, which is hosted by Kent and Medway NHS and Social Care Partnership Trust but has senior CCG commissioner as well as trust membership. KMPT has its own internal governance for its Improving Mental Health Services transformation programme. The Capital Project Board links into this, whilst reporting for the Ruby Ward programme into the system-wide Kent and Medway Mental Health, Learning Disabilities and Autism Improvement Board. This board, a sub-committee of the designated Kent and Medway Integrated Care System Partnership Board,

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operates as a system steering group for the Ruby Ward programme. It ensures stakeholder, clinical, patient, and public input is included in the thinking and development of the programme. It gives a clinical and leadership system perspective on the proposals and ensures strategic 'fit' within Kent and Medway's wider mental health improvement plans. These are part of Kent and Medway's response to the *Long Term Plan for Mental Health*[Error! Bookmark not defined.] and other policy frameworks.

1.5. KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and teams caring for patients in different locations. This needs-led approach to inpatient admissions means that there is no concept of 'local' specialist inpatient beds designated for particular communities or geographies as services are provided for all Kent and Medway residents. Patients requiring admission to hospital for mental health care may not be admitted to a unit closest to their home, but they will be admitted to the most appropriate facility to meet their needs. Whilst Ruby Ward is located in the former Medway CCG catchment area, it takes patients from across Kent and Medway.

1.6. A robust process to identify possible sites for the proposed new build has been undertaken, including looking extensively at potential sites in Medway. However, only one site, in Maidstone, met the criteria – adequate space; availability of the site for work to begin to meet the deadline for the build; ownership of the land for the building to be a KMPT asset; co-location with general acute hospital services; and co-location with other inpatient mental health services. Therefore, the preferred option is for Ruby Ward to be relocated to the Maidstone site.

1.7. Board members are aware that the timelines for the Ruby Ward programme work are challenging, to ensure that the Kent and Medway system can draw down the £12.65million available investment in the financial year's 2021/22 and 2022-23.

1.8. Between 3 August and 21 September 2021, KMCGG undertook a formal public consultation on the proposal. KMPT supported the consultation effort by raising awareness of the proposal and sharing information and inviting involvement through its existing engagement and communications channels and mechanisms. KMPT made a formal response to the Ruby Ward proposal during the consultation period, giving its firm support for the proposal, endorsing the compelling clinical case for change and citing the significant benefits for patients and staff of relocation to a new purpose-built facility.

1.9. Gathering feedback from KMPT staff was an important part of the process and the consultation activity included within this report and accompanying appendices outlines the views and insights that staff shared during the formal consultation period. Around 40 nursing and allied health professional staff are affected by the proposals and they have been engaged throughout the development of the proposals and this will continue during the next steps of the process. A separate consultation as part of KMPT's HR process will be undertaken with current staff members on Ruby Ward if the proposal is given the go-ahead.

1.10. KMCCG undertook formal consultation with Medway Council via the Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) as per its legal duties and in accordance with Regulation 23 (1) of The Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. Medway HASC

Eradicating dormitory wards in mental health facilities in Kent and Medway

decided in March 2021 that this proposal is considered to be a substantial change of service for Medway residents. Kent HOSC did not consider the Ruby Ward proposal to constitute a substantial development of or variation in the provision of health services in the local authority's area.

1.11. KMCCG consulted on the proposal with an open mind. Consultation gives people the opportunity to feed in their views and there may be an alternative option, aspects or evidence that are put forward for consideration. An important piece of work post-consultation, and for inclusion in the CCG's decision-making business case, is the review and evaluation of additional sites, locations or suggestions raised during the seven week public consultation period against the agreed criteria. This work is in process.

1.12. A final decision on the proposed relocation of Ruby Ward will be taken by KMCCG's Governing Body in November 2021.

2. Headline findings from the formal public consultation

2.1. A variety of research, engagement, and involvement methodologies were used to elicit views, feedback, and ideas in response to the Ruby Ward consultation proposal. Information and headline results from these primary methodologies are set out in Appendix A. The results are included in the final independent analysis and report of the consultation responses, along with a second report detailing the total activity undertaken during the formal public consultation period, (Appendix B and Appendix C).

2.2. Analysis of the consultation responses makes it clear that there is support for, and an understanding of, the Ruby Ward case for change and the proposal to relocate the current service to a new purpose-built facility. Many respondents understood the important role that environment plays in the therapeutic process for this cohort of patients and are firmly of the belief that mental health patients should be treated in facilities where their safety, dignity and privacy can be maintained. However, it is also clear that people have concerns about travel and transport and have made suggestions about how the impact of a longer journey to a new facility for both staff and patients might be mitigated. We understand that the people of Medway value local mental health services and hear the reservations about any perceived loss of service within the area. The consultation responses are also clear that people would like more information and clarity about the implementation process, should the decision to relocate Ruby Ward go ahead, especially around the relocation of patients and staff.

3. Next steps

3.1. KMCCG has presented the consultation findings including the details outlined in this report and appendices to Medway HASC and KMCCG's Governing Body and expressed its gratitude to the partners, stakeholders, organisations, and individuals who have taken part in the consultation process and shared their views, thoughts, and experiences. The CCG, through the Ruby Ward programme team, is carefully considering the responses and feedback received and will develop mitigations to the issues raised during the consultation as part of the creation of the decision-making business case. These may include:

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- A continued commitment to make existing volunteer drivers or taxi service options available. The NHS will continue to fund the costs of these services for family members who wish to visit patients on admission to Ruby Ward and are experiencing difficulties relating to the additional travel requirements (impacted by mobility, disability or access to financial resources), following the proposed relocation of the ward from Medway to Maidstone.
- Monitoring the number of requests received for support and number of journeys supported on a quarterly and an annual basis.
- The Ruby Ward management team will continue to work closely with voluntary services and the carers and relatives of patients to ensure that the options available are personalised (discussed as part of the patient's care plan) to individual circumstances such as travel distance and ward visiting times.
- Increasing the flexibility around the range of mechanisms that people may want to use to maintain contact with family members, such as telephone contact and digital video calls (as appropriate to individual patient care plans) during a period of inpatient admission.

3.2. Board members are asked to review and consider the findings set out in this paper and within the Appendices and make any suggestions and recommendations about how these mitigations might be developed.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th November 2021
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

Whilst this report (which presents October's activity) includes targets met and some areas of improvement (notably a reduction in the number of our patients placed in beds outside KMPT) it also clearly sets out areas of challenge where targets have been missed, in some instances over several months. The report shows the deterioration in some of our key workforce metrics, many of which have previously been green.

The Board's attention will naturally focus on those areas, seeking assurance that measures are in place to rectify the situation. For some issues (for example, the performance of Community Mental Health Teams in relation to care plans and Care Plan Approach reviews) a clear trajectory for improvement is in place with an expectation of a return to green status by February 2022.

For other indicators however, the cause of the problem is multifactorial and requires a system approach. Examples of these instances include our ability to meet the significant increase in demand for Memory Assessment Services and the increase in the number of our patients who are ready to be discharged but who we are unable to place in appropriate accommodation due to constraints faced by other agencies. The latter creates Delayed Transfers of Care and in turn, further pressure on our beds which can lead to more KMPT patients needing to be placed outside KMPT. In these instances, KMPT through the Mental Health Learning Disability and Autism Improvement Board (MHLDA Board) takes a system leadership role to drive the improvements required.

The executive working with Heads of Service, Clinical Directors and the wider system, is reviewing the areas where the solution is not solely in the gift of KMPT and agreeing trajectories for improvement.

Helpfully, the Board receives today, not only KMPT's IQPR but an update on the work of the MHLDA Board and will therefore see evidence of this work from both perspectives.

The Board should note that the H2 financial plan will be submitted this month. The plan is to deliver break even which will be challenging for the Trust, however there are a number of mitigations in place which will be monitored to ensure delivery.

Governance

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

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

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

Issues of Concern

Executive Commentary

Care Programme Approach (CPA) Patients Receiving Formal 12 Month Review (002.S)

The Older Adults Care Group is at 98% in month against this standard, a positive improvement. By contrast, the adult Community Mental Health Teams (CMHTs), who look after over 55% of all patients subject to CPA in need of a formal review, continue to show variation with only two teams meeting the target.

In order to ensure that the board is fully sighted on the variation in performance, this month a new table and level of detail is provided. The table below shows team performance against this standard for the week beginning the 09/11/21. The team with the poorest performance, Dartford Gravesham and Swanley has had a backlog for CPA 12-month review relating to a time of high Covid sickness; the team has the highest referral rates of any team and it has been a challenge to resolve backlog issues. South West Kent is the other team of concern. This team has had significant staffing challenges. Both teams have all outstanding CPA reviews booked and improvement is expected to be delivered on month, returning to full compliance by February 2022. Those teams with smaller numbers of people with an outstanding CPA review have been tasked with immediate improvement, meeting the required standard by January

Team	No of Patients on CPA	Number Compliant	Compliance
Ashford Community Mental Health Team	83	72	86.7%
Canterbury & Coastal Community MHT	57	55	96.5%
DGS Community Mental Health Team	197	154	78.2%
Dover & Deal CMHT	31	28	90.3%
East EIS	134	129	96.3%
Maidstone Community Mental Health Team	146	130	89.0%
Medway and West EIS	175	173	98.9%
Medway Community Mental Health Team	179	179	100.0%
Open Dialogue Service	31	31	100.0%
Shepway CMHT	31	28	90.3%
Swale Community Mental Health Team	40	39	97.5%
SWK Community Mental Health Team	89	70	78.7%
Thanet Community Mental Health Team	84	71	84.5%

Restrictive interventions (011-013.S)
The four main restrictive interventions that are reported and monitored by the Trust include use of rapid tranquilisation, all incidents of restraints including in a prone position and use of seclusion. There has been a gradual reduction in all incidents of restrictive practice in the last year, with recent national NHS Benchmarking showing KMPT in a good position in relation to the Trust's low use of prone restraints.

The Trust maintains its focus on reducing restrictive interventions and is currently consulting on a revised policy on Restrictive Interventions. Included in this draft policy, is the strengthening of reporting and monitoring of blanket restrictions on our wards.

The existing Promoting Safe Services strategy (2019-2022) provides an overarching framework for reducing violence and aggression, restrictive interventions and increasing the range of therapeutic interventions on offer on the wards. Progress on this strategy delivery was shared with the Quality Committee at its November meeting. Positive impact has been seen already, in low level of harm following management of aggressive behaviour and a reduction in seclusion use through use of Safety Pods, Safety Huddles and increased therapeutic activities including the creative use of off ward space.

A review of **seclusion incidents** show that the majority of these episodes were under 24 hours in duration and were linked to a female ward in Littlebrook Hospital and the Psychiatric Intensive Care Unit. An audit of records found adherence to policy in terms of reporting and monitoring and that care was provided in accordance with the Mental Health Code of Practise.
Episodes of restraint are often attributable to a small group of patients in acute services and last under ten minutes for each incident. Oversight, scrutiny, testing and assurance of the use of restrictive interventions remain at trust wide level, led by senior nursing and medical staff.

The majority of **prone restraints** occur in acute services and were necessary to administer intramuscular injections after de-escalation techniques had failed. Reasons for prone restraint are always captured and reported in great detail in the Quality Digest report to Quality Committee. They range from patient's' preferences and the inability of the clinical team to safely hold the patient in a supine position. Prone restraints ranged from five seconds to two minutes before the patient was turned into a supine position. No level of harm was reported in any of the 15 instances reported in September and October.

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IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	97.1%	97.1%	96.4%	96.4%	95.5%	95.8%	94.7%	94.5%	94.2%	93.2%	92.8%	92.3%
003.S	% Inpatients With A Physical Health Check Within 72 Hours		90%	L	94.3%	95.2%	95.8%	92.9%	96.4%	96.2%	96.5%	98.8%	96.5%	95.8%	97.1%	97.5%
005.S	Number Of Unplanned Absences (AWOL and Absconds on MHA)		-	-	13	15	26	8	22	17	18	20	25	19	24	16
006.S	Serious Incidents Declared To STEIS		-	-	11	23	23	15	21	24	16	13	11	13	21	20
007.S	% Serious Incidents Declared To STEIS within 48 hours		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
008.S	Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days		0	L	20	14	5	0	5	2	4	5	4	1	0	0
010.S	All Deaths Reported On Datix And Suspected Suicide		-	-	232	225	275	178	155	150	77	146	75	123	106	91
011.S	Restrictive Practice - All Restraints		-	-	105	96	114	106	146	103	145	88	151	96	82	62
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	6	3	10	3	6	4	8	4	6	5	11	4
013.S	Restrictive Practice - No. Of Seclusions		-	-	32	17	16	8	24	12	21	21	26	19	17	12
015.S	Ligature Incidents - Ligature With Fixed Points (moderate to severe harm)		0	L	0	0	0	0	1	0	0	0	0	0	0	2
016.S	Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm)		-	-	0	0	0	0	0	0	0	0	0	0	0	2
017.S	RIDDOR Incidents		-	-	1	1	2	0	3	2	6	0	2	2	3	3
018.Sa	Infection Control - MRSA bacteraemia		0	N	0	0	0	0	0	0	0	0	0	0	0	0
018.Sb	Infection Control - Clostridium difficile				0	0	0	0	0	0	0	0	0	0	0	0
019.S	Safer staffing fill rates		80%	L	109.4%	106.5%	106.0%	104.3%	108.8%	108.9%	110.1%	110.7%	110.5%	110.5%	110.5%	110.3%

Kent and Medway NHS
NHS and Social Care Partnership Trust

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

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

Issues of Concern

The percentage of patients on CPA with a Care Plan reduced in month to 88.7% overall. However, it is the adult community teams, which look after over 50% of all patient's subject to CPA requiring a Care Plan, where the challenge to improve is most significant. A programme of improvement is in place with compliance against targets set for all teams affected.
The Forensic and Specialist Care Group (FSCG) have improved their position on % of patients on CPA with a valid care plan, however there has been a decrease in the number of of patients with a care plan distributed to them. This reduction is attributed to two community teams. A robust action plan is in place to address this including additional support to improve this position by the calendar year end.

Delayed Transfers of Care: DTOC is an increasing area of concern in KMPT and nationally. Of note 12 months ago it was at a similar level. There are specific challenges this year with NHSE/I noting Winter pressures are likely to be extreme for all areas of the health and social care system. A weekly focus on individual delays, chaired by the Integrated System's Chief Operating Officers and Local Authority senior officers ensures a clear focus on the causes of each delay. A new joint appointment between KMPT and KCC started in October to oversee DTOC. Positively in the last week the number of DTOC has reduced but it is an area of challenge requiring relentless focus. The Winter planning challenges (including DTOC) are on the Trust Risk Register and will be considered for inclusion on the Board Assurance Framework via the executive.

Average Length of Stay: The ALoS for both adults and older adults is increasing. There are a number of factors at play, including any person with a long length of stay impacting in month on the trend, acuity, staff vacancy including sickness and annual leave. There were five discharges from Younger Adult Acute wards with lengths of stay over 200 days (425, 324, 265, 232, 222), this is double the annual average for discharges of over 200 days in month and if the two longest stays were removed from the report in this period, lead to the ALoS being revised from 80.2 to 56.7 days. The Patient flow team are closely monitoring to understand the reasons and identify solutions, in addition a Quality Improvement project is underway to identify potential improvements in older adult length of stay.

Kent and Medway NHS
NHS and Social Care Partnership Trust

Executive Commentary

Research and Innovation Director, Profesor Sukhi Shergill started in post in Oct 2021. He will be strengthening our approach to Research and Development and improving the quality of our offer as a result. A new NICE lead for the organisation is also being appointed. The NICE lead will support delivery of care in line with NICE guidelines.

	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			42.0	0.0	-66.0	141.9	37.9
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			133.0	0.0	2.1	299.7	150.9
4	**Trust Total**			175.0	0.0	-4.6	373.8	184.6

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

Narrative

KMPT remains committed to ensuring that patients are admitted to a KMPT bed as close to home as possible. In instances where the trust does not have the type of bed a person requires, (female Psychiatric Intensive Care Unit [PICU] for example), we commission quality assured beds from external providers. It is unusual for a KMPT patient who requires an ordinary, acute bed to have to be admitted to a non KMPT bed and it is our aim always, to bring patients back to KMPT as quickly as possible.

During this reporting period, a number of KMPT beds were out of commission, due to refurbishment. Our use of external overspill beds therefore was higher (42 days) than we would like (zero days). This position will be resolved by the year end, with the opening of our refurbished Orchards Ward.

October saw a decrease in month in external bed usage at 175 days (133 PICU, 42 YA Acute) compared to 205 days in September.

Kent and Medway NHS
NHS and Social Care Partnership Trust

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute		F	73.3%	95.0%	62.0%	93.0%	77.5%
2	CRCG	L	F	86.9%	95.0%	87.7%	92.4%	90.0%
3	FSS		?	93.3%	95.0%	91.1%	98.1%	94.6%
4	OPMH		?	96.7%	95.0%	94.4%	99.3%	96.9%
5	Trust Total	L	F	88.7%	95.0%	89.0%	93.4%	91.2%

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG	L	F	70.2%	95.0%	67.3%	73.3%	70.3%
2	FSS	H	F	79.3%	95.0%	62.1%	75.9%	69.0%
3	OPMH	L	F	62.5%	95.0%	62.5%	73.1%	67.8%
4	Trust Total	H	F	73.8%	95.0%	66.2%	72.6%	69.4%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Special cause of **Concerning** nature to **lower** values *Non CPA PSP & Care Plans:* Special cause of **Improving** nature to **higher** values
Assurance	Variation indicates consistently **failing short of target**

Narrative

The percentage of patients on CPA with a valid Care Plan reduced further in month from 89.5% to 88.7%. Special cause variation continues due to the metric being seven consecutive data points under the mean of the last 18 months.

Personal Support Planning - PSP:

People who are not subject to CPA are in receipt of a care plan or a Personal Support Plan (PSP) It is important to note the PSP has been rolled out in year and is completed for all new patients and for people already on a caseload it is only updated on review – this does mean it will take up to the end of April for all historical clients to have an updated PSP – in the meantime the traditional care plan remains in place and is counted within the indicator.

There are two CMHTs at the lower end of compliance SWK and DGS however SWK has seen a 10% improvement in month against this standard and positively, staffing is much improved. DGS have seen minimal movement in % compliance since last month. This standard, along with CPA, are the two keys area the team leadership is focussing on. The CRCG leadership recognise the imperative to improve and have set a target for significant improvement to be shown in the January IQPR. This is closely monitored by the executive at Quality Performance Review (QPRs) meetings.

Kent and Medway NHS
NHS and Social Care Partnership Trust

FSCG have a worsening position for non-CPA clients with a PSP in place. This is attributed to one team. A deep dive was undertaken to understand the reason. This led to an action plan to significantly improve performance in the next 2 months.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	97.8%	98.7%	96.5%	98.9%	98.3%	98.9%	97.3%	97.8%	97.8%	96.4%	96.3%	95.2%
001b.E	CPA patients receiving follow-up within 72hours of discharge				89.3%	87.5%	88.8%	90.9%	88.4%	86.7%	84.0%	82.7%	86.5%	86.6%	81.7%	87.5%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.4%	95.6%	95.6%	95.7%	95.8%	95.8%	96.0%	95.9%	95.7%	95.7%	95.9%	95.9%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	255	117	171	221	181	189	192	351	201	103	205	175
006.E	Delayed Transfers Of Care		7.5%	L	12.7%	11.9%	10.5%	9.2%	8.5%	8.7%	8.6%	8.4%	8.8%	9.0%	10.6%	11.9%
011.E	Number Of Home Treatment Episodes		224	L	234	192	189	220	250	241	270	291	246	242	250	231
012.E	Average Length Of Stay(Younger Adults)		25	L	33.11	35.75	36.25	31.78	27.75	25.94	26.42	33.92	28.23	27.68	29.78	36.63
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	64.90	92.21	69.97	76.09	70.97	101.79	61.63	65.75	53.24	56.90	72.25	80.22
015.E	%Patients with a CPA Care Plan		95%	L	92.5%	93.0%	91.8%	91.0%	89.5%	90.3%	89.0%	89.9%	90.7%	91.3%	89.5%	88.7%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	55.0%	53.7%	52.8%	52.9%	56.2%	56.7%	58.9%	60.9%	63.5%	64.4%	65.4%	66.3%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	67.2%	67.8%	67.8%	71.2%	73.3%	73.1%	73.6%	74.4%	74.3%	74.4%	73.0%	73.8%

Kent and Medway NHS
NHS and Social Care Partnership Trust

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

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

Issues of Concern
Staff sickness & Turnover, full details within executive summary below.

Executive Commentary

Staff Sickness (001.W-W)

Sickness for the month is 5% for October. This is 1% above the target for 2021/22 (4%).

If we remove the Covid sickness which is 0.75%, the sickness for the month is 4.25%

Sickness is 5.27% year to date – 0.90% of this relates to Covid and therefore is 4.37% year to date without Covid.

Short term sickness increased to 2.27% compared to 1.74% last month. Long term sickness is 2.62%, a decrease from 2.79% the previous month.

Comparisons to other local Trusts as follows, as at June 2021 (last available benchmarking):

- SLAM – 3.4%
- Oxleas – 4%
- Sussex Partnership – 4.3%
- *KMPT – 4.2%*

The latest national benchmarking for all NHS Trusts, as at June 2021, shows the overall sickness absence rate for England was 4.6% (we were below this figure). The June 2021 data was slightly higher than May 2021 (4.3%) and higher than June 2020 (4.0%).

