AGENDA

Title of Meeting Trust Board Meeting (Public)
Date 27th May 2021
Time 09:30 to 11:30
Venue Boardrooms A & B, Farm Villa and video-conferencing

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/21-22/1	1.	Welcome, Introductions & Apologies		Verbal	Chair	09:30
TB/21-22/2	2.	Declaration of Interest		Verbal	Chair	
		PERSONAL STORY				
TB/21-22/3	3.	Supporting Service Users through Lockdown	FI	Verbal		09:40
		STANDING ITEMS				
TB/21-22/4	4.	Minutes of the previous meeting – 25/03/2021	FA	Paper	Chair	09:50
TB/21-22/5	5.	Action Log & Matters Arising	FN	Paper	Chair	
TB/21-22/6	6.	Chair's Report	FN	Paper	JC	10:00
TB/21-22/7	7.	Chief Executive's Report	FN	Paper	HG	
		OPERATIONAL ASSURANCE				
TB/21-22/8	8.	Integrated Quality and Performance Report – Month 1	FD	Paper	HG	10:10
TB/21-22/9	9.	Finance Report: Month 1	FD	Paper	SS	10.30
TB/21-22/10	10.	MHLDA Improvement Board	FD	Paper	HG	10.50
TB/21-22/11	11.	In-Patient Establishment Review	FD	Paper	MM	11.00
TB/21-22/12	12.	Tackling the vacancy challenge	FD	Paper	SG	
		CONSENT ITEMS				
TB/21-22/13	13.	Mental Health Act Committee	FN	Paper	KL	
TB/21-22/14	14.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/21-22/15	15.	Quality Committee Chair Report	FN	Paper	AMD	
TB/21-22/16	16.	Audit and Risk Committee Chair Report	FN	Paper	PC	
TB/21-22/17	17.	Finance and Performance Committee Chair Report	FN	Paper	MW	
		GOVERNANCE				
TB/21-22/18	18.	Board Assurance Framework	FN	Paper	MM	11.15
TB/21-22/19	19.	Any Other Business			Chair	11.20
TB/21-22/20	20.	Questions from Public			Chair	11.25
	Date of Next Meeting: 25th June 2021					

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

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

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the meeting held at 0930 to 1210hrs on Thursday 25th March 2021
Via Videoconferencing

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

Item	Subject	Action
TB/20-21/178	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting, which was livestreamed. No apologies were received.	
TB/20-21/179	**Declarations of Interest** There were no other declarations of interest.	
TB/20-21/180	**Early Intervention and Peer Support – Making a Difference** The Board welcomed Taran Spero, KMPT Peer Support Worker, and Abigail Clarke, former service user, to the Board meeting. Abigail described her treatment journey with KMPT's Early Intervention in Psychosis Service (EIP) and the support that Taran had provided her on her	

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Item	Subject	Action
	journey to recovery. Abigail is now able to work towards goals including the learning of how to play the saxophone. She is also studying an Open University degree in Music. Taran set out the structure of support provided to Abigail, describing how important it is as a Peer Support Worker to develop a connection and be attentive to service users. The intention is to have service users understand their psychosis, see the potential of the future and to feel empowered. The Board reflected on the personal story and was pleased to note how EIP had helped Abigail through the application of therapeutic techniques that are grounded in peer-reviewed research and theory. The Board recognised that there is further work needed to reduce care coordinator turnover for service users and that the role of Peer Support Worker should be more visible in the Trust's Strategy Delivery Plan. The Board thanked Taran Spero and Abigail Clarke for attending the Board meeting.	
TB/20-21/181	**Minutes of Previous Meeting** The Board **approved** the previous minutes save for the following changes: • Item TB/20-21/167 – The words "The Trust is looking to increase the KMPT Bank pay rate for Band 5 staff in order to increase the number of substantive KMPT staff joining KMPT Bank" should be replaced with "The Trust *has increased* the KMPT Bank pay rate for Band 5 staff in order to increase the number of substantive KMPT staff joining KMPT Bank" (emphasis added to identify change) • Item TB/20-21/169 – The words "Staff turnover has in fact remained stable since November 2020 at 9.4%, which is lower than the local 10.5% target" should be replaced with "Staff turnover has in fact remained stable since November 2020 at 9.4%, which is lower than the *KMPT* 10.5% target".	
TB/20-21/182	**Action Log & Matters Arising** The Board **agreed** the Action Log.	
TB/20-21/183	**Chair's Report** The Board received and **noted** the Chair's report. The Chair highlighted that the Kent and Medway Integrated Care System has been informed by NHSE/I that it is to be recognised as a statutory Integrated Care System.	
TB/20-21/184	**Chief Executive's Report** The Chief Executive's Report was received by the Board, which was taken as read.	

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	The Chief Executive highlighted: • The importance the Trust places on the role of Peer Support Workers in supporting recovery. They have both the necessary talent and the lived experience allowing them to make a real difference to service users, as Taran and Abigail had described earlier. The creation of new Clinical Director posts for each Care Group will support the recruitment of significantly more Peer Support Workers. • The Executive Management Team will work on the issue of care coordinator turnover. • The Trust has become aware of an article in the Health Service Journal, which incorrectly states that an increase in security in the Emergency Department at East Kent Hospitals University NHS Foundation Trust (EKHUFT) is as a result of mental health service users going to the department. The Chief Executive of EKUFT has confirmed that the increase in security in the Emergency Department has no link, in any way, with mental health patients. The Board **noted** the Chief Executive's Report.	
TB/20-21/185	**Strategy Delivery Plan 2021/22** The Trust Board received the KMPT Strategy Delivery Plan 2021/22 ('SDP') for approval. The Board took each Strategy Priority in turn and discussing each entry at length. The Board **approved** the Strategy Delivery Plan subject to the following adjustments: <u>Quality</u> • The ambition of 90% of patients have a copy of their crisis plan and care plan was too low and will be amended to 100%. <u>Driving delivery of integrated care</u> • The Trust's percentage targets set out in the "Collaborate to deliver sustainable services and improved care for service users, carers and families" section need to adopt those targets set by the Mental Health Improvement Board. <u>Developing our capabilities to deliver</u> • The deliverables detailed in the Strategy Priority need to be more ambitious in terms given the impact this Strategy Priority will have on the other Strategy Priorities. **Action: The Executive Management Team will adjust Strategy Delivery Priorities 3a to 3c (as detailed within the Strategy Delivery Plan) by end of April 2021 for the Trust Chair's approval. Approval to be received outside of the meeting.**	**EMT**

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Item	Subject	Action
	The 'Streamlining quality and performance from the Board to the Ward' and 'Achieving long term financial sustainability' priorities were approved by the Board without any adjustments needed.	
TB/20-21/186	**Integrated Quality and Performance Report (IQPR) – Month 11** The Board received the IQPR, which now includes an 'IQPR Exceptions Reporting' section. This sets out the areas of concern and focus as identified by the Trust's Executive Management Team. SS and JMG took the Board through the areas so far as they relate to the effectiveness and performance domain, highlighting in particular: • A number of the exception reporting within the Effective domain align themselves to the Strategy Delivery Plan and the Quality Accounts. • The Trust is to extend its contract with the private provider of Psychiatric Intensive Care Unit by 4 weeks. • The Trust will re-introduce the publication of the number of patients who have received a follow-up within 72 hours of discharge within the IQPR. • There has been an improvement in the Trust's Referral to Assessment within 4 weeks rate, with the rate now standing at 81.4%. However, this is still below the target of 95%. • The Trust's Single Point of Access service remains a high-risk area and the Trust is actively managing that risk. A deep dive audit of the service will be taken to the Trust's Audit and Risk Committee in May 2021. • With respect to the care and crisis planning metrics, there needs to be a 100% target for patients with a copy of their Care Plan or Crisis Plan. Achievement of this target will be assisted by the Clinical Technology Strategy. Safe • The Trust is in an improved position across all of the patient safety metrics. • There have been no breaches to Serious Incident investigation reports. The Trust is benefiting from a Centralised Investigation Team on completing timely reports. • In terms of Physical Health Checks within 72 hours, the Trust remains above target but appears to be on a downward trend. A deep dive into Physical Health Checks is currently being completed and the report will be taken to the Quality Committee. Workforce • Dealt with in the Workforce Quarterly Report item. Finance • Dealt with in Finance Report item. Caring • There has been a low Patient Reported Experience Measure (PREM) for February. For some of the care groups, the scores have been declining. The Trust will be meeting Healthwatch for the areas of Kent	

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Item	Subject	Action
	and Medway in order to understand issues more fully. <u>IQPR data quality paper</u> The IQPR data quality paper was taken as read, and the Board thanked Nigel Lowther for the work completed and the clarity of the report. The Board discussed the question of culture raised in the report and agreed that that this was best achieved by support services adopting a 'customer service' when working in collaboration with clinical teams. The Board **noted** the Integrated Quality and Performance Report – Month 11.	
TB/20-21/187	**Finance Report: Month 11** The Board received the Finance Report (Month 10), with the following matters highlighted: • **Income and Expenditure:** In light of the financial architecture, KMPT is continuing to report a breakeven position. Patient Care Income is included as advised nationally, with an additional £4.8m year to date to reflect additional COVID-19 related costs and top-up to reach breakeven. • **Agency:** Agency spend continues to be high and this is reflective of increased staffing pressures experienced due to vacancies and the heightened COVID-19 pressure, with spend to date for this year totalling £8.0m. Of this, £0.7m is directly related to COVID-19. • **Cost Improvement Plan:** The programme for this year is £5.9m. At the end of February the Trust is £0.9m behind plan with a forecast underachievement of £1.0m. Currently this is being mitigated in the forecast by non-recurrent benefits and vacancy slippage. • **Capital Programme:** In February £3.3m was spent on the capital programme. The year to date performance is currently £6.5m behind plan, with a total spend of £9m. The profile for spend increases considerably in March and is being monitored weekly in advance of year end. In light of the slippage in capital schemes, the programme for the remainder of 2020/21 has been reviewed and updated, as a result the overall forecast programme has been reduced by a further £250k to £14.7m. • **Cash:** The new cash regime has resulted in the monthly block income being paid one month in advance. The Trust has therefore been holding average cash balances in excess of £30m since April. The Trust will not receive any block income in March to unwind this arrangement. The forecast year end cash balance is £16m, this reflects no further block receipts, the £0.25m reduction in the capital programme and creditor payment runs being lower than anticipated in February. The forecast is £9m above the original plan. SS highlighted three areas of concern for the Board's attention: • Underlying deficit – The Board will be discussing this in more detail during its Board Seminar. • Capital – There will be a reduction in the capital amount across the	

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Item	Subject	Action
	system next financial year. • Planning – The first draft of the Capital Pan is to be done by 12th April 2021. The first draft of the Mental Health Investment Standard Plan needs to be done by May, with the first draft to be done by June. The Board noted that the Trust is meeting the Mental Health Investment Standard which means that service users are receiving the investments they deserve. The new Integrated Care System will have sight of all local investment across the whole county. The Board **noted** the Finance Report (Month 11).	
TB/20-21/188	**Recovery and Transform Update** The Board received the Recovery and Transform Update. The Trust has moved out of the emergency response phase and is now in the recovery phase. The Recovery and Transform process is being updated to reflect changes to patients' leave and visitation. There is an expectation that NHSE/I will be sending a fourth Recovery and Transform letter in the coming weeks and the Trust will adapt to that letter once received. The Board discussed the importance of closer working with the Primary Care Networks (PCNs). This included the creation of joint roles for KMPT and PCNs. The Trust's Strategy Delivery Plan – as discussed in item TB/20-21/185 – factors in the time needed for effective working with PCNs. The Board also reflected on the Trust's work regarding Crisis matters such as the Single Point of Access, NHS 111, Safe Havens and Support & Signposting. **Action: TS to schedule a Board Seminar on Crisis Services by April 2021. The Board Seminar is to take place before the end of July 2021.**	**TS**
TB/20-21/189	**Workforce Quarterly Report** The Board received the Workforce Quarterly Report. The Board noted that the Trust was in a good position in terms of all of the Key Performance Indicators except the overall vacancy gap. This stood at a rate of 14% compared to a KMPT target of 11.85%. There are two key areas of work that will help the Trust's Recruitment and Retention. These are: • Embedding the Just and Learning Culture; and • Workforce modelling. Staff retention has improved as staff turnover has reduced from 16% to under 9%. However, for those staff who are leaving, most tend to leave within the first three years.	

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Item	Subject	Action
	An improvement in Recruitment and Retention will help drive down the agency rates currently charged to the Trust. The Trust has achieved the Kent and Medway Workplace Wellbeing Gold Standard for its Health and Wellbeing work. The Board reflected on a number of matters: • The majority of Trust staff has been vaccinated against Covid-19 but the Trust is not sighted on all the data because some staff may have been vaccinated by their GP. The Trust will be writing to those staff in order to get a clearer picture on the staff vaccination rate. The Trust will be holding some more events to help staff decide about taking the vaccine. • In order to understand why staff are leaving within the first few years, the Trust is looking at a centrally driven exit interview process and will consider quarterly meetings with new staff in their first year. • The Trust has reduced the number of physical site visits into care homes, with the majority of consultations taking place over video. Where physical consultations are taking place, the Trust is following strict Infection and Prevention Control processes. The Board **noted** the Workforce Quarterly Report.	
TB/20-21/190	**Workforce and Organisational Development Committee (WFODC) Chair Report** The Board received and **noted** the content of the WFODC Chair report.	
TB/20-21/191	**Quality Committee (QC) Chair Report** The Board received and **noted** the content of the QC Chair report.	
TB/20-21/192	**Audit and Risk Committee (ARC) Chair Report** The Board received and **noted** the content of the ARC Chair report.	
TB/20-21/193	**Finance and Performance Committee (FPC) Chair Report** The Board received and **noted** the content of the FPC Chair report.	
TB/20-21/194	**Register of Interests** The Board received and **noted** the Register of Interests.	
TB/20-21/195	**Any Other Business** There was no Any Other Business.	
TB/20-21/196	**Questions from Public** In response to questions from the public:	

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Item	Subject	Action
	• The Trust makes attempts to reduce the level of 'management speak' at its meetings, with committees providing a check-and-balance on the executive. The question was a welcome reminder to keep attending to this issue. The Board also received positive feedback from David Rogers, Chair of North Staffordshire Combined Healthcare NHS Trust and Taps Mutakati, Deputy Chief Operating Officer on the Board meeting.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 27th May 2021.	

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

Date …………………………………………………………….

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BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/05/2021

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN MAY 2021								
28.01.2021	TB/20-21/148	Chief Executive's Report	TS to invite Justine Norris MBE, Occupational Therapist, to present her Personal Story at a Board meeting in Spring 2021.	TS	April 2021		Justine Norris has confirmed attendance	Closed
25.03.2021	TB/20-21/185	Strategy Delivery Plan 2021/22	The Executive Management Team will adjust Strategy Delivery Priorities 3a to 3c (as detailed within the Strategy Delivery Plan) by end of April 2021 for the Trust Chair's approval. Approval to be received outside of the meeting.	EMT	April 2021		EMT action is complete and the updated document has been signed off by the Chair/ CEO and circulated to the board .	Closed
25.03.2021	TB/20-21/188	Recovery and Transform Update	TS to schedule a Board Seminar on Crisis Services by April 2021. The Board Seminar is to take place before the end of July 2021.	TS	April 2021		Seminar to take place in June 2021	In progress
ACTIONS NOT DUE OR IN PROGRESS								
								Not due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
25.02.2021	TB/20-21/168	Strategy Delivery Plan Priorities 2021/22	VB2 to produce a detailed Strategy Delivery Plan (setting out the priority, target date and how success will be measured) by March 2021.	VB2	March 2021		On agenda	Complete
28.01.2021	TB/20-21/149	Brilliant Care Through Brilliant People – KMPT Organisational Strategy 2020-2023	VB2 to produce an accessible three-page summary of the Organisational Strategy by February 2021.	VB2	February 2021		Organisational strategy summary document to be circulated internally to KMPT Leaders along with strategy delivery plan 2021/21.	Complete
25.02.2021	TB/20-21/170	Finance Report: Month 10	TS to schedule a Finance Seminar for Board. By March 2021, Board to be updated with the date of the Finance Seminar.	TS	March 2021		Seminar has been arranged	Complete

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BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/05/2021

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
26.11.2020	TB/20-21/115	Recovery and Transform Update	SS/JMG to produce target rates for the proportion of video and telephone contacts per team/service within the January 2021 Recovery and Transform Update paper.	SS/JMG	January 2021	March 2021	On agenda	Complete
26.11.2020	TB/20-21/116	IQPR (Responsive domain)	SS/JMG to produce a detailed paper for January 2021 setting out the progress made and solutions achieved regarding the Data Quality issues detailed in Appendix B of the November IQPR.	SS/JMG	January 2021	March 2021	Attached to March's IQPR	Complete

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 27th May 2021**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

In my role as Trust Chair, I present this report focusing on 3 matters:

- Board meetings
- System-wide Meetings
- NED visits

This has been a busy month, with Board appraisals to complete. I was also delighted to be a member of the panel interviewing for our new Director of Research and Innovation; a post that I am sure will bring huge benefits to the Trust.

I also attended sessions of the NHS Providers Quality & Governance Conference. This was interesting with its focus on systemic approaches to patient safety, and its emphasis on culture and 'psychological safety' as being crucial ingredients of high-quality safe care.

2. Board Meetings

The Board has agreed a new working model for its Board meetings, with there now being 6 Board meetings in every financial year rather than 8 meetings. Moving to this model allows more time for Board development purposes as the Trust responds to changes at a system-wide level.

The dates for future Board meetings are published on the Trust's website. For now, meetings are taking place virtually and there is an opportunity for members of the public to join the meeting through livestream. In time, the Trust will move to a model of meeting online or in person on an alternate basis and the Trust Secretariat will publish an update at the relevant time.

3. System-wide meetings

- 11th May – ICS Partnership Board meeting

4. Trust Chair and NED visits

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

Where	Who
April 2021	
Elizabeth House (Medway Hospital)	Venu Branch
Amberwood Ward - Littlebrook Hospital	Venu Branch
Senior Team Meeting of Workforce and Organisational Development Team	Venu Branch
Upnor Ward	Catherine Walker
SWK Community Mental Health Team, Tunbridge Wells	Peter Conway
May 2021	
Chartwell Ward	Peter Conway
Single Point of Access Team,	Peter Conway
Gregory House	Kim Lowe
Fern Ward	Kim Lowe
Willow Suite	Trust Chair
Arndale House	Trust Chair

April 2021

Venu Branch's visit to the Senior Team Meeting of Workforce and Organisational Development on 8th April 2021

The agenda was focused on the results of a deep dive on staff turnover and developing career pathways. There was representation from across the care groups and the discussion was inclusive and of high quality. Ideas were welcomed from anywhere across the organisation with the emphasis on innovation and ensuring we maintain a high-quality service. Due attention was paid to data quality and where improvements are needed.

Catherine Walker's visit to Upnor Ward on 13th April 2021

The atmosphere was calm and relaxed, and several patients were keen to emphasise how kind the staff were. Some raised the matter of how to spend their time. I had a particular focus on mealtime and food. The food was of reasonable quality and variety with lots of fruit, although fruit was the least selected item. Despite that, only 5 or so patients ate and mostly sat alone, with others ordering a take-away. This resulted in a large amount of leftovers of KMPT provided food.

Trust Chair's visit to Willow Suite on 22nd April 2021

The second visit of mine focused on the clear improvements to ward culture which was very positive to hear. A tour of the ward – and the significant improvements being made to the physical structure of all the doors – highlighted the need to embed the learning from the original building specification.

Trust Chair's visit to Arndale House on 22nd April 2021

It was really delightful to have so many staff speak with me; their passion and engagement with the service was very apparent. They had concerns about their ability to deliver a consistent quality of service – but also suggestions for improvement – and this contributed significantly to our very productive subsequent Board development session with the Trust CMHTs.

Peter Conway's visit to SWK Community Mental Health Team, Tunbridge Wells on 26th April 2021

We had really helpful and open discussions reflecting the various challenges the CMHTs face in terms of demand, staffing and quality. The visit showcased for me what we went on to discuss at the Board Development Day on 29 April

Venu Branch's Visit to Elizabeth House (Medway Hospital) Liaison Service on 30th April 2021

I met with two of the Band 6 Nurses and Dr A Bhardwarj (Consultant). They explained the service and the pressures of 'being on call' and managing an on-demand service. They valued the opportunity to speak to a Non-Exec Director and I invited Dr Bhardwarj to attend a future Board meeting.

They volunteered that they thought the Executive had been visible at the coal face - particularly mentioning Dr Qazi, Medical Director and Helen Greatorex, Chief Executive.

They expressed appreciation for the extra day of holiday this year - for birthdays – which was given in recognition of the staff's hard work during the Covid-19 pandemic.

Venu Branch's visit to Amberwood Ward - Littlebrook Hospital on 30th April 2021

I made a visit to this service particularly to cover the evening meal service and observe and discuss on ward activities. The food service was smooth and well organised and the kitchen was spotless. The Healthcare assistants were efficient and quick to serve & clear. The food looked good. 2 patients went out to get a take-away after the service and a number remarked that the food was okay in quality but not enough in quantity. Patients had the opportunity for beans-on-toast or toast between meals.

Patients seemed content with the range of activities on offer although not all facilities were always available due to staff shortage. A couple of patients had been on the ward quite a long time - both those I chatted with said this was because they had nowhere to go and there was a lack of assisted accommodation in the community.

<u>May 2021</u>

Peter Conway's visit to Chartwell Ward on 4th May 2021

Premises appeared modern – having been recently refurbished – light and generally fit for purpose.

Staff were positive and experienced, although concerns regarding recruitment and retention of staff were voiced.

Peter Conway's visit to Single Point of Access Team, Canterbury on 6th May 2021

Some major changes are being introduced which will take time to embed in order to reduce current risks. In the medium term, the changes should have a major impact on meeting the rising demand, improving quality and reducing inefficiencies.

Kim Lowe's visit to Gregory House on 10th May

I met with the Team Leaders, staff and a Consultant during my visit to Gregory House.

There had been strong team work and support during the pandemic, with there being a very inclusive atmosphere and a happy environment. The team was very patient focussed. I discussed with staff the patient waiting lists and targets, as well as the number of systems being used. Inevitably this leads to a certain amount of duplication of data-entry work.

Improvement of Gregory House's physical environment were highlighted and although there had been some improvements (such as the installation of the new doors), further work is needed regarding the paintwork.

Kim Lowe's visit to Fern Ward on 10th May

I visited Fern Ward with a view to focus on food service.

Feedback from staff and patients focussed on portion sizes and the food quality. The combinations of food available was highlighted and the menu had not been followed for several months.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 27 May 2021

Title of Paper: Chief Executive Board report

Author: Helen Greatorex

Executive Director: N/A

Purpose of Paper

Purpose: Noting

Submission to Board: Board requested

Overview of Paper

This is the Chief Executive's fortieth report to the Board and will update the Board on the previous two months since our last public Board on 25th March 2021

Items of focus

Key items covered are

- **Reverse Mentoring**
- **Tackling the vacancy challenge**
- **R and I Director**

Governance

Implications/Impact: N/A

Assurance: N/A

Oversight: N/A

Introduction

In common with other similar trusts nationally, the organisation remains extremely busy. We are experiencing significant pressure on our beds and our community services continue to see high levels of referrals.

Throughout the pandemic the board has sustained its focus on areas of risk and pressure, ensuring a clear line of sight to the areas where additional support may be needed and ensuring that those we serve and our staff are safe.

In April, aligned to this theme the board held a development day exploring the challenges faced by our community services. Twelve members of Community Mental Health Team staff from both our adult and older adult services joined the board for a seminar on the challenges they face.

The open exchange of ideas and experience was both informative and productive. As a result of the work, the Chief Executive has included in her objectives for the year, leadership of what will be a year of quality improvement, focus, celebration and support for our community teams. Updates on this work will be shared in coming months with community staff returning later in the year to update the board on the changes and improvements being made and sustained as a result.

Covid-19

We are proud to be leading a number of system work-streams to provide treatment options to local people affected by Covid. The latest of these is the roll out of the post Covid assessment service. Allied Health Professional Lead Julia Wilson, is the KMPT colleague engaged in this work and, along with Hilary Whibley (Occupational Therapist from the Brain Injury team), supported the development of the GP screening tool.

Maidstone and Tunbridge Wells Trust were awarded the contract to provide Post Covid Assessment Services (PCAS) across the county in February 2021. The service will begin in West Kent in May. Treatment will be mainly through the on line Covid recovery app and can last up to 12 weeks – after that patients can be referred onto other services as needed. This is a good example of cross system working with KMPT fully engaged in both development and delivery

Mental Health Improvement Board – Progress Update

Today's board will receive for the first time, a detailed update on progress against the priorities set out by the Improvement Board. Since the last KMPT board meeting, the first of a programme of assurance meetings with NHSIE has taken place and received positive feedback from NHSI/E. This new way of working with our regulator is felt to be adding value and is ensuring that the Improvement Board is focused on delivering improvement where it is most needed.

Ruby Ward

The Ruby team were pleased to return to their ward at Medway Foundation Trust as planned at the end of April. As part of preparing to return to the ward, a new staff rest space was created, marking the start of the roll out of updated, refreshed and new staff rest spaces across the Trust. This important work is being led by our new Director of Estates and Facilities, Mary Pierre-Harvey.

Reverse Mentoring

The Board will receive an update from the Chief Executive in July on the changes, improvements and work still to do in relation to becoming a truly inclusive and diverse organisation. One element of that work has been the training, accrediting and allocation of sixteen BAME mentors. The mentors have each started working with their mentees. The Chief Executive and her team have all started their programme

of being mentored and it is already proved extremely valuable. A more detailed description of this work and its impact will be shared with the board in July.

