# AGENDA

Kent and Medway NHS and Social Care Partnership Trust

**Title of Meeting** Trust Board Meeting (Public)
**Date** 30th May 2024
**Time** 09.30 – 12.00
**Venue** MS Teams

| Agenda Item | DL | Description | FOR | Format | Lead | Time |
|---|---|---|---|---|---|---|
| **TB/24-25/1** | 1. | Welcome, Introductions & Apologies | | Verbal | Chair | 09.30 |
| **TB/24-25/2** | 2. | Declaration of Interests | | Verbal | Chair | |
| **BOARD REFLECTION ITEMS** | | | | | | |
| **TB/24-25/3** | 3. | Personal Story – Crisis Home Treatment Services | FN | Verbal | DHS | 09.35 |
| **TB/24-25/4** | 4. | Quality Improvement – Violence and Aggression | FN | Verbal | AR | 09.45 |
| **STANDING ITEMS** | | | | | | |
| **TB/24-25/5** | 5. | Minutes of the previous meeting | FA | Paper | Chair | 09.50 |
| **TB/24-25/6** | 6. | Action Log & Matters Arising | FA | Paper | Chair | 09.55 |
| **TB/24-25/7** | 7. | Chair's Report | FN | Paper | JC | 10.00 |
| **TB/24-25/8** | 8. | Chief Executive's Report | FN | Paper | SS | 10.05 |
| **TB/24-25/9** | 9. | Board Assurance Framework | FA | Paper | AC | 10.10 |
| **STRATEGY, DEVELOPMENT AND PARTNERSHIP** | | | | | | |
| **TB/24-25/10** | 10. | Strategic Delivery Plan Priorities – Year 2 | FN | Paper | SS | 10.15 |
| **TB/24-25/11** | 11. | MHLDA Provider Collaborative Progress Report | FN | Paper | AR | 10.25 |
| **TB/24-25/12** | 12. | Community Mental Health Framework Transformation | FD | Paper | DHS | 10.30 |
| **OPERATIONAL ASSURANCE** | | | | | | |
| **TB/24-25/13** | 13. | Integrated Quality and Performance Review | FD | Paper | SS | 10.45 |
| **TB/24-25/14** | 14. | Finance Report | FD | Paper | NB | 11.00 |
| **TB/24-25/15** | 15. | EDI Plan/Brand & Culture | FA | Paper | SG/ KH | 11.05 |
| **TB/24-25/16** | 16. | Patient Survey Results | FD | Paper | AC | 11.15 |
| **TB/24-25/17** | 17. | Safer Staffing Report | FD | Paper | AC | 11.25 |
| **TB/24-25/18** | 18. | Social Value Update | FN | Paper | NB | 11.30 |
| **TB/24-25/19** | 19. | Data and Digital Update | FA | Paper | SS | 11.35 |
| **TB/24-25/20** | 20. | Standing Orders & Standing Financial Instructions | FA | Paper | NB | 11.45 |
| **CONSENT ITEMS** | | | | | | |
| **TB/24-25/21** | 21. | Report from Quality Committee (incl Mortality Report) | FN | Paper | SW | 11.50 |
| **TB/24-25/22** | 22. | Report from People Committee | FN | Paper | KL | |
| **TB/24-25/23** | 23. | Report from Finance and Performance Committee | FN | Paper | MW | |
| **TB/24-25/24** | 24. | Report from Mental Health Act Committee | FN | Paper | SBK | |
| **TB/24-25/25** | 25. | Report from Charitable Funds Committee | FN | Paper | SBK | |
| **TB/24-25/26** | 26. | Use of Trust Seal | FN | Paper | TS | |
| **CLOSING ITEMS** | | | | | | |

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| **TB/24-25/27** | 27. | Any Other Business | | | Chair | 11.55 |
| **TB/24-25/28** | 28. | Questions from Public | | | Chair | |
| | **Date of Next Meeting:** 30th July 2024, MS Teams | | | | | |

| **Members:** | | |
|---|---|---|
| Dr Jackie Craissati | JC | Trust Chair |
| Catherine Walker | CW | Deputy Trust Chair (Senior Independent Director) |
| Sean Bone-Knell | SB-K | Non-Executive Director |
| Kim Lowe | KL | Non-Executive Director |
| Peter Conway | PC | Non-Executive Director |
| Mickola Wilson | MW | Non-Executive Director |
| Stephen Waring | SW | Non-Executive Director |
| Dr MaryAnn Ferreux | MAF | Non-Executive Director |
| Shelia Stenson | SS | Chief Executive |
| Dr Afifa Qazi | AQ | Chief Medical Officer |
| Andy Cruickshank | AC | Chief Nurse |
| Donna Hayward-Sussex | DHS | Chief Operating Officer/ Deputy Chief Executive |
| Nick Brown | NB | Chief Finance and Resources Officer |
| Sandra Goatley | SG | Chief People Officer |
| Dr Adrian Richardson | AR | Director of Partnership and Transformation |
| **In attendance:** | | |
| Kindra Hyttner | KH | Director of Communications and Engagement |
| Hannah Stewart | HS | Deputy Trust Secretary (Minutes) |
| Terry Rolfe | TR | Service User (Personal Story) |
| Wendy Dewhirst | WD | North Kent Deputy Service Director (Personal Story) |
| **Apologies:** | | |
| Tony Saroy | TS | Trust Secretary |
| Dr Asif Bachlani | AB | Associate Non-Executive Director |

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

**Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)**
**Minutes of the Public Board Meeting held at 09.30 to 12.15 hrs on Thursday 28th March 2024**
**At Canterbury Cathedral Lodge, Canterbury**

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|---|---|---|---|
| **Members:** | | | |
| | Dr Jackie Craissati | JC | Trust Chair |
| | Catherine Walker | CW | Deputy Trust Chair (Senior Independent Director) |
| | Peter Conway | PC | Non-Executive Director |
| | Sean Bone-Knell | SBK | Non-Executive Director |
| | Mickola Wilson | MW | Non-Executive Director |
| | Stephen Waring | SW | Non-Executive Director |
| | Kim Lowe | KL | Non-Executive Director |
| | Dr MaryAnn Ferreux | MAF | Non-Executive Director |
| | Dr Asif Bachlani | AB | Associate Non-Executive Director |
| | Sheila Stenson | SS | Chief Executive |
| | Dr Afifa Qazi | AQ | Chief Medical Officer |
| | Nick Brown | NB | Chief Finance and Resources Officer |
| | Donna Hayward-Sussex | DHS | Chief Operating Officer/Deputy Chief Executive |
| | Andy Cruickshank | AC | Chief Nurse |
| | Sandra Goatley | SG | Chief People Officer |
| | Dr Adrian Richardson | AR | Director of Partnerships and Transformation |
| **Attendees:** | | | |
| | Lee Laurence | LL | CED Crisis Group Clinical Lead (Personal Story) |
| | Mark | Mark | Service User (Personal Story) |
| | Claire | Claire | Service User (Personal Story) |
| | Dr Mudasir Firdosi | MF | Clinical Director of Quality Improvement (QI Story) |
| | Dr Rashmi Sharma | RS | Specialty Doctor Forensic Psychiatry |
| | Tony Saroy | TS | Trust Secretary (Minutes) |
| | | | |
| **Apologies:** | | | |
| | Kindra Hyttner | KH | Director of Communications and Engagement |
| | Hannah Stewart | HS | Deputy Trust Secretary |
| **Observers:** | | | |
| | | | There were several members of the public who were in the public gallery. |

| Item | Subject | Action |
|---|---|---|
| **TB/23-24/135** | **Welcome, Introduction and Apologies**<br><br>The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read. | |
| **TB/23-24/136** | **Declarations of Interest**<br><br>None declared. | |
| **TB/23-24/137** | **Personal Story – Complex Emotional Difficulties Crisis Group** | |

| Item | Subject | Action |
|---|---|---|
| | The Board welcomed LL, Claire and Mark to the Board. LL explained to the Board how the Complex Emotional Difficulties Crisis Group (CED Group) was created. This was a unique, KMPT offering and has had a positive impact on patients.<br><br>The CED Group gives an alternative route to admission for patients in crisis due to complex emotional difficulties. As a result of CED Group's work, only 7% of patients who originally presented via Section 136 then went to re-present within six months. Even when re-presenting, only 2% are admitted and they tend to be suitable for discharge within 48 hours.<br><br>Mark and Claire set out their positive experiences of the CED Group and how it compared with general or home treatment care from the Crisis Team. They highlighted the more holistic approach taken by the CED Group and the well-structured programme of contact three times a week.<br><br>The Board thanked LL, Mark and Claire for attending and **noted** the Personal Story – Complex Emotional Difficulties Crisis Group. | |
| **TB/23-24/138** | **Quality Improvement (QI) – Electronic Observations**<br><br>The Board heard the QI story from RS, who set out details of the QI project held at the Trevor Gibbens Unit (TGU).<br><br>RS highlighted how electronic observations were rolled out within TGU. The main factors for missing physical health observations included staff not being trained properly regarding documentation and handovers not being effective.<br><br>Operational changes and effective training were rolled out, with matters monitored on a weekly basis. TGU managers carry out ongoing audits and improvements have been made. Now the average breach rate of 16 has reduced to 2 per week.<br><br>The Board thanked RS for attending, and **noted** the Quality Improvement – Electronic Observations. | |
| **TB/23-24/139** | **Minutes of the previous meeting**<br><br>The Board **approved** the minutes of the previous meeting. | |
| **TB/23-24/140** | **Action Log & Matters Arising**<br><br>The Board **approved** the Action Log subject to one minor amendment to the wording of an action. | |
| **TB/23-24/141** | **Chair's Report**<br><br>The Board received and **noted** the Chair's Report | |
| **TB/23-24/142** | **Chief Executive's Report**<br><br>The Board received the Chief Executive's Report. | |

| Item | Subject | Action |
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| | SS highlighted the following:<br>• As a result of the Greater Manchester Report, which showed evidence of the most shocking abuse and poor care of patients within the Edenfield Centre in Prestwich, all mental health trusts must do a 'lessons learned' exercise. The Board will be updated on this in July 2024.<br>• The opening of Ruby Ward was welcomed. This is a great facility and a success for the Trust.<br>• The Trust's annual employee recognition scheme has been relaunched.<br><br>The Board reflected on the Chief Executive's Report:<br>• The Board supported the relaunched Annual Employee recognition scheme.<br>• Compliments were given to the executive regarding the protected learning time event. The Trust has been working collaboratively with primary care and there remains a good working relationship between the Trust and GPs.<br><br>The Board received and **noted** the Chief Executive's Report. | |
| **TB/23-24/143** | **Board Assurance Framework (BAF)**<br><br>The Board received the BAF and reflected on the following matters:<br>• No risks have been added to the BAF since January 2024.<br>• Two risks have changed their risk score since the BAF was last reported to the Board in January<br>  ○ Risk ID 00524 – Maintenance Services Funding Availability (Decreased to 8 (moderate) from 12 (High))<br>  ○ Risk ID 02241 - Compliance with food legislation - temperature control checks of food (Decreased to 6 (Moderate) from 16 (Extreme))<br>• Two risks were recommended for removal<br>  ○ Risk ID 00524 – Maintenance Services Funding Availability<br>  ○ Risk ID 00871 – Recruitment and Retention<br><br>Since the production of the BAF, Risk ID 07557 – Trust agency usage had decreased in risk rating from 20 to 12.<br><br>PC highlighted his Audit and Risk Committee Chair's report, which set out the Committee's comments regarding risk management and risk strategy and the Board endorsed the direction of travel.<br><br>The Board reflected on the Risk ID 00410 Increased level of Delayed Transfers of Care (DToC), and recommended that the Trust focus on outcomes rather than particular professions. The Board discussed the potentially positive impact of occupational therapists and expressed concerns that focusing on social workers as a solution may not be the most effective approach.<br><br>The memory assessment service (MAS) was also discussed, with the Board noting that the Trust will be reliant on the Integrated Care Board (ICB) for the delivery of community diagnostics. The Board noted that this was previously on- | |

| Item | Subject | Action |
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| | track, but has now become off-track. The Board was informed that mitigations were being put in place, with GP funding for next financial year being achieved. This should reduce caseloads for the Trust.<br><br>The Board **approved** the Board Assurance Framework. | |
| **TB/23-24/144** | **Strategy Delivery Year 1 Update**<br><br>The Board received the Strategy Delivery Year 1 Update.<br><br>The Trust has been focussing on six priorities, but although the delivery of the strategy had been streamlined for this current calendar year, the Board stated that there still appeared to be far too many objectives with the potential to lose focus.<br><br>The Board reflected on the strategy delivery, with the following requests made:<br>• The Trust needs to be clearer as to which objectives would lead to the greatest impact on the delivery of the strategy, and which risks will hinder delivery the greatest;<br>• The digital offering for staff and patients needs to be made clearer, as do the areas in which the Trust wishes to be a leading innovator; and<br>• IQPR metrics need to be clearer regarding national, local, and system metrics.<br><br>The Board raised its concerns regarding the current slippage and the now realistic prospect that the Trust will not deliver its strategy milestones in Year 2. The Board was informed that the Executive Management Team will be reviewing matters to ensure the Trust is on the correct footing to deliver its Year 2 milestones.<br><br>The Board **noted** the Strategy Delivery Year 1 Update. | |
| **TB/23-24/145** | **Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report**<br><br>The Board received and **noted** the MHLDA Provider Collaborative Report.<br><br>**Action: AR to update the reporting of MHLDA workstreams in light of planned changes to the IQPR. Updated reporting to occur by May 2024.** | |
| **TB/23-24/146** | **Integrated Quality and Performance Report (IQPR) – Month 11**<br><br>The Board received the IQPR with the Board discussion focussed on the following:<br>• The Trust has the highest level of bed occupancy for Trusts across the Kent and Medway System. The Board was informed that DToC was placing pressure on patient flow, with the Trust struggling to discharge patients who are clinically fit to be discharged. This hinders patients accessing KMPT beds when they need to do so. The Trust may need to support patients moving into temporary accommodation.<br>• The Trust is looking to have housing officers support the Trust, and the Board noted that NHS England has issued a letter to Integrated Care | |

| Item | Subject | Action |
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| | Boards (ICBs) requiring ICBs to have a housing strategy linked to mental health.<br>• The Trust's community mental health teams' performance regarding dementia diagnosis was still off track.<br>• Regarding the new model of care, the Trust is rolling out the learning from the Thanet pilot, which should positively impact the Trust's future performance.<br>• In the short term, the Trust will change its operating model regarding dementia diagnosis, which should see some improvement. For a more sustainable, high impact improvement, this will occur in the medium term once GPs are involved in diagnosis.<br>• The Board raised its concerns over the amount of change that is occurring within the Trust, which is likely to cause confusion for patients, carers and staff.<br>• There is an overlap between KMPT workstreams and MHLDA Provider Collaborative workstreams. Data should be clearer, with it being easier to identify at which level work was occurring.<br>• In April 2024, the Trust will have a new contact line: 111 press 2.<br><br>The Board **noted** the IQPR. | |
| **TB/23-24/147** | **Finance Report – Month 11**<br><br>The Board received the Finance Report and noted the following:<br>• The Trust will receive a share of the risk share benefit from the Forensic Provider Collaborative and therefore is expecting to deliver a £1.0m surplus outturn position.<br>• The Trust has an agency cap of £7.02m (c3.7% of its total pay bill). At Month 11, the Trust is expecting to exceed this cap by £1.38m. The main driver to this position is vacancies within medical staffing and nursing.<br>• At month 11, the capital programme spend is £0.62m under plan, this is predominantly due to slippage in Estate scheme and VAT reclaims but the annual capital allocation is expected to be fully utilised.<br>• The cash position remains strong at £16.49m at the end of February 2024.<br><br>The Board reflected on the out of area bed use (OOA) and PICU, with the Trust challenged to see if a women's pathway could be designed. The Trust stated that it would consider it, but the biggest impact will be achieved by tackling DToC.<br><br>The Board considered the improving data regarding staff sickness and recruitment rates. The Board was informed that although that does help to reduce agency usage, improvements to the way that duty rotas are overseen will drive down agency usage in a more effective way.<br><br>The Board **noted** the Finance Report. | |
| **TB/23-24/148** | **Financial Plan 2024/25** | |

| Item | Subject | Action |
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| | The Board received the Financial Plan 2024/25 and was informed that planning guidance was issued by NHS England on 27.03.24. This planning guidance will be considered more fully, with the Trust's Finance and Performance Committee updated accordingly. Final plan submission is due on 04.05.24.<br><br>The Trust has reasonable confidence that it will deliver a breakeven position at the end of the financial year. This is based on the delivery of a £10.74m Cost Improvement Programme. In addition, the Trust has a capital programme in year of £13.2m.<br><br>The two main risks to the breakeven position are:<br>• System financial challenges – the system has submitted a deficit plan. It is likely that this position will attract further scrutiny from NHS England.<br>• Agency spend – The Trust has an agency cap target of £6.58m (3.2%), with a present run rate of £7.04m. Plans are being developed to address the outstanding gap.<br><br>The Board reflected on the financial plan and sought assurance that quality should not be adversely affected by the breakeven position.<br><br>Further, the Trust's use of the Mental Health Investment Standard should be invested, in part, in the voluntary sector, and this needs to be evidenced at the MHLDA Provider Collaborative Board.<br><br>The Board **approved** the financial plan 2024/25 subject to minor changes as required by the new issued planning guidance. | |
| **TB/23-24/149** | **Workforce Deep Dive – Staff Survey**<br><br>The Board received the Workforce Deep Dive on the results of the annual NHS staff survey report, and discussed the following:<br>• There was a reduced response rate by 10% when compared to last year's response rate.<br>• The transparency of the reporting of survey findings was welcomed and there will be significant areas of focus for the People Committee. The initial view is that there needs to be a focus on an empowered leadership, which can achieve success.<br>• The 'recommend the trust to a friend or family' result was particularly disappointing. Some trusts receive a positive score of up to 80%, whilst KMPT's response was in the bottom quartile of mental health trusts.<br>• There is an imbalance between the scores achieved by the support services directorate and the frontline staff, with support services scoring higher. The Board highlighted the need for support services to focus on customer service for frontline staff, so that frontline staff can receive the assistance they need in a timely manner.<br><br>The Board **noted** the Workforce Deep Dive on Staff Survey. | |
| **TB/23-24/150** | **Data and Digital Update**<br><br>The Board received the Data and Digital Update. | |

| Item | Subject | Action |
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| | The Board reflected on the paper and stated that it considered it to be foundational and basic; for example, there was no mention of artificial intelligence despite the Data and Digital Plan being over three years. The number of priorities was overwhelming, with a real chance of a loss of focus. Furthermore, there needs to be a clearer plan as to how some of the digital plans will be funded.<br><br>**Action: For May 2024 Board meeting, SS to produce a further iteration of the Data and Digital update paper, which will include the plan with timelines and funding opportunities where appropriate.**<br><br>The Board highlighted that Digital is considered to be a key enabler for staff in the delivery of strategy and care for patients. It is important to have user design experience for the building of digital solutions.<br><br>The Board **noted** the **Data and Digital Update.** | |
| **TB/23-24/151** | **Community Mental Health Framework Transformation**<br><br>The Board received and **noted** the Community Mental Health Framework Transformation paper. | |
| **TB/23-24/152** | **Register of interests**<br><br>The Board **noted** the Register of Interests, with the Chair reminding the Board that members should keep Trust Secretariat informed on a continuous basis. | |
| **TB/23-24/153** | **Report from Quality Committee**<br><br>The Board received and **noted** the Quality Committee Chair's report. | |
| **TB/23-24/154** | **Report from People Committee**<br><br>The Board received and **noted** the People Committee Chair's report. | |
| **TB/23-24/155** | **Report from Audit and Risk Committee**<br><br>The Board received and **noted** the Audit and Risk Committee Chair's report. | |
| **TB/23-24/156** | **Report from Finance and Performance Committee**<br><br>The Board received and **noted** the Finance and Performance Committee Chair's report. | |
| **TB/23-24/157** | **Use of Trust seal**<br><br>The Board **noted** the Use of Trust Seal Report. | |
| **TB/23-24/158** | **Any Other Business**<br><br>None. | |

| Item | Subject | Action |
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| **TB/23-24/159** | **Questions from Public**<br><br>The Board received questions from the Public focussing on:<br><br>• The Trust's charity and its recent progress.<br>• The publicity surrounding Trust Board meetings.<br>• The opening of Ruby Ward. | |
| | **Date of Next Meeting**<br><br>The next meeting of the Board would be held on Thursday 30th May 2024, via MS Teams. | |

Signed …….. (Chair)

Date ……..