Activities in place to reduce sickness absence include:

- Successfully closed 33 long term sickness absence cases in October 2021.
    - 34 employees are returning to same post
    - 2 employees are no longer employed at KMPT
    - We are currently actively supporting managers with 61 cases of sickness absence.
- Part of NHS Health and Wellbeing Framework Trailblazer Project
- Bringing Schwartz Rounds to KMPT
- Wellbeing Conversation Cafés - looking after our people
- Health and Wellbeing sessions and managers training

- Stop smoking practitioner training
- Healthy Workplace Allies eLearning programme
- Health and Wellbeing Conversations
- NatureWell Training for healthcare practitioners
- Learning from SLAM for sickness absence management

Staff Turnover (019.W-W – 022.W-W)

Turnover for October 2021 is 12.6% for rolling 12 months, which is an increase of 0.4% since previous month. The biggest increase is in Older Adult Services Care Group – 1%

Staff turnover year to date is 8%, against 9% target

Activities to reduce turnover:

- Getting recruitment right first time
- Onboarding and first 2 years in service
- Enhancing flexible working
- Staff feedback
- Staff wellbeing
- Development, internal opportunities and career pathways
- Understanding why people are leaving
- A recruitment and retention group is also supporting strategies to address turnover.

This compares to other local Trusts as follows, as at July 2021 (last available benchmarking):

- SLAM - 13.5%
- Oxleas – 18.8%
- Sussex Partnership – 11.1%
- *KMPT – 9.5%*

We had the lowest turnover rate at this time. There is no national benchmarking information available for this indicator.

Staff Retention (015.W-W – 018.W-W)

The October 2021 data shows a retention rate of 82%. The year to date position is 89%, against a target set for 2021/22 of 90%.

The year to date position for the reported staff groups is as below:

- Additional Clinical services from 86% to 90% - currently 88%
- Nursing from 88% to 91% - currently 91%
- Medical from 91% to 92% - currently 89%

Activities to support retention are reflected in turnover:

- Getting recruitment right first time
- Onboarding and first 2 years in service
- Enhancing flexible working

- Staff feedback
- Staff wellbeing
- Development, internal opportunities and career pathways
- Understanding why people are leaving

This compares to other local Trusts as follows, as at July 2021 (last available benchmarking):

- SLAM – 86.3%
- Oxleas – 81.7%
- Sussex Partnership – 88.6%
- *KMPT – 87.3%*

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
001.W-W	Staff Sickness - Overall	✓	4.00%	L	4.4%	5.1%	4.2%	3.8%	3.5%	3.7%	4.0%	4.6%	4.6%	4.2%	4.6%	5.0%
005.W-W	Appraisals And Personal Development Plans		99%	L	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%						
006.W-W	Vacancy Gap - Overall		11.85%	L	12.7%	13.4%	14.1%	14.0%	14.2%	15.3%	15.5%					15.0%
007.W-W	Vacancy Gap - Medical			-	27.0%	26.8%	28.0%	27.9%	28.8%	28.8%	29.8%					28.5%
008.W-W	Vacancy Gap - Nursing			-	13.9%	13.3%	14.5%	14.7%	15.4%	16.2%	16.5%					12.6%
009.W-W	Vacancy Gap - Other			-	12.7%	12.0%	14.1%	12.2%	12.2%	13.6%	13.5%					13.1%
012.W-W	Essential Training For Role		90%	L	89.4%	89.5%	91.3%	90.4%	91.2%	91.8%	92.4%	92.4%	90.4%	90.5%	92.6%	91.5%
015.W-W	Staff Retention (overall)		90%									87.3%	82.7%	84.3%	81.8%	81.8%
016.W-W	Staff Retention (Additional Clinical Services)		90%									85.1%	82.3%	83.9%	77.6%	78.8%
017.W-W	Staff Retention (Nursing)		91%									87.0%	80.5%	82.1%	78.9%	79.3%
018.W-W	Staff Retention (Medical)		92%									89.2%	86.8%	88.4%	82.2%	82.6%
019.W-W	Staff Turnover (Overall)		9.00%		9.4%	9.4%	9.4%	9.6%	9.4%	10.1%	10.5%	9.5%	10.9%	11.3%	12.2%	12.6%
020.W-W	Staff Turnover (Additional Clinical Services)		10.00%									11.9%	13.1%	12.7%	13.1%	15.1%
021.W-W	Staff Turnover (Nursing)		9.00%									9.1%	10.8%	9.7%	10.6%	9.9%
022.W-W	Staff Turnover (Medical)		8.00%									8.1%	10.4%	12.2%	12.5%	12.4%

- *New indicators and targets were introduced June 2021; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

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

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

Issues of Concern
H2 Plan is due for submission in the later part of this month to NHS Improvement/England. The breakeven plan for the Trust will be challenging. Therefore, the Executive have agreed to the following actions: 1. All Care Groups and Support Services will be given an efficiency target based on areas of opportunity (the Trust pillar approach for driving efficiencies will remain in place) 2. The annual efficiency target will be full identified by the end of December 2021 3. New agency control totals for each care group will be put into place these will be monitored on a weekly basis

Executive Commentary

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

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Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
004.W-F	In Month Budget (£000)		0.0	N	(0)	(0)	(0)	0	0	0	0	(0)	(0)	(0)	(0)	0
005.W-F	In Month Actual (£000)		-	-	(0)	800	0	0	3	0	(0)	(0)	0	0	(0)	0
006.W-F	In Month Variance (£000)		-	-	0	800	0	0	3	(0)	(0)	0	0	0	(0)	0
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N						0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	427	427	427	427	427	427	427	427	427	427	427	427
008.W-F	Agency - In Month Actual (£000)		-	-	824	761	638	596	767	699	661	520	664	658	687	562
009.W-F	Agency - In Month Variance from budget (£000)		-	-	397	334	211	169	340	272	234	93	237	231	260	135
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	74.97%	75.34%	72.74%	69.73%	75.78%	74.68%	73.02%	69.04%	60.85%	59.31%	51.76%	48.88%

- *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): Executive Director of Nursing & Quality & Chief Operating Officer
Lead Board Committee: Quality Committee

Issues of Concern

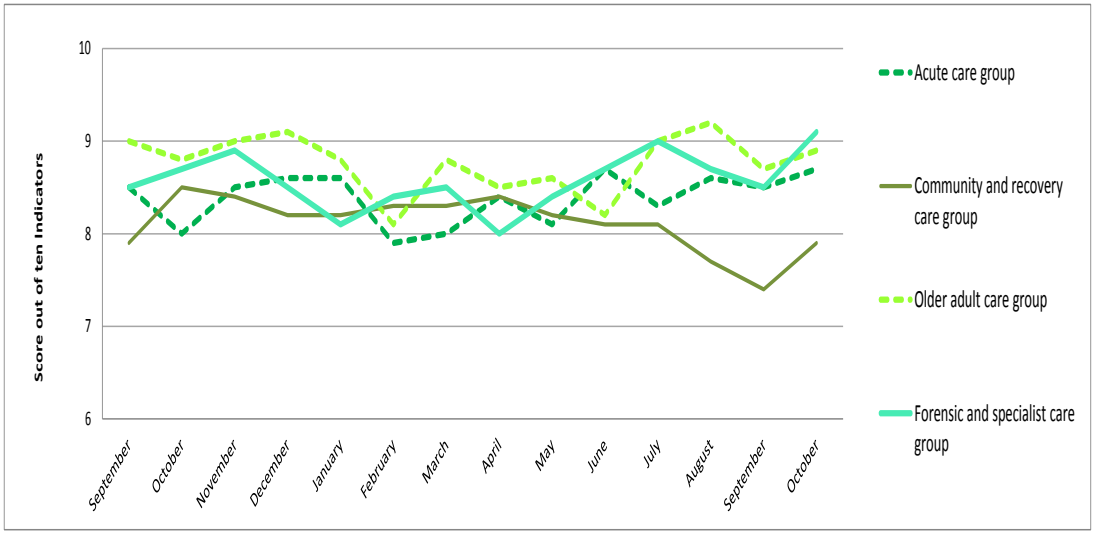
Executive Commentary

Patient Friends and Family Test (PFFT) ask a question about "overall experience of our service". Analysis of data shows that the Trust is exceeding the national response rate. The average overall experience of care was 85.9% which is still in the "very good" range and is comparable to national position. The PFFT target of 93% was locally set by the Trust a few years ago. It is noteworthy that NHS England do not have a target set nationally. They encourage providers to ensure that all patients and people that use services are able to give feedback if they want to, and providers should use the feedback to identify good practice and opportunities to improve.

Patient Reported Experience Measures (PREM) (014-015.S)
The PREM survey responses are gradually increasing but still are below the internally set target of 10% of contacts which is approximately 1400 per month. 585 responses were received in October compared to 541 in the last reporting period. The Acute Care group has consistently exceeded the 10% target with a record 18% of response rate in October.

Although monthly target responses of over 1000 haven't been reached, the average PREM scores have been approximately 8 out of 10 which indicates a very good level of satisfaction. There has been an upward improvement for all three care groups apart from Community Recovery Care Group that had been declining during same time period however saw an improvement in October (graph 1)

Graph 1



Inpatient PREM scores contributing to a less satisfactory experience are listed below; work is ongoing to address the patients experience.

- Food and drinks provided 7.6 out of 10
- Involvement of family and friends 7.6 out of 10
- Being given enough information 8 out of 10

For community services, the following two questions continue to receive poorer responses. Similar to the inpatient low rated questions, there is ongoing work to address these:

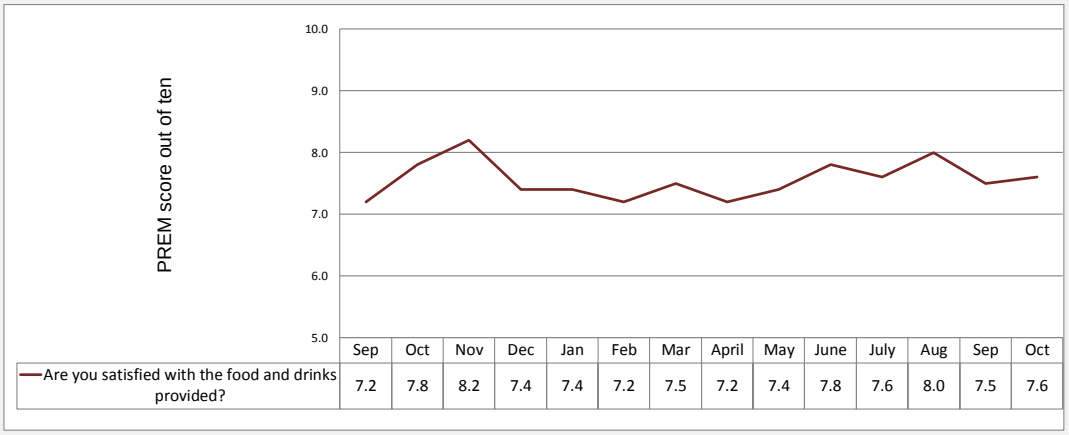
- Do KMPT services give you any help or advice with finding support for financial advice or benefits? 7.9 out of 10 in October 2021
- Do you feel you have been seen by KMPT services often enough for your needs? 7.9 out of 10 in October 2021

Chart 1 indicates the patient experience with regards to food and drinks provided score (7.6 out of 10). It is still within the range where patients 'agree' that they are satisfied. There is an overarching strategic improvement plan to monitor food preparation, serving and mealtime experience. Improvements have been made already to the menu choices, variety of snacks and seasonal fruit on offer.

Kent and Medway NHS
NHS and Social Care Partnership Trust

Chart 1.

2020-2021	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct
Are you satisfied with the food and drinks provided?	7.2	##	8.2	7.4	7.4	7.2	7.5	7.2	7.4	7.8	7.6	8.0	7.5	7.6
Inpatient PREM score out of ten	8.1	##	8.3	8.2	8.3	7.7	7.6	7.8	8.0	8.4	8.0	8.6	7.9	8.0



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct
Are you satisfied with the food and drinks provided?	7.2	7.8	8.2	7.4	7.4	7.2	7.5	7.2	7.4	7.8	7.6	8.0	7.5	7.6

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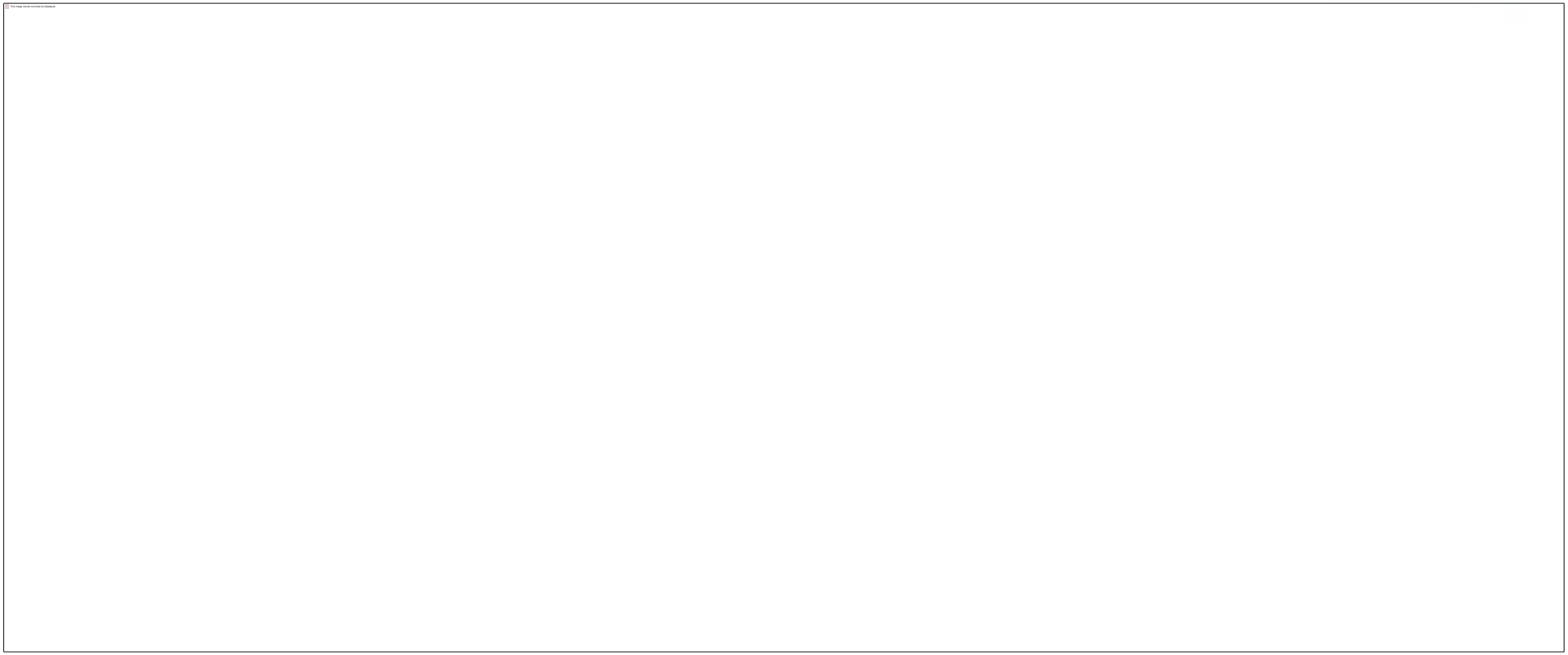


CQC Domain	Responsive
Trust Strategic Objective & Board Assurance Framework	• **Partnering beyond Kent and Medway, where it benefits our population** • **Driving integration to become business as usual for the system and for KMPT.**

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

Issues of Concern

The ability to see people in a timely way remains a priority and a challenge; demand in 2021 has increased as was expected and whilst a lot of work is in place to address both internally and through national programmes such as the community transformation programme balancing the here and now challenges against driving new ways of working and staffing is complex. Both the demand and capacity and staffing issues are on the Trust BAF and mitigations are in place.

Executive Commentary

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			76.0%	95.0%	59.7%	94.7%	77.2%
2	OPMH			39.9%	95.0%	28.4%	70.7%	49.5%
3	Trust Total			51.4%	95.0%	43.3%	75.6%	59.4%

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

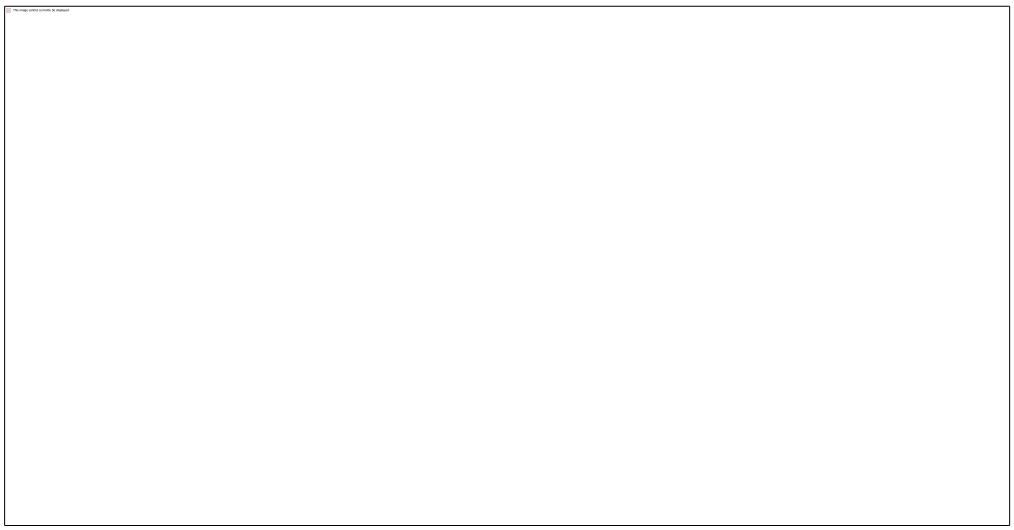
Narrative

Neither the Older Adults or the CMHTs have been able to meet a standard of 95% for referral to assessment for the past 12 months; it is generally an issue of demand outstripping capacity and with referral rates for both areas continuing to be high (above historic levels). In the medium to longer term the developments linked with the community mental health framework will likely improve the ability to meet this standard for people with a serious mental illness but in the short terms the likelihood of meeting the standard is extremely challenging and therefore unlikely.

In terms of the CMHTs Maidstone CMHT was the main outlier in month, with the lowest % compliance of the CMHTs at 56.4%. However, this is a marked improvement on the previous two months where the compliance was 27.8% and 21.6% respectively. There has been an increase in capacity for assessments within the Maidstone team, with all staff now providing capacity for assessments and staffing is improving in both West Kent CMHTs. If we can sustain the staffing position it will allow the two teams to not only cope with the demand of new assessments but also to address some of the backlog

Older Adult performance against the 4 week wait in October 2021 is 32.35% for routine Memory Assessment Service (MAS) and 57.6% for functional and complex dementia referrals. The referral rate remains high, with statistical significance, there were 1105 referrals from 1078 the month previously. 834 initial assessments were completed in October 2021, up from 790 the previous month and from 675 in August 2021. The improvement is in part due to the additional memory assessment clinics which have been delivering 50 additional assessments per month since mid-September; these will run up to the end of the financial year but are dependent on current staff working extra hours.

Now the data can split MAS from other work, action has been taken to ensure that functional and complex dementia patients can be seen more quickly. The table below demonstrates current demand vs capacity:



It is positive to note that the % Patients waiting over 28 days from referral at the end of October (018.R) has reduced for the second successive month showing that despite the challenges with meeting demand a smaller proportion of the waiting list has already breached.

Kent and Medway NHS
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	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			86.7%	95.0%	86.4%	96.5%	91.5%
2	OPMH			80.7%	95.0%	50.9%	78.3%	64.6%
3	Trust Total			83.5%	95.0%	68.8%	84.7%	76.8%

Interpretation of results (Trust wide)	
Variation	Special cause of **Improving** nature or higher pressure due to **higher** values
Assurance	Variation indicates consistently **failing short of target**

Narrative

Performance has reduced for the second successive month to 83.5%, as recently as August 2021 performance was in excess of 89% and increasing monthly. This trend has continued in CMHSOPs (80.7%) with an in-month improvement of 2.9% continuing special cause variation of an improving nature despite falling short of the target. CMHTs (86.7%) reduced in month by 3.5%

The increased referrals observed in the summer has the potential to impact this indicator in future months as patients progress through assessment and into treatment. This will be subject to ongoing monitoring through existing weekly waiting list management processes.

Kent and Medway NHS
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	013.R - 0.15R: Referrals	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			1,469		1,777.9	2,687.6	2,232.7
2	CRCG			5,217		4,109.0	6,301.5	5,205.3
3	FSS			1,734		1,636.8	2,234.5	1,935.7
4	OPMH			1,527		1,119.8	1,715.3	1,417.6
5	Trust Total			9,947		9,147.3	12,435.1	10,791.2

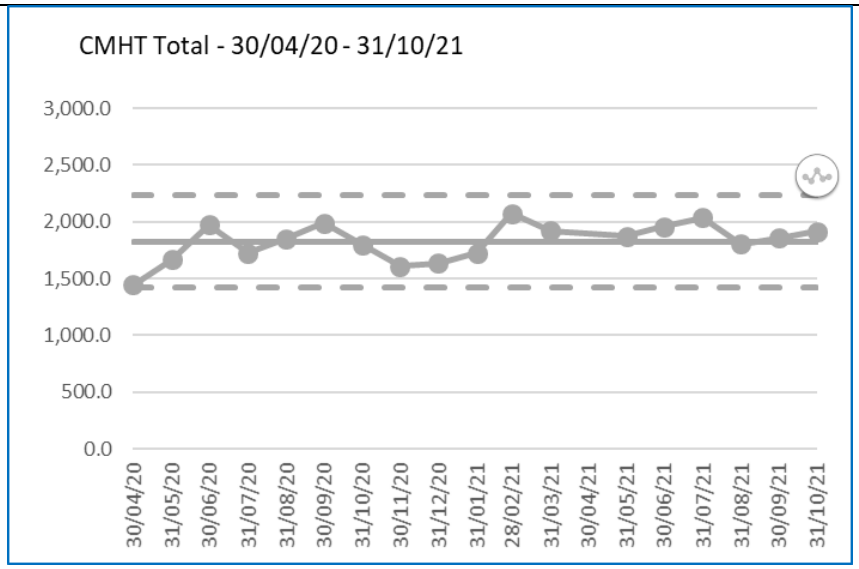
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	N/A – not set target

Narrative

Referrals into CMHTs and CMHSOPs have seen some variation in the last six months. CMHSOPs continue to show Special Cause variation within four teams due to sustained higher pressure compared to the mean of the last 18 months. CMHTs are no longer showing special cause variation against an 18-month average and have stabilised at a higher level in the last 4 months compared to the previous 10 months.