Tackling the Vacancy Challenge

The board is agreed and clear that failing to tackle this challenge is our biggest risk. Today's board papers include one from the Executive Director of Nursing and the Human Resources Director and both clearly set out the challenge and the urgency to find new ways to meet it.

To this end, a new group has been established by the Chief Executive, to be chaired by her and co-chaired by the Human Resources Director. Its aim is simple; to tackle the vacancy challenge and find long term, sustainable solutions to the vacancies that we carry.

Setting trajectories for improvement, measuring performance against them and reporting progress through the Workforce and Organisational Development Committee will ensure that the Board remains sighted on both the challenge and our progress in meeting it.

Appointment to Kent and Medway Medical School and KMPT Director Post

The Chair, Chief Executive and Medical Director were delighted to join the Dean of the Medical School and colleagues to interview for our first jointly appointed Director post.

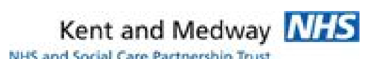
We are pleased to confirm that we interviewed four very high calibre candidates and have offered the position to a Professor of international standing. We are proceeding through all the usual formalities at this stage and will be able to update the Board in July with all the details.

Visiting Services in Person

With the lifting of some restrictions, and after careful assessment by our Director of Prevention and Control of Infection, members of the board have been able to start visiting services in person. Since the last board meeting I spent an afternoon visiting staff at Highlands House, and most recently a day on the Littlebrook Hospital site where I visited four wards, the reception and switchboard teams. I was glad too to be able to meet individually with Natalie Boorman, Clinical Lead, Occupational Therapy Manager and Millie Watts, Assistant Psychologist. Key to the discussions throughout the day was the theme of engagement and activity on the wards. It was encouraging and impressive to see a real focus on this across all the wards but important to note that we have not yet met our ambition of a fully functioning seven day a week activities programme consistently running, everywhere. The Executive Director of Nursing's leadership of a new, Healthy Wards initiative will take this challenge on and the Quality Committee will be updated on progress later this year. This work will address too, feedback from both Non- Executive Director visits (where both activities and food have been a theme).

Patient Story Follow Up

At our last Board in March, we started with Abigail Clarke's story. Abigail was joined by Taran Spero her Peer Support Worker and together they shared their reflections on Abi's experience of recovery. The Chief Executive sent a letter of thanks to both Abigail and Taran and followed up the contact with them in advance of today's meeting. Both Abi and Taran had been positive about the experience of addressing the board and glad to hear that their story had informed the board's debate throughout the day. The Chief Executive's objectives this year include the organisation achieving the target of having one hundred Peer Support Workers with an aim over the next three years to achieve 350 (roughly ten percent of our total workforce)



TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	27/05/2021
Title of Paper:	Integrated Performance and Quality Report (IQPR) Performance Update as of: April 2021
Author:	All Executive Directors
Executive Director:	All Executive Directors

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

A paper presenting the Trust's Integrated Quality and Performance for the month of April 2021.

Items of focus

Items of focus are contained within the Introduction and Exception Reporting sections of the report

Each section has been written by the Executive lead for the domain. The report provides Trust-wide performance data. Metrics of key interest have further analysis by Care Group through exceptions highlighted by Statistical Process Controls. Further Care Group and locality data is monitored by the Executive and their teams.

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

Governance

Implications/Impact:	Patient Safety: Patient safety is a key priority and issues that may affect this, are highlighted in the report and considered by the Board. Identified Risks and Risk Management Action: Risks set out in the report are all reflected in the Trust's risk register or BAF. All risks are outlined within the paper below Resource and Financial Implications: Failure to achieve some of the regulatory, performance or data quality metrics could result in a financial penalty under the NHS Standard Contract and importantly, to a poor-quality service for patients potentially leading to claims.
Assurance:	Where appropriate, the level of assurance is indicated within the IQPR through the SPC Key model
Oversight:	Trust Board

Introduction

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

Indicators to highlight in month include:

- There was an increase in inappropriate out of area bed days; April (375 bed days) saw an increase from 310 in March.
- The Early Intervention in Psychosis service is made up of 5 teams across Kent and Medway. The teams have continued to meet the required national standard of 60%, in April the target was exceeded with 71.4% of those referred commencing treatment within 14 days of referral.
- Continued high performance in the treatment of patients on CPA (Care Programme Approach) receiving a 12 month review, maintaining performance in month which is once again exceeding the National target for this cohort of patients (95.8%). The target has consistently been achieved for over a year.
- The % of patients on CPA Followed Up within seven days of discharge was 98.9% in April, maintaining continuous achievement of the 95% target.
- OPMH LoS has seen an increase in recent months.
- Overall staff sickness remains below target for the third successive month at 3.7%.
- Turnover has increased in month from 9.4% to 10.1% against a target of 9% for 2021/22.

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

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

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

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

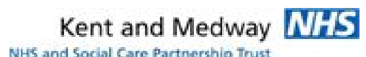
The report is now a familiar tool and point of reference in the Trust and as we had hoped, further strengthening our ability to triangulate information and explore in detail areas of concern. My team will provide detail on the work being done to understand and address these areas of concern whilst maintaining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

Helen Greatorex
Chief Executive

IQPR Change Tracker

Date	Change	Report Reference
December 2020	Latest Trust Strategic Objectives applied to domains throughout report Liaison removed from 4 & 18 week wait measures and Liaison measures redefined as follows: % of Liaison (urgent) referrals seen within 1 hour Numerator – Of the Denominator who has had a face to face contact of any duration within 1 hour Denominator – Urgent or Emergency Referrals starting in the month that are in hours for the teams, Medway and Thanet teams only. Referrals ending with a discharge reason of 'Dropped Out' or 'Patient Non Attendance' are excluded. % of Liaison (urgent) referrals seen within 2 hours Numerator – Of the Denominator who has had a face to face contact of any duration within 2 hours Denominator - Urgent or Emergency Referrals starting in the month that are in hours for the teams, Ashford, Canterbury, Dartford, East Team, Maidstone and SW Kent, Maidstone, Tunbridge Wells teams only. Referrals ending with a discharge reason of 'Dropped Out' or 'Patient Non Attendance' are excluded.	All Domains 002.R & 003.R 005.R & 006.R
January 2021	Statistical Process Control Charts implemented for exception report within a new section within the report. Previous areas of focus within individual domains removed.	
Februray 2021	Indicator removed: Freedom to speak up issues IQPR Overview and Guide moved to appendicles	013.W-W
May 2021	New/amended indicators for 2021/22: Unplanned Readmissions within 30 days (020.S) Replaces 28 day readmission indicator CPA patients receiving follow-up within 72hours of discharge (001b.E) New inclusion in IQPR Care Planning / Crisis Planning / Distribution Previous indicators retired, new measures introduced to include PSP reporting. (015.E – 017.E) Waited time measures Previous indicators retired, new measures introduced to include PSP reporting. (016.R – 018.R) Workforce metrics Vacancy metrics retired, replaced with retention measure (015.W-W) New absence and turnover targets	

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



Regulatory Targets – Single Oversight Framework (SoF)

Overview

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

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

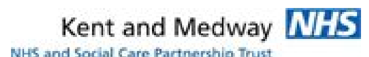
- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

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

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

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

A breakdown of measures reported against the Single Oversight Framework can be found in appendix A. This shows that currently the trusts biggest challenge is achievement of the agency cap



against the national target. It also reports staff turnover as non compliant. This is against a target that is set by the Trust as no target has been set in the SoF.

IQPR Exception Reporting

This section of 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/

Exception Summary:

Effective

	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			72.0	0.0	-5.8	43.6	18.9
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			303.0	0.0	30.1	359.7	194.9
4	**Trust Total**			375.0	0.0	48.7	378.9	213.8

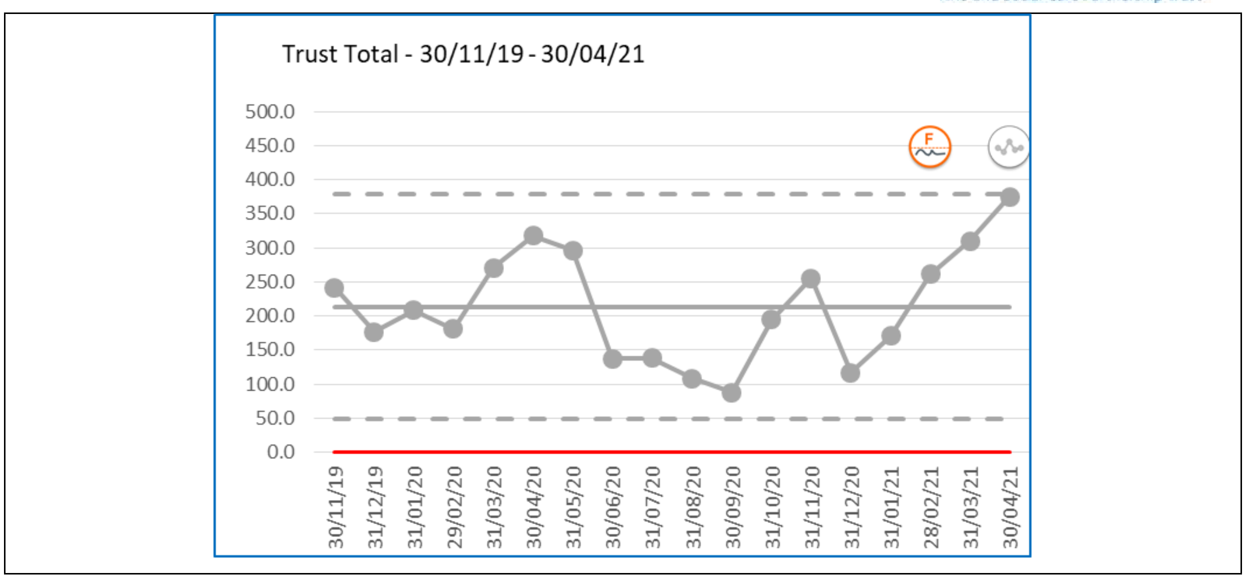
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

The number of out of area placements has increased from 310 bed days in March to 375 in April. This is made up of 303 PICU bed days and 72 Younger Adult Acute bed days.
As reported last month this increase was expected to continue at least up until the end of April 2021 due to an increase in demand following the impact of COVID-19 on admissions and acuity. Work is in place with the performance team to review data to help with understanding if this is likely to remain a trend for the next 6 months. Alongside this work the Deputy Chief Operating Officer for Patient Flow is completing an overarching bed stock review. This work is multifaceted bringing in the role of community teams to prevent admission alongside using national benchmarking to assess ability to operate within current bed stock. The work will be complete in October 2021.

There is no national data available to assess the impact of COVID-19 on psychiatric acuity or the use of PICU at the current time however out of area bed use remains high across the country with very few free beds nationally. The Chief Operating Officer and Deputy Medical Director keep a weekly oversight of any Out-of-area admissions.

Kent and Medway NHS
NHS and Social Care Partnership Trust



	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			71.9%	95.0%	72.0%	85.2%	78.6%
2	CRCG			88.6%	95.0%	88.9%	93.0%	91.0%
3	FSS			94.8%	95.0%	92.4%	98.1%	95.3%
4	OPMH			97.3%	95.0%	94.7%	99.2%	97.0%
5	Trust Total			89.9%	95.0%	90.2%	93.8%	92.0%

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			66.5%	95.0%	64.3%	70.4%	67.3%
2	OPMH			78.1%	95.0%	43.5%	64.9%	54.2%
3	Trust Total			72.0%	95.0%	54.9%	65.9%	60.4%

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

Narrative

New care planning measures have been introduced into the IQPR for 2021/22. As a output of the Data Quality Group new measures 015.E and 017.E have split the CPA care planning out from the Non CPA which is inclusive of the new Personal Support Plan (PSP) in use across the CMHTs for people not subject to CPA. With the introduction of the PSP there is a month on month improvement across the past 12 months as the process has been rolled out and currently stands at 72%.

Care planning for those on CPA has dipped to 89.9% against the 95% standard. All care groups are

required to respond as part of their recovery plans from the recent COVID pandemic lockdown. As a new process it is likely to take up to 6 months to fully embed PSP.

CPA Care Plans distributed to patients sits at around 50%; this does not mean to say people do not have their care plans however it is clear staff are not checking the correct area on RIO to evidence compliance. Whilst the trajectory is positive it is someway off the required 75%. As part of the Quality Committee improving care planning relaunch the requirement for staff to complete RIO fully is included in the communication.

	012.E: Average Length Of Stay (Younger Adults)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Amberwood Ward			16.4	25.0	-7.3	53.4	23.1
2	Bluebell Ward			51.4	25.0	3.5	69.4	36.5
3	Boughton Ward			18.6	25.0	-4.7	66.0	30.6
4	Chartwell Ward			27.9	25.0	-16.0	71.4	27.7
5	Cherrywood Ward			21.5	25.0	1.9	48.9	25.4
6	Fern Ward			53.8	25.0	-9.4	69.7	30.1
7	Foxglove Ward			29.6	25.0	-7.2	66.4	29.6
8	Pinewood Ward			22.6	25.0	-3.5	58.0	27.2
9	Upnor Ward			19.6	25.0	-2.4	55.4	26.5
10	YA Acute			25.9	25.0	17.4	38.4	27.9

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

Narrative

Historically this target has consistently been met by the Acute Care Group for Younger Adult (YA) bed days. There has been an increase in the average LOS in the last three months, April saw a reduction to 25.9 days; this continues to be well within the national benchmarked average length of stay. Variation continues to exist across the younger adult wards, and is easily skewed by a few long stayers being discharged as numbers are small for each ward. Fern Ward had 11 discharges in April of which two were over 100 days, Bluebell had seven discharges of whom two patients had been with us for over 100 days.

Whilst the trust operates a needs led approach to in-patient admissions we continue to report against older and younger adult wards. The older adult wards are clinically more suitable to people who may be physically more vulnerable alongside having age related health and social care issues. On those older adult wards the LoS has been increasing and is now at 102 days for April rather than the required 52 days. This impacts on bed availability for older adults who need in-patient

care. Due to the low number of discharges per month OPMH LoS needs to be viewed over a longer period of time and is not suitable for the application of monthly SPC analysis. The following table shows a rolling three month period for the last 6 months, showing an increasing trend in LoS.

2020-11	2020-12	2021-01	2021-02	2021-03	2021-04
65.2	72.1	74.4	78.5	71.9	83.1

The Patient Flow team have highlighted in month this is a growing challenge. Whilst some of the issue relates to inability to find onward care the Care Group clinical leadership has noted some variation in clinical practice. Both the COO and Executive Medical Director are supporting the care group to review options to support improved patient flow

Responsive

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			75.0%	95.0%	59.4%	98.4%	78.9%
2	OPMH			65.4%	95.0%	28.0%	71.8%	49.9%
3	Trust Total			68.9%	95.0%	43.3%	77.4%	60.3%

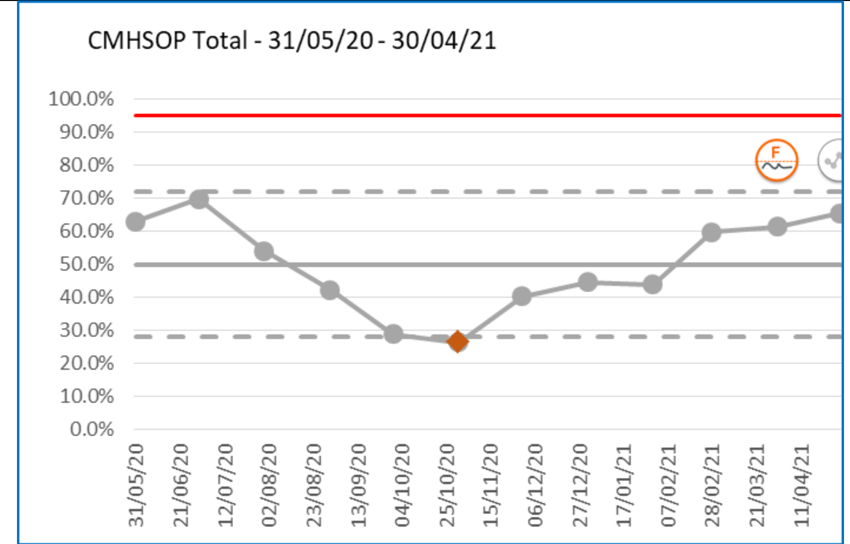
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

The CMHT performance for the 4 week wait standard from referral to assessment continues to improve, analysis by SPC shows that all teams are subject to common cause variation.
It is noted some variance across the teams in levels of performance, with West Kent and Swale as outliers. The staffing issues are directly attributed to this variance. The care group is currently centralising the assessment function across west Kent to utilise staffing in the most effective way. There is also a skill mix in place to support the recruitment and retention of staff.

Whilst not special cause variation it is positive to note a continued improved position with CMHSOP services for the assessment of routine referrals within 4 weeks of referral as shown within the graph.

Kent and Medway NHS
NHS and Social Care Partnership Trust



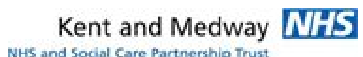
The Older Persons Care Group continues to differentiate between people with a functional illness (e.g. psychosis and bi-polar) and those needing a memory assessment, using the HoNOS clinical cluster information where known. The data highlights those with a functional illness are more likely to require urgent attention and are therefore prioritised in line with the care group 4 week wait recovery plan.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			93.6%	95.0%	87.1%	96.2%	91.7%
2	OPMH			75.8%	95.0%	39.5%	70.7%	55.1%
3	Trust Total			84.1%	95.0%	62.5%	80.7%	71.6%

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

The CMHT performance for the 18 week wait standard from referral to commencement of treatment continues to perform well. The Care Group has recently skill mixed the staff to provide additional appointments for Initial Interventions, thus reducing the wait to commencement this programme, which is also the first treatment for most newly referred patients.

It is positive to note special cause variation of an improving nature within CMHSOPs, the table below shows this is driven by improvements in 4 teams, with two teams achieving the 95% target.



	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			95.6%	95.0%	21.3%	98.3%	59.8%
2	Canterbury CMHSOP			86.3%	95.0%	34.4%	80.0%	57.2%
3	DGS CMHSOP			76.7%	95.0%	26.9%	91.0%	58.9%
4	Dover & Deal CMHSOP			77.8%	95.0%	30.6%	96.5%	63.5%
5	Maidstone CMHSOP			57.7%	95.0%	13.3%	82.3%	47.8%
6	Medway CMHSOP			74.0%	95.0%	22.5%	71.2%	46.8%
7	Sevenoaks CMHSOP			63.6%	95.0%	33.7%	86.0%	59.9%
8	Shepway CMHSOP			97.3%	95.0%	39.1%	95.0%	67.1%
9	Swale CMHSOP			81.8%	95.0%	26.7%	107.4%	67.0%
10	Thanet CMHSOP			85.1%	95.0%	30.7%	81.1%	55.9%
11	Tunbridge Wells CMHSOP			49.2%	95.0%	14.9%	72.9%	43.9%
12	**CMHSOP Total**			75.8%	95.0%	39.5%	70.7%	55.1%

	007.R: DNAs - 1st Appointments	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**Acute**			9.9%		3.2%	8.2%	5.7%
2	**CRCG**			8.1%		4.7%	15.1%	9.9%
3	**FSS**			10.5%		8.3%	18.2%	13.3%
4	**OPMH**			4.2%		0.7%	7.2%	3.9%
5	**Trust Total**			8.3%		6.1%	11.9%	9.0%

	008.R: DNAs - Follow Up Appointments	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**Acute**			12.2%		3.3%	9.2%	6.2%
2	**CRCG**			9.1%		6.8%	13.5%	10.2%
3	**FSS**			8.1%		3.6%	12.3%	8.0%
4	**OPMH**			3.0%		1.4%	4.6%	3.0%
5	**Trust Total**			8.1%		5.5%	10.5%	8.0%

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change Special cause of **Improving** nature or higher pressure due to **lower** values
Assurance	N/A – not set target
Narrative	
A high level of variation continues to exist in DNA rates across care groups, in order to better understand reasons for this the options on RiO were rationalised in April 2021.	

There has been an improving position in two of four care groups for 1st appointment DNAs and within three of four care groups for follow up appointments.

DNAs and Cancellation continue to be scrutinised by the Trust Wide Data Quality Group and any future recommendations for changes to these indicators will be highlighted if required.

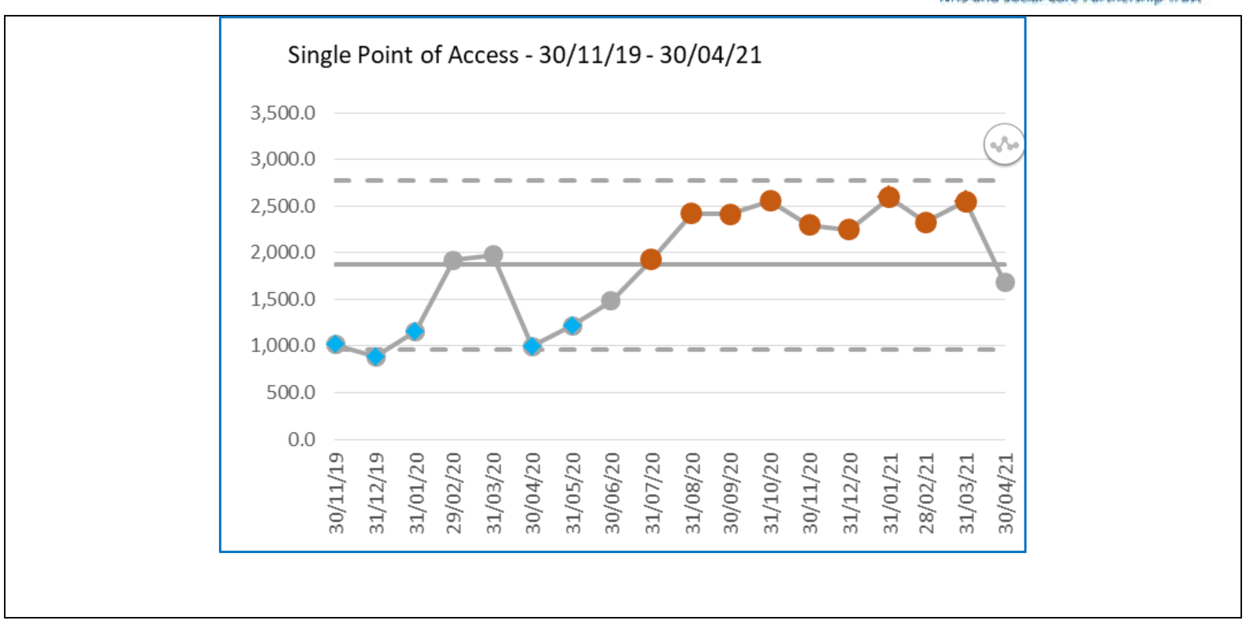
	013.R - 0.15R: Referrals	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			1,783		1,810.3	3,212.9	2,511.6
2	CRCG			5,493		2,900.7	6,293.3	4,597.0
3	FSS			2,024		1,440.6	2,438.9	1,939.7
4	OPMH			1,501		727.0	1,804.5	1,265.8
5	Trust Total			10,801		7,380.1	13,248.9	10,314.5

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

Narrative

SPC analysis has highlighted ongoing increased pressure in month driving increases in the Community Recovery Care Group (CRCG). The increased pressure on CRCG and reduction in Acute is impacted on by the movement of Liaison Psychiatry to CRCG within the management structure for reporting purposes in December 2020.
Within CMHTs It is also acknowledged that whilst referral rates have increased the conversion to assessment remains between 55%-66% over the past 6 month's average. Despite this, managing the referral process takes an amount of clinical capacity per day.

The majority of the CRCG pressure in recent months has been due to Single Point of Access (SPoA), as shown below April saw a reduction compared to recent months. This is the lowest number of referrals received by the service since it moved to function as a public facing Crisis Line and the increase seen in demand due to the pandemic.



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

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

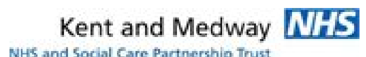
Executive Lead(s): Executive Director of Nursing & Quality
Lead Board Committee: Quality Committee

Issues of Concern
Moderate harm ligature incident - for the first time since August 2018, a moderate harm ligature incident was reported on one of the wards in March 2021. No gaps in practise were identified in the immediate review of the care provided. Immediate action was taken to strengthen the contributory environmental factor. Work is ongoing nationally in collaboration with the Care Quality Commission and National Mental Health Nurse Directors Forums to improve patient safety related to ligature risks in wards.. The outcomes will see the consolidation and development of national best practise guidance.

Executive Commentary

Physical Health Check with 72 hours (003.S)

Following concerns in the last report about a gradual reduction in physical health checks within 72hrs of admission, a series of actions were taken to address performance. An improvement from 92.9% in February to 96.2% in April has been seen and it is anticipated performance will continue to improve. Interventions including team based refresher training, competency assessments, monitoring



completion of physical health checks on a shift by shift basis with oversight and challenge at senior care group level have all driven the improvement.. Quality assurance will continue to be provided through the Cliq Check audits with strategic oversight at Quality Performance Review meetings.

Restrictive interventions (011-013.S)

National context

Use of restrictive interventions such as restraints, seclusion and rapid tranquilisation remains an area of focus both in KMPT and by Regulators nationally. The newly launched Mental Health Safety Improvement Programme (MHSIP) led by NHSE/I is supporting organisations to use Quality Improvement methodology to reduce restrictive interventions.

