AGENDA

Title of Meeting Trust Board Meeting (Public)
Date 29th September 2022
Time 10.10 to 12.40
Venue The Orchards Event Centre, East Malling

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/22-23/59	1.	Welcome, Introductions & Apologies		Verbal	Chair	10.10
TB/22-23/60	2.	Declaration of Interests		Verbal	Chair	
		BOARD REFLECTION ITEMS				
TB/22-23/61	3.	Personal Story – Older Adults		Verbal	TB	10.15
TB/22-23/62	4.	Quality Improvement – Maidstone CMHT		Verbal	AQ	10.25
		STANDING ITEMS				
TB/22-23/63	5.	Minutes of the previous meeting	FA	Paper	Chair	10.30
TB/22-23/64	6.	Action Log & Matters Arising	FN	Paper	Chair	10.35
TB/22-23/65	7.	Chair's Report	FN	Paper	JC	10.40
TB/22-23/66	8.	Chief Executive's Report	FN	Paper	HG	10.45
TB/22-23/67	9.	Board Assurance Framework	FA	Paper	AC	10.50
		STRATEGY, DEVELOPMENT AND PARTNERSHIP				
TB/22-23/68	10.	MHLDA Provider Collaborative Update	FD	Paper	HG	10.55
TB/22-23/69	11.	Risk Management Strategy	FA	Paper	AC	11.00
		OPERATIONAL ASSURANCE				
TB/22-23/70	12.	Integrated Quality and Performance Report – Month 5 (incl waiting times update)	FD	Paper	HG	11.05
TB/22-23/71	13.	Finance Report: Month 5	FD	Paper	SS	11.10
TB/22-23/72	14.	Workforce Deep Dive – Leadership Development Strategy	FD	Paper	SG	11.20
TB/22-23/73	15.	Community Mental Health Framework Transformation (Quarterly)	FD	Paper	DHS	11.30
TB/22-23/74	16.	Closed cultures and professional boundaries	FN	Verbal	AC	11.40
TB/22-23/75	17.	EPRR Annual Report	FD	Paper	AC	11.50
TB/22-23/76	18.	Register of Interests	FN	Paper	TS	12.00
TB/22-23/77	19.	Review of Standing Orders	FA	Paper	TS	12.10
		CONSENT ITEMS				
TB/22-23/78	20.	Quality Committee Chair Report	FN	Paper	FC	12.20
TB/22-23/79	21.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/22-23/80	22.	Finance and Performance Committee Chair Report	FN	Paper	KL	
TB/22-23/81	23.	Report from Audit and Risk Committee	FN	Paper	PC	
TB/22-23/82	24.	Use of Trust Seal	FN	Paper	TS	
		CLOSING ITEMS				
TB/22-23/83	25.	Any Other Business			Chair	12.35
TB/22-23/84	26.	Questions from Public			Chair	

	Date of Next Meeting: Board Meeting – 24th November 2022

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Sean Bone-Knell	SB-K	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Martin Carpenter	MC	NExT Director Scheme
Helen Greatorex	CE	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Organisational Development
In attendance:		
Kindra Hyttner	KH	Director of Communications and Engagement
Tony Saroy	TS	Trust Secretary
Hannah Puttock	HP	Deputy Trust Secretary
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 Extraordinary Board Meeting held at 09.30 to 12.00hrs on Thursday 28th July 2022
Via Videoconferencing

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Peter Conway	PC	Non-Executive Director
Kim Lowe	KL	Non-Executive Director (from mid-point of meeting)
Mickola Wilson	MW	Non-Executive Director
Sean Bone-Knell	SBK	Non-Executive Director
Martin Carpenter	MC	NExT Director Scheme
Helen Greatorex	HG	Chief Executive
Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sandra Goatley	SG	Director of Workforce and Organisational Development
Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:		
Tony Saroy	TS	Trust Secretary (Minutes)
Hannah Puttock	HP	Deputy Trust Secretary
Dr Mary Aston	MA	Consultant in Old Age Psychiatry (for item TB/22-23/36 only)
Karen Bartlett	KB	Prescribing Lead Pharmacist & Clinical Safety Officer (for item TB/22-23/37 only)
Sue Taylor	ST	Senior Clinical Audit Facilitator (for item TB/22-23/37 only)
Oliver Webb	OW	Deputy Head of Nursing for Acute Care Group (for item TB/22-23/37 only)
Daniel Lagadu	DL	Deputy Director of Quality Improvement (for item TB/22-23/37 only)
Mudasir Firdosi	MF	Clinical Director Of Quality Improvement & Consultant Psychiatrist (for item TB/22-23/37 only)
Apologies:		
Fiona Carragher	FC	Non-Executive Director
Dr Afifa Qazi	AQ	Chief Medical Officer
Observers:		
Teresa Barker	TB	Head of Service - Older Adults
Julie-Anne Meadows	JAM	Head of Service FSCG
Michele Curtis	MCu	Director of IT

Item	Subject	Action
TB/22-23/36	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, noting the apologies as above.	
TB/22-23/37	**Declarations of Interest** There were no declarations of interest.	

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Item	Subject	Action
TB/22-23/38	**Personal Story – Dementia Services** MA presented the personal story item by describing the journey of a 72-year-old patient who had been referred into the new Enhanced Memory Assessment and Intervention Service (EMAIS). The new way of working has meant that there was now a "one-stop shop" for patients, allowing for swifter diagnosis and care plan formation with the patient. This allows the diagnosis letter and care plan letter to be sent to the patient and the GP on the day of the appointment. The rollout of EMAIS has reduced waiting times and has been well received by staff and service users. The Board **noted** the Personal Story – Dementia Services.	
TB/22-23/39	**Quality Improvement – Physical Health** The Board received a presentation from KB, ST and OW regarding the quality improvement projects centred on physical health matters. One was focussed on physical observations and the other was an audit focussed on clozapine use. Both were co-produced with patients and staff. Both projects achieved improved performance rates within the teams and gave better outcomes for both patients and staff. The lessons learned from the quality improvement projects will be rolled out across the Trust, including adjustments to clinical policies so that changes are sustained. The Board **noted** the Quality Improvement – Physical Health item.	
TB/22-23/40	**Minutes of the previous meetings** The Board **approved** the minutes for 26th May 2022, subject to the job titles for Geoffrey Lawrence and Alice Sigfrid being corrected. The minutes of 15th June 2022 were **approved** as drafted.	
TB/22-23/41	**Action Log & Matters Arising** The Board **approved** the Action Log. As a matter arising, the Board noted that the Strategic Delivery Plan Priorities (SDPP) were to be finalised by the end of w/c 1st August. The Board requested to be updated on the finalised version.	
TB/22-23/42	**Chair's Report** The Board received the Chair's Report, with discussions focussed on some of the themes from the NED Visit Feedback. The Board reflected on matters of partnership working and RiO, with an expectation that the issues raised will be resolved by the end of the financial year through the SDPP work.	

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Item	Subject	Action
	The Trust's Digital Strategy Board is being invigorated, given its impact on the Trust's capital spending programme. The use of hybrid working has caused a reduction in the footfall in some of the Trust's office space and the Trust has an ambition to reduce its non-clinical estate by 20%. The Board will receive an estates update in September. The Board **noted** the Chair's Report.	
TB/22-23/43	**Chief Executive's Report** The Board received the Chief Executive's Report. The Board was updated on national matters that impact the Trust. One of those matters included the recent report that acknowledged NHS staffing levels across the nation are at in crisis. At a local level, the Kent and Medway system has been at OPAL 4 – the level at which comprehensive care cannot be provided – for the last few days. The Board reflected on the cost of living and the Trust's recent decision to increase the mileage rate for staff. The increase is a temporary measure and dependent on fuel price movements. The Trust is also awaiting national policy on the matter. The Board **noted** the Chief Executive's Report.	
TB/22-23/44	**Board Assurance Framework** The Board received the Board Assurance Framework (BAF) for approval. The Board was updated regarding the two new risks, the five risks that changed their score, and the two risks that were recommended for removal. The Board reflected that there were some further adjustments needed, given that some risks were of a low rating. Some additional risks may need to go on the BAF, such as the potential national strikes in relation to pay. Board feedback was given on Risk ID 6573 (Demand and Capacity for Adult and Older Adult CMHTs compared to pre-pandemic levels), Risk ID 7038 (IT Infrastructure Refresh Funding), and Risk ID 6858 (External Market Forces). The Board noted that in some instances, confidence assessments were missing from the BAF and need to be included in future iterations. The Board **noted** the BAF.	
TB/22-23/45	**Integrated Care Board (ICB) Mental Health Update** The Board received the ICB Mental Health Update. The Board was updated on the four overarching aims of the ICB, with the focus of the discussion being on the first aim of 'Improve outcomes in population health	

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Item	Subject	Action
	and healthcare'. There have been a number of listening activities with a number of seldom heard communities. The Board reflected on the ICB's governance and financial arrangements. The governance arrangements are well-formed, with each NHS Trust retaining its own sovereignty and jurisdiction. In terms of finances, the expectation is that the ICB would cost no more than the Clinical Commissioning Group. The Board **noted** the ICB Mental Health Update.	
TB/22-23/46	**Operation Cavell Annual Progress Report** The Board received the Operation Cavell Annual Progress Report. The Board was updated on the close working between KMPT, Kent Police and the Crown Prosecution Service. The Board requested further assurance regarding the disappointing decrease in the number of reported offences. The Board also noted that many of the offences do not appear to have an outcome and the reasons for that should be considered in future update reports. **Action: VB2 to provide an Operation Cavell update report to the Board in January 2023.** The Board **noted** the Operation Cavell Annual Progress Report.	
TB/22-23/47	**Integrated Quality and Performance Report (IQPR) – Month 3** The Board received the IQPR. The Board noted the ongoing work to improve care planning within the community mental health teams. The Trust is seeking to understand why there is variance in care planning performance and these will need to be managed at a local level. To support that work, the Trust is reviewing the CLiQ check process. The Board reflected on the issues of variances in performance, vacancy gaps and expressed concern regarding the impact of local restrictions on capacity due to the admission of a patient with complex needs. The Trust is embedding its new model of care, which will improve care and address some of the staffing challenges. The patient with complex needs will be moved on 1st August, after which the local restrictions will be removed. However, patients with complex needs will require a Kent and Medway systemwide solution. The Board was pleased to note that in the month of June, no patients were subject to prone restraints. This is the first such occasion since 2015. The Board **noted** the IQPR.	
TB/22-23/48	**Finance Report: Month 3** The Board received the Finance Report: Month 3.	

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Item	Subject	Action
	• **Income and Expenditure**: KMPT is continuing to use temporary staffing due to vacancies and staff absence, but the spend on agency in June was lower than that seen in 2021/22 - £555k in 2022 compared to £661k in 2021, a 16% reduction. There is still significant spend on external placements for PICU – patients numbers remain high due to complexities regarding how the Trust's PICU can be utilised at present. This is expected to improve in August, but in the meantime is being supported by commissioner income. • **Capital Programme**: In June, the Trust spent £0.4m against the plan of £1.4m. Due to overspends in April and May the year to date position is underspent by £0.8m. The underspend is largely due to delayed start and completion dates to a number of schemes. • **Cash**: The cash position has decreased by £0.1m in month to £20.7m. The actual cash position is £1m higher than plan, with receipts £2m lower, due to invoices to the Provider Collaborative being paid later than expected, offset by payments £3m lower than plan. The high level cash plan for year-end has been reported at £10.6m. • **Cost improvement programme:** The Long Term Sustainability Programme (CIPs) for 22/23 has commenced and plans have been identified and phased throughout the year. Further work continues to identify CIP schemes for the unidentified CIP balance. Agency spend is being monitored throughout the financial year and it is anticipated that Agency caps will return nationally to be monitored. The Board reflected on the finance report and discussed confidence levels in the Trust implementing its plan to tackle the underlying deficit. SS was confident the plan to reduce medical agency staff costs. The price increase for Bridge House is also due to have a positive effect in tackling the underlying deficit. The Board **noted** the Finance Report: Month 3.	
TB/22-23/49	**HR Deep dive: Equality, Diversity and Inclusion** The Board received the HR Deep dive: Equality, Diversity and Inclusion (EDI). The Board noted the work being undertaken to create a diverse and inclusive workplace. The Trust has well-established staff networks that supports the EDI work and helps the Trust to engage with staff. The Board considered the work that the Trust has carried out for staff with protected characteristics. The Trust's reverse mentoring programme was recognised as being an opportunity for the Trust in becoming an anti-racist organisation. WFODC is reviewing the EDI data to understand the narrative behind the data. The Board **noted** the HR Deep dive: Equality, Diversity and Inclusion item.	
TB/22-23/50	**Delayed Transfers of Care IQPR Deep Dive** The Board received the Delayed Transfers of Care IQPR Deep Dive.	

Item	Subject	Action
	The Board noted that currently the Trust has more than 40 in-patients (equivalent to more than two in-patient wards) who cannot be discharged due, largely, to social care delays, although a few relate to housing delays. In order to resolve the issues, the Trust has set out a number of short term and longer-term actions. The Board reflected on the possible repurposing of a rehabilitation unit into a step-down care place, which may alleviate some of the pressure in acute settings. However, there is a risk that this could simply shift the delayed transfers in the acute setting to a step-down care setting. The priority, therefore, is to support the Kent and Medway system in resolving the social care element. The Trust recognises that working practices will need to change in order to reduce variances in the length of stay periods on different wards. The Trust is using Quality Improvement methodology to reduce that variance. The Board **noted** the Delayed Transfers of Care IQPR Deep Dive.	
TB/22-23/51	**Safer Staffing Action Plan Update** The Board received the Safer Staffing Action Plan Update. The Board noted that the Trust is seeking to review shift working patterns, with negotiations with staff taking place. The Trust is using Quality Improvement methodology to monitor rosters and the changes to date have caused a positive impact on patient observations. The Board requested the additional metrics be reported to the Finance and Performance Committee. The Board **noted** the Safer Staffing Action Plan Update.	
TB/22-23/52	**Self-Certification Declaration for NHSI** The Board **approved** the self-certification declaration.	
TB/22-23/53	**Quality Committee Chair Report (including Mortality Report Q1)** The Board received and **noted** the Quality Committee Chair's Report including the Mortality Report Q1.	
TB/22-23/54	**Workforce and Organisational Development Committee Chair Report** The Board received and **noted** the Workforce and Organisational Development Committee Chair's Report.	
TB/22-23/55	**Mental Health Act Committee Chair's Report** The Board received and **noted** the Mental Health Act Committee Chair's Report.	
TB/22-23/56	**Finance and Performance Committee Chair's Report**	

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Item	Subject	Action
	The Board received and **noted** the Finance and Performance Committee Chair's Report.	
TB/22-23/57	**Any Other Business** There were no matters of any other business.	
TB/22-23/58	**Questions from Public** There were no questions received from the Public, but there were comments from observers. The	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 29th September 2022	

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

Date ……………………………………………………………..

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BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/09/2022

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2022								
26.05.2022	TB/22-23/13	IQPR	Results of Waiting times work to be brought back to Board in September	DH-S/AC	September 2022		September IQPR includes commentary on waiting times	COMPLETE
26.05.2022	TB/22-23/15	Workforce Deep Dive into Equality, Diversity and Inclusion	The WFODC was asked to consider what should be monitored to create an EDI Dashboard.	SG	September 2022		The dashboard was reviewed and discussed at the September WFODC meeting. This action can now be closed.	COMPLETE
ACTIONS NOT DUE OR IN PROGRESS								
29.07.2022	TB/22-23/46	Operation Cavell Annual Progress Report	VB2 to provide an Operation Cavell update report to the Board in January 2023.	VB2	January 2023			NOT DUE
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.11.2021	TB/21-22/75	Strategic Delivery Plan Priorities Update	HG to give a year-end progress report on Operation Cavell in May 2022.	HG	May 2022	July 2022	This is on the agenda for discussion.	Closed
31.03.2022	TB/21-22/133	Workforce and Organisational Development Committee Chair Report	By July 2022, TS to support the Trust Chair in advising NEDs about the different assurance levels contained within the Committee Chair Reports.	TS	July 2022		Guidance on assurance levels sent to NEDs.	Complete
26.05.2022	TB/22-23/08	Chief Executive's Report	TS to agree with JC and HG an appropriate time and occasion for Board follow up on Sustainability.	TS/JC/HG	July 2022		Item to come back in January 2023	Complete
26.05.2022	TB/22-23/09	Board Assurance Framework	DH-S agreed to provide an IQPR deep dive on the DTOC topic for the July Board.	DH-S	July 2022		This is on the agenda for discussion.	Closed

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 22/09/2022

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
26.05.2022	TB/22-23/11	Strategic Delivery Plan Priorities 2021/22 Review	VB2 and HG to provide tabular format for 2022-23 Strategic Priorities delivery	VB2	July 2022		The finalised Strategic Delivery Plan Priorities document has been circulated.	Closed
26.05.2022	TB/22-23/17	Safer Staffing Report	The Board requested a high level plan of action in response to the finding of the Establishment Review with timescales be shared in July.	AC	July 2022		This is on the agenda for discussion.	Closed

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 29th September 2022**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

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

- Kent & Medway System
- Changes to Non-Executive Directors
- KMPT Charity – Health, Heart, Hope @KMPT
- Board Self-Assessment 21/22
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

System-wide meetings picked up again in September, and I have been involved in the Integrated Care Partnership board meetings regarding a population health strategy for Kent & Medway, as well as preparing for the forthcoming Dartford, Gravesham and Swanley Health & Care Partnership Board workshop. I also participated in the focus group for the appointment of a new CEO for Dartford & Gravesham NHS Trust.

3. Changes to Non-Executive Directors

At the end of September, we will be saying goodbye to Fiona Carragher, one of our Non-Executive Directors, who is leaving her role. I would like to formally record my thanks to Fiona for her work whilst working for KMPT, particularly chairing the Quality Committee and being a member of the Audit and Risk Committee. Recruitment is currently underway to recruit a new Clinical Non-Executive Director and an Associate Non-executive Director with digital expertise, and I will keep you updated via my Chair's Report as recruitment progresses.

4. KMPT Charity – Health, Heart, Hope @KMPT

On 18th August, the inaugural Charitable Trustees meeting was held. At the meeting we agreed the name of the charity 'Health, Heart, Hope @KMPT' and discussed the registration of the charity, as well as its proposed strategy. A Charitable Funds Committee will meet regularly to oversee the work of the charity and I look forward to seeing how the charity progresses.

5. Board Self-Assessment 21/22

All NHS Trusts Boards should self-assess their performance against the CQC Well Led framework. As a Board, each member recently undertook a self-assessment survey of the Board's current performance and governance processes. This is so important to us as a Board, as it helps us to identify where we feel can improve and any development work may be needed. It also allows us to celebrate and learn from what we are doing well in order to embed it going forward.

Since the last public meeting, the results of the surveys have been gathered and I have received a report of the data. As the Chair, I will be developing an action plan, consulting with Board members before finalising it. I intend for the finalised action plan to come to the public Board meeting in November.

6. Trust Chair and NED visits

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

Where	Who
August 2022	
111 Tonbridge Road Rehabilitation Unit	Jackie Craissati
Tarantfort Centre	Jackie Craissati
East Kent Community Mental Health Services for Older People	Sean Bone-Knell
Dover & Deal Community Mental Health Team	Sean Bone-Knell
St Martins Crisis Resolution and Home Treatment Team	Kim Lowe
Estates Team	Peter Conway

Chair Visits

It was a real pleasure to be able to return to 111 Tonbridge Road to talk with residents and staff about the rehabilitation service. I was impressed by their commitment and care, the focus on recovery, and the excellent contribution made by peer support workers in the team. My subsequent visit to the low secure service at Tarantfort was equally positive. I was struck by the commitment of many staff who have served KMPT over many years, and who are devoted to the service and its residents. The quality and quantity of food was one of the concerns raised, as well as the time required by staff to prepare meals – a more complicated process than I had previously realised. There has been some turbulent in the service recently, and I have picked up these issues with my executive colleagues.

Sean Bone-Knell – East Kent Community Mental Health Service for Older People (CMSHOP)

I met the locality Manager, Service Manager and met with the teams there. I spent sometime in the Multi-Disciplinary Team (MDT) meeting listening to the team talk through the care they are providing and the patient pathway from this point. I found the MDT a great example of the excellent care our staff provide for our patients and the level of detail and support options considered were excellent.

We had a good discussion over the new one stop shop for memory assessments, but one observation was the booking of rooms to obtain the space required. It is not always possible to get the rooms near enough together and with sections having competing pressures perhaps some priority could be given to booking of rooms. Other matters such as the premises, RiO, and Lifesize (videoconferencing) were discussed.

Sean Bone-Knell – Dover & Deal Community Mental Health Team (CMHT)

I was hosted and guided by the Locality Manager, who I was very impressed with. His people management skills and awareness of the current risks for the Trust and for the Dover & Deal CMHTs. During the visit, I discussed a number of matters with staff including the use

of agency staff compared with the option of overtime, the use of electric pool cars and the increase in the mileage rate. Positive practice found at the CMHT included the use of an appreciation posting board. I noted the staff concerns regarding the condition of Coleman House.

Kim Lowe – St Martins Crisis Resolution and Home Treatment Team (CRHT)

I received a warm welcome to the busy team. There was a lovely team spirit, with wellbeing high on their agenda. I attended the morning handover. There was a real focus on care for their patients. I listened to positive ideas regarding the conversion of a room into a relax/quiet space, as their current working practice was to work, drink and eat at their desks. The issue of the mileage rate was raised, with a request that the trust reviews the 3K business miles cap that is currently in place. Issues regarding RiO were also raised.

Peter Conway – Estates and Facilities Management Meeting

I did a virtual visit to Estates and Facilities Management attending their Directorate Management Team Meeting on 25th August. A lot of material, issues and risks were covered during the 2.5 hour meeting attended by approximately 16 people (seven apologies). There was a good balance between breadth and depth, information sharing and discussion. Papers were comprehensive but, because of timing, resources (HR and Financials) were not available. Attendees were enthusiastic and demonstrated a good grip.

7 Congratulations

The Board was pleased to hear that Dr Afifa Qazi, Chief Medical Officer, has been shortlisted for Psychiatrist of the Year by the Royal College of Psychiatrists. The awards ceremony will be held on 9th November. The Board also wishes Dr Qazi the best of luck with the awards.

Chief Executive's Board Report

Date of Meeting: 29 September 2022

Introduction

Since the last board meeting in July, a new Prime Minister, Liz Truss has been appointed. The new Prime Minister went on to appoint Therese Coffey as Secretary of State for Health and Social Care. Ms Coffey is the fourth person to hold this important role in fourteen months.

The appointment of the new Prime Minister on 6th September was Queen Elizabeth's last official act and news of her death followed just two days later. Along with NHS trusts nationally, KMPT followed the National Mourning Guidance issued by NHS England. Our focus as always, was to ensure that our patients and their loved ones remained safe and continued to have access to our services when and where they needed them. I am extremely grateful to our staff who so calmly and willingly made sure that the unexpected Bank Holiday did not distract from that important focus.

Supporting our Staff - Cost of Living

KMPT's simple mission, to provide brilliant care through brilliant people is at the heart of all we do. In order to deliver brilliant care, we recognise that our people are our biggest and most important asset. At this time of an increasing cost of living, we are more than ever aware of our responsibility as an employer to do all that we can to support our people. In July we increased by 10 pence per mile our travel reimbursement rate. This was welcomed by colleagues and we received positive feedback about the gesture. We are now exploring other ways in which we can as an organisation ensure that our staff can access not only practical help (a discount, 'Blue Light' card for example) but advice and support about finance. This work is ongoing and further updates will be presented to the board as work unfolds.

Integrated Care Board (ICB)

As the partner member for both Kent Community Health Foundation Trust (KCHFT) and KMPT, I have since the last board meeting, attended an ICB board meeting. The meetings are held in person, and live streamed in order to increase access to members of the public. Significant items on the agenda included planning for the anticipated increase in demand for services this Winter, the importance of primary care in supporting communities and the ICB's ambition to support the consistent improvement of the quality of services across the county.

Memorandum of Understanding

Kent Community Health Foundation Trust (KCHFT) and KMPT held a board to board meeting on 21st June as part of a pattern of annual review and discussion about our shared areas of interest and work. As part of that discussion it was agreed that KMPT's Chief Executive and the incoming Chief Executive at KCHFT would review the Memorandum of Understanding and progress to date, whilst considering other potential areas for joint working.

KCHFT Chief Executive Mairead McCormick and KMPT's Chief Executive have established a series of meetings and are completing a brief, co written update report that will be shared with both boards later in the autumn.

Mental Health CEOs meeting with Claire Murdoch

In mid-September, the National Director for Mental Health, Learning Disability and Autism, Claire Murdoch brought together all the Chief Executives for specialist trusts. The meeting was an all day in person event held in London. Together we considered progress against the Long-Term Plan priorities, in addition to considering future areas of focus. It was an excellent opportunity to network with colleagues in person, and something that had not happened since well before the pandemic. Several opportunities for the South East Region to showcase our work have since arisen and together my Chief Executive colleagues and I are planning how best to share our experiences.

Preparing for Winter

NHSE have been clear in setting out their anticipation of increasing pressure on all NHS services this Winter. All providers along with social care and third sector partners are clear that in order to effectively respond to demand we must work together to streamline and improve some areas of practice. Key amongst these is tackling our Delayed Transfers of Care (DToCs). KMPT has been prioritising this work over the Summer with an expectation that we will reduce the number of patients who have effectively become stuck in beds with us, when they no longer need to be in hospital. Early indicators from this focused work is that we are making a positive impact and reducing our DToCs. The challenge however, is that whilst our DToCs may reduce, the demand for KMPT beds increases. Balancing, predicting and managing both demand and capacity remains a focus for the Chief Operating Officer and her team.

Changes in the Executive

Since the last board meeting, Deputy Chief Executive Vincent Badu has been appointed to the role of Executive Director of Strategy for NHS Kent and Medway. Vincent leaves his post with KMPT for his new role on November 1st. I know that members of the board will want to join me in formally recording our thanks to Vincent for the significant difference that he has made across a range of areas since he joined us in October 2016 as Director of Transformation Older Adults and then in September 2018 as my Deputy Chief Executive Officer/ Executive Director of Partnerships and Strategy. We are delighted that he will still be in our system and that we will not lose his contribution to our work on continuously improving KMPT's services. The search for Vincent's successor is underway.