High numbers of referrals, challenges with staffing and the need to address the Covid backlog especially for Memory Assessment Services compounds the ability to sustain improvement especially against the 4 week wait standard. It is unclear if the increase in referrals will continue or revert to historic levels however post Covid hypothesis suggests ongoing increase in mental illness, with anything up to a 20% increase on pre Covid levels, likely.

The transformation programmes across community and urgent care will deliver improvements in meeting the demand but it will remain a challenge in the short term to improve significantly against these standards especially as we anticipate a challenging winter. The system and the organisation are engaged in a number of workstreams to both address and maintain stability of the current situation in the short term allowing for the longer term work to continue knowing that we will be in a very improved place once new system ways of working are fully embedded.


CMHT Total - 30/04/20 - 31/10/21
3,000.0
2,500.0
2,000.0
1,500.0
1,000.0
500.0
0.0
30/04/20
31/05/20
30/06/20
31/07/20
31/08/20
30/09/20
31/10/20
30/11/20
31/12/20
31/01/21
28/02/21
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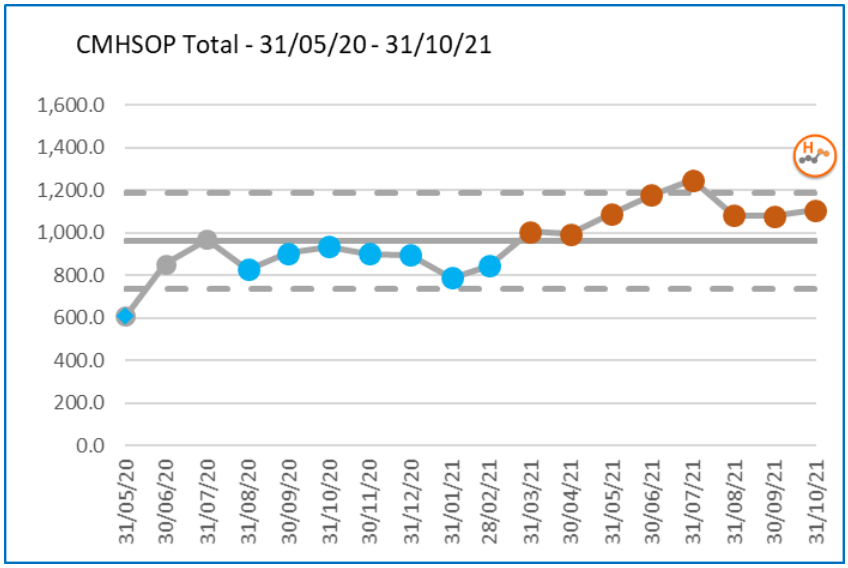
31/05/21
30/06/21
31/07/21
31/08/21
30/09/21
31/10/21


CMHSOP Total - 31/05/20 - 31/10/21
1,600.0
1,400.0
1,200.0
1,000.0
800.0
600.0
400.0
200.0
0.0
31/05/20
30/06/20
31/07/20
31/08/20
30/09/20
31/10/20
30/11/20
31/12/20
31/01/21
28/02/21
31/03/21
30/04/21
31/05/21
30/06/21
31/07/21
31/08/21
30/09/21
31/10/21

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	Referrals Received	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			77.0		36.4	107.1	71.8
2	Canterbury CMHSOP			187.0		94.8	188.1	141.4
3	DGS CMHSOP			121.0		64.6	142.8	103.7
4	Dover & Deal CMHSOP			75.0		30.2	83.1	56.6
5	Maidstone CMHSOP			139.0		82.6	162.7	122.7
6	Medway CMHSOP			132.0		88.2	157.0	122.6
7	Sevenoaks CMHSOP			63.0		28.8	88.2	58.5
8	Shepway CMHSOP			77.0		30.3	108.5	69.4
9	Swale CMHSOP			52.0		29.9	70.9	50.4
10	Thanet CMHSOP			103.0		70.2	130.3	100.2
11	Tunbridge Wells CMHSOP			79.0		41.3	85.5	63.4
12	CMHSOP Total			1,105.0		736.2	1,185.3	960.7

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IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	78.3%	69.6%	78.9%	63.6%	80.0%	71.4%	69.2%	75.0%	87.5%	78.6%	85.2%	82.8%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	92.4%	90.9%	88.3%	83.2%	82.5%	93.1%	88.3%	87.5%	85.7%	85.6%	83.9%	80.0%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	94.9%	93.5%	94.4%	90.7%	90.7%	88.2%	93.9%	89.1%	90.2%	96.0%	91.3%	93.8%
007.R	DNAs - 1st Appointments		-	-	13.0%	13.5%	12.6%	12.9%	11.3%	8.3%	8.7%	9.8%	11.0%	11.2%	11.5%	11.2%
008.R	DNAs - Follow Up Appointments		-	-	11.3%	11.1%	11.0%	9.9%	9.4%	8.1%	8.2%	10.7%	12.4%	9.8%	8.7%	8.5%
009.R	Patient cancellations- 1st Appointments		-	-	1.1%	1.3%	0.9%	1.0%	0.8%	1.5%	1.4%	2.0%	1.9%	2.0%	2.5%	1.9%
010.R	Patient cancellations- Follow Up Appointments		-	-	2.8%	3.2%	2.9%	2.6%	2.7%	3.5%	3.9%	3.9%	4.2%	4.5%	4.5%	4.5%
011.R	Trust cancellations- 1st Appointments		-	-	11.6%	3.7%	4.4%	3.9%	3.3%	2.9%	3.5%	3.9%	4.3%	3.9%	4.6%	4.9%
012.R	Trust cancellations- Follow Up Appointments		-	-	9.5%	8.9%	9.2%	9.2%	8.9%	8.0%	8.8%	8.9%	8.5%	9.7%	10.2%	10.4%
013.R	Referrals Received (ave per calendar day)		-	-	359.4	331.4	342.5	363.4	399.0	360.0	361.6	372.0	359.5	335.1	345.5	320.9
014.R	Referrals Received (ave per working day)		-	-	426.0	400.1	419.1	433.8	459.6	427.4	458.7	434.8	427.0	405.9	404.7	400.5
015.R	Referrals Received (per 10,000 Kent and Medway Registered GP population))		-	-	667.0	622.1	625.9	628.3	744.2	642.7	632.8	695.7	697.8	631.3	653.3	621.7
016.R	Referral to Assessment with 4 weeks Care Spell		95%	-	52.8%	53.0%	52.2%	68.7%	70.4%	68.9%	67.7%	63.6%	62.1%	57.3%	43.8%	51.4%
017.R	Referral to Treatment within 18 weeks Care Spell		95%	-	71.8%	72.5%	72.7%	74.0%	78.6%	84.1%	87.7%	90.0%	88.8%	89.1%	83.3%	83.5%
018.R	% Patients waiting over 28 days from referral		-	-	44.9%	45.6%	39.0%	30.9%	23.1%	28.0%	30.4%	28.5%	33.7%	43.3%	41.2%	39.9%
019.R	Urgent referrals seen within 72 Hours		95%	-	55.6%	57.6%	54.2%	61.6%	63.1%	59.6%	62.3%	62.4%	59.2%	62.6%	59.8%	60.4%

A further breakdown of 016.R is provided below which shows performance by all contributing teams with an additional split of CMHSOP activity.

															Oct-21	
		Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Care Spell Assessments	Average Wait (days)
016.R - Service Type & CMHSOP Split	**CMHT**	95%	80.2%	72.9%	67.6%	86.9%	86.6%	74.8%	75.1%	72.4%	79.1%	73.9%	66.4%	76.0%	358	25.0
	Open Dialogue	95%	100.0%	0.0%		50.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		N/A	N/A
	CMHSOP*	95%	40.3%	44.5%	43.8%	59.6%	61.3%	65.4%	63.9%	58.9%	51.2%	48.5%	30.4%	39.9%	767	43.0
	CMHSOP routine memory assessment	95%									42.7%	40.3%	22.1%	32.5%	539	46.5
	Functional, Urgent, Complex Memory Ass.	95%									64.6%	63.6%	51.2%	57.4%	223	35.0

** CMHSOP totals don't match breakdown as small proportion of activity uncoded at triage*

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Appendix A: Single Oversight Framework

Overview

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

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

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

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

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

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

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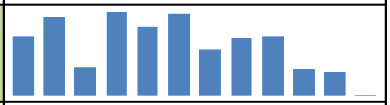
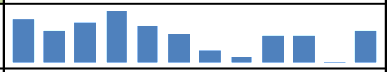
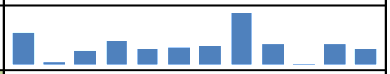
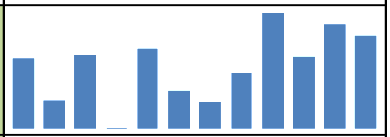
IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Sep-21	Oct-21	Trend *(Last 12 months where available, left to right)*
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	96.3%	95.2%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		81.7%	87.5%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		205	175	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	85.2%	82.8%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.9%	95.9%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	4.6%	5.0%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93%	82.5%	85.6%	

**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*

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Appendix B: IQPR Overview and Guides

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

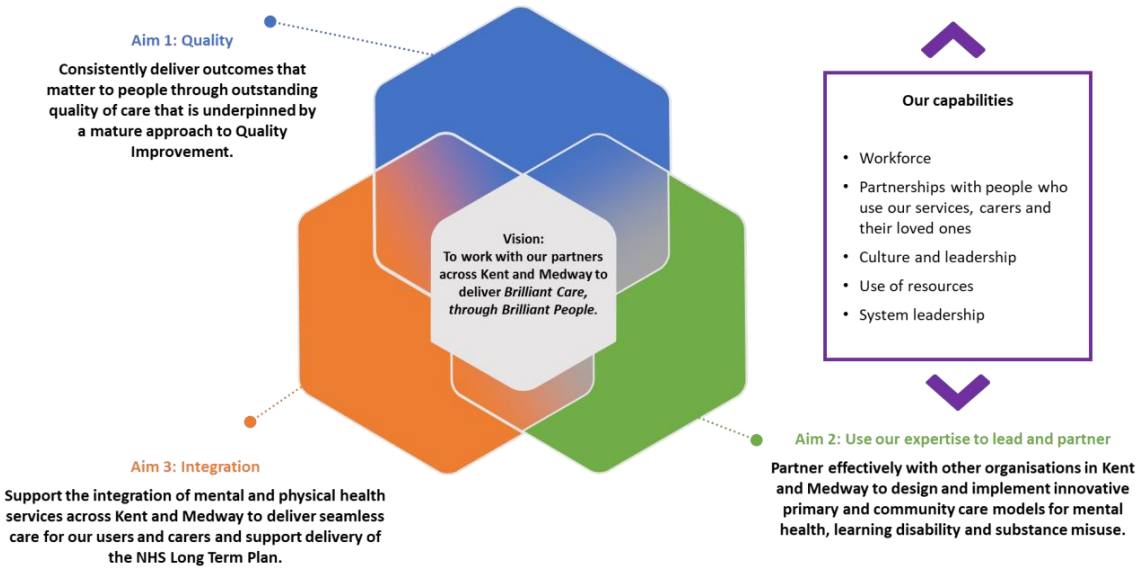
Good examples of IQPRs from high performing organisations change and improve over time. KMPT's is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the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

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

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

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

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


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

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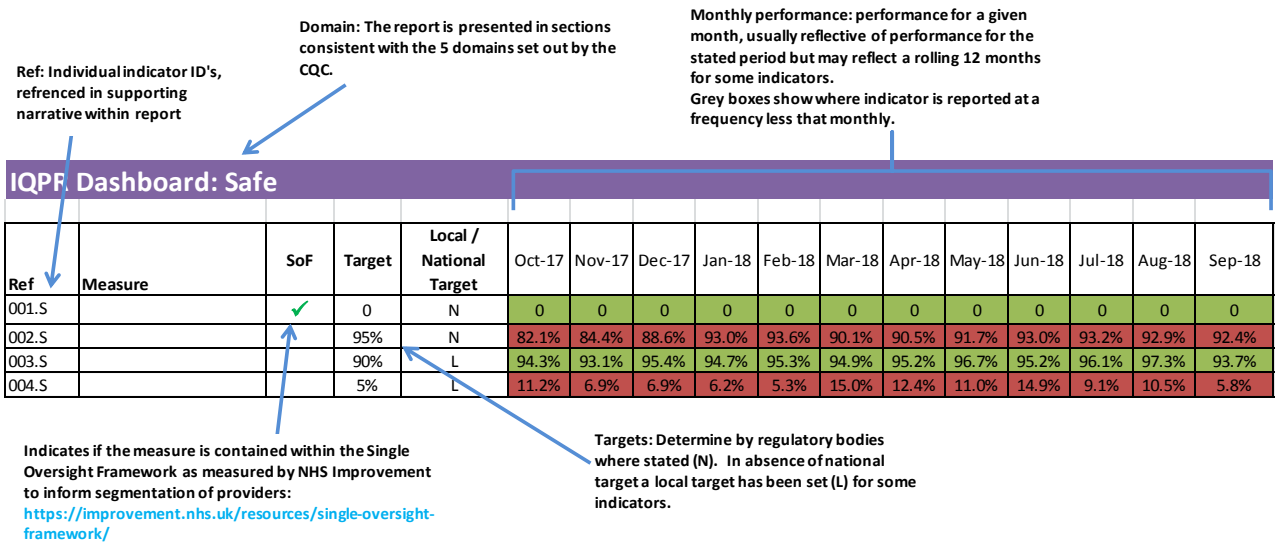
IQPR Dashboard Guide

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

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



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

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IQPR Exception Reporting

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

SPC Key:

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

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IQPR Change Tracker

Date	Change	Report Reference
January 2021	Statistical Process Control Charts implemented for exception report within a new section within the report. Previous areas of focus within individual domains removed.	
Februray 2021	Indicator removed: Freedom to speak up issues IQPR Overview and Guide moved to appendicles	013.W-W
May 2021	New/amended indicators for 2021/22: Unplanned Readmissions within 30 days (020.S) Replaces 28 day readmission indicator CPA patients receiving follow-up within 72hours of discharge (001b.E) New inclusion in IQPR Care Planning / Crisis Planning / Distribution Previous indicators retired, new measures introduced to include PSP reporting. (015.E – 017.E) Waited time measures Previous indicators retired, new measures introduced to include PSP reporting. (016.R – 018.R) Workforce metrics Vacancy metrics retired, replaced with retention measure (015.W-W) New absence and turnover targets	
July 2021	New indicator for urgent referrals	019.R

Changes made prior to January 2021 removed from table, these can be viewed in IQPR versions pre Dec 2020

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th November 2021
Title of Paper:	Finance Report for month 7 (October 2021)
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director of Finance

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for Month 7 (October 2021). This is consistent with the position submitted to NHS Improvement in the Month 7 Financial Performance Return.

Items of focus

As at the end of October 2021, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with forecast and expectation for H2.

H2 plans are due to be submitted by the 25th November with an expectation of a breakeven position. It will be a significant challenge for the Trust to deliver breakeven in H2. To ensure we deliver the following actions/controls are being put into place:

1. All Care Groups and Support Services will be given an efficiency target based on areas of opportunity (the Trust pillar approach for driving efficiencies will remain in place)
2. The annual efficiency target will be fully identified by the end of December 2021
3. New agency control totals for each care group will be put into place, these will be monitored on a weekly basis. A new weekly meeting will take place with the care groups with the Executive Director of Finance, Medical Director and Director of Workforce

Page five of the finance report highlights the exceptions to bring to the Board's attention. These are Temporary Staffing Spend: Agency, Private Placement Spend, Planned and Reactive maintenance, and Patient Travel spend.

The Trust Capital year to date position is underspent by £5.4m, of which £0.8m relates to IM&T, £3.7m on estates and £0.9m on strategic schemes and the Improving Mental Health Services programme.

The cash position remains strong at £16.3m at the end of October.

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

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Finance Report

Trust Board

October 2021

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Contents

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Executive Summary

Key Messages for October 2021

As at the end of October, the Trust continues to report a breakeven position both in month and year to date. This is in line with the expectation for H2.

The H2 plan submission is being finalised in accordance with issued guidance. For the second half of the year systems are asked to continue meeting the Mental Health Investment Standard (MHIS) and KMPT is actively engaged with the local Mental Health Improvement Board. System returns are due 16th November with Provider specific returns being submitted on the 25th November. Achieving breakeven for H2 will be challenging but there are mitigations in place to manage delivery and KMPT will be submitting a breakeven plan for H2.

The Trust is progressing with the Long Term Sustainability Programme, with a renewed focus in H2 to ensure delivery of breakeven. Of the £7m target set, £6m has now been identified with the aim to identify the full £7m by the end of December. Some of this is non-recurrent in year, whilst longer term plans are made to secure recurrent savings.

Income and Expenditure

Within the breakeven position reported, there are several key factors. There are continued pressures in temporary staffing and private placements above budget. Year to date agency spend at the end of October was £4.45m, £704k lower than the same period last financial year. Any overspend is being mitigated currently by vacancies due to challenges recruiting into substantive roles.

Year to Date

	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(129,377)	(127,964)	1,413
Employee Expenses	100,267	97,941	(2,326)
Operating Expenses	26,205	27,067	862
Operating (Surplus) / Deficit	**(2,905)**	**(2,956)**	**(51)**
Finance Costs	2,905	2,956	51
(Surplus) / Deficit	**0**	**(0)**	**(0)**

At a Glance - Year to Date

Income and Expenditure
Efficiency Programme
Agency Spend
Capital Programme
Cash

Key

On or above target

Below target, between 0 and 10%

More than 10% below target

Capital Programme

The year to date position is underspent by £5.4m, £0.8m on IM&T, £3.7m on estates and £0.9m on strategic schemes and the Improving Mental Health Services programme. The main reasons for the underspend in estates are delays in completion of prior year schemes, new year estates schemes being in the tendering stage and VAT reclaims/ retention adjustments. There is an underspend on IT schemes including Crisis Mobile Rio and devices replacement due to equipment supply issues across the sector.

The detailed forecast is being reviewed and updated, this will be shared with the Kent and Medway System Capital Group.

Cash

The cash position increased by £2.3m in month to £16.3m, predominantly due to pay award funding and two months SLA for the Provider Collaborative being received in October. The actual is £2.8m higher than the original plan with receipts and payments below plan by £1.8m and £4.6m respectively.

The year end forecast has increased by £1m to £11.6m to reflect the H2 plan to break even and lower depreciation forecast

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Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	(18,570)	(18,258)	312	(129,377)	(127,964)	1,413
Employee Expenses	14,562	13,880	(682)	100,267	97,941	(2,326)
Operating Expenses	3,593	3,955	362	26,205	27,067	862
Operating (Surplus) / Deficit	**(415)**	**(423)**	**(8)**	**(2,905)**	**(2,956)**	**(51)**
Finance Costs	415	423	8	2,905	2,956	51
(Surplus) / Deficit	**0**	**0**	**0**	**0**	**(0)**	**(0)**

Commentary

Pay continues to underspend and is £2.3m underspent at the end of October.
Within this, substantive pay is £4.4m underspent, this is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives, some of which have delays in mobilisation. For these areas, corresponding income has also been deferred to match.

Operating expenses is overspent by £862k. The key area contributing to the overspend is Private Placements with a greater number of bed days being utilised than planned.

Long Term Sustainability Programme (Efficiency Programme)

	Annual	Current Month			Year to Date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Pillar	£000	£000	£000	£000	£000	£000	£000
Back Office	(2,000)	(167)	(94)	72	(1,167)	(752)	414
Workforce	(1,000)	(100)	(66)	34	(500)	(156)	344
Service Line Reporting	(1,000)	(167)	0	167	(167)	0	167
Patient Pathways	(1,500)	(163)	(80)	82	(688)	(562)	126
Procurement and Purchasing	(1,000)	(100)	(44)	56	(500)	(283)	217
Commercial Development	(500)	(56)	(15)	40	(222)	(137)	86
Non-recurrent slippage	0	0	(169)	(169)	0	(972)	(972)
Total	**(7,000)**	**(751)**	**(469)**	**283**	**(3,243)**	**(2,861)**	**382**

Commentary

The majority of schemes are progressing through H2. Due to the nature of some of these schemes in-depth work needs to be undertaken with Care Groups and external stakeholders in order for them to progress. To ensure the gap is mitigated for this financial year, non-recurrent slippage of £2.8m has been identified. Currently the gap for 21/22 is £974k of the £7m target.