Plans are underway and on track, to ensure the Trust's training designed to prevent and manage incidents that may result in restrictive interventions, is revised to demonstrate full compliance with the Restraint Reduction Network Standards. The standards support health and social care staff to understand and apply principles of minimising use of force with the aim making cultural changes necessary to reduce restrictive practices, promote human rights and person centred care. This has become a requirement for all NHS Commissioned and CQC regulated services from April 2021. Providers have until September 2021 to demonstrate that they are working towards delivering accredited training.

Use of all forms of restraints has been the lowest number reported year to date, 103 compared to a high of 159 incidents in August 2020. Similarly the use of seclusion and prone restraints also saw a reduction in this reporting period, with a 50% reduction in seclusion. The Trust has robust monitoring mechanism in place for these interventions. There were no reported injuries or harms as a result of prone restraints and seclusion. There is ongoing work across inpatient services to prevent incidents of violence and aggression through de-escalation, purposeful admissions, and use of Positive Behaviour Support Plans, Safety Huddles, and provision of meaningful therapeutic interventions. The easing of national lockdown, coupled with a significant reduction in new Covid-19 infections has afforded individuals increased freedom and ability to reconnect with family and friends through visiting and off ward leave periods, all of which would be impacting on people positively.

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	95.6%	95.8%	95.9%	96.0%	95.6%	95.9%	97.1%	97.1%	96.4%	96.4%	95.5%	95.8%
003.S	% Inpatients With A Physical Health Check Within 72 Hours		90%	L	95.2%	97.7%	95.8%	97.0%	95.4%	97.5%	94.3%	95.2%	95.8%	92.9%	96.4%	96.2%
005.S	Number Of Unplanned Absences (AWOL and Absconds on MHA)		-	-	19	26	19	16	17	21	13	15	26	8	22	17
006.S	Serious Incidents Declared To STEIS		-	-	8	22	20	24	15	17	11	23	23	15	21	24
007.S	% Serious Incidents Declared To STEIS within 48 hours		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
008.S	Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days		0	L	4	8	3	8	17	12	20	14	5	0	5	2
010.S	All Deaths Reported On Datix And Suspected Suicide		-	-	206	286	232	218	140	134	232	225	275	178	155	150
011.S	Restrictive Practice - All Restraints		-	-	105	152	129	159	132	146	105	96	114	106	146	103
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	5	6	1	10	13	11	6	3	10	3	6	4
013.S	Restrictive Practice - No. Of Seclusions		-	-	28	39	22	32	22	29	32	17	16	8	24	12
015.S	Ligature Incidents - Ligature With Fixed Points (moderate to severe harm)		0	L	0	0	0	0	0	0	0	0	0	0	1	0
016.S	Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm)		-	-	0	0	0	0	0	0	0	0	0	0	0	0
017.S	RIDDOR Incidents		-	-	1	0	2	2	4	4	1	1	2	0	3	2
018.Sa	Infection Control - MRSA bacteraemia		0	N	0	0	0	0	0	0	0	0	0	0	0	0
018.Sb	Infection Control - Clostridium difficile				0	0	0	0	0	0	0	0	0	0	0	0
019.S	Safer staffing fill rates		80%	L	114.7%	116.4%	114.7%	114.5%	111.9%	111.2%	109.4%	106.5%	106.0%	104.3%	108.8%	108.9%
020.S	Unplanned Readmissions within 30 days		8.8%	L	9.5%	10.3%	6.7%	13.7%	11.3%	7.8%	8.2%	6.2%	7.8%	7.5%	5.1%	5.3%

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

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

Issues of Concern
Please see the exception reporting section of this report.

Executive Commentary

We are strengthening Clinical Leadership across the organisation and have created Clinical Director posts in all Care groups. The Clinical Directors will be in post in June 2021 and will drive the implementation of the improvement of Care Pathways in all Care Groups, and will take charge of delivering the Quality Account Priorities for the year which includes Care planning.

The increased bed usage through increased admissions and patient acuity plus added infection prevention challenges has resulted in bed pressures; this is being robustly monitored by the patient flow team. Work is in place with the performance team to review data to help with understanding if this is likely to remain a trend for the next 6 months. Alongside this work the Deputy Chief Operating Officer for Patient Flow is completing an overarching bed stock review, which will be completed in October 2021. This work has three work streams: demand and capacity, discharge process and alternatives to admissions.

Older Adult wards have seen an increased length of stay on certain wards and additional clinical support via the Associate Medical Director has been put in place. This is monitored by the Executive Medical Director.

We have been successful in creating and recruiting jointly with KMMS to the post of a Professor of Psychiatry who will hold the position of a Research and Innovation Director at KMPT. We have offered the post to an outstanding clinical academic from Kings' College London. This appointment marks a landmark moment in the organisation and the start of a journey of strengthening our approach to Research and Innovation and delivery of evidence-based care to our population.

See SPC exception report for further information on key metrics.

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	98.9%	95.9%	97.6%	95.5%	98.2%	98.0%	97.8%	98.7%	96.5%	98.9%	98.3%	98.9%
001b.E	CPA patients receiving follow-up within 72hours of discharge				84.2%	88.2%	87.1%	83.1%	88.8%	90.3%	89.3%	87.5%	88.8%	90.9%	88.4%	86.7%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.5%	95.1%	95.0%	95.4%	95.2%	95.4%	95.4%	95.6%	95.6%	95.7%	95.7%	95.7%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	296	137	138	108	88	195	255	117	171	261	310	375
006.E	Delayed Transfers Of Care		7.5%	L	9.8%	8.0%	6.8%	6.4%	8.1%	10.7%	12.7%	11.9%	10.5%	9.2%	8.5%	8.7%
008.E	Crisis Plans (All Patients)		95%	L	88.2%	88.9%	90.0%	89.5%	88.1%	87.3%	86.5%	86.1%	85.9%	86.8%	87.4%	86.4%
011.E	Number Of Home Treatment Episodes		224	L	159	174	204	219	225	248	234	192	189	220	250	241
012.E	Average Length Of Stay(Younger Adults)		25	L	26.64	23.71	24.74	18.30	26.25	25.29	33.11	35.75	36.25	31.78	27.75	25.94
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	82.25	57.93	57.98	49.32	66.31	64.35	64.90	92.21	69.97	76.09	70.97	101.79
013b.E	Average Length Of Stay(Older Adults - Continuing Care)		-	-												
015.E	%Patients with a CPA Care Plan		95%	L	91.8%	92.5%	93.3%	92.8%	93.1%	93.0%	92.5%	93.0%	91.8%	91.0%	89.4%	89.9%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	17.1%	16.8%	16.2%	16.1%	17.7%	19.6%	22.6%	24.3%	26.1%	29.9%	39.3%	50.9%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	57.5%	57.5%	55.9%	53.4%	53.5%	56.1%	59.6%	60.8%	62.0%	66.2%	70.2%	72.0%

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

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

Issues of Concern
Turnover has increased to 10.1%, above the new set target for 2021/22 (9%).

Executive Commentary

Staff Sickness (001.W-W)

The overall sickness rate increased by 0.2% in April 2021 to 3.7% and 0.24% of this was Covid related, so sickness rate was 3.46%. This is below the new 21/22 set target of 4%.

Short term sickness remains at 1.6% for the 3rd month consecutively. Long term sickness remains at 2% for the 2nd consecutive month.

Activities in place to reduce sickness absence include:

- Successfully closed 31 long term sickness absence cases in April 2021.
    - 29 employees are returning to same post
    - 2 employees are no longer employed at KMPT
    - We are currently actively supporting managers with 53 cases of sickness absence.
  - The pilot of a health and wellbeing advisor recruited in the Acute Care Group has been extended and continues to work on a range of health and wellbeing initiatives. The plan to implement Schwarz rounds is in place. The musculo-skeletal provision for employees business case has also been approved.
  - We have put in place many support offers for our staff to improve their health and wellbeing, including access to Virgin Pulse, Psychologists piloting 'Reflecting on Covid-1 year on' team sessions using video of staff reflections as a talking tool, 12 more Mental Health First Aiders fully trained including Peer Support workers and all offers/news in Well Being Wednesday weekly communication. This all forms part of our People Strategy and people recovery plan
  - Staff continue to be offered the COVID vaccination (80% front line staff and 77% all staff 1st vaccination completed and 44% front line staff and 48% all staff 2nd vaccination completed), with a particular focus on supporting front line staff to access this, on-line support sessions, 121's with managers and staff

- Support for Staff reporting symptoms of long covid via setting up support groups, promoting new Kent hub and new category for reporting so that we can monitor staff affected

Staff Turnover (004.W-W)

The 12 month rolling turnover for this reporting period (April 2021) has increased by 0.7%, since the previous month and to the highest rate since September 2020.

The increase is in all Care Groups, except Corporate Services:
Older Adults is 9.4%
Community Recovery is 10.2%
Acute is 13.6%
Forensics and Specialist Services is 10.6%
All care group areas are developing their workforce plans, which include approaches to retention as part of the 'Growing for the Future' People strategy pillar.

The increase is within all areas, except Forensics and Specialist Services and Corporate. This rate is also above the new 21/22 set target of 9%.
Activities to reduce turnover:

- Executive Directors to follow up with new starters, 6 months after induction
- Health and Wellbeing initiatives and support
- Career pathways to improve staff retention
- Specific focus on leavers within first 3 years

Staff Retention (015.W-W)

This is a new KPI for 21/22. The April 2021 data shows a retention rate of 89%, against a target set for 2021/22 of 90%. Activities to support retention are reflected in turnover, but also include approach to recognising and celebrating long service.

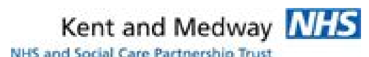
Freedom to Speak Up

For April 2021, 7 concerns have been handled by the Freedom To Speak Up Guardian (FTSUG). All of these concerns were received via the Green Button. 3 of these concerns (43%), if accurate, could be considered whistleblowing concerns. The concerns are categorised and the FTSUG develops a plan of action according to the issue.

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
001.W-W	Staff Sickness - Overall	✓	4.00%	L	4.5%	3.5%	3.6%	4.1%	3.7%	4.4%	4.4%	5.1%	4.2%	3.8%	3.5%	3.7%
004.W-W	Staff Turnover	✓	9.0%	L	10.6%	10.5%	9.3%	10.2%	10.1%	9.6%	9.4%	9.4%	9.4%	9.6%	9.4%	10.1%
005.W-W	Appraisals And Personal Development Plans		95%	L	98.5%					96.4%	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%
012.W-W	Essential Training For Role		90%	L	90.4%	89.8%	90.7%	91.0%	90.4%	90.0%	89.4%	89.5%	91.3%	90.4%	91.2%	91.8%
013.W-W	Freedom to speak up issues		-	-	0.4%	0.5%	0.5%	0.6%				0.4%				
015.W-W	Staff Retention		90%	-												89.2%

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



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

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

Issues of Concern

Executive Commentary

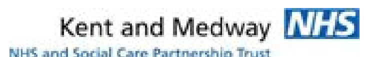
Please see the financial performance report included as a separate agenda item for the detailed financial performance narrative.

NHS Kent and Medway

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
004.W-F	In Month Budget (£000)		0.0	N	0	0	0	0	0	0	(0)	(0)	(0)	0	0	(0)
005.W-F	In Month Actual (£000)		-	-	0	0	(0)	0	0	0	(0)	800	0	0	3	0
006.W-F	In Month Variance (£000)		-	-	0	0	(0)	0	0	0	0	800	0	0	3	0
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)		-	-	638	724	823	743	804	825	824	761	638	596	767	699
009.W-F	Agency - In Month Variance from budget (£000)		-	-	211	297	396	316	377	398	397	334	211	169	340	272
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	44.46%	52.84%	62.84%	65.08%	68.95%	72.41%	74.97%	75.34%	72.74%	69.73%	70.56%	72.57%
011.W-F	CIP Plan (£000)		6m	L	282	283	561	564	564	564	564	564	564	564	564	
012.W-F	CIP Actual (£000)		-	-	187	233	427	467	834	372	421	470	471	501	452	
013.W-F	CIP Variance (£000)		-	-	(95)	(125)	(87)	(97)	270	(213)	(143)	(94)	(93)	(63)	(112)	

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



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

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

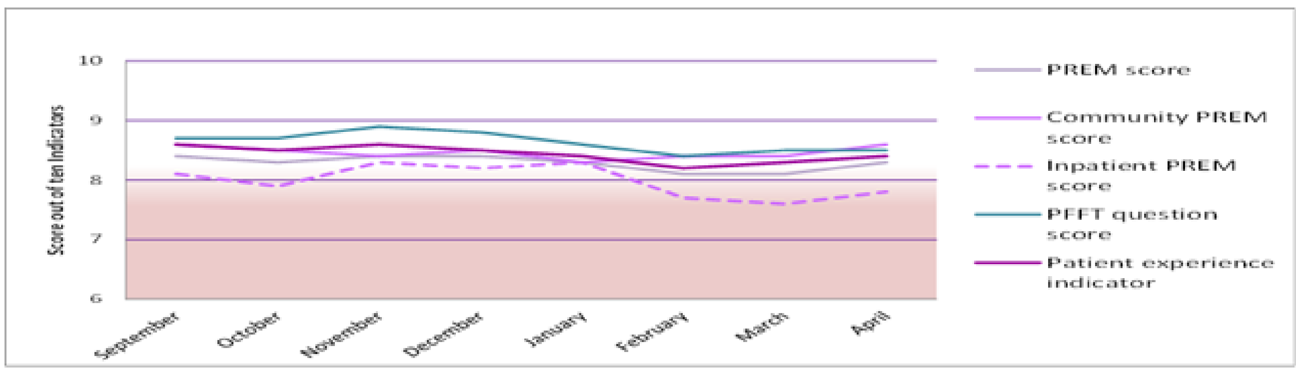
Issues of Concern
Patient Reported Experience Measure (PREM) average response rate (2.4%) remains lower than the local target of 10%. The only exception is Acute Care group who are exceeding this at (18.6%). The Quality Performance Reviews with Care Groups will discuss this and agree some trajectories for improving feedback.

Executive Commentary

Patient Reported Experience Measures (014-015.S)
447 (2.8%) and 372 (2.6%) PREM responses were gathered in March and April respectively. Analysis of the results indicates that the majority of patients are reporting on average a 'very good' experience in the quality of their care (above 8 out of 10). There has been a gradual improvement across all services in last few months (graph 1). Broken down by setting, the inpatient PREM score has improved slightly from 7.7 out of 10 in March to 7.8 out of 10 in April 2021. Scores of between 6 and 7 out of 10 are considered to be "good" while anything above this is considered as" very good".

Older adults care group had the highest average score of 8.5 out of 10 for April 2021, an indication of high quality of care as experienced by the patients.

The Patient Experience indicator which is an average of PREM and Patient Friends and Family Test also improved slightly from 8.3 out of 10 to 8.4 out of 10 in April.



Areas for improvement

For inpatient services, there are four acute wards that have had lower scores over a few months. The areas contributing to a poor experience are related to the environment which is being addressed, feeling safe, food, involvement of friends and families as much as one wishes, and checking progress with medication all of which are being addressed. There is a food and nutrition improvement plan underway led by the Executive Director of Nursing and Director of Estates and involving the Catering contractor and Matrons, set about to also address the actions from the last CQC inspection.

External feedback from people using services

Healthwatch Kent and Healthwatch Medway have started providing feedback from their engagement with people who use mental health services and liaising directly with Locality Managers in the Community Mental Health Teams (CMHTs) and Community Mental Health Services for Older People (CMHSO). The quarterly engagement meetings with the Trust resumed in May. This is in order to inform a strategic overview of themes from externally gathered feedback and to ensure any concerns raised are responded to in a timely manner and that good practice is enforced.

A total of 130 people provided feedback about health services in the last few months, with most feedback related to adult mental health services. Themes from the feedback are broadly similar to the findings from complaints and PALS enquiries. They included the negative impact of virtual therapy particularly for individuals with Complex Emotional Disorders; difficulties in communication with community teams, discharge arrangements, accessibility to services and timely medication reviews. Community teams have got work underway to address these areas of concern.

Healthwatch in Kent and Medway has agreed to continue gathering feedback to test out impact of the changes and improvements being made to the function of community teams and accessibility of telephone system. This is an action agreed with them as part of the current CMHT CQC quality improvement plan.

As the lockdown restrictions are eased, plans are underway to restart the annual 15 Steps Challenge in the summer, with all wards scheduled to have a visit by the end of March 2022. In addition to these visits, the "Mystery Shopper" initiative is also starting next month to community teams, findings will be reported on in the coming months. Both programmes of work will build on the various methods used to gather feedback on quality of care which in turn, will inform improvement priorities.

IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N									86.4%	81.8%	82.6%	84.4%
003.C	Complaints - actuals		-	-	19	33	38	36	39	29	31	23	33	29	29	36
004.C	Complaints - per 10,000 contacts		-	-	5.86	8.67	9.92	11.00	10.63	7.79	8.04	6.45	8.97	7.90	6.88	6.88
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
007.C	Compliments - actuals		-	-	86	87	128	89	111	132	120	99	97	96	122	111
008.C	Compliments - per 10,000 contacts		-	-	26.54	22.85	33.42	27.20	30.26	35.46	31.14	27.76	26.36	26.15	28.93	28.93
010.C	PALS acknowledged within 3 days (or agreed timeframe)		-	-	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%
011.C	PALS responded to within 25 days (or agreed timeframe)		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
012.C	PALS - actuals		-	-	67	78	90	84	128	117	105	53	86	81	110	97
013.C	Patient Reported Experience Measures (PREM): Response count		-	-					207	394	348	357	249	391	447	372
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-						2.6	2.1	2.3	1.6	2.6	2.8	2.4
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-					8.4	8.3	8.4	8.4	8.3	8.1	8.1	8.3

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

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
As part of the data quality revision of the Responsive element of the IQPR several changes have been made to the information reported as part of the IQPR; the reports are now more effectively aligned to how the care groups operate, especially the CMHTs and CMHSOPs however there will need to be an element of fine tuning over the next two months to ensure the reporting is a fully accurate reflection of news ways of working and subsequent reporting of data.

Executive Commentary

See SPC exception report for further information on key metrics.

IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	90.0%	80.0%	66.7%	85.7%	81.3%	78.3%	78.3%	69.6%	78.9%	63.6%	80.0%	71.4%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	88.4%	85.2%	84.0%	89.3%	93.6%	87.1%	92.4%	90.9%	88.3%	83.2%	82.5%	93.1%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	92.2%	94.0%	92.1%	93.9%	96.0%	95.5%	94.9%	93.5%	94.4%	90.7%	90.7%	88.2%
007.R	DNAs - 1st Appointments		-	-	6.8%	6.1%	6.2%	6.5%	8.4%	11.7%	13.0%	13.5%	12.6%	12.9%	11.3%	8.3%
008.R	DNAs - Follow Up Appointments		-	-	4.8%	4.4%	5.6%	5.9%	7.7%	11.4%	11.3%	11.1%	11.0%	9.9%	9.4%	8.1%
009.R	Patient cancellations- 1st Appointments		-	-	0.2%	0.4%	0.5%	0.6%	1.1%	1.0%	1.1%	1.3%	0.9%	1.0%	0.8%	0.1%
010.R	Patient cancellations- Follow Up Appointments		-	-	2.0%	2.4%	2.7%	2.9%	3.1%	3.1%	2.8%	3.2%	2.9%	2.6%	2.6%	0.4%
011.R	Trust cancellations- 1st Appointments		-	-	11.3%	13.0%	14.5%	19.9%	17.7%	18.6%	11.6%	3.7%	4.4%	3.9%	3.4%	4.2%
012.R	Trust cancellations- Follow Up Appointments		-	-	11.1%	9.9%	9.5%	10.8%	10.9%	9.8%	9.5%	8.9%	9.2%	9.2%	9.0%	11.2%
013.R	Referrals Received (ave per calendar day)		-	-	283.3	336.2	367.6	361.7	377.2	382.3	359.4	331.4	342.5	363.4	399.0	360.0
014.R	Referrals Received (ave per working day)		-	-	352.1	386.7	424.0	433.1	436.1	449.2	426.0	400.1	419.1	433.8	459.6	427.4
015.R	Referrals Received (per 10,000 Kent and Medway Registered GP population))		-	-	484.8	619.0	717.9	641.9	715.6	718.9	667.5	622.3	625.2	627.7	743.3	641.6
016.R	Referral to Assessment with 4 weeks Care Spell		95%	-	69.2%	77.0%	68.2%	55.2%	44.3%	44.1%	52.8%	53.0%	52.2%	68.7%	70.4%	68.9%
017.R	Referral to Treatment within 18 weeks Care Spell		95%	-	72.1%	67.0%	59.8%	68.4%	67.8%	70.3%	71.8%	72.5%	72.7%	74.0%	78.6%	84.1%
018.R	% Patients waiting over 28 days from referral		-	-	58.9%	55.5%	55.7%	58.2%	54.9%	50.5%	44.9%	45.6%	39.0%	30.9%	23.1%	28.0%

Appendix A

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Mar-21	Apr-21	Trend (Last 12 months where available, left to right)
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	98.3%	98.9%	
001b.E	CPA patients receiving follow-up within 72hours of discharge	95%	88.4%	86.7%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		310	375	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	80%	71%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95.0%	95.7%	95.7%	
001.S	Occurrence Of Any Never Event	0.0%	0.0%	0.0%	
001.W-W	Staff Sickness - Overall	4.2%	3.5%	3.7%	
002.W-W	Staff Sickness - Short term	1.7%	1.6%	1.6%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93%	82.6%	84.4%	

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

Appendix B: IQPR Overview and Guide

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).

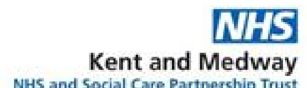
Good examples of IQPRs from high performing organisations change and improve over time. KMPT's is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the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

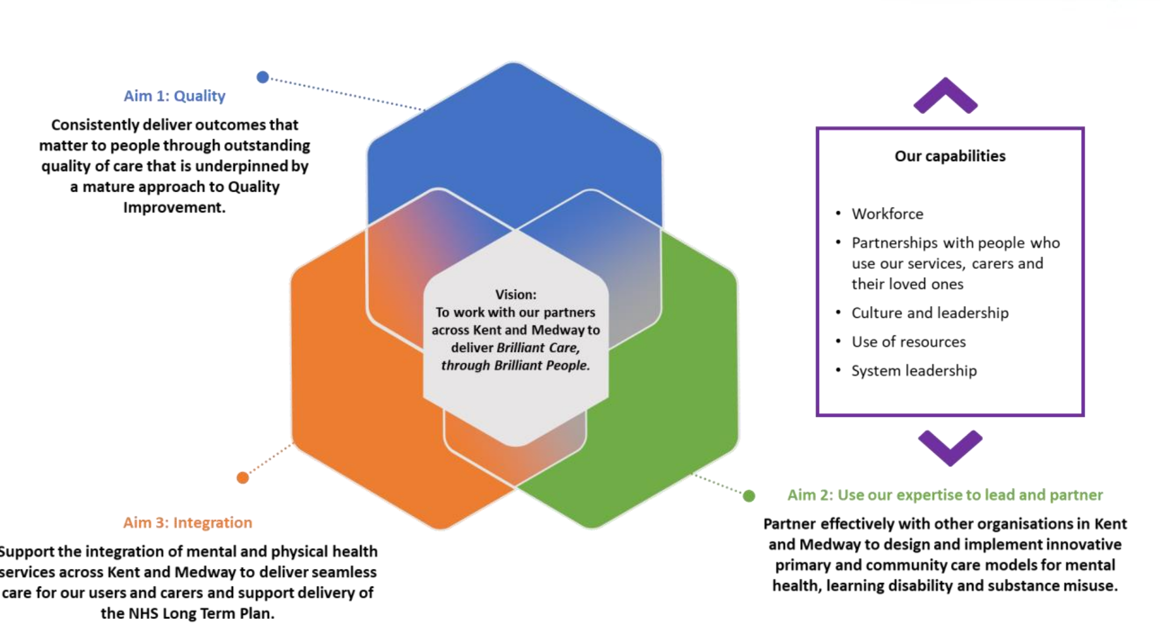
The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally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

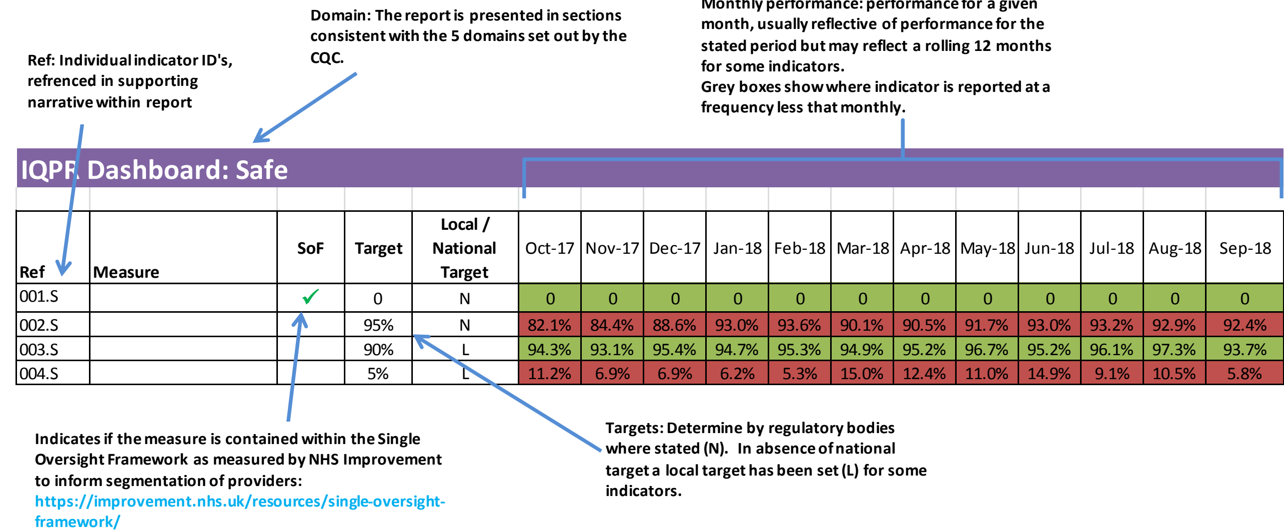




IQPR Dashboard Guide

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%

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	27th May 2021
Title of Paper:	Finance Report for April 2021 (Month 1)
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director

Purpose of Paper

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

Overview of Paper

A report containing a positional statement relating to the delivery of the Trust's functions for which the Board has a corporate responsibility but is not explicitly required to make a decision.