Helen Greatorex
Chief Executive

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 29 September 2022

Title of Paper: Board Assurance Framework

Author: Louisa Mace, Risk Manager

Executive Director: Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose: Approval

Submission to Board: Regulatory Requirement

Overview of Paper

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in July 2022. It has since been presented to the Audit and Risk Committee on 13th September.

- 2 new risks have been added to the BAF since July
  - Risk ID 5991 – Organisational Risk – Industrial Action (Rating of 6 (Moderate))
  - Risk ID 7084 – New Landscape (New Operating Model)
- 4 risks have changed their risk score since July
  - Risk ID 3164 – Capital Projects – Availability of Capital (increased from 12 (High) to 16 (Extreme))
  - Risk ID 5345 – Participation in Research and Innovation (reduced from 4 (Low) to 2 (Low))
  - Risk ID 6628 – Long Term Financial Sustainability (reduced from 16 (Extreme) to 12 (High))
  - Risk ID 6966 – 2022/23 Financial Planning (reduced from 12 (High) to 9 (High))
- 2 risks are recommended for removal
  - Risk ID 5345 – Participation in Research and Innovation
  - Risk ID 5989 – Organisational Risk – Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)

Governance

Implications/Impact: Ability to deliver Trust Strategy.

Assurance: Reasonable Assurance

Oversight: Oversight by the Audit and Risk Committee and Board level risk Owners (EMT)

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 28th July 2022, and subsequently to the Audit and Risk Committee on 13th September 2022.

The Top Risks are

- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6881 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID 7038 – IT Infrastructure Refresh Funding (Rating of 16 – Extreme)

Risk Movement

4 risks have changed their risk score since the Board Assurance Framework presented to Board on 28 July

- **Risk ID 3164 – Capital Projects – Availability of Capital (Increased from 12 (High) to 16 (Extreme))**
  This risk has increased in risk score as there remains close monitoring of delivery of the capital programme.
- **Risk ID 5345 – Participation in Research and Innovation (Decreased from 4 (Low) to 2 (Low))**
  This risk has reduced in risk score as funding has been agreed for 1 year to deliver the Research and Innovation Strategy. There remains some uncertainty about funding for years two and three of the Strategy.
- **Risk ID 6628 – Long Term Financial Sustainability (Decreased from 16 (Extreme) to 12 (High))**
  This risk has reduced in score to reflect the progress made in addressing the underlying Trust deficit
- **Risk ID 6966 – 2022/23 Financial Planning (Decreased from 12 (High) to 9 (High))**
  This risk has reduced in score to reflect the updated thresholds for the consequence scores in the risk matrix.

Risks Recommended for Removal

Two risks are recommended for removal

- **Risk ID 5345 – Participation in Research and Innovation (Rating of 2 (Low))**
  This risk is being considered for recommendation for removal to the Board. The work to mitigate this risk has progressed significantly, with funding to deliver the Research and Innovation strategy being agreed for 1 year. Due to the reduction in risk score and the improvements made this risk is recommended for removal from the BAF. It will remain open as there is currently uncertainty with regard to funding for years 2 and 3 of the strategy.

Version Control: 01

- **Risk ID 5989 – Organisational Risk – Emerging Infectious Diseases (including response to Covid-19 and subsequent variants) (Rating of 9 (High))**
  This risk is being recommended for removal to the Board after reappearing on the BAF for July. The most recent peak of cases has passed with minimal impact on services. The risk remains well controlled, with an autumn vaccine booster programme starting soon. This risk will remain open and be managed via the EPRR risk register.

New Risks

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

- **Risk ID 5991 – Organisational Risk – Industrial Action**
  This risk has been added to reflect an increased risk proximity. There is an increased likelihood of industrial action being called over dissatisfaction with the national pay award and cost of living pressures. There is concern that unions will ballot their members with regard to strike action. Junior Drs in particular have been vocal for the past 6 months regarding their dissatisfaction from not being included in the national pay award having agreed a multi-year deal previously. There is some concern that if one union initiates strike action, others will follow suit.

- **Risk ID 7084 – New Landscape (New Operating Model)**
  This risk has been added to the BAF as it relates to the planned move to a new operating model. A full project plan is in place for this with engagement from support services to ensure a smooth transition. A communications plan is in place to be delivered in September and October with ongoing engagement with staff through to the end of the project.

Emerging Risks

The Audit and Risk Committee discussed concerns about the potential for disruption to energy supplies over the winter period. The Trust holds a risk regarding failure of the electrical supply as part of the emergency planning risks. This is reviewed regularly, but the risk controls and plans in place are currently under review to ensure they remain a robust mitigation to any disruption.

Other Notable Updates

- Work continues to sense check the following Workforce and Organisational Development risks and see if they need to be refreshed and refocussed. Following this, the confidence assessment will also be updated.
  - Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
  - Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
  - Risk ID 6847 – Sickness (Rating of 16 – Extreme)

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

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: 15 September 2022

NHS Kent and Medway NHS and Social Care Partnership Trust

Board Assurance Framework

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

Definitions:

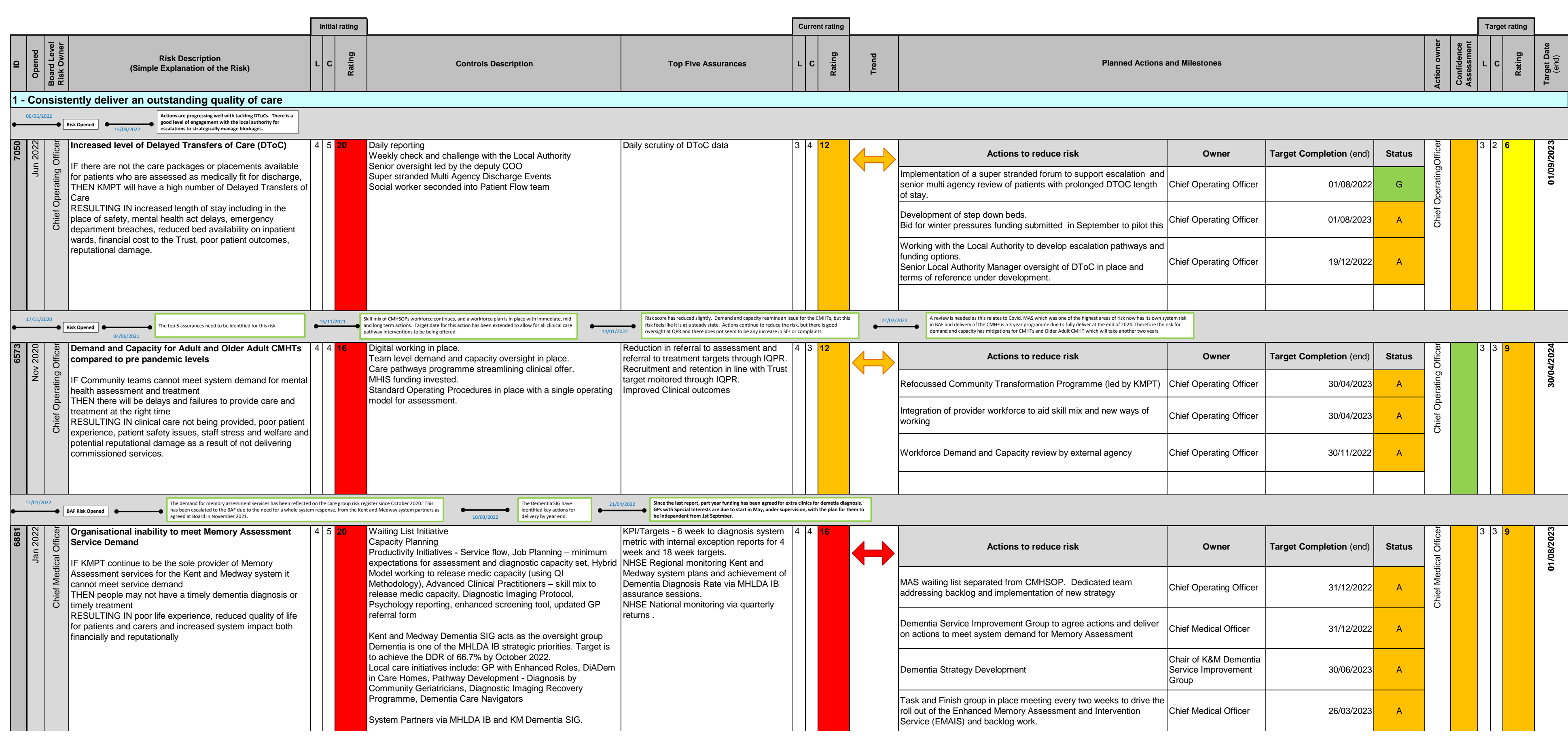
Initial Rating = The risk rating at the time of identification

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

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

Action status key:

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



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current Rating	Trend	Action owner	Confidence Assessment	Target rating L	Target rating C	Target Rating	Target Date (end)
1 - Consistently deliver an outstanding quality of care																		
7050	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events Social worker seconded into Patient Flow team	Daily scrutiny of DToC data	3	4	12	↔	Chief Operating Officer		3	2	6	01/09/2023
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs compared to pre pandemic levels** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	3	12	↔	Chief Operating Officer		3	3	9	30/04/2024
6881	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by October 2022. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG.	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16	↔	Chief Medical Officer		3	3	9	01/08/2023

Risk 7050 – timeline

06/06/2022 Risk Opened

15/09/2022 Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages.

Risk 7050 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Implementation of a super stranded forum to support escalation and senior multi agency review of patients with prolonged DTOC length of stay.	Chief Operating Officer	01/08/2022	G
Development of step down beds. Bid for winter pressures funding submitted in September to pilot this	Chief Operating Officer	01/08/2023	A
Working with the Local Authority to develop escalation pathways and funding options. Senior Local Authority Manager oversight of DToC in place and terms of reference under development.	Chief Operating Officer	19/12/2022	A

Risk 6573 – timeline

17/11/2020 Risk Opened

04/06/2021 The top 5 assurances need to be identified for this risk

15/11/2021 Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered.

14/01/2022 Risk score has reduced slightly. Demand and capacity reamins an issue for the CMHTs, but this risk feels like it is at a steady state. Actions continue to reduce the risk, but there is good oversight at QPR and there does not seem to be any increase in SI's or complaints.

22/02/2022 A review is needed as this relates to Covid. MAS which was one of the highest areas of risk now has its own system risk in BAF and delivery of the CMHF is a 3 year programme due to fully deliver at the end of 2024. Therefore the risk for demand and capacity has mitigations for CMHTs and Older Adult CMHT which will take another two years

Risk 6573 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Refocussed Community Transformation Programme (led by KMPT)	Chief Operating Officer	30/04/2023	A
Integration of provider workforce to aid skill mix and new ways of working	Chief Operating Officer	30/04/2023	A
Workforce Demand and Capacity review by external agency	Chief Operating Officer	30/11/2022	A

Risk 6881 – timeline

12/01/2022 BAF Risk Opened

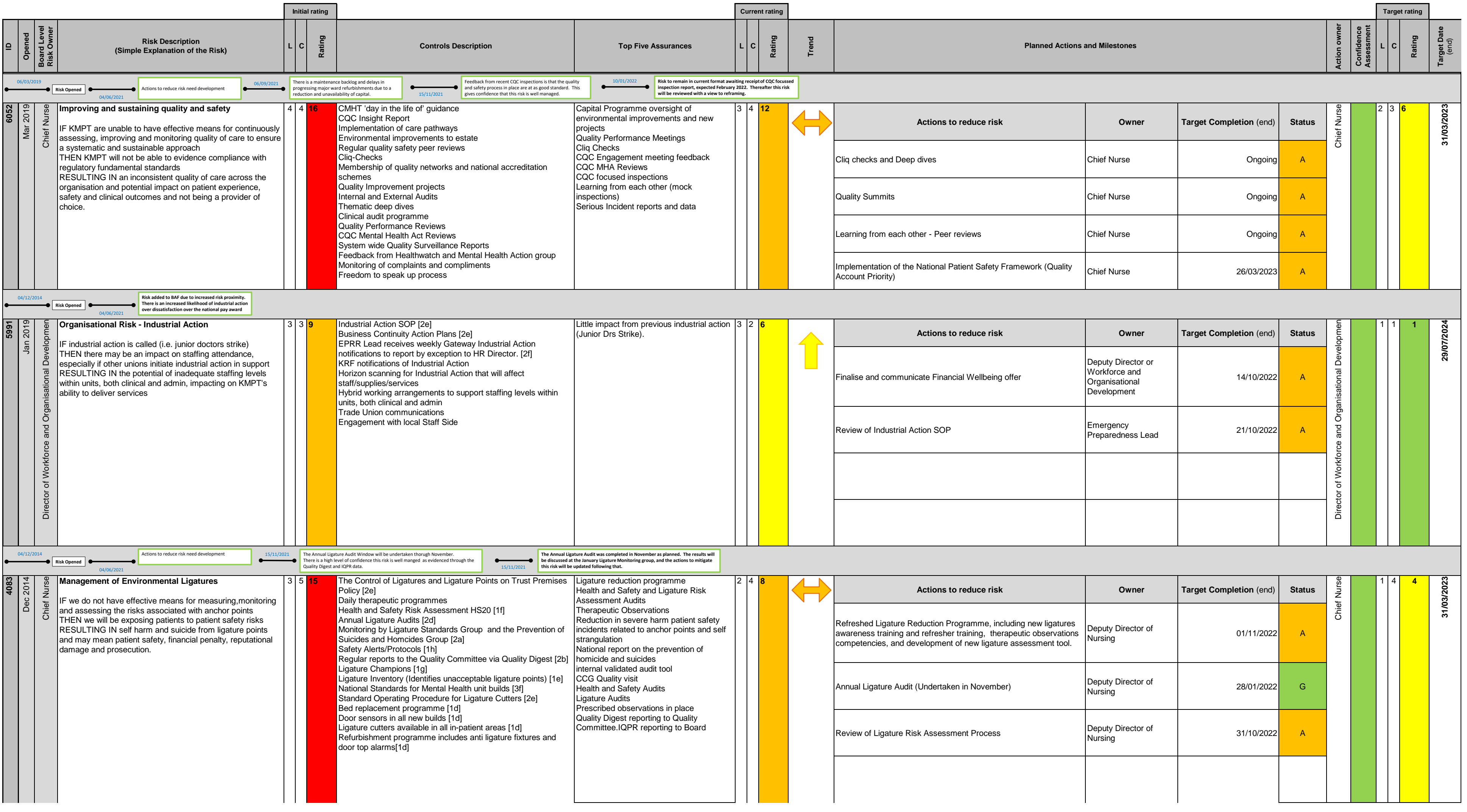
The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021.

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

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

Risk 6881 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
MAS waiting list separated from CMHSOP. Dedicated team addressing backlog and implementation of new strategy	Chief Operating Officer	31/12/2022	A
Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment	Chief Medical Officer	31/12/2022	A
Dementia Strategy Development	Chair of K&M Dementia Service Improvement Group	30/06/2023	A
Task and Finish group in place meeting every two weeks to drive the roll out of the Enhanced Memory Assessment and Intervention Service (EMAIS) and backlog work.	Chief Medical Officer	26/03/2023	A

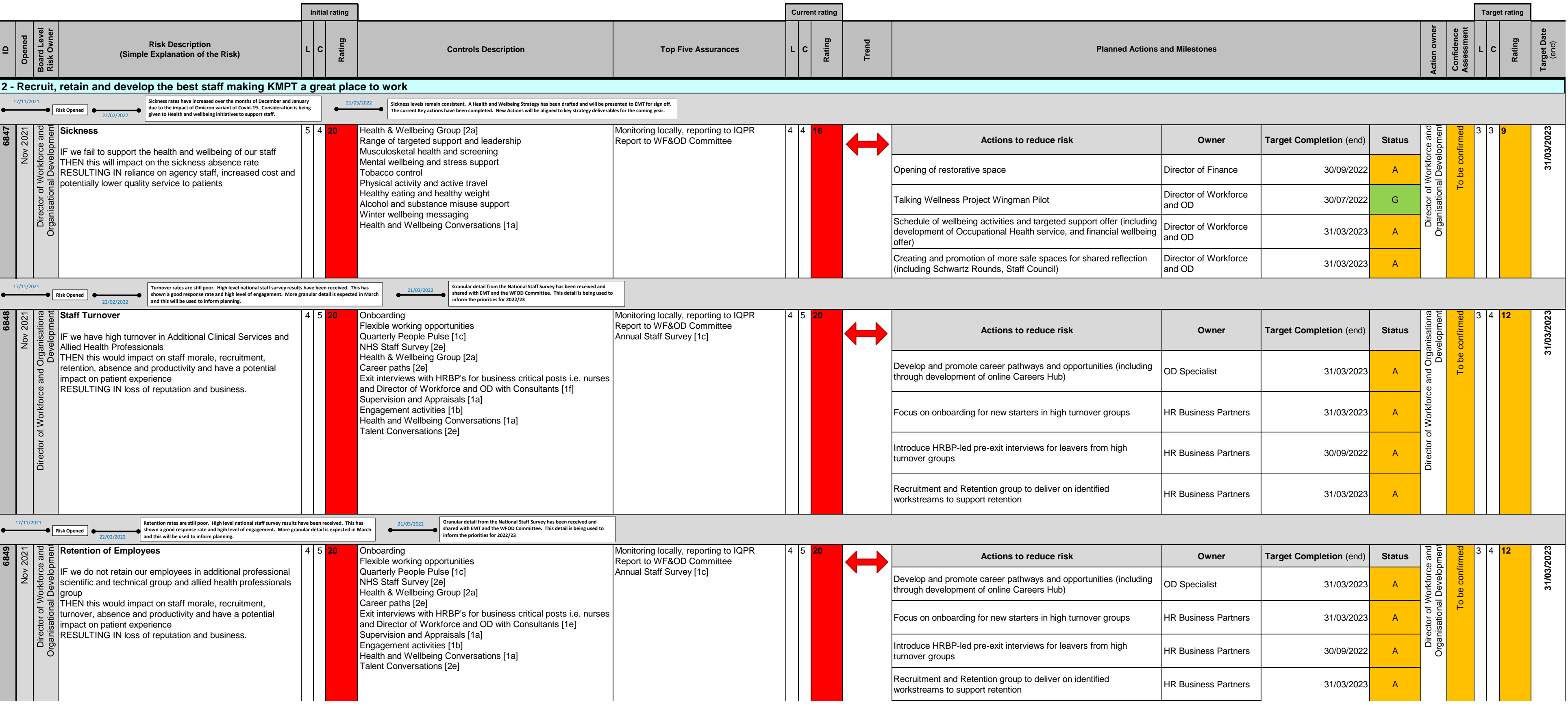


ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend
06/03/2019 Risk Opened; 04/06/2021 Actions to reduce risk need development; 06/09/2021 There is a maintenance backlog and delays in progressing major ward refurbishments due to a reduction and unavailability of capital.; 15/11/2021 Feedback from recent CQC inspections is that the quality and safety process in place are at as good standard. This gives confidence that this risk is well managed.; 10/01/2022 **Risk to remain in current format awaiting receipt of CQC focussed inspection report, expected February 2022. Thereafter this risk will be reviewed with a view to reframing.**												
6052	Mar 2019	Chief Nurse	**Improving and sustaining quality and safety** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice.	4	4	16	CMHT 'day in the life of' guidance CQC Insight Report Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Membership of quality networks and national accreditation schemes Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CQC Mental Health Act Reviews System wide Quality Surveillance Reports Feedback from Healthwatch and Mental Health Action group Monitoring of complaints and compliments Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock inspections) Serious Incident reports and data	3	4	12	
04/12/2014 Risk Opened; 04/06/2021 **Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award**												
5991	Jan 2019	Director of Workforce and Organisational Developmen	**Organisational Risk - Industrial Action** IF industrial action is called (i.e. junior doctors strike) THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services	3	3	9	Industrial Action SOP [2e] Business Continuity Action Plans [2e] EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side	Little impact from previous industrial action (Junior Drs Strike).	3	2	6	
04/12/2014 Risk Opened; 04/06/2021 Actions to reduce risk need development; 15/11/2021 The Annual Ligature Audit Window will be undertaken thorugh November. There is a high level of confidence this risk is well manged as evidenced through the Quality Digest and IQPR data.; 15/11/2021 **The Annual Ligature Audit was completed in November as planned. The results will be discussed at the January Ligature Monitoring group, and the actions to mitigate this risk will be updated following that.**												
4083	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8	

Planned Actions and Milestones

ID	Actions to reduce risk	Owner	Target Completion (end)	Status
6052	Cliq checks and Deep dives	Chief Nurse	Ongoing	A
6052	Quality Summits	Chief Nurse	Ongoing	A
6052	Learning from each other - Peer reviews	Chief Nurse	Ongoing	A
6052	Implementation of the National Patient Safety Framework (Quality Account Priority)	Chief Nurse	26/03/2023	A
5991	Finalise and communicate Financial Wellbeing offer	Deputy Director or Workforce and Organisational Development	14/10/2022	A
5991	Review of Industrial Action SOP	Emergency Preparedness Lead	21/10/2022	A
4083	Refreshed Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool.	Deputy Director of Nursing	01/11/2022	A
4083	Annual Ligature Audit (Undertaken in November)	Deputy Director of Nursing	28/01/2022	G
4083	Review of Ligature Risk Assessment Process	Deputy Director of Nursing	31/10/2022	A

ID	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6052	Chief Nurse		2	3	6	**31/03/2023**
5991	Director of Workforce and Organisational Developmen		1	1	1	**29/07/2024**
4083	Chief Nurse		1	4	4	**31/03/2023**



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

6847 – Sickness

17/11/2021 Risk Opened — 22/02/2022: Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff.

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

Planned Actions and Milestones

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

6848 – Staff Turnover

17/11/2021 Risk Opened — 22/02/2022: Turnover rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.

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

Planned Actions and Milestones

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

6849 – Retention of Employees

17/11/2021 Risk Opened — 22/02/2022: Retention rates are still poor. High level national staff survey results have been received. This has shown a good response rate and hgih level of engagement. More granular detail is expected in March and this will be used to inform planning.

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

Planned Actions and Milestones

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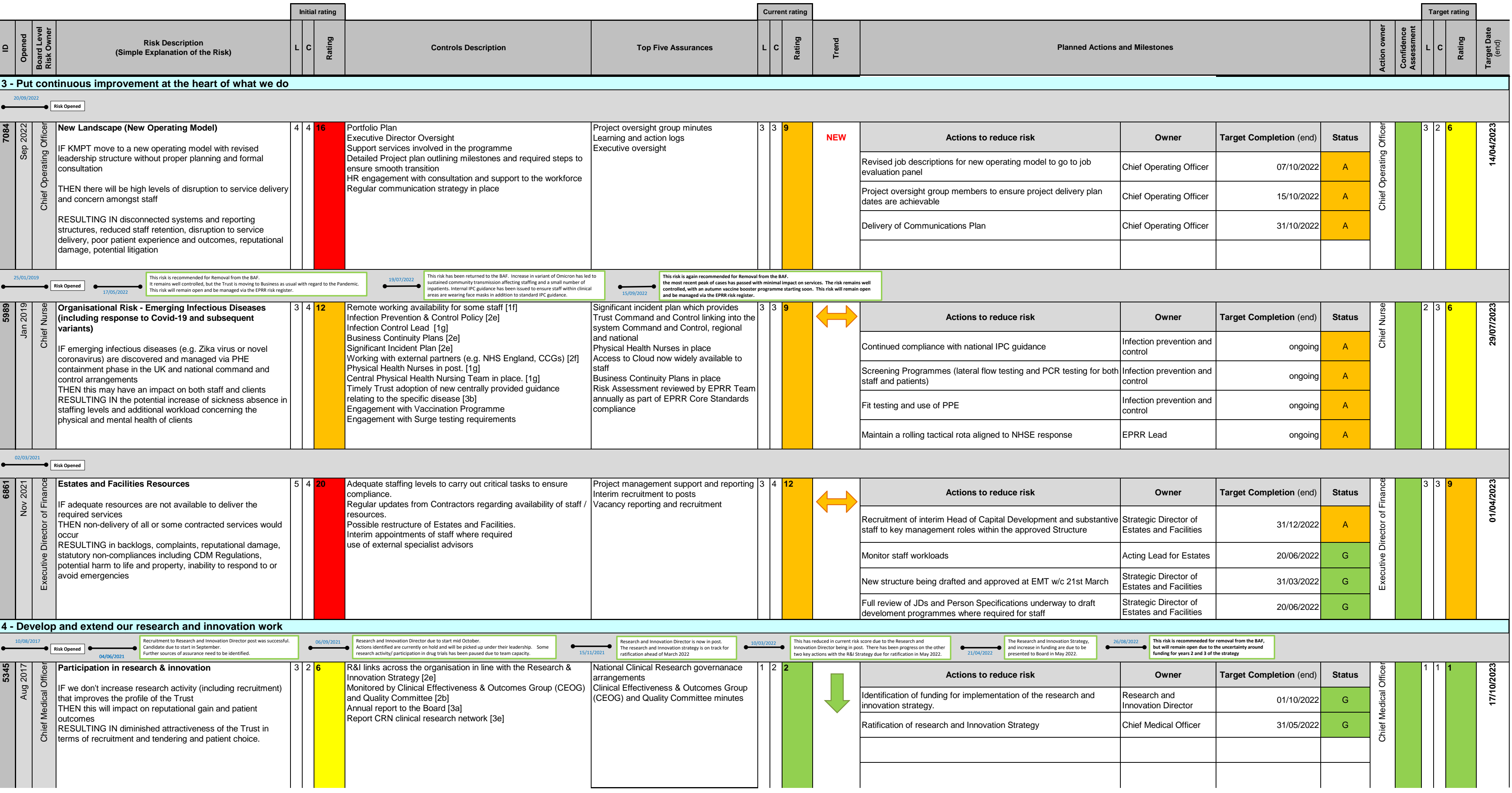
Introduce HRBP-led pre-exit interviews for leavers from high turnover groups	HR Business Partners	30/09/2022	A
Recruitment and Retention group to deliver on identified workstreams to support retention	HR Business Partners	31/03/2023	A