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 22/05/2024**

| 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 2024** | | | | | | | | |
| 25.01.2024 | TB/23-24/124 | Finance Report – Month 9 | AC to bring an update on zonal observations to the Quality Committee in May. | AC | May 2024 | September 2024 | This has been deferred to the September Quality Committee. | **In Progress** |
| 28.03.2024 | TB/23-24/145 | Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report | AR to update the reporting of MHLDA workstreams in light of planned changes to the IQPR. Updated reporting to occur by May 2024. | AR | May 2024 | | This is on the agenda for discussion. From July 2024, the MHLDA paper to be presented by SS, with the Provider Collaborative Director drafting the paper | **In Progress** |
| 28.03.2024 | TB/23-24/150 | Data and Digital Update | For May 2024 Board meeting, SS to produce a further iteration of the Data and Digital update paper, which will include the plan with timelines and funding opportunities where appropriate. | SS | May 2024 | | This is on the agenda for discussion | **In Progress** |
| **ACTIONS NOT DUE OR IN PROGRESS** | | | | | | | | |
| 25.01.2024 | TB/23-24/120 | Progress against Purposeful Admissions Programme | AQ to bring an update on the Purposeful Admissions Programme to the July Board meeting. | AQ | July 2024 | | | |
| 25.01.2024 | TB/23-24/126 | Freedom to Speak Up – Six month Interim Report | SG to prioritise the list of recommendations within the Freedom to Speak Up Report and assign each recommendation an owner and completion date. An update should then be provided to the Trust Board within the next 6 monthly update of the report. | SS | July 2024 | | | |
| 25.01.2024 | TB/23-24/122 | IQPR | By December 2024, DHS and AQ to deliver a Board Seminar in the future on those clinically ready for discharge, and how this links to the Purposeful Admissions Programme. | SS/AQ | December 2024 | | | |
| **CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS** | | | | | | | | |
| 25.01.2024 | TB/23-24/116 | Chief Executive's report | SS to provide an update by the next Board meeting, on how informal EMT visits will be captured going forward | SS | March 2024 | | EMT visits included within Chief Executive's Report | **CLOSED** |

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 22/05/2024**

| Key | DUE | IN PROGRESS | NOT DUE | CLOSED |
|---|---|---|---|---|

| Meeting Date | Minute Reference | Agenda Item | Action Point | Lead | Date | Revised Date | Comments | Status |
|---|---|---|---|---|---|---|---|---|
| 25.01.2024 | TB/23-24/125 | Workforce Deep Dive – Health and Wellbeing | SG to confirm to SW why backs are not included in musculoskeletal problems reporting for sickness absence ahead of the next meeting. | SG | March 2024 | | Backs are not listed in the top 3 reasons for sickness- it is 5th- it is other musculoskeletal problems that is in the top 3 reasons for sickness | CLOSED |

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| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **Thursday 30th May 2024** |
| 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 key matters of significance.

## 2. Kent & Medway system and national activity

There are some changes to the group of chairs of NHS providers in Kent and Medway: I am pleased to confirm that my colleague, John Goulston, will become Chair of Medway as well as Chair of Kent Community Trust (KCHFT), so there will now be two of us with oversight of two Trusts. There will now be quarterly in person meetings for the Chairs under the leadership of the Integrated Care Board Chair.

I attended the NHS Confederation Mental Health Network Annual Conference in Leeds. This was a well-attended event, with particularly strong presentations on new pathways of care for Attention Deficit Hyperactivity Disorder (ADHD), and next steps in relation to the Patient & Carer Race Equality Framework.

## 3. Board Development Day

On 25th April, the Board met to work on the outcomes from the external 'well-led' review and to receive an update on the ongoing work on the Trust's brand identity. It was an enjoyable and effective meeting, which was externally facilitated. The Board will be receiving a final paper on the brand identity at Board this summer.

## 4. Trust Chair and NED visits

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

| Where | Who |
|---|---|
| **April 2024** | |
| Community Mental Health Team Younger -Medway, Swale | MaryAnn Ferreux |
| Community Mental Health Team Older - Medway, Swale | MaryAnn Ferreux |
| Early Intervention in Psychosis - Medway/Swale | MaryAnn Ferreux |
| Dartford, Gravesham & Swanley (DGS) Liaison | Jackie Craissati |
| Pharmacy leadership team | Jackie Craissati |
| Ruby Ward | Jackie Craissati |
| Medway Liaison, Safe Haven & Newhaven Lodge | Jackie Craissati |
| Boughton Ward (West Kent) | Kim Lowe |
| Chartwell Ward (West Kent) | Kim Lowe |
| Upnor Ward (West Kent) | Kim Lowe |
| Orchards/Ruby Ward (West Kent) | Kim Lowe |

**Kim Lowe – Boughton Ward, Chartwell Ward, Upnor Ward and Orchards/Ruby Ward**
My visit to these wards was predominantly to 'sense check' staff wellbeing and how it was feeling at the moment. Two themes came through, workloads and the higher acuity of patients.

Service managers and matrons all aware and taking steps where they could to support staff. The members of staff I spoke to were supportive of their local leadership but a strong plea to reduce the admin and understand the impact of changing wards (Male/Female) was highlighted.

Well-being centred around their own team spirit, staffing numbers and time to think and recover. Reducing violence and aggression towards staff remains a very high priority for the teams, although many believe strongly that increasing numbers of HCAs and therapists on the wards would make a difference along with creating a flexible 'float team' to support different wards under pressure.

**MaryAnn Ferreux – Community Mental Health Team Younger -Medway & Swale, Community Mental Health Team Older – Medway & Swale and Early Intervention in Psychosis – Medway& Swale**

I was invited by the clinical Director Mo to meet with the Medway teams with a view to exploring health inequalities for patients who access these services. It was really helpful to be able to understand the services in more detail, see the facility and observe interactions between staff and patients. It was good to see the amount of collaboration and team support across the services, it was generally a very positive environment.

I met with a number of senior doctors who talked about opportunities for quality improvement and innovation to address access and experience for patients. From listening to them it seems that there are a lot of opportunities to improve triage, assessment processes and primary care management. I also observed encouragement to use Dialogue however uptake was limited as many of the clinicians hadn't been through training yet. This would a useful tool that could be used to identify inequalities.

**Chair visits**

I spent a really energising two hours with the Pharmacy leadership team, learning about their various roles in the Trust, and areas for development. It was clear that this is a well-led team, with ambition and long-term commitment to the Trust. They clearly have the capability to step into advanced roles and really make a difference to the way in which we think about multi-disciplinary teams.

I was delighted to host our Integrated Care Board Chair – Cedi Frederick – on a visit to Ruby Ward. It was lovely to see the environment with patients now resident in it, and we spent time with staff who were a real credit to the Trust in terms of their commitment to working with older adults.

I visited DGS liaison team at Darent Valley Hospital, with Dartford & Gravesham Trust's Chief Nurse. This was a great opportunity to talk about the quality of joint working between the Trusts which, for the most part, is excellent. There are a number of joint ventures, and areas where KMPT supports the hospital. The key area of concern for me is that the

hospital admits patients to a medical ward who are waiting for a mental health bed, thereby contributing to the excess bed occupancy in the hospital. The KMPT liaison team acknowledged that once in a bed, the patient no longer remained a priority for our patient flow team. Both teams are trying to do the right thing for the patient, but it is a very unsatisfactory situation.

I will be visiting Medway Liaison, it's Safe Haven and Newhaven Lodge just before this board meeting, and will report on this visit next time.

Finally, I joined the KMPT Digital Conference this month, and it was a really excellent day. On behalf of the Board, I would like to thank Asif Bachlani, our very own Associate Non-executive Director, and Claire Hursell Director of Digital and Performance: their efforts resulted in a really rich programme with good engagement from the audience.

# Chief Executive's Board Report

**Date of Meeting:** 30th May 2024

## Introduction

I have just celebrated my first six months in post, it has been a brilliant six months where I have met many staff, patients and carers. I want to thank everyone for their support, openness and honesty I have experienced. I have heard clearly our staff's feedback. I am immensely proud to be the Chief Executive of KMPT and look forward to the year ahead as we start to implement improvements from all the engagement work we have done over the last six months with regards to our culture, equality, diversity and inclusion priority ensuing KMPT is a great place to work.

## Regional and National Update

### System Chief Executive Meeting

This month I attended a meeting with all of the Chief Executive Officers (CEOs) from Kent and Medway with the CEO of the NHS and the Chief Finance Officer to discuss our system financial and performance plans. It is a challenging time financially for the NHS and in particular the Kent and Medway system. KMPT has secured financial sustainability but we must now play our role to support the wider system.

## Integrated Care System and Provider Collaborative Update

### System First NHS Strategy

Over the course of the past three months executives from all providers across Kent and Medway have been working with the ICB to establish a System First strategy to drive improvement and tackle some of the large challenges that the system and providers are experiencing.

The strategy utilises a True North structure, where four strategic themes provide the structure to drive collaboration and bring about change. This is underpinned by the use of a Continuous Improvement methodology which most providers are already utilising and which KMPT is now introducing. Using an A3 structure the initial problem statements, vision, goals and targets are being drafted for agreement by all provider Boards by the end of June.

The four strategic themes are:

1. Patient experience, access and outcomes
2. People
3. Service Sustainability
4. Finance and Resources

A CEO from across the system will lead one of the themes. I will be leading the People theme.

### Provider Collaborative (PC) Update

We have had very successful recruitment to the roles in the team. Staff will be onboarding from June to September. This team will play a critical role in the long-term financial and service sustainability for the system.

The Better Use of Beds Programme, has been scoped and a clear programme is in place. This programme is designed to work across all three health sectors but it is critical that the programme has strong working relationships with social care.

The Mental Health Learning Disability and Autism PC heard about the excellent progress being made with the Urgent and Emergency Care pathway to which KMPT is part of.

A sub-group is being established to look at how the PC can support to address population health inequalities.

The Acute PC has highlighted 5 specialities for further consideration. 2-3 of these will be the areas of focus, in addition the data analytical work that has been completed in the past 4 months has highlighted significant variation and this will be a key focus to see what improvements can be delivered in this coming year.

## Operational Update

## KMPT Update

Roll out of Community Mental Health Framework (CMHF)

Community Transformation continues to be implemented with phase 1, Mental Health Together Services established in 3 areas with a further 4 planned by the end of May. The full model, phase 2 is on track to be delivered in the summer of this year. This includes new roles and interventions provided by partner organisations.

We are ensuring we also listen to staff feedback following the roll out of phase 1 and where required make any changes before we continue with the next roll out. We have undertaken a lesson learned from the Thanet implementation and will be taking this learning with us into the Memory Assessment service improvements.

Financial Plan

The Trust submitted its final 2024/25 financial plan at the end of April. We are planning to deliver a breakeven position in year, with a cost improvement plan totalling £10.76m. This position is in line with the position previously discussed and approved by the board.

The Trust operates within the wider Kent and Medway System which has submitted a significant financial deficit plan. Work remains on-going to identify further potential mitigations and to identify longer term opportunities to bring the system into balance. This work is closely aligned to the System First Strategy.

Virtual Leaders

During our February Leaders Event I shared with the group my reflections on the feedback from staff in my first 100 days and thoughts on the challenges we face as leaders along with my expectations of us to transform KMPT together – with every single leader playing their part. There was a lot to digest and reflect on following our session. For that reason, I created the opportunity to meet the leaders, in smaller groups, to hear their reflections, barriers and ideas. This opportunity enabled some rich discussions and the ability to hear from everyone who attended. Themes were collated and ideas on how we can move forward have been captured. This will now shape our in-person Leaders event planned for June.

Staff Development Council Session

To foster a culture where colleagues feel heard and valued, their feedback is acted upon, and positive change is driven, we will be establishing a KMPT Staff Council. This council will create a structured listening environment, encouraging active participation in shaping our future at KMPT together. As a first step towards achieving this met on the 23rd May to discuss the concept of the council, to ascertain its alignment with our objectives and its contribution to our cultural initiatives. This work will build on the widely attended Speak to Sheila session where we encourage an open conversation with our staff and our role as leaders in doing so.

Senior Medical Staff Committee

I had the pleasure of attending the morning session of the Senior Medical Staff Committee last month. It was great to see all our medics together. I presented the 6 priorities to them and shared feedback from my first 100 days and what staff have been sharing on my visits. I was clear with our medical staff, I am really keen to hear the medical voice more in the organisation and for them to be actively part of our transformation and improvements. There was a good sense of commitment to this and I look forward to working closer with the medical body as we take KMPT forward.

GP Presentation – Protected Learning Time

In continuing efforts to work collaboratively with Primary Care, Dr Qazi attended the Time to Learn Event where 150 GPs were in attendance and she delivered a presentation on CMHF. This was received positively and the Thanet CMHF pilot, which has seen a reduction in referrals being returned to GPs was discussed. The dates of the roll out of CMHF model were shared with GP colleagues.

Integrating Data into Clinical Practice

On 16th May KMPT held its first ever Data Conference for clinical colleagues across the Trust, only the second of its kind in the country. The event was very well attended and feedback was really positive. We had a broad range of speakers, both internal and external and we are really grateful to everyone who gave up their time to speak on the day. The golden thread throughout all the presentations was how clinically relevant data could be used to support decision making at national, system, KMPT and patient level. Some great examples were provided on how data that is captured on Electronic Patient Record Systems (Rio for KMPT) is used and it was really interesting to see how Rio data had been used to show a significant link between physical and mental health. We also heard about how KMPT compares to other Mental Health Trusts in terms of performance using the data provided from the NHS Benchmarking Network. The conference explored how other Mental Health Trusts have used data to good effect when designing services and we discussed how KMPT can improve digital literacy within the Trust. We had an interactive session from Dr Qazi which focused on some of the barriers that prevent access to data and some tips for how to improve the quality of data recorded within Rio. We will be looking to run a similar event in approximately 6 months to review our progress regarding making better use of data as an organisation.

Multi-Agency Discharge Events

As part of the work to reduce the Clinically Ready for Discharge (CRFD) patients, our Chief Medical Officer has led two Multi Agency Discharge Events (MADE) in the East and West of the county. These events were attended by multiple stakeholders including social care and housing. The events identified numerous actions across the system to improve patient flow. These actions will form part of the wider

work happening as part of the patient flow priority. We have now received our independent report into our CRFD. The actions from this will be part of the patient flow priority and work undertaken by the MHLDA PC. There are a number of improvements for KMPT to make internally regarding our processes.

Transforming our culture, identity and staff experience

We have a really exciting paper on the board's agenda today, which sets out our plans to transform our culture, identity and staff experience, which is one of my six priorities. As the new CEO, I have heard loud and clear from our people, patients and partners what they think about KMPT – both the good and bad. At times this has been hard to listen to, particularly when I hear we're not giving enough attention to the service our patients might want, that staff don't feel included or cared for by us as an organisation and that the vital role and presence we have in our communities doesn't always shine through. There are so many positives about our organisation that are also felt, but not always heard. We're at a critical moment of change, which is felt across all our stakeholders.

I am determined we will take a bold, ambitious approach to tackling this challenge so we are proud every day of the services we deliver and achieve positive outcomes for our patients. We have truly listened to, involved and engaged with our stakeholders on this journey so that the action we take is meaningful to them, and means they come on this journey of growth with us. I am confident that the plans we have on equality, diversity and inclusion, alongside the plans we have to reposition our identity will help us achieve this and ultimately have a significant and positive impact on our people, patients, and partners. It will feel different and uncomfortable at times, and it will take time, but these are the foundations we now need to grow as an organisation and achieve our ambitions.

**Summary and Conclusion**

It has been a truly enjoyable first six months in post. We remain focussed on the six priorities I set as I commenced in post. The key for me and my Executive team now will be ensuring our aims and ambition for the organisation are connected to all our hard-working staff. We will be launching our plans for our identity and EDI work in the coming weeks, I am confident this will truly make a difference for KMPT. I look forward to the year ahead and the exciting things we have planned to take KMPT to that next level.

**Sheila Stenson**
**Chief Executive**

**APPENDIX**

Executive Team Visits

Sheila Stenson

- Rivendell
- Thanet CMHSOP
- Ruby Ward

Donna Hayward-Sussex

- Highlands House
- Trevor Gibbens Unit
- Priority House

Nick Brown

- Highlands House

Andy Cruickshank

- New Haven Lodge
- Priority House (Boughton, Chartwell, Orchards Ward)
- Ruby Ward
- Fern Ward

Kyndra Hyttner

- St Martin's
- TGU
- Coleman house

Sandra Goatley

- Riverhill Ward
- Tarentfort Centre
- Bow Arrow Lane
- Shepway CMHT, Ash Eton

Dr Adrian Richardson

- Swale Home Treatment Team

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Board Assurance Framework |
| **Author:** | Louisa Mace, Risk Manager |
| **Executive Director:** | Andy Cruickshank, Chief Nurse |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Approval |
| **Submission to Board:** | Regulatory Requirement |

## Overview of Paper

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

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

## Issues to bring to the Board's attention

The BAF was last presented to the Board in March 2024.