Items of focus

As at the end of the 20/21 financial year Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with the forecast and plan.

The cash position remains strong at £14.4m, but has reduced by £2.8m, with lower receipts from NHS England and payments against year-end capital creditors. Planning for 2021/22 has commenced, with guidance being issued at the end of March from the national team for H1 (the first half of the financial year). This bases plans on Q3 from 2020/21 and the first system submission is due on 6th May.

The approach for Mental Health in 2021/22 has been to plan a full 12 months of investment so as not to disrupt progress against the Long Term Plan. KMPT's Director of Finance is leading this submission across the system. Capital plans were submitted on 12th April in line with the system control total. There is reduced funding available for 2021/22, which has resulted in a prioritisation exercise led by the Executive Director of Nursing via the Trust Capital Group.

Governance

Implications/Impact:	New financial regime being mapped out so at this stage the requirements regarding efficiencies are not clear. Auditable records are being maintained for all Covid related spend and the national message is for finance not to obstruct sensible decision making at this time.
Assurance:	Significant
Oversight:	Finance and Performance Committee

Finance Report

Trust Board

April 2021

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Executive Summary

Executive Summary for April 2021

As at April 21, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with the draft plan.

Planning for 2021/22 is underway with the draft plan submission due on 26th May for H1 (April to September). Despite the plan submission being only for the first half of the financial year the Trust has undertaken business planning for all of 2021/22. The approach for Mental Health in 2021/22 has been to plan a full 12 months of investment so as not to disrupt progress against the Long Term Plan. KMPT's Executive Director of Finance led this submission across the system.

Income and Expenditure

Patient Care Income is reported as agreed with key commissioning organisations. This involved block payments based on historic contractual arrangements in line with planning guidance.

Additional costs for COVID-19 have been recognised in line with national guidance and April spend showed a reduction from the previous month with total spend of £211k, £148k less than the previous month. This is compared to indicative COVID-19 funding from commissioners of £200k in month.

Other pressures include private PICU placements and a upward trend in drug spend particularly within the Acute Care Group. These are being mitigated by underspends on vacancies and travel elsewhere.

Agency Spend

Agency spend for April is consistent with the last four months at £699k in month. Spend was high throughout the last financial year and the pressure is continuing into this financial year. Usage is reflective of increased staffing pressures experienced due to vacancies and the difficultly in filling shifts with bank staff in some areas. Particular pressure continues to be seen in the Nursing and Medical staff groups. A dedicated role has been introduced with NHS Professionals, our outsourced temporary staffing provider, to support the Acute Care Group with shift fill rates and cover.

Of the in-month spend, £41k is aligned to Covid related pressures.

Capital Programme

Capital plans were submitted in April in line with the system control total. There is reduced funding available for 2021/22, which has resulted in a prioritisation exercise led by the Executive Director of Nursing via the Trust Capital Group. The control total for the coming year is £15.5m for capital, including £4.6m for the nationally funded Eradicating Dormitories project.

In April capital spend was £1.4m against a plan of £1.6m with underspends on IT and the Maidstone Mental Health Transformation project.

Cash

The cash regime in 2020/21 resulted in the monthly block income being paid one month in advance. This in no longer the case for 2021/22 and block income is received in the month it is due.

The cash position remains strong at £14.4m, but has reduced by £2.8m, with lower receipts from NHS England and payments against year-end capital creditors.

The detailed cash plan for 2021/22 is being developed and will be included in the month 2 Finance Report.

Cost Improvement Programme

The Trust is currently working through a new long term sustainability programme which will support delivery of the savings programme for 2021/22.
There are schemes already underway which continue to progress and will bring cash releasing savings whilst the proposed “pillars” approach is embedded within the organisation. This will be deputy director led and encourage cross organisational working with a particular focus on addressing the underlying deficit.

Statement of Comprehensive Income

	Current Month			Year End Forecast		
	Budget £000	*Actual* £000	*Variance* £000	*Budget* £000	*Actual* £000	*Variance* £000
Income						
Income from Activities	(17,195)	(17,152)	43	(211,757)	(211,757)	0
Other Operating Income	(775)	(818)	(43)	(10,426)	(10,426)	0
Total Income	**(17,970)**	**(17,970)**	**(0)**	**(222,183)**	**(222,183)**	**0**
Expenditure						
Substantive	12,707	11,614	(1,092)	162,035	162,035	0
Bank	733	1,343	610	8,203	8,203	0
Agency	218	699	481	2,621	2,621	0
Total Employee Expenses	**13,658**	**13,657**	**(1)**	**172,860**	**172,860**	**0**
Clinical supplies	156	158	2	1,871	1,871	0
Drugs	266	286	20	3,190	3,190	0
Other non pay	2,903	2,876	(27)	33,292	33,292	0
Non Exec Director	12	14	2	147	147	0
Redundancy Costs	0	0	0	0	0	0
Depreciation	561	561	0	7,049	7,049	0
Total Non Pay	**3,897**	**3,895**	**(2)**	**45,550**	**45,550**	**0**
Total Expenditure	**17,555**	**17,552**	**(3)**	**218,409**	**218,409**	**0**
Operating (Surplus) / Deficit	**(414)**	**(418)**	**(3)**	**(3,774)**	**(3,774)**	**0**
Finance Costs	414	418	3	4,973	4,973	0
(Surplus) / Deficit	**(0)**	**(0)**	**0**	**1,200**	**1,200**	**0**

Commentary

The April position has been reported based on information known at this time. The budget for comparison is as per the draft plan as worked through by the Finance team in line with national guidance and is subject to national submission on 3rd June.

At this stage the Trust is planning a breakeven position for H1 (April 21-September 21) and a deficit of £1.2m for H2 (October 21 - March 22).

Income

Income from Activities includes nationally provided contract values for main commissioners and also Mental Health Investment for 2021/22 which is in line with Kent & Medway CCG expectations.

Pay

Substantive pay continues to underspend against budget due to vacancies. This has been offset by bank and agency costs.

Pay costs relating specifically to Covid 19 total £0.2m to date which is a reduction on the March spend of £0.4m. This includes both bank and agency spend. Agency spend remains high and is consistent with previous months.

Non-pay

Other non pay includes additional IT licences due to increased homeworking and travel which is still reported at lower levels due to home working. Drug spend has increased in month but this tends to vary month on month throughout the year.

Trust Board - Public-27/05/21

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Statement of Financial Position

	Opening	30th April 2021
	2021-22	*Actual*
	£000	£000
Non-current assets		
Property Plant and Equipment	127,056	127,980
Intangible Assets	2,221	2,172
Other non-current receivables	725	713
Total non-current assets	**130,002**	**130,865**
Current Assets		
Trade and other receivables	5,416	6,256
Cash and cash equivalents	17,266	14,442
Assets held for sale	0	0
Total current assets	**22,682**	**20,698**
Current Liabilities		
Trade and other payables	(22,867)	(21,834)
Provisions	(855)	(857)
Borrowings	(1,055)	(1,061)
Other Financial Liabilites	0	0
Total current liabilities	**(24,777)**	**(23,752)**
Non-current Liabilities		
Provisions	(2,090)	(2,088)
Borrowings	(9,886)	(9,792)
Total non current liabilities	**(11,976)**	**(11,880)**
Total Net Assets Employed	**115,931**	**115,931**
Total Taxpayers Equity	**115,931**	**115,931**

Commentary

Non-current assets
The value of non current assets has increased by £0.9m in month reflecting the capital expenditure, partially offset by depreciation.

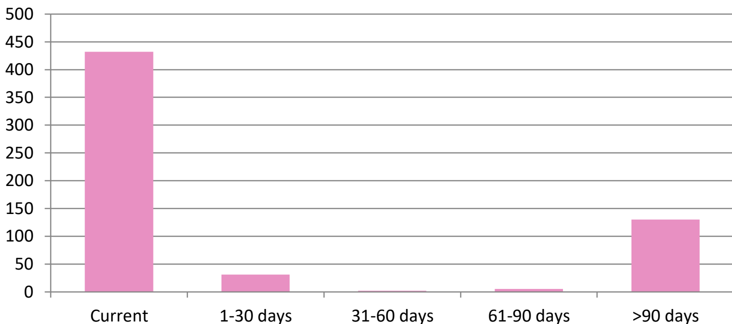
Current Assets
The cash position remains strong but has reduced by £2.8m due to lower receipts from NHS England and payments against year-end capital creditors.

Receivables have increased by £0.8m, predominantly due to a £0.4m increase in prepayments and a £1.9m increase in accrued income (£1.1m relating to the Provider Collaborative and £0.5m for the main block). This was partially offset with a £0.75m reduction in invoiced debt and a £0.7m decrease in the VAT debtor due to two months being paid in April.

Current Liabilities
Trade and other payables includes over £3m of capital creditors, a reduction of £1.7m from March, and £3.1m of deferred income.

Aged Debt
Our total invoiced debt is £0.6m, of which £0.5m is within 30 days. Debt over 90 days has remains at £0.1m.

Aged Debt Analysis



Capital Expenditure

	Current Month			
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000
Information Management and Technology	235	131	(104)	2,856
Capital Maintenance and Minor Schemes 2021/22	52	0	(52)	2,142
Capital Maintenance and Minor Schemes from 2020/21	1,056	1,088	32	3,635
Capital Maintenance and Minor Schemes Prior Year Adjustments	0	41	41	0
Strategic Schemes - Orchards Ward	174	164	(10)	1,045
Improving Mental Health Services (Maidstone)	118	7	(111)	5,787
PFI 2020/21	3	3	0	40
Total Capital Expenditure	**1,639**	**1,435**	**(204)**	**15,505**

Commentary

The Trust Capital Group met in April and agreed the priortisation of schemes which enabled the revised capital plan submitted to NHSI. As part of this there are a number of schemes that cannot be funded this year. The risks associated with these schemes have been correlated against the Trust Risk Register and are being actively monitored and reviewed. If additional funding becomes available during the year, the Trust will be in a position to progress schemes and this has been reported to the Kent and Medway system.

During April the Trust has spent £1.4m on the capital programme against the intial plan of £1.6m. The underspend relates to the Improving Mental Health Services project and IT projects, both of which are expected to catch up during the remainder of the year.

NHSE/I have yet to agreed the Trust's Capital Resource Limit (CRL) for 2021/22, pending feedback from the April capital plan submission, however the spend and plan is in line with the agreed system submission.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 27th May 2021

Title of Paper: Mental Health, Learning Disability & Autism Improvement Board Update

Author: Vincent Badu, Executive Director of Partnership and Strategy

Executive Director: Vincent Badu, Executive Director of Partnership and Strategy

Purpose of Paper

Purpose: Discussion and to note content

Submission to Board: Board requested

Overview of Paper

A paper that provides the Trust Board with an update on the Mental Health, Learning Disability & Autism Improvement Board's six workstreams.

Items of focus

- The Mental Health Learning, Disability and Autism Improvement Board is well embedded and progress is being achieved across all the workstreams, outcomes, aims and clear KPIs have been established for all workstreams. Lead organisations have been assigned within the system to provide leadership to ensuring appropriate resources and effective leadership around performance and improvement can be achieved.

- Where performance is off plan, trajectories have been established to support improvement and a monthly dashboard is in place to report on progress to the Improvement Board.

- As part of our system and regional assurance approach further work has been progressed on development of the MHLDA Improvement Board's governance structures and performance oversight against nation long term plan (LTP) priorities and local targets/ milestones using where indicated validated data.

Governance

Implications/Impact: Delivery of service/Partnership working

Assurance: Significant

Oversight: Trust Board

Background

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

The MHLDA Improvement Board brings together senior representatives from across the Integrated Care System (ICS), to work collaboratively to drive delivery of Mental Health Learning Disabilities and Autism Improvement priorities at scale across Kent & Medway.

The MHLDA Improvement Board operates as a strategic board, supporting development of the vision, outcomes, purpose and scope of Kent & Medway Mental Health Strategy, and alignment with the NHS Long Term Plan. It also holds a key role to ensure that the ICS is working collaboratively with the four Integrated Care Partnerships (ICPs) at a place-based level to ensure local innovation is considered and supported within the mental health, learning disability and autism programmes of work.

This paper provides an overview update for the Trust Board on:

a) Headline workplan for each of the 6 priority work streams, with the intended aims, outcomes and timescale.
b) KPIs against each of these 6 work streams, and progress/performance against those KPIs.

As part of our system and regional assurance approach further work has been progressed on development of the MHLDA Improvement Board's governance structures and performance oversight against nation long term plan (LTP) priorities and local targets/ milestones using where indicated validated data. This report provides an overview of progress on this work and highlights the outcome of NHS England regional team's currents assessment of our system.

Update

Since the last report to Trust Board, further work has been undertaken by the MHLDA Improvement Board through each of its priority work streams to ensure that focus continues to be clear and align to local and national priorities. At the end of March 2021, a stocktake meeting was held with NHS England regional team to provide assurance around our system improvement programme, performance on key priorities and recovery plans.

In the South East mental health assurance processes have been regionally led and have been in place for a number of years. With the changing system architecture, NHSE/I recognise the importance of updating and devolving some of the assurance processes to reflect the emerging and maturing ICS and Sustainability and Transformation Partnership (STP), providing systems greater autonomy but also increased responsibility for delivery. The MHLDA Improvement Board is supporting the ongoing work with NHSE/I South East region and the development of a new Kent and Medway dashboard and assurance framework that included key elements:

- Design of a new mental health self-assurance process that fits with both system governance and SE Region operating model and
- Development of a plan that transforms what we look at, how it is presented and understood by decision makers using new skills and tools

The regional group made up of STPs and ICS with the aim to co-design a shared reporting model for all mental health assurance has made significant progress. In Kent and Medway key roles such as Lead

Provider, Senior Responsible Officer (SRO) and Programme Lead have been confirmed together with interim ICS governance and reporting lines to MHLDA Improvement Board, ICS Partnership Board, ICS Exec Group for Corporate Assurance and Risk as well as to SE Region NHSEI Programme Board. In addition increasing numbers of project leads across the system, began to report monthly on progress towards targets; this in turn provides the narrative for the system assurance dashboard.

NHSE/I was updated in March 2021 on our contribution and progress with our own mental health system framework and in April 2021 rated the SE region STPs and ICSs; giving Kent and Medway green on assurance and infrastructure and amber on data quality. The 4th domain for patient, public and community engagement has not been rated but work is in hand to ensure the significant work currently underway, including the Prevention Concordat for public mental wellbeing and engagement plans related to the delivery of the Community Mental Health Framework is rated through our future submissions.

This report is provided as a one off for Trust Board oversight. The Trust Board is asked to note the content.

Improvement Priority	Local/National Target (KPIs)	RAG	Planned trajectory/key actions to address variance
Specialist Out of area (OOA) placements Overall outcome: The goal was to ensure that all Kent and Medway patients receive the right care, in the right place at the right time with the view to returning those persons to Kent and their community as soon as is practicable. Ensure systems and processes in placing people out of area in specialist care, are fit for purpose. **System Lead : KMPT**	• Reduce patient cohort to 80 • Reduce annual spend by 20% (£2.5m) (within first 12 months)		Current performance: • Patient cohort reduced to 67 • Net annual spend reduced by £2,113,436 In year savings £778,602
Community mental health framework and transformation Overall outcome: The aim is to achieve radical change in the design of community mental health care by moving away from siloed, hard-to-reach services to joined-up care and establishing a revitalised purpose and identity for traditional community mental health services serving those most in need with serious mental illnesses. **System Lead : KMPT/Kent & Medway CCG**	Transformation programme completed by March 2024 Local ICP rollout Medway &Swale – 2021/22 East Kent – 2022/23 DGS West Kent – 2023/24		Kent & Medway Development Plan approved by NHSE and transformation fund £10.6 m awarded. • Programme Management Office in place and clear about priorities by June 2021 21/22 programme plan in place Programme to achieve new ways of working operational and led by the local system - June 2021 – March 2022
Urgent and emergency care Overall outcome: The Mental Health Urgent and Emergency Care Programme will ensure people who experience a mental health emergency can access support and care from outside of hospitals, including NHS 111 in the same way a person can with a physical health emergency. **System Lead : KMPT / Kent & Medway CCG**	Acute Mental Health Adults Target: 0 OOA (general needs) Current performance (Feb 2021): Younger Adults – 84 days PICU - 188 YTD Crisis Resolution Home Treatment Team (CRHTT)		CRHTTs scoring 4 or above on all 39 Fidelity standards Common point of entry to mental health services via NHS 111 MH CAS CORE 24 standard service delivered in 3 acute hospitals

Trust Board - Public-27/05/21

MHLDA Improvement Board

Improvement Priority	Local/National Target (KPIs)	RAG	Planned trajectory/key actions to address variance
	Target: 100% CRHTTs scoring 4 or above on 39 Fidelity standards Current performance: 94% Mental Health Liaison Target: 3 acute hospitals to reach CORE 24 Current performance: All acute hospitals across Kent and Medway have Liaison Mental Health Service (LMHS)		Implementation of Community Crisis Alternative Services (NHSEI Transformation funding April 2021)
Dementia <u>Overall outcome:</u> People living with dementia and the people who care for them are able to access safe, timely, and high quality diagnosis and support. **System Lead : Kent and Medway CCG**	Dementia Diagnosis rate: National target: 66.7% Local target: 70% Current Local Performance: 54.3%		Aim to move to national target by March 2022 Q1. Business case under development by KMPT and CCG to utilise system recovery funds to both reduce the waiting list to 8 weeks and develop primary care capacity in 2021-22.
Children and Young Peoples Mental Health <u>Overall outcome:</u> The Long Term Plan requires that by 2023/24, at least an additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. Over the coming decade the goal is to ensure that 100% of children and young people who need specialist care can access it. **System Lead : North East London Foundation Trust**	National target:35% Local performance: 43.4% January 21 (total of 15,545 children in the preceding 12 months had accessed services) Coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions National Target: 57% Local Performance: 25%		System-wide coordinated plan to deliver plan plus investment to intervene earlier and to increase capacity within the voluntary sector and mental health services Increasing capacity through Medium Term Bids for 3 additional General KMAH beds plus up to three 72 hour crisis beds

MHLDA Improvement Board

Improvement Priority	Local/National Target (KPIs)	RAG	Planned trajectory/key actions to address variance
Learning Disability and Autism (LDA) Overall outcome: The Kent and Medway LDA program has submitted a detailed 3yr plan (2021-2024) to NHSE this month for sign off by the NHSE national team. Region has agreed the content. The plan has been developed in collaboration with key partners including trust providers, Kent and Medway councils, along with support of NHSE regional team, and for the first time articulates agreed trajectories for both AHC for the year and Adult and CYP inpatient discharges until 2024. A detailed LDA governance review has been completed. **System Lead : Kent Community Health Foundation Trust**	National Target: • Annual Health Check (AHC) – 67% • Learning Disability Mortality Reviews (LeDer) reviews - 100% • Adult inpatient Discharges - 72 • Children inpatient Discharges - 6 • Whole system LDA strategy – 2021/22 Current Performance: • AHC completion – 71% - 6704 completed AHC. This is an unverified position (data verification under way) • LeDer reviews - 100% • Adult inpatient Discharges – 100% • Children inpatient Discharges – 100% • Whole system LDA strategy - 3 year plan submitted to NHSE for sign off.		Amber rating due to a number of planned actions in Q1/2 2021/22 require complex system agreement

Trust Board - Public-27/05/21

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 27th May 2021

Title of Paper: Annual inpatient establishment review

Author: Tumi Banda, Deputy Director of Nursing and Practise

Executive Director: Mary Mumvuri, Executive Director of Nursing, AHPs and quality

Purpose of Paper

Purpose: Discussion

Submission to Board: Regulatory Requirement

Overview of Paper

This annual establishment review has been conducted in line with national regulatory requirements. An evidence based tool, Mental Health Optimal Staffing Tool (MHOST) was used to benchmark all inpatients services. Professional judgement was used to analyse and to make recommendations for the next establishment review. A detailed paper showing benchmarking data and Care Hours Per Patient Day (CHPPD) for each service is available on request and in the Board reading room.

Items of focus

- KMPT Safer Staffing fill rates were within the set standard of not falling below 80% and not above 130%.
- High levels of acuity and hospital detentions across the care groups, leading to increased use of resources and enhanced observations compared to national benchmarks
- There was adequate staffing for the acuity on the wards during review period
- Vacancies remain high for nursing and medical professionals across all care groups. ”Tackling the Vacancy Challenge” paper on the Board agenda sets out the work underway to address this for critical roles.
- New and extended roles and skill mixing is in place to address staffing gaps and to increase therapeutic interventions.
- Review peripatetic model for Allied Health Professionals and psychology with a view to increase resources. This is in order to further support recovery, quality of care and to enhance therapeutic interventions on offer.

Governance

Implications/Impact: Vacancies and use of temporary staff can impact on quality of care

Assurance: Reasonable

Oversight: Oversight by Workforce and Organisational Development Committee

Annual inpatient establishment review

1. Background and context

1.1 The annual inpatient establishment review is a statutory responsibility for the Executive Director of Nursing, Quality and Allied Health Professionals to complete on behalf of the Board. This review complies with requirements set within the National Quality Board (NQB) issued updated guidance and expectations for nursing and midwifery staffing to support the need for a triangulated approach to staffing decisions based on patient's needs, acuity and risk, using evidence-based tools and triangulated with professional judgement. The review has fully considered multi professional contributions to inpatient care settings across all care groups.

2. Methodology

2.1 The establishments were reviewed using the Mental Health Optimal Staffing Tool (MHOST) which was developed by the Shelford Group and commissioned and funded by Health Education England. The MHOST is a multi-disciplinary evidence based system that enables ward based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms. The criteria for acuity levels range from 1-5 specifically designated for a particular service with 1 being the lowest level of dependency and 5 the highest. In addition, staff use professional judgment in deciding the most appropriate level of acuity. The tool is applicable to all settings our settings apart from substance misuse. Training was delivered to ward staff to enable data collection over a 21 days period.

3. Results

- KMPT Safer Staffing fill rates from May 2020 to March 2021 ranged from 106% to 114%, which is within the set standard not to fall below 80% and not above 130%.
- Most wards apart from one had high Care Hours per Patient Day (CHPPD) which was influenced by the increased use of therapeutic observation in response to high acuity levels
- Most wards, apart from Mother and Baby Unit and rehabilitation units, had high levels of acuity compared to national benchmarks. Resources deployed reflected the levels of complexity
- There have been significant improvements to the management of the duty rosters, ensuring they are published twelve weeks in advance in line with the People Plan.

3.1 Community Recovery Care Group (CRCG)

Data was received from all 6 rehabilitations units (Ethelbert, Rosebud, The grove, 111 Tonbridge Road, Rivendell and New Haven). The acuity in the care group was low overall compared to the MHOST benchmark wards. The low acuity in the rehabilitation units may have been affected by delayed discharges which would have resulted in low acuity. Discharges had been impacted by the restrictions during the on-going Covid -19 Pandemic. There were fewer patients (reduced occupancy) on 4 out of 6 wards because the wards were going through major refurbishment works during the period the data was collected. Quality and safety reviews indicate low levels of complaints, incidents and staff turnover.

There are good therapeutic activities on offer which are well evaluated by the patients. There is an interim arrangement for addressing career progression for Band 5 nursing staff; however a long term financial solution needs to be secured in order to respond to CQC inspection actions.

3.2 Forensics and Specialist Care Group

3.2.1 Rosewood Mother and Baby Unit (MBU)

The ward was benchmarked against other 7 MBUs in the MHOST. The acuity was low on Rosewood compared to other MBUs with the majority of the patients were in Level 1. Level 1 criteria sets out that patients are at Pre-discharge stage, that the mother fully looks after her baby, engages in activities, interaction with baby is safe and consistent, attachment is good, risk level is low and baby requires no support from staff and is on 'general observation' only.

The acuity on the ward was affected by Covid-19 Pandemic restrictions during the collection period and by discharges that were disrupted and accounted for the low acuity. In addition, leave, support from family and partners and engagement was heavily reduced and restricted during the peak of the Covid-19 Pandemic. Although the mothers were assessed to be at Level 1, support may be required for the babies. Rosewood is operating and complaint with the standards set by the Royal College of Psychiatry: Service Standards for Mother and Baby Units (2014) and NHSE/I standards.

3.2.2 Medium Secure Unit (MSU)

The wards included in this section are Penshurst (male acute ward with an Extra Care Area), Groombridge (sub-acute male ward), Walmer (female Acute ward), Walmer/Bedgebury (5 bedded step down), Emmetts and Emmetts/Bedgebury (male step down and male rehabilitation). There was high acuity on Penshurst Ward at either level 4 or 5 which indicated sustained high-dependency, likely serious aggression or high self-harm risk usually associated with new admissions and a need for long-term segregation, seclusion and high usage of enhanced observations.