The SLR pillar has been progressed further during October with deep dive information being finalised for Older Adults, CRCG and Forensics & Specialist Services in readiness for discussion by early December, slightly ahead of the original plan.

The output for the Acute Care Group has been shared which highlighted areas of potential efficiencies and the Care Group and Finance team will work together to confirm metrics and opportunities and agree action plans and deadlines for delivery.

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Exception Report

Top 4 Variances

	Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last report
Agency	3,675	4,450	775	21%	35%
Private Placements	1,908	2,215	307	16%	46%
Planned and reactive maintenanc	1,487	2,101	614	41%	27%
Patient travel	338	602	264	78%	90%

1. Temporary Staffing Spend: Agency £775k

Although agency spend remains a high variance, the percentage overspend has reduced from 35% reported last month to 21% in October.

Mitigations continue to be explored with Care Groups and agency and bank spend is forecast to slow because of successful recruitment in CRCG and the Trustwide newly qualified nurse programme. International recruitment is expected to impact positively on agency use in the latter part of the financial year with recruitment plans currently being finalised. Agency control targets will be issued for the remainder of the financial year.

	2017/18	2018/19	2019/20	2020/21	2021/22 YTD	2021/22 FOT
Bank	11,131	11,390	13,560	16,968	9,828	17,233
Agency	***6,924***	***6,459***	***6,395***	***8,740***	***4,450***	***7,529***
Total	18,055	17,849	19,955	25,708	14,278	24,762

2. Private placement Spend £307k

As part of the Trust's block contract a level of private placement spend is commissioned due to KMPT not having female PICU capacity within existing bed base.

The cost pressure for this financial year is due to three main factors:

1. Refurbishment work on Willow Suite resulting in closed beds temporarily
2. An increase in acute bed days purchased to cope with acute inpatient pressures due to an increase in demand
3. Three "non core" placements which have now ended but were in the spend figures above plan for April - June

3. Planned and reactive maintenance £614k

The budget for Planned and Reactive maintenance charges is based on trend analysis from previous financial years with input from Estates in order to horizon scan what works are planned. For 2021/22 this spend has increased and represents a significant year on year increase.

At the end of the month 7 spend is over and above these levels by £614k. The Executive Director of Finance is working with the estates function and the supplier to manage both spend and the overall maintenance schedule. Interim support has been sourced to help in this area.

4. Patient Travel £264k

Between April and October the Trust has seen consistently high levels of spend above budget, much of which aligns to the increase in private placements and associated travel costs.
To date the budgetary pressure for all of patient travel totals £264k. This is a deteriorating position and a task and finish group is being led by the Deputy Director of Finance to review all patient travel and standardise booking processes across the Trust.
This has resulted in the transfer of a key element of patient transport (AMHP bookings) over to the CCG to manage as these bookings are made by KCC and not KMPT. Costs incurred this year so far of £112k will be transferred to the CCG. This will reduce the total spend on patient travel and enable clearer focus on KMPT influenceable journeys.

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Appendices

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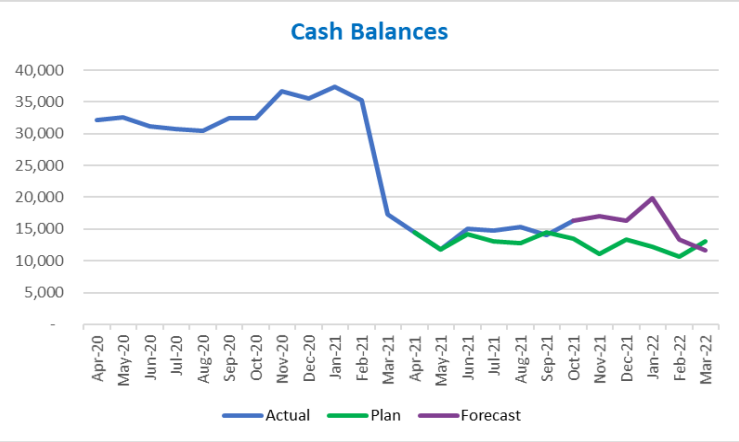
Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2021 Actual £000	Prior Month 30th September 2021 Actual £000	Current Month 31st October 2021 Actual £000
Non-current assets	130,002	129,735	129,747
Current assets	22,682	23,285	22,945
Current liabilities	(24,777)	(25,668)	(25,439)
Non current liabilities	(11,976)	(11,420)	(11,322)
Net Assets Employed	**115,931**	**115,931**	**115,931**
Total Taxpayers Equity	**115,931**	**115,931**	**115,931**



Commentary

Non-current assets

The value of non current assets has remained at a similar level to the prior month, reflecting the increased capital expenditure in October which offset depreciation.

Current Assets

The cash position remains strong with an increase of £2.3m, predominantly due to pay award funding being received in October. Receivables have decreased by £2.6m with a £2.3m reduction in accrued income largely due to payment for the pay award and a slight decrease of £0.2m in the aged debt position.

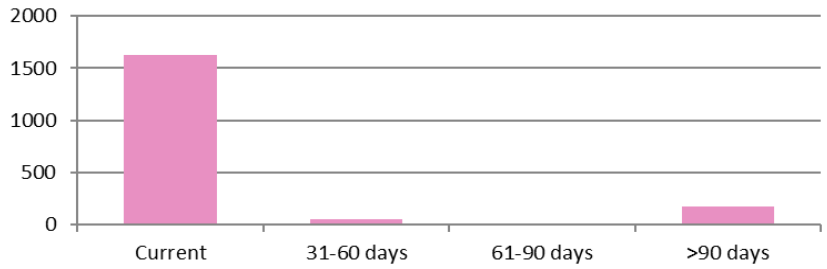
Current Liabilities

Trade and other payables have decreased by £0.2m. There was a £1m decrease for tax and pension creditors as the impact of the M1-6 backpay was paid in October. This decrease was partially offset by a £0.3m increase in PDC accruals, £0.3m increase in deferred income and £0.2m increase in capital creditors (reflecting the higher in month capital spend).

Aged Debt

Our total invoiced debt is £1.9m, of which £1.6m is within 30 days. Debt over 90 days has increased to £0.2m. This is largely due to non-payment by the Lime Property Fund for the Greenacre site, this issue has been escalated to the Contracts team to progress.

Aged Debt Analysis



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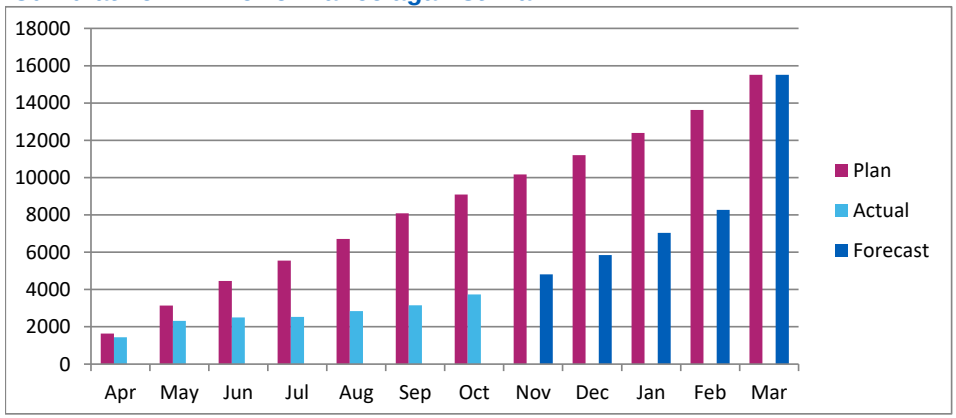
Capital Expenditure

	Current Month			Year to Date			Full Year
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000	*Actual* £000	*Variance* £000	*Plan* £000
Information Management and Technology	125	88	(37)	1,642	848	(794)	2,856
Capital Maintenance & Minor Schemes 2021/22	325	6	(319)	1,917	22	(1,895)	2,142
Capital Maintenance & Minor Schemes from 2020/21	0	17	17	3,100	1,483	(1,617)	3,635
Capital Maintenance & Minor Schemes Prior Year Adj	0	(0)	(0)	0	(143)	(143)	0
Strategic Schemes - Orchards Ward	0	197	197	1,045	681	(364)	1,045
Improving Mental Health Services (Maidstone)	560	276	(284)	1,371	826	(544)	5,787
PFI 2020/21	3	3	0	23	23	0	40
Total Capital Expenditure	**1,013**	**588**	**(425)**	**9,098**	**3,740**	**(5,358)**	**15,505**

Cumulative YTD Performance against Plan



Commentary

In October, the Trust spent £0.6m against the plan of £1.0m, an increased spend against trend.

The year to date position is underspent by £5.4m, £0.8m on IM&T, £3.7m on estates and £0.9m on strategic schemes and the Improving Mental Health Services programme. The main reasons for the underspend in estates are delays in completion of prior year schemes, new year estates schemes being in the tendering stage and VAT reclaims/ retention adjustments. New project management has been procured to support the delivery of the estates capital programme. There is an underspend on IT schemes including Crisis Mobile Rio and devices replacement due to equipment supply issues across the sector.

The forecast for capital schemes is being reviewed and updated this month to reflect latest estates plans and tender pricing. This will be shared with the Kent and Medway System Capital Group.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th November 2021
Title of Paper:	Workforce Report
Author:	Jennie Cogger Deputy Director of Workforce and Organisational Development
Executive Director:	Sandra Goatley Director of Workforce and Organisational Development

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper provides a progress update on the Workforce and Organisational Development work:

- Position against Key Performance Indicators (KPI's). A comparison of the KPI's are presented with historic data, year to date position and local benchmarking.
- Updates in line with 4 areas of the People plan; Looking after our people, Encourage belonging, New ways of working and delivering care and Growing for the future, including actions being taken to address the KPI's.

Issues to bring to the Board's attention

Not performing against targets in month for essential training for the role, sickness, retention and turnover.

Governance

Implications/Impact:	Impact on patient safety/staff morale/recruitment and retention
Assurance:	Limited Assurance at this stage
Oversight:	Oversight by Workforce and Organisational Development Committee and Audit Review Committee

Workforce Report
November 2021

Sandra Goatley

Director of Workforce and Organisational Development

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Our KMPT Cultural Heart, is the core of our People Strategy and has 3 key principles:

Just and learning approach

An empowered team of teams

Living our values

Our 20/21 People Plan Objectives cover 4 areas:

Looking after our people
Encourage belonging
New ways of working and delivering care
Growing for the future
We also support the national NHS People Promise at KMPT

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Priority 3 : Developing our capabilities to deliver

Goal	Executive Lead & Board Committee	Success by Q4 will look like…
3a. Looking After Our People by creating the Perfect Day and delivering the People Recovery Plan	Director of Workforce & OD Workforce and OD Committee	Drive delivery of our People Recovery Plan • Reduce sickness absence from 4.22% to target maximum of 4.0% • Reduce staff turnover from 10.5% to a maximum of 9% • Increase number of trained Mental Health First Aiders • Improve staff survey result on health & wellbeing question by at least 5%
3b. Encourage Belonging by becoming a fully diverse and inclusive organisation with anti-discriminatory behaviour	Director of Workforce & OD Workforce and OD Committee	Further embed and drive develop of KMPT organisational culture • Workforce race equality standards (WRES) performance improved • Workforce disability standards (WDES) performance improved • Reduce staff turnover from 10.5% to a maximum of 9%
3c. New ways of Working and Delivering Care by creating innovative Workforce Modelling for the future, delivering Brilliant Care	Director of Workforce & OD Workforce and OD Committee	Leadership and implementation of structured plan for workforce remodelling • Staff retention rates improved to 90% • Staff turnover reduced from 10.5% to 9% • Expenditure on use of locum/agency staff reduced
3d. Growing for the Future by ensuring we maximise potential of all employees to be the best we can	Director of Workforce & Communications Workforce and OD Committee	People talent is enhanced and embedded as centre of practice excellence across KMPT • Appraisal rates improved to 99% • PDP completion improved to 85% • Staff retention rates Improved to 90%

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IQPR

Measure	Target	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Staff Sickness - Overall	4.00%	4.4%	5.1%	4.2%	3.8%	3.5%	3.7%	4.0%	4.6%	4.6%	4.2%	4.6%	5.0%
Appraisals And Personal Development Plans	99%	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%						
Vacancy Gap - Overall	11.85%	12.7%	13.4%	14.1%	14.0%	14.2%	15.3%	15.5%					15.0%
Vacancy Gap - Medical		27.0%	26.8%	28.0%	27.9%	28.8%	28.8%	29.8%					28.5%
Vacancy Gap - Nursing		13.9%	13.3%	14.5%	14.7%	15.4%	16.2%	16.5%					12.6%
Vacancy Gap - Other		12.7%	12.0%	14.1%	12.2%	12.2%	13.6%	13.5%					13.1%
Essential Training For Role	90%	89.4%	89.5%	91.3%	90.4%	91.2%	91.8%	92.4%	92.4%	90.4%	90.5%	92.6%	91.5%
Staff Retention (overall)	90%								87.3%	82.7%	84.3%	81.8%	81.8%
Staff Retention (Additional Clinical Services)	90%								85.1%	82.3%	83.9%	77.6%	78.8%
Staff Retention (Nursing)	91%								87.0%	80.5%	82.1%	78.9%	79.3%
Staff Retention (Medical)	92%								89.2%	86.8%	88.4%	82.2%	82.6%
Staff Turnover (Overall)	9.00%	9.4%	9.4%	9.4%	9.6%	9.4%	10.1%	10.5%	9.5%	10.9%	11.3%	12.2%	12.6%
Staff Turnover (Additional Clinical Services)	10.00%								11.9%	13.1%	12.7%	13.1%	15.1%
Staff Turnover (Nursing)	9.00%								9.1%	10.8%	9.7%	10.6%	9.9%
Staff Turnover (Medical)	8.00%								8.1%	10.4%	12.2%	12.5%	12.4%

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Key Performance Indicators (1)

	2019/20	2020/21	Year to date
Sickness	4.48%	4.02%	4.37%
Vacancy	15.8%	13.1%	14.54%
Retention	84.05%	87.48%	89.31%
Turnover	11.5%	9.4%	8.21%

- Substantive budget as at 1/4/20 was 3255.89 WTE
- Vacancy rate was 14.3%

- Increase in establishment 20/21 (plus to date) was 437.49 WTE

- Substantive budget today is 3693.38 WTE
- Vacancy rate now 14.5%

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Local Benchmarking

	KMPT	Oxleas	Sussex Partnership	South London & Maudsley
Retention (July 2021)	87.3%	81.7%	88.6%	86.3%
Sickness (June 2021)	4.2%	4%	4.3%	3.4%
Turnover (July 2021)	9.5%	18.8%	11.1%	9.5%

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Key Performance Indicators (2)

Target by August 2022	Current Position
Being part of KMPT – encouraging belonging	
Workforce Race Equality Standards (WRES): • Indicator 5: Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months: from 44.3% to 34.4% • Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months: from 25.5% to 17.5%	WRES: • Indicator 5: 42.9% • Indicator 6: 23.45%

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Vacancy Information (1)

Indicator	Service	Oct-21
Vacancy Gap - Overall	Trust wide	15.0%
	Acute Service	15.3%
	Community Recovery Service	16.5%
	Older Adult	15.1%
	Forensic & Specialist	8.7%
	Corporate Services	19.2%
Vacancy Gap - Medical	Trust wide	28.5%
	Acute Service	28.8%
	Community Recovery Service	37.3%
	Older Adult	11.2%
	Forensic & Specialist	29.4%
	Corporate Services	35.9%
Vacancy Gap - Nursing	Trust wide	12.6%
	Acute Service	25.6%
	Community Recovery Service	7.7%
	Older Adult	7.7%
	Forensic & Specialist	22.8%
	Corporate Services	-1.0%
Vacancy Gap - Other	Trust wide	13.1%
	Acute Service	5.9%
	Community Recovery Service	19.7%
	Older Adult	18.9%
	Forensic & Specialist	1.3%
	Corporate Services	19.5%

As at October 2021
(not including recruitment pipeline)

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Vacancy Information (2)

Vacancy Information – nursing

2019/20 = 16%
2020/21 = 14%
2021/22 (YTD) = 16%

Vacancy information – medical

2019/20 = 33%
2020/21 = 28%
2021/22 (YTD) = 30%

Looking after our people

- NHS Health and Wellbeing Framework Trailblazer pilot project
- Schwartz Rounds
- Wellbeing Wednesday
- Appraisals and Supervision
- Supporting staff through Health and Wellbeing Cafes
- Starting work on wellbeing spaces

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Encourage belonging

Culture Change Workstreams

Just and Learning Approach
- Psychological safety
- Policy and process review - Early resolution

Living our Values
- Embedding the KMPT values

Empowered team of teams
- What does good look like
- Employee engagement and agile working

Diversity and Inclusion
- Annual Equality report
- Staff Networks
- Reverse mentoring
- Awareness and Training opportunities
- Active Ally Training

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New ways of working and delivering care

Recruitment
International recruitment
Tackling the vacancy group
Workforce planning
Workforce modelling – new roles
Acute medical workforce test for change

Retention
Career development and career pathways
Improved engagement within 1st year of employment
Promotion of flexible working and health and wellbeing
Improved exit interview process
Just and learning culture work
Closed Cultures
Talent conversations
Creating an inclusive organisation
Agile working

Care Group Recruitment and retention plans and doing work on closed cultures

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Growing for the future

- Supervision
- Career pathways
- Education and Training
- Talent conversations

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Staff Survey update

Response rate: 57.8% (as at 17/11/21)

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Risk Register

Refreshed risk register agreed at recent Workforce and OD Committee:

- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)

Any questions?

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	Quality improvement (QI)
Author:	Martine Mccahon (Assistant Director Transformation and Improvement)
Executive Director:	Dr Afifa Qazi (Executive Medical Director)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This Board paper provides an overview of what has been achieved by the Quality Improvement team in quarter one and quarter two of 2021/22 and the key areas of focus until April 2022. It notes good progress in terms of delivering KMPT's Quality Improvement strategy.

The appointed resource of Clinical Director (4 sessions per week), Head of Quality Improvement and two Quality Improvement facilitators (see appendix one for the KMPT's QI team) has established the fundamental building blocks for embedding KMPT's Quality Improvement approach. The priorities have been a clear and consistent approach and governance, commencement of live QI work, building capacity and capability within all levels of the organisation and accessible and engaging communications.

Significant progress has been made to date despite the limited staff resource in the QI team. Additional resource would enable deeper focus in each goal allowing us to take Quality Improvement to the next level, growing the culture and delivering increased project activity.

Issues to bring to the Board's attention

Items of excellence:

- Six brand-new custom-built Quality Improvement modules launched; accessible to all staff in the organisation through i-Learn.
- Championed QI throughout the organisation resulting in 1042 staff attending QI awareness events – 2021/22 target overachieved of 800 staff.
- Established the enabling infrastructure including clear governance routes for projects and a supportive project toolkit.
- Robust communications approach utilising internal and external channels to engage in and promote QI. Bespoke QI website being developed.
- Sharing learning and successes resulting in external organisations seeking guidance for Safety pods.

Items of concern and hot spots:
At end of quarter two we have 5 completed projects with measurable outcomes, 11 Live QI projects and 19 pipeline projects. This is variance against trajectory towards a goal of 25

completed projects delivered by April 2022. This is due to a number of large-scale complex projects requiring significant resource as well as all projects currently requiring direct QI team support. Action is being taken to address this by building capability for people to independently lead projects, actively encouraging more front line driven, smaller scale projects and ensuring a unified view of all current QI activity within the organisation.

The QI team have been driving forward communications internally and externally although this report acknowledges that we need to enhance our visibility of QI across the organisation.