- No risks have been added to the BAF since March
- Three risks have changed their risk score since the BAF was last reported to the Board in March
  - Risk ID 00580 – Organisational Inability to Memory Assessment Service Demand (increased to 20 (Extreme) from 16 (Extreme))
  - Risk ID 07557 – Trust Agency Usage (reduced from 20 (Extreme) to 12 (High))
  - Risk ID 00582 – Organisational Sickness Absence (Reduced to 9 (High) from 12 (High))
- Three risks are recommended for removal
  - Risk ID 04682 – Organisational Risk – Industrial Action (Rating of 6 (Moderate))
  - Risk ID 00582 – Organisational Sickness Absence (Reduced to 9 (High) from 12 (High))
  - Risk ID 07556 – Expiry of lease for Littlebrook (Rating of 9 (High))

## Governance

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

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# The Board Assurance Framework

The BAF was last presented to the Board on 28th March 2024.

**The Top Risks are**

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme)
- Risk ID 05075 – Community Psychological Services Therapy waiting times (Rating of 16 – Extreme)
- Risk ID 00410 - Increased level of Delayed Transfers of Care (DToC) (Rating of 16 – Extreme)

**Risk Movement**
Two risks have changed their risk score since the Board Assurance Framework was presented to Board in March:

- **Risk ID 00580 – Organisational Inability to Memory Assessment Service Demand (increased to 20 (Extreme) from 16 (Extreme))**
  This risk has been reviewed and updated. Dementia is a key priority for the ICB and is being overseen by the Ageing Well Board. Internally at KMPT it is a Trust priority and one of six programmes of work underway in transformation of the organisation. Work needs to be undertaken internally to strengthen and improve KMPT processes and externally to increase capacity to meet anticipated demand growth over the coming years. Actions are currently in place to roll out a new MAS model for KMPT services in June and July, with an improvement plan in place to additionally look at MDT assessments and system level response, subject to ICB buy in.

- **Risk ID 07557 – Trust Agency Usage (reduced from 20 (Extreme) to 12 (High))**
  This risk has reduced in score as, from a financial perspective Agency Spend is more under control.
  This risk has been revised and refocussed to reflect the Quality aspect of Agency usage. Recruitment can still be a challenge in some areas, so Agency usage remains in those areas. Actions for this risk are being reviewed and will be updated.

- **Risk ID 00582 – Organisational Sickness Absence (Reduced to 9 (High) from 12 (High))**
  There has been good progress on mitigating this risk, and sickness absence has reached the year-end target. This risk is also being recommended for removal from the BAF (please see below).

**Risks Recommended for Removal**

3 risks are being recommended for removal at this time:

- **Risk ID 04682 – Organisational Risk – Industrial Action (Rating of 6 (Moderate))**
  There is little change to this risk at this time. There remains the potential for further periods of Industrial action, but it is not clear when these are planned for. There is some concern about any impact or collision with the anticipated general election. It is recommended this risk is removed from the BAF and managed on the EPRR risk register.

- **Risk ID 00582 – Organisational Sickness Absence (Reduced to 9 (High) from 12 (High))**

There has been good progress on mitigating this risk, and sickness absence has reached the year-end target. Consideration is being given as to how this risk is managed going forward, and a tolerable level for the Trust on an ongoing basis. It is recommended this risk is removed from the BAF and managed through the People Committee.

- **Risk ID 07556 – Expiry of lease for Littlebrook (Rating of 9 (High))**
  This risk is being recommended for removal from the BAF. Negotiations are still ongoing, but this is currently a stable risk, and the financial implications are better understood. It is proposed that this risk remains open and is managed by the Finance and Performance Committee at this time. It will be escalated to the BAF again if insufficient progress is made to mitigate the financial risk to the Trust.

**New Risks**

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

**Emerging Risks**

One new emerging risk has been identified for the BAF at this time

- **Organisational Management of Violence and Aggression**
  A new risk is being developed to reflect the impact of the increased level of incidents relating to violence and aggression being seen across KMPT services. This will capture the areas of work that are being undertaken to address this and tie into the Trust strategic objectives for violence and aggression to determine if this has been mitigated.

**Other Notable Updates**

- **Risk ID 04232 – Management of Environmental Ligatures**
  While this risk is well understood and remains stable, actions have been identified through the Annual Ligature Audit which need addressing across the Trust. Capital funds have been identified to progress the work according to the priority of works. It is recommended to keep this risk on the BAF at this time as it is important to keep robust oversight of this risk.

- **Risk ID 02241 - Compliance with food legislation - temperature control checks of food**
  This risk remains at its target risk score since the introduction of the new catering contract which includes a hostess role. The responsibility for completing HACCP forms now rests with the contractor as part of the contract. HACCP reporting will form part of the monthly reporting to the Catering Steering Group. This risk will be monitored over the first 6 months of the contract, with a view to closure if the temperature control checks are completed satisfactorily.

- **Risk ID 00119 – Availability of Capital**
  This risk is under review. The capital funding available to the Trust is still at a challenging level, but an improved process for prioritisation of schemes is in place.

**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.

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The Board are requested to note that work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

Version Control: 01

**Updated: 16 May 2024**

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# Board Assurance Framework

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

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

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

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

**Action status key:**

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

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

**1.1 - Improving Access to Quality Care**

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

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

15/05/2024 — This risk has been reviewed and reframed. There remains an ongoing need for a system response to the demand for Memory Assessment services. Risk scores have increased due to the current position and anticipated growth in demand over the coming years.

| | | | Initial rating | | | Current rating | | | | | Target rating | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | L | C | Rating | Controls Description | Top Five Assurances | L | C | Rating | Trend | Planned Actions and Milestones | Action owner | Confidence Assessment | L | C | Rating | Target Date (end) |
| ID 00580 | Jan 2022 | Director of Partnerships and Transformation | **Organisational inability to meet Memory Assessment Service Demand**<br><br>If KMPT remain the sole provider of Memory Assessment Services, despite the internal work to redesign services,<br><br>Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services.<br><br>Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment of services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years. | 5 | 5 | 25 | Internal:<br>COVID Backlog Plan complete in November 2023<br>Demand and Capacity modelling completed for the new Standalone MAS Model in March 2024<br>Updated Triage guidance signed off in May 2024<br>New Imaging guidance signed off in May 2024<br><br>External:<br>GPs with Enhanced rolls in place to support KMPT clinics (ICB commissioned)<br>ICB Pilot for Diagnosis of Dementia in Care Homes - Diagnosing Advanced Dementia Mandate (DiADem) in place<br><br>The Ageing Well Board from January 2024 now acts as the oversight group. It is developing a number of initiatives including DiADem in care homes and community based diagnostic provision that they anticipate will reduce demand to KMPT by circa 50%.<br>KMPT will support the development of community based diagnostic provision and provide advice and guidance for DiADem. | Highlight report to Strategy Deployment Group on internal standalone Memory Assessment Service<br>6 week performance reported to organisation IQPR to Trust Board<br>Progress report and performance to FPC and QC<br><br>As part of internal audit review for 25/26 planned Referral to Assessment<br>Scoping clinical audit to be confirmed | 4 | 5 | 20 | ↑ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Power BI reporting to support Improvement — Director of Partnerships and Transformation — 31/05/2024 — A<br>Phase 1: Pilot of standalone Memory Assessment Service in line with Community Mental Health Framework rollout — Director of Partnerships and Transformation — 31/07/2024 — A<br>Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 31/10/2024 — A<br>Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment — Director of Partnerships and Transformation — 31/03/2025 — A | Director of Partnerships and Transformation | | 3 | 3 | 9 | 31/03/2026 |

30/08/2023 — BAF Risk Opened

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID 05075 | Aug 2023 | Chief Operating Officer | **Community Psychological Services Therapy Waiting Times**<br><br>IF the demand on psychological services outstrips the services capacity.<br><br>THEN there will be an increase in the number of clients waiting for assessments and therapy.<br><br>RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust. | 4 | 4 | 16 | 1.Active Review is in place in each CMHT locality. This involves an understanding and review of risk on a regular basis for all patients who are waiting some form of intervention.<br>2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce.<br>3. Psychological Services to maintain spreadsheet database to track patients in pathway.<br>4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions<br>5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO.<br>6. Hybrid working in place as requested by patients needs<br>7. Expansion of psychological practice workforce use of Mental Health Wellbeing Practitioners, Clinical Associate Psychologists, Recruit to Train staff and Assistant Psychologists continues to grow.<br>8. Ongoing group interventions to reduce waiting times and parity of offer at place. | Assurances from dashboard data | 4 | 4 | 16 | ↔ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Waiting list review for mental health together — Director of Psychological Therapies — 31/08/2024 — A<br>Recruitment of new supervisory posts for Mental Health Together — Director of Psychological Therapies — 31/10/2024 — A | Chief Operating Officer | | 1 | 2 | 2 | 30/08/2024 |

| | | | | Initial rating | | | | Current rating | | | | | | Target rating | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | L | C | Rating | Controls Description | Top Five Assurances | L | C | Rating | Trend | Planned Actions and Milestones | Action owner | Confidence Assessment | L | C | Rating | Target Date (end) |
| **1.2 - Creating safer and better experiences on our wards** | | | | | | | | | | | | | | | | | | | |
| 04/12/2014 — BAF Risk Opened — 05/07/2023 — Risk returned to BAF | | | | | | | | | | | | | | | | | | | |
| **ID 04232** | Dec 2014 | Chief Nurse | **Management of Environmental Ligatures**<br><br>IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points<br>THEN we will be exposing patients to patient safety risks<br>RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution. | 3 | 5 | **15** | The Control of Ligatures and Ligature Points on Trust Premises Policy [2e]<br>Daily therapeutic programmes<br>Health and Safety Risk Assessment HS20 [1f]<br>Annual Ligature Audits [2d]<br>Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a]<br>Safety Alerts/Protocols [1h]<br>Regular reports to the Quality Committee via Quality Digest [2b]<br>Ligature Champions [1g]<br>Ligature Inventory (Identifies unacceptable ligature points) [1e]<br>National Standards for Mental Health unit builds [3f]<br>Standard Operating Procedure for Ligature Cutters [2e]<br>Bed replacement programme [1d]<br>Door sensors in all new builds [1d]<br>Ligature cutters available in all in-patient areas [1d]<br>Refurbishment programme includes anti ligature fixtures and door top alarms[1d] | Ligature reduction programme<br>Health and Safety and Ligature Risk Assessment Audits<br>Therapeutic Observations<br>Reduction in severe harm patient safety incidents related to anchor points and self strangulation<br>National report on the prevention of homicide and suicides<br>internal validated audit tool<br>CCG Quality visit<br>Health and Safety Audits<br>Ligature Audits<br>Prescribed observations in place<br>Quality Digest reporting to Quality Committee<br>IQPR reporting to Board | 3 | 4 | **12** | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Annual Ligature Audit (Undertaken in November) and subsequent ligature removal/reduction actions Trustwide (via Trust Capital Programme) also monitored/actioned via Directorate action plans and risk registers. — Deputy Director of Nursing — Completed — G<br>Capital Expenditure on Environmental Ligature risk areas — Head of Capital Planning — 31/03/2025 — A | Chief Nurse | | 1 | 4 | **4** | **31/03/2025** |
| 16/01/2020 — Risk Opened — 18/08/2023 — Risk added to BAF — 22/02/2024 — Risk Recommended to close | | | | | | | | | | | | | | | | | | | |
| **ID 02241** | Jan 2020 | Chief Nurse | **Compliance with food legislation - temperature control checks of food**<br><br>IF Food temperatures are not being consistently recorded at point of food service in food safety log books<br>THEN the risk to the Trust is non compliance with food safety regulations.<br>RESULTING IN possible inappropriate food temperatures, prosecution for non compliance via environmental health (EHO), possibility of food poising, burns, death, impact on food quality, reputation, criminal action against the Trust and individual staff (Server of food) | 5 | 4 | **20** | 1/ HACCP - Safety log books on all wards - daily sign off by nurse in charge, weekly sign off ISS supervisors, monthly sign off KMPT Catering compliance mgr. 1d<br>2/ Modern matrons discussing with wards & ward managers non compliance 1a<br>3/ Acute wards as part on counting in out cutlery also confirm and sign that HACCP sheet has been completed. 1f<br>4/ Policies and procedures in place 1f<br>5/ Monthly catering contract review meetings with care groups 1h<br>6/ Risk being monitored via Nutritional steering group 1h<br>7/ Sending Deputy Director of Nursing regular e-mails with concerns/non compliance 1f | Further training is being provided by Catering compliance Manager and ISS where required<br>Being reported into Nutritional Steering group to feed into board report (6 monthly from November 2023)<br>08.02.2024 - ISS have taken over the HACCP completion as part of new contract - Draft SOP added to documentations<br><br>ISS hosts complete the HACCP books throughout the day and ISS Managers check them weekly. ABri (KMPT Catering | 2 | 3 | **6** | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** | Chief Nurse | | 2 | 3 | **6** | **30/09/2024** |
| **1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **2 - We are a great place to work and have engaged and capable staff living our values** | | | | | | | | | | | | | | | | | | | |
| **2.1 - Creating a culture where our people feel safe, equal and can thrive** | | | | | | | | | | | | | | | | | | | |
| 04/12/2014 — Risk Opened — 04/08/2021 — Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award — 03/11/2021 — Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing. — 13/03/2023 — So far there has been little impact from Industrial action. Business continuity plans and Command and control arrangements are in place and have so far proved adequate. This is being kept under review. — 15/05/2024 — This risk is recommended for removal from the BAF. It will remain open and be managed on the EPRR risk register. | | | | | | | | | | | | | | | | | | |
| **ID 04682** | Jan 2019 | Chief Nurse | **Organisational Risk - Industrial Action**<br><br>IF industrial action is enacted within KMPT by Unison, Unite, BMA, RCN etc, or any external service affected by industrial action, which may have an effect on the business continuity of the Trust<br>THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support<br>RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services and a backlog of delivery due to cancellations. | 3 | 3 | **9** | Industrial Action SOP inclusive of Command and Control [2e]<br>Unique operational order/s.<br>Significant Incident Plan [2e]<br>Business Continuity Plans [2e]<br>Workforce and OD Industrial Action Monitoring Group<br>EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f]<br>KRF notifications of Industrial Action<br>Horizon scanning for Industrial Action that will affect staff/supplies/services<br>Hybrid working arrangements to support staffing levels within units, both clinical and admin<br>Trade Union communications<br>Engagement with local Staff Side<br>Situation Reporting to ICB via OCC | Little impact from previous industrial action (Junior Drs Strike in 2016; RCN 2022 - No Impact; GMB Ambulance Staff 2022/23 - Minor Impact; ASLEF Train 2022/23 - Minor Impact; Teachers and Headteachers Union 2023 - Minor Impact; CWU Postal Union - Minor Impact; CSP Physiotherapists - Minor Impact).<br>ICB Oversight of Trust Arrangements via ICB Operational Control Centre on non strike days for assurance and ICB Emergency Control Centre on Strike Days.<br>Strikes are planned and therefore mandates are known in advance when they overlap or and concurrent. | 3 | 2 | **6** | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Post BMA Industrial Action Debrief to include update of SOP at the end of IA series. — EPR Lead — 30/06/2024 — A | Chief People Officer | | 1 | 1 | **1** | **29/07/2024** |

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | Owner | Target Completion (end) | Status | Action owner | Confidence Assessment | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 17/11/2021 Risk Opened | | Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff. 22/02/2022 | | | | | 21/03/2022 Sickness levels remain consistent. A Health and Wellbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year. | | | | | 15/05/2024 This risk is recommended for removal from the BAF. It will remain open and be managed on the WFOD risk register. | | | | | | | | |
| ID 00582 | Nov 2021 | Chief People Officer | **Organisational Sickness Absence**<br><br>IF we fail to manage Covid-19 and Mental health Sickness Absence rate<br>THEN we will be inadequately supporting the health and wellbeing of our staff and see sickness absence rates remain above the target of 5%<br>RESULTING IN reliance on agency staff, increased staff turnover rate, reduced staff retention rates, increased cost and potentially lower quality service to patients. | 5 | 4 | 20 | Sickness absence policy<br>Health & Wellbeing Group [2a]<br>Range of targeted support and leadership<br>Mental wellbeing and stress support<br>Winter wellbeing messaging<br>Health and Wellbeing Conversations [1a]<br>Promotion of Flu and Covid vaccinations | Monitoring locally,<br>Sickness Absence reporting through QPR, Workforce Committee and Trust Board | 3 | 3 | 9 | ↓ | | Owner | Target Completion (end) | Status | Chief People Officer | | 3 | 3 | 9 | 31/03/2025 |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| **2.2 - Building a sustainable workforce for the future** | | | | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | | | | |
| **2.3 - Creating an empowered, capable and inclusive leadership team** | | | | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | | | | |
| **3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities** | | | | | | | | | | | | | | | | | | | | | | |
| **3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation** | | | | | | | | | | | | | | | | | | | | | | |
| | 15/02/2023 Risk Opened | | | | | | | | | | | | | | | | | | | | | |
| ID 04347 | Feb 2023 | Chief Operating Officer | **Implementation of the Community Mental Health Framework across Kent and Medway**<br><br>IF the Community Mental Health Framework is not piloted with the appropriate governance and data systems in place, THEN it may not be possible for agencies to work effectively together<br>RESULTING IN poor data quality for reporting to IQPR, Staff dissatisfaction and engagement with the pilot, continued capacity issues, lack of improved waiting times, inability to achieve parity of access regardless of patient age, reputational damage | 4 | 4 | 16 | CMHF Programme Board with Implementation group with associated plan, including 3 phases of implementation across county reporting in<br>CMHF Programme Board with multi- agency digital workstream<br>CMHF Programme Board dedicated communications lead<br>Clear reporting lines established with clinical leadership and oversight of new models.<br>Robust programme management in place with phases 1 and 2 review in place | Community Mental Health Framework Programme Board | 3 | 4 | 12 | ↔ | **Actions to reduce risk**<br>Digital Solution for Data Collection and Reporting to be identified and implemented<br>Integration of provider workforce to aid skill mix and new ways of working | **Owner**<br>Deputy Chief Operating Officer<br>Chief Operating Officer | **Target Completion** (end)<br>31/01/2024<br>31/07/2024 | **Status**<br>A<br>A | Chief Operating Officer | | 2 | 3 | 6 | 30/09/2024 |
| **3.2 - Working together to deliver the right care in the right place at the right time** | | | | | | | | | | | | | | | | | | | | | | |
| | 06/06/2022 Risk Opened | | 15/09/2022 Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages. | | | | | 14/03/2023 This remains a high risk for the Trust. There is a better grip and understanding of our DTOCs, and things are improving, but there are daily fluctuations. | | | | | | | | | | | | | | | |
| ID 00410 | Jun 2022 | Chief Operating Officer | **Increased level of Delayed Transfers of Care (DToC)**<br><br>IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care<br>RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage. | 4 | 5 | 20 | All delayed discharges are discussed at the weekly escalation meeting with ICB and social care colleagues looking at how to reduce Delayed transfer Cohort. Progress is monitored via this group with regular Multi Agency Discharge taking place regularly for super stranded cases.<br>Daily reporting<br>Weekly check and challenge with the Local Authority<br>Senior oversight led by the deputy COO<br>Super stranded Multi Agency Discharge Events<br>ICB led meetings - focus on creating capacity across K&M for onward transfer. | Daily scrutiny of DToC data | 4 | 4 | 16 | ↔ | **Actions to reduce risk**<br>ICB diagnostic analysis of reasons for DTOC<br>Recruitment of social workers for inpatients<br>Exploring Step down options for DTOC | **Owner**<br>Deputy Chief Operating Officer<br>Deputy Chief Operating Officer<br>Chief Operating Officer | **Target Completion** (end)<br>Completed<br>29/04/2024<br>30/04/2024 | **Status**<br>G<br>A<br>A | Chief OperatingOfficer | | 3 | 3 | 9 | 06/05/2024 |
| **3.3 - Playing our role to address key issues impacting our communities** | | | | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | | | | |

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | Action owner | Confidence Assessment | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **4 - We use technology, data and knowledge to transform patient care and our productivity** | | | | | | | | | | | | | | | | | | | |
| **4.1 - Have consistent, accurate and available data to inform decision making and manage issues** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **4.2 - Enhance our use of IT and digital systems to free up staff time** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **4.3 - Effective digital tools are in place to support joined-up, personalised care** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **5 - We are efficient, sustainable, transformational and make the most of every resource** | | | | | | | | | | | | | | | | | | | |
| **5.1 Achieve financial sustainability** | | | | | | | | | | | | | | | | | | | |
| | 10/03/2021 Risk Opened | | 06/09/2021 As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit. | | | | | | | | | | 14/03/2023 This risk has been reviewed and updated for the coming financial year. | | | | | | |
| ID 00256 | Mar 2021 | Executive Director of Finance | **Long Term Financial Sustainability**<br><br>IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate<br>THEN funds will not be available to support existing services<br>RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed | 4 | 5 | 20 | Reporting to Trust Board [3a]<br>Reporting the NHSI [3b]<br>Monthly Finance Report [1h]<br>CIP Process [2a]<br>QPR Meetings [2a]<br>Care Group Management Meetings [2a]<br>Finance and Performance Committee monitoring [2b]<br>Finance position and CIP update [1h]<br>Standing financial instructions [2e]<br>Internal audit [3d]<br>Agency recruitment restriction [1a]<br>Monthly statements to budget holders [1a]<br>Budget holder authorisation and authorised signatories | Long Term Sustainability Programme (LTSP) has been launched in the organisation and is being led by the deputies.<br>Monthly reporting is taking place through QPRs and Finance report, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs.<br>Service Line reporting data has been utilitised to identidfy loss making services and to focus discussions on opportunities.<br>Papers reported to FPC and Trust Board.<br>SLR data reviewed routinely to ensure Directorates clear on the position. | 3 | 4 | 12 | ⟷ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Identify CIP programme to meet 2024/25 savings target / Deputy Director of Finance / 30/06/2024 / A<br>Align SLR and Budgeting to give clearer service line on reporting / Deputy Director of Finance / 30/09/2024 / A<br>Implement 3 year planning Model / Deputy Director of Finance / 30/09/2024 / A | Executive Director of Finance | | 3 | 3 | 9 | 31/03/2025 |
| | 22/08/2023 Risk Opened | | | | | | | | | | | | | | | | | | |
| ID 07557 | Aug 2023 | Chief Medical Officer | **Trust agency usage**<br><br>IF the Trust fails to recruit to its establishment and relies on Agency staff<br>THEN this could impact on the quality and safety of services<br>RESULTING IN an increased risk and impact on the Trust ability to deliver safe care and long term financial sustainability and a risk to the ICS system financial performance. There maybe further sanctions from NHSE which have not yet been confirmed. | 4 | 5 | 20 | Reporting to Trust Board [3a]<br>Reporting the NHSE [3b]<br>QPR Meetings [2a]<br>Monthly Exec led Directorate Management Meetings to review Agency Usage [2a]<br>Finance and Performance Committee monitoring [2b]<br>Standing financial instructions [2e]<br>Agency recruitment restriction [1a]<br>Budget holder authorisation and authorised signatories<br>Weekly monitoring of agency spend<br>Medical lead for recruitment appointed to support areas which are challenging to recruit to. | Monitoring of agency usage and compliance with usage and rate limits is an NHSE expectation of all systems and providers with established governance processes in place to oversee agency staffing. | 3 | 4 | 12 | ↓ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Identify plan for address temporary staffing within Nursing / Associate Director of Financial Management / 30/06/2024 / A<br>Identify approach for Medical Staffing within East / Chief Medical officer / 30/06/2024 / A | Executive Director of Finance | | 3 | 3 | 9 | 28/03/2025 |
| **5.2 Exceed the ambitions of the NHS Greener programme** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **5.3 Transform the way we work** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |
| **6 - We create environments that benefit our service users and people** | | | | | | | | | | | | | | | | | | | |
| **6.1 - Maximise our use of office spaces and clinical estate** | | | | | | | | | | | | | | | | | | | |
| | | | No Risks Identified against this Strategic Objective | | | | | | | | | | | | | | | | |

| ID | Opened | Board Level Risk Owner | Risk Description (Simple Explanation of the Risk) | Initial rating L | Initial rating C | Initial rating Rating | Controls Description | Top Five Assurances | Current rating L | Current rating C | Current rating Rating | Trend | Planned Actions and Milestones | Action owner | Confidence Assessment | Target rating L | Target rating C | Target rating Rating | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **6.2 - Invest in a fit for purpose, safe clinical estate** | | | | | | | | | | | | | | | | | | | |
| 01/04/2020 Risk Opened → 04/06/2021: Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. → 06/09/2021: This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway → 17/01/2022: The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022. → 14/03/2023: **The capital allocation for 2023/24 is severely limited across the system, which limits the ability of the Trust to invest in life expired buildings and equipment.** | | | | | | | | | | | | | | | | | | |
| **ID 00119** | Apr 2020 | Executive Director of Finance | **Capital Projects - Availability of Capital**<br><br>IF the capital programme is not prioritised robustly, and delivered as planned<br>THEN the restricted capital allocation for 2023/24 may not be fully utilised despite a high need for capital spend across the organisation,<br>RESULTING IN inability to invest in life expired equipment or buildings, increased pressure on the operational maintenance budget, potential for an increasing backlog, clinical and workplace environments which may not be fully fit for purpose, potential loss of use of a facility. | 5 | 5 | **25** | 1. EFM now have a Head of Capital Development in post who has been tasked with leading on the development of a Trust risk assessed capital development plan, ready for commencement from April 2024. The plan will be agreed through TCG, CWG and Operational Estates to ensure that the higher risk issues (per the 7 facet survey etc.) are addressed as early as possible, taking into account any lifecycle replacement requirements . Once agreed the plan will feature on the EFM QPR/Estates dashboard for regular review, monitoring and executive oversight. CWG have already begun the supporting process of reviewing wider capital project demand and allocating funding for the plan, according to risk.<br>2. In addition, the Capital Development Team are working with key stakeholders such as Procurement and Finance colleagues to establish standardised processes, frameworks and design/material specifications to provide a common path for capital projects for efficient, timely and effective delivery against specifications ("build it right first time").<br>3. To assist with design management, ensuring that specifications are fit for purpose, it has now been agreed through Trust Capital Working Group that key stakeholder sign-off will be required for all capital projects, prior to commencement (e.g. ICT, IM & T, Finance, Risk, IG).<br><br>Trust Capital group managing programme.<br>Programme delivery reported to TCG. | IQPR dashboard and reporting,<br>Board, FPC and Trust Capital Group Oversight<br>Board, FPC and Trust<br>Business case review group<br>Capital Group Oversight<br>Business case review group<br>EFM Senior Management Team<br>Dashboard and reporting | 4 | 3 | **12** | ⟺ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>Robust capital plan to be in place for 2024/25 (timings) / Director of Estates and Facilities / 30/05/2024 / A<br>Quarterly, In Year Review of Capital Programme and Priorities (half yearly review) / Director of Estates and Facilities / 30/09/2024 / A | Executive Director of Finance | | 2 | 3 | **6** | **31/03/2025** |
| 22/08/2023 Risk Opened | | | | | | | | | | | | | | | | | | | |
| **ID 07556** | Aug 2023 | Executive Director of Finance | **Expiry of lease for Littlebrook**<br><br>IF we cannot negotiate a suitable settlement figure for terminating the Littlebrook lease arrangement in 2025 and cannot secure capital and cash support to progress this<br>THEN the Trust will need to negotiate a further long term lease agreement for the site so that services can continue to be delivered from this location<br>RESULTING in potentially higher lease charges with vulnerability to future changes in inflation and the Trust not holding ownership of the building until the new lease terminates. If capital funding cannot be provided by the ICB the Trust would need to meet this from internal capital allocations, thus reducing monies available for other schemes. | 4 | 3 | **12** | Reporting to Trust Board [3a]<br>Finance and Performance Committee monitoring [2b] | Reporting to FPC | 3 | 3 | **9** | ⟺ | **Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**<br>External legal advisers have been appointed to advise the Trust on options / Executive Director of Finance / 31/10/2023 / G<br>Negotiations will be required with the investors to reach a suitable way forward / Executive Director of Finance / 31/03/2024 / A<br>Discussions have commenced with NHSE and the ICB to secure capital funding (noting whichever option we pursue will require capital funding.) / Executive Director of Finance / 30/06/2024 / A | Executive Director of Finance | | 2 | 3 | **6** | **31/12/2024** |

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Strategic Deliver Plan Priorities 2024 |
| **Author:** | Adrian Richardson, Director of Transformation and Partnerships |
| **Executive Director:** | Sheila Stenson, Chief Executive |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Noting |
| **Submission to Board:** | Board requested |

## Overview of Paper

This paper provides an update to Board, following March's Board paper on the delivery of our three-year strategy in year one (2023-24). As agreed at Board, the executive management team (EMT) and our deputies have reviewed the number of outcome measures in the strategy overall, as well as our priority areas of focus. This paper sets out our agreed approach and how we have rationalised these outcomes to ensure they are manageable and deliverable over the next two years of our strategy.

## Issues to bring to the Board's attention

All 73 outcomes set as part of the three- year strategy have been reviewed, prioritised and categorised into three areas for delivery in year two of our strategy:

(1) priorities - chosen as the areas where we can together make the biggest difference to our patients, people and partners; and to help us internally know where to focus our efforts as we cannot do everything in our strategy at once. These are our drivers.
(2) business as usual, which includes elements of our strategy and wider initiatives that are important parts of our core business and will continue to be delivered as part of our day-to-day delivery
(3) areas for continual monitoring that do not need an improvement approach. These are called our watch metrics.

The number actively being worked in year two has been reduced to 28, across six priorities.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Trust Strategy |
| **Assurance:** | Reasonable |
| **Oversight:** | Trust Board/Board Sub-Committees |

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Overview

The strategy is based on three strategic ambitions (our three Ps) and three strategic enablers. Each ambition and enabler have a number of outcomes associated with it.

| **Strategic Ambition** | **Number of Outcome Objectives** |
|---|---|
| We deliver outstanding, person centred care that is safe, high quality and easy to access | 14 |
| We are a great place to work and have engaged and capable staff living our values | 16 (originally 17) |
| We lead in partnership to deliver the right care and to reduce health inequalities in our communities | 12 (originally reported as 10 due to two additional outcomes as part of Community Mental Health Framework transformation) |

| **Strategic Enabler** | **Number of Outcome Objectives** |
|---|---|
| We use technology, data and knowledge to transform patient care and staff productivity | 10 |
| We are efficient, sustainable, transformational and make the most of every resource | 14 (originally 12 with two additional added) |
| We create environments that benefit our service users and people | 7 |

It was acknowledged that with 73 outcomes, engagement and resources would be stretched. This is why we agreed six priority areas of focus in November 2023. However, following the year 1 delivery review of the trust strategy at March 2024 Board, it was recognised that there was a pressing need to further prioritise and rationalise the outcomes.

The outcomes contained in the Trust Strategy 2023 – 2026 have been categorised as follows:

| **Group** | **Number of Outcomes** | **Approach** |
|---|---|---|
| Drivers | 28 (6 which are from strategic enablers) | Where an active improvement approach is supporting the strategic ambitions and enablers. |
| Business as Usual | 14 + (9 UEC and Patient Experience) | Where the metrics/outcomes are monitored and reported frequently through the Strategy Deployment Group (SDG) or as part of the Trust Integrated Quality & Performance Report (IQPR) and Quality Performance Reviews (QPRs), without the need for an improvement approach. |
| Watch | 20 | Where monitoring and further progress will be made within a business as usual approach without the need for an improvement approach |

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We will keep six priorities this year, categorised above as our drivers, but will replace recruitment and retention because we have done so well to achieve our ambitions. We have filled many staffing gaps, especially in our nursing workforce, bringing our overall vacancy gap down significantly. Our people team will continue to support teams and 'hot spot' areas experiencing the greatest staffing gaps, but this work no longer needs to be an organisational priority. And work on retention will continue under our culture, identity and staff experience priority as this is all about making KMPT a great place to work.

In its place, will be our getting the basics right priority. This will make everyone's working day easier by improving and streamlining over burdensome processes, poor technology and access to data which we know are huge barriers to our people delivering their best, and causes so much unnecessary frustration.

We will balance these drivers with the regular demands of working in a fast-paced, evolving health service, and responding to national changes and initiatives covered in our business as usual outcomes.

Therefore, for 2024, our six priorities are:

1. Patient flow, so we can see people quicker, closer to home and in the least restrictive settings
2. Mental Health Together, so we can transform how we care for people with complex mental health needs, alongside our partners, in the community
3. Dementia, so we can diagnose and care for more people who are waiting to be seen in a quicker time
4. Reducing all forms of violence and aggression, including racially motivated, against our people so that they can come to work and feel safe and supported
5. Transforming our culture and identity so that we have the right behaviours within KMPT and do more to help our patients, partners and community know who we are and what we do, ultimately making us a better place to work, be cared for and partner with.
6. Getting the basics right, so we make everyone's working day easier and enable them to deliver the best possible care.

These six priorities, with the drivers (outcomes) for each are set out in the table below:

| | |
|---|---|
| Patient flow | Decrease our bed occupancy to 85% |
| | Reduce the length of stay for patients waiting onward transfer by 75% |
| Dementia | 95% of people referred for a dementia assessment will be seen within 6 weeks |
| Mental Health Together (MHT) (*Community Mental Health Framework*) | Patients receive treatment within 4 weeks of a referral into Mental Health Together |
| | Increase the number of patients accessing care in the Mental Health Together service to levels representative of the local population. |
| | 85% of people with a severe mental health illness presenting through Mental Health Together will have a physical health check |
| | See 85% of routine referrals within 4 weeks |
| | Forecast mental health capacity and meet demand |
| Violence and aggression | Decrease violence and aggression on our wards by 15% |
| | Reduce racist violence and aggression incidents to 15%, in line with the national average. |

| | |
|---|---|
| Culture, identity and staff experience (two previous outcomes have been removed due to overlap) | Increase percentage of BAME staff in roles at band 7 and above |
| | Increase our raising concerns sub-scores from 6.6 to 6.9 |
| | Increase our burnout sub-score from 5.2 to 5.5 |
| | Increase staff satisfaction with their line managers from 7.6 to 7.9 in our staff survey |
| | Reduce our agency spend to 3.7% of the trust total pay bill |
| | Our people feel KMPT is a supportive and compassionate employer |
| | Increase engagement score from 6.9 to 7.1 |
| | 90% of leaders at Band 7 to have attended KMPT leadership and management development |
| Getting the Basics Right* | Reduce unwarranted variation in services |
| | Reduction in time spent capturing and revalidating non-value adding data by 25% |
| | Process Re-Engineering of operational support systems |
| | Process Re-Engineering of corporate support systems |

* Scoping is currently underway for the pathways and opportunity areas associated with Getting the Basics Right and will completed by the end of June.

In addition to the driver outcomes within the three strategic ambitions there are six outcomes that form part of the strategic enablers that will be drivers for 2024:

| | |
|---|---|
| Enablers | Clinical staff report that our Electronic Patient Records System is quicker and easier to use. |
| | Sharing information and data internally is smoother and quicker and we have one version of the truth |
| | Electronic solutions have been delivered for referrals and consultations |
| | A service user portal has enabled access to personalised information and freedom to control their own care |
| | Embed hybrid working |
| | Secure shared clinical spaces with our partners |

Conclusion

The trust will continue to have 6 priorities moving forward for year 2 of its strategy that deliver 28 outcomes. These are manageable within current resources and structure.

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update |
| **Author:** | Adrian Richardson, Director of Partnerships & Transformation |
| **Executive Director:** | Adrian Richardson, Director of Partnerships & Transformation |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Noting |
| **Submission to Board:** | Board requested |

## Overview of Paper

This paper provides an overview of the continued developments of the Mental Health, Learning Disability and Autism Provider Collaborative (PC) and the plans for the PC.

## Issues to bring to the Board's attention

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

The PC operates at a strategic level aimed at continuous improvement. Supporting it are multiagency working groups focusing on each of the PC's priority areas, the report contains details of the current workstream SRO, resourcing and deliverables.

## Governance

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|---|---|
| **Implications/Impact:** | KMPT Trust Strategy |
| **Assurance:** | Reasonable |
| **Oversight:** | Trust Board and Provider Collaborative (PC) Board |

Version Control: 01

## Provider Collaborative Board

The Provider Collaborative (PC) Board is now well established within the governance structure for the Kent and Medway system. As a reminder the Board has the following PCs reporting into the Board:

- MHLDA Provider Collaborative
- Community, Social and Primary Care Provider Collaborative
- Acute Provider Collaborative
- And Diagnostic and Imaging networks

In March 2024 a Programme Director for all PCs was appointed to work alongside the SRO (KMPT Chief Executive) in forming and standardising the PCs and their governance across Kent and Medway.

The programmes of work for the MHLDA PC are:

- Community Mental Health Transformation Programme
- LDA, including out of area placements Project
- Dementia
- Mental health urgent and emergency care (UEC)

## Provider Collaborative Governance Update

The structure of the PC governance for the Kent and Medway System is outlined in figure one and the governance for the MHLDA PC is outlined in figure 2 on the following pages.

In April the PC membership was expanded to include a representative from the Health Innovation Kent, Surrey and Sussex.