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3 - Put continuous improvement at the heart of what we do																		
7084	Sep 2022	Chief Operating Officer	**New Landscape (New Operating Model)** IF KMPT move to a new operating model with revised leadership structure without proper planning and formal consultation THEN there will be high levels of disruption to service delivery and concern amongst staff RESULTING IN disconnected systems and reporting structures, reduced staff retention, disruption to service delivery, poor patient experience and outcomes, reputational damage, potential litigation	4	4	16	Portfolio Plan Executive Director Oversight Support services involved in the programme Detailed Project plan outlining milestones and required steps to ensure smooth transition HR engagement with consultation and support to the workforce Regular communication strategy in place	Project oversight group minutes Learning and action logs Executive oversight	3	3	9	NEW	Chief Operating Officer		3	2	6	**14/04/2023**
5989	Jan 2019	Chief Nurse	**Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK and national command and control arrangements THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical and mental health of clients	3	4	12	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Significant Incident Plan [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g] Timely Trust adoption of new centrally provided guidance relating to the specific disease [3b] Engagement with Vaccination Programme Engagement with Surge testing requirements	Significant incident plan which provides Trust Command and Control linking into the system Command and Control, regional and national Physical Health Nurses in place Access to Cloud now widely available to staff Business Continuity Plans in place Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance	3	3	9	⟺	Chief Nurse		2	3	6	**29/07/2023**
6861	Nov 2021	Executive Director of Finance	**Estates and Facilities Resources** IF adequate resources are not available to deliver the required services THEN non-delivery of all or some contracted services would occur RESULTING in backlogs, complaints, reputational damage, statutory non-compliances including CDM Regulations, potential harm to life and property, inability to respond to or avoid emergencies	5	4	20	Adequate staffing levels to carry out critical tasks to ensure compliance. Regular updates from Contractors regarding availability of staff / resources. Possible restructure of Estates and Facilities. Interim appointments of staff where required use of external specialist advisors	Project management support and reporting Interim recruitment to posts Vacancy reporting and recruitment	3	4	12	⟺	Executive Director of Finance		3	3	9	**01/04/2023**
4 - Develop and extend our research and innovation work																		
5345	Aug 2017	Chief Medical Officer	**Participation in research & innovation** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment and tendering and patient choice.	3	2	6	R&I links across the organisation in line with the Research & Innovation Strategy [2e] 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	1	2	2	↓	Chief Medical Officer		1	1	1	**17/10/2023**

Risk 7084 — timeline: 20/09/2022 Risk Opened

Risk 7084 — Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Revised job descriptions for new operating model to go to job evaluation panel	Chief Operating Officer	07/10/2022	A
Project oversight group members to ensure project delivery plan dates are achievable	Chief Operating Officer	15/10/2022	A
Delivery of Communications Plan	Chief Operating Officer	31/10/2022	A

Risk 5989 — timeline: 25/01/2019 Risk Opened; 17/05/2022 This risk is recommended for Removal from the BAF. It remains well controlled, but the Trust is moving to Business as usual with regard to the Pandemic. This risk will remain open and be managed via the EPRR risk register.; 19/07/2022 This risk has been returned to the BAF. Increase in variant of Omicron has led to sustained community transmission affecting staffing and a small number of inpatients. Internal IPC guidance has been issued to ensure staff within clinical areas are wearing face masks in addition to standard IPC guidance.; 15/09/2022 **This risk is again recommended for Removal from the BAF. the most recent peak of cases has passed with minimal impact on services. The risk remains well controlled, with an autumn vaccine booster programme starting soon. This risk will remain open and be managed via the EPRR risk register.**

Risk 5989 — Planned Actions and Milestones

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

Risk 6861 — timeline: 02/03/2021 Risk Opened

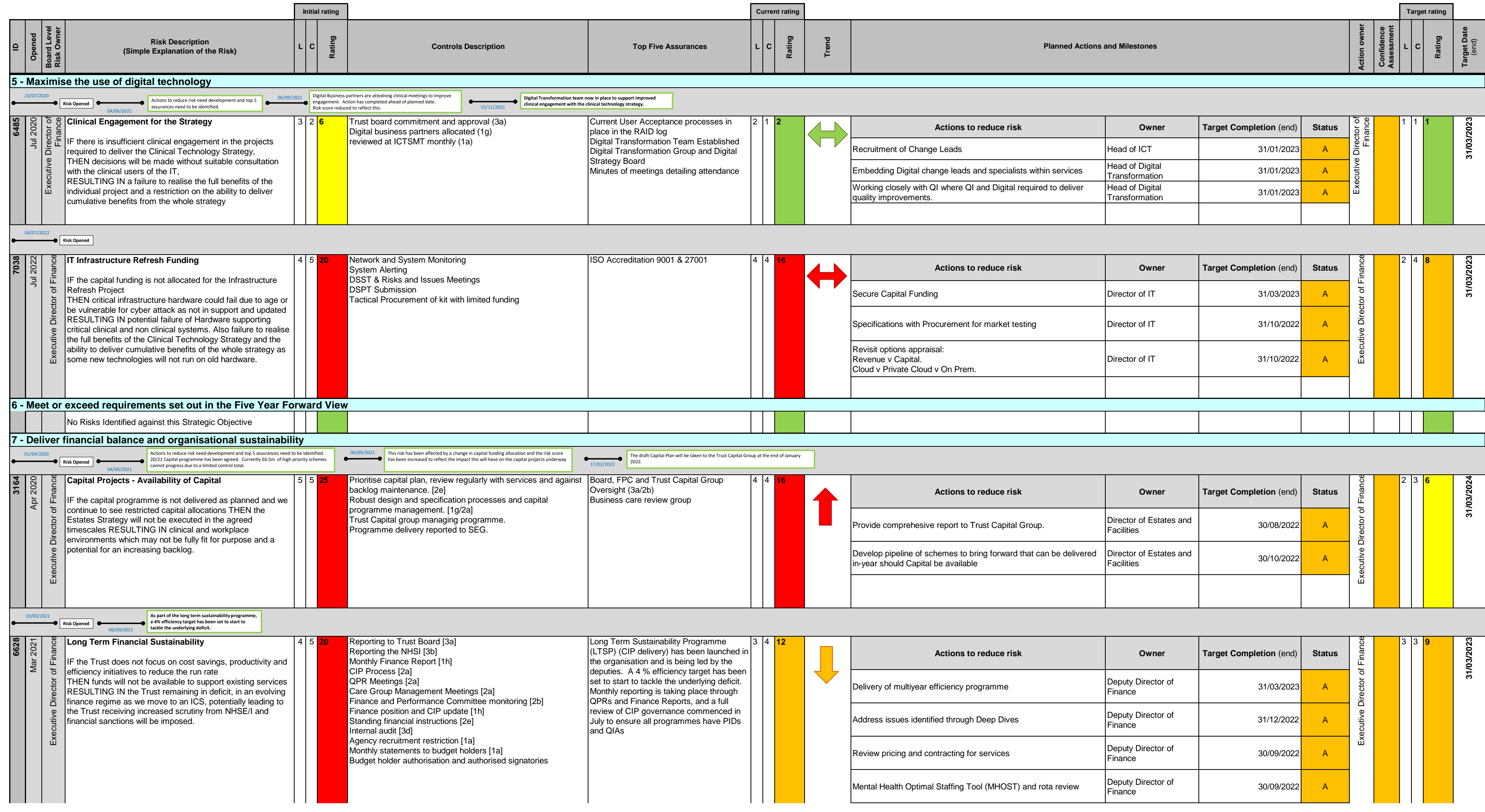
Risk 6861 — Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Recruitment of interim Head of Capital Development and substantive staff to key management roles within the approved Structure	Strategic Director of Estates and Facilities	31/12/2022	A
Monitor staff workloads	Acting Lead for Estates	20/06/2022	G
New structure being drafted and approved at EMT w/c 21st March	Strategic Director of Estates and Facilities	31/03/2022	G
Full review of JDs and Person Specifications underway to draft develoment programmes where required for staff	Strategic Director of Estates and Facilities	20/06/2022	G

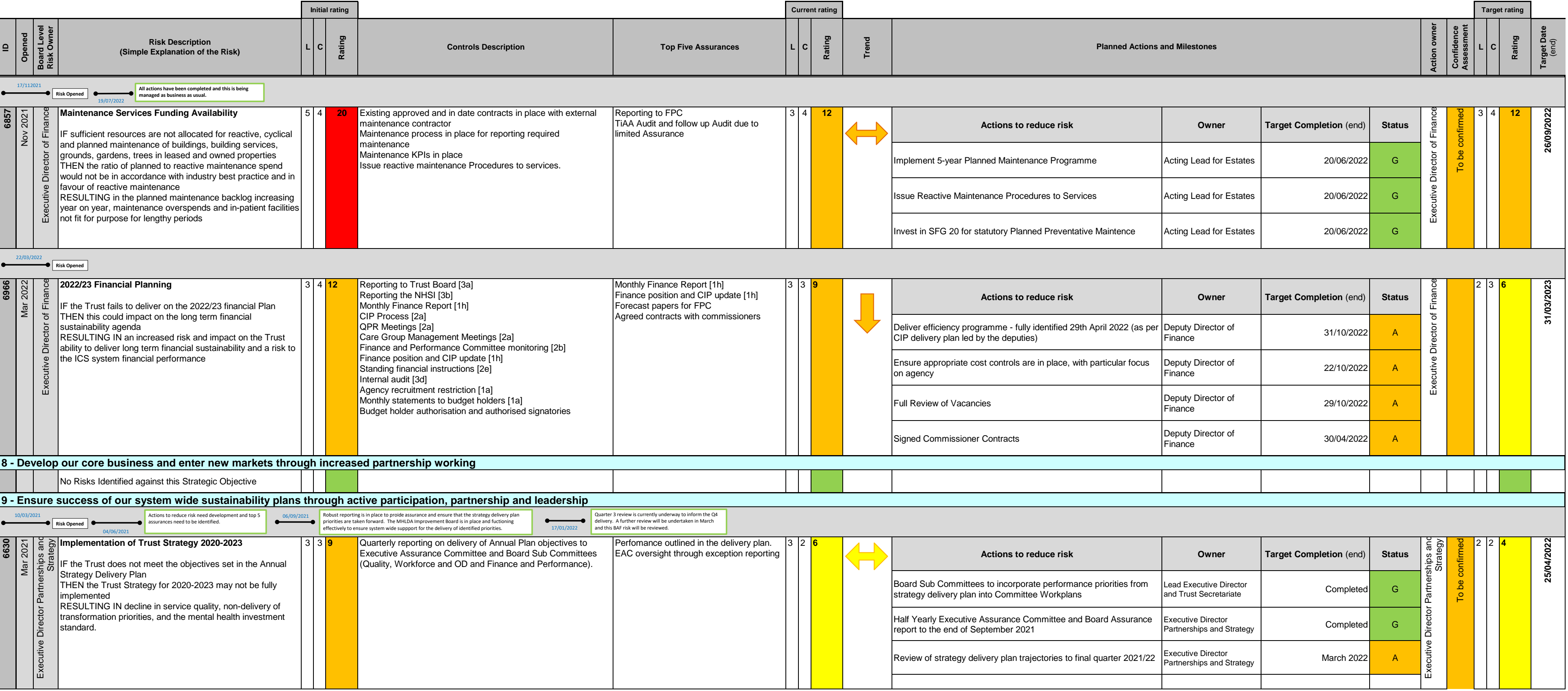
Risk 5345 — timeline: 10/08/2017 Risk Opened; 04/06/2021 Recruitment to Research and Innovation Director post was successful. Candidate due to start in September. Further sources of assurance need to be identified.; 06/09/2021 Research and Innovation Director due to start mid October. Actions identified are currently on hold and will be picked up under their leadership. Some research activity/ participation in drug trials has been paused due to team capacity.; 15/11/2021 Research and Innovation Director is now in post. The research and Innovation strategy is on track for ratification ahead of March 2022; 10/03/2022 This has reduced in current risk score due to the Research and Innovation Director being in post. There has been progress on the other two key actions with the R&I Strategy due for ratification in May 2022.; 21/04/2022 The Research and Innovation Strategy, and increase in funding are due to be presented to Board in May 2022.; 26/08/2022 **This risk is recommneded for removal from the BAF, but will remain open due to the uncertainty around funding for years 2 and 3 of the strategy**

Risk 5345 — Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Identification of funding for implementation of the research and innovation strategy.	Research and Innovation Director	01/10/2022	G
Ratification of research and Innovation Strategy	Chief Medical Officer	31/05/2022	G



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones: Actions to reduce risk	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5 - Maximise the use of digital technology																						
			23/07/2020 Risk Opened; 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified.; 06/09/2021 Digital Business partners are attedning clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this.; 15/11/2021 Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy.																			
6485	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	3	2	6	Trust board commitment and approval (3a) Digital business partners allocated (1g) reviewed at ICTSMT monthly (1a)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	2	1	2		Recruitment of Change Leads	Head of ICT	31/01/2023	A	Executive Director of Finance		1	1	1	31/03/2023
													Embedding Digital change leads and specialists within services	Head of Digital Transformation	31/01/2023	A						
													Working closely with QI where QI and Digital required to deliver quality improvements.	Head of Digital Transformation	31/01/2023	A						
			04/07/2022 Risk Opened																			
7038	Jul 2022	Executive Director of Finance	**IT Infrastructure Refresh Funding** IF the capital funding is not allocated for the Infrastructure Refresh Project THEN critical infrastructure hardware could fail due to age or be vulnerable for cyber attack as not in support and updated RESULTING IN potential failure of Hardware supporting critical clinical and non clinical systems. Also failure to realise the full benefits of the Clinical Technology Strategy and the ability to deliver cumulative benefits of the whole strategy as some new technologies will not run on old hardware.	4	5	20	Network and System Monitoring System Alerting DSST & Risks and Issues Meetings DSPT Submission Tactical Procurement of kit with limited funding	ISO Accreditation 9001 & 27001	4	4	16		Secure Capital Funding	Director of IT	31/03/2023	A	Executive Director of Finance		2	4	8	31/03/2023
													Specifications with Procurement for market testing	Director of IT	31/10/2022	A						
													Revisit options appraisal: Revenue v Capital. Cloud v Private Cloud v On Prem.	Director of IT	31/10/2022	A						
6 - Meet or exceed requirements set out in the Five Year Forward View																						
			No Risks Identified against this Strategic Objective																			
7 - Deliver financial balance and organisational sustainability																						
			01/04/2020 Risk Opened; 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total.; 06/09/2021 This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway; 17/01/2022 The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.																			
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose and a potential for an increasing backlog.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16		Provide comprehensive report to Trust Capital Group.	Director of Estates and Facilities	30/08/2022	A	Executive Director of Finance		2	3	6	31/03/2024
													Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available	Director of Estates and Facilities	30/10/2022	A						
			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 been set to start to tackle the underlying deficit. Monthly reporting is taking place through QPRs and Finance Reports, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs	3	4	12		Delivery of multiyear efficiency programme	Deputy Director of Finance	31/03/2023	A	Executive Director of Finance		3	3	9	31/03/2023
													Address issues identified through Deep Dives	Deputy Director of Finance	31/12/2022	A						
													Review pricing and contracting for services	Deputy Director of Finance	30/09/2022	A						
													Mental Health Optimal Staffing Tool (MHOST) and rota review	Deputy Director of Finance	30/09/2022	A						



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	C	Rating	Controls Description	Top Five Assurances	Current rating L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	C	Rating	Target Date (end)
			17/112021 Risk Opened — 19/07/2022 All actions have been completed and this is being managed as business as usual.																
6857	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Existing approved and in date contracts in place with external maintenance contractor Maintenance process in place for reporting required maintenance Maintenance KPIs in place Issue reactive maintenance Procedures to services.	Reporting to FPC TiAA Audit and follow up Audit due to limited Assurance	3	4	12		**Actions to reduce risk / Owner / Target Completion (end) / Status** Implement 5-year Planned Maintenance Programme / Acting Lead for Estates / 20/06/2022 / G Issue Reactive Maintenance Procedures to Services / Acting Lead for Estates / 20/06/2022 / G Invest in SFG 20 for statutory Planned Preventative Maintence / Acting Lead for Estates / 20/06/2022 / G	Executive Director of Finance	To be confirmed	3	4	12	26/09/2022
			22/03/2022 Risk Opened																
6966	Mar 2022	Executive Director of Finance	**2022/23 Financial Planning** IF the Trust fails to deliver on the 2022/23 financial Plan THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance	3	4	12	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Monthly Finance Report [1h] Finance position and CIP update [1h] Forecast papers for FPC Agreed contracts with commissioners	3	3	9		**Actions to reduce risk / Owner / Target Completion (end) / Status** Deliver efficiency programme - fully identified 29th April 2022 (as per CIP delivery plan led by the deputies) / Deputy Director of Finance / 31/10/2022 / A Ensure appropriate cost controls are in place, with particular focus on agency / Deputy Director of Finance / 22/10/2022 / A Full Review of Vacancies / Deputy Director of Finance / 29/10/2022 / A Signed Commissioner Contracts / Deputy Director of Finance / 30/04/2022 / A	Executive Director of Finance		2	3	6	31/03/2023
8 - Develop our core business and enter new markets through increased partnership working																			
			No Risks Identified against this Strategic Objective																
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																			
			10/03/2021 Risk Opened — 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. — 06/09/2021 Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide suppport for the delivery of identified priorities. — 17/01/2022 Quarter 3 review is currently underway to inform the Q4 delivery. A further review will be undertaken in March and this BAF risk will be reviewed.																
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2023** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2023 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	9	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	3	2	6		**Actions to reduce risk / Owner / Target Completion (end) / Status** Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans / Lead Executive Director and Trust Secretariate / Completed / G Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021 / Executive Director Partnerships and Strategy / Completed / G Review of strategy delivery plan trajectories to final quarter 2021/22 / Executive Director Partnerships and Strategy / March 2022 / A	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	25/04/2022

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 29 September 2022

Title of Paper: Mental Health Learning Disability and Autism Provider Collaborative Update

Author and Executive Director : **Helen Greatorex Chief Executive**

Purpose of Paper

Purpose: Information

Submission to Board: Board requested

Overview of Paper

This paper provides an overview update for the Board on:

The endorsement of the Provider Collaborative by the Integrated Care Board, its new Terms of Reference, current areas of focus and September Development Day.

Issues to bring to the Board's attention

There has been a significant amount of change at a number of levels in the Kent and Medway system over the last four months including the formation and ratification in July of the Integrated Care Board.

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

The PC will operate at a strategic level aimed at continuous improvement. Supporting it are multiagency working groups focusing on each of the PC's six priority areas;

Dementia Diagnosis Rates

Access to Children and Young Peoples Services

Community Mental Health Framework Transformation

Physical Health Checks for Serious Mental Illness

Out of Area (acute) Beds

Section 136

Annual Health Checks for People who have a Learning Disability

Perinatal Mental Health

Governance

Implications/Impact: KMPT Trust Strategy - Use our expertise to lead and partner

Assurance: reasonable

Oversight: Integrated Care Board

A Newly Formed Board, Working in a Different Way

Chaired and Vice Chaired by KMPT and Kent Community Health Foundation NHS Trust's (KCHFT) chairs, the Provider Collaborative (PC) has new Terms of Reference (attached as appendix 1) and membership which importantly includes representation from the voluntary sector. A combination of virtually convened meetings and in person development days are planned over the next year. The first development day took place in September and was externally facilitated. It took as its focus, building relationships and understanding between its members, and explored the different definitions and forms of provider collaboratives. As with all PC meetings, it included a deep dive in to two workstreams; Children and Young Peoples services and Learning Disability and Autism services.

Importantly, in between the PC's inaugural meeting in May, and the September development day, the chairs of the PC's predecessor group (the Mental Health, Learning Disability and Autism Improvement Board) were tasked with considering and recommending to the PC chair and vice chair, the most appropriate PC model.

The diagram below, provided by Attain sets out the options considered ....

Provider collaboratives…

Lead provider model	Shared leadership model	Provider leadership board model (alliance)
National - specialist mental health and LDA provision (e.g. Sussex Health & Care Partnership where providers are working together to improve how mental health services for adults from Kent, Surrey and Sussex who require secure inpatient care, are commissioned and delivered) Surrey & Borders Partnership – CAMHS	***CMH Transformation model*** The Foundation Group – group of acute trusts working together to maintain sustainability of three small to medium acute trusts. Each year, all three trusts set their organisational level objectives, as well as collectively setting some group objectives. The Foundation Group has a committee in common governance arrangement which binds the interests of all three organisations together	North East Essex Alliance – 10 year contract across multiple providers to deliver community services / transformation The West Yorkshire Association of Acute Trusts (WYAAT) is a partnership of six acute trusts in West Yorkshire and Harrogate ICS

8 Attain PowerPoint Slide Bank, April 2018

Collaborative models: provider collaborative guidance

Lead provider model	Shared leadership model	Provider leadership board model (alliance)
Commissioned and contracted once, via a lead provider who subcontracts with other organisations, by health and local authority (or together)	Members share a defined leadership structure in which the same person or people lead each of the providers involved	Commissioned collectively, through an alliance MOU or alliance contract

Lead provider model

A lead provider is responsible for the delivery of the entire scope of services, including coordination of its sub contractors.

A lead provider may take on a degree of commissioning responsibility in creating the proposed service model and pathways and manage the budget and delivery of all sub-contractors, with overarching responsibility for contract delivery.

Shared leadership model

Shared leadership structure is established to which NHS trust / partner organisations appoint people to leadership posts – with delegated responsibilities - consistent with the remit of the provider collaborative, to them/the structure.

Each provider's / organisation's board remains separately accountable for the decisions it takes (even if aligned). Nevertheless, alignment of decision-making can be supported by using shared governance (such as committees in common).

This model is supported by an MOU between the parties to support strong collaboration and drive shared outcomes.

Committees in common are likely to vary from one to another and could include NHS trust, local authority and third sector and management, elected members, NHS NEDs or trustees.

Provider leadership board model (alliance)

Representatives from all participating organisations come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), so that they can tackle areas of common concern and deliver a shared agenda as an alliance.

The alliance can be formalised through an MOU or through a contract.

7 Attain PowerPoint Slide Bank, April 2018

This work took place over the Summer, was facilitated by Attain and included discussion with the ICB to ensure that the recommended model met its requirements and expectations.

It was agreed that a shared leadership model would be the most effective means of ensuring clear leadership. The ICB confirmed that it was satisfied with the suggested approach that a mental health provider, social care provider and community provider share a three-way lead. Expressions of interest in the leadership role are now being sought from agencies across the county. It was suggested by the ICB that this initial model be revisited in twelve to eighteen months' time when the new system landscape is more settled.

Next Steps

The supporting, delivery groups continue to focus on their areas of detailed work, and anticipate the imminent publication of 2022-3 Quarter 2's performance.

Some significant areas of improvement are already evident (physical health checks for people with enduring mental health needs have improved from 9% to 41.7% in the last twelve months and the use by police of Section 136 of the Mental Health Act has reduced by over 30%. Dementia diagnosis rates are also showing an improved position.

Where performance needs further support to drive improvement, for example the Community Mental Health Framework, refreshed vigour and system-wide leadership is setting out clearly the aim, the current position and most importantly, the gap.

What is clear at this early stage of its development, is that there is a strong commitment and shared belief in members of the board that working together, across organisational boundaries can deliver improvements that historically we have as a multi-agency, county-wide system failed to achieve.

Summary and Conclusion

The Summer has seen significant change both in and around what is now the Provider Collaborative for Mental Health, Learning Disability and Autism. The newly formed ICB is supportive of its focus and recognises its determination to drive significant improvements across the county. This new, system focused way of working has a programme of work and a plan which will enable KMPT to play its part in delivering system wide continuous improvement.

Further updates will be shared with KMPT's board as the work unfolds over the year.

PROVIDER COLLABORATIVE BOARD; MENTAL HEALTH, LEARNING DISABILITY AND AUTISM

Terms of Reference

May 2022

Document History

Version	Date	Author	Comments
V0.1	02.02.2022		DRAFT
V0.2	12.04.2022		DRAFT – Attain incorporated updates as requested by Vincent Badu on 15/03/2022 and 22/04/2012.
V0.3	11.05.2022		FINAL DRAFT – Incorporates feedback from Executive Director of Corporate Affairs, Kent and Medway CCG.

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INTRODUCTION

Across Kent and Medway, we have been on a journey of developing our collaborative approach to the design and delivery of Mental Health, Learning Disability and Autism (MHLDA) services. Formal establishment of the Provider Collaborative Board for Mental Health, Learning Disability and Autism (the Board) is the next step in our journey to working together more closely across our Integrated Care System (ICS) in alignment with the national direction of travel set out in the Health and Care Bill 2021.

The Board will seek to add value to the MHLDA agenda in all its work, and not replicate activities already being undertaken elsewhere in the system. Through its broad membership, representative of many key partners in Kent and Medway, the Board will provide assurance to mitigate risks, and provide strategic advice to programmes of work across the ICS that pertain to MHLDA. Given that the Board will have oversight of work being undertaken across the ICS it will be well placed to support shared learnings across Kent and Medway where applicable – for example between our place-based partnerships.

It is proposed that Board meetings take place virtually on a quarterly basis. Two in-person Board development session per year will focus on developing a forward plan and honing the performance and effectiveness of the Board itself.

In line with the government's Health and Care Bill, the existing Kent and Medway ICS architecture changed on 1st July 2022 with the formal establishment of an Integrated Care Board (ICB).The Provider Collaborative Board will be accountable to the ICB.

1. GENERAL

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Kent and Medway Provider Collaborative Board for Mental Health, Learning Disability and Autism (the Board).

1.1. The Board is established as a formal Board of the ICB
1.2. The Board will liaise with, and function as, a resource for other improvement Boards across the ICS as appropriate, for example the Improving Outcomes Committee
1.3. The Board is authorised by the ICB to act within its Terms of Reference. All employees and individuals appointed by partner organisations are directed to co-operate with any request made by the Board.
1.4. Outside of individual powers of authority and delegated limits, the Board shall not have any collective delegated authority, unless explicitly agreed by the ICB.
1.5. It is expected that the Board will be conferred with additional delegated authority in relation to the planning, commissioning, and delivery of in scope services. The exact nature of the delegated authority will be detailed in the ICB Scheme of Reservation and Delegation (SoRD), and will be appropriately referenced in an updated terms of reference for this group as and when appropriate.