This acuity was an outlier compared to the MHOST benchmark wards. Similar high levels of acuity above the MHOST benchmark wards were also noted on the female acute ward Walmer. All the wards however had adequate staffing levels and skill mix which were adjusted to respond to acuity levels. Local environmental and design challenges were mitigated by increased staffing levels. Wards in MSU are due to be refurbished in the next phase of the Trust Capital programme.

Penshurst has an Extra Care Area separate from the main wards which requires a staffing complement of its own. Walmer and Emmetts also have additional areas completely separate to the main wards (Walmer-Bedgebury and Emmetts-Bedgebury) that require additional staffing; this is reflected in the resources used. The lay out of the wards is a challenge that can only be overcome by increased staffing particularly nursing staff. This is

professional judgement that the MHOST requires staff to make in response to local challenges.

The wards in the care group have peripatetic allied health team, with the unregistered staff working on sessional basis. The level of acuity on the wards suggests an increase in allied health professionals and psychology would be beneficial in complimenting the therapeutic programme on offer.

3.2.4 Forensic Low Secure wards

Acuity was high in Allington care due to having an adjacent High Dependency Unit (HDU) and also having patients on high levels of enhanced observation during the data collection period.

Tarenfort centre which is two adjacent wards for people with a learning disability also had high levels of acuity. The Trust had worked collaboratively with NHSE to support a couple of patients due to lack of nationally available appropriate beds for their care needs. The national challenges of the Autism Pathways also influenced the services to admit to services that would not otherwise admit patients with these care and support needs. Professional judgement is required to set the staffing levels to reflect the care pathway.

In contrast, Brookfield which is a learning disability step down unit had low acuity compared to the others wards in its comparison group.

4. Older Adults Care Group (OACG)

There were five wards included in this review, namely The Orchards, Sevenscore, Woodchurch, Heather and Jasmine. Ruby Ward was temporarily closed at the time of the data collection therefore was excluded in the MHOST review.

Sevenscore is a male 12 bed ward for people with Dementia. It had high acuity compared to other wards in the care group and in the MHOST benchmark wards. This is because most patients were reported to require personal care support, which needed a 2-4 staff due to high incidents of aggression. There was generally high rate of violence and aggression and staff assessed the patients to be either level 4 or 5 acuity.

Jasmine and Orchards had high acuity with most of their patients in Level 4 and 5 however Jasmine’s establishment was below the recommended level for the levels of acuity. A further review of this will be undertaken. Woodchurch, Heather and Orchards had acuity within the range of comparator wards.

The number of DToCs would have influenced the low acuity levels because the rate of discharges had been disrupted by the Covid-19 Pandemic restrictions in older adult community placements.

5. Acute Care Group

5.1 Psychiatric Intensive Care Unit (PICU): Willow Suite

During the period of data collection, the ward had 4 patients with high levels of acuity and dependency, significantly higher than MHOST benchmark wards, resulting in exceptionally high use of enhanced observations.

The ward had however adequate staff for the acuity, a significant component was nursing. There is a low ratio of peripatetic allied health professionals and psychology input, this needs an urgent review in order to reduce the use of enhanced observation and increase therapeutic engagement by the wider MDT. There are plans underway to increase occupational therapy and psychology provision as part of the additional investment to improve therapeutic interventions and support patient flow in acute environments. This will include sports and exercise technician and more use of the gym facility on the ward.

5.2 Acute wards

All the nine acute wards had high acuity levels (4 and 5) compared to the MHOST benchmark wards due to enhanced observations or long term segregation. From April 2020 to March 2021, the acute wards had on average, 75.6% of bed occupancy by patients detained under MHA (1983) which shows a high level of need. The patients admitted were likely to be acutely unwell. The Trust has some of the lowest bed stock for acute wards according to national benchmarking data, which impacts on rates of admission and discharges and high acuity levels. With high number of detentions, there is increased demands on the Responsible Clinicians and registered nurses on the wards to meet the MHA requirements, from MHA assessments, patients' rights, MHA related review such as consent and first tier tribunals. The MHA requirements are met in the current establishments. The workload related to this group of patients' advances a recommendation to have a skill mix of at least 2 RNs per shift with a third registered professional being a Registered Nursing Associate

The Care group has been proactive in gathering feedback from patients and have consistently exceeded the response rate of 10% set by the Trust. Patients experience tends to be rated as good on the PREM scores and the outlier areas are in relation to food and in one ward environmental.

It was noted that the wards have nursing vacancies and inexperienced staff who require increased clinical leadership support to enhance their confidence with decision making. The preceptorship programme has been further strengthened to ensure full support for these nurses.

There is a dedicated Occupational Therapist and an assistant on each ward including 0.5 Full Time Equivalent for psychology. There are a number of vacant psychology posts for which there is ongoing recruitment. All wards have dedicated inpatient consultants, mainly in substantive roles apart from two which are filled by long-term Locum consultants. They are supported by qualified or trainee Advanced Clinical Practitioners or Consultant Nurse which ensures continuity of care in the event of medical cover changes.

Due to limited extra care facilities on one of the hospital sites, in addition to some environmental improvements during the data collection period, the care group had mitigated the risks to safety by using increased levels of observations. This is reflected in the resources utilised.

6. Recommendations

1. Immediate review of wards that are outliers in terms of high acuity to ensure that staff are supported to avoid burnout.
2. Review and increase input from Allied Health Professionals and Psychology to meet increased acuity levels. This will reduce restrictive interventions, promote opportunities for recovery and contribute to safer and healthier environments.
3. Skill mix and fully utilise the role of the Registered Nursing Associate to cover tasks that may have traditionally been fulfilled by Registered Nurses.
4. Through vacancy challenge programme of work, accelerate development and recruitment of new and extended roles such as Occupational Therapy Assistants, Sports and Exercise technicians, Psychology Assistants, Peer Support Workers, Family Intervention Workers in Older Adults, Nursing Associates, Advanced Clinical Practitioners, non-Medical Responsible Clinicians and Social Therapist. Social Workers would be a valuable addition to assist Patient Flow Team with Delayed Transfer of Care.
5. Repeat the review in six months' time in line with national guidance to seek further assurances about the safety of staffing and impact on quality and safety.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	27 May 2021
Title of Paper:	Tackling the Vacancy Challenge
Author:	Jennie Cogger, Deputy Director of Workforce and Organisational Development
Executive Director:	Sandra Goatley, Director of Workforce and Communications

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

A paper setting out the various methods the Trust is undertaking, or plans to undertake, to tackle its vacancy gap.

Items of focus

We currently have critical vacancies in our front-line services (clinicians). We use bank and agency staff to cover these vacancies through NHS Professionals. We operate an internal locum medical bank. Whilst we value the contribution that the bank and agency staff make to the care of our patients we know that it is expensive and the quality of service is not always as good as our substantive staff would provide. We have committed to reducing our agency spend by £2 million for the financial year 2021/22.

Driving up the quality of what we do and reducing our reliance on temporary staff is fundamental to this and the newly established 'tackling the vacancy challenge group' will drive delivery. This paper shares what we already have in train to close the vacancy gap and also what we are planning.

Governance

Implications/Impact:	Impact on service delivery and Trust finances
Assurance:	Limited
Oversight:	Oversight by Workforce and Organisational Development Committee

1. KMPT's mission is to provide Brilliant Care through Brilliant People. In order to do this we must attract and retain the very best staff. We know that our most pressing challenge is the number of vacancies that we carry in front line roles. Of our total establishment of 3514.99 whole time equivalents (WTE) we have 378.8 (WTE) vacancies (11%). Of most concern are the posts that relate directly to patient care.
A breakdown of the KMPT vacancies by band/profession can be found at appendix 1.
A breakdown of the KMPT vacancies by Care Group can be found at appendix 2.

Vacancies - areas of concern:

Organisationally:

Consultant Psychiatrist - 16%
Speciality Doctors - 42%
Nursing Band 5 - 32%
Nursing Band 6 - 13%

This paper sets out the size and scale of the challenge and shows the sequential steps that we are taking to address this challenge at pace.

A new group, chaired by the Chief Executive, 'tackling the vacancy challenge' has been established and held its inaugural meeting on the 26th May 2021. It is proposed that the group will report to the Workforce and Organisational Development Committee with a clear trajectory of vacancy reduction by care group and profession.

There are four key areas of focus:

- Recruitment pipeline (we need a constant stream of high-quality new starters)
- Recruitment processes (making it quick and easy for people to join us)
- Retention (holding on to our existing talent and making them want to stay)
- New ways of working (being creative with vacancies and not always replacing like for like).

2. **Meeting the Challenge – work already underway**

We have aligned our KMPT People Strategy to the priorities set out in the newly launched NHS People Strategy. Under each of the four headings work is already underway and is detailed below:

a) **Looking after our people**
   - Promoting flexible and agile working
   - A renewed focus on health and wellbeing
   - Review of the leavers in the first 3 years of starting
   - Improved on boarding of health care workers
   - Improved experience in the first 3 years.

b) **Encourage belonging**
   - Embedding our cultural heart to attract and retain staff
   - Delivering on the challenges set out to Board on diversity and inclusion.

c) **New ways of working**

- Implementing new roles – Nurse Consultants, Advanced Clinical Practitioners, Non-Medical Prescribers, Assistant Psychologists, Support Time Recovery Workers, Band 7 Senior Practitioners, Sports and exercise technicians, Registered Nursing Associates and Social Workers
- Monthly roster check and challenge sessions (to reduce reliance on agency staff)
- Joint working with North East London Foundation Trust (NELFT)
- Revised Acute medical model business case for the Executive Management Team (EMT).

d) **Growing for the future**

- Care Group workforce plans
- International recruitment (30 nurses)
- Nursing Associates apprenticeships recruited
- Nurse Degree apprenticeship cohort recruited
- Apprenticeships across all professions
- Developing our digital work experience offer to local colleges and schools
- Remote open days being held for students across universities.
- Increasing trainees placement capacity through virtual learning.

3. Examples of this work in practise

Community Recovery Care Group

- 2.45 whole time equivalent (WTE) Speciality Doctor Posts converted to recruit to both Advanced Clinical Practitioners (ACPs) and Non-Medical Prescribers (NMPs)
- Converted 8 Band 6 Nurse posts into Social Worker posts in 5 localities
- Introduced Band 7 Senior Practitioner roles to 3 localities to aid retention and provide a clinical career pathway
- Continued to increase Support Time Recovery roles (STR) over the last 12 months by 24.69 WTE
- Converted 8 Nursing posts to Occupational Therapist (OT) posts in line with the Clinical Care Pathway work which identified more specific OT specific interventions.

Acute Care Group

- Acute medical model – paper being submitted to EMT
- New roles linked to Menu of Interventions and Therapeutic Adult Mental Health Inpatient Care (TAMHIC) investment e.g. Gym Instructor, increased OT and Psychology roles over the next 2 years.
- Nurse Approved Clinician.

Forensics and Specialist Services Care Group

- ACP role introduced in Perinatal.

Older People Care Group

- A demand and capacity review has been completed in the Community Mental Health Service for Older People (CMHSOPs). They are now working with the Dementia Specialist Interest Group. The plan is to have:
  - NMPs available to all teams
  - An ACP in each of the super localities
- 2 Nurse Consultant posts are being advertised in areas where there are less senior clinical roles.

New roles already recruited to:

- 8 qualified ACP and 24 NMPs already in post
- Nursing Associates – 20 in training and offering a further 20 places this year
- Nurse Degrees – 1st Cohort 10 places and offering 21 places this year
- Occupational Therapy Degree – 1st cohort 6 places and offering 4 places this year
- New Research and Innovation Director post created in partnership with the Kent and Medway Medical School and we have appointed to this role
- New Clinical Director for Quality Improvement/Consultant Upnor ward – position has been offered.

Trust wide

- KMPT target to recruit 6 Nurse Consultants in 2021/22
- The Chief Executive's objectives include the appointment of an additional 100 peer support workers this year
- Innovative approaches to recruitment including videos and virtual open days.

4. Summary and conclusion

Our mission to provide Brilliant Care through Brilliant People is dependent on attracting and retaining brilliant people.

Driving up the quality of what we do and reducing our reliance on temporary staff is fundamental to this and the newly established 'tackling the vacancy challenge group' will drive delivery.

5. Assurance

At this stage, limited assurance can be provided, given that the Trust's ongoing and planned work will tackle the vacancy challenge. The work is still at an early stage and so it is too early at this stage to determine if these workstreams will yield the results the Trust anticipates. The Board has recognised that at a national level, there are difficulties for NHS Trusts in recruiting medical and nursing staff.

The risks connected to the vacancy challenge are being monitored and mitigated accordingly, with risks recorded on the Board Assurance Framework and various risk registers. Regular updates regarding the vacancy challenge are provided to the Workforce and Organisational Development Committee.

6. Action required from the Board

The Board is asked to:

- Discuss the paper
- Agree the proposal that the 'tackling the vacancy challenge group' reports on a clear trajectory through to the Workforce and Organisational Development Committee
- Agree the frequency of reporting.

APPENDIX 1

Vacancies by Staff group and band

	Funded Wte	Contracted	Vacancies	% vacancy
Admin, Clerical & Management	**782.75**	**726.84**	**55.91**	**7%**
2	120.38	112.95	7.43	6%
3	220.24	196.06	24.18	11%
4	126.27	124.57	1.70	1%
5	76.50	77.14	- 0.64	-1%
6	69.30	65.94	3.36	5%
7	59.74	64.11	- 4.37	-7%
9	1.00	2.00	- 1.00	-100%
8a	29.82	25.10	4.72	16%
8b	20.00	20.80	- 0.80	-4%
8c	8.50	10.25	- 1.75	-21%
8d	7.00	7.91	- 0.91	-13%
Chief Executive	1.00	1.00	-	0%
Director	5.00	4.00	1.00	20%
Executive Director	5.00	5.00	-	0%
Modern Apprentice	33.00	10.01	22.99	70%
Healthcare Assistants	**765.77**	**711.81**	**53.96**	**7%**
1	- 2.33	-	- 2.33	100%
2	343.92	307.01	36.91	11%
3	308.42	307.33	1.09	0%
4	84.61	65.16	19.45	23%
Peer Support Worker	31.15	32.31	- 1.16	-4%
Medical	**253.08**	**174.28**	**78.80**	**31%**
Consultant	112.45	94.15	18.30	16%
Core Trainee	2.78	8.79	- 6.01	-216%
Core Training - CT1	10.05	6.80	3.25	32%
Core Training - CT2	8.93	5.38	3.55	40%
Foundation Programme - F2	14.78	-	14.78	100%
GP Sessions / Staff Fund	0.15	0.15	-	0%
Locum Consultant	7.00	3.00	4.00	57%
Locum S.H.O. (including FY2)	-	-	-	0%
Specialty Doctor	50.05	29.21	20.84	42%
Specialty Higher Trainee	3.85	-	3.85	100%
Specialty Registrar Permt	30.60	0.80	29.80	97%
Specialty Training - ST4	4.80	8.00	- 3.20	-67%
Specialty Training - ST6	6.84	17.00	- 10.16	-149%
Staff Grade Practitioner	0.80	1.00	- 0.20	-25%

APPENDIX 1

	Funded Wte	Contracted	Vacancies	% vacancy
Nursing	**1,034.85**	**882.41**	**152.44**	**15%**
5	279.30	190.79	88.51	32%
6	514.30	446.53	67.77	13%
7	185.14	181.88	3.26	2%
8a	33.80	35.40	- 1.60	-5%
8b	18.31	19.81	- 1.50	-8%
8c	2.00	2.00	-	0%
8d	2.00	6.00	- 4.00	-200%
Other Non Clinical	**181.01**	**162.45**	**18.56**	**10%**
2	27.70	28.72	- 1.02	-4%
3	6.47	4.87	1.60	25%
4	4.00	4.00	-	0%
5	0.20	-	0.20	100%
6	1.40	1.40	-	0%
7	1.00	1.00	-	0%
8b	1.00	1.00	-	0%
Ancillary - Domestic Staff	111.94	98.36	13.58	12%
Domestic Assistant	6.00	6.00	-	0%
Local Authority Staff	2.00	-	2.00	100%
Social Worker Unqualified	2.00	2.00	-	0%
Social Worker/Counsellor Qualified	17.30	15.10	2.20	13%
Scientific, Therapeutic & Technical	**497.53**	**478.40**	**19.13**	**4%**
2	1.33	1.33	-	0%
3	30.11	35.55	- 5.44	-18%
4	38.46	36.47	1.99	5%
5	56.31	50.64	5.67	10%
6	108.54	114.36	- 5.82	-5%
7	115.36	109.75	5.61	5%
9	2.80	2.00	0.80	29%
8a	79.83	66.14	13.69	17%
8b	33.18	31.65	1.53	5%
8c	18.81	19.81	- 1.00	-5%
8d	7.80	9.70	- 1.90	-24%
Paramedic	2.00	1.00	1.00	50%
Seconded staff other org	3.00	-	3.00	100%
Grand Total	**3,514.99**	**3,136.19**	**378.80**	**11%**

APPENDIX 2

Vacancies by Care Group and staff group

	Funded Wte	Contracted	Vacancies	% vacancy
Acute	**594.99**	**506.78**	**88.21**	**15%**
Admin, Clerical & Management	38.79	35.49	3.30	9%
Healthcare Assistants	248.51	223.29	25.22	10%
Medical	27.05	15.40	11.65	43%
Nursing	235.54	184.20	51.34	22%
Scientific, Therapeutic & Technical	45.10	48.40	- 3.30	-7%
Community Recovery	**902.38**	**810.94**	**91.44**	**10%**
Admin, Clerical & Management	135.92	128.65	7.27	5%
Healthcare Assistants	153.58	148.64	4.94	3%
Medical	61.10	45.74	15.36	25%
Nursing	391.32	331.40	59.92	15%
Other Non Clinical	9.86	6.10	3.76	38%
Scientific, Therapeutic & Technical	150.60	150.41	0.19	0%
Forensic and Specialist Services	**745.88**	**652.79**	**93.09**	**12%**
Admin, Clerical & Management	134.98	106.17	28.81	21%
Healthcare Assistants	221.16	205.53	15.63	7%
Medical	42.80	31.86	10.94	26%
Nursing	177.05	151.82	25.23	14%
Other Non Clinical	28.01	28.72	- 0.71	-3%
Scientific, Therapeutic & Technical	141.88	128.69	13.19	9%
Older Peoples Services	**561.70**	**513.79**	**47.91**	**9%**
Admin, Clerical & Management	83.60	79.86	3.74	4%
Healthcare Assistants	136.40	124.75	11.65	9%
Medical	34.70	32.01	2.69	8%
Nursing	189.63	166.55	23.08	12%
Other Non Clinical	6.00	6.00	-	0%
Scientific, Therapeutic & Technical	111.37	104.62	6.75	6%
Support Services	**710.04**	**651.89**	**58.15**	**8%**
Admin, Clerical & Management	389.46	376.67	12.79	3%
Healthcare Assistants	6.12	9.60	- 3.48	-57%
Medical	87.43	49.27	38.16	44%
Nursing	41.31	48.44	- 7.13	-17%
Other Non Clinical	137.14	121.63	15.51	11%
Scientific, Therapeutic & Technical	48.58	46.28	2.30	5%
Grand Total	**3,514.99**	**3,136.19**	**378.80**	**11%**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th May 2021**
Title	**Mental Health Act Committee Report**
Author	**Kim Lowe, Non-Executive Director & Committee Chair**
Presenter	**Kim Lowe, Non-Executive Director & Committee Chair**
Executive Sponsor	**Dr Afifa Qazi**
Purpose	**For Noting**

Executive Summary

The Mental Health Act Committee (MHAC) met on 12 April 2021 and discussed the following:

- Report from Mental Health Legislation and Operational Group (MHLOG)
- KMPT Consultation on White Paper of Mental Health Act
- CQC Oversight and Trust MHA Assurance
- MHA & MCA Training Report
- CLiQ Check Audits – MHA Section
- Executive Medical Director Report
- Report from Associate Hospital Managers

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

1 White Paper Response

The Committee were informed that the White Paper consultation response is due by the 21 April 2021. To ensure the Trust response included the voice of service users and a range of staff, focus groups and engagement at various forums had been sought and a paper has been collated for submission. The overall responses to the proposed changes were positive but the document highlights the operational and cost challenge implications.

2 Managers Hearings

The Committee were informed of the backlog of Community Treatment Orders (CTO) and Section 3 appeal hearings, dating back to last year in the Maidstone locality. This was partly to do with the staff shortages in the MHA Team at the Maidstone site. Assurances have been given that recruitment has been completed at the Dartford site, which was impacting on this and another staff member is being recruited to at the Maidstone site. Once the substantive position is filled in the Maidstone area the MHA Team will be able to get back on schedule with these

renewals. It was noted that all Consultants have been informed to include a review of CTO and Section 3 status at ward multi disciplinary meetings and at community red board meetings to avoid unlawful detention.

3 Section 132 Deterioration

The Committee were informed that there has been a small lapse in Section 132 rights and these had not always been fulfilled on admission. Assurance was given that this has been addressed through global communication and within the Care Groups and will be closely monitored on the ward scrutiny visits.

The Committee agreed that a QI project would be carried out in respect of the Section 132 rights and conversations held with staff to establish the barriers and understand why the rights are not always being given.

4 Devon Paper

The Committee were informed that following the ruling from the Devon Partnership Trust, where the court concluded that the physical attendance of the Allied Mental Health Professional and a Doctor was required when assessing a person for detention under the Mental Health Act. The Trust identified one Mental Health Act assessment had taken place virtually. The patient was informed in a timely manner of the Devon ruling and assessed again and detained under Section 3 of the MHA. It was noted that at the time of the virtual assessment the patient was suffering from COVID-19 and it was considered that a virtual assessment was the safest option.

The Trust has taken further legal advice around the implementation of virtual Community Treatment Order renewal hearings and further guidance was issued following the Devon ruling to ascertain no action was required on the assessments that were undertaken prior to the judgement.

Recommendation

The Board is asked to:

1) Note the content of this report.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27th May 2021**
Title	**Workforce and Organisational Development Committee Report**
Author	**Venu Branch, Non-Executive Director & Committee Chair**
Presenter	**Venu Branch, Non-Executive Director & Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Executive Summary

The Workforce & Organisational Development Committee (WFODC) met on Tuesday 18th May 2021 and discussed the following agenda:

- Older Adults Care Group Presentation
- Workforce and Organisational Development People Plan Updates, Concerns and Achievement presentation
- Culture Change Programme Update
- Diversity and Inclusion (Progress on becoming an Anti-Racist Organisation) Report
- Leavers' in 1st 3 years Report
- Apprenticeship Report
- Workforce, Organisation Development and Communications Risk Register
- Key Performance Indicators 2021/2022
- Freedom to Speak up Bi-annual Review

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

- A presentation from the Older Adults Care Group
- Workforce, OD and Communications Presentation
- Report on Apprenticeships
- Freedom to Speak Up Bi-annual Review

Older Adults Care Group and People Plan

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

The Committee noted the key priorities, concerns and achievement and their relation to KPIs.

The Committee was informed of a number of Operational Priorities:

- The re-opening of Ruby ward
- Skill-mixing and competencies
- On -going work with the Dementia Service Improvement Group

There have been a number of sessions held to agree the key principles, one of those being Skill Mixing to help work towards the planning for the Older Adults Care Group. The Care

Group is also looking at triangulating performance data which will help prepare their workforce plan for this year.

Work underway across the organisation included: The multi-disciplinary establishment review and 'Tackling the Vacancy Challenge' paper that will be discussed at the May Board. The vacancy challenge group will be chaired by Helen Greatorex and will report as required.

The main concerns outlined were:

- Delivering the Clinical Pathways across the Community Mental Health Service for Older People.
- The Committee heard that, conversations have taken place at great length with staff experiencing long COVID & fatigue. This is impacting on their daily lives and the ability to function. The Head of Service was informed there will be a Long COVID hub in Kent where staff can be referred to and access further information. There is also a Mental Health Hub which is located nearby.

Workforce, Organisational Development and Communication Presentation

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

Recruitment & Retention

The Committee heard this is the first year where the KPI's for Workforce are showing a great deal of green across the dashboard, which is an achievement.

A recent HRD meeting across Kent took place where a number of areas were identified where trusts can work in collaboration. Recruitment and Retention being one of the main topics.

International Recruitment is high on the agenda and KMPT will be working with the Yeovil Trust, who are experienced at recruiting nurses from abroad to recruit up to a maximum of 30 nurses this year. Funding has already been agreed for this.

The Director of Workforce and Organisational Development went on to inform the Committee that a consultant has been appointed on Upnor Ward. This post has been vacant for the last 18 months. We have linked this role to the Clinical Director for Quality Improvement and this created more interest in the post and may be a good indicator of what will attract good clinical staff.

The review of the exit interview process is taking place and the process will become centralised.

A Business Case is being prepared for a Centralised Investigation Team to be in place to assist with all investigations and hearings which will release clinical resource.

Health & Wellbeing

The Committee heard that the HRD's across Kent discussed joining up to help deliver Health and Wellbeing across Kent. There is consideration of an Occupational Nurses resource across Kent to monitor sickness.

Apprenticeships

The Committee reviewed the Apprenticeship programme which enables Kent and Medway Partnership Trust to grow talent and develop existing staff to provide a leading service to our patients. The NHS continues to be one of the top three employers for Apprenticeships in the country. Fiona Anderson outlined some of the figures which was received from one of our main training providers on the make-up of our apprentices, but we will obtain the figures from all our providers going forward to help attainment. The figures below are a quick snapshot.