Governance

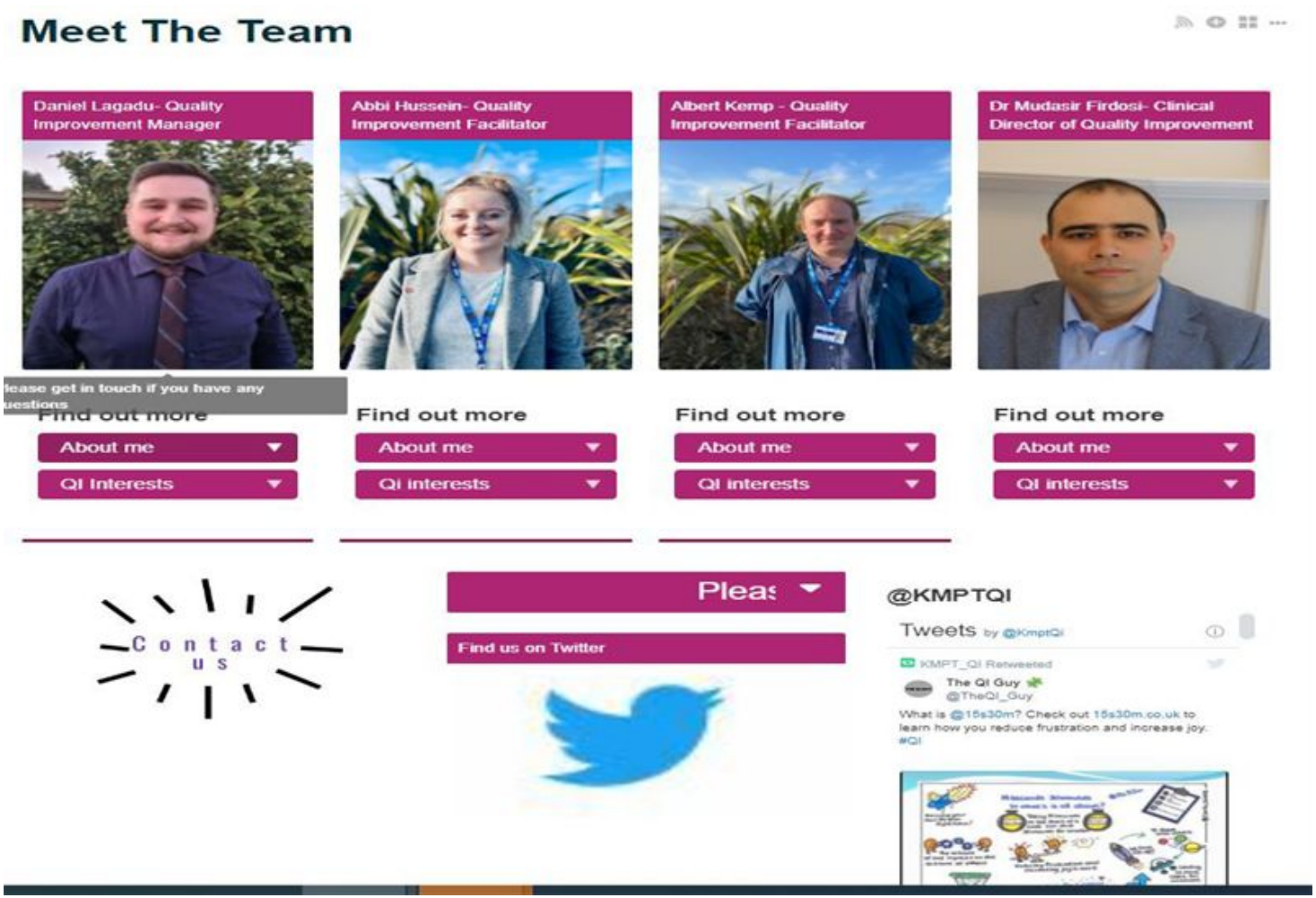
Implications/Impact:	Ability to deliver Trust Strategy
Assurance:	Reasonable
Oversight:	Oversight by Quality Committee

KMPT quality improvement's implementation plan – completed and ongoing activity for 2021/22

Goals	Outcomes the goal will achieve	Ongoing activity *completing by April 2022*	Completed Activity to date 2021/22
Further engagement with the Board with regards to Quality Improvement	• The Executive team are accountable for delivering the Quality Improvement strategy • There is alignment with Board subcommittee's remits and QI • Quarterly update to Board	• Patient story at November Board • QI training for Board members including their role in QI	• Quality Committee reported positively to September Trust Board in terms of improvements in the QI team • QI has been included at Trust wide forums including Leaders' event, the Big conversation, Executive Assurance Committee, Annual General Meeting • Executive sponsors for each live QI project, charters signed
To further build the infrastructure across KMPT including a coherent QI offer which includes the KMPT way	• A clear and consistent KMPT QI approach which is easily accessed by staff across the Trust • Live reporting of QI project status • Tools which support delivery of our approach in a face to face and virtual setting	• Agreement of options appraisal for QI reporting platform • Development of QI section on external KMPT website • Learning from other organisations	• QI Clinical Director now in place enhancing interface between clinical services and QI • QI approach developed informed by a comprehensive literature review of best practice, based on IHI model for improvement. • The QI team has created infographics to present the QI approach in a way that is accessible and easily understandable to a wide audience • Identification and use of tools to support our work including virtual engagement platforms and measurement for improvement • The QI team has been undertaking wide engagement with key teams and individuals within the organisation
Building the culture of QI across the Trust	• Increasing awareness, confidence and application of QI through aligning with existing networks and people responsible for quality • Learning from others and raising our profile	• Participation in national FLOW dementia programme • Delivery of Leading the Way Programme module • Further engage with research and clinical audit department • Identify QI pioneers in all care groups and across all professional groups	• Promoting the culture through branding which is fun, accessible and clear • Working collaboratively across professional groups involving staff from all levels in QI projects • Application of QI coaching and facilitation skills to encourage stakeholders to think differently and explore opportunities • Built connections with organisations at a system level. including Kent County Council and national Quality Improvement teams. Developing a Kent and Medway ICS unified QI ambition and working with the South East collaborative on the national Mental Health Safety Improvement Programme which enables sharing of best practice and facilitates scaling of local and pilot projects • Joint training with KCHFT and KCC
Building QI capacity and capability across the Trust including a menu of training	• Deliver 2021/22 strategic priorities; • 350 staff trained in bitesize QI modules • 800 staff attended QI awareness events • Development of a sustainable	• Include QI from induction to appraisal and job planning for all staff • Include QI in CPD events and conferences across the organisation • Coproduce service user QI	• 83 staff trained in bitesize QI modules • 1042 staff attended QI awareness events – 2021/22 target overachieved • Six QI training modules are live • Targeted training for various groups including; • Junior and middle grade doctors resulting in QI projects • The offer of special interest sessions to higher trainees (registrars) to lead on QI projects across services

Goals	Outcomes the goal will achieve	Ongoing activity *completing by April 2022*	Completed Activity to date 2021/22
	and effective QI training approach • QI will be part of our induction for all new starters and students	training	• Preceptorship training for AHP and Nursing staff • Leading the Way programme for managers • Student supervisor training for consultants • Discipline specific, tailored QI training sessions • Proactively working with patient engagement team fostering relationships with service users to support coproduction in QI
Development and delivery of a coordinated approach to QI projects	• Deliver 2021/22 strategic priorities; 25 completed QI projects across the Trust • Each QI project to have clear outcome of measures and evidences the positive impact on staff and patient experience	• Sustain and scale up projects • Cultivate the number of front-line driven projects • Further deliver QI projects within all care groups • Submission of QI work for presentation at conferences and publication • Further working with all professional groups and education departments ensuring all QI activity across the organisation is reported through the QI team • Psychiatric higher trainees to be offered support and training in leading QI projects across care groups	• 5 completed QI projects, 11 Live QI projects and 19 pipeline projects • As a result of the liaison psychiatry project productivity has improved (saving up to 20 minutes walking per patient for printing and incoming calls for referrals reduced from 28% to 5% of total) and this project is being scaled up across the Trust. • The collaborative QI Project focusing on older adults' doctors recording of a patient's capacity to consent in the MCA/BI areas of RIO achieved a significant improvement with the average number of missed high impact areas in CiQ checks moving from an average of 14 before the QI project to 2.5 after implementation of change ideas. • QI team are supporting strategic QI projects for dementia to diagnosis to reduce the time taken to deliver a diagnosis of dementia and improving the experience of the complaints process to reduce level 3 complaints, reduce recurrent complaints and increase learning from complaints. • QI team have a robust approach from idea inception to completion • QI team attend all care group Governance meetings • QI working group provides oversight and reports to quality committee for assurance • An application has been submitted to the Healthcare heroes' awards • QI was included and received positive feedback from the Positive Practice in Mental Health visit
Development and delivery of proactive communications through multiple channels.	• Each QI project to hold an appreciation event and learning to be shared • Utilising available platforms for engagement of internal and external stakeholders	• QI annual celebration and learning event • All completed projects to develop a poster and a vlog • Roadshows • Quarterly newsletter • Induction pack for all new starters	• Launch event for QI with daily themes • An active twitter account with growing followership and regular championing of QI content • Regular communications through available internal channels • Comprehensive QI page developed on i-connect and NHSFutures platform • All completed projects have a completed pack used to share learning

Appendix one – KMPT's quality improvement team



Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th November 2021
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, Executive Director of Finance
	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

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

Items of focus

The Trust Board last approved the Standing Orders and Standing Financial Instructions in November 2020.

Following an annual review, the key areas of proposed change relate to the establishment of a KMPT Charity, amendments to the Business Case Policy and Capital programme and adjustments to the scheme of delegation for bad debt.

All of this relates to existing changes that the Board or Executive Team have been engaged with, and in relation to the changes to delegated limits award no more authority than already exists in other sections of the scheme of delegation.

Governance

Implications/Impact:	The Standing Orders and Standing Financial Instructions are a statutory requirement for all NHS Organisations
Assurance:	Significant
Oversight:	Oversight of policy by Audit and Risk Committee

Kent and Medway
NHS and Social Care Partnership Trust

Standing Orders and Standing Financial Instructions Paper

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

2. Previously, a full review of the Standing Orders and Standing Financial Instructions ('SOs & SFIs') took place in Autumn 2020. The amended SOs & SFIs were taken to the Audit and Risk Committee and then to the Trust Board in November 2020.

3. A review of the SOs & SFIs this year has led to a few changes being proposed and with the authority of the Chair of the Audit and Risk Committee, the changes have been presented to the Board directly.

4. To record the changes concisely, the proposed changes and reasons for them are recorded in the table attached.

5. The Board is requested to approve the changes as proposed.

Key Changes Requested for Approval

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

SO/SFI number	Current wording	New wording	Reason
Throughout	Integrated Audit and Risk Committee	Audit and Risk Committee	Change in name of Committee
8.7	Minutes, or a representative summary of the issues considered and decisions taken, of any Committee appointed under this SO 8 are to be formally recorded and submitted for inclusion onto the agenda of the next possible Board meeting. Minutes, or a representative summary of the issues considered and decision taken of any Governance Group shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.	Minutes of any Committee appointed under this SO 8 shall be made available to all Board Members, except for the Remuneration and Terms of Service Committee, the minutes of which shall only be available to its Members. With the exception of those items that are required to be reported to the Board under these Standing Orders or as a statutory/regulatory requirement, the Chairs of Committees will have a discretion as to matters to be brought to the Board's attention. Minutes, or a representative summary of the issues considered and decision taken of any Governance Group shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.	To reflect the changes requested by Committee Chairs and agreed by the Trust Chair
8.10.7	New item	**Charitable Funds Committee** Primary Role: The Charitable Funds Committee will act on behalf of the Corporate Trustee, with delegated responsibility for overseeing, monitoring and	To reflect the Trust Board's decision in September 2021 for the creation of a Trust Charity

SO/SFI number	Current wording	New wording	Reason
		evaluating all charitable activities to ensure they are in accordance with the charity's objectives. Its purpose, on behalf of the Board, is to: • advise the Board on the management of the funds of the Charity; • apply scrutiny and constructive challenge to the Charity's financial information and systems of control, including the annual accounts; • provide assurance to the Board that the administration of charitable funds is distinct from its exchequer funds and compliant with legislation and Charity objectives.	
13.3	New item	Following formal approval of Board minutes by the Board, the Trust Secretary is authorised to apply the electronic signature of the Chairperson to those minutes. Following formal approval of Committee minutes by that Committee, the Trust Secretary is authorised to apply the electronic signature of the Committee Chair to those minutes. The application of an electronic signature is an administrative function, with decisions of the Board and Committees taking effect at the time of its making and not the time of the application of an electronic signature.	To ensure efficient application of signatures to minutes.
15.2	all financial procedures must be approved by the Director of Finance	all financial **policies** must be approved by the Director of Finance	Change to "policies" instead of procedures because

SO/SFI number	Current wording	New wording	Reason
			procedures are agreed locally by the Deputy Director of Finance, and only policies need Director sign off
28.1.3	The approval limits for capital investments as stipulated in the Business Case Policy are as follows: a) The Trust Capital Group will approve schemes up to £75,000; b) Executive Assurance Committee or Business Case Review Group with delegated authority from Executive Assurance Committee will approve all schemes from £75,001 to £250,000; c) The Finance and Performance Committee will approve all schemes from £250,001 to £750,000; and d) The Board will approve all schemes over £750,000.	The approval limits for capital investments is as stipulated in the Business Case Policy.	Remove reference to specific limits and instead refer to the Business Case Procedure to avoid the need to refresh multiple policies with every change.
28.1.5	The approval of a capital programme shall not constitute approval for expenditure against that scheme.	The approval of the annual capital programme **by the Trust Board shall constitute approval for expenditure against that scheme.**	Streamline governance to ensure that if an annual programme has been prepared, risk assessed and taken via Trust Board there is not a need for duplication of approval by completing individual business cases for each scheme.
28.3.6	The value of each asset shall be indexed to current values in accordance with methods specified in the DHSC's Group Accounting Manual.	Remove	We no longer apply indexation to assets
Scheme of Delegation 19.1	New item	Trust Board to approve annual accounts	Currently the Scheme of Delegation sets out who prepares and presents the accounts but not who has

SO/SFI number	Current wording	New wording	Reason
			delegated authority to approve
Scheme of Delegation	Bad debts and claims abandoned. Private patients, overseas visitors and others. Current delegation to Chief Executive and Director of Operations up to £50,000	Bad debts and claims abandoned. Private patients, overseas visitors and others. Revise delegation in line with other limits as follows: - Associate Director of Finance (Financial Accounting) - £10,000 - Deputy Director of Finance – up to £250,000 - Chief Executive and Director of Operations – above £250,000	Allow delegated authority to Associate Director of Finance (Financial Accounting) and Deputy Director of Finance who deal with debt in practice on a regular basis, and have existing delegated authority for other areas. Maintain reporting on all write offs to Audit and Risk Committee

Kent and Medway NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 November 2021
Title of Paper:	Development, Approval and Management of Formal Trust Documents – Policy and Procedures
Author:	Tony Saroy, Trust Secretary
Executive Director:	Tony Saroy, Trust Secretary

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

A paper setting out the proposed changes to 'The Development, Approval and Management of Formal Trust Documents - Policy and Procedure'.

Issues to bring to the Board's attention

'The Development, Approval and Management of Formal Trust Documents - Policy and Procedure' is a well-established document that is used to control the creation and maintenance such documents, thereby providing a consistency across the Trust.

Agreed change in the process for developing, approving and managing formal Trust documents have been consulted upon, with views taken from the Audit and Risk Committee and the Executive Management Team.

The new process simplifies the entire system for formal Trust document control, allows the executive function of the Trust to operate at speed and allows the Board, through its committees, receive the assurance it needs.

Governance

Implications/Impact:	Impact on legal where policies are not reviewed in a timely manner
Assurance:	Reasonable
Oversight:	Trust Board

Version Control: 01

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NHS and Social Care Partnership Trust

System for formal Trust documents.

1. An uncontrolled system for the development, approval and management of formal Trust documents creates a structural risk for the Trust that would impact patients, staff and the Trust itself. The Trust has therefore had an established controlled system, underpinned by a policy and procedure.

2. The system is overseen by the Trust Secretariat, with operational management undertaken by the Trust's Policy Manager. Previously, assurance of the system was provided to the Audit and Risk Committee (ARC). However, following changes to ARC's Terms of Reference, the policy and procedure now falls under the Trust Board remit and therefore approval of the policy and procedure is given by the Trust Board. Oversight of Trust policy effectiveness and compliance remains with ARC.

3. In March 2021, a paper on Trust Policy Effectiveness and Compliance was taken to ARC, providing assurance and seeking views of the committee on potential changes to the system. The committee was neutral regarding its preference but it was supportive of changes and suggested that the matter be considered by the Executive Management Team.

4. The Executive Management Team considered the matter and was also supportive of potential changes.

New system

5. In short, the proposed changes are:
    a. Formal Trust documents are presented to a relevant Trust-Wide Group (a group that reports to a sub-Board Committee, often chaired by an executive or deputy director) or an executive director if no relevant Trust-Wide Group
    b. The formal Trust documents are then consulted upon,
    c. Responses to the consultation are considered,
    d. The Chair of the Trust-Wide Group, or the executive director decides if the formal Trust document can be approved.
    e. Upon approval, the Chair of the Trust-Wide Group or the executive director certifies that the system has been complied with – a formal certificate is completed and filed with Trust Secretariat.
    f. Assurance on the approval process of a formal Trust document is given by the Chair of the Trust-Wide Group or the executive director at the next meeting of the sub-Board Committee.

6. System oversight will remain with Trust Secretariat, with ARC retaining its role in seeking assurance on the system.

7. A full review of the Development, Approval and Management of Formal Trust Documents Policy and Procedure has been undertaken. The review focused on updating the Policy and Procedure to reflect the new system. In addition, the policy has been streamlined and a number of new appendixes added, including an appendix on the administration of formal trust documents and another appendix including the new certification of Formal Trust document approval form.

8. Board is requested to endorse the new system by approving the attached policy.

Version Control: 01

Kent and Medway
NHS and Social Care Partnership Trust

Development, Approval and Management of Formal Trust Documents - Policy and Procedures

Document Reference No.	KMPT.CorG.001.07
Replacing policy	KMPT.CorG.001.06
Target Audience	All staff and volunteers Trustwide
Author	Policy Manager
Group responsible for development of this policy	Integrated Audit & Risk Committee
Status	Authorised
Version No.	7.4
Authorised/Ratified By	Trust Board
Authorised/Ratified On	
Date of Implementation	
Review Date	
Distribution Date	
Number of Pages	20
Contact Point for Queries	policies@kmpt.nhs.uk
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DOCUMENT TRACKING SHEET

DEVELOPMENT, RATIFICATION AND REVIEW OF FORMAL TRUST DOCUMENTS

Version	Status	Date	Issued to	Comments
1.1	Draft	19 July 2007	Internal review	Draft update prepared to incorporate changes required for NHSLA
1.2	Draft	22 Aug 2007	Policy Process Group	Draft update, includes ref to volunteers and revised consultation process
1.3	Draft	10 Sept 2007	Policy Process Group	Updated as discussed in PPG 04.09.07. formatted by Policy Manager
1.4	Draft	22 Sept 2007	Performance & Governance Committee (P&G)	Updated as discussed in PPG 04.09.07. formatted by Policy Manager
2.0	Approved	2 Oct 2007	Performance & Governance /Trustwide	
3.0	Approved	October 2009	Governance and Risk Committee	
3.1	Draft	April 2010	Policy Manager	Revisions made
3.2	Draft	17 May 2010	Policy Group	Review / Comment
3.3	Draft	June 2010	Policy Manger	Updated EIA for review / comment to Head of Equality / Diversity
4.0	Approved	16 Sept 2010	Governance & Risk Committee	Approved for Use
4.1	Draft	11July 2012	Policy Manager	Updated policy
4.2	Draft	Nov 2012	Policy Group	Review
5.0	Approved	Jan 2013	Integrated Audit & Risk Committee	Approved for Use
6.0		Nov 2016	Integrated Audit & Risk Committee	Ratified
6.1	Draft	April 2017	Policy Manager	Review, revisions made
6.2	Draft	June 2017	Policy Manager	Further revisions made following consultation
6.3	Draft	July 2017	Trust Secretary	Flowchart inserted
7.0	Approved	July 2017	IARC	Authorised
7.1		August 2017	Policy Manager	Minor revisions made
7.2		August 2017	Policy Manager	Inclusion of a counter fraud statement
7.3		August 2017	Assistant Director of HR	Comment , minor revisions made
7.4		October 2018	Policy Manager	Amendment made to table 6.6
8.0		November 2021	Trust Secretary	Policy updated

REFERENCES

Human Rights Act 1998
Health and Social Care Act 2001
The Equal Pay Act 1970 (Amendment) Regulations 2003
Civil Partnership Act 2004
Equality Act 2010
The Equality Act 2010 (Statutory Duties) Regulations 2011
Department of Health, NHS Confederation and NHS Appointments Commission. (2005). *Promoting equality and human rights in the NHS - a guide for non-executive directors of NHS boards*. London: Department of Health. Available at: www.dh.gov.uk
The Equality and Human Rights Commissionwww.equalityhumanrights.com
NHS Litigation Authority Risk Management Standards
Freedom of Information Act 2000

RELATED POLICIES/PROCEDURES/PROTOCOLS/FORMS/LEAFLETS

	Reference
Freedom Of Information (FOI) Policy	KMPT.Infg.021
Request For Information Procedure	KMPT.Infg.021
Freedom Of Information Publication Scheme	KMPT.Infg.021
Health and Social Care Records Policy	KMPT.CliG.071
Standing Orders	KMPT.Fin.003
Standing Financial Instructions	KMPT.Fin.002

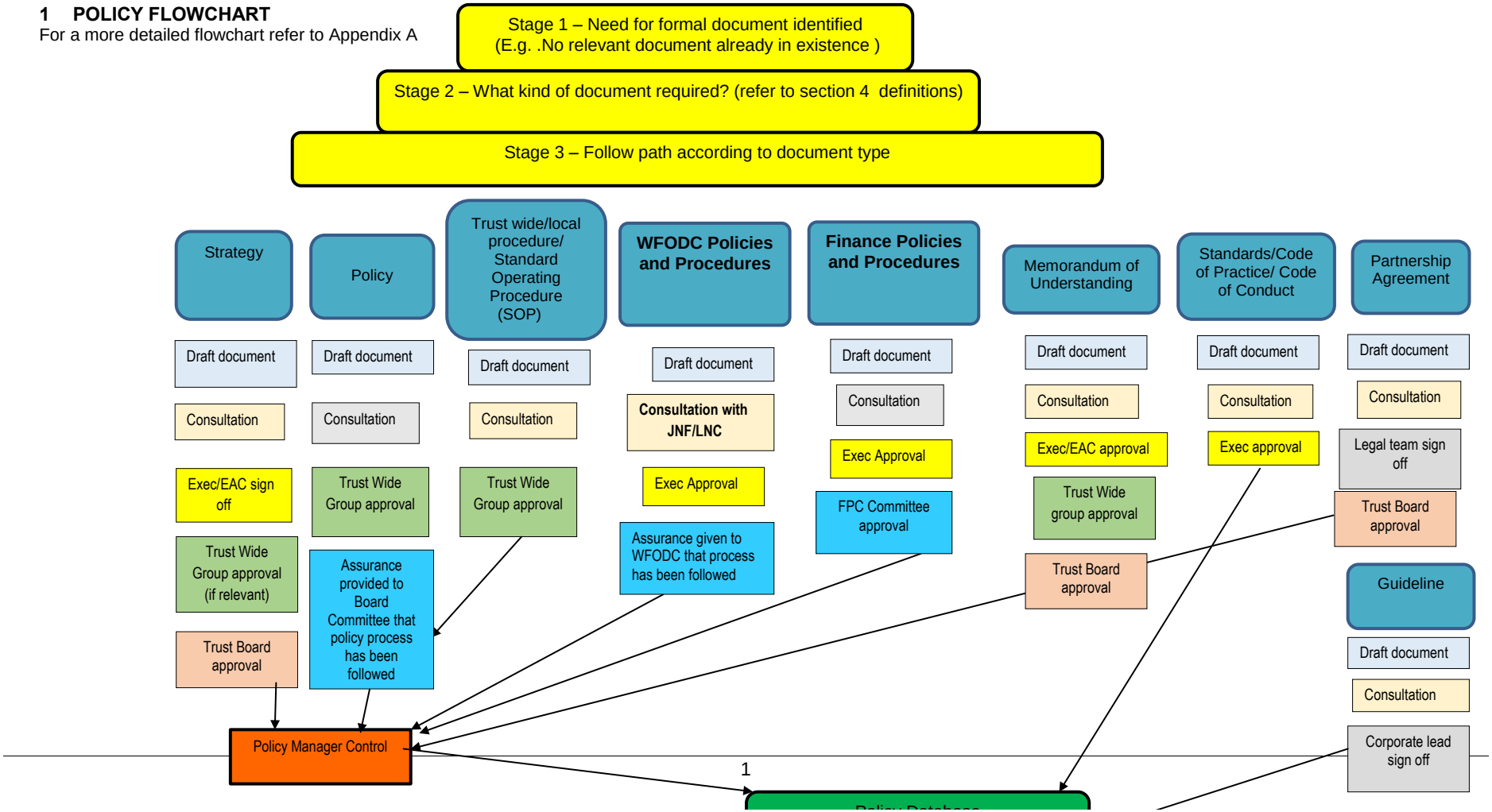
SUMMARY OF CHANGES

Minor change to clarify responsibilities for inclusion of NICE and National Guidance		
Page 1 Purpose and Page 17 Author's Responsibilities	Reference to requirement for all clinical policies to reference NICE or other National Guidance	Added December 2016
Page 3 definitions	Inclusion of definitions of ratification and approve	August 2017
Page 8 Approval & ratification process	Inclusion of a virtual ratification process	August 2017
Page 7 & 8 Fraud proofing	Inclusion of a Fraud proofing section	August 2017
Page 1 Purpose	Inclusion of correct ownership	August 2017
Page 5: Table B	JNF/LNC removed from ratifying column to clarify approval process. JNF/LNC are not accountable groups within the Trust governance structure, so cannot on their own approve policies on behalf of the Trust Board.	October 2018

CONTENTS

1 POLICY FLOWCHART

For a more detailed flowchart refer to Appendix A



INTRODUCTION

1.1 This document sets out a framework for developing Kent and Medway NHS Partnership and Social Care Trust (KMPT or the Trust) policies, guidelines, procedural and competency documents and to set out a Trust wide process for their production, review, monitoring and approval/ratification.