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2. PURPOSE

2.1. The Board exists to formally bring together key partners across Kent and Medway to collaborate effectively and drive delivery of Mental Health Learning Disability and Autism improvement priorities at scale. Strategic in nature, the Board will enable and support the Operational Delivery Group to drive the delivery of agreed strategic aims.

2.2. The Board:

- Provides leadership, oversight, and enables partnership working to improve the mental health and mental wellbeing outcomes of the population of Kent & Medway.
- Adopts a strategic focus, acknowledging wider development of the Kent and Medway system and the collaboration required to deliver our Long-Term Plan ambitions.
- Supports strategic thinking about the development of the MHLDA Provider Collaborative. The Board will play a key role in the development of a MHLDA Provider Collaborative if agreed by system partners.
- Maintains a close relationship with other ICS Improvement Boards, recognising interdependencies that exist with the MHLDA agenda and other priorities across Kent and Medway.
- Identifies risks and issues to delivery and agrees mitigations to effectively resolve these.
- Empowers our Health & Care Partnerships to deliver solutions that meet the neds of their communities by providing a framework within which to operate where appropriate
- Ensures that programmes of work are being delivered effectively, reviewing any specific reporting by exception.

3. RESPONSIBILITIES

3.1. The Board will support development of a Mental Health Improvement framework that describes primary functions of the Board, and how they align with the other parts of the Kent & Medway system. Appendix One sets out the proposed MHLDA governance structure in Kent and Medway.

3.2. The Board will have a key role in helping to develop a shared understanding of system-wide improvement priorities beyond MHLDA providing leadership on integrated system-wide transformation programmes that will deliver improved outcomes to the population

3.3. The Board will maintain oversight of mental health needs assessment across the county. This will inform decisions relating to 'at scale' commissioning, and the delivery of compliance with the Mental Health Long Term Plan (MHLTP) and Mental Health Investment Standard (MHIS).

4. MEMBERSHIP

4.1. The Board will be chaired by the Chair of Kent and Medway NHS and Social Care Partnership Trust (KMPT). The Vice Chair will be the Chair of Kent Community Health NHS Foundation Trust (KCHFT).

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4.2. It is recognised that a number of individuals undertake 'dual roles' across Kent and Medway representing both their own organisations and system roles. For the purposes of the Board, broad representation of views is required, and as such some members will be expected to represent the partnership(s) they represent (e.g. local Health and Care Partnership (HCP) or the ICS) as opposed to their employing organisation.

4.3. To ensure clarity, the organisation each member is expected to represent is indicated in the membership list below:

Name	Role Title	Employing Organisation	Representing at Board
Dr Jackie Craissati (Chair)	Chair	KMPT	ICB
John Goulston (Vice Chair)	Chair	KCHFT	ICB
Helen Greatorex	CEO	KMPT	Joint SRO MHLDA - Kent & Medway ICS
TBC	Executive Director of Health Improvement	Kent & Medway ICS	Joint SRO MHLDA - Kent & Medway ICS
TBC	TBC	TBC	Third Sector
TBC	TBC	TBC	Lived Experience Reference Group
Dr Lee-Anne Farach	Director of People (Children and Adults)	Medway Council	Medway Council
Richard Smith	Director, Adult Social Care	Kent County Council	Kent County Council
Karen Sharp	Programme Director	Kent Community Health NHS Foundation Trust	East Kent Integrated Care Partnership
David Peck	Director	Kent and Medway CCG / ICB	Dartford, Gravesham and Swanley Heath & Care Partnership
Sally McKinnon	Director	Maidstone and Tunbridge Wells NHS Trust	West Kent Health & Care Partnership
Louise Parker	Programme Director	Medway Community Healthcare CIC	Medway & Swale Health & Care Partnership
Dr Jihad Malasi	ICS Clinical lead for Mental Health, CYP & Maternity	Kent and Medway ICS	MHLDA Clinical & Professional Advisory Board
Ivor Duffy	Director of Finance	Kent and Medway ICS	Kent & Medway ICS

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Brid Johnson	Director of Operations	North East London NHS Foundation Trust	North East London NHS Foundation Trust
In Attendance – Non-Voting Members			
TBC	Director, System Transformation	Kent and Medway ICS	Kent and Medway ICS
Taps Mutakati	Director, System Collaboration	Kent and Medway ICS	Kent and Medway ICS

4.4. Deputies by exception may be accepted with prior agreement of the Chair. When deputies are accepted by the Chair they will be expected to fully particpiate and make decisions on behalf of the organisaiton they represent.

4.5. The Group may call additional individuals to attend ad-hoc meetings or to attend on a regular basis. Attendees may present at Group meetings and contribute to discussions but are not allowed to participate in any decision making.

5. QUORUM

5.1. Whilst the Board is not currently a decision-making body outside of individual delegated powers of authority, there is a requirement for a minimum number of members to be present to enable the business of the Board to be effectively undertaken. For the purposes of these Terms of Reference this shall be known as the quorum and shall be noted as such in meeting agendas and minutes.

5.2. For the meeting to be considered quorate at least 75% of the membership needs to be in attendance, one of whom will be the Chair or Vice Chair of the Board.

5.3. The function of the Board will be supported by the senior ICS roles - the Director of System Transformation, and Director of System Collaboration. Both roles will hold shared responsibility and accountability to the Board for driving the delivery of improvement priorities.

5.4. Deputies may be appointed in the absence of a member, subject to the agreement of the Chair, but may not be another member of the Board or represent more than one member.

5.5. Members who are not physically present at a meeting but are present through the means of teleconference or other acceptable digital media shall be deemed to be present.

5.6. If any representative is conflicted on a particular item of business they may not participate in the discussion and may be asked to leave the meeting at the discretion of the Chair. These individuals shall not count towards the quorum for any decision/recommendation made. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the requirement for that category of member to be present may be relaxed.
- Members have a collective responsibility for the operation of the Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

6. MEETING FREQUENCY

6.1. Meetings shall be held quarterly online.

6.2. The Board will meet in private.

6.3. The Board Chair may request additional meetings if they consider it necessary, including facilitating the function of assurance to the ICB and partner organisations.

7. AGENDA AND PARTICIPATION

7.1. The agenda and associated papers will be issued five working days in advance of each meeting.

7.2. Requests for agenda items should be sent to the Director of System Transformation a minimum of two weeks in advance of the meeting. The Chair will decide if items can be added, depending on previous commitments and time constraints.

7.3. To ensure that meetings run smoothly and effectively, members will be expected to:

- Read circulated papers and other materials in advance of meetings
- Follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus and aim to seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting.

8. DECISION MAKING

8.1. The Board does not currently have any delegated decision-making authority outside of individual delegated powers of authority. Recommendations outside of any delegated or contracted authority will be made to the ICB.

8.2. Whilst the Board is not currently a formally delegated decision-making body, any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.

8.3. Any decisions endorsed will be shared with the four Health and Care Partnerships through their representatives to support local planning. Unless individual delegated powers of responsibility authorise otherwise, recommendations which are material in scope and/ or have significant financial impact will be required to also go to Board member organisations for agreement as appropriate.

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9. DISPUTE RESOLUTION

9.1. Where a dispute or concern arises regarding the operation or management of the Committee, this should be brought to the attention of the Chair in the first instance. The Chair will consider what appropriate action to take and whether the matter is to be discussed by the Committee or escalated to the ICS System Executive Group or ICB for resolution. Where a dispute or concern arises relating to the actions of the Chair, where possible the matter should be discussed with the Chair or Vice Chair and progressed as above. Where it would be inappropriate to raise the matter directly with the Chair or Vice Chair, the matter should be raised with the ICB Chair.

9.2. For clarity, any decision made by the Board, including decisions not to support a proposal, cannot be challenged where the proposal has been put to a vote in accordance with these terms of reference, i.e. a concern cannot be formally escalated by a member simply because they do not like the outcome.

10. REPORTING PROCEDURE AND MINUTES

10.1. Minutes will be taken at each meeting by a member of the ICS Governance Team and distributed to Board members no later than a week after each meeting.

10.2. The Board will have a responsibility to report to the Improviong Outcomes Committee of the ICB as and when appropriate.

10.3. The board will produce formal bi-annual communication to key stakeholders across Kent & Medway such as MPs and Elected Members to highlight improvement work and outcomes being delivered to support the population.

11. POLICY AND BEST PRACTICE

11.1. The Board may instruct professional advisors and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for or expedient to the exercise its responsibilities.

11.2. The Board is authorised to establish such sub- groups as it deems appropriate in order to assist in discharging its responsibilities.

11.3. Unless stated otherwise in these terms of reference, the Board will be conducted in accordance with Kent and Medway CCG Standing Orders and Standards of Business Conduct and Managing Conflicts of Interest Policy. Specifically:

- There must be transparency and clear accountability
- The Group will hold a Register of Interests in accordance with good governance practice
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take in discussion with the lead executive officer as appropriate. This may include requesting that individuals withdraw from any discussion/voting until the matter is concluded.
- The Chair will reserve the right to refer a matter to the ICB should an item or issue arise where it is judged that additional consideration would secure essential good corporate

governance and decision making. In turn the ICB may refer any matter referred to it by the Board to the member organisations for consideration, and in particular where a formal decision outside of any delegated authority is required.

- The Board shall undertake a self-assessment of its effectiveness bi-annually at the face to face board development meetings.
- Members of the Board should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year. Where members do not meet these criteria and there are no extenuating circumstances as deemed reasonable by the Chair, the Chair will discuss the matter with the member's relevant line manager, chief executive officer or chair as appropriate to seek improved attendance. Where, this is not satisfactorily resolved, the chair may seek agreement of the other members of the Board to amend the TOR and exclude the associated role from the membership on a temporary or permanent basis.

12. CONFIDENTIALITY

12.1. Members of the Board shall respect the confidentiality requirements set out in relevant corporate policies and these Terms of Reference, unless separate confidentiality requirements are set out for the Board, in which event these shall be observed.

12.2. Recommendations and actions of the Board will be detailed in the minutes of the meeting, and these shall be disclosable under the Freedom of Information Act, except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

13. REVIEW

13.1. The Terms of Reference of the Board shall be reviewed annually.

Approved:
May 2022

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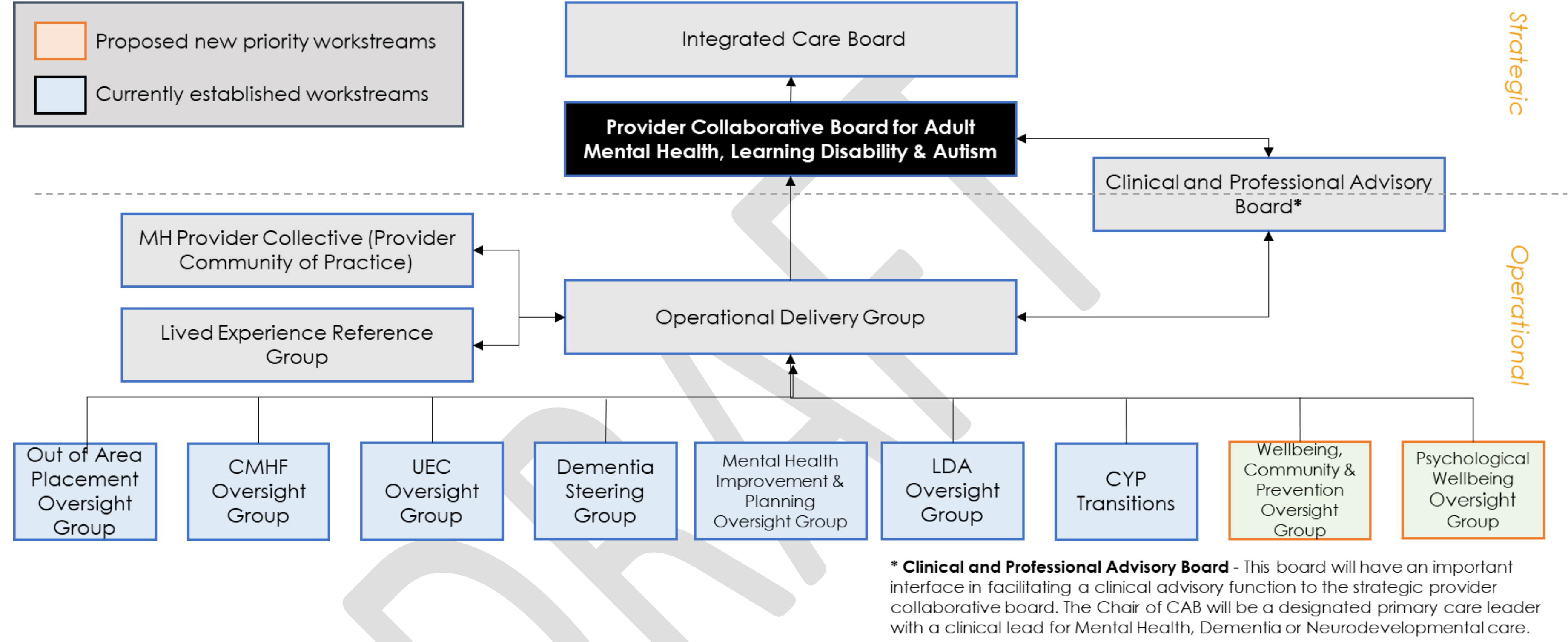
Apendix One – Kent and Medway MHLDA Governance Structure



* **Clinical and Professional Advisory Board** - This board will have an important interface in facilitating a clinical advisory function to the strategic provider collaborative board. The Chair of CAB will be a designated primary care leader with a clinical lead for Mental Health, Dementia or Neurodevelopmental care.

Appendix Two – Glossary of Terms, Abbreviation and Acronyms

- **Board -** Provider Collaborative Board for Mental Health, Learning Disability and Autism
- **CPAB –** Clinical & Professional Advisory Board
- **CCG –** Clinical Commissioning Group
- **CMHF –** Community Mental Health Framework
- **CMHT –** Community Mental Health Transformation
- **ICB –** Integrated Care Board
- **HCP –** Health and Care Partnership
- **ICS –** Integrated Care System
- **LTP –** NHS Long Term Plan
- **MHIS –** Mental Health Investment Standard
- **MHLDA -** Mental Health, Learning Disability and Autism
- **MHLTP –** Mental Health Long Term Plan
- **OOA –** Out of Area Placement
- **PBP –** Place Based Partnership
- **SoRD –** Schemes of Reserved Delegation
- **UEC –** Urgent & Emergency Care

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29/09/2022
Title of Paper:	Risk Management Strategy 2022-2024.
Author:	Jessica Scott, Emergency Preparedness and Resilience Lead
Executive Director:	Andy Cruikshank, Chief Nurse

Purpose of Paper

Purpose:	Approval
Submission to Board:	Assurance, having been supported by the Audit and Risk Committee.

Overview of Paper

This paper has been submitted for approval against the following document:

Risk Management Strategy

The strategy is of two years duration; commencing September 2022.

The document has been uplifted based on the outcome and recommendations as presented by TIAA within the Core Review of Assurance Framework and Risk Management Processes Audit Report 2021/22 and will form part of the TIAA of Risk Management Audit 2022/23.

Issues to bring to the Board's attention

Three objectives have been included within the strategy document:

Improve each risk owner's cognisance of the impact of social, political, environmental and regulatory drivers of change; so, risk management is dynamic, iterative and responsive to change.

Improve the organisation's understanding of the process of risk management; by demonstrating an improved awareness of the effectiveness and ineffectiveness of controls

Improve the confidence in assurance via the types, quality and timeliness of systematic and structured management information. The policy has taken the feedback from TIAA and ensured within the update that the roles and responsibilities of staff are clearly defined.

Version Control: 01

Governance

Implications/Impact:	The portfolio of Risk Management has an accountable Executive Officer: The Chief Nurse. The TIAA Core Review of Assurance Framework and Risk Management Processes as an audit confirmation was received in August 2022/23 denoting that the trust had maintained a status of 'Reasonable Assurance'.
Assurance:	Continuous improvement of Risk Management is assured in its delivery to the Audit and Risk Committee (ARC) via the Trust-wide Health, Safety and Risk Group.
Oversight:	Audit and Risk Committee (ARC) via the Trust-wide Health, Safety and Risk Group.

Version Control: 01

Risk Management Strategy 2022-2024

(To be read in conjunction with the Risk Management Policy and Risk Management Standing Operating Procedure)

Document Reference No.	KMPT.CorG.012.01 (New title)
Replacing document	KMPT.CorG.012.08 (Expired)
Target audience	Trust Wide
Author	Trust Risk Manager
Group responsible for developing document	Trust wide Health Safety and Risk Group reporting via ARC to Board
Status	Final
Authorised/Ratified By	Trust Wide Health and Safety Group supported by Audit and Risk Committee.
Authorised/Ratified On	September 2022
Date of Implementation	September 2022
Review Date	September 2024
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	September 2022
Number of Pages	4
Contact Point for Queries	kmpt.policies@nhs.net
Copyright	Kent and Medway NHS and Social Care Partnership Trust 2022

DOCUMENT TRACKING SHEET

Risk Management Strategy 2022-2024

Version	Status	Date	Issued to/ approved by	Comments
1	New 2022/24	20/06/2022	TWHS&RG ARC	Awaiting Board approval

REFERENCES

Risk Management Standard ISO 31000. 2009
The Health and Care Act 2022
Care Quality Commission Essential Standards 2009
Care Quality Commission (Registration) Regulations 2009.
NHS Standard contract 2022-23 service conditions
Defining risk appetite and managing risk by CCGs and NHS Trusts. Good Governance Institute. Jan 2012
Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis) Report. Feb 2013
Board Assurance: A toolkit for health sector organisations. NHS Providers (2015)

RELATED POLICIES/PROCEDURES/protocols/forms/leaflets

Policy/Procedure	Reference No:
Risk Management Policy	KMPT.CorG.112
Risk Management Process Standing Operating Procedure	TBC

CONTENTS

1 INTRODUCTION 1
2 VISION 1
3 AIMS AND OBJECTIVES 1
4 IMPLEMENTING THE STRATEGY 1
5 RISK MATURITY 2
6 MONITORING THE IMPLEMENTATION OF THIS STRATEGY 2
7 TRAINING 2
8 EQUALITY IMPACT ASSESSMENT 3
9 HUMAN RIGHTS 3

1 INTRODUCTION

1.1 Kent and Medway NHS and Social Care Partnership Trust (the trust) is committed to the management of risk associated with caring for patients, staff and others affected by our activities and recognises that these risks are present on a day to day basis.

1.2 The process of risk management is an essential tool which provides the board with assurance on the control mechanism framework for clinical, non-clinical and corporate governance.

1.3 This strategy establishes a positive direction for the process of advancing risk management maturity to maintain and improve the quality and safety of care for patients, staff and others affected by our activities.

2 VISION

2.1 To achieve the aims and objectives of this strategy, everyone involved needs to understand what risk is, how it impacts on our clients, ourselves, our services and what needs to be done to self-assuredly give guarantees of controls, or mitigate, the consequences via actions generated and assured to reduce risk.

3 AIMS AND OBJECTIVES

3.1 The aim of this strategy is to have effective risk management systems that are embedded throughout the organisation at every level and are integral to everyday working and planning of services.

3.2 To achieve this aim the responsibilities of key individuals and managers will be set out in the risk management policy and associated risk management process standard operating procedure.

3.3 The three objectives of the 2022 – 2024 strategy are:

3.3.1 Improve each risk owners' cognisance of the impact of social, political, environmental and regulatory drivers of change; so, risk management is dynamic, iterative and responsive to change.

3.3.2 Improve the organisations understanding of the process of risk management; by demonstrating an improved awareness of the effectiveness and ineffectiveness of controls

3.3.3 Improve the confidence in assurance via the types, quality and timeliness of systematic and structured management information.

4 IMPLEMENTING THE STRATEGY

4.1 Successful implementation of this strategy requires leadership at all levels of the organisation

4.2 The board will own the risk management strategy and retain responsibility for achieving objective 3.3.1 as well as receiving assurance on its implementation and the risks against the trust strategic objectives.

4.3 Care group heads of service and corporate support services directors and their management teams are responsible for ensuring that all the objectives within the strategy have been met and that all reasonable actions have been taken to mitigate risk.

4.4 The strategy is supported by the compliance and risk team who will provide the risk management policy along with information and guidance on the process of risk assessment, the common tools for evaluating risks and controls, with the use of risk registers.

5 RISK MATURITY

5.1 A risk maturity scale is used to illustrate different levels of risk maturity as risk management becomes more embedded in the organisation (Figure 1)

Figure1: Risk Maturity Framework

5.1.1 It is the intention of the board to continue to develop the risk maturity of the organisation from ‘Defined’ to a ‘Risk Enabled’ status.

5.1.2 The annual internal audit of risk management includes an assessment of the risk maturity of the organisation. The audit and risk committee (ARC) will monitor the implementation of recommendations arising from this audit.

6 MONITORING THE IMPLEMENTATION OF THIS STRATEGY

6.1 The ARC is responsible for monitoring the strategy’s implementation plan on behalf of the board and scrutinises the risk management process which forms the assurance for the board.

6.2 Internal and external audit reports give assurance that the trust’s risk management systems are being implemented.

6.3 The board will monitor the delivery of this strategy through its governance committees.

7 TRAINING

7.2 Staff and managers are expected to familiarise themselves with the risk management strategy, risk management policy and standard operating procedure and training relevant to their role.

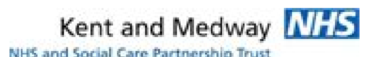
8 EQUALITY IMPACT ASSESSMENT

8.1 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.

9 HUMAN RIGHTS

9.1 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.

End document.



TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: **29th September 2022**

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

Author: All Executive Directors

Executive Director: Helen Greatorex, Chief Executive

Purpose of Paper

Purpose: Discussion

Submission to Board: Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

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

The Board's attention will naturally focus on those areas below target, seeking assurance that measures are in place to rectify the situation. The report shows continued pressure in some of our key workforce metrics along with examples of the work in train to improve the situation. Sickness Absence increased to 4.8% compared to the 4% target and the Vacancy Gap and turnover continue to exceed target, consequently recruitment and retention remains a strong focus as well as being a priority area in the trust's strategic priorities for 2022-23.

Bed pressures is an area of focus for the Executive Team, this is partially driven by high levels of Delayed Transfers of Care. Bed days lost to delayed transfers of care increased, for the third successive month, by 1.1% to 13.3% which is the highest position of the last 12 months. The Chief Operating Officer continues to oversee a detailed piece of work which is outlined in the Board Paper.

Out of Area placements which exceed contracted beds remains a challenge. 176 bed days were used in August 2022 which is slightly above the annual average of 161 days. This remains an area of focus with robust processes overseeing all placements.

It has previously been highlighted that our community teams require an increased focus, this includes; care planning and waiting times for assessment and treatment. Despite ongoing challenges, it is positive to note that both access measures (4 weeks for CMHT and functional CMHSOP, 6 weeks for organic CMHSOP presentations) increased in month and attained the highest position for of the last 12 months. Further improvement is being managed at a team level supported by exception reporting, the impact of factors such as vacancy rates, sickness and referral rates continue to result in variation across teams.

A number of changes to the report have been made this month, this includes amendments of targets as well as the movement of some indicators to being monitored by Care Group QPR meetings and no longer reported in the IQPR, full details can be seen in the appendix on page 29 of this report. In all cases of target amendments national benchmarks were considered where available as well as variation in delivery across teams with new targets identified which remain challenging but are also attainable for some services. The rationale for each change is detail within each domain. Where indicators have been removed from this report this is due to low levels of activity being reported and little variability, these will be managed appropriately within existing governance structures and escalated where required.

Governance

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

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

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

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

Executive Commentary

Restrictive Practice - No. Of Prone Incidents (012.S)
The Trust's approach to the use of restraint is carefully monitored and reviewed in line with national best practice. The use of restraint is always a last resort and staff are trained in de-escalation techniques which are always considered before restraint is implemented.

There were 103 reported incidents of restraint needing to be used in August 2022, a decrease of 17 from the previous month. The majority of restraints occurred in the Acute Care Group (ACG) with 83 reported in August 2022. All use of restrictive interventions is monitored in line with Trust policy with strategic oversight by the Promoting Safe Care group which has membership from all care groups and subject matter experts.

There were a reported nine prone restraints in August 2022. Although KMPT have seen a continual decrease in prone restraints over the last two years, occasional peaks may continue to occur such as seen this month. No moderate or severe harm was reported in any use of prone restraint and all but one of these were used to give IM medication.

The use of seclusion continues to fluctuate monthly with twenty-eight episodes reported in July decreasing to fifteen episodes in August 2022. The majority of these occurred in the Acute Care Group (10) with the remaining five in the Forensic & Specialist Care Group. These involved eleven different patients throughout the Trust. All instances of seclusion are reviewed and an overview retained in order to identify outliers or patterns.

IQPR Dashboard: Safe

Ref	Measure	SoF	Exclude from Public IQPR	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
001.S	Occurrence Of Any Never Event	✓		0	N	0	0	0	0	0	0	1	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review			95%	N	92.8%	92.3%	92.9%	93.0%	93.2%	93.5%	93.8%	93.4%	92.7%	93.0%	93.2%	91.3%
011.S	Restrictive Practice - All Restraints			-	-	82	62	72	71	88	83	105	82	121	97	120	103
020.S	Unplanned Readmissions within 30 days			8.8%	L	5.6%	8.5%	5.8%	7.2%	5.3%	4.5%	7.7%	6.7%	6.4%	6.3%	5.5%	3.6%

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

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

Issues of Concern

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

Target Changes September 2022:

Ref	Measure	Previous Target	New Target	Rationale
012.E	Average Length Of Stay (Younger Adults)	25	34	Stretch targets to aim to continue to achieve national mean of 34 days and 77 days respectively (NHSB 2021/22 draft report). Attaining national mean given our low bed stock and significantly higher % of DToC compared to national mean would still be deemed a good level of performance.
013a.E	Average Length Of Stay (Older Adults - Acute)	52	77	
017.E	% Patients with Non-CPA Care Plans or Personal Support Plans	95%	80%	Achievable stretch target for most. Some CMHT's and CMHSOP (which equate to >90% of activity in the indicator) demonstrating ability to achieve.

Executive Commentary

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. A key focus for both older and younger adult mental health teams is the required reduction in caseloads. This can only be achieved with support from all agencies supporting a step-down model for patients who mental state is stable.