- 71% are female
- 21% are BAME
- 51% - is level 1 attainment which is an equivalent GCSE D-G
- 24% - disadvantage postcodes
- 30% additional Learning Needs

The Apprenticeship Programme is included in the Recruitment and Retention Strategy. The programme forms part of our strategy to encourage more young people to work for the organisations.

Freedom to Speak Up

The Committee reviewed the Bi-annual report from Freedom to Speak up Guardian. It was reported there had been a decline in the number of raised concerns. One explanation could be that the team have not been visible across the Trust since the beginning of COVID. As we are coming out COVID, the Freedom to Speak Up team are starting to create opportunities to meet with staff, re-invest in those relationships which are key to building and creating a safe space for staff to speak up. There is a plan in place to increase visibility.

Recommendation

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

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**27 May 2021**
Title	**Quality Committee Report**
Author	**Fiona Carragher, Non-Executive Director and Committee Chair**
Presenter	**Fiona Carragher, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Executive Summary

The Quality Committee was held on 18 May 2021. In line with the Committee work plan, the following items were discussed and scrutinised as part of the meeting:

1. Quality Digest
2. Quality Risk Register
3. CMHT and CMHSOP Waiting Lists
4. Quality Impact Assessments
5. Quality Account 2020-21
6. Mortality Report Q4
7. Research and Innovation Strategy
8. Clinical Care Pathways Programme Report

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

1. CMHT and CMHSOP Waiting List

The Committee received and discussed the report which showed the current position on waiting lists related to referrals to assessment (28 days target) and referrals to treatment (18 weeks target). The report also covered information on interventions that people are waiting for and length of wait.

There is a difference in approaches to the management of waiting lists between CMHTs and CMHSOP, mainly informed by clinical needs and risks. The Older Adults care group has a high number of referrals for people requiring memory assessment (MAS) while the CMHTs predominantly provide specialist treatment interventions for people with complex serious mental illness. The Committee noted that Covid-19 had an impact on the Older Adult assessments, whereas the CMHT assessments were able to continue with virtual treatment offers. Assurance was provided that the both Care Groups have mitigations in place to ensure patient safety whilst awaiting required treatment.

The Committee noted that an active review process is in place to support people waiting for treatment which has received a positive response from the CQC. The Committee discussed good practice around this process, and the potential for it to remain in place in the future to ensure demand tracking and future planning.

Recruitment is underway to increase capacity for treatments individuals are waiting for.

The Committee were advised that the Mental Health Learning Disability Clinical and Professional Board are working on the Dementia Pathway in order to ensure a system response and collaboration required to improve capacity for undertaking dementia assessments. The Committee commended the hard work of Executive colleagues on this piece of work.

2. Clinical Care Pathways Programme Report

The Committee received and noted the report.

It was reported that here have been significant steps within the programme, all of which are a first within KMPT, and have received overwhelmingly positive outcome measure results (with the exception of Schema Therapy, which is no longer running).

The Committee noted that progress continues towards some availability of the interventions in each area; however work has been slower than anticipated in some areas due to pressures around staffing resource and change fatigue during the pandemic. Skill mixing is in progress to help reduce this resource gap.

It was noted that digital technology is required across all Care Groups, with early work underway with the performance team in relation to capturing outcomes on Rio for initial interventions and the potential for extending to all interventions. The Committee were assured that staffing is adequate for this service; however there is a need to ring fence their work and protect their time, with strengthened clinical leadership being implemented.

The Committee discussed and recommended sharing clinical outcomes externally with patients, third Sector organisations, GPs as well as with our staff for our internal learning.

3. Quarter 4 Mortality Report

This report was discussed and is attached to the Committee Chair's report

The Board is asked to:

1) **Note the content of this report.**
2) **Receive the attached Quarter 4 Mortality Report for publication.**

Front Sheet

Title of Meeting	Quality Committee	Date	18 May 2021
Title of Paper	Quarterly Mortality Review (Quarter 4)		
Author	Frances Lowrey, Mortality Review Manager		
Executive Director	Mary Mumvuri, Executive Director of Nursing, AHPs and Quality		

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

Recommendation:

The Committee is asked to discuss the report and to note assurances in place to review mortality incidents.

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

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

- 608 mortality incidents were reported on Datix in Q4 compared to 586 in Q3 in 2020/21. Two KMPT older adult inpatient deaths were reported, one related to COVID-19 and the other followed a short physical health illness. There were five Covid related mortality incidents of older people whose physical health deteriorated and required transfer and treatment in an acute hospital
- Four suspected suicides of people in the community occurred in Q4 2020/21. All have been reported as serious incidents and are in the stages of investigation. The number of suspected suicides remained the same in both Q3 and Q4.

- Overall, serious incidents have increased in Q4, with a total of 23 reported compared to 11 in Q3. Six incidents related to patients who have died from COVID-19, where it is believed they contracted the virus on a KMPT ward.

- Initial review of non COVID-19 related mortality incidents, identified learning required to strengthen follow up in the community, care planning and risk assessments and use of virtual contacts. There were no mortality serious incidents within the Acute Care Group and Forensic and Specialist Care Group in Q4 2020/21.

- Serious incidents relating to mortality from Community Recovery Care group increased from 9 in Q3 to 16 in Q4.
- There were 15 mortality incidents relating to patients from a Black Asian and Minority Ethnic (BAME) background in Q4. This is an increase of nine compared to Q3 2020/21. All 15 incidents have been reviewed in the Trust-wide SI and Mortality Panel where two have been declared as a serious incident (STEIS reported). The remaining 13 incidents indicated no care or service delivery problems following scrutiny of care, therefore not reported as serious

incidents.

- Of the total 608 mortality incidents in Q4, eight patients had a diagnosis of a learning disability and were spread across the four care groups. All eight patients died from natural causes, including COVID-19 for three patients. As there were no care or service delivery concerns following KMPT's scrutiny, the incidents will not be subject to further learning reviews but have been reported through the Learning Disabilities Mortality Review (LeDeR) process which is led by the University of Bristol.

- There were 116 mortality incidents relating to COVID-19 in Q4 2020/21 with a total of 85 COVID-19 deaths reported in January 2021 alone. This is an increase of 23 since Q3 and is to be expected given the significant increase in new cases associated with the Kent Covid-19 variant and the entire system being a national outlier. The figures reported in February and March 2021 significantly reduced however, with eight reported COVID-19 mortality incidents in March 2021. This appears to be in line with the national and local picture of COVID-19 deaths.

Report History:

A Q3 report was presented to the Board in January 2021 as per NHSI's expectations for Mortality Reporting.

Strategic Objectives:	• **Select as applicable**

☒ Deliver outstanding quality of care across all of our domains

☒ Deliver and embed continuous improvement in all we do.

Implications / Impact:

Patient Safety:
Training for the SJR (Structured Judgement Review) process has now been delivered to a total of 18 staff members including 11 doctors and the SJR process is now in place.

Identified Risks and Risk Management Action:
There is an organisation risk if learning from mortality is not embedded into practice.

Resource and Financial Implications:
Additional funding for recruitment of a Mortality reviewer member was agreed and the post has been recruited to. The staff member commenced in post in March 2020.

Legal/ Regulatory:
The Structured Judgement Review process is a national requirement for provider organisations.

Engagement and Consultation:
Engagement with other Mental Health NHS organisations.

Equality:
None identified.

Quality Impact Assessment Form Completed: No

1. INTRODUCTION

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

2 MORTALITY SCRUTINY

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

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

3 ANALYSIS OF INFORMATION

3.1 In Q4, a total of 608 mortality incidents were reported on Datix. The graph (1) below indicates that since January 2020, we have been reporting and collating the data on all mortality cases which includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality in Q4 have slightly increased compared to 586 in Q3 2020/21, with a significant increase of STEIS reported cases compared to Q3 figures. The increase in STEIS reported cases is partially linked to COVID-19 related deaths. Six cases relate to patients who died either in the acute hospital or a KMPT ward as a result of COVID-19, and have been STEIS reported in line with national guidance. A review of the initial learning from non COVID-19 incidents, identified the need to strengthen community follow up, completion of care planning and risk assessments, and mode of clinical contact based on need and risk. In some cases, low staffing levels due to COVID-19 related absence in the community, are believed to have contributed to gaps in care highlighted. Most of these incidents are still going through the learning review where the root causes will be identified and all learning shared and implemented.

3.2 As previously highlighted to the Board, the figures will continue to fluctuate depending on the timing of updating patients' records on the national spine by General Practitioners. The vast majority of these incidents were reported by Older Adults community teams and would have been people who had previous contact with community teams and from areas in the County with a high proportion of older people and also with more nursing or residential homes.

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

Graph 1 Mortality reported cases

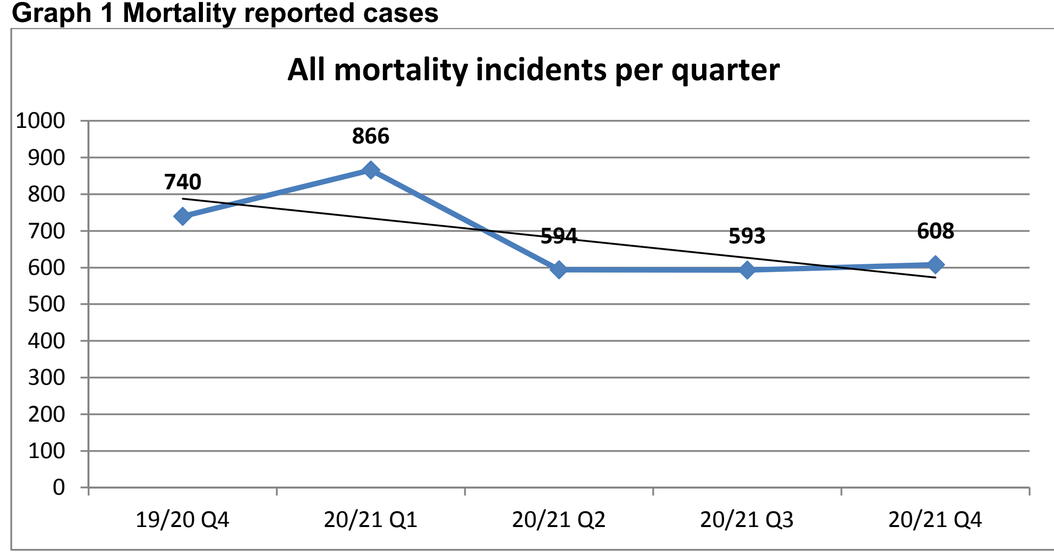


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Mar -20	Apr -20	May -20	Jun -20	Jul -20	Aug -20	Sep -20	Oct -20	Nov -20	Dec -20	Jan -21	Feb -21	Mar -21	Total
Suicide (actual)	5	3	2	7	4	5	6	0	2	1	3	1	0	39
All Deaths reported on Datix	184	374	205	287	238	216	140	135	232	226	275	178	155	2845

3.4 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q4, 0.6% of deaths of patients are suicide or suspected suicide related. This compares to 0.7% reported in the previous quarter. The average number of deaths for the 13 months above was 219 per month. For this quarter, there was an average of 202 per month. This is similar to last quarter's data with an average of 196 per month in Q3 2020/21.

3.5 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services were the highest reporters. The number of suspected suicides presented in the Q3 Mortality Report was four. As shown in table 1, this is now showing as three. This is due to the cause of death now confirmed as not being suicide related. The figures relating to historic mortality and suspected suicide will differ due to new information being known, which can ultimately change the outcome and category that the incident is recorded as on Datix. There were four suspected suicide related deaths reported in Q4, this is showing as a slight increase compared to Q3, when initially the number remained the same. There were no suspected suicides reported by Forensic and Specialist Services or the Acute Care Group.

3.6 Three of the four suspected or confirmed suicides were in the Community Recovery Care Group; this is an increase of one since Q3 2020/21. All four cases related to male patients, with an age range of between 45 to 74years of age, from different teams and have been reported as serious incidents. This is fitting with the national data in that

suicide in males between the ages of 45 to 49 tends to be higher. Any themes from suicide related deaths will be captured as part of the suicide thematic review, completed every six months.

3.7 **Analysis by age and gender**

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

Age Band	19/20 Q4	20/21 Q1	20/21 Q2	20/21 Q3	20/21 Q4	Total
100+	4	3	2	1	1	**11**
90-99	159	162	11	138	97	**567**
80-89	289	348	13	215	255	**1120**
70 to 79	136	192	34	110	124	**596**
60 to 69	44	53	33	49	50	**228**
50 to 59	44	45	52	30	31	**202**
40 to 49	35	34	118	16	24	**227**
30 to 39	15	24	232	16	18	**305**
20 to 29	13	6	94	10	5	**128**
10 to 19	1	0	4	1	1	**7**
Unknown	0	1	0	0	2	**4**
Total	**740**	**868**	**593**	**586**	**608**	**3395**

Table 3 Deaths reported on Datix by gender and age

	100+	90-99	80-89	70-79	60-69	50-59	40-49	30-39	20-29	10-19	Total
Male	0	37	128	66	32	21	22	11	3	1	321
Female	1	60	127	58	18	10	2	7	2	0	285

Table 4 COVID-19 deaths by gender

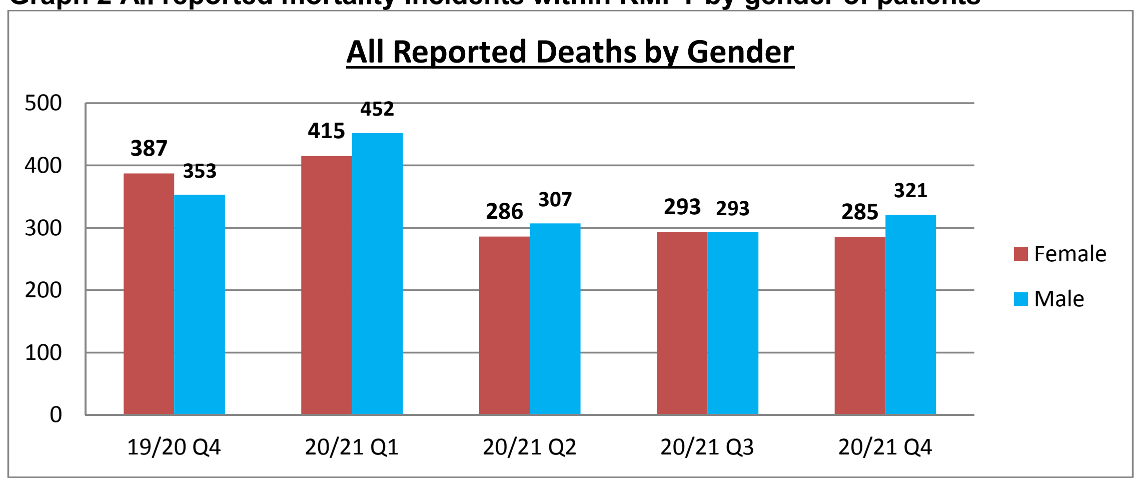
	Aug 2020	Apr 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Total
Female	4	21	1	2	6	25	44	10	4	117
Male	4	21	2	2	7	20	41	13	4	114
Total	8	42	3	4	13	45	85	23	8	231

3.7.3 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age and residing in residential or nursing homes and presenting with co-morbidities. Nonetheless, they are subject to the same scrutiny as younger age group when reported by KMPT staff. There have been five older adult incidents that have been subject for an SJR, due to the patient having a diagnosis of psychosis during their last episode of care.

3.7.4 The figures relating to mortality have increased slightly in Q4 2020/21 compared to Q3 2020/21. This was expected in view of the significant increase in COVID-19 cases and mortality across the Kent and Medway system and the area being an outlier. There is evidence however of the numbers reducing, with a total of eight patient deaths reported in March 2021. Mortality incidents relating to COVID-19 are likely to fluctuate in the coming months. The roll out of the Covid -19 vaccination has possibly impacted on the reduction in mortality.

3.7.6 When data is analysed of reported deaths within KMPT according to gender, indications are that figures of all mortality in men and women has fluctuated in each quarter (see graph 2). In Q4, the number of deaths in males was higher than in females, and has been higher in most quarters, with the exception of Q4 2019/2020 and Q3 2020/21. From a review of patient deaths reported between Q4 2019/20 and Q4 2020/21, the figures relating to older patients are higher in comparison to younger patients (below the age of 60), with figures relating to older female mortality being slightly higher; whereas deaths of working age males is higher than females.

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



3.7.7 In Q4, the four cases of suspected suicide by age and gender were as follows in table 5.

Table 5 Suspected suicide by age and gender

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

70 – 79 years	1	-
80 – 89 years	-	-
90 – 99 years	-	-

3.7.8 Nationally, middle-aged males (between the ages of 40 – 60 years) are at a higher risk of death by suicide although suicide occurs in all ages and genders (NCiSH data). It would be expected that figures for male suicide in this age group would be over-represented in this specific age range. Nationally there is a steep rise in suicide from the age of 15 to 25 years which plateaus out and then begins to decline after 60 years approximately.

3.7.9 The numbers of suspected suicides reported in Q4 2020/21 has slightly increased with a total of four reported in both Q4 compared to three Q3 2020/21. There was one female suspected suicide reported in Q4 compared to zero in Q3. A review of suspected suicide deaths during the COVID-19 lockdowns has been carried out by Professor Louis Appleby (Professor of psychiatry who leads the National Suicide Prevention Strategy for England) found no evidence of a large national rise in suicide post lockdown. Their review found higher figures in 2020 which should be seen in the context of a rising national rate and maturing real time surveillance systems.

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

- Patients who have died by suspected suicide within 12 months of contact with KMPT services, for deaths occurring since 1 January 2020.

3.7.11 So far, KMPT have identified 56 patient deaths that meet the criteria of a NCiSH questionnaire. 51 questionnaires have been completed thus far with four more to go. The NCiSH has confirmed with KMPT that the study has been extended to 31/03/2022.

3.8 Mortality review by ethnicity
Table 6 Deaths by ethnicity

	19/20 Q4	20/21 Q1	20/21 Q2	20/21/Q 3	20/21 Q4	Total
Bangladeshi	0	0	1	0	1	2
Black African	0	3	1	0	1	5
Black Caribbean	0	2	2	2	0	6
Chinese	0	1	0	0	0	1
Indian	1	2	1	0	3	7
Mixed white and Asian	0	0	0	0	1	1
Mixed white and black African	0	2	0	0	1	3
Mixed white and black Caribbean	2	1	0	0	1	4
Not stated	72	76	65	42	49	304
Other Asian	1	3	4	1	3	12
Other Mixed	0	0	2	1	2	5
Other ethnic category	0	1	0	1	2	4

Pakistani	0	0	0	1	0	1
White - British	652	757	504	524	528	2965
White - Irish	4	7	3	3	4	21
White - other white	8	12	10	11	10	51
Unknown	0	1	0	0	2	3
Total	740	868	593	586	608	3395

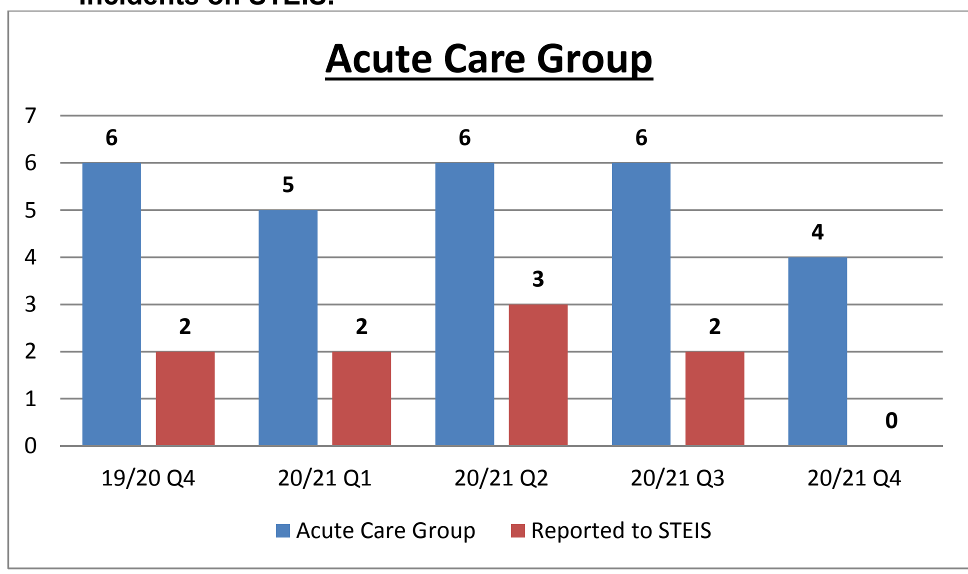
3.8.1 The majority of the incidents relate to people who are from a white British background. This is consistent with the local population profile being predominantly white British. Reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were 15 in Q4 2020/21 compared to six in Q3 2020/21. Of the BAME deaths in Q4 2020/21, two were Datix death notifications (this may have been related to GP practices completing administration work). For the remaining 13 BAME patients, four were patients who died from COVID-19, one was reported to KMPT by the coroner. Two of these incidents have been reported as serious incidents in line with national criteria. ,

3.8.2 Of the 608 incidents reported on Datix during Q4, 49 (8%) had no ethnicity recorded. This has slightly increased since Q2 where 7% had no ethnicity recorded.. Where ethnicity was not recorded, this could be due to some patients declining to provide their ethnicity, or were people under KMPT care for a number of years before the renewed focus on ethnicity reporting. Work is ongoing in operational and performance team to improve on ethnicity recording.

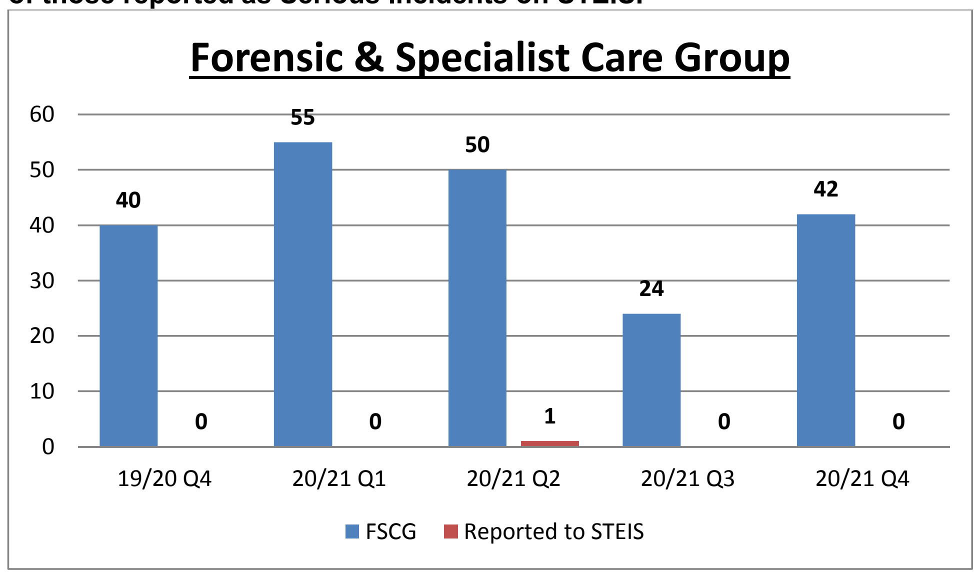
3.9 Serious Incidents and LeDeR cases

3.9.1 The following graphs (3 to 6) show the mortality incidents reported for the period 01/01/2020 to 31/03/2021 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

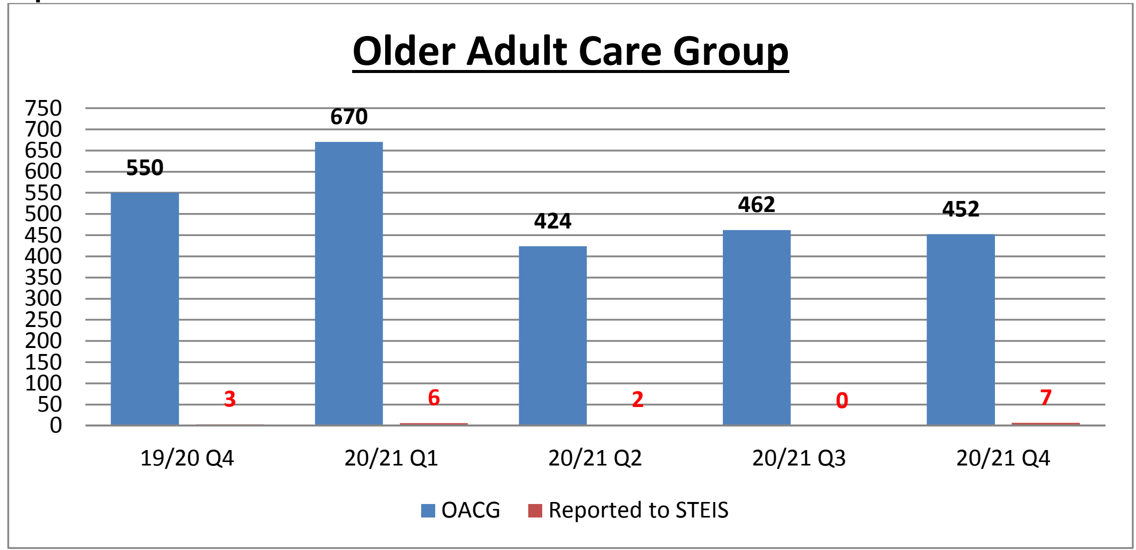
Graph 3 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.