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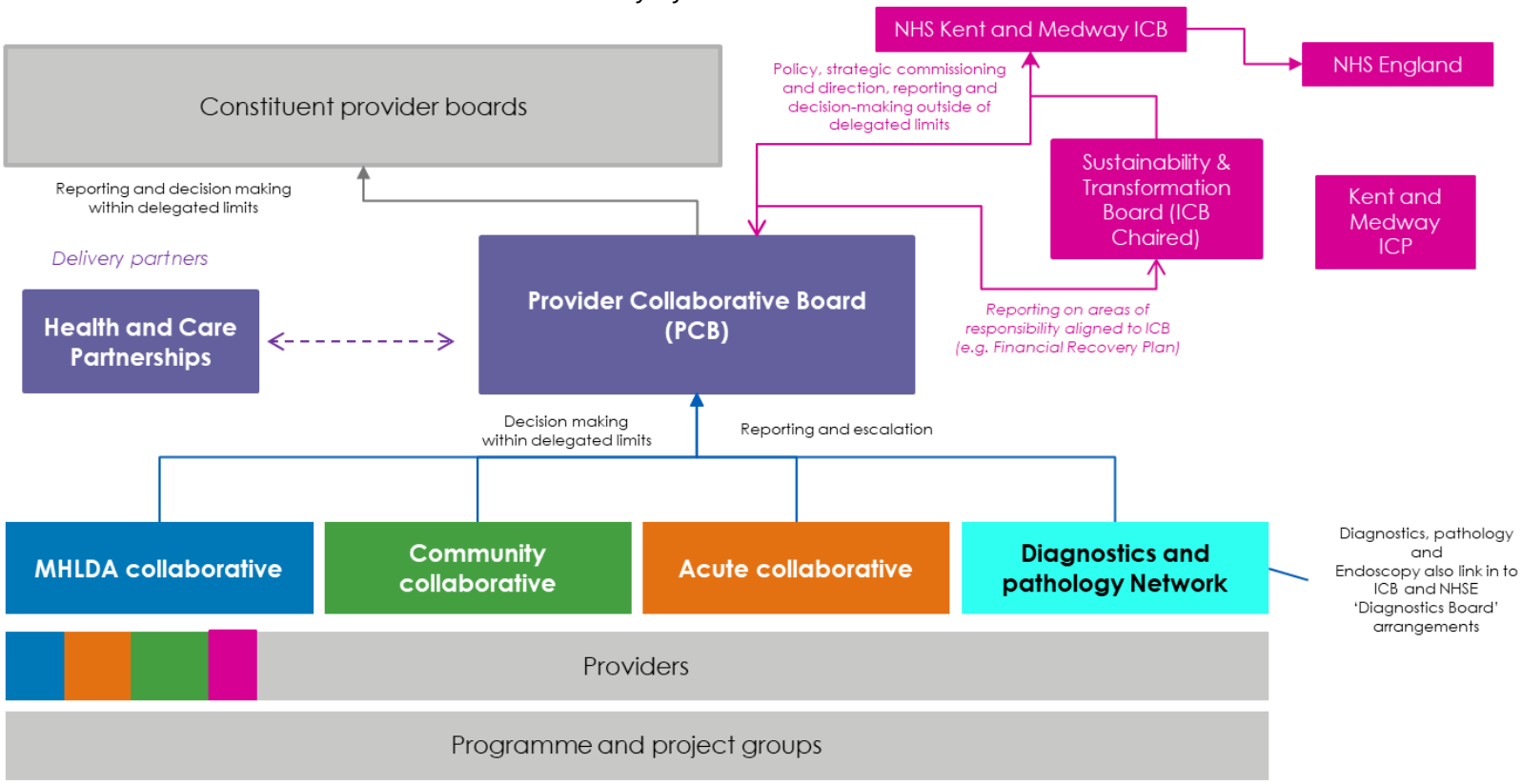
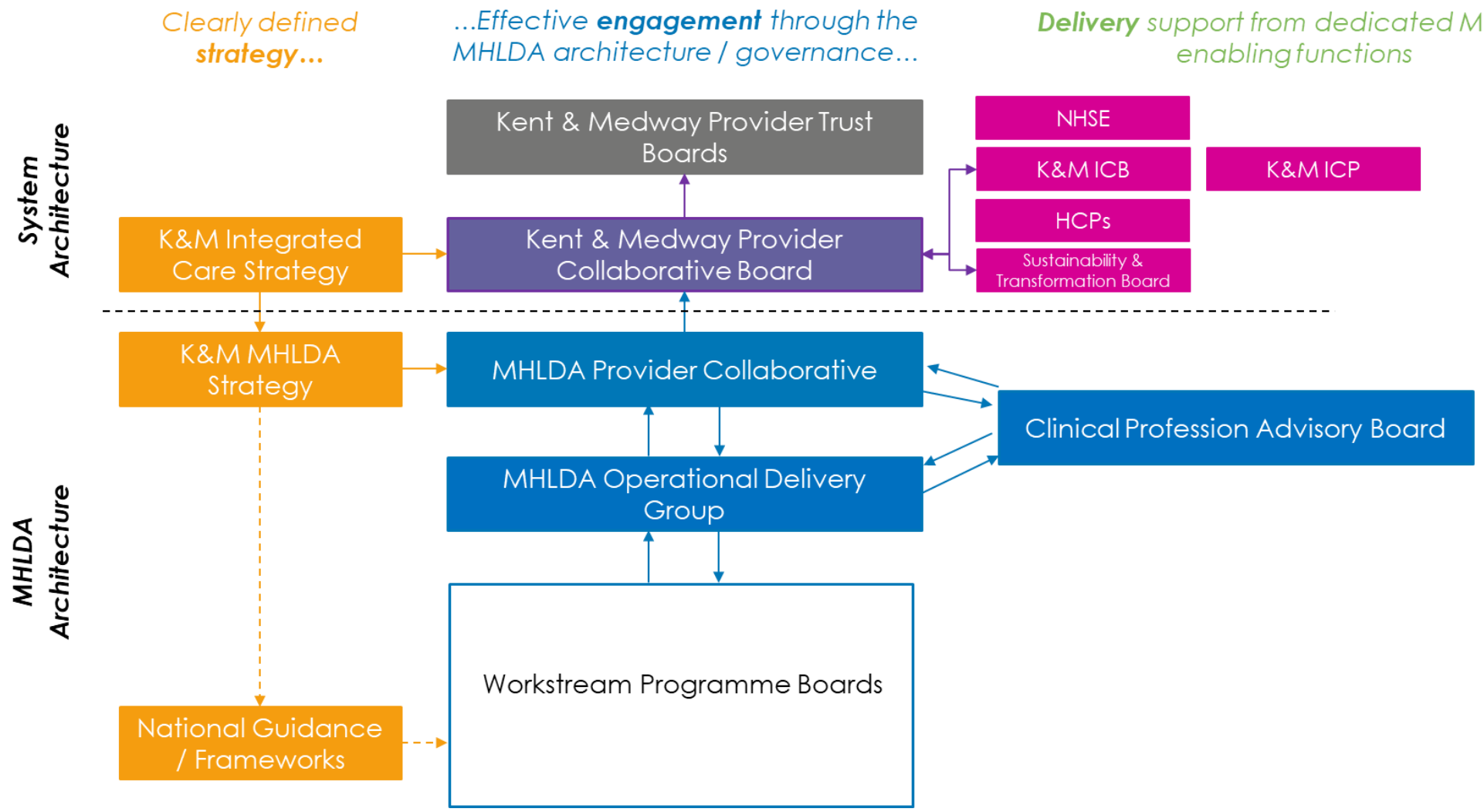
Figure 1 – Structure of PC Governance for the Kent and Medway System




Version Control: 01

Figure 2 MHLDA PC Programme Governance Structure May 2024




Version Control: 01

**MHLDA Provider Collaborative Update**

The PC met in April and was chaired by the KMPT Chief Executive. The PC reviewed and approved the Charter for the Urgent and Emergency Care workstream, the charter is attached as appendix 1. The membership and terms of reference of the PC and sub-groups have been reviewed and will be finalised by the end of May following stakeholder feedback.

The PC has also requested two additional sub-groups are established to form:

1. Task and finish overview for driving improvements to dementia diagnosis rates through a system wide response including a system wide solution and model, this is due to commence in June.
2. Health Inequalities sub-group to scope the potential opportunities and initiate improvements where necessary.

Charters articulating the aims, objectives, achievements and timeframes for delivery for each workstream have been drafted. The PC and the Operational Delivery Group (ODG) have continued to work with workstream SROs and programme teams to define the scope of the work within each workstream. An overview of the four active workstreams is contained in the table below.

| Workstream | Deliverable | Next step | SRO | Resourcing Q1 | Resourcing Q2 | Resourcing Q3 &4 | Savings? |
|---|---|---|---|---|---|---|---|
| Bring people with LDA back from out of area placements | People returning from placements | Progress shared via MHLDA collaborative | Nick Brown | KMPT | KMPT | KMPT | £1m to be reinvested |
| Improve UEC flow and ensure people with mental health crisis cared for in the most appropriate environment | eg Reduced waits in A&E for people with mental health problems Improved range of out of hospital options | Confirm milestones at MHLDA Collaborative meeting Confirm savings assumptions | Louise Clack | ICB/PC | ICB/PC | ICB/PC | TBC – savings in acute CIP assumptions need to be clarified |
| Ensure there is an appropriate Dementia offer for local people | Robust implementation plan | Establish oversight and plan | Adrian Richardson | KMPT | KMPT/PC | KMPT/PC | No |
| Community Mental Health Transformation Programme | Roll out of new model | Progress being shared via collaboratives | Donna Hayward-Sussex | KMPT | KPMT | KMPT | No – improved effectiveness – enables UEC improvements |

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**Next steps**

- Over the next two months the ODG and PC will continue to work with the workstream SROs and programme teams to ensure deliverables are mapped to timeframes and can articulate the advantage to the citizens of Kent and Medway including measurable outcomes where appropriate.
- The establishment and recruitment of the central team will allow for discussions on proposed governance and the associated assurance routes as well as an agreed standardised method for working across all PC in Kent and Medway. This will be driven by the PC Programme Director who has recently been appointed and is working closely with the KMPT Director of Transformation and Partnership to transition the oversight of the PC in line with the others across Kent and Medway.
- A refresh of the function and reporting from ODG and the Clinical Professional Advisory Board to ensure a clinically aligned and where possible clinically driven improvement within the workstreams.

Version Control: 01

# Programme Name: Mental Health UEC

**Date: 05 March 2024 Updated By:**

## 1. Governance

**Exec Sponsors:** Lee Martin (ICB)
**Clinical leads:** Dr Jihad Malasi
**Information Lead:** Poppy Whiteside
**Finance Lead:** Kevin Tupper
**Quality Lead:** Ian Brandon
**Programme Management: Louise Clack, Jacqui Davis**
**Project Managers:** Louise Piper, Phill Hall and Sarah Parker

Gateway

## 2. Description

**Aim:** Delivery of a system wide Mental Health Urgent and Emergency Care Pathway, that aligns with Community Mental Health Transformation, for the adult population in Kent And Medway who are experiencing mental health crisis and /or acute mental illness.

**24/25 System Objectives:** Deliver a suite of community crisis alternatives including Safe Havens and Recovery (Crisis) Houses, Mental Health Urgent Ambulance Response/Blue-light Triage, Open Access Crisis: 111 select mental health option, a bespoke mental health conveyance service incorporating a sit and care service for individuals detained on S136 in Emergency Departments and fit-for purpose revised Section 136 crisis pathway standards. Development of a 3 year Action Plan aligned to the NHSE Inpatient Quality Framework, with tailored intervention to build on alternatives to inpatient care, reduce length of stay and zero out of area placements, trauma informed care and purposeful admission. Coordinate the awareness and preparedness of the system for implementation of Right Care Right Person.

**Not currently resourced:** Mental Health and Housing Strategy, which includes appointment to a Mental Health and Housing Strategic Lead role, and temporary funding for up to 14 stepdown beds.

**Key Interdependencies:** Community Mental Health Transformation, Police & SECAMB, VCSEs (MHM, Hestia, Mind, Porchlight), Local Authorities Housing and Approved Mental Health Practitioners (AMPH), Acute Hospital Trusts

## 3. Timeline and key milestones

| Lead | Milestone/ Target Description | Date | RAG |
|---|---|---|---|
| ICB | Implementation of revised Safe Haven model | June 24 | On Track |
| ICB | Implementation on Recovery houses | July 24 | On Track |
| ICB | Implementation of bespoke MH transport and sit and care service | July 24 | On Track |
| ICB | OAC 111 select MH option | April 24 | On Track |
| ICB | Blue Light Triage/Urgent Ambulance Response | TBC | Delayed |
| ICB | S136 crisis pathway standards | March 25 | On Track |
| ICB/KMPT | Implementation of Inpatient quality standards | TBC | Planned |
| ICB | RCRP Implementation | April 24 | On Track |

## 4. Key Risks

| Risk | PRE-MITIGATING SCORING | Mitigating Action | POST-MITIGATING SCORING |
|---|---|---|---|
| IF there are increased numbers of inpatients clinically ready for discharge THEN people are waiting for admission in environments that are clinically unsafe RESULTING IN possible major injury. | 16 | Escalation process. Procurement of community crisis alternatives, regular MADEs, weekly multi-agency patient flow meeting, Deep dive analysis of root cause to CRFD. | 16 |
| If 72hr referral pathway sits within NHS 111 Select 2/Urgent Crisis Line (in the absence of curent alternatve respository) capacity within the urgent crisis line is reduced for answering Crisis Calls resulting in poor service user experience, and non-compliance with NHSE requirements. | 16 | "Use of temporary staffing to try to meet demand. Monthly reporting of KPIs in line with NHSE requirements and sharing by KMPT of any untoward incident where harm has occurred. Roll out of MH2gether. | 16 |
| IF implementation of blue light triage/Urgent Ambulance response is delayed THEN there will be continued unnecessary conveyance of people with primary MH issues to EDs and will hinder reduction in S136 RESULTING IN poor patient experience and continued *pressure upon emergency services.* | 12 | KMPT meeting regarding mobilisation of / blue light triage.<br>KMPT to enable RIO access to SECAMB | 12 |
| Hard of hearing line to be escalated to KMPT contracts and director of contracts/IG and business development due to a capacity issue to man the line 24/7. NHSE required line to be functioning in 2023 so risk escalated. Business case for additional CYP resources that is with CYP commissioners currently. | 16 | | 16 |

## 5. Impact Assessment

| Impact Assessment | RAG | Date completed | Date approved | Review date | Key issues raised (if applicable) |
|---|---|---|---|---|---|
| Quality Impact Assessment | | August 23 | | | NA |
| Equality Impact Assessment | | August 23 | | | NA |
| Privacy Impact Assessment | | ?? | | | NA |

## 6. Activity Assumptions

| Key Outcome/Benefit | Baseline | Current | Aim |
|---|---|---|---|
| 5% reduction in KMPT Bed Occupancy | 95% | 95% | 90% |
| KMPT Length of Stay at 32 days | 34 | Tbc | 32 |
| Reduction in primary mental health self-presentation to ED | 1.85% of all ED attendance | 1.85% | 0.85% |
| Reduction in Primary mental health ambulance conveyance to ED | 4.1% | 4.1% | 2.05% |
| Reduction in primary mental health police conveyance to ED | 3.7% | 3.7% | 3% |
| Reduction in 12hr waits in ED that are attributable to mental health | 3% | 3% | 1% |
| 4hr response to urgent referral for assessment | tbc | tbc | 80% |
| Increased footfall to Safe havens | 2135 contact per quarter | 2135 contact per quarter | 5885 contacts per quarter |
| Reduction in incidence of S136 (by 10%) | 46.5 | 46.5 | 41.85 |
| Reduction in police hours spent on S136 supervision in ED | 08:51 | 8:51 | 4:25 |
| Increase in conversion rate of S136 to inpatient admission | 21.2% | 21.2% | 70% |
| Reduction in clinically ready for discharge | 26.5 | 26.5 | 13.25 |

**Project RAG**

## 7. Financial Overview

| | |
|---|---|
| **Adult Safe Havens** | £3.7m |
| **Crisis Houses** | £800K |
| | |
| **MHM Helpline** | £70K |
| **Mental Health Ambulance/Blue Light Triage** | £800K |
| **Mental Health Conveyance Service** | £1.2m |
| **Step Down beds** | £ tbc |
| | |
| **External consultant to lead on a mental health and housing strategy** | £ tbc |
| | £ |

## 8. Route to Market

Full procurement for Safe Havens, Bespoke MH transport and one of the Recovery houses. Three quote tender for the Medway recovery house.

## 9. Non Financial Benefits and Quality Metrics

Improved patient experience of conveyance
Improved patient experience of inpatient stay/purposeful admission
Improved patient experience of Section 136 Pathway
Improved experience of timely response when in mental health crisis
Reduction in time waiting for an inpatient bed

## 10. Communication and Stakeholder Engagement

- Service user and stakeholder engagement, including workshops to develop the revised crisis alternative service model
- Lived experience leads employed as project group members and evaluators on Safe Haven, Recovery House and MH transport procurements.
- Ongoing lived experience involvement in service mobilisation.
- Extensive system and stakeholder engagement on Right Care Right Person.

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Community Mental Health Framework – Quarterly Update |
| **Author:** | Victoria Stevens, Deputy Chief Operating Office |
| **Executive Director:** | Donna Hayward-Sussex, Chief Operating Officer |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Board requested |

## Overview of Paper

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

## Issues to bring to the Board's attention

Phase 1 of the Community Mental Health Framework is now life with 7 new Mental Health Together Services being implemented. Phase 1 deploys existing resource from all current providers. The full model is planned with delivery partners, following recruitment and contracting being in place.

## Governance

**Implications/Impact:**

The Trust has agreed to award contracts under the Provider Selection Regime to three key partners as lead provider for the Community Mental Health Framework. An agreement has been reached with Invicta Health CIC for the provision of additional staff to support the programme. Invicta Health CIC have previously provided Primary Care Mental Health Services in the East of the county.

Two further contracts with key voluntary sector providers is underway. Both organisations currently provide mental health services across the county and are confident in their ability to recruit to the new community roles as identified in the new model of care.

It should be noted that any slippage in negotiations regarding contracts will have an impact on the planned delivery of phases 2 and 3 of the programme. Progress continues to be monitored and measures to address any deviations addressed swiftly.