Average Length Of Stay: Older Adults - Acute (013a.E)

Length of stay almost doubled in month compared to the previous two months, this was due to a number of long stayers within the 24 discharges in month. There were 3 discharges in excess of 200 days, 2 of which were in excess of 400 days. By comparison there was only one discharge in excess of 200 days in June and none in July.

	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			6.0	0.0	-42.0	104.5	31.2
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			170.0	0.0	20.7	268.6	144.6
4	**Trust Total**			176.0	0.0	7.9	343.8	175.9

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

Narrative

August 2022 saw an increase in the use of out of area beds not procured in advance by KMPT, 176 bed days were used (6 YA Acute and 170 PICU), compared to 117 in July.

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**Acute**			88.0%	95.0%	58.6%	93.0%	75.8%
2	**CRCG**			86.5%	95.0%	86.0%	91.9%	89.0%
3	**FSCG**			93.2%	95.0%	91.0%	97.7%	94.3%
4	**OPMH**			94.5%	95.0%	93.6%	98.8%	96.2%
5	**Trust Total**			88.3%	95.0%	88.0%	92.6%	90.3%

	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**			67.4%	80.0%	64.6%	70.9%	67.8%
2	**FSCG**			75.4%	80.0%	66.2%	76.9%	71.6%
3	**OPMH**			69.4%	80.0%	69.1%	82.5%	75.8%
4	**Trust Total**			68.8%	80.0%	68.7%	74.5%	71.6%

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

Narrative

CPA Care Planning

The percentage of patients on CPA with a valid Care Plan is showing as special cause variation of a concerning nature. CRCG remains the biggest contributor to this indicator, the care group position reduced by 1% in month to 86.5%.

OPMH and FSS are exceeding 90%, the Acute Care Group Figure reflects a low number of patients (25).

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

There has been small reduction in performance driven by CMHSOP teams, whilst overall performance is in excess of that of CRCG there has been a reduction of 10.9% within OPMH over the last 12 months.

Despite the improved position CMHTs continue to experience wide variation in levels of achievement with Dover & Deal and Medway CMHT showing special cause variation of a concerning nature. It is positive to note that two teams are achieving the new target of 80%.

Medway CMHT are showing special cause variation, this is partly driven by having the highest number of patients on the Active Review caseload which accounts for the majority of patients requiring a PSP. Work is underway to review this caseload to allow step down to a more appropriate provision where possible and ensure that patients have a PSP in place. This team are also experiencing a challenge with staffing across Band 6 staff and medical staff. Recruitment is being addressed and plans to support the team are in place.

Dover & Deal CMHT are also showing special cause variation of a concerning nature, this team had a number of vacancies, due to staff being promoted elsewhere within KMPT service. The team has had a very successful recruitment campaign and have recruited 11 WTE staff. Once start dates are finalised the trajectory for compliance will be revised.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford & Canterbury CMHT		F	74.9%	80.0%	67.5%	78.8%	73.2%
2	DGS CMHT	H	F	72.5%	80.0%	56.1%	71.0%	63.6%
3	Dover & Deal CMHT	L	?	72.8%	80.0%	66.2%	87.4%	76.8%
4	Maidstone CMHT		F	61.0%	80.0%	45.8%	66.7%	56.2%
5	Medway CMHT	L	F	50.1%	80.0%	58.4%	74.1%	66.2%
6	Shepway CMHT		?	82.5%	80.0%	74.1%	92.6%	83.4%
7	Swale CMHT		F	58.3%	80.0%	57.2%	74.9%	66.1%
8	SWK CMHT		F	62.2%	80.0%	41.6%	66.4%	54.0%
9	Thanet CMHT		?	88.9%	80.0%	73.2%	93.2%	83.2%
10	**CMHT Total**		F	68.4%	80.0%	65.4%	71.0%	68.2%

CMHSOPs are subject to special cause variation overall, driven by five CMHSOPs who are showing special cause variation.

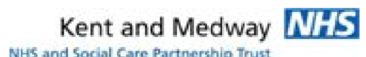
Non CPA care plans were historically reviewed annually, when the PSP was introduced in 2021 a review period of 6 months was adopted and built into standard operating procedures. This increased frequency is a contributory factor to the ongoing reduction in performance, there is a clinical review of this underway.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			72.4%	80.0%	69.9%	87.4%	78.7%
2	Canterbury CMHSOP			71.2%	80.0%	62.7%	86.5%	74.6%
3	DGS CMHSOP			80.5%	80.0%	73.2%	88.9%	81.0%
4	Dover & Deal CMHSOP			87.8%	80.0%	78.9%	91.4%	85.2%
5	Maidstone CMHSOP			46.4%	80.0%	63.8%	85.4%	74.6%
6	Medway CMHSOP			71.5%	80.0%	67.5%	85.3%	76.4%
7	Sevenoaks CMHSOP			62.7%	80.0%	62.0%	81.6%	71.8%
8	Shepway CMHSOP			72.5%	80.0%	77.7%	87.8%	82.8%
9	Swale CMHSOP			67.6%	80.0%	63.4%	82.8%	73.1%
10	Thanet CMHSOP			75.0%	80.0%	72.1%	86.8%	79.5%
11	Tunbridge Wells CMHSOP			54.7%	80.0%	54.3%	73.5%	63.9%
12	**CMHSOP Total**			69.4%	80.0%	72.3%	82.2%	77.3%

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

IQPR Dashboard: Effective

Ref	Measure	SoF	Exclude from Public IQPR	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓		95%	N	96.3%	95.2%	95.3%	96.2%	98.5%	98.6%	93.8%	95.6%	95.8%	95.2%	97.0%	98.4%
001b.E	CPA patients receiving follow-up within 72hours of discharge					81.7%	87.5%	88.0%	80.0%	78.6%	85.0%	84.4%	84.1%	83.9%	85.7%	85.1%	85.3%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓		95%	-	95.9%	96.2%	96.1%	96.1%	96.1%	95.9%	95.7%	95.7%	95.7%	95.6%	95.6%	95.5%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓		-	-	205	175	142	108	120	69	168	253	255	141	117	176
006.E	Delayed Transfers Of Care			7.5%	L	10.6%	11.9%	9.6%	10.6%	13.1%	12.8%	12.4%	10.9%	9.9%	10.7%	12.2%	13.3%
012.E	Average Length Of Stay(Younger Adults)			34	L	29.78	36.63	33.96	26.85	35.99	33.63	36.23	38.84	37.11	36.38	35.88	37.30
013a.E	Average Length Of Stay(Older Adults - Acute)			77	L	72.25	80.22	85.18	85.90	53.88	57.41	72.63	81.88	85.15	69.11	64.40	117.17
015.E	%Patients with a CPA Care Plan			95%	L	89.5%	88.7%	91.4%	90.7%	90.6%	90.2%	89.3%	87.9%	87.7%	88.9%	89.0%	88.3%
016.E	% Patients with a CPA Care Plan which is Distributed to Client			75%	L	65.4%	66.3%	67.9%	71.7%	74.2%	73.3%	72.5%	71.5%	72.2%	75.3%	75.2%	71.8%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans			80%	L	73.2%	74.0%	73.7%	72.6%	73.5%	73.4%	70.9%	69.2%	68.7%	71.1%	69.9%	68.8%
018.E	Bed Occupancy (Net)					96.8%	96.1%	95.5%	90.7%	95.0%	93.7%	94.4%	94.4%	96.1%	96.5%	95.6%	97.8%



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

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

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

Executive Commentary

Addressing vacancy levels continues to be a key priority for KMPT, and a deep dive into these vacancy levels is due at the time of writing to be considered by Workforce and OD Committee. The employment market has over recent months been particularly volatile, with a national picture of increased numbers of vacancies, increased competition for candidates, and increased levels of resignations.

When new investment is considered, KMPT is currently carrying over 600 WTE worth of vacancies, with the nursing and SAS doctor workforce being most impacted.

Recruitment efforts continue, and there is a recruitment pipeline (offers to successful candidates) for around 90% of all vacant posts. However, keeping pace with turnover remains a challenge. In August, although there were 68 (61.66 WTE) new starters, there were also 54 (49.38 WTE) leavers.

This turnover is markedly lower than experienced in July, but, at 13.3%, continues to be around 4% above target and slightly above trend. The HCA workforce consistently sees particularly high rates of turnover, with the most prevalent reason for leaving being work-life balance.

We continue to focus on attraction of new candidates, getting recruitment right first time, and onboarding. Simultaneously, much work is ongoing around retention. With work life balance being cited as the most prevalent reason for leaving amongst our staff, this work focuses on enhancing opportunities for flexible working, as well as on physical, psychological, social and, particularly in light of cost of living increases, financial wellbeing.

Following a decrease in July, August saw an increase in sickness absence. Owing to reporting timelines, it is too early at the time of writing to determine the make-up of this absence. Alongside a robust and supportive approach to attendance management, a range of holistic health and wellbeing

interventions have recently been put in place. These include the training of an additional 50 Mental Health First Aiders, opening of Chill Out Spaces, and a schedule of wellbeing activities. KMPT's new Health and Wellbeing Strategy will be launched in September and builds on these foundations. Feedback and impact on workforce wellbeing will continue to be evaluated.

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Exclude from Public IQPR	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
001.W-W	Staff Sickness - Overall	✓		4.00%	L	4.6%	5.0%	4.9%	4.7%	4.3%	4.3%	4.3%	4.3%	4.5%	4.5%	4.2%	4.8%
005.W-W	Appraisals And Personal Development Plans			95%	L			98.8%	99.0%	99.0%	99.0%	99.0%	99.0%				
005a.W-W	Medical Staff Appraisal			90%	L												
006.W-W	Vacancy Gap - Overall			10.00%	L		15.0%	14.9%	14.9%	15.1%	15.2%	15.7%	15.1%	15.3%	16.6%	17.8%	15.8%
012.W-W	Essential Training For Role			90%	L	92.6%	91.5%	92.7%	93.1%	92.5%	93.0%	92.0%	91.9%	92.5%	92.6%	92.8%	93.0%
015.W-W	Staff Retention (overall)			87%		81.8%	81.8%	81.0%	83.2%	85.9%	85.4%	83.2%	83.4%	84.0%	83.3%	84.2%	84.2%
019.W-W	Staff Turnover (Overall)			9.00%		12.2%	12.6%	12.8%	13.6%	13.1%	13.4%	12.7%	13.0%	13.1%	12.6%	14.9%	13.3%
023.W-W	Safer staffing fill rates			80.00%	L	110.5%	110.3%	110.2%	100.6%	102.5%	101.3%	101.5%	103.5%	103.6%	101.9%	100.5%	102.1%

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

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

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

Issues of Concern
The Trust has a challenging efficiency target for this financial year (£7m). Plans are in place for 66% of this target and RAG rated green, 16% are amber. The gap is currently £1.2m, which is to be identified, there are clear areas of focus for all care groups and support services, final delivery plans are now required.

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
004.W-F	In Month Budget (£000)		0.0	N	(0)	0	0	0	0	0	0	0	0	0	0	
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-0.32%	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)		-	-	687	562	536	741	595	516	698	533	572	612	708	544
009.W-F	Agency - In Month Variance from budget (£000)		-	-	260	135	109	314	168	89	271	106	145	185	281	117
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	51.76%	48.88%	45.97%	49.04%	48.08%	45.60%	47.08%	43.84%	29.37%	34.03%	41.98%	39.05%

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

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

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

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

Executive Commentary

Friends and Family Test (002.C)

KMPT are exceeding the national response rate. Nationally 2.2% were submitted in June 2022 and KMPT submitted 4.7%. We are also exceeding a regional comparison which is currently a 0.9% response rate.

In terms of how we compare nationally and regionally for performance, analysis observes a rise in performance. We are 1% below the national 'positive percentage' in June 2022. Nationally patients are 86% positive about their experience. For KMPT, patients are 85% positive about their experience. This is in the range where overall, the experience of our service is 'very good'. We are exceeding a regional comparison.

Patients who rated their overall experience as 'poor' or 'very poor' often comment on how their experience could have be improved in the free text. In July and August 2022, poor communication and not being involved in care planning were the main themes that contributed to their 'poor' or 'very poor' experience.

Further improvement is being managed at a team level as the impact of factors such as vacancy rates, sickness and referral rates continue to result in variation in performance across teams. There is recognition of continued challenges across Community mental health teams and CMHSOPs. A focussed piece of work to review the Memory Assessment caseload and apply the new operating model has commenced within CMHSOPs. Information is being disseminated to the care groups that patient wishes regarding appointments should be accommodated where possible and staff should be mindful of making reasonable adjustments.

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

The trust target is to receive 10% which is 1500 each month.

- 740 were collected in July 2022, 5.1% response rate
- 686 were collected in August 2022, 4.7% response rate

The Trust wide PREM response rate increased to 5.1% in July 2022, the highest response rate so far. This is a result of the embedding of the PREM which has extended its reach and uptake. In August there were postal strikes and this impacted on the receipt of the PREM, the response rate was lower. Despite this, the latest analysis shows improving variation is being maintained. Currently, performance can be expected to vary in the range between 4% and 5%.

It is positive to note that the trust patient experience indicator is above 8 out of 10 which is in the top range where patients 'strongly agree' that they experience our services positively. In July 2022 the patient experience indicator was 8.3 out of 10, this level was maintained in August 2022. All Care Groups achieved above 8 out of 10.

IQPR Dashboard: Caring

Ref	Measure	SoF	Exclude from Public IQPR	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓		93%	N	82.5%	85.6%	87.8%	81.3%	84.5%	84.9%	84.5%	84.5%	79.5%	84.9%	83.8%	86.6%
005.C	Complaints acknowledged within 3 days (or agreed timeframe)			100%	L	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%	98.0%	98.0%	97.0%	98.0%	99.0%	97.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)			100%	L	100.0%	96.0%	98.0%	100.0%	98.0%	98.0%	97.0%	98.0%	98.0%	98.0%	98.0%	97.0%
007.C	Compliments - actuals			-	-	106	106	195	148	187	131	162	113	115	89	174	184
008.C	Compliments - per 10,000 contacts			-	-	28.93	29.83	50.38	45.53	52.16	38.93	43.68	34.90	30.79	25.70	50.87	52.97
013.C	Patient Reported Experience Measures (PREM): Response count			-	-	526	585	641	653	651	634	698	511	738	691	740	686
014.C	Patient Reported Experience Measure (PREM): Response rate			-	-	3.3	3.8	4	4.6	4.2	4.1	4.6	3.6	4.8	4.7	5.1	4.6
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %			-	-	8.2	8.2	8.4	8.0	8.1	8.2	8.3	8.2	8.0	8.3	8.2	8.3

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

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

Issues of Concern
Memory Assessment Services, demand continues to outstrip capacity. Actions include the role out of a new model *(see below)*

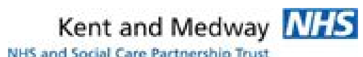
Ref	Measure	Previous Target	New target	Rationale
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)	95%	75%	Ongoing challenges in meeting demand of new referrals which has resulted in backlogs in many teams. CMHF transformation aims to address.
016b.R	Care spell start to Assessment within 6 weeks (MAS only)	95%	75%	Known issue with backlog and capacity which are being addressed in year and therefore likely to see decreases before performance increases. Therefore 75% by year end with a further review of progress at year end would provide an attainable target.

Executive Commentary

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. The work being undertaken to address the waiting list for the Memory Assessment Service is progressing well with the both the backlog reducing and the new model being implemented.

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			82.4%	75.0%	52.8%	87.3%	70.0%
2	OPMH			78.3%	75.0%	46.8%	85.5%	66.1%
3	Trust Total			81.6%	75.0%	54.1%	83.0%	68.6%

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



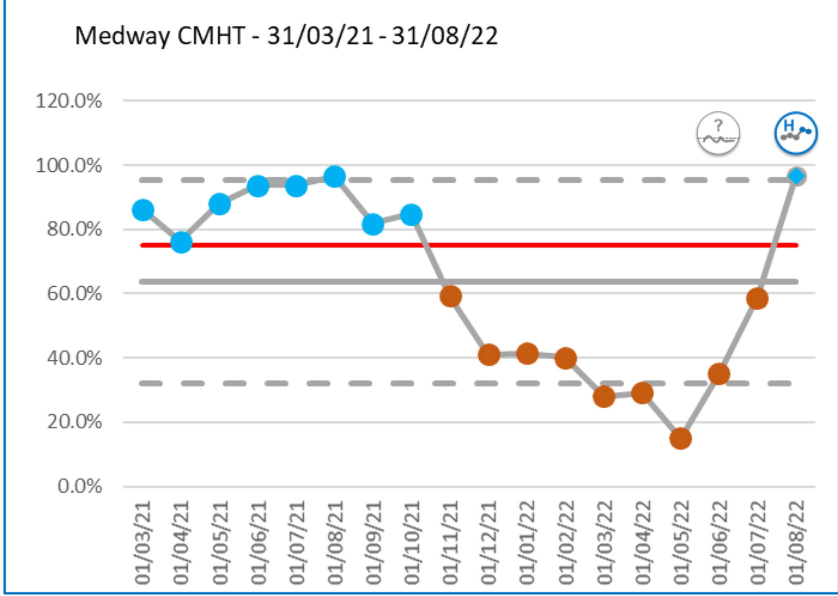
This indicator has been amended for 2022/23: Older Adult activity related to organic presentations is now reported within a separate measure against a 6-week target (reported below). The activity reported against CMHSOPs for the 4 week target reflected Functional and Complex Dementia presentations until 14th July 2022 when changes were made to RiO to give the ability to split the two pathways. Work was undertaken to retrospectively update old pathways to one of the two new separate pathways, however this work took some weeks to complete and so patients continued to be assessed under the old pathway. In August the OPMH denominator against the 4 week target reduced to 83 compared to 180 in July, demonstrating this movement. As a result, CMHTs now equate for 80% of the activity within this indicator.

Across CMHTs there is wide variation in performance (60.5%-100% in month), overall six of nine CMHTs are meeting the new target of 75% resulting in an overall CMHT position of 82.3%.

	Routine Referral to assessment in 4 weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford & Canterbury CMHT			81.0%	75.0%	56.1%	102.6%	79.3%
2	DGS CMHT			94.4%	75.0%	69.0%	100.7%	84.8%
3	Dover & Deal CMHT			100.0%	75.0%	56.7%	115.3%	86.0%
4	Maidstone CMHT			60.5%	75.0%	-6.3%	108.0%	50.9%
5	Medway CMHT			96.6%	75.0%	32.1%	95.3%	63.7%
6	Shepway CMHT			61.5%	75.0%	15.5%	116.9%	66.2%
7	Swale CMHT			89.5%	75.0%	38.3%	104.7%	71.5%
8	SWK CMHT			63.3%	75.0%	35.1%	94.0%	64.5%
9	Thanet CMHT			100.0%	75.0%	61.1%	109.5%	85.3%
10	CMHT Total			82.3%	75.0%	53.9%	88.5%	71.2%

The performance of Medway CMHT should be noted, achieving 96.6% in month reflecting a below average 58 assessments in month due to the summer period compared to an average of 78 over the last 12 months. The team have also continued to reduce their waiting list from 240 at the end of January to 74 at the end of August, the % of which waiting over 28 days has reduced considerable to 10%. This has been achieved by increasing assessments slots in recent months to meet new demand as well as addressing backlogs. Whilst a much improved position, assessment slot availability has once more reduced due to staff leaving, management of attempting to match capacity to demand will continue.

Kent and Medway NHS
NHS and Social Care Partnership Trust



It is important to note that the measure reflects routine assessments and does not include the urgent assessments completed by the teams within this period. In addition to note, is client cancellations and DNAs affect the teams' ability to reach the target as the 'clock' starts at the point the referral is opened to KMPT.

The following table shows the performance of CMHSOP teams against the 6 week target for Routine Memory Assessments and Complex Dementia, highlighting two teams showing special cause variation: Medway and Shepway CMHSOPs. Overall there remains a large variance across teams in performance against the 6 week to assessment measure with a range in month of 22% to 92.6%. The implementation of the new service model Enhanced Memory Assessment and Intervention Service has commenced across all CMHSOP teams.

	016.R: Care Spell start to Memory Assessment (Routine) Assessment Within 6 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			92.6%	75.0%	73.9%	112.2%	93.1%
2	Canterbury CMHSOP			57.8%	75.0%	2.2%	74.4%	38.3%
3	DGS CMHSOP			39.1%	75.0%	19.6%	109.1%	64.3%
4	Dover & Deal CMHSOP			65.7%	75.0%	14.3%	87.3%	50.8%
5	Maidstone CMHSOP			87.0%	75.0%	47.6%	103.1%	75.4%
6	Medway CMHSOP			25.0%	75.0%	10.8%	55.9%	33.3%
7	Sevenoaks CMHSOP			22.5%	75.0%	-14.7%	63.6%	24.5%
8	Shepway CMHSOP			51.3%	75.0%	52.3%	97.5%	74.9%
9	Swale CMHSOP			68.9%	75.0%	58.0%	106.0%	82.0%
10	Thanet CMHSOP			90.6%	75.0%	24.5%	91.2%	57.9%
11	Tunbridge Wells CMHSOP			22.0%	75.0%	-9.5%	43.0%	16.7%
12	CMHSOP Total			61.5%	75.0%	38.4%	77.5%	58.0%

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**CRCG**			93.6%	75.0%	85.1%	97.9%	91.5%
2	**OPMH**			68.2%	75.0%	59.9%	79.8%	69.8%
3	**Trust Total**			78.7%	75.0%	73.5%	84.9%	79.2%

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

Narrative

Overall performance (78.7%) remains stable having been 75-80% for 10 months, following previous reductions from August 2021 when performance was in excess of 89% and increasing monthly. The overall position remains common cause variation.

CMHTs are within 1.5% of the target in August, however CMHSOPs remain a distance from target. This is in part a result of the increased referrals received in the latter half of 2021 as well as issues of capacity not matching demand.

The table below highlights two CMHSOPs (Canterbury and Shepway) showing special cause variation as well as DGS CMHSOP who were able to achieve 89.2% and continue to be subject to special cause variation of an improving nature.

This metric continues to include MAS patients. The stage of implementation of EMAIS varies across teams due to differing caseload and waiting list sizes. In teams that are further forward in rolling out EMAIS, this is reflected in the current 18 week wait performance.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			93.2%	95.0%	71.3%	106.8%	89.0%
2	Canterbury CMHSOP			63.2%	95.0%	52.3%	88.3%	70.3%
3	DGS CMHSOP			89.6%	95.0%	62.9%	101.7%	82.3%
4	Dover & Deal CMHSOP			82.4%	95.0%	46.2%	98.2%	72.2%
5	Maidstone CMHSOP			65.6%	95.0%	34.9%	87.9%	61.4%
6	Medway CMHSOP			67.2%	95.0%	50.3%	93.2%	71.8%
7	Sevenoaks CMHSOP			36.0%	95.0%	35.9%	85.2%	60.6%
8	Shepway CMHSOP			43.1%	95.0%	63.2%	102.4%	82.8%
9	Swale CMHSOP			85.5%	95.0%	62.6%	106.4%	84.5%
10	Thanet CMHSOP			60.0%	95.0%	49.2%	95.1%	72.2%
11	Tunbridge Wells CMHSOP			37.5%	95.0%	20.8%	81.5%	51.1%
12	**CMHSOP Total**			68.2%	95.0%	62.8%	82.1%	72.4%

IQPR Dashboard: Responsive

Ref	Measure	SoF	Exclude from Public IQPR	Target	Local / National Target	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓		60%	N	85.2%	82.8%	75.0%	89.5%	81.3%	86.4%	75.0%	76.5%	77.4%	75.0%	45.8%	69.6%
007.R	DNAs - 1st Appointments			-	-	11.5%	11.2%	10.3%	9.6%	10.0%	10.7%	10.7%	11.0%	12.4%	11.4%	13.4%	13.4%
008.R	DNAs - Follow Up Appointments			-	-	8.7%	8.5%	8.4%	7.8%	8.5%	7.8%	7.9%	8.4%	8.3%	8.4%	9.1%	8.2%
009.R	Patient cancellations- 1st Appointments			-	-	2.5%	1.9%	2.1%	2.7%	2.2%	1.9%	2.7%	2.3%	2.3%	2.5%	2.5%	2.1%
010.R	Patient cancellations- Follow Up Appointments			-	-	4.5%	4.5%	4.9%	5.0%	4.7%	4.9%	5.2%	5.4%	5.4%	5.2%	5.6%	5.1%
011.R	Trust cancellations- 1st Appointments			-	-	4.6%	4.9%	5.2%	5.4%	4.0%	3.9%	4.5%	4.9%	5.0%	4.2%	4.6%	4.0%
012.R	Trust cancellations- Follow Up Appointments			-	-	10.2%	10.4%	10.0%	10.8%	10.4%	11.4%	12.0%	11.6%	9.9%	11.4%	11.1%	10.4%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)			75%	-	60.8%	68.9%	70.0%	68.1%	57.2%	70.8%	68.3%	67.0%	63.8%	67.2%	71.4%	81.6%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)			75%	-	35.5%	49.4%	54.3%	58.0%	53.1%	59.9%	55.6%	58.2%	61.1%	52.6%	59.0%	61.5%
017.R	Care spell start to Treatment within 18 weeks			95%	-	83.3%	83.5%	83.4%	80.2%	76.8%	81.7%	78.3%	77.5%	76.1%	76.5%	78.2%	78.7%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)			-	-	36.7%	34.4%	31.4%	39.1%	37.2%	30.3%	32.2%	36.5%	26.5%	26.1%	22.7%	24.1%
019.R	Urgent referrals seen within 72 Hours			95%	-	59.8%	60.4%	61.3%	65.1%	62.3%	60.2%	58.4%	62.6%	63.4%	61.5%	62.8%	65.1%

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

Appendix A: Single Oversight Framework

Overview

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

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

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

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

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

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

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Jul-22	Aug-22	Trend (Last 12 months where available, left to right)
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	97.0%	98.4%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		85.1%	85.3%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		117	176	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	45.8%	69.6%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.6%	95.5%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	4.2%	4.8%	
002.C	Mental Health Scores From Friends And Family Test – % Positive		83.8%	86.6%	

**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*

Appendix B: IQPR Overview and Guides

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

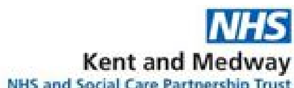
Good examples of IQPRs from high performing organisations change and improve over time. KMPT’s is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the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