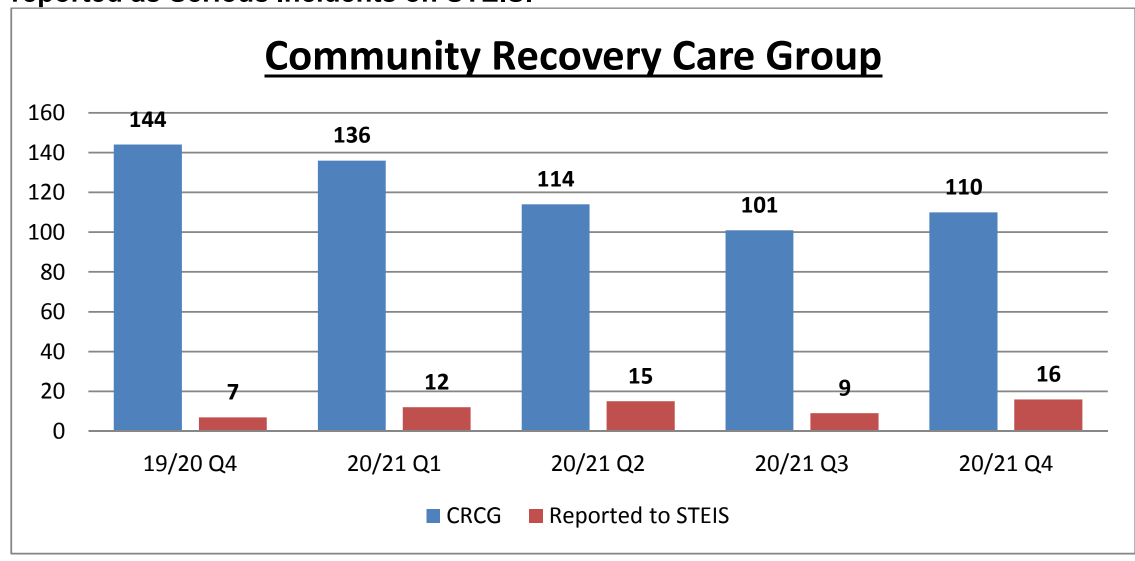
Graph 4 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.



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



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



3.9.2 Figures relating to mortality have increased in Forensic and Specialist Care Group and Community Recovery Care Group. The overall mortality incidents for Older Adult Care Group in Q4 have decreased whereas serious incidents within the care group have increased. Of the seven Older Adult serious incidents relating to mortality reported, six were of inpatients whose death was related to COVID-19. Five patients died in the acute hospital following transfer from a KMPT ward and one patient died on an Older Adult KMPT ward. Overall, serious incidents reported across the Trust in Q4 increased by 12 from Q3. The mortality figures relating to COVID-19 increased in January 2021 with a total of 85 reported deaths compared to 45 in December 2020. The figures have continued to reduce in February and March 2021. This is in keeping with the national data, as the rate of infection began to reduced and also likely to be linked to roll out of the COVID-19 vaccine.

3.9.3 There have been two inpatient deaths reported in Q4. Both patients were female and in their 70s. One patient died as a result of a COVID-19 diagnosis and has been STEIS reported in line with national guidance. The other incident related to a short physical health illness which was responded to appropriately therefore not deem to be a serious incident.

3.9.4 On review of the 23 Serious Incidents relating to mortality that were reported on STEIS, four related to suspected suicide. The remaining incidents relate to mortality where cause of death is not yet known, but where care and service delivery problems have been identified.

3.9.5 In Q4, there were eight mortality incidents where the service user had a diagnosis of a learning disability which was reported to LeDeR. Seven patients were of white-British ethnicity and one of other white ethnicity. Five patients were male and three female, ages ranged between 58 and 74 years. Three patients contracted COVID-19 prior to their death.

4. STRUCTURED JUDGEMENT REVIEW LEARNING

4.1 There have been a total of 10 SJRs completed since implementation of the process in October 2020. The reviews have identified a mixture of very good care and areas of care that could be improved. It is important to note that the SJR outcome has not changed the original decision where it was not deemed to be a serious incident. The care groups with the highest number of cases for SJR are Community Recovery and Older Adults. This is to be expected as the caseload is typically higher for both services. The Mortality Review Manager is working closely with the Head of Patient Safety to develop a process for sharing and implementing the learning identified from SJR's in order to further improve quality of care.

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

- Diagnosis of psychosis during the patients last episode of care

4.3 A themed SJR review will be carried out over the upcoming months and will be presented to Quality Committee. A review of ad-hoc cases will also be introduced over the next few months, this had been put on hold due to COVID-19 operational pressures.

5. CONCLUSION AND NEXT STEPS

5.1 Mortality incidents recorded on Datix slightly increased in Q4 compared to Q3; STEIS reported mortality incidents have significantly increased in Q4 compared to Q3. This is partially relating to six COVID-19 related deaths whereby one patient died on a KMPT ward and the others within an acute hospital after it was believed that they contracted COVID-19 whilst on a KMPT inpatient ward. A review of the initial learning from non-COVID-19 incidents identified the need to strengthen community follow up, completion of care planning and risk assessments, and a focus on mode of clinical contact i.e. virtual or face to face, based on health need and risk.

5.2. Themes of learning drawn from serious incidents will be reviewed as part of the six monthly suicide thematic review, as well as learning relating to COVID-19 as part of the COVID-19 thematic review.

5.3 The Trust will continue to review mortality incidents through the Structured Judgement review process and relevant thematic reports.

	Title of Meeting	**Board of Directors (Public)**
	Meeting Date	**27 May 2021**
	Title	**Audit and Risk Committee (ARC) Report**
	Author	**Peter Conway, Chair of ARC**
	Presenter	**Peter Conway, Chair of ARC**
	Executive Director Sponsor	**N/A**
	Purpose	**Assurance**

Summary

The Audit and Risk Committee (ARC) met on 13 May 2021. This was a meeting limited to members only plus Finance in order to consider:

- Draft Annual Accounts 2020-21
- Draft Annual Report 2020-21
- Review of External Auditors

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

Area	Assurance	Items for Board's Consideration and/or Next Steps
Financial Reporting	Draft Annual Accounts: Overall, the Accounts look satisfactory with a good quality draft submitted for audit which is now underway	ARC meets again on 15 June following which it is hoped that the Committee will be able to recommend approval of the Accounts to the Board at its next meeting on 24 June
Financial Reporting	Draft Annual Report**: ARC considered the report and suggested some amendments ***most of the Annual Report is not audited and therefore ARC will not make a recommendation to the Board as such except for the Annual Governance Statement and some additional staff information both of which are scrutinised by the Auditors*	1)PAC to discuss the draft AGS further with HG 2)ARC to consider the auditable items of the Annual Report on 24 June
Financial Controls	External Auditors: the current 3+2 contract has a year 3 anniversary next June. ARC considered the options available at the present time	ARC to review again in Q4 2021

1 Recommendation

The Board is asked to:

1) **Note the content of this report**
2) **Provide direction regarding ‘’Items for Board’s Consideration’’ where appropriate**

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 27 May 2021

Title of Paper: Board Assurance Framework

Author: Louisa Mace, Risk Manager

Executive Director: Mary Mumvuri, Executive Director of Nursing, AHPs and Quality

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. A summary of key controls and evidence is added as appendix 1. Following the Board Seminar in April 2021, work is underway to transition to a new style of BAF from July.

Items of focus

- No risks have reduced their risk score since the last report
- 5 risks have been removed following review and agreement from Audit and Risk Committee
- 4 new risks have been added
  - Risk ID 6623 – Easing of Lockdown National Roadmap - Agile working (Rating 8)
  - Risk ID 6626 – Development of a Crisis Line (Rating 16)
  - Risk ID 6628 – Financial Sustainability (Rating 16)
  - Risk ID 6630 – Implementation of Trust Strategy 2020-2024 (Rating 8)

Governance

Implications/Impact: Compliance with regulatory requirements

Assurance: Not applicable

Oversight: Audit and Risk Committee

The Board Assurance Framework

The Top Risks are

- Risk ID 6570 New Finance Regime 2020/21 (Rating of 16 – Extreme)
- Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 – Extreme)
- Risk ID 6626 Development of a Crisis line (Rating of 16 - Extreme)
- Risk ID 6628 Financial Sustainability (Rating of 16 - Extreme)

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

Risk Movement

No Risks have changed their risk score since the last report

Risks Removed

The BAF was reviewed by the Audit and Risk Committee in March. The following risks were agreed for removal.

6274 – Lack of commissioned care for people with Learning Disabilities and Autism
This risk has been removed from the BAF as the risk is considered well managed from a Trust perspective. There have been improvements in gatekeeping for this patient cohort, so the risk score has reduced, but there are still occasional admissions to KMPT beds of patients with Autism or Attention Deficit Hyperactivity Disorder (ADHD), therefore this risk remains on the care group risk register for ongoing monitoring.

6098 – Long Term Financial Sustainability
This risk has been removed from the BAF and replaced by a new risk amalgamating the Long term financial sustainability and Cost Improvement programmes into one risk. This new risk will focus on identifying concerns around the financial performance of the Trust. New Risk ID is 6628 – Financial Sustainability

6428 – 2020/21 CIP Programme
This risk has been removed from the BAF and replaced by a new risk amalgamating the Long term financial sustainability and Cost Improvement programmes into one risk. This new risk will focus on identifying concerns around the financial performance of the Trust. New Risk ID is 6628 – Financial Sustainability

6431 – Covid secure workplaces
This risk has been removed from the BAF as KMPT workplaces are certified as Covid Secure and mitigations are effective in reducing the spread of disease in the workplace. This risk will be monitored for a year to ensure workplaces remain Covid secure and in line with any government guidance. Since the government announcement on 22 February 2021 on the roadmap for easing restrictions, focus is on the return to the workplace. This risk has been replaced by a new risk relating to the easing of the lockdown and agile working (Risk ID 6623)

5920 – Female PICU Bed use
This risk has been removed from the BAF as the contract for out of area beds is working well and is set at the correct level. It is recommended that this risk is closed.

New Risks

6623 – Easing of Lockdown National Roadmap - Agile working
This risk has been added to replace risk ID 6431 Covid secure workplaces. The risk has changed and now consideration is being given to how to manage a return to the workplace in line with the government roadmap for easing of restrictions. This is an emerging risk.

6626 – Development of a Crisis Line
This risk was opened by the Chief Operating Officer. It reflects the NHSE/I requirement for a 24/7 Crisis line. Currently this is provided by the Single Point of Access Service, which was not designed to offer this service. This risk reflects the gap while the service is reconfigured.

6628 – Financial Sustainability
This risk has been added to replace two financial risks around long term financial sustainability and achievement of CIP targets. Currently this risk has met its performance metric as funding streams are linked to the response to the Covid-19 pandemic, however this is a lack of clarity on the cost savings which will be required and at what part of the year these will run from.

6630 – Implementation of Trust Strategy 2020-2024
This risk has been added to ensure delivery of the Trust strategy.

Recommendations

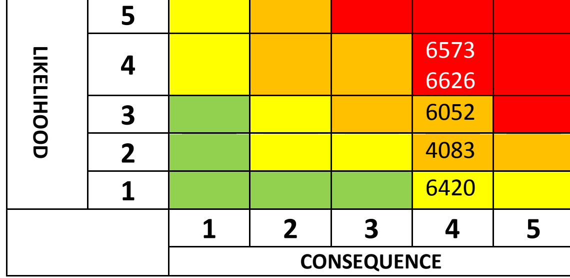
The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.

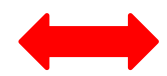
Kent and Medway
NHS and Social Care Partnership Trust

Strategic Objective 1

Consistently deliver outstanding quality of care

Risk Report





Opened:
17/11/2020
Target rating: 9
Target Date:
30/09/2021

Risk ID 6573: IF Community teams cannot meet system demand for mental health assessment and treatment
THEN there will be delays and failures to provide care and treatment at the right time
RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.

Performance Metric: Improvement in the 4 and 18 week wait trajectory.

Performance Metric Status: **Not Met**

BAF Owner: Chief Operating Officer

Directors Comment: As described at Finance and Performance committee and Board via the IQPR in Feb 2021 the ability of the CMHTs (adult and older adult) to achieve improved access to timely services (4 and 18 week wait) remains challenging due to the impact of Covid. Overall the performance across the teams is steady however the impact has been seen in the 2 largest CMHTs due to Covid sickness in January and February. For older adults, West Kent teams were particularly challenged.

The response rates for the 4 week wait across the CMHTs is an improving position each month, as identified in the monthly IQPR. The care group is monitoring each team's ability to respond each week and the improved position is related to a reduction in staff sickness absence.
The response rate for the 18 week wait across the CMHTs remains consistent at approx. 90%. The care group is undertaking a skill mix across all teams to increase capacity for Initial Interventions, which is the first treatment for the majority of people accessing services.

The key issue for older adult remains inability to meet the demand for memory assessment which requires a system response as in new commissioned pathways or additional funding. Memory assessment changes are a key element for change of the dementia workstream aligned to the MHLDA improvement board. The current demand and capacity data is clear that even with fully staffed teams the demand outstrips capacity to provide timely memory assessment for all

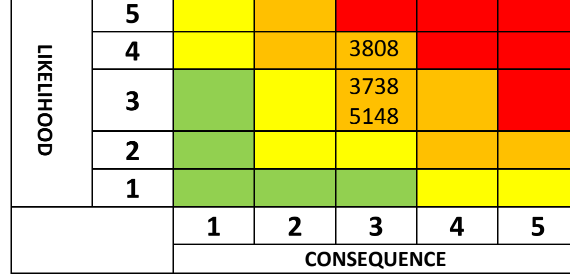
As the Covid impact decreases some improvement across the CMHTs are expected towards the end of quarter 4.

	NEW Opened: 14/12/2020 Target rating: 12 Target Date: 30/09/2021	**Risk ID 6626:** IF the SPoA is unable to respond to additional demand and requirements as it moves to become a Kent-wide Crisis Line as required by NHSE in response to the Covid pandemic in addition to its existing functions THEN there will be people who do not have their calls answered and/or clinical decision making may be compromised. Response to urgent referrals may also be compromised by an increase of crisis line calls RESULTING IN poor patient and referrer experience, patient safety issues, increased staff stress and reputational damage as a result of not delivering a nationally required service. **Performance Metric:** Number of abandoned calls decreases in line with national standards for similar services (TBA) Waiting times for calls is reduced in line with national standards for similar services (TBA) Reduction in Serious Incidents compared to March 20 and March 21 relating to patients within 7 days of contacting the service compared to March 20 and March 21 **Performance Metric Status: Not Met** **BAF Owner: Chief Operating Officer** Directors Comment: Since May 2020 the SPOA has been required to operate as a system wide, public facing crisis line for mental health; this was in response to wave 1 and the fact 111 was under significant strain. The initial agreement was to offer this change of service up the end of June 2020. The trust set the service up quickly noting the risk level could increase due to the service operating in a more public facing role – the Standard Operating Procedure was revised at this point. Since May 2020 the number of calls has increased by around 50% with the number of abandoned calls increasing due to capacity issues and telephony In August NHSE required all counties in England to continue with the changes. For the KMPT SPOA to embed fully a new telephony system was required as was significant additional funding to ensure a robust 24/7 service alongside the need to change operational functions to offer a crisis line rather than a SPOA into secondary mental health services. In November 2020 additional funding was agreed to enhance the service, in January 2021 the phone line became an 0800 number in line with national requirements and a senior Urgent Access Lead role was employed to progress the work at pace;

		The functions of the service will change considerably from access to specialist care for mental health crisis to more of a triage telephone crisis line linked to 24/7 urgent assessment. The work is overseen by a DCOO who is leading the wider system work to develop a single crisis line for mental health with existing providers of similar services; KMPT, Mental Health Matters and 111. Key actions include: • New telephony system • Recruitment to newly funded posts to deliver a 24/7 safe service) • Development and publication of a revised Standard Operating Procedure meeting the needs of a crisis line • Continued work with partners to develop a single crisis response • Additional staff training in new ways of working • Increased medical leadership to drive the clinical redesign of the service
	 Opened: 06/03/2019 Target: 3 Target Date: 30/09/2021	**Risk ID 6052:** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice. **Performance Metric:** CQC Well Led ratings; Enforcement Actions **Performance Metric Status:** Met **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: We have needed to make some minor amendments to ensure clinical staff could be delivering high quality care during the COVID pandemic this has included moving to CLIQ check light however this has not changed the assurance process. We had an unannounced inspection from the CQC of our Acute Wards on the Littlebrook site in December 2020 and to 4 CMHT's in November 2020. The Acute wards inspection identified some areas of improvement and some areas of notable practice; the service rating has not been changed. The CMHT's rating however has been reduced from an overall Good to Require Improvement in safety, responsiveness and Well Led. A quality improvement plan is in place to address the three Regulatory Notices given. Progress is monitored internally by the Quality Committee and externally, through the quarterly CQC Engagement meeting. The Trust overall rating remains Good.

	Opened: 04/12/2014 Target rating: 4 Target Date: 30/06/2021	**Risk ID 4083:** IF we do not have effective means for measuring, monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to safety risks RESULTING IN self-harm and or death from suspension from anchor points and may mean patient safety, financial penalty, reputational damage and prosecution **Performance Metric:** Reduced number of moderate to severe harm incidents involving anchor points **Performance Metric Status:** **Met** **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: Ligature risks are mitigated operationally through individual patient risk assessments, ligature risks audits, environmental checks, use of technology such as door top alarms, use of formal observations and therapeutic interventions. We continue to modernise our Estates as part of the Trust Capital programme. Trends and themes relating to ligature incidents are reviewed by relevant Trust governance groups. The IQPR report includes numbers of any such incidents where harm has been caused and there has been one moderate harm incident in three years.
	Opened: 28/04/2020 Target rating: 4 Target Date: 23/05/2022	**Risk ID 6420:** IF there are not adequate national stocks of COVID-19 PPE provided through the national supply chain to NHS Organisations THEN there is a risk that Trust Staff (including contractors, partners and volunteers on Trust sites) will not have access to appropriate PPE RESULTING IN a failure of the Trust to comply with Health and Safety regulations which may lead to increased staff sickness and unions instructing staff to withdraw from the working environment which in turn will impact on the health and safety of patients. **Performance Metric:** Stock control and Sitrep data **Performance Metric Status:** **Met** **BAF Owner: Executive Director of Nursing & Quality** Directors Comment: The Trust continues to have good stock levels of all PPE, including emergency contingencies held in the East of the County in the event of road disruptions related to e.g. adverse weather or the end of EU Transition. Across all core lines there is a minimum of 21 days stock held and for non-core items there is an ongoing locally sourced supply ordered on a weekly basis. Regular updates are given by the Trust's Associate Director of Procurement via Tactical group and elsewhere as appropriate with escalations and resolutions made as suitable. Supply chains have remained stable since the end of EU transition. Staff are being encouraged to ensure PPE stocks are reviewed ahead of the weekends to ensure there is time for stocks to be delivered to them.

Linked Risks (Current Rating)**:** **Risk ID 5875:** 4248 Community Flow, High Caseloads & Unallocated Cases (4 Mod); 5623 Referral to assessment within 4 weeks (9 High); 6031 – 6040 CMHTs Demand & Capacity (16 Extreme) 6149 High levels of referrals into the organisation **Risk ID 4083:** 2667: H&S Compliance (9 High)	**Assurances:** • **Risk ID 5875:** Investment via the MH investment standards, revised Standard Operating Procedures, weekly performance information to team level, improved CPA performance • **Risk ID 6052 –** Capital Programme oversight of environmental improvements and new projects; Quality Performance Meetings; CQC Well Led Inspection report February 2019; CQC Engagement meeting feedback; MHA reviews; QPR Performance and Quality report; patient safety incidents. • **Risk ID 4083:** Monitored by NHS England via STEIS; Datix incident reports, therapeutic observations and engagement; Health & Safety ligature Audits; Refurbishment programme is reducing anchor points; *National Standards for Mental Health unit builds* • **Risk ID 6420:** PHE Outbreak overview spreadsheet available to Trust IPC. Pre-planned requirement for PPE to service Seasonal Flu campaign mapped via IPC/Trust Procurement. Products are being assured via IPC/Procurement to assure of HSE compliance for new national stockpile/product ‘push’ receipts. • **Risk ID 6626:** Governance meetings/QPR; CliQ checks and local quality audits; OAC Programme Board
Performance Report X	**Key Controls:** • **Risk ID 5875:** Care Group management overview; QPR oversight; Recruitment policy; CliQ Checks; Caseload Management tool • **Risk ID 6052 –** Achievement of good/outstanding regulatory standards; Implementation of care pathways; Environmental improvements to estate; CliQ-Checks; CCG Quality Visits; CQC Mental Health Act Reviews; Thematic deep dives • **Risk ID 4083:** Health & Safety Risk Assessment (HS20); Annual Ligature Audits; Ligature inventory; Oversight by Prevention of Suicides and Homicide Group and Trust Wide Health Safety and Risk Group; Ligature Champions; Refurbishment programme includes anti-ligature fittings and door top alarms; standardised ligature cutters • **Risk ID 6420:** Local and national sitrep reporting, central procurement strategy, mutual aid between partners in Kent and Medway • **Risk ID 6626:** Urgent Access Lead role in place; Oversight by COO and EMT; MHIS funding invested in year and recruitment underway; Delivery group in place with all relevant stakeholders; Standard Operating Procedures

Strategic Objective 2	Recruit retain and develop the best staff making KMPT a great place to work	
Risk Report  LIKELIHOOD 5 / 4: 3808 / 3: 3738 5148 / 2 / 1; CONSEQUENCE 1 2 3 4 5	 Opened: 12/05/2014 Target Rating: 9 Target Date: 31/03/2022	**Risk ID 3808:** IF we fail to recruit appropriate numbers of healthcare professionals THEN this will impact on the ability to meet safe staffing requirements RESULTING IN continued reliance on agency staff, increased cost and potentially lower quality service to patients. **Performance Metric**: Reporting to CCGs, Vacancy rate, reduced use of agency/bank/NHSP staff, over performance on Agency Cap (national target) **Performance Metric Status: Not Met** **BAF Owner: Director of Workforce & Communications** Directors Comment: New approach will supplement the Recovery Transformation Board work stream, including MDT establishment review to be concluded in May 2021. New roles developed – 1st Nurse Consultant recruited. Advanced Clinical Practitioners steering group in place. Nursing Associates and Nursing degree training in place. Reviewing vacancy rate to take into account new roles/posts associated with developments such as the Mental Health Investment Standard Medical Improvement Plan in place, overseen by Executive Management team Acute development of a new medical model to aid recruitment and draft International Business Case for medical recruitment to be considered at next Programme Board on 12th May 2021. Continuing culture work journey & best place to work ethos, alongside the People Promise Employer branding – pilot for Health Care Support Workers, supporting other media than nhs.jobs to attract Innovative methods to support recruitment i.e. Virtual Open Day video International recruitment monies secured for nursing Work started with North East London Foundation Trust to look at a joint recruitment programme. Task and finish group set up chaired by Chief Executive for 'Tackling the Vacancy Challenge'

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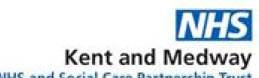
	⟺ Opened: 01/04/2014 Target Rating: 6 Target Date: 31/03/2022	**Risk ID 3738:** IF we do not have engaged employees THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business **Performance Metric:** Response rate and staff engagement indicator from annual staff survey **Performance Metric Status: Not Met** **BAF Owner: Director of Workforce & Communications** Directors Comment: Staff Survey 2020 completed – action plans being developed by Care Groups/Support Services Just and learning approach with Big Conversation events, Leadership Forums – now held virtually. Culture Programme Board in place Leadership and management development, plus career development work Talent management and succession planning Freedom to Speak Up Guardian Preventative work on sickness absence - pilot in Acute extended Improvements to appraisal and supervision Health and Wellbeing focus – health and wellbeing team funds Schwartz rounds agreed
	⟺ Opened: 05/03/2017 Target Rating: 6 Target Date: 31/03/2022	**Risk ID 5148:** IF we do not retain our employees THEN this would impact on staff morale, absence and productivity and have a potential impact on patient experience RESULTING IN impact on Turnover, Absence etc. **Performance Metric:** Turnover rate **Performance Metric Status: Not Met** **BAF Owner: Director of Workforce & Communications** Directors Comment: Embedding new approach to supervision processes and recording, including appraisal and talent management discussions Business Case written to move band 5 nurses to band 6 once they have reached certain competencies – this will also aid recruitment as more attractive for Band 5 nurses Career pathways to improve staff retention Leadership and management development Health and Wellbeing focus (as above) 6 month check in for new starters with Executive Management Team Focussed work on improving retention of staff for first 3 years in post



Linked Risks (Current Rating):	**Assurances:**
3954: Recruiting an effective workforce (16 Extreme) 4617: Revalidation of Nurses (2 Low) 4540: Recruitment & retention of medical staff (6 Moderate) 5073: Appraisals (8 High)	• **Risk ID 3808:** Monitoring of recruitment and retention; Monitored by WFOD Committee bi Monthly • **Risk ID 3738:** Workforce Committee oversight; Green Button activity; Leadership and management development; *Report to Trust Board – Staff Survey and appraisals;* Cultural work • **Risk ID 5148:** External monitoring – various bodies; *(Text in italics denotes a 3rd line control)*
Performance Report [ ] [X] [ ] [ ]	**Key Controls:** • **Risk ID 3808:** Review of Roster templates; Escalation policy; Recommend a Friend; Review of end to end recruitment process with transformation Team; SafeCare. • **Risk ID 3738:** Quarterly Staff Friends & Family Test Survey; NHS Staff Survey; Care Group and Staff Awards; Green Button on i-connect; Freedom to Speak Up Guardian; Big Conversation events; 'Just learning' approach review of culture; EMT Working With Days **Risk ID 5148:** Exit Interviews; Supervision and Appraisals;

Strategic Objective 3	**Put continuous improvement at the heart of what we do**	
Risk Report (Risk matrix, LIKELIHOOD 1–5 vs CONSEQUENCE 1–5: 5989 at likelihood 3 / consequence 3; 6623 at likelihood 2 / consequence 4)	⟺ Opened: 25/01/2019 Target rating: 6 Target Date: 31/03/2021	**Risk ID 5989:** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical health of clients **Performance Metric:** No impact on service delivery **Performance Metric Status:** Unknown **BAF Owner: Executive Director of Nursing and Quality** Director's comment: The trust's response mirrors the guidance from Public Health England, NHSE/I and Department of Health and Social care. The trust is aligned to the national command and control structure for a level 3 Major Incident response (led by Public Health England on a regional basis). The Trust command and control arrangements run as per the national requirement of 08:00 to 20:00 7 days per week. The following National work streams have been introduced: - NHS Staff Vaccination programme - Priority Group Vaccinations - Updated Shielding List based on an evaluation of evidence. The Indian Variant: A new variant of C19 has been noted as a continuation of the risk at the current score. The national roadmap announced in February continues

		along its expected trajectory, with no additional guidance issued given nationally to suggest a change in mitigations. Those eligible for vaccination are being encouraged to take it when offered.
	NEW Opened: 02/03/2021 Target Rating: 4 Target Date: 27/08/2021	**Risk ID 6623:** IF Staff misinterpret the national roadmap for easing of lockdown (22/02/2021) THEN they may conclude that they can return to work in Trust buildings around 21 June 2021. RESULTING IN a non-controlled plan which will not be based on new guidance on working from home which the national roadmap states will not be issued until at least 5 weeks after step 3 of national roadmap has been implemented. **Performance Metric:** Agile working policy published and communicated **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: This new emerging risk has been added to ensure we are prepared for staff who have been working from home to return to Trust buildings as the lockdown restrictions ease. This replaces risk ID 6431, the establishment of Covid secure workplace.
Linked Risks (Current Rating)**:**	**Assurances:** • **Risk ID 5989:** Physical Health Nurses in place, Access to Cloud now widely available to staff, Business Continuity Plans in place, EPRR Core Standards compliance • **Risk ID 6623:** Reporting through Agile working group *(Text in italics denotes a 3rd line control)*	
Performance Report X	**Key Controls:** • **Risk ID 5989:** Remote working availability for some staff, Infection Prevention & Control Policy, Infection Control Lead, Business Continuity Plans, Physical Health Nurses in post • **Risk ID 6623:** Agile working group; Communications re continuation of work from home and stay at home where possible messages; Covid secure SOP;	

Strategic Objective 4	**Develop and extend our research and innovation work**	
Risk Report LIKELIHOOD 5: yellow, amber, red, red, red 4: yellow, amber, amber, red, red 3: green, 5345, amber, amber, red 2: green, yellow, yellow, amber, amber 1: green, green, green, yellow, yellow CONSEQUENCE 1 2 3 4 5	Opened: 10/08/2017 Target Rating: 1 Target Date: 31/12/2021	**Risk ID 5345:** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment, tendering and patient choice **Performance Metric:** Increase in research recruits; Increase in bid submissions; **Performance Metric Status: Met** **BAF Owner: Executive Medical Director** Directors Comment: Research strategy has been deferred until the new R&I Director is in post. The R&I Director post has been appointed to an outstanding candidate from Kings College London and will be starting with the Trust in early September.
Linked Risks (Current Rating): 3808: Recruitment (12 High)	**Assurances:** • **Risk ID 5345 –** National research governance arrangements; *Annual report to Board; Performance Metrics monitored by CRN, KSS and NIHR* *(Text in italics denotes a 3rd line control)*	
Performance Report red / amber / yellow X / green	**Key Controls:** • **Risk ID 5345 –** Increasing principle investigators and R&D links across the organisation in line with the R&D Strategy; R&D SoP; Statistical analytical software available on the Cloud; Monitored by CEOG and Quality Committee; Annual report to the Board; Report ERN comprehensive research network.	