2 PURPOSE

2.1 The purpose of this document is to ensure that:

- 2.1.1 All formal trust documents are developed and reviewed within a clearly defined accountability framework;
- 2.1.2 Staff involved in the process have access to appropriate guidance and support;
- 2.1.3 All new policies are generated due to a clearly identified need and are streamlined where possible for ease for staff;
- 2.1.4 There is consistency in the development, implementation and review of all Trust policies;
- 2.1.5 All Trust policies are compliant/consistent with the Trust's strategic objectives, national guidance and relevant legislation;
- 2.1.6 Appropriate consultation takes place when policies are being developed;
- 2.1.7 All policies are properly disseminated throughout the Trust;
- 2.1.8 All formal trust documents are subject to regular review of their effectiveness.
- 2.1.9 Correct ownership for all policies developed as detailed in table B

2.2 This document seeks to reduce risk by having a robust document control process, so that the right policies are available to the right staff at the right time, by ensuring that staff receive appropriate training, and ensuring that each policy is regularly reviewed.

2.3 The objectives of this document are to:

- 2.3.1 Define a framework by which procedural documents are developed and managed in a systematic way within the Trust.
- 2.3.2 Detail the generic content and structure of policy documents
- 2.3.3 Ensure all clinical policies reference NICE or other national guidance appropriate to the topic
- 2.3.4 Define the format standards to be applied to all formal documents, including Terms of Reference for all Groups that have responsibilities for developing and/or ratifying formal documents.

3 SCOPE

3.1 This document applies to all formal Trust documents developed for KMPT. Lead managers of existing Trust Policies will be required to ensure that the requirements of this Policy are incorporated into them when reviewed, and updated.

3.2 All new formal Trust documents are to be developed following the principles and format laid out within the content of this policy.

3.3 All care group specific policies are to be developed in line with this policy and the care group director will be responsible ensuring out of date versions are retained electronically in an archive.

3.4 These requirements apply to:

- 3.4.1 New documents
- 3.4.2 Documents which have reached their declared review date or which need to be changed prior to stated review date e.g. as a result of audits, legislative changes etc.

3.5 The process of consultation and ratification in this policy does not include local procedural documents. However, the style, format, content & document numbering/logging should be adhered to. Local policy documents are developed and approved through Local Care Group arrangements.

3.6 Multi-agency policies may be developed independently of the requirements of this policy. However, the Trust approval process must still be complied with.

4 DEFINITIONS

4.1 **Strategy** - A plan of action designed to achieve a long term or overall aim or goal. Approach taken will affect the overall direction of the organisation. e.g. Quality Strategy

4.2 **Memorandum of Understanding** - Agreement between partner organisations setting out the way in which the organisations will work together

4.3 **Partnership Agreement –** Formal contractual agreement between the Trust and another organisation based on legal requirement e.g. Section 75 agreement with KCC

4.4 **Policy** - A policy is a specific statement of principles/guiding actions that provide a basis for consistent decision-making and resource allocation. A policy will give details of how a practice or course of action will be implemented and adopted. It is considered binding and a breach of policy may have contractual consequences for the employee (e.g. the Equal Opportunities Policy). A policy should set out a minimum specification for Trust-wide practise in any setting.

4.5 **Trustwide Procedure/ Local Procedure** - A procedure is a series of steps followed in regular order (to implement a policy or otherwise). Procedures can also be mapped by use of a flow chart. It may be necessary to develop local variations to procedures, given the range of services provided by the Trust.

4.6 **Standard Operating Procedures** (replacing operational protocols) – SoPs give detailed guidance about how a particular task should be carried out and recorded on Trust wide systems, a step-by-step guide which someone not familiar with the work can follow.

4.7 **Guidelines** - A guideline is a set of systematically developed, evidence based or informed statements that assist in decision making about how to implement particular policies and/ or procedures or appropriate management of specific conditions or tasks. Frequently, though not exclusively applied to clinical practice. Guidelines are often used to underpin a policy or procedure. e.g. advance care planning guideline

External documents

4.8 **Standards** - Statements specifying a required level of performance for the purpose of monitoring or auditing.

4.9 **Codes of Practice** - Laid down specifications of standards which have to be met within a legal, statutory or mandatory framework. Strictly some are not legally binding but adherence will usually constitute a good defence to an allegation of negligence. e.g. Confidentiality code of practice

4.10 **Codes of Conduct** - Standards laid down by a regulatory or professional body which have to be adhered to by members of that profession.

5 DUTIES

In relation to developing and managing policies within the Trust, the following key duties have been identified:

5.1 **The Chief Executive:** is responsible for ensuring that all staff follow policies

5.2 **Trust Directors** have accountability for all policies within their area of operation, and will consult and involve the relevant committee/ group within the Trusts governance structure as set out in table A below. Each director will have responsibility for identifying a lead member of staff to carry out the work needed to develop the policy

5.3 The Trust Secretary: will report compliance with this policy to the Trust Board on an exceptions basis.

5.4 **Trust Policy Manager**: is responsible for ensuring that this document is adhered to when new formal Trust documents are developed and/or current formal Trust documents are reviewed, updated, and are comprehensible, and consistent with other policy documents. The policy manager shall also ensure that controlled numbering for documents is in place and to arrange for the ratified documents to be available to staff via i-connect. The policy manager will arrange prompts for reviews of formal Trust documents by set time intervals, and be responsible for withdrawal and archiving of all out-dated formal Trust documents. The policy manager shall be the first point of contact for general enquiries relating to policies; and shall provide training and support to formal Trust documents developers as required. The Policy Manager will monitor compliance with this document.

The Policy Manager is responsible for ensuring that formal documents are published, distributed and, when no longer active, are archived and that records are maintained to provide an effective audit trail.

5.5 Approval Framework for KMPT – Table A

Type of Document	Ownership	Control mechanism
Strategy	Trust Board/Board Committee	Controlled document through Policy Manager/Trust Secretary
Memorandum of Understanding	Trust Board	Controlled document through Policy Manager/Trust Secretary
Partnership Agreement	Trust Board	Controlled document through Policy Manager/Trust Secretary
Policy & Trustwide Procedure	Trust wide Groups	Controlled document through Policy Manager/Trust Secretary
Local Procedure	Care Group	Bi annual report to Trust wide groups
Standard Operating procedure	Care Group Team or Department	Care Group governance groups
Guidelines	Corporate Lead	Executive responsible for corporate department
Standards/ Codes of Practice/ Codes of Conduct	Executive Director	External Body – Issuing Authority

5.6 Policy Framework for KMPT – Table B

Type of policy	Lead Director	Consultation with	Approved by	Assurance provided to
Clinical	Executive Director of Nursing & Quality/ Executive Medical Director	Patient Safety Group/ Clinical Effectiveness Group/ Patient Experience Group	Patient Safety Group/ Clinical Effectiveness Group/ Patient Experience Group	Quality Committee
Estates & Facilities	Director of Estates (Executive Director of Finance)	Trust Capital Group	Trust Capital Group	Finance and Performance Committee
Finance	Executive Director of Finance		Executive Director of Finance and Performance	Finance & Performance Committee
Human Resource	Director of Workforce and Organisational Development	Learning & Development Group/Health and Wellbeing Group / Diversity & Inclusive Group	Director of Workforce and Organisational Development	Workforce and Organisational Development Committee
Infection Control	Executive Director of Nursing & Quality	Infection Control Group	Patient Safety Group	Quality Committee
Information Management & Technology	Director of Information Management & Technology	Information Governance Group	Information Governance Group	Finance and Performance Committee
Mental Health Act	Executive Director of Nursing & Quality	Mental Health Act Legislation and Operational Group	Mental Health Act Legislation and Operational Group	Mental Health Act Committee
Pharmacy	Executive Medical Director	Drugs & Therapeutics Group	Patient Safety Group	Quality Committee
Risk Management	Executive Director of Nursing & Quality	Trust-wide Health, Safety & Risk Group	Trust-wide Health, Safety & Risk Group	Audit and risk Committee
Safeguarding	Executive Director of Nursing & Quality	Trust wide Safeguarding Group	Patient Safety Group	Quality Committee

6 EQUALITY IMPACT ASSESSMENT

6.1 Equality Impact Assessments (EIAs) are completed to demonstrate that the policy has been reviewed to ensure that different groups are not placed at a disadvantage to others.

6.2 As part of the policy review process, the Policy Author will review the existing EIA to ensure it is adequate. Once the final draft of the policy is ready, the Policy Author should sign it and send it to the Diversity Lead who will review the EIA and, if it is adequate, approve it. The approved EIA and the final draft of the policy should be submitted to the appropriate ratifying group

6.3 For guidance on completing an equality impact assessment please follow the below link
http://i-connect.kmpt.nhs.uk/document-library/policy-templates-and-guidance-notes/119

6.4 It is a Policy Authors' responsibility to ensure that a policy has an approved EIA prior to the policy's submission for ratification

6.5 The Equality Impact Assessment for this document can be found on the Equality and Diversity pages on the trust intranet.

7 CONSULTATION, APPROVAL AND RATIFICATION PROCESS

7.1 Consultation Process

7.1.1 Consultation must take place throughout the drafting of the policy to ascertain the requirements the policy needs to fulfil. This will include consultation with representatives of those responsible for carrying out the aims of the policy.

7.1.2 A document tracking sheet will need to be completed to confirm consultation has taken place using job titles only

7.1.3 It is an expectation that service users and carers will be consulted with regards to all formal Trust documents that have a direct impact on the patient experience. Advice regarding consultation should be sought from the Trust Secretariat.

7.1.4 The level and extent of consultation will depend upon the formal Trust document. End users of the policy must be consulted at all times.

7.1.5 Staff who have been consulted to comment on a policy and have not replied within the designated time frame should note that this equates to agreement with it.

7.2 Approval Process

7.2.1 The Author will present the formal Trust document for approval with an EIA to the relevant Director or Chair of a Trust-wide Group.

7.2.2 Following approval, the Director, or the Chair of the Trust-wide Group shall certify that consultation has occurred, responses have been considered, that the formal Trust document has been finalised and is now approved. The certificate at appendix D must be completed.

7.2.3 The above approval process can be done by electronic means. Consultation length will depend on the circumstances, but must always be at least 1 week.

7.2.4 The relevant Director, or the Chair of the Trust-wide Group will provide assurance by way of a written report to the relevant Committee at the earliest opportunity.

8 REVIEW AND REVISION ARRANGEMENTS

8.1 All formal Trust documents must be reviewed every three years. An Executive Director may decide to set a shorter review period, if appropriate/required. There may also be a need to review a policy in advance of a planned review date, i.e. due to changes in national policy/legislation.

8.2 The accountable Trust director will be responsible for the review process. All reviews and revision to any policy document must be approved according to the process set out in section 8.

8.3 The Policy Manager will remind policy authors 6 months before the policy expires that review is due. If a review is indicated sooner then the lead for that policy should initiate the review.

8.4 Any minor changes that do not affect the meaning or substance of the document, e.g. spelling, grammar, phrasing, etc, can be made by the policy author at any time.

8.5 If amendments are required the updated version should be substituted for the previous version on the Trust's intranet.

9 ASSOCIATED DOCUMENTS

9.1 It is recognised that some policies have associated documents which require review and revision more frequently than the main policy or have forms or templates for use as part of compliance with the policy. In order to avoid the need to update the main document for a revision to an associated document and to provide easy access to frequently used forms, Forms/additional documents will be added separately alongside the policy on the policy's individual page.

9.2 Policy documents should provide details of any supporting/linked documents, particularly in light of the need to avoid duplication of work and lengthy documents.

9.3 Guidance notes and forms can be included as an appendix or separate document, but be aware that both will need to be readily accessible together, so that they can be read side by side. The contents page will clearly state the appendices used in the document.

10 IMPLEMENTATION

10.1.1 Policy authors are responsible for completing an implementation plan for every new or significantly changed, policy, which must be submitted to the Policy Manager. This should record how the document will be disseminated and implemented, as well as identifying any training or audit requirements. The Policy Author should also consider whether confirmation that staff have read and understood the document is required, and if so, arrange for this to take place with the relevant service managers.

11 EQUALITY IMPACT ASSESSMENT

11.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

12 HUMAN RIGHTS

12.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the Trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

13 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

13.1 Every policy must contain details of how compliance with that policy's particular requirements will be monitored.

13.2 Those details should include:

13.2.1 how the monitoring will be carried out;

13.2.2 who will do the monitoring;

13.2.3 the frequency of monitoring; and

13.2.4 to whom the monitoring results will be presented.

13.3 Compliance with the requirements of this policy will be monitored by the Trust Secretary. Several randomly selected policies that have been developed in the course of the year will be audited (their content, style, format, consultation carried out, completion of ratification, etc) and a report of their findings presented to Audit and Risk Committee .

14 EXCEPTIONS

14.1 This document does not cover the process or formats for the following document types, which will be covered by a separate document:

14.1.1 Trust leaflets and notices for the public

14.1.2 Service, drug and treatment information

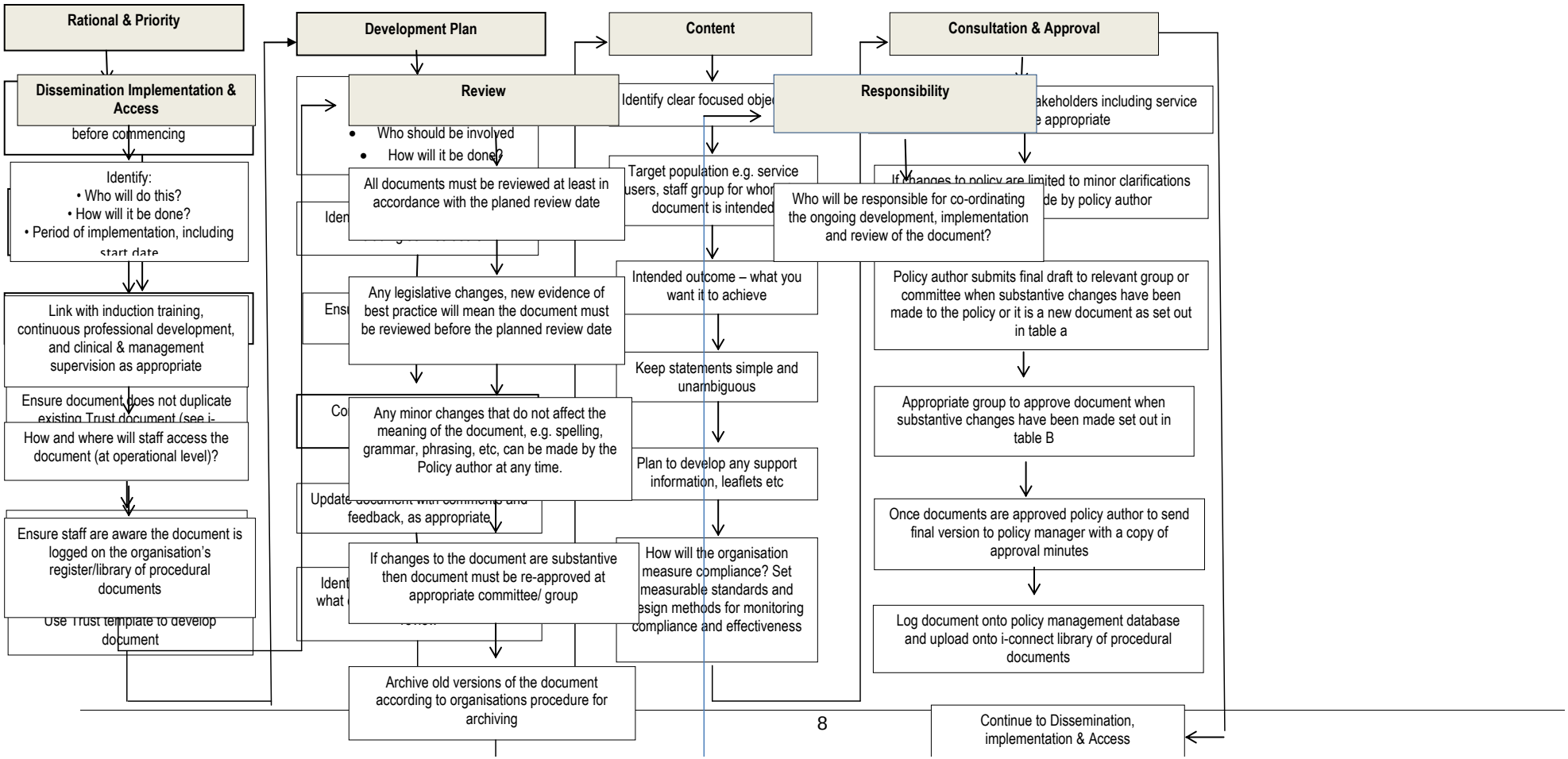
14.1.3 Generic information for the public, carers and clients e.g. how to complain

14.2 This document does not cover the format and layout of the following types of documents but it is expected that such documents should meet the Trust standards for content, scope, approval and review.

14.2.1 Documents developed by external parties that are accepted and implemented as Trust best practice e.g. Professional Codes of Practice, Codes of Conduct.

14.2.2 Documents that are developed collaboratively with health and social care colleagues and are to be implemented across the health community e.g. information sharing protocols.

APPENDIX A POLICY PROCESS FLOWCHART



APPENDIX B FORMAL DOCUMENT FORMAT

To view the formal template for Trust Policies/Strategies please click on the link below

: http://i-connect.kmpt.nhs.uk/document-library/policy-templates-and-guidance-notes/119

APPENDIX C ADMINISTRATION OF FORMAL TRUST DOCUMENTS

1 STYLE AND FORMAT OF PROCEDURAL DOCUMENTS

1.1 Formal documents should conform to the Trust standard format.

1.2 When drafting a formal Trust document, it is important to consider that the document needs to be read and understood by all members of Trust staff, as well as (in some cases) service users and members of the public. All formal Trust documents should therefore be written with their target audience in mind, with the objective of increasing awareness

1.3 Whilst the content of documents will obviously change, the formal structure should always be used and include at least the mandatory paragraph/headings.