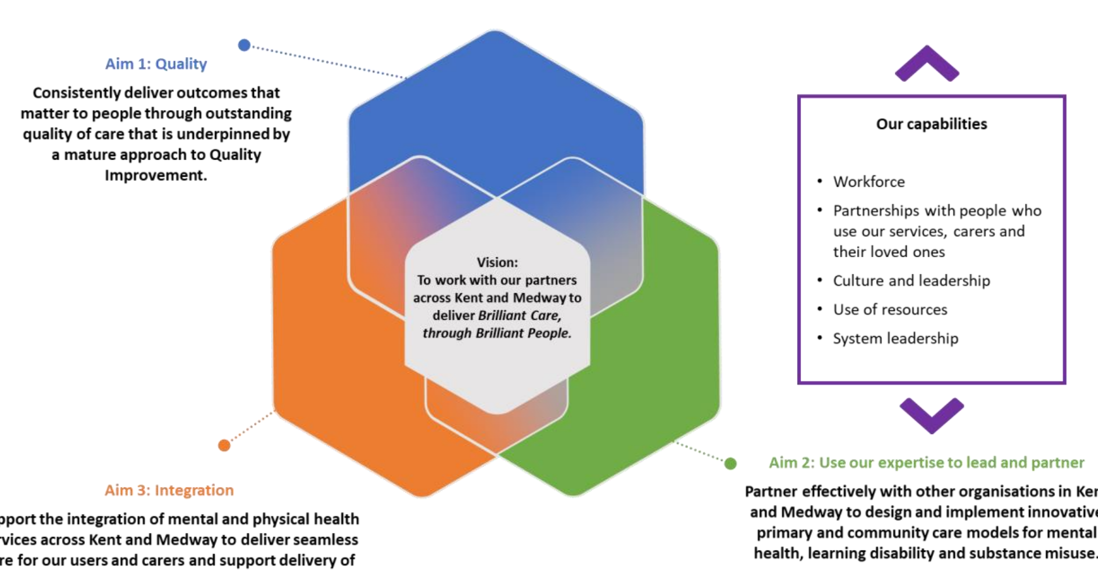
The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally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

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

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

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

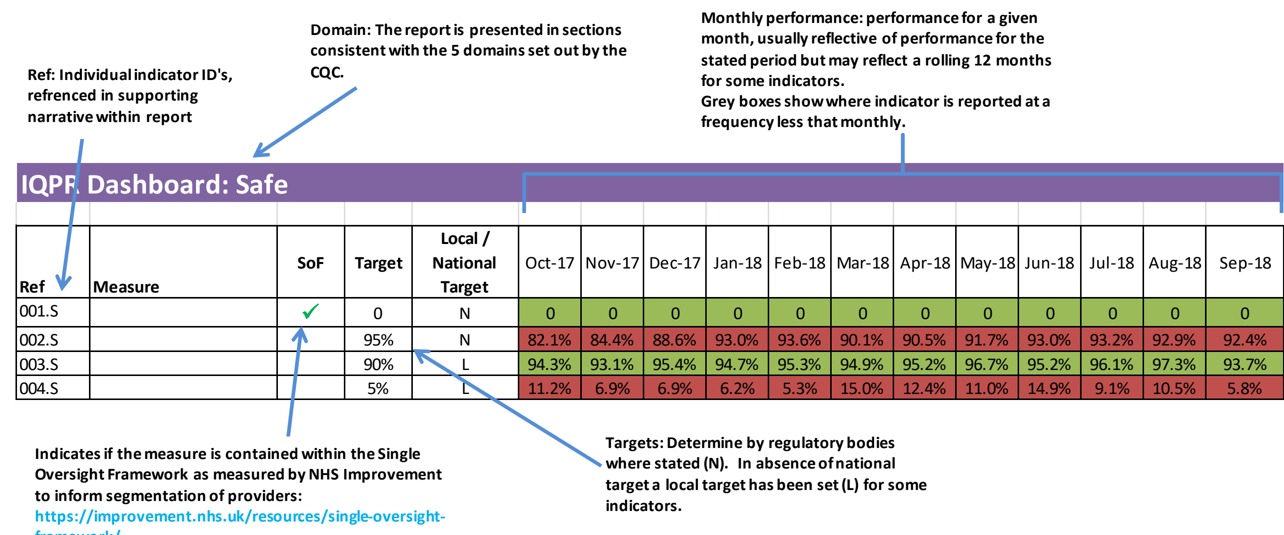

NHS
Kent and Medway
NHS and Social Care Partnership Trust


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

IQPR Dashboard Guide

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

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



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

IQPR Exception Reporting

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

SPC Key:

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

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

IQPR Change Tracker

Date	Change	Report Reference
April 2022	Removals: • 003.S % Inpatients With A Physical Health Check Within 72 Hours • 007.S % Serious Incidents Declared To STEIS within 48 hours • 008.S Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days • 010.S All Deaths Reported On Datix And Suspected Suicide • 015.S Ligature Incidents - Ligature With Fixed Points (moderate to severe harm) • 016.S Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm) • 018.Sa Infection Control - MRSA bacteraemia • 018.Sb Infection Control - Clostridium difficile • 011.E Number Of Home Treatment Episodes • 005.R % of Liaison (urgent) referrals seen within 1 hour • 006.R % of Liaison (urgent) referrals seen within 2 hours • 013.R. 014.R, 015.R Referral counts *All removals are subject to appropriate internal governance despite no longer being reported in the IQPR with routes of escalation if required.* Amendments and Additions: • 019.S. Safer staffing fill rates – moved to workforce section with new reference • Acute bed occupancy introduced • Amendments to inclusions for 4 week wait and additional 6 week wait metric for Dementia waits introduced	023.W-W 018.E 016.R (a,b)
September 2022	Removals: • 006.S Serious Incidents Declared To STEIS • 012.S Restrictive Practice - No. Of Prone Incidents • 013.S Restrictive Practice - No. Of Seclusions • 017.S RIDDOR Incidents • 003.C Complaints - actuals • 004.C Complaints - per 10,000 contacts • 010.C PALS acknowledged within 3 days (or agreed timeframe) • 011.C PALS responded to within 25 days (or agreed timeframe) • 012.C PALS - actuals Target Changes: • 012.E Average Length of Stay (Younger Adults) • 013a.E Average Length of Stay (Older Adults - Acute) • 017.E %Patients with Non-CPA Care Plans or Personal Support Plans • 016a.R Care spell start to Assessment within 4 weeks (Excl. MAS) • 016b.R Care spell start to Assessment within 6 weeks (MAS only)	

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

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29 September 2022
Title of Paper:	Finance Report for month 5 (August 2022)
Author:	Nicola George, Associate 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 5 (August 2022). This is consistent with the position submitted to NHS Improvement in the Month 5 Financial Performance Return.

This is consistent with the position submitted to NHS Improvement in the Month 5 Financial Performance Return.

Items of focus

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

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

1. Focus remains on minimising agency spend. It has been confirmed that Agency caps will be reintroduced this financial year so the Trust's agency spend will be under external scrutiny as per the pre-Covid regime. Executive led meetings are in place to target agency spend, with particular focus on areas with high levels of spend.

2. Focus needs to continue on ensuring the progress on the sustainability programme continues. Progress has been made but it is vital that any gaps and delays in planned savings plans are mitigated. This is in line with the Trust objective to eradicate the Financial deficit by March 2023.

3. Capital spend remains under plan, with a year to date underspend of £2.8m. The detailed forecast for the year is being developed with Estates and IT and will be shared in month 6.

4. The cash position remains strong at £25.6m at the end of August 22.

Governance

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

Finance Report

Trust Board

August 2022

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Executive Summary

Key Messages for August 2022

The Trust has reported a break even position for the period ending 31 August 2022. This is in line with the annual plan submission and expectation in the Kent and Medway ICS.

The KMPT contract with the ICB has now been signed which fully reflects the level of ICB income detailed in the annual plan.

The annual pay award has now been confirmed nationally and payment to employees will be transacted in September. As per national guidance the pay award and subsequent contractual uplift has not been included with the month 5 financial position.

The annual pay award has now been confirmed nationally and payment to employees will be transacted in September. The impact of the pay award is being calculated and discussions will be held with commissioners to ensure that the Trust is fully reimbursed for these costs.

A submission has been made for £4.2m funding in relation to developing Electronic Patient Records (£3.7m capital), £0.4m of this relates to the current financial year with a further £0.95m per year for the next 4 years. We are awaiting confirmation as to whether the bid has been successful.

At a Glance - Year to Date

Income and Expenditure	Green
Efficiency Programme	Amber
Agency Spend	Green
Capital Programme	Red
Cash	Green

Key

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

Income and Expenditure

KMPT is continuing to use temporary staffing due to vacancies and staff absence and agency spend remains below plan. Agency spend remains below the level seen in 2021/22, with a £0.25m reduction in the year to date position compared to Month 5 last year.
Agency caps are being reintroduced so this position will attract an increase in external scrutiny over the coming months. Executive led meetings are in place to review agency spend.

In other expenditure areas, month 5 saw an increase in the run rate in external placement with 285 bed days being utilised in month, an average of 9 bed days through the month, an increase on July usage which saw an average of 7 beds days being used. All of which younger adult PICU beds.

Building Maintenance spend remained stable when compared to previous month but spend still remains high compared to the average run rate in previous years.

	Year to date		
	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(96,789)	(95,934)	855
Employee Expenses	75,427	72,760	(2,667)
Operating Expenses	18,950	20,825	1,874
Operating (Surplus) / Deficit	**(2,412)**	**(2,350)**	**63**
Finance Costs	2,412	2,350	(63)
(Surplus) / Deficit	**0**	**(0)**	**(0)**

Capital Programme

In August, the Trust spent £0.7m against the plan of £1.7m. The year to date position is underspent by £2.8m.

The underspend relates to the delayed start and completion dates for Estates schemes, £1.5m, delays in recruitment to new digital staffing posts, £0.4m, and slippage in the Improving Mental Health Services Programme due to issues found during groundworks, £0.9m.

A design team has been commissioned by the Estates team to support developing the scope of the schemes and the tender documents.

The detailed forecast for the year is being developed with involvement from Estates and IT and will be shared in month 6.

Cash

The cash position remains strong with a slight decrease of £0.1m in month to £25.6m. The actual cash position is £5.3m higher than the original plan, the main factor is lower payments for both trade and capital creditors, £6.7m. This has been partially offset by £1.3m lower receipts with delays in billing Transforming care invoices and some smaller SLAs and lower PDC funding as a result of slippage in the Improving Mental Health Services Programme.

The year-end forecast remains at £13.1m, cash payments for capital will be reprofiled in month 6 following an update of the phasing for the capital forecast.

Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to date		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Income	(19,359)	(19,188)	171	(96,789)	(95,934)	855
Employee Expenses	15,120	14,602	(519)	75,427	72,760	(2,667)
Operating Expenses	3,756	4,122	366	18,950	20,825	1,874
Operating (Surplus) / Deficit	**(483)**	**(465)**	**18**	**(2,412)**	**(2,350)**	**63**
Finance Costs	483	465	(18)	2,412	2,350	(63)
(Surplus) / Deficit	**0**	**(0)**	**(0)**	**0**	**(0)**	**(0)**

Commentary

Pay is underspent at the end of August by £2.7m. Within this, substantive pay is £3.7m underspent against plan, partly offset by bank and agency spend. This is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives. For these areas, corresponding income has also been deferred to match and performance is being closely monitored between the Trust and ICS colleagues.

Other non pay includes a high level of spend on external placements when compared to run rates in 21/22. August continued the trend with higher levels of spend being reported. 285 bed days representing an average of 9 PICU patients were in external beds.
The run rate has increased from that seen earlier in the calendar year due to a patient being admitted to PICU with complex care requirements. This patient has now been discharged and all costs in this regard are being recharge to Kent and Medway ICB.

Long Term Sustainability Programme (Efficiency Programme)

Pillar	Annual Plan £000	Current Month Plan £000	Current Month Actual £000	Current Month Variance £000	Year to Date Plan £000	Year to Date Actual £000	Year to Date Variance £000
Back Office	(816)	(54)	(114)	(60)	(191)	(343)	(152)
Workforce	(938)	(57)	(5)	52	(180)	(40)	140
Service Line Reporting	(2,905)	(190)	54	244	(670)	(365)	306
Patient Pathways	(905)	(61)	(47)	13	(217)	(385)	(168)
Procurement and Purchasing	(300)	(23)	0	23	(90)	0	90
Commercial Development	(1,130)	(94)	(240)	(146)	(426)	(1,200)	(774)
Non-recurrent slippage	0	0	0	0	0	0	0
Total	**(6,995)**	**(478)**	**(352)**	**126**	**(1,775)**	**(2,332)**	**(557)**

Commentary

The Long Term Sustainability Programme (CIPs) for 22/23 continues to make progress with a focus on the identified plans delivering as per plan.

Further work has continued in order to identify further CIP schemes in order to close the gap and achieve the annual target and support the eradication of the underlying deficit by March 2023.
Agency spend is being monitored throughout the financial year and Agency caps are returning across the system to be monitored against.

Focussed agency meetings with Executive leads will commence with all areas to ensure that spend is closely and regularly monitored.

Exception Report

Top Variances	Year to date Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last report
Agency	3,035	2,951	(84)	(3%)	(2%)
Bank	6,803	7,888	1,085	16%	13%
External Placements	1,594	1,979	385	24%	27%

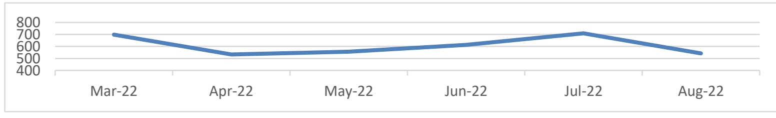
1. Temporary Staffing Spend: Agency (£84k)

Agency spend remains below plan in month 5. There was a decrease in month compared to trend predominantly due to spend being aligned to Capital projects. Agency spend within Care Groups was stable with no material movement.

There will be continued focus and scrutiny on all agency spend as the new financial year progresses to ensure spend remains within budget. Agency caps have been reintroduced for the Kent and Medway system and are currently being worked through therefore it is vital to have clear plans in place to enable the reduction in spend. Further national initiatives are expected.

ANNUAL	2018/19	2019/20	2020/21	2021/22	2022/23
Agency	6,459	6,395	8,740	7,537	2,951

MONTHLY TREND



2. Temporary Staffing Spend: Bank £1.085m

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

There has been an increase in the run rate in month 5 seen mostly within Nursing and Health Care Assistants. The increase will be predominantly due to covering vacancies and higher sickness across the Trust as well as annual leave cover being higher during the summer months.

The Acute and Forensic Care Groups have been required to use higher levels of bank due to the clinical requirements and the high level of observations of a specialist patients These additional costs are being recharged to NHS England and the Integrated Care Board.

MONTHLY TREND	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Nursing	643	577	595	625	591	617
Healthcare Assistants	733	984	814	757	835	933
Other	- 12	144	123	150	145	140
Total	**1,364**	**1,705**	**1,532**	**1,532**	**1,571**	**1,691**

3. External placements £385k

As at month 5 the year to date spend remains high. The average number of patients in August increased to 9.
The run rate has increased from that seen earlier in the calendar year due to a patient being admitted to PICU with complex care requirements.
This will cease in September now the patient has been discharged. All costs in this regard are being recharged to Kent and Medway ICB.

The external placement utilisation will continue to be closely monitored particular as we approach autumn and winter.

Structural Deficit

Current Annual Underlying Deficit £6.4m

Key Drivers

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

Key Actions currently being implemented

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

Psychology review*	£0.4m
Agency controls	£0.6m
Bridge House price increases	£0.3m
Forensic service establishment review	£0.7m
MHOST (Mental Health Optimal Staffing Tool) and ward establishment reviews	£0.3m
Brookfield price increase	£0.1m
FOLS contracted prices	£0.25m
Total	**£2.65m**

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

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

72 %

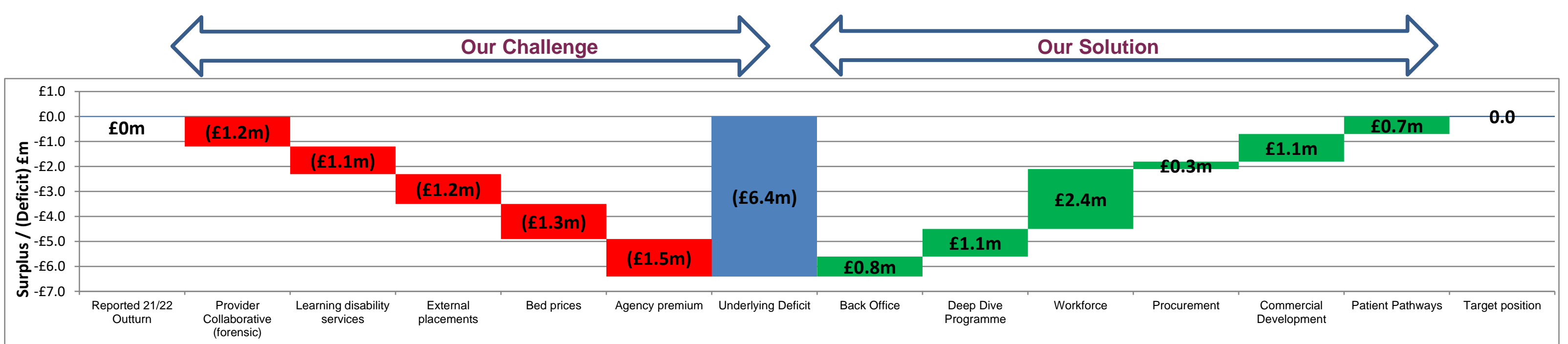
27 %

Residual Annual Underlying Deficit £4.0m

Target position for 31st March 2023 £0m

Remaining Gap £3.75m

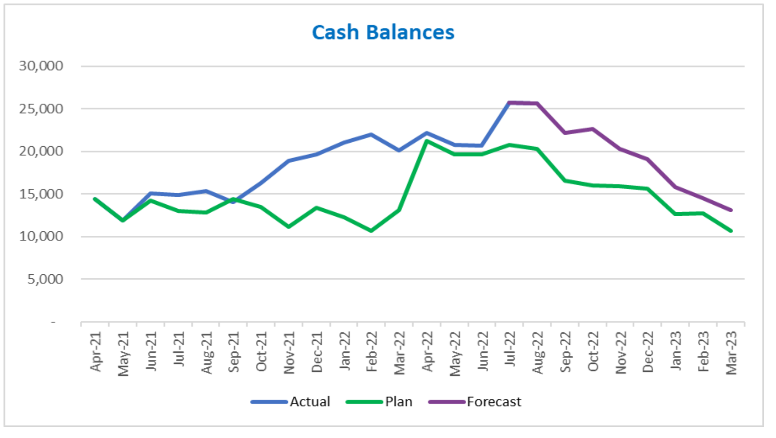
Bridging the Gap



Appendices

Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2022 *Actual* £000	Prior Month 31st July 2022 *Actual* £000	Current Month 31st August 2022 *Actual* £000
Non-current assets	139,701	157,187	157,314
Current assets	26,599	34,427	32,868
Current liabilities	(25,907)	(35,053)	(33,299)
Non current liabilities	(17,502)	(32,962)	(32,957)
Net Assets Employed	**122,891**	**123,599**	**123,926**
Total Taxpayers Equity	**122,891**	**123,599**	**123,926**



Commentary

Non-current assets

There has been a marginal movement in the value of Property, Plant and Equipment as the additions are largely offset by depreciation.

Current Assets

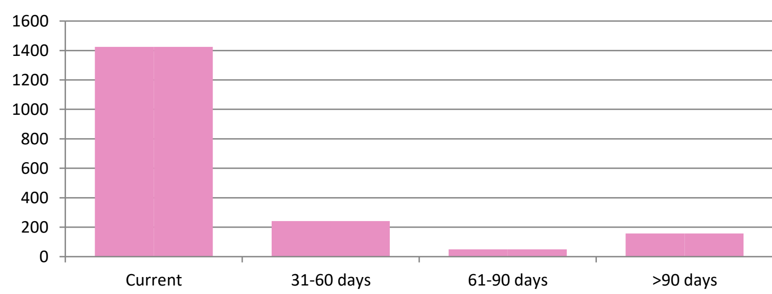
The cash position remains strong at £25.6m. Receivables have decreased by £1.4m mainly due to a reduction in NHS receivables of £0.8m. This is as a result of the Transforming Care invoice to the ICB, that was incorrectly raised for the full year, being credited and replaced with an invoice for Q1 and 2.

Current Liabilities

Trade and other payables have decreased by £1.7m. There was a £1m reduction in deferred income, £0.8m of this relates to the release of deferred income for the Transforming Care invoice discussed above (that had previously been billed for the full year). Trade creditors reduced by £1.2m, largely due to clearance of invoices from NHS Professionals. The decrease has been partially offset by increase in capital creditors of £0.3m and monthly PDC accrual of £0.3m.

Aged Debt

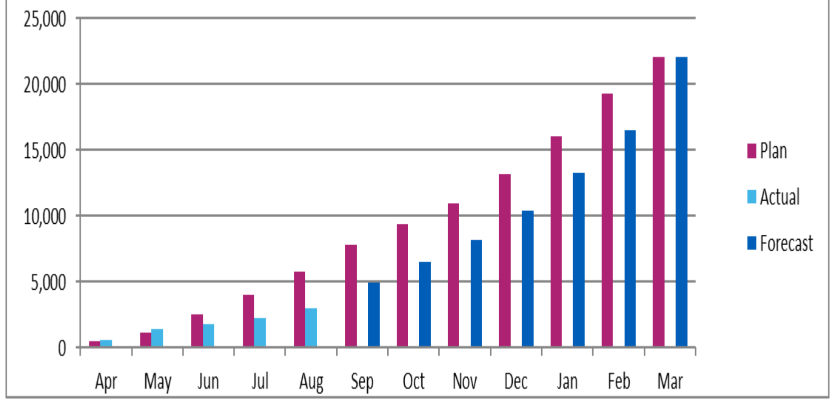
Our total invoiced debt is £1.9m, of which £1.4m is within 30 days. Debt over 90 days stands at £0.2m.



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	220	(22)	(242)	753	388	(365)	2,350
Capital Maintenance & Minor Schemes 2022/23	393	149	(244)	370	149	(222)	3,742
Capital Maintenance & Minor Schemes from 2021/22	606	383	(223)	2,521	1,213	(1,308)	3,412
Capital Maintenance & Minor Schemes Prior Year Adj	0	0	0	0	0	0	0
Strategic Schemes - Ward Refurbishment	0	7	7	0	7	7	2,000
Improving Mental Health Services (Maidstone)	555	222	(333)	2,108	1,202	(906)	10,545
PFI 2021/22	3	3	0	15	17	2	41
Total Capital Expenditure	**1,777**	**741**	**(1,036)**	**5,768**	**2,976**	**(2,792)**	**22,090**

Cumulative Performance against Plan



Commentary

In August, the Trust spent £0.7m against the plan of £1.7m. The year to date position is underspent by £2.8m.

Much of the underspend relates to the delayed start and completion dates for the following schemes - Fern Ward refurbishment £0.7m, TGU Sink Holes £0.25m, and Emmetts/Walmer Heating £0.1m. New year estates schemes such as legionella works, BMS upgrades and fire alarm panels have not yet been out to tender and works have not commenced.

The underspend on IT schemes is as a result of delays in recruitment to new digital staffing posts.

There has also been slippage in the Improving Mental Health Services Programme due to issues found during groundworks causing an underspend of £0.9m .

A design team has been commissioned by the Estates team to support developing the scope of the schemes and the tender documents.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29 September 2022
Title of Paper:	Leadership Development
Author:	Natalie Adams, Organisational Development Specialist
Executive Director:	Sandra Goatley, Director of Workforce and Organisational Development

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

The paper gives an overview of the current Leadership and Management development offer at KMPT, including plans for the future.

Issues to bring to the Board’s attention

Our support for managers and leaders during COVID019 was recognised by the South East Leadership Academy as an example of best practice, where we were invited to share our tools with others at a series of workshops.

The NHS Staff Survey shows our results relating to management performance are the highest in our comparator group of 51 trusts with a score of 7.5.

We are currently working with partners in Communications, Learning and Development, the wider organisation and partners such as the Integrated Care Board and Kent Community Healthcare Foundation Trust (KCHFT) to further improve and promote access to our offer and continue to evolve it to meet ‘on demand’ needs and developing themes such as debiasing recruitment and leading transformation.

We have a number of new developments in the pipeline for the coming 2 years. Whilst current programmes and opportunities focus on building leadership and management capability, the ambitious offer over coming years capitalises on those strengths and focuses on identifying and mobilising talented managers to tackle KMPT’s greatest cultural, operational, clinical and transformational challenges.

Governance

Implications/Impact:	Risk ID 6848 – Turnover Risk ID 6849 - Retention

Version Control: 01

Assurance: reasonable

Oversight: Workforce and Organisational Development Committee, KMPT Learning and Development Group

Version Control: 01

1. Background and Context

Recruitment and retention of our people is the biggest challenge facing NHS trusts in the current climate. Having strong, capable current and future leaders and robust leadership development is a key driver of organisational performance and a vital part of delivering our recruitment and retention plan.

There is a wide range of management and leadership development offered to staff both via the in house Organisational Development (OD) Team and externally through the NHS Leadership Academy. Some of this is offered as structured programmes and some is via ad hoc or needs based development throughout the year. Not all of this learning is formal and as an organisation we support people to gain learning in many ways through shadowing, reflective space, project work, coaching and mentoring and action learning.

Within the KMPT OD team there are 2 dedicated Management and Leadership development designers and facilitators (1 permanent and 1 part time fixed term contract) that work with the wider OD team, HR Business Partners and the Learning and Development team to understand the needs of managers and leaders across KMPT and ensure there is a provision to develop the capabilities needed both now and in the future. Our design process is based on OD and Learning theory and uses co production design and iterative development cycles to ensure quality of service.

From August 2020 to August 2021 685 places were taken up by managers and leaders on our inhouse workshops and programmes and 106 sessions delivered in total by KMPT facilitators, both in the OD team for core programmes such as Leading The Way and in the wider Workforce and OD team on technical subjects such as HR Essentials.

We also started to transfer all of our programmes to online delivery. This came with some challenges due to limited capacity within the current Learning Management System and an inability to offer a fit for purpose workshop style space via Lifesize. We have worked with the IT team and now have access to facilitate via Microsoft Teams to enable a more interactive learning environment without capacity restrictions, however as this is not widely used by KMPT staff it has meant needing to offer additional support to ensure people can take part.