Strategic Objective 5	**Maximise the use of digital technology**	
Risk Report	Opened: 19/09/2019 Target Rating: 2 Target Date: 31/10/2021	**Risk ID 6193**: IF we are unable to establish a Mobile RiO solution and get approval and funding THEN staff would not realise the benefits to utilising mobile devices to access clinical records RESULTING IN the inability to improve services and realise improved productivity and improve patient experience. **Performance Metric:** Effective mobile RiO solution to be in place and used by mobile staff **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: The Trust Board approved the Clinical Technology Strategy and invested 5 year funding to deliver it. Capital funding has been allocated for Mobile RIO in 2020/21 and this funding has continued in 2021/22 to support the roll out. Solution testing is underway in Crisis Resolution and Home Treatment teams. The Trust has completed the specification and procurement has started.
	Opened: 23/07/2020 Target Rating: 1 Target Date: 30/09/2021	**Risk ID 6485**: IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy **Performance Metric:** Completed 'Project on a Page' reports for each project to communicate progress specifically with regards to communications and engagement with users and risks and issues. The Governance structures are ultimately responsible ensuring representation, resources and the success of the Clinical Technology Strategy **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: A number of meetings have occurred with our Digital Transformation Group, however our Digital Strategy Board (Group) has not met regularly. The Clinical Technology strategy programme is undergoing a review. A number of staff are joining to assist in the Digital Transformation and Change management that is needed to ensure that clinical engagement and participation is in place. They will ensure benefits realisation and that ROI is fully documented, captured and realised. The team will be joining in from June to September and will progress this further.

LIKELIHOOD						
	5					
	4					
	3					
	2		6485	6193		
	1					
		1	2	3	4	5
		CONSEQUENCE				

		A further RIO workshop was held and participation with clinical and administrative staff was well received and an action plan will in place soon, however we would look for clinical sign off and continued clinical leadership as this will require change to working practices.
Linked Risks (Current Rating):	**Assurances:** • **Risk ID 6193** - Trust Board Minutes, Capital plan for IM&T., Project update sheets for mobile RIO Project. • **Risk ID 6485** – Governance meetings in operation with clear ToR and outcomes	
Performance Report X	**Key Controls:** • **Risk ID 6193** Progress monitored via digital delivery board, Engagement with vendors for hardware, software and mobile networks, Engagement work with clinical teams, Benchmarking with other NHS trusts, Evaluation of potential solutions and suitability • **Risk ID 6485** Trust board commitment and approval, Digital business partners allocated, reviewed at ICTSMT monthly	

Strategic Objective 6	**Meet or exceed requirements set out in the Five Year Forward View**	
Risk Report LIKELIHOOD 5, 4, 3, 2, 1 CONSEQUENCE 1, 2, 3, 4, 5	Opened: Target: Target Date:	No risks identified against this strategic objective.
Linked Risks:	**Assurances:** •	
Performance Report	**Key Controls:** •	

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Strategic Objective 7	**Deliver financial balance and organisational sustainability**	
Risk Report	Opened: 01/04/2020 Target Rating: 6 Target Date: 30/09/2020	**Risk ID 3164:** IF the capital programme is not delivered in full THEN the Estates Strategy agreed at Board may not be executed in the timescales set out RESULTING IN clinical and workplace environments which may not be full fit for purpose. **Performance Metric:** Delivery of completed schemes as per revised 2021-22 capital programme **Performance Metric Status: Not Met** **BAF Owner: Executive Director of Finance** Directors Comment: The Trust has agreed a capital programme for 2021/22 as part of the in-year planning process. This has been agreed with the Kent and Medway system. There is currently £6.5m of high priority schemes that cannot progress due to a limited control total. The capital resource for this financial year is being managed on a system basis again. There is currently a system held contingency, and allocation of this out to individual Trusts is being discussed. The Trust has flagged to the system the risks associated with schemes not being progressed.
	Opened: 17/11/2020 Target Rating : 12 Target Date: 31/03/2022	**Risk ID 6570:** IF the national team do not acknowledge the financial pressure for KMPT created as a result of the calculation for control totals THEN KMPT will need to rely on expenditure controls and contingency to deliver its breakeven position RESULTING IN a higher chance of not achieving breakeven this financial year and will have an impact on future financial years if the funding regime remains the same. **Performance Metric:** delivery of financial position in line with breakeven control total **Performance Metric Status: Met** **BAF Owner: Executive Director of Finance** **Directors Comment:** This risk covers the new finance regime and how the baseline has been set. The regime has based the expenditure plans for the last six months of this year on month's 8-10 actual expenditure during 2019/20. This has therefore led to a financial pressure for KMPT as the Trust moved their forecast favourably in month 10 last financial year. The risk is £5m per annum. The Trust has now received confirmation that a 6 month planning adjustment will be made recognising the issue that has been created by the

Risk matrix:

LIKELIHOOD		1	2	3	4	5
	5					
	4				6570 6628	
	3					
	2				3164	
	1					
		CONSEQUENCE				

		national regime. The value received is not the full year effect (FYE) required. The impact of the FYE has been discussed with the system for 21/22 planning and has been funded for H1.
	NEW Opened: 10/03/2021 Target: 9 Target Date: 31/03/2022	**Risk ID 6628:** 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, receiving increased scrutiny from NHSE/I and financial sanctions will be imposed **Risk Owner: Executive Director of Finance** **Risk Type: Strategic Risk** **Performance Metric:** Achieving CIP targets Remaining in line with financial control totals Adhering to SFIs and budget limits **Performance Metric Status: Met** **Risk Manager Comment:** Following a review of risks we have amalgamated Long Term Financial Sustainability and CIPs into one main risk. This will focus on identifying concerns around the financial performance of the Trust, relating to budgetary variances, efficiency and productivity initiatives and recovery of the underlying deficit. Programmes of work are commencing in the next few months. The new approach focuses on a "pillar" based approach with deputy directors leading cross-organisational programmes.
Linked Risks:	**Assurances:** • **Risk ID 3164 –** Board, FPC and Trust Capital Group oversight; Business Case Review Group • **Risk ID 6570 –** Board, FPC, QPR meetings • **Risk ID 6628 –** Board, monthly review of KPIs, QPR meetings	
Performance Report X	**Key Controls:** • **Risk ID 3164 –** Clear prioritised capital plan, reviewed regularly with services; Tight design and specification processes and capital programme management • **Risk ID 6570 –** Monthly reporting to Board and FPC, Monthly QPR, Financial forecasting, scenario modelling, Agency controls • **Risk ID 6628 -** Board reporting; NHSI reporting; QPRs; SFIs; Budget Meetings; CIP Meetings; Budget Holder authorization and authorized signatories	

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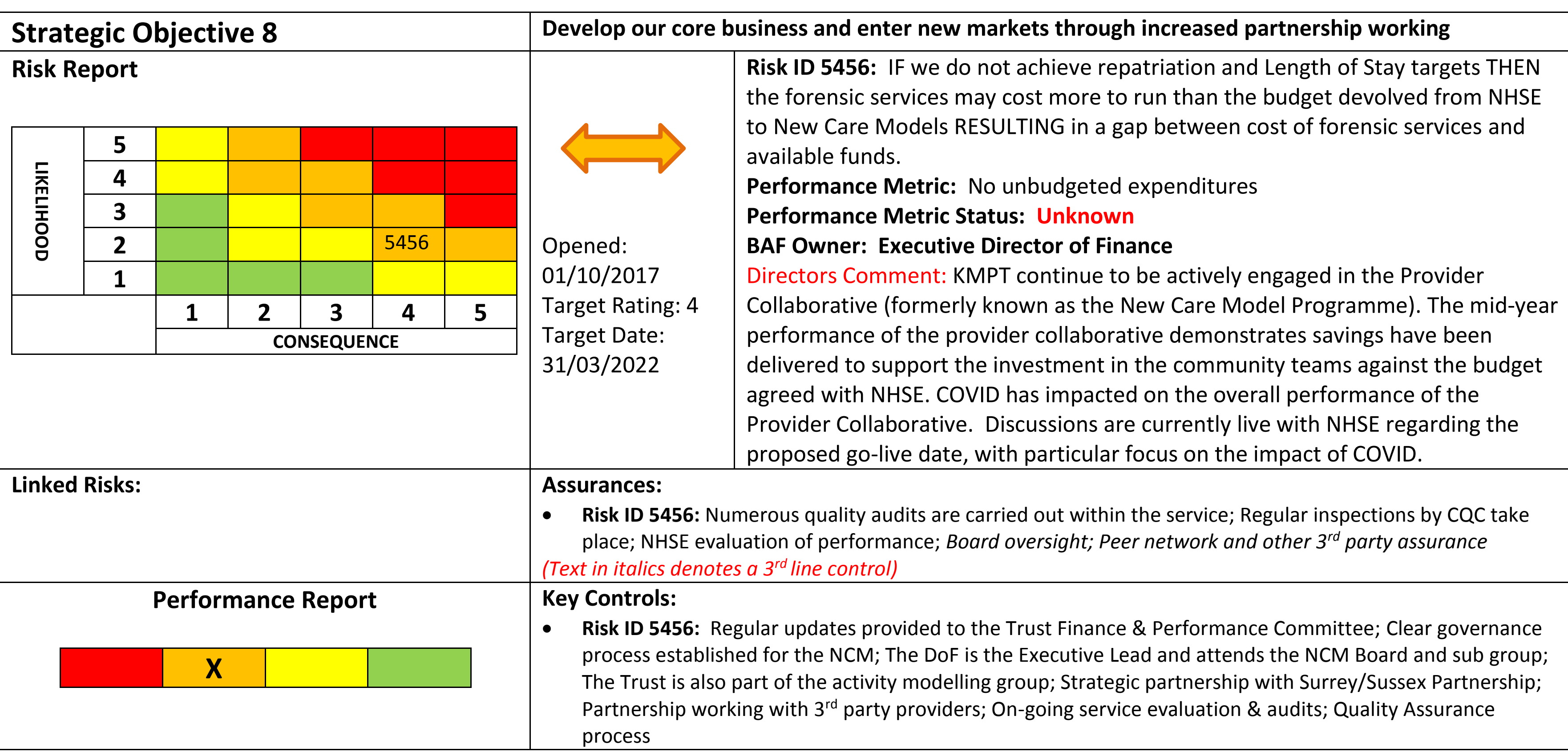

Strategic Objective 8	**Develop our core business and enter new markets through increased partnership working**

Risk Report

LIKELIHOOD						
	5					
	4					
	3					
	2				5456	
	1					
		1	2	3	4	5
		CONSEQUENCE				

Opened: 01/10/2017
Target Rating: 4
Target Date: 31/03/2022

Risk ID 5456: IF we do not achieve repatriation and Length of Stay targets THEN the forensic services may cost more to run than the budget devolved from NHSE to New Care Models RESULTING in a gap between cost of forensic services and available funds.

Performance Metric: No unbudgeted expenditures

Performance Metric Status: Unknown

BAF Owner: Executive Director of Finance

Directors Comment: KMPT continue to be actively engaged in the Provider Collaborative (formerly known as the New Care Model Programme). The mid-year performance of the provider collaborative demonstrates savings have been delivered to support the investment in the community teams against the budget agreed with NHSE. COVID has impacted on the overall performance of the Provider Collaborative. Discussions are currently live with NHSE regarding the proposed go-live date, with particular focus on the impact of COVID.

Linked Risks:

Assurances:

- **Risk ID 5456:** Numerous quality audits are carried out within the service; Regular inspections by CQC take place; NHSE evaluation of performance; *Board oversight; Peer network and other 3rd party assurance*

(Text in italics denotes a 3rd line control)

Performance Report

	X		

Key Controls:

- **Risk ID 5456:** Regular updates provided to the Trust Finance & Performance Committee; Clear governance process established for the NCM; The DoF is the Executive Lead and attends the NCM Board and sub group; The Trust is also part of the activity modelling group; Strategic partnership with Surrey/Sussex Partnership; Partnership working with 3rd party providers; On-going service evaluation & audits; Quality Assurance process

Strategic Objective 9	**Ensure success of our system-wide sustainability plans through active participation, partnership and leadership**	
Risk Report	**NEW** Opened: 10/03/2021 Target Rating: 4 Target Date: 10/03/2022	**Risk ID 6630**: IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2024 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard. **Performance Metric:** Delivery of KPIs, Key deliverables and outcomes on an annual basis **Performance Metric Status: Unknown** **BAF Owner: Executive Director of Transformation** Directors Comment: The strategy delivery plan 2021/2022 was approved by Board in March and has been communicated to senior leaders across the organisation. This will support the annual appraisal/objective setting for all staff between May and September. Performance reporting to EAC and Board sub committees is in place with oversight responsibilities for specific priorities allocated to each committee. There will also be an overarching half yearly performance exception report to Board scheduled for the end of quarter 2 to highlight any significant areas of risk to performance or emerging risks to the achievement of outcomes.
Linked Risks	**Assurances:** • **Risk ID 6630:** There are designated Executives and sub committees responsible for each high level priority and exceptions will be reported bi-annually to Board	
Performance Report	**Key Controls:** • **Risk ID 6630:** Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	

Risk matrix:

LIKELIHOOD	1	2	3	4	5
5					
4		6630			
3					
2					
1					
	CONSEQUENCE				

Appendix 1 – Summary of key controls and evidence for mitigation

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
Strategic Objective 1: Consistently deliver an outstanding quality of care								
6573	Demand and Capacity for Adult and Older Adult CMHTs	Trust Board (3a)	None identified	None Identified	Team level demand and capacity information available, Trajectories for improvement set, Funding requirements known and built into contracting	None identified	Lack of triangulation of data (workforce, performance and quality) Gaps in staffing and inability to recruit into certain teams – primarily due to location No agreement at a system level (CCG) to progress changes needed to address memory assessment service challenges	
6626	Development of a crisis line	Trust Board (3a)	Governance Meetings/QPR CliQ checks and local quality audits	None Identified	Urgent Access Lead recruited and in place to provide senior operational management with oversight by	Action plan in place to mitigate gaps in control and evidence progress on mitigations	None identified	

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
					Chief Operating Officer and EMT			
6052	Improving and sustaining quality and safety	Trust Board (3a)	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Well Led Inspection Report February 2019 CQC Engagement meeting feedback MHA Reviews QPR Performance and Quality Report	CCG Quality Visits to be re-established	Achievement of good/ outstanding regulatory standards	Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CCG Quality visits	Clinical care pathways because they are still in implementation phase Cliq Checks have yet to be extended to non CQC Core Services	Y
4083	Management of Environmental Ligatures	3e - Third party assurance (CQC / NHSI/E	Monitored by NHS England via STEIS [3b] CCG Quality Visit	anti lig fixture testing not done consistently during vacation cleans	Program for removing anchor points and restricting access to staff only areas	Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by the Prevention of Suicides and Homicides Group and Trust Wide Health Safety and Risk Group [2a]	Anchor points identified on Forensic wards Wards Some wards have yet to be fitted with the door top alarms	Y
6420	COVID-19 Personal Protective Equipment	Trust Board (3a)	Situation reporting locally and nationally Exception reporting	None Identified	Procurement Management Processes	Central procurement strategy Centralised stock and buffer store Internal and External Situation reporting Kent and Medway Incident control and mutual aid arrangements.	None Identified	

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
Strategic Objective 2: Recruit retain and develop the best staff making KMPT a great place to work								
3808	Recruitment	3e - Third party assurance (CQC / NHSI/E	Establishment review Monitoring of recruitment and retention Monitored by CCG and CQC Shift by Shift Analysis reported to WODC Incident rates and monitoring compliance with tool Report to WF&OD Committee	None identified	System controls in place	Review of Roster Templates in line with agreed safe staffing levels. (1a) Medical Recruitment and Retention Group [2a] Recommend a Friend (1a) New Hire Bonus nurse and Consultant (1a) Consultant mentoring in place (1a) SafeCare Pilot [O]	Establishment review Recruitment and Retention Strategy	Y
3738	Staff engagement, acting on feedback and cultural change	Trust Board (3a)	Staff FFT surveys run quarterly [1c] Monthly service line performance monitoring [2b] Workforce Committee oversees reporting against various different HR policies and other methods of reporting [2b] Stress Management Tool used by Workforce Advisors as a team approach to Stress Management Green Button & FTSU activity reports to Workforce Committee and EMT [2b] Cultural audit tender specification	None identified	2e - Policies / Constitution / Strategy / Plan People Strategy	Quarterly Staff Friends & Family Test (FFT) Survey [1c] NHS Staff Survey [2e] Engagement with staff through Intranet, staff forum, local and KMPT wide leadership groups. [1h] Freedom to Speak Up and Safe Working Guardians, with Green Button option [1g] Health & Wellbeing Group [2a] Big Conversation [1b] EMT Working With Days [2a] Report to Trust Board - Staff Survey and appraisals [3a]	None identified	Y
5148	Retention of employees	3b - NHS England / PHE / DoH / Government property	Monitoring of retention External monitoring - various bodies (3e) NHSI Cohort 2 retention project [O]	No gaps in assurances	3b - NHSI Programme	Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants (1e)	National shortages in Consultants and Registered Nurses	Y

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ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
		unit				Supervision and Appraisals (1a) Health & Wellbeing Group [2a] Medical Recruitment and Retention workgroup - 8 point plan, including on-call rota (1a) Engagement activities (1b) EU exit implications reported and actions in place (1a) NHSI retention programme cohort 2 [O]		
Strategic Objective 3: Put continuous improvement at the heart of what we do								
5989	Organisational Risk - Emerging Infectious Diseases	3b - NHS England / PHE / DoH / Government property unit	Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance Internal and external SITREPs Completed Business Continuity Plans Staffing fill rates	Limited number of Physical Health Nurses available in in-patient areas only	1g - Project/operation management	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g]	Quality of BCPs	N
6623	Easing of Lockdown National Roadmap – Agile Working	Trust Board (3a)	Reporting through Agile Working Group	None Identified	Agile Working Group	Agile working group Covid Secure SOP Restriction on number of staff in rooms against risk Assessment. Use of face masks on site	No Agile working policy in place Government guidance has not been issued.	

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
Strategic Objective 4: Develop and extend our research and innovation work								
5345	Participation in international research & development	None Identified	National clinical research governance arrangements	None Identified	CEOG report & QC oversight	Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b]	No clinical lead to oversee clinical risk or to drive research forward from a clinical perspective.	N
Strategic Objective 5: Maximise the use of digital technology								
6193	Mobile RiO Approval & Funding	3a – Trust Board	Trust Board Minutes, Capital Plan for IM&T, Project update sheets for Mobile RIO project.	None Identified	3a - Trust Board Awaiting Board Approval	Progress monitored via digital delivery board Engagement with vendors for hardware, software and mobile networks Engagement work with clinical teams Benchmarking with other NHS trusts Evaluation of potential solutions and suitability	Disarticulation of strategic planning Lack of coherent strategic direction in requirements No established timeline as it is too early in the process	N
6485	Clinical Engagement for the Strategy	None identified	None identified	None identified	ICT SMT	None identified	None identified	
Strategic Objective 6: Meet or exceed requirements set out in the Five Year Forward View								
No risks identified against this strategic objective.								
Strategic Objective 7: Deliver financial balance and organisational sustainability								
3164	Capital Projects - Availability of Capital	Trust Board (3a)	Business Case Review Group Board, FPC and Trust Capital Group oversight [3a/2b]	None identified	1g - Project/operation management	Clear prioritised capital plan, reviewed regularly with services. [2e] Tight design and	None identified	N

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
						specification processes and capital programme management. [1g/2a] Newly formed Estates Operational Group adjunct to the Estates Strategy and Capital Planning Group [2a]		
6570	New Finance Regime 2020/21	3a - Trust Board	None identified	None identified	Escalation from the executive team to NHSE/I	None identified	Adjustment to baseline requested from NHSE/I due to a repositioning of forecast expenditure in month 10 of the last financial year. This will impact the baseline next year if the regime is kept the same.	
6628	Financial Sustainability	Trust Board (3a)	EAC, FPC and Board Review of performance [2b/3a]	None Identified	Finance and Performance Committee Monitoring	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]	Uncertainty of financial regime from NHSE/I Lack of planning guidance for 2021/22 Focus on Covid response across the organisation	

ID	Title	Primary Assurance	Evidence	Gaps Identified	Primary Control	Evidence	Gaps Identified	IQPR Y/N
Strategic Objective 8: Develop our core business and enter new markets through increased partnership working								
5456	New Care Models - Secure Services	3e - Third party assurance (CQC / NHSI/E	Numerous quality audits are carried out within the service Regular inspections by CQC take place NHSE evaluation of performance	No gaps identified	2b - Committee of the Board Trust is a member of the NCM Board	Clear governance process established for the NCM [1f] The DoF is the Executive Lead and attends the NCM Board and sub group [2f] The Trust are also part of the activity modelling group [2f] Financial governance (1g) Quality assurance processes (1f) Strategic Partnership with Surrey/Sussex Partnership (2f) Partnership working with 3rd party providers (2f) On-going service evaluation & audits (2d) Board oversight (3a) Peer network and other 3rd party assurance (3e)	No gaps in quality controls identified No gaps in financial controls identified	N
Strategic Objective 9: Ensure success of our system-wide sustainability plans through active participation, partnership and leadership								
6630	Implementation of Trust Strategy 2020-2024	Trust Board (3a)	Annual report on KPIs, key deliverables and outcomes against the 5 strategic priorities	None identified	Reporting to Board sub committees (Quality, Workforce and OD and Finance and Performance).	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	None identified	

Appendix 2 – Table of target risk values

Inherent (starting) score	Target (without performance measure)	Target (with performance measure)
25	16	12
20	12	9
16	9	6
15	8	6
12	6	4
10	4	3
9	4	2
8	3	2
6	2	1
5	3	2
4	1	N/A
3	1	N/A
2	1	N/A
1	N/A	N/A

The above table shows the Target Ratings as calculated using the Control Calibration Tool.