**Assurance:** Reasonable

**Oversight:** Executive Management Team

Mental Health Together

NHS

# Community Mental Health Framework

Trust Board Update – May 2024

# High Level Delivery Plan

| Locality | Jan-24 | Feb-24 | Mar-24 | Apr-24 | May-24 | Jun-24 | Jul-24 | Aug-24 | Sep-24 | Oct-24 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Thanet** | Mental Health Together (MHT) Go Live (phase 1) | **Crisis Line** phase-1 | - Test and learn<br>- Sign-off SOP | | | | Phase-2 | | | Phase-3 |
| **A&C** | | | Identify workforce | 08 April - **MHT** Go Live (phase 1) | **Crisis Line** phase-1 | | Phase-2 | | | Phase-3 |
| **SKC** | | | Identify workforce | 29 April - **MHT** Go Live phase 1) | **Crisis Line** phase-1 | | Phase-2 | | | Phase-3 |
| **Maidstone** | | | Identify workforce | | 13 May- **MHT Go Live** | **Crisis Line** phase-1 | Phase-2 | | | Phase-3 |
| **SWK** | | | Identify workforce | | 20 May - **MHT Go Live** (phase 1) | **Crisis Line** phase-1 | Phase-2 | | | Phase-3 |
| **DGS** | | | Identify workforce | | 20 May – MHT Go Live | **Crisis Line** phase-1 | Phase-2 | | | Phase-3 |
| **M&S** | | | Identify workforce | | 13 May – MHT Go Live | **Crisis Line (Phase 1)** | Phase-2 | | | Phase-3 |

# Progress update

**Locality Implementation**

- Implementation groups established in North, West and East with representation from all key stakeholders. Meet bi-weekly to agree workforce planning and recruitment. Engagement activities with local teams. Alignment with Memory Assessment Service (MAS) and other key dependencies. Clinical pathway allocation for patients. Local meet and greet all completed and well received by all agencies. Planning for evaluation of the trailblazer is currently underway for East Kent.

**Finance & Contracting**

- **Finance:** The 24/25 Integrated Care Board (ICB) contract includes £8.43m for 24/25 which covers the areas of spend KMPT is lead provider for such as Mental Health Together (MHT) and Community Rehabilitation Services. Spend is forecast to increase as services go live as per the delivery plan.
- **Contracting:** Contract finalised with Invicta Health, letters of intent agreed with Porchlight & Shaw Trust, all designed to support recruitment of workforce alongside Mental Health Together (MHT). Recruitment to Link Worker posts anticipated from May/June 2024. Lived Experience recruitment anticipated to complete August/September 2024.

**Enablers**

- **Estates:** Planning meetings with Health and Care Partnerships (HCP) to jointly plan future of shared estate footprint in each locality continues. Phase 2 for North Kent will commence May 24 with a focus on identifying estate in the area.
- **Comms & Engagement**: Engagement events with staff and partners planned throughout May to December 2024.
- Performance and Outcomes: 4 Week Wait process to start and stop clock agreed. Business Intelligence supporting data reporting. Key Performance Indicators agreed. Business Intelligence are working on developing a reporting dashboard. Dialog+ training roll out continues.

# Community Rehabilitation Update

Recruitment and go live timeline for all areas detailed below. West Kent are currently reviewing workforce requirements as part of the recruitment process for staff which is now underway. Recruitment for West Kent should be finalised by July 2024.
Planning for go live in East Kent will realign existing staff and/or recruit to additional posts to enable go live of the model starting in July 2024. Voluntary Community Social Enterprise (VCSE) partner recruitment discussions ongoing, liaising with Head of Contracts to develop an appropriate specification/role description.

| High-level plan | 2024 | | | | | | | | | | | | 2025 | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Jan | Feb | March | April | May | June | July | Aug | Sept | Oc | Nov | Dec | Jan | Feb | March | April | May | June | July | Aug |
| Recruitment | West Kent | | | | | | | | All roles in post | | | | | | | | | | | |
| | | | | | | | East Kent (realign/recruitment) | | | | | | All roles in post | | | | | | | |
| | | | | | | | | | | | North Kent | | | | | | All roles in post | | | |
| Go live | | | | | WK soft launch | | | | WK full model | | | | | | | | | | | |
| | | | | | | | | | | | EK soft Launch | | EK full model | | | | | | | |
| | | | | | | | | | | | | | | | NK soft launch | | | NK full model | | |
| Evaluation | | | | | | West Kent Test and Learn | | | | | Evaluation | | | | | | | | | |
| | | | | | | | | | | | | | East Kent Test and Learn | | | Evalutation | | | | |
| | | | | | | | | | | | | | | | | | North Kent Test and Learn | | | Evaluation |

Mental Health Together

# Key Risks/Issues

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| Risk/Issues | Initial Rating | Current Rating | Aim | Mitigations |
|---|---|---|---|---|
| **IF** partners are not comfortable with the contract and adopting Trust Standard Operational (SOP) policies and procedures **THEN** partners may have to adhere to two policies if they work in both MHT and also their own organisation **RESULTING IN** duplication of time and the potential for ineffective use of resource or reduced capacity within the service. | 12 | 12 | 6 | Head of Contracting liaising with partners to discuss the options. Partners will be involved in developing SOPs for use within MHT which will hopefully accommodate their working practices. Staff will be trained on KMPT policies as required. |
| **IF** agreement is not reached quickly on the adoption of KMPT policies by partners **THEN** the procurement exercise that is required by Shaw Trust and Porchlight to recruit Lived Experience staff may be delayed later than the current suggested date of August **RESULTING IN** Lived experience workers recruitment delayed for longer. Slippage in agreement runs the risk of slipping the timescale also. | 12 | 12 | 6 | Head of Contracting liaising with partners to discuss the options. Partners will be involved in developing SOPs for use within MHT which will hopefully accommodate their working practices. Staff will be trained on KMPT policies as required. Confirmation of Lead Provider continuation is required to enable contracts to be developed for periods exceeding March 2025. |
| **IF** the programme has difficulty recruiting to new roles due to known workforce issues for the Kent and Medway system **THEN** MHT might not be able to deliver all of the interventions **RESULTING IN** patient's not receiving a mental health service within 4 weeks that suits their presenting needs. | 12 | 12 | 9 | • A system wide recruitment drive to promote job roles to be flexible and attractive to candidates.<br>• Working closely with stakeholders to establish and utilise existing staff to avoid unnecessary recruitment.<br>• Skill-mix interventions model, which includes Lived Experience roles. |
| **IF** the core model continues to include resource or changes that were not part of the original model **THEN** there is a possibility that the original calculation of funding required may be insufficient **RESULTING IN** potential overspend of the CMHF budget or a reduction in the level of services provided | 12 | 9 | 6 | • Change control process has now been implemented and finance sign off any changes required prior to recruitment. Review of the community rehab business case taking place to ensure that the recruitment matches the business case allocated funding |
| **IF** there is a delay in signing off the Dialog+ completion report currently in the testing system **THEN** there it will not be possible to understand how many Dialog+ are carried out in MHT and MHT+ **RESULTING IN** lack of performance data to understand if they are being completed as required and to measure any improvement in patient outcomes associated with the assessment | 16 | 12 | 4 | • Working closely with Business Information colleagues to obtain timelines for release of the report. The report has been developed and is now in the testing phase to ensure it is pulling the correct data. Business Analysts are able to provide localised reports showing how effectively the service is being delivered |
| **IF** Clinical Pathway Leads and other key staff in MHT do not have access to the primary care system, Egton Medical Information Systems (EMIS) **THEN** it will not be possible to access the Primary care record for all patients **RESULTING IN** incomplete patient records, duplication of entries and delays in processing referrals. | 12 | 12 | 6 | • Digital colleagues identifying options for using Kent Medway Care Record (KMCR) instead of EMIS. |
| **Issue:** Currently there is no Medication support for MHT, which means people are being stepped up to MHT+. The Clinical Model has been designed so people do not need to be stepped up to MHT for medication support. | 16 | 16 | 6 | • West Kent Clinical Director leading on job planning for all consultants to in-reach into MHT across all localities. East Kent Clinical Director organising a short-term local arrangement for Thanet to support the pilot sites.<br>• Mental Health Pharmacist to work with MHT to support Primary Care Networks to manage some medication reviews.<br>• Encourage GPs to use Medication Advice line. Demand and capacity work to understand the slots needed for diagnosis and medication initiation |

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Integrated Quality and Performance Report (IQPR) |
| **Author:** | All Executive Directors |
| **Executive Director:** | Sheila Stenson, Chief Executive |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Standing Order |

## Overview of Paper

A paper setting out the Trust's performance across the three Ps' from our trust strategy with aligned the targets and metrics to reflect the multiple service transformations we have underway as part of the strategy.

## Issues to bring to the Board's attention

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

The Chief Executives Overview at the start of the report highlights the key areas of focus, specifically patients Clinically Ready for Discharge (CRFD), new liaison measures and updates on the implementation of Mental Health Together (MHT) and dementia pathways and their associated measures. In addition, positive work regarding violence and aggression on inpatients wards is highlighted.

## Governance

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

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# Integrated Quality & Performance Report

## (IQPR)

May 2024

# Contents

# Chief Executive Overview

I am excited to present the new Integrated Performance and Quality Report (IQPR). The Board is aware that this report is supported by a range of reports across Board committees and within the supporting Performance Management Framework across directorates.

This new report includes a radical review of the metrics we measure, with the ultimate aim of focusing on what makes the biggest difference to the patients we care for, the people who work for us and the partners we work with. Therefore, we have structured the report (domains) using the three Ps' from our trust strategy, and have aligned the targets and metrics to reflect the multiple service transformations we have underway as part of the strategy - including crisis response, Mental Health Together and dementia pathways - within this report.

The review resulted in 22 measures being added or amended, and an overall increase from 56 to 65 measures. I am confident these measures reflect the most pertinent issues facing KMPT and where our focus must lie. Each domain includes a short narrative that focuses on the areas that are the most challenging for KMPT and, where feasible, we have included the actions we are taking with clear deadlines for delivery.

Before I set out the current month's performance, and the use of statistical process control (SPC) that underpins our analysis, I wanted to bring the Board's attention to two areas which are not where I would want them to be and do not reflect the level of service we all wish to provide to our patients.

- For the first time, this report includes the performance of our liaison teams across the county and the vital role they play in supporting our acute hospitals and their emergency departments. We have included two metrics. The first looks at the % of patients presenting to liaison services that are seen triaged within one hour; the second metric is the % of patients presenting to liaison services that are seen admitted to a psychiatric bed within 12 hours. The performance is 30.1% and 1.6% respectively. There were 63 breaches of the 12 hour wait within April. Clearly this is far from where we aspire to be and I have provided further information below regarding the work we are undertaking to improve this performance across our 6 liaison teams.
- Work has been ongoing before I started as CEO looking at our dementia waiting times and the clinical model we have in place at KMPT. The Finance and Performance Committee will receive a report in June that sets out the model of care and the roll out timeframe for the new standalone memory assessment service (MAS). The new metric for dementia performance is the % referred for a dementia assessment who are diagnosed with 6 weeks. Our performance against this metric is 7.7% in April. Under 'the people we care for domain: Access' we have set out the actions we are taking to

radically improve this performance. It is widely recognised that we need a system solution for the dementia pathway, and I am pleased to say the first working group tasked with redesigning the system model meets in the 1st week of June and will report back to the Provider Collaborative that same week with a proposed timescale for a solution. Partners have been invited to this critical group.

It is good to see the excellent work that is being undertaken to reduce violence and aggression on our wards and the open and honest engagement we are having with our people. We have seen an increase in staff reporting of incidents, which we expected and welcome seeing. The Safety Culture Bundle programme of improvement on the acute inpatient wards promotes an increased focus on recognising and reporting incidents of violence and aggression. It is likely that staff were previously tolerating and underreporting incidents. 75% of all acute wards have now commenced the improvement programme. Work continues to implement the Quality Improvement approach on all wards, with the aim of full roll out by the end of July 2024.

Finally, we have received the independent report on our Clinically Ready for Discharge patients (CRFD). Our CRFD is currently at 20.9% for younger adults and 32.9% for older adults, with targets set at 7% and 12% respectively. The independent report sets out clearly the actions that KMPT needs to take which are included in this report. The actions for the wider system will be undertaken by the Provider Collaborative which KMPT will be part of.

Where relevant Statistical Process Control (SPC) is used to assist in the identification of significant change (see appendix 3 for information regarding this process); of the 49 indicators analysed using SPC, 36 show common cause variation with no clear evidence of improvement or deterioration currently, 7 show evidence of improvements and 5 are of concern. Of those demonstrating improvements it is positive to note that 4 are workforce metrics as well as the number of dialog assessments completed within the Mental Health Together (MHT) teams. Of the 5 showing a deterioration, the greatest area of concern continues to be Clinically Ready for Discharge (CRFD) as mentioned above and further on in this report.

Appendix one includes the Single Oversight Framework (SoF), which KMPT is monitored against from a national perspective and forms part of the executive quarterly oversight meetings with the Integrated Care System (ICS). Where appropriate the measures within the SoF have been adopted into the IQPR. It should be noted that KMPT has 8 metrics in the lower quartile, 4 in the higher quartile, 1 in the top quartile and 7 in the inter quartile. Of the 8 metrics in the lower quartile these all relate to the People who work for us. Many actions are underway to improve staff engagement and experience in the organisation. Some of these will be covered later today in the report to Board regarding our culture, identity and staff experience priority update.

Appendix two reflects the recent data analysis we have completed to view the patients we care for and the people who work for us using a demographic and equity lens. This is the first draft and further work is required for this to be meaningful data that we can use to tackle areas of inequity for our patients and staff. I will be working with the Director of Transformation and Partnerships to take this work forward at pace.

# Trust Wide Integrated Quality and Performance Dashboard

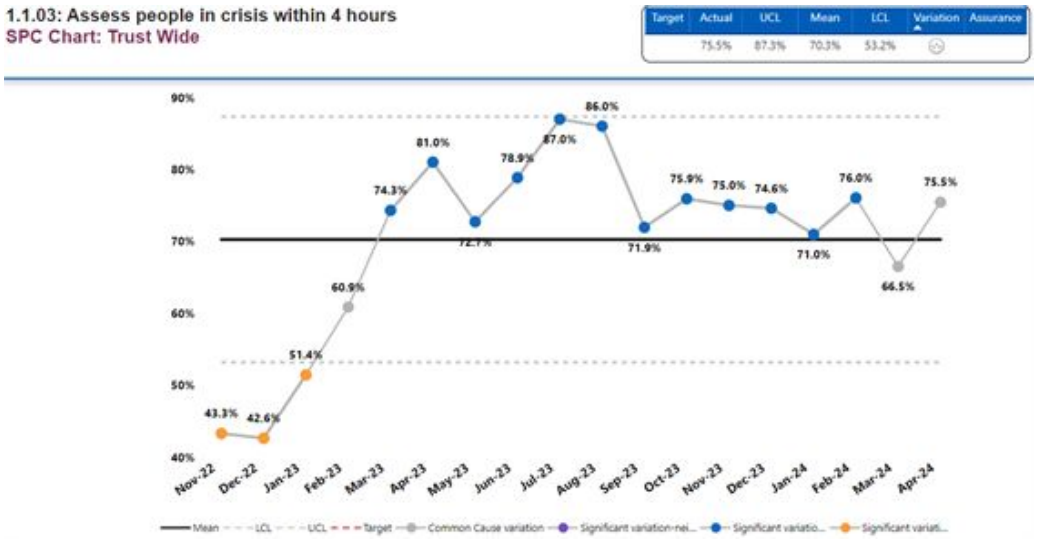
## People We Care For: Access

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1.01: Open Access Crisis Line: Calls received | | 5,016 | 5,433 | 5,245 | 4,910 | 5,248 | 5,249 | 5,473 | 5,380 | 5,842 | 4,737 | 4,900 | 3,604 |
| 1.1.02: Open Access Crisis Line: Abandonment Rate (%) | | 31.7% | 38.1% | 35.2% | 38.6% | 45.4% | 41.4% | 44.9% | 43.7% | 42.3% | 39.5% | 42.3% | 37.1% |
| 1.1.03: Assess people in crisis within 4 hours | | 0.0% | 25.0% | 12.5% | 82.3% | 71.9% | 76.4% | 75.3% | 75.7% | 71.4% | 76.0% | 66.5% | 75.8% |
| 1.1.04: People presenting to Liaison Services: triaged within 1 hour | | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.2% | 2.3% | 4.4% | 5.2% | 9.9% | 30.1% |
| 1.1.05: People presenting to Liaison Services: admitted to a psychiatric bed within 12 hours where required | | | | | | | | | | 0.0% | 0.0% | 1.4% | 1.6% |
| 1.1.06: Place of Saftey LoS: % under 36 hours | | 65.4% | 57.8% | 70.2% | 66.0% | 60.7% | 82.5% | 76.7% | 78.6% | 50.0% | 56.0% | 40.5% | 60.5% |
| 1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral | 60.0% | 88.2% | 60.7% | 52.2% | 88.2% | 65.2% | 76.9% | 64.7% | 94.1% | 71.4% | 61.5% | 66.7% | 53.3% |
| 1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks | | 6.4% | 6.6% | 8.1% | 8.4% | 7.6% | 14.5% | 15.5% | 9.7% | 4.6% | 6.2% | 7.5% | 7.7% |
| 1.1.09: % MHLD referrals commencing treatment in 18 weeks | | 66.0% | 73.7% | 87.0% | 89.4% | 75.0% | 72.7% | 73.6% | 60.0% | 80.0% | 67.7% | 84.2% | 62.5% |
| 1.1.10: Perinatal access (assessments completed) | 175 | 179 | 165 | 171 | 153 | 146 | 158 | 163 | 118 | 145 | 139 | 113 | 483 |
| 1.1.13: Care spell start to Assessment within 4 weeks (Excl. MAS) | 75.0% | 73.3% | 68.4% | 60.5% | 59.8% | 58.6% | 53.3% | 63.7% | 57.6% | 54.5% | 72.5% | 72.5% | 71.5% |
| 1.1.14: Care spell start to Assessment within 6 weeks (MAS only) | 75.0% | 32.0% | 28.4% | 35.1% | 38.2% | 30.6% | 36.6% | 37.0% | 34.4% | 29.2% | 37.9% | 41.1% | 41.7% |
| 1.1.15: Care spell start to Treatment within 18 weeks | 95.0% | 68.2% | 73.9% | 76.5% | 75.4% | 71.9% | 73.5% | 75.2% | 74.4% | 73.2% | 75.5% | 77.8% | 74.1% |

**Note:** *1.1.10 Perinatal Access – National methodology results in a significantly larger figure reported in April compared to other months. Review of how to apply a monthly target underway.*

## Areas of note in domain:

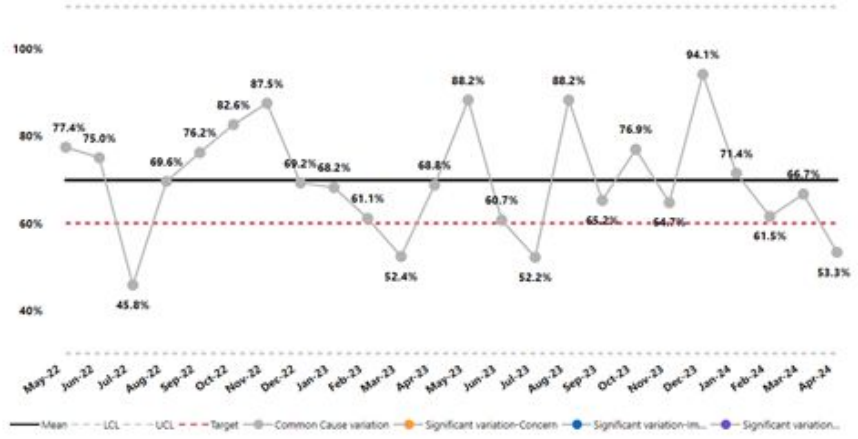
**Assess people in crisis within 4 hours** (1.1.03): A new national definition has been applied to the wait for assessment for those presenting in crisis within 4 hours (emergency referrals to Rapid response teams), this has resulted in increased percentages than previously reported. Levels of performance are consistent across all three community Directorates. It should be noted that whilst April saw a higher level of referrals into Rapid Response, more people were seen than in any month of the previous year – 220 assessments were completed in April compared to an average of 190 over the last six months. The biggest improvement in performance has been in the West Kent and South East Kent Rapid Response teams this month. Trust Board approved a business case for Crisis home treatment teams last year, this is one element of the change proposed within the business case and is beginning to show improvement. Previous to this sadly no patients were seen within the required timeframe.