Over the last 2 years we have also moved to structuring our core offer in line with the KMPT Values and Cultural Heart. We identified 3 key areas of capability that underpin all our management and leadership programmes:

- Leading with Care- Developing self-awareness to promote positive behaviour and interactions
- Leading the Team- Developing effective working relationships and strong team dynamics
- Leading the Service- Developing the knowledge & skills to provide an excellent service

The NHS Leadership Academy has undertaken a similar exercise and though the above are unique to KMPT there is clear alignment with the model they are also developing to align with the NHS People Promise. They continue to develop their own offer nationally and regionally and

whilst there is often a lot available this is sometimes communicated sporadically or last minute and therefore isn't easily accessible for our leaders to attend.

To further explore partnership working the OD Specialist has begun regular meetings with the Deputy Director of People and OD at KCHFT to identify opportunities for closer working, we are currently exploring the possibility of a joint local cohort of the Mary Seacole programme to support those in a Band 7 management role to build on their leadership skills.

2. **Current KMPT Leadership Development Offer** (see Appendix 1 - Your KMPT Development Journey for a visual representation of the offer)

   The current offer is divided into 3 areas of experience:

   - New to KMPT or Team Leader/New Manager (recommend to all)
   - Developing Leader
   - Accomplished Leader

Mapped to each of these stages there are a range of behavioural and/or technical development programmes or workshops and supplementary offers and external offers (viewable with the attached Appendix 1 slides 7-10). Some of these are recommended for every manager to complete and some are suggestions for discussion when managers are planning their own development objectives through discussions with their line manager.

In addition to this we work closely with the Learning and Development team and the KMPT Training Panel to ensure appropriate governance around the equity of access, funding and suitably of programmes for individuals. Ensuring people have attended what is relevant to meet their needs internally before funding additional development. Types of development available to all Managers and Leaders include:

- Core Management and Leadership Development Programmes (Management pathway, Leading the Way, new Aspire programme for Aspirant Senior Clinical Leaders and Coach 2 Lead)

- Apprenticeships-Chartered Management Degree and Senior Leaders Masters delivered through University partners including the University of Kent and Henley Business School.

- NHS Leadership Academy Programmes – such as Mary Seacole, Elisabeth Garret Anderson and Nye Bevan (currently via Training Panel request)

- Coaching and Mentoring- internally, via the South East Region and NHS Leadership Academy) and through our trained Insights Discovery practitioners.

- Experience of working with Boards, shadowing opportunities for Senior Leaders in preparing, contributing and presenting at Board level.

- Kent and Medway System Development- Currently paused by previous opportunities such as Leading Across Kent & Medway, we hope this will resume with the ICB in place

- Short workshops on key topics-Hybrid working, Recruitment & HR skills, Wellbeing, NHS Leadership Espresso topics

- Supporting Performance and Talent Development- a range of tools and development opportunities to support performance and career conversations and planning

- Cultural Team Development- Workshops designed to support team health delivered by the OD team

Feedback is gathered as part of every session and programme and regular evaluation reviews and redesigns of workshops and programmes are undertaken within the team. OD Facilitators and HR Business Partners work with local leaders to gain insight into how those that have undertaken a development programme are applying learning on the job. Further development to the Performance and Talent side of our Learning Management System would enable us to better track internal promotion following programme completion and this is something we would hope to see in a future rebuild, along with greater usability to identify and build Talent Pools of future managers and leaders within the system.

Another indicator of performance of our development offer comes from the NHS Staff Survey where in the theme of ‘we are always learning’ KMPT scores above our average comparator group at 5.9 and in the questions related to our Managers we are top of our comparator group of 51 trusts with a score of 7.5.

3. Future Plans

Detailed below are the current initiatives that are being scoped or designed to further enhance the offer for Managers and Leaders, drawn from our feedback and Learning Needs Analysis. We have seen a number of themes come out strongly across KMPT such as Band 7 leadership capability, positive cultural leadership behaviours at all levels and further development required around career development. The below have been prioritised in line with the current team capacity :

- Coaching and Mentoring Strategy- Development of a new strategy giving greater access to learning skills to Coach and Mentor and taking part in Coaching and Mentoring at KMPT. Due to be finalised in early 2023

- Management and Leadership Pathway- Completion of a review of how the current pathway is delivered, converting some elements to mandatory training for all managers and delivering more digital and ‘on demand’ options. Due this Autumn with a piloting of ‘on demand’ learning on key topics via inhouse videos and the Leadership Learning Zone Library (a new portal designed for NHS Leaders and Managers)

- Local cohort of Mary Seacole programme- Working with Nursing, Quality and HR Business Partners we have identified a need for some specific development of core management capability for Band 7 leaders in Clinical Services. We are currently working

to see if a local cohort of this 6 month programme would meet these needs and if we would be able to deliver jointly with KCHFT, if so we aim to begin delivery in January.

- When the new Equality, Diversity and Inclusion team are in place a more ambitious plan for tackling the factors in our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reporting about stepping into leadership, including the possibility of working with the NHS Leadership Academy to adapt the existing Edward Jenner Programme with additional learning opportunities exploring some of the challenges faced.

- Cultural Development-Teams & Leadership- As part of our culture change programme we have identified key capabilities such as building psychological safety and leading change and transformation that may need extra focus outside of our core programmes. The wider OD team is developing an innovative team health toolkit for managers to use with their teams and will run a short programme for all Senior Leaders so they are able to role model the behaviours effectively. (Due to the planned large scale change to the proposed Place model we believe this is a key time to deliver this as an integral part of the change programme.) Some targeted test cases will also be delivered for teams facing specific challenges.

- Talent and Career Development- We are working with Communications to design an easy to access Careers Hub on iconnect, included in this will be clear information about management and leadership programmes and workshops and how to access as well as the different professional fields.

- Using our Leadership Talent conversation data to build internal talent pools for ‘ready now’ and ‘ready later’ development opportunities such as shadowing, mentoring and experiential learning events, ensuring a stronger and more diverse talent pipeline into key senior leadership and Board level roles.

- Debiasing Recruitment Training for Managers-We are currently involved in the design of a funded system project pilot to deliver training for managers on debiasing all aspects of the recruitment cycle, due to begin delivery in the Autumn as part of the ICB Equality and Diversity plan.

- Using middle management forums to facilitate reflective leadership practice and enhance peer learning and support.

- More detailed annual review of equity of access to external funded programmes and career development leading to promotion from our WRES and WDES indicator reporting.

4. Conclusion

Ensuring that KMPT is able to identify, develop and retain motivated and capable staff is the greatest challenge that KMPT faces, and delivering high quality development is key to achieving that. Current and aspiring managers and leaders at KMPT have available to them a wide range of programmes and development opportunities, and their positive impact is evidenced through the high ratings our managers

receive through the National Staff Survey. Over the coming months and years, we will continue to build on the strength of our existing programmes through testing some innovative approaches, and mobilising our talented managers to successfully take on KMPT's most ambitious challenges.

Your KMPT Development Journey

- This document outlines the development journey from a newly appointed colleague to a senior leader at KMPT

Please note-This is a working document and those interventions in red are currently being in design or review

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Development at KMPT

- In 2019 we asked everyone at KMPT to take part in research to understand what would be the best environment for us all to work and thrive in which led to the creation of our cultural heart
- We all play a part in making this change – what we all do and how we all behave is how we will change our culture at KMPT
- We also have a responsibility to our patients and service users to deliver the best care possible

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Development at KMPT

With this in mind we have created three areas of focus:

Leading with care	Leading the team	Leading the service
Developing self-awareness to promote positive behaviour and interactions	Developing effective working relationships and strong team dynamics	Developing the knowledge & skills to provide an excellent service

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Living our values

These three areas of focus help to us to connect with our KMPT values:

Leading with care

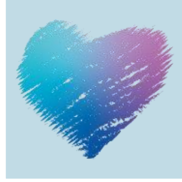
Open
- This means our views and needs matter. They are heard without judgement

Respect
- This means we are kind to one another. We value each person for who they are and what they bring

Leading the team

Working together
- This means we support one another. We come together to work towards shared goals

Accountable
- This means we are responsible professionals. We learn from experiences and focus on solutions



Leading the service

Excellence
- This means our aim is to provide outstanding care. We can all contribute to making a difference

Innovation
- This means we are open to new ideas. We are flexible in our views and action

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The journey at a glance...

New to KMPT

- Alongside your corporate induction and introduction to your new role, the events and activities here will help you to develop the core skills and behaviours that have been identified as fundamental to creating the culture we all want to experience at KMPT.
- These workshops also provide you with an opportunity to connect with colleagues across the organisations to share experiences and learn from each other.

Team Leader/new Manager

- As a new manager your journey starts with the manager induction.
- Exploring & building critical management skills are supported by the variety of behavioural workshops we offer.
- Attending workshops is a great way to connect with your peers and build your network, share your experiences and learn new ways to become more agile in the way you manage and lead.
- You may also want to become a coach or find a mentor – we can help with this.

Developing Leader

- As a developing manager you may be taking on increasing responsibility, looking for your next career step or aiming to be an expert in your role.
- Attending the available behavioural and technical sessions is invaluable as you are more aware of how you operate, where you get stuck and what you want to improve or achieve.
- You may decide to become a coach or mentor for KMPT – we can support you to hone your skills and build confidence.

Accomplished Leader

- Are you looking to take on a senior role and expand your leadership?
- The development programmes we offer will support you with that journey by providing bespoke development sessions, peer mentoring and leadership development and insights.
- To take your learning further you may want to explore the range of Apprenticeships we offer at Degree level.

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The internal training offer at a glance…

New to KMPT

Behavioural workshops:
Core offer:
1. Understanding your Personal Impact
2. Communicating Effectively
3. Self-management

Technical workshops:
- Appraisal & Supervision - Your Contribution
- Equality & Diversity
- Quality Improvement

***Each stage builds on the offer in the preceding stage. Courses at this stage are relevant to all KMPT colleagues**

Team Leader/new Manager

Additional behavioural workshops:
- Manager Induction
- The KMPT Leader
- Leading Change

Additional technical workshops:
- Appraisal & Supervision – a quality conversation
- Conversations about Potential (Talent)
- HR Essentials
- Disciplinary & Investigations
- Grievance & Dignity at Work
- Performance Management
- Recruitment & selection

Developing Leader

Additional behavioural workshops:
- Coach to Lead
- Leading the Way programme

Additional technical workshops:
Finance for Clinicians & Managers

Accomplished Leader

Additional behavioural workshops:
- Aspire programme (future Senior Clinical Leaders)
- Leading across Kent & Medway programme

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New To KMPT

NHS
Kent and Medway
NHS and Social Care Partnership Trust

These opportunities are open to all colleagues at KMPT, irrespective of role or banding. They form our 'core' offer

Behavioural Workshops

- Understanding your Personal Impact
- Communicating Effectively
- Self-management

Other internal development opportunities

- Coaching
- Mentoring
- Insights Discovery Psychometric Profile – individual preferences
- Working with days
- Secondments
- Project groups
- Working groups

Technical Workshops

- Appraisal & Supervision - Your Contribution
- Equality & Diversity
- Quality Improvement

Apprenticeships

- Role specific opportunities

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Team Leader/new Manager

These opportunities are suitable for those working towards a management or leadership position or those new to the role

Behavioural Workshops

- Manager Induction
- Understanding your Personal Impact
- Communicating Effectively
- Self-management
- The KMPT Leader
- Leading Change

Other internal development opportunities

- Coaching
- Mentoring
- Insights Discovery Psychometric Profile – leadership style
- Action Learning Sets
- Working with days
- Secondments
- Project groups
- Working groups

Technical Workshops

- Appraisal & Supervision
- Conversations about Potential (Talent)
- HR Essentials
- Disciplinary & Investigations
- Grievance & Dignity at Work
- Performance Management
- Recruitment & selection
- Equality & Diversity
- Quality Improvement

Apprenticeships & NHS Leadership Academy Programmes

- Team-Leader (Level 3)
- Edward Jenner – Foundation Skills
- Stepping Up – leadership development for BAME staff, band 5-7

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Developing Leader

NHS
Kent and Medway
NHS and Social Care Partnership Trust

These opportunities are suitable for those working towards or operating in a more strategic leadership role

Behavioural Workshops

- Manager Induction
- Understanding your Personal Impact
- Communicating Effectively
- Self-management
- The KMPT Leader
- Coach to Lead
- Leading Change
- Leading the Way programme

Other internal development opportunities

- Coaching
- Mentoring
- Insights Discovery Psychometric Profile – leadership style
- Action Learning Sets
- Working with days
- Secondments
- Project & Working groups

Technical Workshops

- Appraisal & Supervision
- Conversations about Potential (Talent)
- HR Essentials
- Disciplinary Investigations
- Grievance & Dignity at Work
- Performance Management
- Finance for Clinicians & Managers
- Recruitment & selection
- Equality & Diversity
- Quality Improvement

Apprenticeships & NHS Leadership Academy Programmes

- Operational/Department Manager (Level 5)
- Coaching (Level 5)
- Mary Seacole – first time leaders
- Rosalind Franklin – middle leaders
- Stepping Up – Leadership development for BAME staff, band 5-7

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Accomplished Leader

NHS
Kent and Medway
NHS and Social Care Partnership Trust

These opportunities are suitable for those working towards or operating in a senior role within KMPT & across the system

Behavioural Workshops

- Leading the Way programme
- Coach to Lead
- Aspire programme (future Senior Clinical Leaders)
- Leading across Kent & Medway

Other internal development opportunities

- Coaching
- Mentoring
- Insights Discovery Psychometric Profile – leadership style
- Action Learning Sets
- Working with days
- Secondments
- Project & Working groups

Technical Workshops

- Appraisal & Supervision
- Conversations about Potential (Talent)
- HR Essentials
- Disciplinary & Investigations
- Grievance & Dignity at Work
- Performance Management
- Finance for Clinicians & Managers
- Recruitment & selection
- Equality & Diversity
- Quality Improvement

Apprenticeships & NHS Leadership Academy Programmes

- Chartered Management Degree (level 6)
- Senior Leaders Master Degree (level 7)
- Coaching (level5)
- Elizabeth Garrett Anderson – mid to senior leaders
- Nye Bevan – senior leaders
- Aspiring Chief Executive
- Ready Now – leadership development offer for Senior BAME staff, band 8a+

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 29th September 2022

Title of Paper: Community Mental Health Framework – Quarterly Update

Author: Donna Hayward-Sussex

Executive Director: Donna Hayward-Sussex

Purpose of Paper

Purpose: Discussion

Submission to Board: Board requested

Overview of Paper

This paper outlines the current position on the development and progress regarding new models of care within the Community Mental Health Framework Programme.

Issues to bring to the Board's attention

The maturity of the programme has been evaluated with recommendations outlined to support next steps. These include a need to bring the KMPT transformation projects, which have enablers workstreams running in parallel, alongside the overall programme to support these workstreams to be established as a system.

The scale and complexity of the programme has been underestimated and there is an urgent need for a single comprehensive plan which identifies milestones for delivery.

A revised governance process is required to ensure successful implementation, monitoring and evaluation.

Governance

Implications/Impact: Delays in the delivery of new models of care impacting on patients being able to receive the appropriate level of care at the right time.

Assurance: Reasonable

Oversight: Executive Management Team

Community Mental Health Framework – Quarterly Update (Sept 22)

Background

Community mental health services play a crucial role in the delivery of mental health care having been established as Community Mental Health Teams (CMHTs) for over 30 years. Unlike many service areas the model of care for CMHT's has largely remained unchanged and is now in need of fundamental transformation and modernisation.

This Framework provides a significant opportunity to address the gap in innovation and achieve radical change in the design of community mental health care. Specifically, it provides opportunity for moving away from siloed, hard-to-reach services towards joined up care and whole population approaches. It is specifically recognised that Community Mental Health Teams are central to the delivery of mental health services, but their development has stagnated whilst the creation of specialist teams has led to fragmentation and discontinuity of care.

Discontinuity of care is largely due to over 50% of referrals to Community Mental Health Teams being generated from sources other than primary care, including other community or inpatient teams and social care. When people's care moves between teams, typically over 20% of them do not reach the intended service. Complicated referral and transition processes or a lack of the most appropriate support in one place to address multiple needs is often evidenced. Transitions are a particular issue for young people moving into adult mental health services with a proportion of whom never receive care along with transition challenges for those moving from general adult services to older adult services.

A noteworthy element of the Framework is the emphasis placed on a need to break down the current barriers between mental health and physical health, health and social care, voluntary, community and social enterprise organisations, local communities and both primary and secondary care. Moreover, the Framework locates community mental health services in the centre of the local community with Health Care Partnerships tasked with addressing inequalities at 'place'.

To enable the transition from current state to radical redesign the Framework should be initiated by a group of leaders with a shared vision, who can drive change and establish strong relationships. The leaders should be experienced clinicians, commissioners, practitioners, managers and people who have used and have experience of services, who can work effectively across organisational and professional boundaries.

Sound clinical governance underpinning the Framework is critical to successful implementation with agreed governance structures for effective operation of all services. Systems should be in place to be able to routinely collect outcome data and people's experience of care. Additionally, the Framework requires a contracting model which supports the review of performance at all levels to enable a focus on the quality of community mental health care provision as well as timely access.

Community Transformation - Programme Stocktake

The plans to transform community mental health services across Kent and Medway commenced in early 2021 with the submission of a bid to NHS England for transformation funding. New funding has been identified to support the introduction of a four-week access wait time target and moreover the expectations set out in the NHS Mental Health Implementation Plan 2019/20 – 2023/24, confirms that

from 2021/22 to 2023/24, all Integrated Care Systems ‘will receive a fair share of central/transformation funding to develop and deliver new models of integrated primary and community care. This central/transformation funding will be in addition to the continuous uplifts in all CCGs’ baseline funding for adult and older adult community mental health’.

We have had an independent health advisory organisation recently undertaken a programme stocktake to enable next steps in the delivery of the change. The findings from the stocktake are summarised by four overarching key messages.

- The programme requires a single comprehensive plan with a ‘golden thread’ for all partners and the public.
- The scale and complexity of the programme has been underestimated.
- The Programme Management Office would benefit from additional capacity and capability to undertake the strategic development and programme planning.
- It is time to incorporate the KMPT transformation programme activities within the overall Framework.

Programme Maturity

We have assessed the maturity of the programme against seven domains. The assessment provides an indication of programme strengths and areas for development.

PROCESS LEVEL	FEATURES OF THIS LEVEL
LEVEL 0 PROCESS BLIND	No or little programme control/awareness evident.
LEVEL 1 AWARENESS OF PROCESS	Some recognised processes evident, but these are not standardised across the programme.
LEVEL 2 REPEATABLE PROCESS	Minimum standardised processes applied to the programme, but there is likely to be lack of detail around monitoring and change control.
LEVEL 3 DEFINED PROCESS	Programme change control processes and application is evident at this level.
LEVEL 4 MANAGED PROCESS	Programme process change control process is evident at this level impacting project/programme prioritisation and resources.
LEVEL 5 OPTIMISED PROCESS	Continual review process for both programme performance, and the programme itself, is evident at this level impacting programme prioritisation and resources. Evaluation is a standardised process at this level and informs mid-course correction and processes going forward.

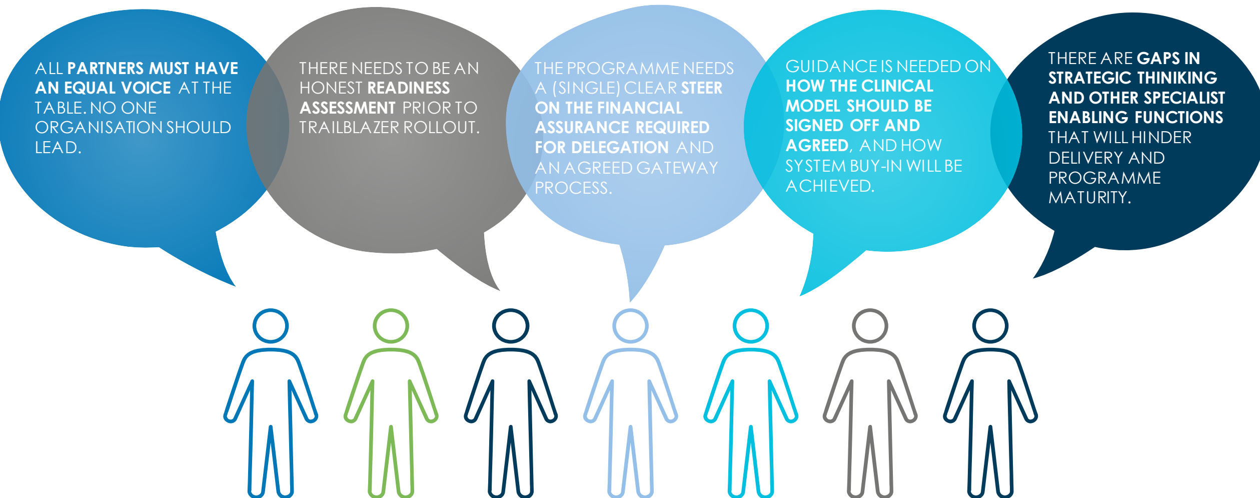
*** Stocktake Tool**

DOMAIN	% DOMAIN MATURITY SCORE	MATURITY LEVEL
PMO Objectives and Resources	70.00%	LEVEL 3 - DEFINED PROCESS
Programme Design and Control	66.67%	LEVEL 2 - REPEATABLE PROCESS
Outcome Management	57.14%	LEVEL 1 - AWARENESS OF PROCESS
Programme Support	70.00%	LEVEL 3 - DEFINED PROCESS
Risk and Issue Management	66.67%	LEVEL 2 - REPEATABLE PROCESS
Reporting and Documentation	62.50%	LEVEL 2 - REPEATABLE PROCESS
Stakeholder Management	75.00%	LEVEL 3 - DEFINED PROCESS
OVERALL PROGRAMME MATURITY	66.25%	LEVEL 2 - REPEATABLE PROCESS

*** Stocktake Analysis**

Thematic analysis

A number of stakeholder interviews were undertaken with the Programme Management Team and wider stakeholders. The intention was to harness opinion on progress of the CMHF programme, key areas for development and key strengths. Five key themes emerged as a result of the stakeholder interviews.



Progress on Delivery

The Community Mental Health Transformation Programme is large in both scope and ambition. At the outset the programme endeavoured to fully deliver the intentions of the Framework having identified it represents a once in a generation opportunity to bring about real change and provide an integrated service offer for community mental health across Kent and Medway.

There has been extensive work to drive forward the change needed as identified in the Framework with engagement across the system highlighted as a strength. Areas for development with the programme are referenced below.

- Leadership of the Programme Management Office has been challenging as Senior Responsible Officers have changed over the last 12 months. With this has come a different view on how to move forward and deliver the programme most effectively. With permanent joint-SROs now in post (KMPT COO and ICB MH Director of System Partnerships) there is an opportunity to reflect and move forwards in a more joined up manner with clear direction.

- It is unclear how the five workstreams aligned to the Kent and Medway CMHF funding bid a) core Community Mental Health Offer b) Community rehabilitation c) Complex emotional difficulties d) 18-25 transition e) Eating Disorders are being managed as an overall strategy. This has the potential to create fragmentation in addition this approach is problematic when aligning transformation funding against the new models of care identified in the bid. Programme controls therefore need to be re-established along with brining these programmes together under one umbrella for change.

- A focus on outcomes and measurables is needed with a monitoring and evaluation framework recently drafted to enable the monitoring of the effectiveness of a trailblazer site. It remains unclear how data to support monitoring will be collected across multiple providers to ensure consistency and full appraisal of the model against outcomes. It is therefore recommended that a digital and reporting workstream is established.

- Baselining cost, activity and workforce is required to deliver the new model which was not undertaken initially within the programme. This is being addressed through the build of a bespoke demand and capacity model for the planned trailblazer site. This model will help to inform costs (and therefore affordability) of implementing the model, but also provide assurance to finance colleagues on delegation of funds so the programme can move to implementation.

- Performance and quality management of the programme needs to be formally established, and the right forum for this needs to be agreed.

- The programme needs more support with the delivery of specific enabling functions which are yet to be established including workforce, business intelligence and digital. These areas require significant focus going forward.

- Change management capability needs to build across teams in each of the partners involved in the transformation and the Programme Management Office itself. At a senior level this is evident, but it is critical that ‘change agents’ are established at all levels in order to promote planned change.

- The Programme Management Office is well resourced and has a balance of capability across the team. One gap that has been identified is strategic planning resource that can pull together all of the different activities into a single overarching plan.

In summary, the programme is delivering, but not at the pace anticipated. The engagement across the system is highlighted as a strength with a need for more rigor in essential areas for delivery including

enabler functions to be established, systems to be agreed for data collection and monitoring along with demand and capacity analysis to inform workforce planning. Furthermore, the governance process needs to be reviewed to support financial approvals across all bid areas. This should be achieved with a single coherent plan.

Next Steps

There is an urgent need to review the governance processes of the entire programme which should include all five workstreams aligned to the Kent and Medway CMHF funding bid. This is underway with the joint SRO's for the programme with the aim of having this in place by the end of October 2022. In reviewing the governance process there is an opportunity to align enablers workstreams across all transformation programmes which could aid all delivery partners in resourcing key meetings.

The transformation will be consolidated into logical workstreams and phases (yet to be agreed) with clear milestones and a gateway process before moving onto subsequent stages. Operating in a complex system, the programme is too large in scale be delivered in one single tranche of work. This work commences in October 2022.

The continued focus on demand and capacity planning and thereafter the workforce redesign will be a key focus of activity during the autumn and winter months. This work will coincide with the overall finance baseline spend for mental health provision which will truly enable new models of care to emerge. A draft of the baseline spend is now available.

Engagement in the proposed model of care across provider organisations has commenced with the likelihood of more information sharing needed. Specifically, the Mental Health Together (first point of access) offer is largely agreed with more work needed to agree the more complex case offer provided by Community Mental Health Teams. In KMPT this is being addressed via the service transformation programmes with clinical staff leading the programme of change and overseen by the Deputy Chief Operating Officer.