1.4 Style

1.4.1 Documents should have titles that reflect the content and that clearly indicate the type of document e.g. Strategy, policy etc.

a) The following standards will apply to all formal documents:

b) All text to be Arial and paragraph text to be 11 or 12

c) All paragraph text to be justified

d) All paragraphs to be numbered for easy reference

1.5 Within documents:

1.5.1 Statements should be clear and unambiguous

1.5.2 Where paragraph headings are used, content should reflect the heading

1.5.3 Statements should be as brief as possible to ensure that the meaning is clear

1.5.4 Diagrams, flowcharts or tables should be used wherever this would aid clarity

1.5.5 Where abbreviations/acronyms are used, clear definitions must be given in the first instance with the abbreviation/acronym in brackets

1.5.6 An explanation of any terms used within the document must be explained with clear definitions

1.5.7 Documents must conform to the Trusts Standing Orders and Standing Financial Instructions where appropriate

1.5.8 Multi-agency policy documents the Trust has signed up to can be accepted in the format agreed between agencies.

1.6 Format

1.6.1 Whilst the content of documents will obviously change, the formal structure should always be used and include at least the mandatory paragraph/headings.

a) Introduction

b) Purpose

c) Duties

d) Implementation Including Training and Awareness

e) Data Collection and Evidence.

f) Stakeholder, Carer and User Involvement

g) Record Keeping

h) Equality Impact Assessment Screening

i) Monitoring Compliance With And Effectiveness Of This Document

2 THE DEVELOPMENT OF FORMAL TRUST DOCUMENTS

A flowchart summarising the process is attached to this policy as appendix A

2.1 Prioritisation of Work

2.1.1 Before new formal Trust documents are developed a check should be made with the Policy Manager to ensure there is not already a relevant policy document in existence.

2.1.2 Development of an existing formal Trust document rather than developing a separate document should be considered, in order to prevent duplication of work

2.2 Identification of Stakeholders

2.2.1 The involvement of staff, unions, relevant groups, committees and external stakeholders including service users is central to the development and review of effective formal Trust documents, and to the success of their subsequent implementation.

2.2.2 The Document Author with advice from the Accountable Director will identify any relevant stakeholders and their level of involvement e.g. development, consultation, or receipt of final version.

2.3 The main groups of stakeholders to be involved in the development of formal Trust documents are as follows:

2.3.1 Service users/carers and the local community (including specialist groups) Service users/carers and the local community should be involved in the development and consultation of formal Trust documents that have a direct impact on clinical services.

2.3.2 Staff/Staff groups - The Joint Negotiating Forum (JNF) will be involved in the development and consultation of all Human Resource policies.

2.3.3 For other classes of formal Trust documents, staff involvement will normally occur through the involvement of the appropriate group in the Governance framework. In some cases, it may be appropriate to consult with a wider staff group.

2.4 Finalised versions of formal Trust documents will be available on the Trust's intranet.

2.5 Specialist staff/staff groups
Consideration should be given as to whether specialist staff/staff groups should be involved in the development of formal Trust documents. For example, legal services, finance etc.

2.6 Relevant external stakeholders

2.6.1 For formal Trust documents that impact on beyond the organisations boundaries (i.e. CPA policy, care pathways) consideration should be given to involving relevant external stakeholders in their development

2.7 Fraud proofing

2.7.1 All new or revised documents must be robust enough to counter any potentially fraudulent activity. The author is responsible to ensure that documents are also developed in accordance with the Anti fraud, Bribery & Corruption Policy

2.7.2 Trust documents must be resilient enough to counter any potentially fraudulent activity and all declarations must be adequately worded in order to ensure subsequent disciplinary, Civil or Criminal Sanctions are successful.

2.7.3 Not all documents will need a counter fraud element to be considered but indications would be;

a) Financial processes

b) HR processes

3 DOCUMENT CONTROL INCLUDING ARCHIVING ARRANGEMENTS

3.1 Database of Policy Documents

3.1.1 The Policy Manager maintains the policy database and is responsible for recording, storing and controlling policies. As set out in table A

3.2 Version Control

3.2.1 All policies must have the version number, date of issue and the review date clearly marked on the front cover.

3.2.2 The Policy Manager is responsible for allocating an official document number to all policies and logging the document on the policy database where appropriate

3.2.3 Version control of each document should start at 0.1 for a first draft of a new document, 0.2 for second draft, 0.3 for third draft etc Once a document had been approved the number will be 1.0 If the document is then revised again, the new reference number will be 1.1 i.e. version 1 first new draft, then 1.2, 1.3 etc until it is approved, at which stage the number will be 2.0 (Detailed example in appendix B)

3.3 Archiving Arrangements

3.3.1 The Policy Manager will maintain an archive of previous versions of policy documents and will update the central database and website. Archived procedural documents will be listed on the database, with details of the date they were archived and removed from the intranet.

3.3.2 Policy documents will be archived in accordance with the Trust policy for the management of corporate administrative records.

3.3.3 Requests from staff to access archived procedural documents can made to the Policy Manager contact kmpt.policies@nhs.net

4 REFERENCES

4.1 Procedural documents should provide details of any references used in order to provide an evidence base.

4.2 All references should be cited in full, using the Harvard style, e.g.:

Books
FAMILY NAME, INITIAL(S). Year. *Title*. City of publication: Publisher

Journal article
FAMILY NAME, INITIAL(S). Year. Title of article. *Journal title*. **Volume** (issue number), page number of your quotation

Organisation report
ORGANISATION. (Unpublished, year). *Title*. Report dated date

APPENDIX D **CERTIFICATION OF FORMAL TRUST DOCUMENTS APPROVAL**

Certification of Formal Trust Document Approval

Type of document:	Policy/ Procedure/ Standard Operating Procedure/ Guidelines (delete as appropriate)		
Certified by:	Name:		
Position:			
Start date of consultation:	[insert text here]		
End date of consultation:	[insert text here]		
Date responses considered:	[insert text here]		
Formally approved by:	[insert text here]	**Date:**	[insert text here]
Assurance to be given too:	XX Committee	**Date:**	[insert text here]

Title of Meeting	Board of Directors (Public)
Meeting Date	25 November 2021
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, Executive Medical Director
Purpose	Assurance

Matters to be brought to the Board's attention

- Backlog of renewal hearings
- Liberty Protection Safeguards

Items referred to other Committees (incl. reasons why)

- None

Executive Summary

The Mental Health Act Committee (MHAC) met on 11 October 2021 to consider:

- Executive Medical Director Report
- MHLOG Report
- MHA Monitoring Report
- MHA/MCA Training Report
- Report from the Associate Hospital Managers
- Approval of the following policies:
  - Section 17
  - Section 5(2) and 5(4)
  - Standards for reviews of detention by hospital managers and mental health tribunal

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

Area	Assurance	Items for Board's Consideration and/or Next Steps
Backlog of renewal hearings.	There are 59 outstanding renewal appeals to be processed at the MHA office in Maidstone. This was initially due to a vacancy which was filled,	The Board to receive an update from MHAC following the next meeting in December.

	but now there has been additional sickness in the team. The risk to the Trust is high, as given the period of delay, the service user may have recourse to bring legal action for being detained longer than was required. A part time member of the MHA Team from another site, who is experienced in supporting with this work, has started to work one extra day a week to support with the backlog. Finance has now identified for additional resource to support the team for a six-month period to enable clearing the backlog. The MHA Compliance Manager will continue to monitor the numbers and report back to MHAC on the progress of this work.	
Liberty Protection Safeguards (LPS) are due to replace DOLS as of April 2022, which will radically alter who can authorise a deprivation of liberty. A new joint code for MCA and LPS is due to be issued.	The Head of Safeguarding is recommending an increase in staffing to the Professional Lead for Adult Safeguarding, with a separate MCA/LPS Lead, this request is being taken to EMT. A paper is to be taken to the November MHLOG meeting and MHAC is to be updated at their December meeting with a plan for how the Trust will, in collaboration with partner agencies, be ready for this change. This will need to include plans for operational and administration support and will establishing an LPS Task Group to ensure KMPT is prepared.	The Board to receive an update from MHAC following the December meeting giving details of the plan for ensuring the Trust is ready for the introduction of the LPS.

Recommendation

The Board is asked to:

1) **Note the content of this report**
2) **Provide direction regarding ''Items for Board's Consideration'' where appropriate and/or complete recommended next steps**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25 November 2021**
Title	**Quality Committee Chair's Report**
Author	**Fiona Carragher, Non-Executive Director and Committee Chair**
Presenter	**Fiona Carragher, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Executive Summary

The Quality Committee was held on 16 November 2021. In line with the Committee work plan, the following items were discussed and scrutinised as part of the meeting:

1. CQC Quality Improvement Plan (QIP) Report
2. Quality Risk Register
3. Quality Digest
4. Strategic Delivery Plan Priorities
5. Memory Assessment
6. Promoting Safer Services Strategy Progress Report
7. Operational Hotspots Presentation
8. High Level Serious Incident Action Plan Report
9. Mortality Review -Q2
10. National Patient Strategy Updates
11. System Suicide Prevention Strategy Update
12. Active Review Process Implementation Update
13. CQC Community Mental Health Patient Survey 2021
14. Policy Exception Report
15. New Risks
16. Quality Committee Workplan

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

1. Memory Assessments

In September 2021, the Board delegated Quality Committee, to receive and scrutinise the position in relation to delays in referral to assessment/diagnosis for people with dementia. A detailed report was provided to the Committee at their November meeting, setting out the current performance alongside ensuring people waiting are safe. It was noted that demand has significantly increased compared to pre-pandemic figures. It was reported that Covid-19 has impacted negatively on Memory Assessment programmes nationally, with a national backlog noted. Data is now split based on patient's needs, (from October 2021 onwards) with routine referrals following a new triage process, and receiving a follow up information letter to keep them updated whilst they are waiting.

Further work is ongoing to strengthen processes alongside GP surgeries, develop competencies and increase capacity, which is being monitored via supervisions. Assurance

was provided that the system wide challenge is being picked up via the Dementia Strategic Improvement Group (SIG) and Mental Health and Learning Disability (MHLD) Improvement Board local challenges are also being considered via the Clinical and Professionals Board. Diversity and inclusion concerns were briefly discussed, with agreement that further work needs to be done to ensure access to services by all community groups.

Assurance was provided that a number of patient safety processes are in place following recent serious incidents, with the short, medium and long-term plans to improve the dementia pathways outlined for the committee.

The Committee were informed that the service concerns are on the Care Group risk register, with an agreement from the Committee that it should be escalated to the Trust risk register and through the Chair's report, escalated to the Board. It was recommended by the Committee that this system wide risk is referred to the MHLD Improvement Board and the ICS to ensure collaborative system solution and oversight.

2. CQC Quality Improvement Report

It was reported that progress has been made against the two QIPs in response to the previous inspection to Acute Services in Littlebrook Hospital and the inspection of Community Mental Health Teams. The improvement plan has been in place since March/April and significant improvements have bene made. There are ongoing actions related to the monitoring of maintenance issues, improving mandatory training compliance, continuously improving the quality of documentation (risk assessments, crisis plans, physical health documentation such as NEWS 2) and seeking assurance through CliQ checks audits, reducing waiting times within the CMHTs and ensuring that trust wide systems and processes are working effectively (this includes governance mechanisms).

The Committee noted a number of risks that continue to be monitored via the internal CQC Oversight Group, which include; estates (both planned works and maintenance), safeguarding particularly around professional boundaries and allegations against staff, closed cultures, blanket restrictions, recruitment and retention.

Well Led Inspection

The Committee were advised that three unannounced inspections to inpatient core services took place from 16-18th November as part of the Well- led inspection. Eighteen wards were inspected across older adults, acute, Psychiatric Intensive Care Unit, Medium and Low Secure Forensic wards. Initial feedback has been positive, in particular, the quality of risk assessments, care plans, and physical health. Staff were reported to be welcoming and facilitated the visits well. The Committee were informed that the Well Led inspection will be taking place on 30th November and 1st December. Assurance was provided that the board are fully sighted on arrangements.

The areas of concern were identified as relating to the experience of food, estates and facilities and responsiveness to maintenance work, all of which the Trust is aware of and have plans underway to ensure improvement

3. System Suicide Prevention Strategy Update

The Committee noted that the Suicide Prevention Programmed received a 2019 nomination and runner up award in the Positive Practice in Mental Health Awards, and in 2021 were a winner.

4. Any Other Business

The Committee discussed a potential change in approach around ‘customer engagement’, from reactive to more proactive. The Committee agreed that this would need to be considered at board level, as it would need to be implemented as a Trust wide change of direction.

5. Q2 Mortality Report

Report attached for noting by the board.

The Board is asked to:

1) **Note the content of this report.**
2) **Receive the attached Q2 Mortality Report.**

Quarterly Mortality Report (Q2)

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

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

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

3 ANALYSIS OF INFORMATION

3.1 In Q2, a total of 299 mortality incidents were reported on Datix. The graph (1) below shows the figures relating to mortality that have been reported since July 2020. This includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality in Q2 have decreased compared to 370 in Q1 2021/22. The number of COVID–19 deaths has again remained low in Q2, with a total of seven reported, compared to 11 in Q1. The reduction in mortality incidents has also slightly impacted on the number of STEIS reported cases, with a total of 14 in Q2 compared to 17 in Q1. It is unconfirmed at this stage why the numbers of mortality have decreased over the course of the 2021/22 financial year. When comparing the rate of mortality to Q2 in the previous year (2020/21), the figures were almost 300 more than what we have seen this quarter. It is however likely that the reduction in Q2 2021/22 is largely associated with the number of Datix Death notifications reported as part of the data reconciliation work. A total of 48 were reported in Q2, whereas 143 were reported in Q1 2021/22. The reduction in COVID–19 deaths over the course of 13 months is also likely to have contributed to the decrease in mortality numbers.

3.2 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.

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

additional learning points are identified, the individual incidents are reviewed and action is taken to prevent reoccurrence. This can include further review in the form of a Structured Judgement Review.

Graph 1 Mortality reported cases

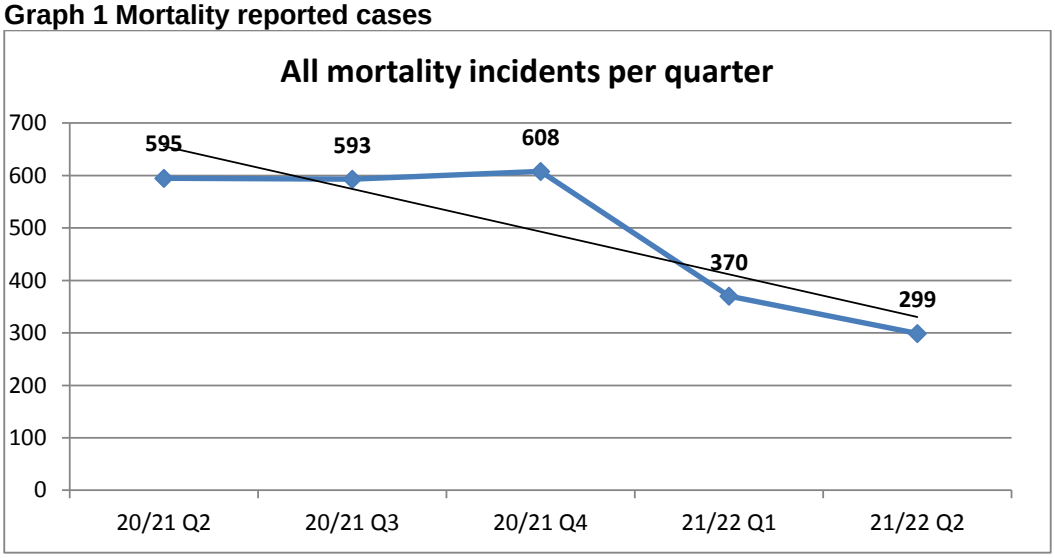


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Total
Suicide (actual)	6	0	2	1	3	1	0	2	5	3	2	2	2	29
All Deaths reported on Datix	140	135	232	226	275	178	155	150	75	146	74	122	103	2161

3.4 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q2, 2% of deaths of patients are suicide or suspected suicide related. This compares to 2.9% reported in the previous quarter. The average number of deaths for the 13 months above was 154 per month. For this quarter (Q2), there was an average of 100 per month. This is less than the previous quarter, where there was an average of 123 per month in Q1 2021/22.

3.5 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services were the highest reporters. In Q2 2021/22, the number of suspected suicide incidents decreased with a total of six compared to 11 in Q1 2021/22. There were no suspected suicides reported by Forensic and Specialist Services.

3.6 50% of suspected or confirmed suicides reported in Q2 were of patients in the Community Recovery Care Group; all patients were under the care of different community teams. All patients were male, two patients were in their twenties and one in his late fifties. Older adults reported two suspected suicides in Q2, with both patients being male. Older Adult and Community Recovery Services have however seen a reduction in suspected or confirmed suicides in Q2 2021/22, compared to Q1.

3.7 The data for KMPT shows that the number of suspected or confirmed suicides in Older Adult services has slightly decreased in Q2 2021/22. The previous mortality report (Q1 2021/22) identified an increase in suspected or confirmed or suspected suicides for older adults, with a total of three reported. The number of suspected or confirmed suicides for the Older Adult Care Group will continue to be monitored over the coming months to identify any early trends or themes. A focussed piece of work around older adult suspected suicide was undertaken in September 2021. This report identified themes relating to the influx in suspected suicide deaths for the care group and compared the data to previous themed reports, as well as patient demographics and risk factors in older adults. A theme relating to care planning and risk assessment was identified within the review, such as a lack of documentation around risk and self harm. The review was shared Trust–wide and via the Older Adult Care Group governance meetings. Key points from the review have been added to an easy–read learning bulletin to prompt care group and local team discussion.

3.8 Analysis by age and gender

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

Age Band	20/21 Q2	20/21 Q3	20/21 Q4	21/22 Q1	21/22 Q2	Total
100+	4	1	1	5	2	**11**
90-99	94	138	97	61	47	**354**
80-89	232	215	255	121	99	**703**
70 to 79	118	110	124	74	58	**400**
60 to 69	52	49	49	33	28	**192**
50 to 59	33	30	31	31	27	**171**
40 to 49	34	16	24	20	21	**199**
30 to 39	13	16	18	17	8	**291**
20 to 29	11	10	5	8	9	**126**
10 to 19	4	1	1	0	0	**6**
Unknown	0	0	3	0	0	**3**
Total	**593**	**586**	**608**	**370**	**299**	**2456**

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	22	54	28	23	17	12	6	7	0	169
Female	2	25	45	30	5	10	9	2	2	0	130

Table 4 COVID-19 deaths by gender

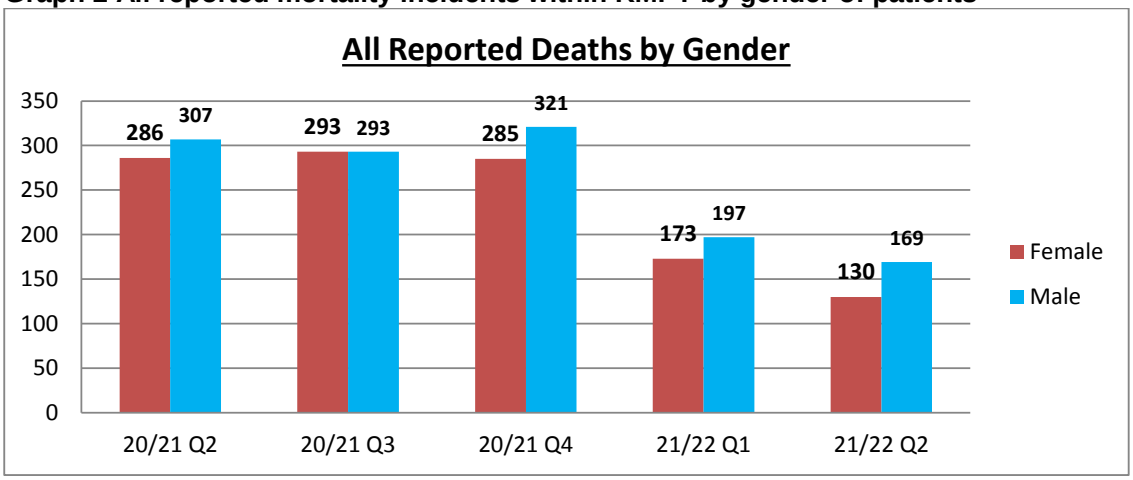
	Sep -20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul–21	Aug –21	Sep –21	Total
Female	1	2	6	23	47	17	11	2	0	1	0	3	0	113
Male	2	2	7	27	45	17	14	2	5	1	0	2	2	126
Total	3	4	13	50	92	34	25	4	5	2	0	5	2	239

3.8.1 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age and residing in residential or nursing homes and presenting with co-morbidities. In Q2 there have been two older adult incidents that have been subject for a Structured Judgement Review, due to the patients having a diagnosis of psychosis during their last episode of care.

3.8.2 The number of mortality incidents relating to COVID–19 has reduced significantly across each quarter. This will continue to be monitored via Trust–wide Serious Incident and Mortality Panel and figures of COVID–19 deaths will be included in the Mortality Report for the remainder of the year.

3.8.3 When data is analysed of reported deaths within KMPT according to gender, indications are that figures of all mortality in men are usually higher than in women, with the exception of Q3 2020/21 where the figures for both genders were the same. 113 of the 169 male mortality incidents relate to patients under the care of older adult mental health teams with the vast majority reported to have died from natural causes and were living in a care or nursing home at the time of their death. The overall figures of mortality are higher in older adults with 74% of the total mortality incidents reported in Q2 2021/22 relating to patients over the age of 65. As identified in previous reports, mortality in older patients has usually been higher in females. From a review of the mortality incidents reported in Q2, older males have had the higher number of mortality with a total of 117 compared to a slightly lower number of females of 105.