**People presenting to Liaison Services: triaged within 1 hour** (1.1.04): New measures for the Liaison Service are contained within this report for the first time. The current performance for April is 30.1% of our patients were triaged within an hour. This is clearly not where we want to be with our aim to have 95% of our patients seen within an hour by the end of 2025/26. The Business Intelligence team are working closely with the liaison teams and directorates to implement a robust framework for recording patient waiting times. Therefore, this data is not yet an accurate representation of the current situation. We will have completed the implementation in the next 3 months. It is estimated that triage information is only currently being collected for approximately a third of relevant referrals. Before the winter a review of the establishment for the liaison teams to become Core24 compliant will be completed.

**1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral**
SPC Chart: Trust Wide

| Target | Actual | UCL | Mean | LCL | Variation | Assurance |
|---|---|---|---|---|---|---|
| 60.0% | 53.3% | 109.6% | 69.9% | 30.1% | | |



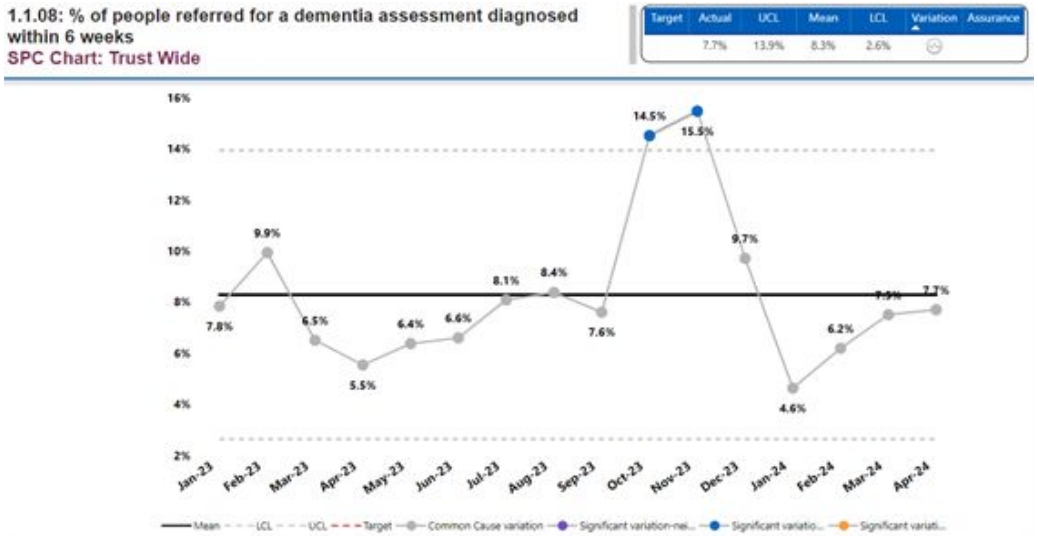
**People presenting to Liaison Services: admitted to a psychiatric bed within 12 hours where required** (1.1.05): Our performance of April is 1.6% of our patients requiring a bed were admitted within 12 hours. Sadly, again this is not where we want to be as a Trust, however we must flag that this is the first time we have reported this information and we are currently reviewing the quality of the data presented. We are working collaborating with our acute trust colleagues to support patients being cared for within their Emergency departments. In April we saw a total of 1,277 referrals across our 6 liaison teams, 63 patients out of the 64 identified for a bed breached the 12-hour target. The patient flow programme is addressing the demand for inpatient beds. The table below shows the performance by team.

| Team | Breach over 12 hours | Under 12 Hours | Grand Total |
|---|---|---|---|
| Ashford Liaison Team | 11 | | 11 |
| Dartford Liaison Team | 6 | | 6 |
| Maidstone Liaison | 8 | | 8 |
| Medway Liaison Team | 18 | | 18 |
| Thanet Liaison Team | 14 | 1 | 15 |
| Tunbridge Wells Liaison | 6 | | 6 |
| Grand Total | 63 | 1 | 64 |

**Place of Safety LOS: % under 36 hours:** (1.1.06): This is a new metric we are introducing as we are highly aware of the pressures we have on our ED and liaison services. It is not a nationally mandated metric but it is important that we triangulate the demand we are experiencing for our services, for example liaison, inpatient beds etc.

**People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral** (1.1.07): Waits for assessment within EIP services were below target in April but remains above target over a 12-month period, the monthly numbers remain low with 53.3% in April representing 8 of 15 assessments completed in the period having been done so in two weeks. A number of those not assessed in two weeks were a result of patients being unable to make the original scheduled appointment. KMPT is awaiting a response from NHS England regarding how nationally published data for this measure is calculated from the Mental Health Minimum Data Set (MHSDS) as a disparity currently exists, as a result nationally published data is not felt to be an accurate reflection of trust performance.

**% of people referred for a dementia assessment diagnosed within 6 weeks (1.1.08)**: This report contains a new measure regarding all of our patients receiving a dementia diagnosis within 6 weeks. Our current performance is not where we want it to be, nor is it what our patients deserve. Currently the measure represents approximately 200 diagnosis each month. This is below the number of patients being seen for the first time, this is due to the diagnosis not being recorded when relevant. It has been agreed that the Chief Executive and Chief Medical Officer will be writing to the medics to set out clearly the expectation that a diagnosis must be recorded and the importance of this from a patient's perspective and a data quality perspective. The expectation is this will improve within 3 months and the backlog of recording will need to be addressed. There are currently 4,800 referrals open without a diagnosis recorded against it, this reflects a waiting list of initial assessments of 2,000 patients and a further 2,800 without diagnosis despite having received some form of memory assessment. Whilst issues with diagnosis recording are being addressed the % diagnosis within 6 weeks is unlikely to improve in the short term. Where diagnosis has been recording in April the average time to diagnosis was 29 weeks, reflecting the fact that many were recorded against the current backlog and the challenge faced in achieving the 6-week target within current capacity. The Finance and performance Committee will be receiving an update on the new model and current performance of the service at its June committee.



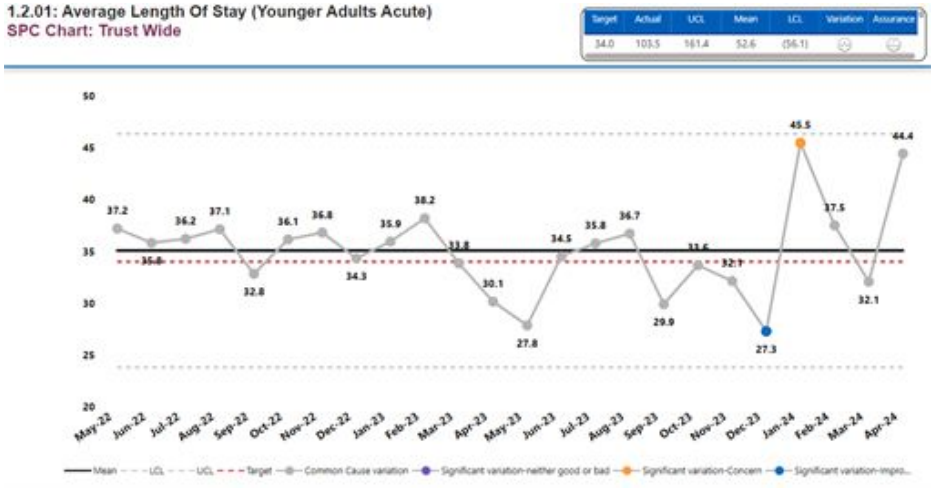
**Waits for assessment (4/6 weeks) and Treatment (18 weeks)** (1.1.13 - 1.1.15): These metrics have been used to monitor the performance of services for many years. With the implementation of the Community Mental Health Framework (CMHF) and the standalone Memory Assessment Service (MAS) these metrics will be stood down nationally during 24/25 with the trust moving to metrics that better reflect interventions delivered in the form of the new measures in this report in CMHF waits (2.1.01) & Dementia wait times (1.1.08). These historic indicators will be subject to variation in year as areas transition to new models reducing the sample size. We will ensure this is clear in future reporting to the Trust Board.

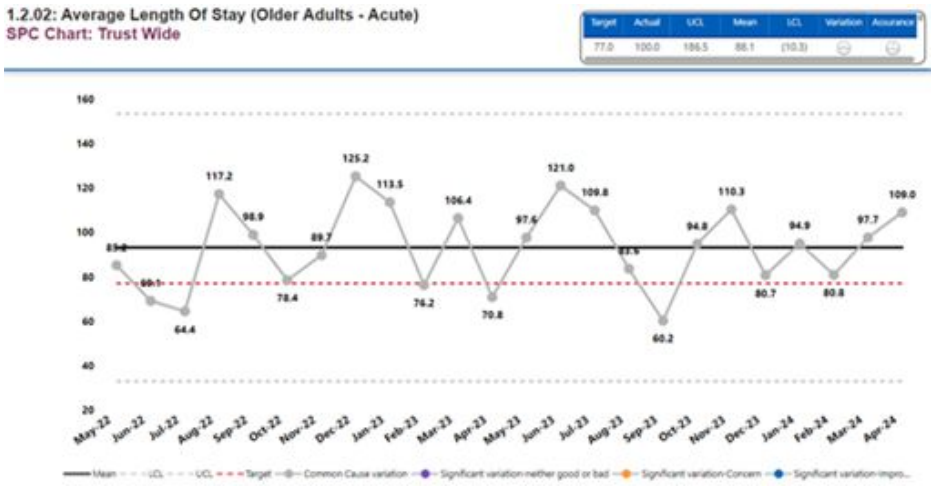
# People We Care For: Care Delivery

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.2.01: Average Length Of Stay (Younger Adults Acute) | 34.0 | 27.8 | 34.5 | 35.8 | 36.7 | 29.9 | 33.6 | 32.1 | 27.3 | 45.5 | 37.5 | 32.1 | 44.4 |
| 1.2.02: Average Length Of Stay (Older Adults - Acute) | 77.0 | 97.6 | 121.0 | 109.8 | 83.6 | 60.2 | 94.8 | 110.3 | 80.7 | 94.9 | 80.8 | 97.7 | 109.0 |
| 1.2.03: Adult acute LoS over 60 days % of all discharges | | 12.3% | 15.1% | 14.6% | 16.5% | 13.3% | 16.2% | 10.3% | 9.2% | 16.3% | 12.8% | 10.8% | 17.5% |
| 1.2.04: Older adult acute LoS over 90 days % of all discharges | | 36.4% | 55.2% | 52.4% | 34.6% | 29.2% | 41.7% | 45.5% | 34.8% | 32.0% | 34.6% | 46.2% | 38.7% |
| 1.2.05: Patients receiving follow-up within 72 hours of discharge | | 77.4% | 79.5% | 79.3% | 72.3% | 80.9% | 81.3% | 76.1% | 82.0% | 79.8% | 83.0% | 88.9% | 83.4% |
| 1.2.06: Unplanned Readmissions within 30 days (YA & OP Acute) | 8.8% | 3.9% | 7.8% | 9.7% | 6.5% | 3.8% | 2.1% | 5.2% | 5.6% | 1.7% | 3.0% | 5.1% | 8.2% |
| 1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) | | 351 | 285 | 213 | 295 | 376 | 239 | 250 | 204 | 263 | 350 | 280 | 242 |
| 1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end | | 10 | 8 | 6 | 12 | 8 | 8 | 5 | 8 | 9 | 12 | 9 | 9 |
| 1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab) | | 70 | 65 | 76 | 96 | 47 | 46 | 57 | 50 | 108 | 190 | 281 | 448 |
| 1.2.10: %Patients with a CPA Care Plan | 95.0% | 83.5% | 82.8% | 80.9% | 82.5% | 81.7% | 83.2% | 83.1% | 81.0% | 81.6% | 83.3% | 85.4% | 86.4% |
| 1.2.11: % Patients with a CPA Care Plan which is Distributed to Client | 75.0% | 68.0% | 72.5% | 73.7% | 75.6% | 77.6% | 79.0% | 79.2% | 77.4% | 77.1% | 77.4% | 75.6% | 76.8% |
| 1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans | 80.0% | 68.2% | 69.2% | 68.8% | 71.4% | 70.9% | 71.2% | 73.3% | 70.9% | 69.8% | 69.9% | 68.6% | 70.9% |

**Note:** *1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. Included in the figures in order to align to national reporting. See narrative below for adjusted monthly position.*

## Areas of note in domain:



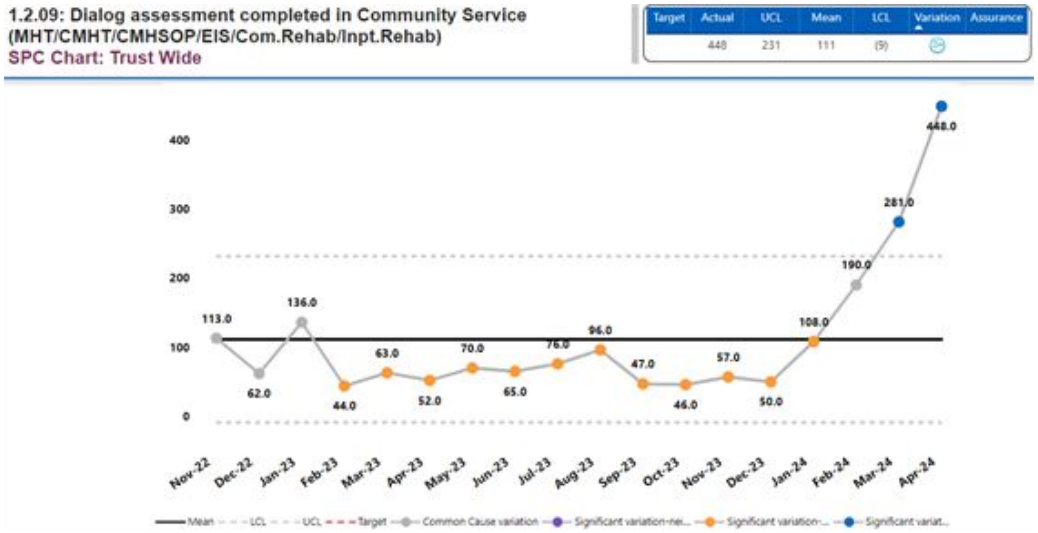

**Average Length Of Stay: Younger Adults Acute** (1.2.01) Despite the significant issues in discharging patients that are clinically fit, KMPT continues to be close to national average for length of stay for younger adults which should be celebrated given the relatively low bed stock within KMPT compared to its peers nationally. Average length of stay should be seen in the context of issues surrounding discharging patients that are clinically fit which is explored under the partners section of this report. Average length of stay for KMPT acute wards continues to see monthly variation around the mean, whilst not significant there was however an increase in April 2024. This was largely as a result of two patients discharged from YA acute wards with a LoS in excess of 300 days, both having experienced a delay. Over the last 12 months the variation on our wards ranges from 25 days on Amberwood Ward to 50 days on Upnor Ward, it has been acknowledged that there is a clinical variation of approach to discharging on thee wards and therefore lessons can be learned and shared as part of the patient flow priority work. This contributes to a notably lower average LoS for patients and does not have a negative impact on readmission rates.

**Average Length of Stay: Older Adults – Acute** (1.2.02) KMPT is a little further away from the national average for older adults LoS, over the previous 12 months on average we have a 95-day LoS compared to the national average of 86 days. OA Acute LoS increased to 109 days, this included a patient discharged in April who had a stay of 441 days and a further four patients who's stay exceeded 200 days, all having been subject to a delay attributable to CRFD.

The work of the Home Treatment Team daily in reach into wards has been evidence as an effective approach in assisting reductions in length of stay, further work is underway including the use of red to green to review all acute inpatients daily to consider all options to expediate discharge where clinically appropriate. This report now contains new measures aligned to the Single Oversight Framework measuring % of discharges over 60/90 days, the latest SoF position shown in appendix 1. Positively this reports KMPT as ranked 7th out of 53 trusts nationally for YA discharges over 60 days and 18th out of 53 trusts for OA acute discharges over 90 days.

**Out of Area Placements** (1.2.07 & 1.2.08): As noted above the reported figure includes contracted female PICU beds to align to national reporting, of the 242 bed days used in April 2024, 93 were female PICU patients within contracted beds resulting in 149 out of area placements days as an accurate reflection of trust performance. An additional measure of placements at period end has been introduced for 2024/25 as this will now form part of national reporting. Out of Area Placements are included in the Single Oversight Framework (appendix 1), however due to known issues with the national submission the nationally reported figure (0) is currently inaccurate. As of April 2024, the data collection will move to the Mental Health Minimum Data Set (MHSDS) which will result in accurate national data and a reported increase in levels of OAP where previously it has been artificially low.

**Dialog assessment completed in Community Service** (1.2.09). The Trust have implemented Dialogue + as part of the implementation of the CMHF and the roll out of Mental Heath Together (MHT). Staff are being trained as we implement MHT in localities, therefore we will be seeing an increase in the number of Dialog+ assessments completed month on month to ensure that for a first time we can effectively see the impact our interventions are having on our patients care and recovery. We have therefore had 448 assessment completed in April compared to 281 in March. Additional analysis is available for our clinical teams with a new report that identifies paired scores and improvements evidenced. Whilst the sample is currently, small where paired scores exist the majority are demonstrating improved outcome scores in ten of eleven domains. The next steps will be to ensure that this data is used routinely to monitor the effectiveness of our services and improve patient outcomes with actions being taken where we can see our interventions are not having the clinical impact we would want for our patients. Planning is underway for the roll out of additional outcome measures of (REQOL and Goals Based Outcome). This is likely to be completed by the end of this calendar year. By year three of our trust strategy Dialogue + will be informing all care planning. Please note comments below regarding care planning.