In order for the transformation to meet the needs as identified in the Long-Term Plan and Framework, KMPT will need to transition the work being undertaken centrally with the recruitment and overall development of the Additional Roles Reimbursement Scheme (ARRS) to work alongside the transformation programme and eventually integrate with the new model of care at place. It is anticipated that this will coincide with the implementation of Mental Health Together.

Conclusion

There is an urgent need to test the proposed model with the current phase of the programme focused on moving to implementation of Mental Health Together across one trailblazer site. This should commence in Q3 2022/23, but will be contingent on providing assurance regarding affordability of the proposed model based on the demand and capacity modelling for all pathways including the KMPT Community Mental Health Teams. In addition, there needs to be in place a robust process for the collection and monitoring of data to support model reshaping if required and moreover to meet the reporting requirements of the new national waiting time targets. This needs to take place across all provider partnerships.

Lastly, it is important to note that the Provider Collaborative Board will have oversight of the CMHF Programme going forward with quarterly updates provided to the KMPT Board.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th September 2022
Title of Paper:	Emergency Planning, Resilience and Response (EPRR) Annual Report, Compliance Self-Assessment Statement.
Author:	Jessica Scott, Emergency Preparedness and Resilience Lead
Executive Director:	Andy Cruikshank, Chief Nurse (Accountable Executive Officer, EPRR)

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

A paper setting out the Trust's compliance of matters falling under the Civil Contingencies Act 2004.

Issues to bring to the Board's attention

This paper has been submitted to give assurance that the Trust is assured against the Civil Contingencies Act (CCA) 2004 and fully aligned to the NHS England and Emergency Preparedness, Resilience and Response Framework/Core Standards Assurance Programme.

The annual report sets out the Trust's compliance under the Civil Contingencies Act 2004, the EPRR work for 2021/2022, statement of compliance and improvement plan. The Board has a copy of the EPRR Policy and 2022/23 EPRR workplan in the Diligent Reading Room.

Governance

Implications/Impact:	Compliance with the Civil Contingencies Act 2004
Assurance:	reasonable
Oversight:	Oversight by Trust Board

Emergency Preparedness, Resilience and Response – Annual Report to Board (Period September 2021 – August 2022)

Background and context

1. The Civil Contingencies Act (2004)

1.1. The Civil Contingencies Act (2004), requires the trust to put in place the following duties with fellow Category 1 responders:

- Risk Assessment
- Develop Emergency Plans
- Develop Business Continuity Plans
- Warning and Informing
- Sharing Information
- Co-operation with other local responders.

1.2. This annual report provides assurance to the Board that the Trust has embedded plans and processes that will ensure that it is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response (EPRR) as defined within the duties above.

2. Assessing and documenting compliance

2.1 The NHS EPRR Core Standards Framework is the mandated method for assessing compliance and giving assurance across the NHS in the subject of Emergency Preparedness, Resilience and Response.

2.2 Assessment is undertaken firstly by all NHS providers using an NHSE&I predetermined set of data, as part of a self-assessment which aligns to the duties held within the Civil Contingencies Act 2004.

2.3 In 2021 KMPT was requested to submit evidence within the self-assessment for the audit against a reduced set of 37 lines of inquiry. Of those 37 the Trust was fully compliant with 34 and scored 92%.

2.4 The 2021 self-assessment data sets were audited by the CCG and the regional results collated and submitted for ratification by NHSE&I. NHSE&I confirmed the ratified

position via a confirmation letter. In March 2022 the letter was received and presented to the Audit and Risk Committee, where it was noted.

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

2.5 The 8% gap in assurance, set out in the EPRR Improvement Plan was addressed via the agreed EPRR Work plan for 2021/22.

2.6 The 2022 self-assessment process and templates were published by NHSE&I on 28 July. The aspiration set by the Local Health Resilience Partnership Executive Group and documented in the November 2021 minutes of that Executive Group was that Providers would sustain Full compliance or improve their score in 2022.
For 2022 KMPT have been requested to submit evidence within the self-assessment for the audit against 55 lines of inquiry. Of the 55 the Trust is fully compliant with 52 and has self-assessed at 94.5%.

2.7 The remaining 4.5% are rated at 'partially compliant' and accompany this report on the prescribed EPRR Improvement Plan template (appendix 1) for Board approval and noting of inclusion into the EPRR Work plan for 2022/23 at appendix 2

2.8 *'Media and Communications Strategy'.*

It is noted that one action has rolled forward from the 2021 EPRR Improvement Plan into 2022. On this one element, the Director of Media and Communications has given written assurance, for the ICB audit, that the following will be in place: *'Following the appointment of a new director of communications and engagement, a new crisis communications plan is being developed, along with a communications and engagement plan. These will be completed in 2022 and will receive Board approval'.*

3. Risk assessment

3.1. The Trust EPR Lead is the deputy chair of the Kent Resilience Forum Risk Assessment Group. As a member of the Local Health Resilience Partnership and the Kent Resilience Forum the Trust fully supports the review of the Community Risk Register against the National Threat and Risk Register held by the Cabinet Office.

3.2 Annually, or as a new risk or threat emerges the Trust reviews its position using its own internal risk management process. The Emergency Preparedness, Resilience and Response Risk Register is managed to ensure risks are escalated to the Trust Risk Register and additionally submitted to the Board Assurance Framework for assurance against the Trust Strategic Objectives.

4. Develop emergency plans

4.1. Within 2021/22 with the exception of the Media and Communications Strategy and finalisation of a new plan to replace the Pandemic Flu Plan (New and Emerging Pandemic Plan) plans have been maintained and developed. Lately, the two main response plans have been updated to reflect the change of Clinical Commissioning Group to Integrated Care Board and the communication flow re-exercised.

5. Develop business continuity plans (aligned to ISO 22301)

5.1. The EPRR Policy defines the scope of the Business Continuity programme. The management of business continuity is detailed within the trust Management of Business Continuity Policy and template documents.

5.2 The Audit and Risk Committee have reviewed the rolling audit work plan and listed a business continuity audit for 2024/25; to confirm that the trust is conforming with its own business continuity programme outside of the Annual EPRR Core Standards Framework audit where is currently is rated at fully compliant.

6. Warning and informing

6.1 Via the Trust Communications Team, arrangements are in place to make available information on resilience and response to the public and staff. Examples of this in the 2021/2022 work plan have in in relation to summer and winter preparedness, Planned Information Technology down time potentially requiring IT System Business Continuity Plan activation, planned motorway closures, Met office forecasts, South East water outages and the continued COVID19 Rational Major Incident response.

7. Sharing information

7.1. The Trust as part of the Kent Resilience Forum has processes in place to share information with other local responder organisations to enhance co-ordination both ahead of and during an incident.

- The KMPT page on Resilience Direct was rolled out by the trust as a resilient EPRR repository; this has given on call staff a designated point of truth for plans, templates and briefings as the 'Master on call file' and allowed for sharing of information in response across the Kent Resilience Forum such as daily common information pictures.

7.2. Throughout the national level 4 and regional level 3 response to COVID19 the trust has been fully compliant with command and control arrangements. Situation Reports (SITREPs) have flowed via the Mental Health Cell to the Kent and Medway Incident Control Centre and briefings, instructions and information has been received as briefings and items for action.

8. Co-operation with other local responders.

8.1. The Trust as part of the Kent Resilience Forum has processes in place to co-operate with other local responder organisations to enhance co-ordination both ahead of and during an incident. To support this approach the Joint Emergency Services Interoperability programme principles are embedded into the EPRR Policy, Significant Incident and Major Incident Plans.

9. Training programme

9.1. During 2020/21 and to date, training has been limited to:

- eLearning induction
- Loggist training
- New staff entering onto either the Director on call rota or Manager on call rota
- and those requiring support with Business Continuity Plans.
- Refresher training sessions have been by request only.

9.2 This approach to training whilst in response in 2021/22 was the most pragmatic solution and the backlog for refreshers has been reflected in the forward work plan.

10. Exercise programme and Incidents

10.1. The duty placed on the Trust within the NHSE&I Core Standards is that it performs a communications cascade bi-annually and a table top exercise annually with a live exercise tri-annually. These elements have all been achieved in the last work plan with the live exercise being mapped to the ongoing response for COVID19.

10.2 Two table top exercises were undertaken, with care not to compromised safety of staff and service users within the COVID19 response, but to allow for learning in

support of Service Business Continuity Plans; outside of that gained from the COVID response.

The Trevor Gibbens Unit (TGU) annual table top exercise (Exercise Learning Curve#4) was executed on 04/03/2022

- The Forensic Low Secure Unit (annual table top exercise (Exercise Arrow) was undertaken on 20/06/2022

10.3. Within 2021/2022 the trust responded to the following Major Incident declarations:

- COVID19 (National and Regional) ongoing variants September – August 2022
- Sheppey Water Outage (Whole Island) July 2022
- Heatwave Level 4 (Kent and Medway) July 2022
- Ports – Impact on Dover/Folkestone and surrounding road infrastructure July 2022

11. Methodology on opening of the 2022/2023 EPRR work plan

11.1. Duties, core standards and NHS Contract have been reviewed for change against a refresh of the corporate EPRR Policy.

11.2 The NHS Core Standards Framework self-assessment has been undertaken and used to generate the EPRR Improvement Plan (2022).

11.3 The process of monitoring and managing risks to the lowest level is a continuous process and will move seamlessly from one plan year to the next.

11.4 Identification of Plans, Policies and Standard Operating Procedures for 2022/2023 is set against master index held by the Trust Policy Manager.

11.5 Identification of new plans is set against risk methodology to close actions and provide further risk controls.

11.6 Trust Business Continuity Programme baseline at September 2022 and forward plan against the priority of a plan.

11.7 Exercises which are mandated against the NHS EPRR Core Standards Framework.

11.8 Training to be set against an EPRR Training programme and Training Needs analysis aligned to the EPRR National Occupational Standards, 2022.

12. Workforce Resource 2022/23

12.1. The current resource available to EPRR for a substantive team is:

Chief Nurse	Accountable Emergency Officer
Deputy Director of Nursing and Quality	Deputy Accountable Emergency Officer
Emergency Preparedness and Resilience Lead	Subject Matter Expert
Emergency Preparedness and Resilience Officer	Non-Clinical Subject Matter Expert
Resilience and Risk Administrator	Office functions

13 Action required from the Board

13.1. The Board are requested to accept this annual report and re-affirm its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act 2004) and

- Note the closing of the 2021/2022 EPRR work plan.
- Note the EPRR 2022/23 Statement of Compliance (Appendix 1)
- Ratify the EPRR Improvement Plan (Appendix 2).
- Note the EPRR Policy (Appendix 3)
- Note the content of the 2022/2023 EPRR work plan commencing 1 September 2022 (Appendix 4).
- Share the NHSE&I ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Appendix 1.

Emergency Preparedness, Resilience and Response 2022/23 Statement of Compliance.

EPRR Statement of Compliance

The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

NHS England has published NHS core standards for Emergency Preparedness, Resilience and Response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Accountable Emergency Officer in each organisation is responsible for making sure these standards are met.

As part of the national EPRR assurance process for **2022/23**, Kent and Medway Social Care Partnership Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 55 of the core standards which are applicable to the organisation, Kent and Medway Social Care Partnership Trust

- is fully compliant with 52 of these core standards;

The attached improvement plan sets out actions against all core standards where full compliance has yet to be achieved.

- The overall rating is: Substantially Compliant

Andy Cruickshank

Kent and Medway Social Care Partnership Trust

12 September 2022

NHS England South East EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

Version Control: 01

Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Version Control: 01

Appendix 2.

Emergency Preparedness, Resilience and Response 2022/23 Improvement Plan

EPRR Improvement Plan:

Version: 1.0

Kent and Medway Partnership Trust (KMPT) has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2022/2023. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

This is a live document and it will be updated as actions are completed.

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
3	Partially Compliant	EPRR Board Report	12 September 2022	Chief Nurse	Board Paper September 2022
36	Partially Compliant	The Trust Media and Communication Strategy	31 December 2022	Director of Communications	To be ratified by Board 2022
13	Partially Compliant	New Plan – New and Emerging Pandemics	December 2022	EPR Lead	Current Draft, to be ratified via Trust-wide, Health, Safety and Risk in November and reported to ARC

Version Control: 01

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 29 September 2022

Title of Paper: Register of Board Members Interests – September 2022

Author: Tony Saroy, Trust Secretary

Executive Director: Helen Greatorex, Chief Executive

Purpose of Paper

Purpose: Noting

Submission to Board: Regulatory Requirement

Overview of Paper

The paper sets out the Trust's Register of Board members' interests, which will be published on the Trust website.

Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

It is the Trust's practice to formally update the Register of Interests twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board is attached.

All Board members have made declarations to the Trust Secretary who has the responsibility of maintaining the Register of Interests including where the member had no interests to declare.

This information will be made publicly available on the Trust website following the meeting.

Governance

Implications/Impact: Compliance with regulatory requirements

Assurance: Reasonable

Oversight: Audit and Risk Committee/Remuneration and Terms of Service Committee

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS
SEPTEMBER 2022

Director	Position	Interest declared
Jackie Craissati	**Trust Chair**	Jackie's current company, Psychological Approaches is on the NHS England framework for Independent Serous Incident Investigations but does not undertake investigations relating to KMPT. Jackie is Trustee on the Board of Samaritans and Independent Governor on the Board of the University of East London
Venu Branch	**Deputy Trust Chair**	None declared
Catherine Walker	**Non-Executive Director** (Senior Independent Director)	Catherine is Lay Chair of the Advisory Appointments Committee at Kings College Hospital NHS Foundation Trust, London Catherine works for Walkers Solicitors of which her husband, Ivan Walker, is the Principal. Walkers is an Employment law practice specialising in Pensions. Walkers acts for the majority of UK Trade Unions including a number of Trade Unions active in the Health sector. (Walkers Solicitors do not act for the NHS but clients do negotiate with the NHS – declared to ensure full transparency). Catherine is Chair of an advisory and scrutiny Panel of the National Employment Savings Trust (' NEST') Corporation. NEST is the pension auto enrolment vehicle used by KMPT for workers who are not members of the NHS pension scheme. Catherine is holds judicial appointments with the Social Entitlement Chamber and the Health Service

		Products (Pricing Cost Control and Information) Appeals Tribunal.
Fiona Carragher	**Non-Executive Director**	Fiona is an Executive Director – Alzheimer's Society and a Trustee of the UK Dementia Research Institute
Kim Lowe	**Non-Executive Director**	Kim is a Non-Executive Director at Kent Community Health Foundation Trust, started Feb 2022 She is also Chair of the Board of Trustees University of Kent Academies Trust, since Nov 2020 and a Lay Member University of Kent since April 2018
Mickola Wilson	**Non-Executive Director**	None declared
Sean Bone-Knell	**Non-Executive Director**	None declared
Peter Conway	**Non-Executive Director**	Non-Executive Director – Kent Community Health NHS Foundation Trust
Helen Greatorex	**Chief Executive Officer**	Partner Member of the Kent and Medway Integrated Care Board from July 2022
Vincent Badu	**Executive Director of Partnerships and Strategy**	Vincent is Interim Chief Strategy Officer Kent & Medway Integrated Care Board (ICB) from 1st July – 31st October 2022 and takes up my his new ICB exec role substantively from 1st November 2022
Donna Hayward-Sussex	**Chief Operating Officer**	None declared
Sheila Stenson	**Executive Director of Finance**	Sheila is the Chair HFMA Kent, Surrey and Sussex
Afifa Qazi	**Chief Medical Officer**	None declared
Andrew Cruickshank	**Chief Nurse**	None declared
Sandra Goatley	**Director of Workforce and OD**	None declared

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	29th September 2022
Title of Paper:	Changes to Standing Orders
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

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

Items of focus

The Trust Board last approved the Standing Orders and Standing Financial Instructions in November 2021.

The Chief Executive has announced that Deputy Chief Executive Vincent Badu has been appointed to the Integrated Care Board (ICB) and will join the ICB on 1st November. As a result of Vincent Budu's departure from KMPT, changes have been made within the Executive Management Team that will come into effect on 1st November.

Some of those changes affect the Board's composition, which require Board's approval and amendments of the Standing Orders.

Governance

Implications/Impact:	The Standing Orders and Standing Financial Instructions are a statutory requirement for all NHS Organisations
Assurance:	Significant
Oversight:	Oversight by Trust Board

Standing Orders

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, with minor amendments made and approved by the Trust Board in November 2021 and March 2022. Those changes were to reflect and support the efficient execution of Trust business.

3. Following Vincent Badu's appointment to the ICB, there have been changes made within the Executive Management Team that will affect how the Board will operate. Those changes, from 1st November, are:

    a. The Executive Director of Finance and Performance will be the Deputy Chief Executive as well; and
    b. The Director of Workforce and Organisational Development will become Chief People Officer and will be a voting member of the Board.

4. On 25th August 2022, those changes were taken to the Trust's Remuneration and Terms of Service Committee, which endorsed the changes.

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

6. 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
5.8.4	Executive Director of Finance	**Executive Director of Finance and Performance (Deputy Chief Executive)**	To reflect changes agreed at EMT level and endorsed by the Remuneration and Terms of Service Committee
5.8.6	Director of Workforce and Communications; (non-voting)	**Chief People Officer**	To reflect changes agreed at EMT level and endorsed by the Remuneration and Terms of Service Committee
Throughout	The new job titles will be reflected throughout the Standing Orders and Standing Financial Instructions.		

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**29 September 2022**
Title	**Quality Committee Report**
Author	**Catherine Walker, Committee Chair**
Presenter	**Catherine Walker, Senior Independent Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- In the context of allegations of abuse made by patients against staff, the Committee received a safeguarding deep dive report. The Committee discussed the risks of closed cultures and the need to understand the range of factors that constitute a "closed culture" and for these to be actively monitored.

Positive Assurance

- The Committee were informed that the implementation of the new service model Enhanced Memory Assessment and Intervention Service was happening at pace across all teams. The number of people waiting for a dementia diagnosis appointment had dropped from 1669 to 1336 in August, despite staff being away during the summer period.
- The Committee received the results of the 2022 Duty of Candour audit which showed significant improvements since the 2020 audit.
- The Committee received and approved the Director of Infection Prevention and Control (DIPC) Annual Report and Statement. The DIPC was again able to give a positive statement and the Infection Control Team were commended for their continued good work.
- The Medical Director informed the Committee that she had been shortlisted to the last three nominees for Clinician of the Year by the Royal College of Psychiatrists.

Items referred to other Committees (incl. reasons why)

- The Committee asked that the Finance and Performance Committee to note the quality concerns associated with the pausing of the implementation of the ICT Comms Rooms Refresh and to ensure the scheme was given appropriate scheduling in the capital programme.

The Quality Committee was held on 20 September 2022. The following items were discussed and scrutinised as part of the meeting:

1. Quality Impact Assessments
2. Quality Risk Register
3. Quality Digest
4. Strategic Delivery Plan Priorities – Quality Improvement
5. Guardian of Safe Working Hours Report
6. Operational Hot Spots
7. Safeguarding – Allegations Against Staff Deep Dive
8. Duty of Candour Audit
9. Participation and Involvement Report – Communications Plan
10. Clinical Audit Annual Report – National Audits and Accreditation
11. Annual Review of Committee Effectiveness
12. Quality Committee Terms of Reference

The Board is asked to:

1) Note the content of this report.

Title of Meeting	Workforce and Organisational Development Committee (WFODC)
Meeting Date	29th September 2022
Title	Workforce & OD Committee (WFODC) Report
Author	Venu Branch, Chair of WFODC
Presenter	Venu Branch, Chair of WFODC
Executive Director Sponsor	Sandra Goatley, Director of Workforce & OD
Purpose	Assurance

Matters to be brought to the Board's attention

Positive Assurance:

- It was encouraging to hear from the Acute Care Group about the progress of skills mixing and new roles. Also the learning that was already emerging from the Physician Associate roles and the support that the Theraputic Staff are able to provide to RMNs and vice versa. The former has allowed additional links to be made with local Universities. Challenges remain around recruitment and retention of Nurses and Band 2 Support Workers.
- A presentation from the Community Recovery Group reported an improved recruitment position around staffing on the South Kent coast.
- Useful reports were received on WDES and WRES, which will inform the work plan of the newly appointed Equality and Diversity Manager. Good discussion was had around the creation of an Ethnicity Dashboard which has been structured around the People Promise. And the WFOD committee looks forward to seeing how this develops building on the limited last 4 months data set.

Issues of Concern

- One of our mitigations for staff hardship is looking at this being delivered through the Charity of the Trust. There was discussion at the meeting about whether we ought to support a short term concentrated campaign to advocate for a sustained and workable response to the current staffing crisis from the centre. The Director of Workforce and OD will be raising this through the Integrated Care Board HR team. There is also the potential risk of industrial action by staff which is a new risk on the risk register. Although KMPT staff have not previously taken part in industrial action, the likelihood of participation maybe greater in the current economic circumstances.

Policies Ratified

- The Committee ratified the following policies:
  - Fee Paying Policy
  - Uniform Policy
  - Policy Handbook

Items referred to other Committees (incl. reasons why)

- None

The Workforce and OD Committee was held on 20 September 2022. The following other items were discussed and scrutinised as part of the meeting:

1. WFOD Main Report
2. Leave Provision and Diversity
3. Vacancy Gap Deep Dive
4. Strategic Delivery Plan Priorities – Quality Improvement
5. Communications Plan for Engagement/Involvement Strategy for Transformation Programme
6. Annual Review of Committee Effectiveness
7. WFODC Workplan

The Board is asked to:

1) Note the content of this report.

Note to: KMPT Board
From: Peter Conway
Date: 14.9.22
Subject: Audit & Risk Committee (ARC) meeting on 13 September 2022

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Management and BAF	*Limited Assurance*	1)Updates to the Risk Management Strategy and Risk Management Policy noted 2)BAF - undergoing refresh particularly risk definitions, confidence, timeliness/sufficiency of actions, accuracy of current ratings and trends. ARC would prefer more lower risks to be removed but pending the refresh support the Exec recommendation of one only (Participation in Research and Innovation) 3)Trust Risk Register - contains 2 building specific high risks (Coleman House and the Cube House). Consideration to be given to how best to report the numerous Estates risks on the BAF 4)Risk Deep Dive on governance and risk costs - further peer calibration needed by December to validate £907k potential savings and contribution to Financial Deficit reduction during 2023/4.
Financial Reporting	*Substantial Assurance*	Verbal update from Grant Thornton advising their completion report on the 2022 Audit delayed by one week. There are no items of concern, nothing new to raise that has not already been advised, unqualified opinion and 4 low level improvement recommendations
Financial Controls	*Substantial Assurance*	1)Single Tender Waivers - continued demonstration that the process is well managed 2)Salary Overpayments - 15 month review undertaken. Total amount overpaid a modest (£210k) relative to total paid (0.2% of the total) with the amount written off insignificant (£11k). Awareness and training are key actions going forwards
(1) Internal Controls - Auditors	*Reasonable Assurance*	1)NHSI requires a mandatory audit of all Trusts' financial governance to be completed by January 2023. This will be undertaken by TIAA and resource found from delaying the audit of SPoA. 2)substantial assurance reports received on Data Security and Protection Tools and the Software Development Team; and reasonable assurance reports on Temporary Medical Staffing, Finance System, Temporary Staffing, Assurance Framework and Risk Management, SARD (system for capturing medical staff appraisals, plans, leave etc) and Data Quality of KPIs. 3)Counter-Fraud - green rating for Counter Fraud Functional Standard Return, the same rating as all other Kent Trusts. Positive review of Prescription FP10 Security and Usage
(2) Internal Controls - Trust	*Reasonable Assurance*	1)Health & Safety - 96% self-assessed compliance against HSE key lines checklist. Also, ''substantially

		compliant'' self-assessment against the core standards for Emergency Preparedness and BRP 2)Fire Safety - satisfactory updating report for period January-June 2022 3)Cyber Security - positive updating report including confirmation that the recent Advanced cyber incident did not affect the Trust (2 systems being used, neither impacted). Central funding for cyber being switched to EPR systems adds to the scarcity of funds for essential activity such as Data Centres' refresh 4)Data Quality - further progress and the Data Quality Group (chaired by Sheila) to be revamped to include Clinical Directors and re-emphasis of the criticality of IT enablement going forward 5)Estates Backlog - robust process for capturing and evaluating the state of our Estates explained. By December, a sufficient fact base will be in place to advise the Board (through F&PC) of current position and risks. In the meantime - ''all our buildings are not inherently unsafe'' and where parts of the estate are, areas are closed and taken out of service.
Governance	*Reasonable Assurance*	ARC self-effectiveness review - completed and satisfactory. Score of 4 (= strongly agree) for all key lines: 1)fulfilment of committee's responsibilities, 2)quality assurance, 3)quality of relationships and 4)effectiveness of processes and meetings. No suggestions for improvement
Other		Risk deep dive at next meeting in November - energy supply risks (financial, business continuity, sustainability goals)

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 29th September 2022

Title of Paper: Sealing Report

Author: Kay Learmond, Head of Service

Executive Director: Helen Greatorex, Chief Executive

Purpose of Paper

Purpose: Noting

Submission to Board: Standing Order

Overview of Paper

A paper setting out the use of the Trust Seal.

Issues to bring to the Board's attention

The report is to give assurance to the Board that all documents endorsed with the Trust Seal have been done in accordance with the Trust Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation.

Three documents have been signed and sealed as a deed during from Q2 2021 to Q1 2022. This process has been undertaken by Legal Services as per the Trust Standing Orders

Governance

Implications/Impact: Compliance with Standing Orders

Assurance: Reasonable

Oversight: Trust Board

Version Control: 01

Number	Date of Sealing	Description	Signatures	Comments
145	02.08.2021	Licence to Alter Flete at Thanet Mental Health Unit.	Helen Greatorex Jack Craissati	Authorised by Director of Finance and Director of Capital Planning and Estates
146	24.11.2021	Parent Company Agreement with Compass Groupe for facility services at DVH	Helen Greatorex Jackie Craissati	Noted in board and agreed at FPC July 21
147	01.02.2022	Charitable Fund Governing Document	Helen Greatorex Jackie Craissati	Authorised by the CEO and Chair on 27.01.22
148	02.02.2022	Lease of Sarre at Thanet Mental Health Unit to EKUFT	Helen Greatorex Jackie Craissati	Authorised by the Deputy Director of Finance
149	21.02.2022	Kier Contract	Helen Greatorex Jackie Craissati	Authorised by the Director of Finance.

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