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



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

Table 5 Suspected suicides by age and gender

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

80 – 89 years	1	–
90 – 99 years	–	–

3.8.5 Nationally, middle-aged males (between the ages of 40 to 54 years) are at a higher risk of death by suicide although suicide occurs in all ages and genders (NCiSH data). There was only one male patient of this age category that died from suicide in Q2 2021/22. There were two male patients between the ages of 20 to 29 that died from suspected or confirmed suicide in Q2.

3.8.6 The number of suspected suicides reported in Q2 2021/22 has decreased, with a total of six reported compared to 11 in Q1 2021/22.

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

3.8.8 So far, KMPT have identified 84 patient deaths that meet the criteria of a questionnaire. The NCiSH has confirmed with KMPT that the study has been extended to 31/03/2022.

3.9 Mortality review by ethnicity

Table 6 Deaths by ethnicity

	20/21 Q2	20/21/Q3	20/21 Q4	21/22 Q1	21/22 Q2	Total
Bangladeshi	1	0	1	0	0	2
Black African	1	0	1	2	0	4
Black Caribbean	2	2	0	0	0	4
Chinese	0	0	0	1	0	1
Indian	1	0	3	1	0	5
Mixed white and Asian	0	0	1	0	1	2
Mixed white and black African	0	0	1	0	0	1
Mixed white and black Caribbean	0	0	1	2	0	3
Not stated	65	42	49	33	22	211
Other Asian	4	1	3	1	1	10
Other Mixed	2	1	2	0	1	6
Other ethnic category	0	1	2	0	1	4
Pakistani	0	1	0	0	0	1
White - British	504	524	528	324	267	2147
White - Irish	3	3	4	1	1	12
White - other white	10	11	10	5	5	41
Unknown	0	0	2	0	0	2

Total	593	586	608	370	299	2456

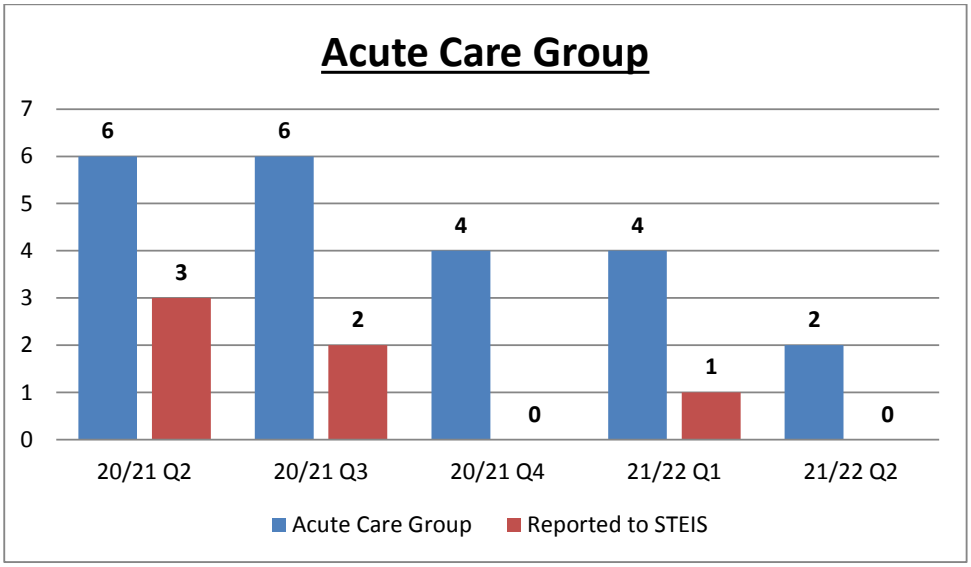
3.9.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white British. On reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were four in Q2 2021/22, this compares to seven in Q1 2021/22. The number of ethnic minority deaths reported in each quarter has continued to decline. It is unclear why numbers have reduced, however it is possible that the overall reduction of mortality incidents may have contributed to this. Of the BAME deaths in Q2 2021/22, one incident was reported to legal services by the Coroner. All incidents have been reviewed in Trust–wide Serious Incident and Mortality Panel, where one incident has been STEIS reported as a serious incident and is in the stages of investigation. This relates to a 22 year old male of mixed White and Asian background. The remaining three incidents have been downgraded following review in the Trust–wide Serious Incident and Mortality Panel as no KMPT care or service delivery problems were identified.

3.9.2 Of the 299 incidents reported on Datix during Q2, 33 (7.3%) had no ethnicity recorded compared to 8.9% in Q1. Where ethnicity was not recorded, this could be due to some patients declining to provide their ethnicity, or were people under KMPT care for a number of years before the renewed focus on ethnicity reporting. Work is ongoing in the operational and performance team to improve on ethnicity recording.

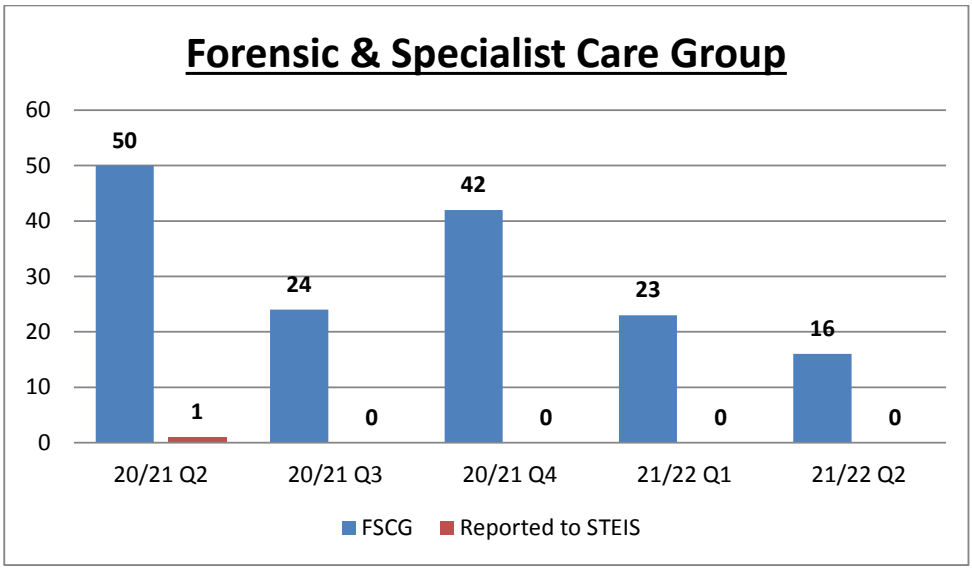
4 Serious Incidents and LeDeR cases

4.1 The following graphs (3 to 6) show the mortality incidents reported for the period 01/07/2020 to 30/09/2021 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

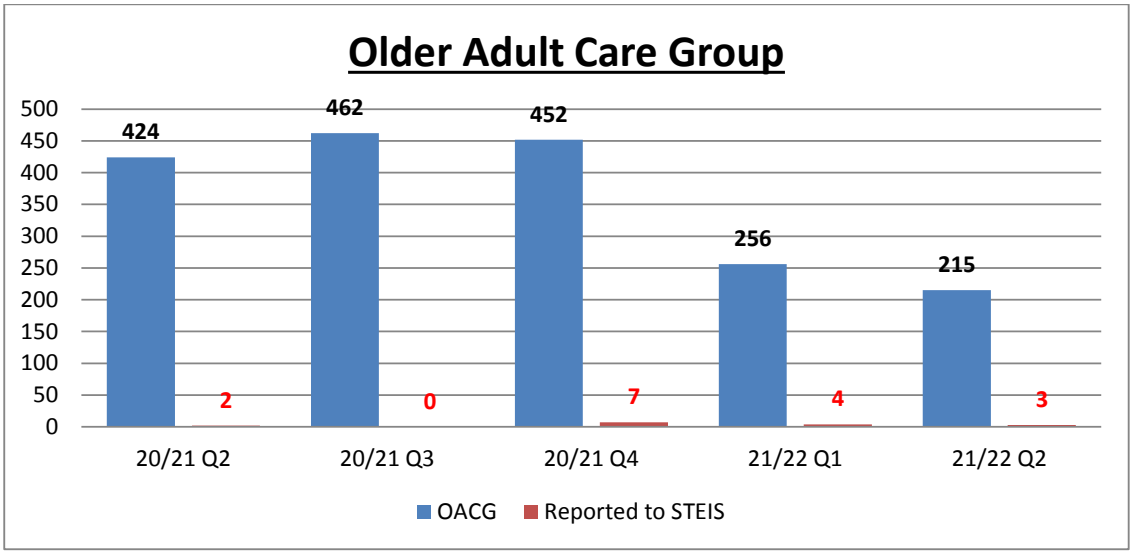
Graph 3 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.



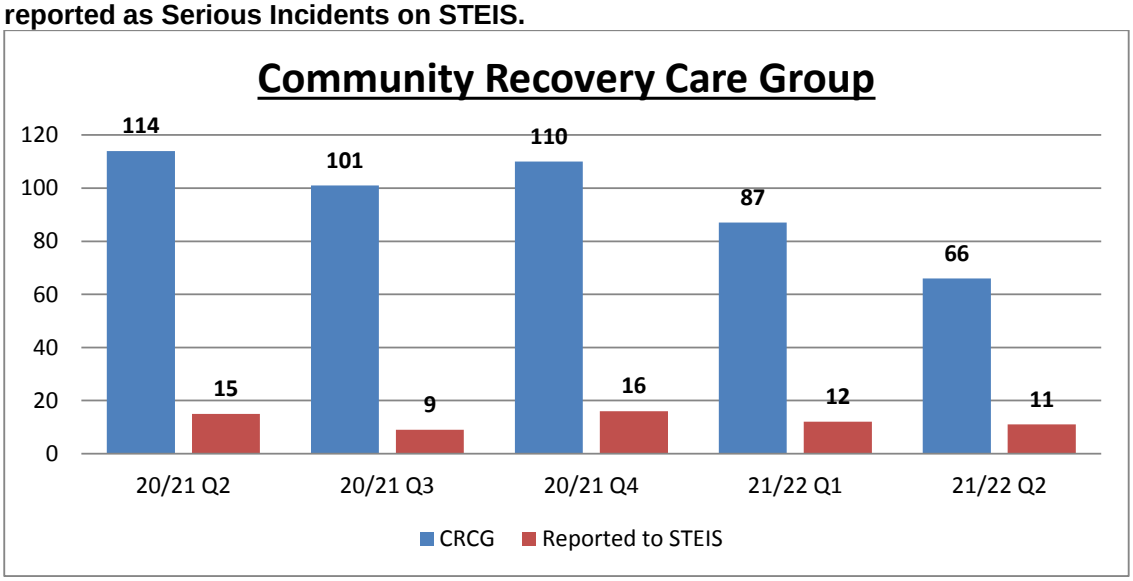
Graph 4 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.



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



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



4.1.2 It is important to note that the decrease in mortality incidents has not reduced the overall percentage of STEIS reported serious incidents, when comparing data to Q1 2021/22. The percentage of serious incidents compared to overall mortality in Q1 was 4.6%, whereas the percentage of serious incidents in Q2 compared to overall mortality is 4.7%. The number of Datix Death notifications (data reconciliation work) reported in Q2 was much lower than those reported in Q1, by almost 100 incidents. This is likely to have contributed to the overall reduction of incidents in all care groups over the past three months (July to September 2021). Further review into the reduction of mortality incidents may be required to determine if there is another reason why the numbers have reduced in every care group.

4.1.3 On review of the 14 Serious Incidents relating to mortality that were reported on STEIS, four relate to suspected suicide and are in the stages of investigation. The remaining serious incidents relate to mortality where cause of death may not be known

but where care and service delivery problems have been identified that may have contributed to the patient's death.

4.1.4 In Q2, there were three mortality incidents where the patient had a diagnosis of a learning disability which was reported to LeDeR. All patients were of white-British background. Two patients were female and one male and were between the ages 28 and 67. One patient died from natural causes of a cancer related illness, whereas two patients died unexpectedly, with one patient presumed to have taken an overdose prior to their death. All three incidents were reviewed in the Trust–wide Serious Incident and Mortality Panel and were downgraded to an incident, as no gaps in KMPT care were identified.

5. STRUCTURED JUDGEMENT REVIEW LEARNING

5.1 There have been a total of 17 SJRs completed since implementation of the process in October 2020, with some others in the stages of review. The reviews have identified a mixture of very good care and areas of care that could be improved. One Structured Judgement Review identified care and service delivery problems relating to the care and treatment provided the year before the patient died, resulting in a prolonged stay in the acute hospital. It was felt that the gap in care met the criteria for STEIS reporting and is currently in the stages of investigation. The care groups with the highest number of cases for Structured Judgement Review are Community Recovery and Older Adults. This is to be expected as the caseload is typically higher for both services.

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

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

5.3 A themed SJR review is currently underway and will be complete by the end of Q3 2021/22.

5.4 The Mortality Review Manager is working with the care groups to ensure that the learning from reviews is shared with the wider teams. Evidence of discussion is uploaded to Datix. Work is ongoing to improve the Structured Judgement Review process to ensure that the Trust is learning from the good care as well as areas that could be improved. Learning from some SJRs will captured in the learning events.

6. CONCLUSION AND NEXT STEPS

6.1 Mortality incidents recorded on Datix have again decreased in Q2 compared to Q1. STEIS reported mortality incidents have also reduced, although the percentage of overall incidents compared to STEIS reported for Q2 has slightly increased. Incidents relating to suspected or confirmed suicide have decreased in Q1. One community recovery team in particular is an outlier for STEIS reported deaths, with a total of three reported in Q2. From initial review, there is learning regarding the method of contact for patients and queries relating to patients being cared for on the correct care pathway/service (also highlighted in the Q1 mortality report). Full analysis of the initial findings will be included in the serious incident learning review investigation.

6.2 Themes of learning drawn from serious incidents will continue to be reviewed as part of the six-monthly suicide thematic review. A review of learning reviews

submitted to the CCG between Q1 and Q2 2021/22 will be presented to the Trust Board and relevant Trust–wide meetings for discussion.

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

6.4 The Trust is continuing to work with RL Datix with the implementation of Datix Cloud. This has provided the Trust with the opportunity to amend the way we report incidents, including mortality. Datix Cloud has a separate Mortality Review module, which will primarily be used for recording of Structured Judgement Reviews. The module will also be useful for when the Medical Examiner role is introduced for Mental Health Trusts. Additional incident categories will be introduced which will improve the accuracy of reporting and in turn improve themed analysis reports.

6.5 Care Groups to continue to review their incident reporting data to determine the reasons for the overall reduced number of incidents, including figures relating to mortality. Care Groups to work with their teams to increase the number of incidents reported to Datix.

Title of Meeting	**Workforce and Organisational Development Committee (WFODC)**
Meeting Date	**25th November 2021**
Title	**WFODC Chair Report**
Author	**Venu Branch, Non-Executive Director**
Presenter	**Venu Branch, Non-Executive Director**
Executive Director Sponsor	**-**
Purpose	**Noting**

Matters to be brought to the Board's attention

- Workforce KPI's
- HR Risk Register
- HR Policies
- Cultural Work

Summary of Committee Meeting:

The Workforce & Organisational Development Committee (WFODC) met on Tuesday 16th November and discussed the following agenda:

- Forensic and Specialist Service Care
- Workforce, OD and Communications Overview Report, including KPIs
- Strategic Delivery Plan Priorities
- Health and Wellbeing Winter Pressure Plan
- HR Policies
- HR Risk Register

Workforce and Organisational Development Overview Report

The Committee wanted to bring the following 4 items to the attention of the Board:

- Workforce KPIs
- Workforce Risks
- Culture work
- Workforce policies

Workforce KPIs

The Committee received a comprehensive presentation setting out a range of datasets. Discussions covered Key Performance Indicators (KPI's) for Sickness, Turnover and Retention.

The Committee felt it important to note that the following KPIs are improving year on year:

- Retention
- Turnover

Sickness is worse than last year and a discussion was had about the effects of Covid and having a very tired workforce.

The Committee is fully sighted on the KPI's in terms of our comparator organisations and national benchmarking and notes that data trends over the last few years have shown that not only are we obtaining higher quality and more granular data but we have made substantial progress over the last few years in respect of retention, sickness absence, turnover and appraisals, but the Committee acknowledges there are areas that are still at risk.

This information will be covered in the Workforce update to the November Board from The Director of Workforce and OD.

Appraisals is at 95% completion and they are still being uploaded onto i-Learn, which the Committee noted as a great achievement.

Essential training for the role - The Committee was assured as an organisation we are showing as compliant, but there are a number of areas where some essential training is not compliant. A major effort is underway to ensure bookings where individuals need training, and the table below is indicative of the effort. It was reported a CPR Trainer is being recruited to help with the backlog. The Deputy Director of Nursing highlighted to the Committee that there are still some room restrictions which are limiting the room capacity for training and they are working around 50% capacity.

Physical Interventions	568 compliant	215 not compliant	127 booked onto course out of 215	88 people sent reminders to book on
ILS	314 compliant	71	41 booked out of 71	30 people sent reminders to book on
CPR & AED	1,459	414	104 booked out of 414	310 people sent reminders to complete

Risks

The Committee received a paper on proposed revised strategic risk areas for the Workforce, Organisation Development (OD). The report seeks to triangulate the new risks from local risk registers, workforce and finance data and provide risks against the Strategic Delivery Plan (SDP). New risks are in relation to Sickness, Turnover, Recruitment and Retention, which are targets in the Strategic Delivery (SDP). The Committee was presented with appendices which provide full detail of the newly written risks and areas of concern where appropriate. Once these are added to the Board Assurance Framework they will continue to be presented and discussed at the Workforce and OD Committee at every meeting in the normal way.

Whilst it was noted that progress is being made on recruitment and retention, a full discussion was had at the Committee in relation to newly developed roles and new ways of working. It was agreed that whilst we require specific levels of nursing staff and consultants on every shift it is unlikely we will resolve our risks around recruitment in the short or arguably medium terms. Without mitigation the Board and the Trust therefore need to acknowledge that there will be a continued impact on bank and agency spend and it is highly unlikely that we will meet our target on agency spend this year. With reliance on agency staff there is the added risk of impact on retention and turnover.

Cultural work

The Committee discussed and accepted there are gaps in the cultural work due to COVID over the last two years where the team has had to refocus its work. The Committee is assured that this work will be picked up and we have secured some additional resource through the Wellbeing Collective.

Workforce policies

There has been some discussion that WFOD is an outlier in terms of policies being updated. Director of Workforce and Organisation Development updated the Committee on the Workforce policies. A number of these policies had become out of date during Covid. All of these policies have recently been reviewed and brought up to date. The Joint Negotiating Forum has approved all of these policies and they have now been ratified by the Committee with a review date for the draft handbook set for 31 March 2022. The policies will then become part of an employee handbook which will be launched in April 2022.

The Board is asked to note the content of this report.

Title of Meeting	**Finance and Performance Committee**
Meeting Date	**26th October 2021**
Title	**Board Report**
Author	**Mickola Wilson, Non-Executive Director and Chair of Finance & Performance Committee**
Presenter	**Mickola Wilson, Non-Executive Director and Chair of Finance & Performance Committee**
Executive Director Sponsor	
Purpose	**Noting**

Matters to be brought to the Board's attention
• Financial Budgets: risk that the required break even for the year is not delivered. Mitigations are in place and being actively managed • iQPR: decline in the delivery of performance for a number of metrics, which will be further impacted with the onset of winter • Capital Projects: shortfall in delivery of capital projects

Items referred to other Committees (incl. reasons why)
• New Workforce Model as critical element to the plan to improve performance and the financial position

Executive Summary

Financial Report
Guidance has been received on the financial regime for H2 2021/2022, which requires break even for the year. Current forecasts shows delivery of breakeven, when a number of mitigations are put into place. A number of assumptions have been made to support delivery of breakeven, one being an additional £600k savings will need to be delivered during the remainder of the year, over and above those required for the long-term sustainable plan.

The Committee requests the full support of the Executive team to deliver the required savings.

IQPR / Performance Measures

The report on performance measures shows a continuing downward trend in meeting some key performance targets. The national trajectories in terms of performance targets are being

met, but the targets set by the Trust locally for its own performance are being impacted by an increase in demand for services and a lack of resources for delivery.

The problem is most severe in the Older Adult Care Group where the delays to referrals to treatment are less than 50% of target for 4 week wait (referral to assessment). Priority is being given to functional needs and complex memory assessment rather than the more routine Memory Assessment Service referrals and discussions are in progress to change the approach to routine assessments with greater input from GPs. This is a change in the clinical model currently available within the system.

The issues of memory assessments is being escalated to the Trust Board recognising that the Board can either tolerate the current level of risk or make this a priority for action .

CMHF

This programme is a whole system response required as part of the Long-Term Plan to deliver transformed mental health pathways for people with serious mental illness; the programme aims to improve efficiency, outcomes and address long standing workforce issues through a provider collaborative arrangement. It will impact positively on KMPT community mental health teams with an expectation of a national standard to meet referral to assessment within 4 weeks through the revised cross agency/system working. This is progressing and will lead to improvement in performance and patient care in the long term.

The Board are asked to note that this project is a critical step in improving performance

Capital Programme

The planned expenditure for 2021/2022 year to date is £5.4m significantly behind programme due to delays in the delivery of mainly Estates projects. Steps are being taken to accelerate some of the projects including the delivery of improvements to Comms Rooms across the Estate.

Long Term Sustainability Plan (Cost savings)

The target for this financial year is sustainable savings of £7m, £4.6m have been identified with a further £2.4m to be found . The largest gap is in the Acute Care Group budgets. The Executive are asked to prioritise the delivery of these savings.

Business Plan Approvals

- Recruitment of Nurses Budget £1.19k
- NHS Health line Hub Budget £962k recommended for Board Approval
- PATH Project £342k