**Care Planning and Distribution** (1.2.10 – 1.2.12)

Executive leads have agreed the commencement of a task and finish group to support moving away from CPA which will result in the retirement of care planning measures in year and new measures being identified. It is recognised that this change is a significant development that will affect all aspects of clinical care across all directorates within KMPT. The programme of work will be clinically led with input from all stakeholders including service users. The work will commence in May 2024. For assurance, whilst this work is completed existing measures will continue to be monitored to ensure that care plans are maintained at a sufficient standard with no impact on patient safety or patient experience. there is no reduction in patient experience.

# People We Care For: Patient Experience

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.1.11: Complaints acknowledged within 3 days (or agreed timeframe) | 100% | 82% | 83% | 86% | 96% | 96% | 98% | 95% | 97% | 98% | 100% | 99% | 100% |
| 1.1.12: Complaints responded to within 25 days (or agreed timeframe) | 100% | 87% | 84% | 84% | 87% | 73% | 65% | 79% | 78% | 87% | 91% | 100% | 95% |
| 1.3.01: Mental Health Scores From Friends And Family Test – % Positive | 86.0% | 84.2% | 85.8% | 86.4% | 83.4% | 88.3% | 87.1% | 89.2% | 87.4% | 85.9% | 86.5% | 87.9% | 87.6% |
| 1.3.02: Complaints - actuals | | 43 | 43 | 44 | 50 | 47 | 53 | 48 | 27 | 44 | 44 | 35 | 42 |
| 1.3.03: Compliments - actuals | | 114 | 97 | 115 | 112 | 117 | 106 | 131 | 115 | 112 | 82 | 126 | 120 |
| 1.3.04: Compliments - per 10,000 contacts | | 31.1 | 26.7 | 36.0 | 34.6 | 35.7 | 30.9 | 38.5 | 41.2 | 30.6 | 24.9 | 39.3 | 35.8 |
| 1.3.05: Patient Reported Experience Measures (PREM): Response count | | 685 | 709 | 675 | 512 | 460 | 510 | 631 | 532 | 417 | 452 | 496 | 596 |
| 1.3.06: Patient Reported Experience Measure (PREM): Response rate | | 4.8 | 4.9 | 4.7 | 3.6 | 3.2 | 3.4 | 4.2 | 4.0 | 3.0 | 3.1 | 3.4 | 4.0 |
| 1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly % | | 8.3 | 8.3 | 8.3 | 8.4 | 8.4 | 8.1 | 8.6 | 8.5 | 8.3 | 8.1 | 8.5 | 8.4 |

## Areas of note in domain:

No exceptions in this period.

# People We Care For: Safety

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.4.01: Occurrence Of Any Never Event | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 1.4.02: All Deaths Reported And Suspected Suicide | | 80 | 90 | 85 | 130 | 420 | 230 | 127 | 135 | 117 | 113 | 105 | 115 |
| 1.4.03: Restrictive Practice - All Restraints | | 73 | 82 | 94 | 120 | 77 | 105 | 44 | 58 | 67 | 78 | 99 | 129 |
| 1.4.04: Restrictive Practice - No. Of Prone Incidents | 0 | 6 | 3 | 7 | 15 | 12 | 6 | 0 | 2 | 3 | 5 | 10 | 23 |
| 1.4.05: Decrease violence and aggression on our wards | (7.5%) | (5.2%) | (6.5%) | 2.5% | 5.7% | (18.1%) | 1.9% | (21.3%) | (7.1%) | 11.6% | 23.8% | 19.9% | 32.2% |
| 1.4.06: Medication errors | | 48 | 40 | 57 | 52 | 49 | 71 | 106 | 56 | 55 | 40 | 48 | 28 |

## Areas of note in domain:

**Decrease violence and aggression on our wards** (1.4.05) The target for year one of the trust strategy was achieved for the decrease in violence and aggression on our wards, in 24/25 it is the ambition to reduce this further with a 7.5% reduction on the 2022/23 baseline. The data demonstrates significant variances month to month with a reduction of performance in 2024 to date. An increase in reporting has been seen as staff awareness increases, this is a positive step and one we would expect as we focus on addressing this with our staff and patients. KMPT are promoting and moving towards a more open and speak up culture, which is evident in the paper on the Board agenda today addressing our culture. The Safety Culture Bundle programme of improvement on the acute inpatient wards promotes an increased focus on recognising incidents of violence and aggression and anticipated an increase in reporting as more wards started the programme. It is likely that staff were previously tolerating and underreporting incidents. 75% of all acute wards have now commenced the improvement programme. Work continues to implement the QI approach on all wards with the aim of full roll out by the end of July 2024.

**Restrictive Practice - No. Of Prone Incidents** (1.4.04) The number of prone incidents was 23 in April against an average of 7.7 per month for the last 12 months. The significant variation results from unusually high reporting on Willow Suite (17) where sixteen incidents involved one patient who was non-concordant with treatment.

# Partners we work with

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.1.01: Referrals to MHT & MHT+ commence treatment within 4 weeks | | | | | | | | | | | 100.0% | 40.0% | 32.6% |
| 2.1.02: MHT & MHT+ waiting list size | | | | | | | | | | 49 | 193 | 387 | 772 |
| 2.1.03: MHT 2+ contacts | | 16,776 | 16,638 | 16,383 | 16,303 | 16,244 | 16,308 | 16,406 | 16,348 | 16,455 | 16,459 | 16,385 | 16,493 |
| 2.1.04: Clinically Ready for Discharge: YA Acute | 7.0% | 14.5% | 14.8% | 16.2% | 16.8% | 21.6% | 18.8% | 21.3% | 21.2% | 22.3% | 24.3% | 20.8% | 20.9% |
| 2.1.05: Clinically Ready for Discharge: OP Acute | 12.0% | 26.1% | 25.9% | 25.1% | 23.8% | 23.9% | 28.4% | 25.3% | 25.9% | 28.1% | 34.2% | 33.5% | 32.9% |
| 2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge) | 44.0 | 63.7 | 50.0 | 65.1 | 46.6 | 63.6 | 84.9 | 71.0 | 89.3 | 69.0 | 61.0 | 71.4 | 99.3 |

## Areas of note in domain:

**Referrals to MHT & MHT+ commencing treatment within 4 weeks** (2.1.01): The reporting of the new national metric for waiting times in CMHF is in its infancy nationally with no nationally comparable data yet available against the latest definition, NHSE has confirmed that no targets will exist for 2024/25 in recognition of the size and complexity of the changes.

The above data is our early dashboard for capturing the implementation of MHT. It is very early days with some teams only going live in recent weeks. Therefore, we acknowledge that there will be data quality issues and that this data should be treated with caution and not as a reflection of performance of the teams.

The waiting list as at 21/05 is 1,352 patients of which 45% of those waiting are in Thanet, the first MHT to go-live. In order to stop the clock patients, require an initial assessment, the completion of an outcome measure and the commencement of a clinical or social intervention - approximately 35% of the waiting list have completed initial assessment and have an outcome measure completed, however are now awaiting the commencement of an intervention. 800 patients are yet to receive an initial meeting and outcome score, 530 have been referred in the last 10 days and therefore are yet to be seen., This is relevant as we will always expect there to be a number of patients waiting to be seen. 265 patients remain on the waiting list longer than 15 days without any initial assessment, of these 147 are in Thanet where phase 2 of CMHF implementation is taking place.

**MHT 2+ contacts (2.1.03)**: This metric is measured nationally as a measure of Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses and highlighted as an area of concern by the ICB as is subject to special cause variation of a negative nature and an Oversight Framework bottom

decile metric, ranked 40/42 as at January 2024. This has presented a high degree of complexity in establishing methodology applied to MHSDS data, work is ongoing with the current position being that local KMPT data does not support what is published nationally. The total numbers we are reporting are believed to be lower than that shown nationally and a there is consistent levels of performance over the last 12 months as shown within the IQPR metric. We believe the variation between local and national figures relates to the exclusion of organic presentations to CMHSOP mid-year, as the national measure is a rolling 12 months it will take a year for data to align.

**Clinically Ready for Discharge (CRFD), YA Acute** (2.1.04) **& OP Acute** (2.1.05) We are continuing to see high numbers of patients that are clinically ready for discharge but are unable to be discharged into the care of community teams or discharged from KMPT services due to delays in providing effective accommodation or care packages. This is preventing KMPT from admitting patients that require a bed, putting pressure on our community services as well as system accident and emergency resources.

Variation across Health Care Partnerships (HCPs) areas is minimal in Younger Adult acute CRFD however within Older Adults acute wards over the last 12 months West Kent beds have seen 35.3% of bed days lost compared to 23.9% and 26.2% in East Kent and North Kent beds respectively.

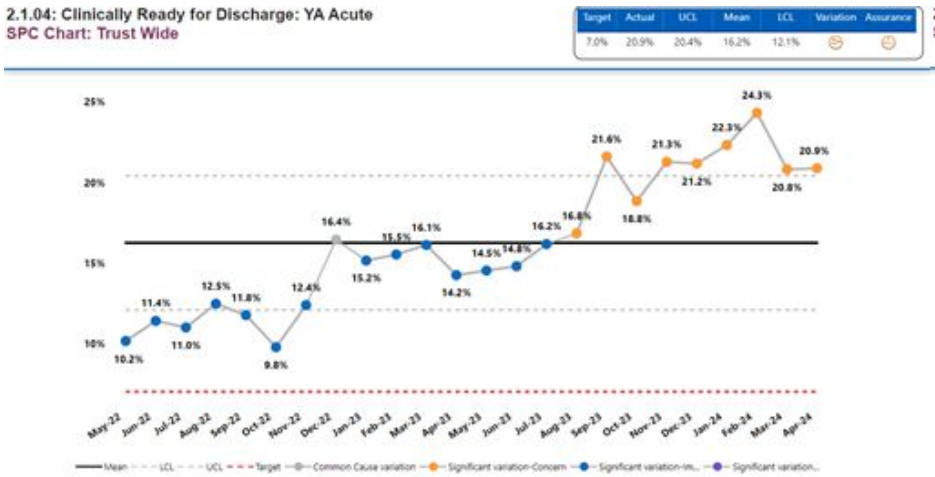
In order to reduce the impact of CRFDs a series of Multi Agency Discharge Events (MADE) are underway. Events in East Kent and West Kent have taken place, chaired by the Chief Medical Officer, with all agencies including Local Authorities and District Councils.

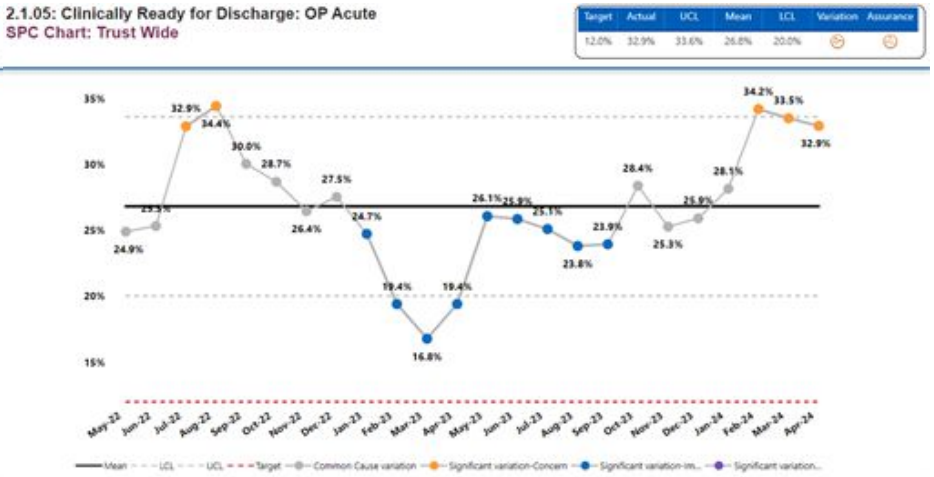
The Trust has now received the independent CRFD report. The following are the actions for KMPT to take forward internally, these will be addressed as part of the patient flow programme.

- Community and in-patient interface
- KMPT interface with providers
- Escalation processes.
- Process to identify clinically ready for discharge
- Collaboration with patient and their carers
- Recommended opportunities for large scale change

The following are the actions for the system to take forward to which KMPT will be part of; these actions will be taken forward by the Mental Health and Learning Disabilities Provider Collaborative (MHLDA PC).

- Step down and Discharge To Assess (DTA) pathways
- Transfer of care hub



# People who work for us

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.1.01: Staff Sickness - Overall | 5.3% | 4.9% | 4.8% | 4.7% | 4.6% | 4.4% | 4.9% | 5.1% | 5.3% | 4.8% | 4.2% | 4.5% | 4.4% |
| 3.1.02: Vacancy Gap - Overall | 15.5% | 14.0% | 13.7% | 13.6% | 12.9% | 12.9% | 11.8% | 11.8% | 11.8% | 11.8% | 11.9% | 11.9% | 11.9% |
| 3.1.03: Essential Training For Role | 90.0% | 92.8% | 92.9% | 93.6% | 93.8% | 93.4% | 93.4% | 93.7% | 94.1% | 94.0% | 94.3% | 93.9% | 94.0% |
| 3.1.04: Leaver Rate | 16.5% | | | | | | | | | | | | 14.7% |
| 3.1.05: Leaver Rate (Voluntary) | 15.0% | 14.2% | 13.8% | 13.1% | 13.0% | 13.4% | 11.4% | 11.3% | 11.8% | 10.8% | 10.7% | 10.7% | 9.9% |
| 3.1.06: Safer staffing fill rates | 80.0% | 102.3% | 103.7% | 105.8% | 108.7% | 108.7% | 105.5% | 108.8% | 109.3% | 106.1% | 108.1% | 112.5% | 111.7% |
| 3.1.07: Increase percentage of BAME staff in roles at band 7 and above | 18.5% | 15.1% | 15.1% | 15.3% | 15.0% | 14.9% | 15.0% | 14.7% | 14.4% | 14.6% | 14.7% | 14.0% | 13.6% |
| 3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected. | 0.8% | | | | | 0.3% | 0.5% | 0.5% | 0.6% | 0.1% | 0.1% | 0.4% | 0.5% |

## Areas of note in domain:

**Vacancy Gap (3.1.02)** has consistently achieved set targets since June 2023. We continuously look for wares that we can make further improvement. Three areas have been identified for greater focus, South West Kent CMHSOP, Medway CMHT & Thanet CMHT. Work to understand specific problems within these areas is ongoing led operationally at a local level, with support from the Workforce & Recruitment teams. Additionally, quality improvement initiatives have been initiated at a local level to improve retention through a focus on staff wellbeing, commencing in South West Kent CMHSOP now the new Mental Health Together model is live.


**Increase percentage of BAME staff in roles at band 7 and above** (3.1.07): Following a review of methodology, a new definition was identified which has resulted in the percentage of BAME staff in roles at band 7 and above being recalculated resulting in lower percentages than previous reported (approx. 3% lower). This measure is important for two reasons. Firstly, it allows us to understand the ethnic diversity of our leadership and management workforce, which we know is a critical predictor of inclusive culture and more widely of performance and quality. Secondly, it allows us assess whether we're improving opportunities for career progression for BAME staff, which is an area our BAME staff highlight as being a challenge, and which they and the data highlight becomes a particular challenge at Band 7 level and above. Work continues in talent management for BAME band 7 and above, data analysis is ongoing to understand if some ethnic groups progress quicker than others and identify any barriers. BAME network members are to be invited to share their experiences of recruitment process and are encouraged to become a cultural inclusion ambassador and sit on interview panels for band 7 and above roles.

# Efficiency

| Measure Name | Target | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Apr-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4.1.01: Bed Occupancy (Net) | 92.0% | 97.0% | 95.8% | 95.0% | 95.2% | 94.1% | 92.1% | 92.4% | 93.4% | 95.2% | 96.9% | 96.7% | 95.8% |
| 4.1.02: DNAs - 1st Appointments | | 13.3% | 12.4% | 13.4% | 11.7% | 11.5% | 12.4% | 13.2% | 14.0% | 12.0% | 12.7% | 12.3% | 12.6% |
| 4.1.03: DNAs - Follow Up Appointments | | 10.1% | 10.6% | 10.9% | 10.8% | 10.6% | 10.8% | 10.7% | 11.5% | 11.0% | 11.0% | 11.3% | 11.2% |
| 4.1.04: In Month Budget (£000) | 0 | (13,279) | (14,931) | (13,739) | (13,651) | (14,390) | (13,607) | (13,941) | (13,756) | (13,746) | (13,746) | (13,754) | (13,524) |
| 4.1.05: In Month Actual (£000) | | (12,909) | (14,708) | (13,669) | (14,063) | (14,108) | (13,362) | (13,702) | (13,581) | (14,226) | (14,201) | (14,630) | (14,080) |
| 4.1.06: In Month Variance (£000) | | 370 | 224 | 71 | (411) | 283 | 245 | 239 | 175 | (480) | (456) | (876) | (556) |
| 4.1.07: Agency spend as a % of the trust total pay bill | 3.2% | 4.4% | 4.5% | 4.8% | 4.3% | 4.5% | 4.1% | 4.0% | 4.2% | 4.0% | 3.4% | 2.3% | 2.9% |

**Agency spend as a % of the trust total pay bill** (4.107) We have achieved a big reduction in agency spend which is a significant improvement in our position in previous years. The main driver for spend has been Medical agency usage which has seen a big reduction from 11 to 6 posts in April. Whilst small in number the use of medical agency to cover consultants' posts is a significant contributor to the overall agency spend bill. Two areas for focus were identified: medical recruitment & improved management of medical agency contracts. Both workstreams would build on the already established BAU work of the Medical Staffing Team and provide away to bring all the activity around these two areas together. The new Recruitment Business Manager, Deputy Chief Medical Officer, Workforce & Medical Staffing Team developed and commenced delivery of a strategy for medical recruitment, reviewed and tightened medical recruitment processes and developed a plan to promote recruitment to KMPT medical consultant posts at a national level.

**Bed Occupancy** (4.1.01): Inpatient bed occupancy continues to be variable, reaching 95.8% in April. Bed occupancy is high across all our hot sites with minimal variance, ranging from 95.7% in Dartford and Canterbury to 96.5% in Maidstone. As per above we are experiencing delays with CRFD patients relating to a number of internal factors but also external factors regarding social care and housing. The Trust Board will be having a Board seminar in October regarding Housing, with the PC supporting in taking the external factors forward for the system. There is a massive overlap with the Better use of Beds programme that is part of the Community and Primary Care Provider Collaborative.

# Appendices

Appendix 1 –Regulatory compliance against the system oversight framework

Appendix 2 –Demographic Profiles

Appendix 3 –Exception Reporting Guide

## Appendix 1: Regulatory compliance against the system oversight framework

**Overview**

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

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

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

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

The following table represents the latest position for KMPT's Provider Oversight against which the trust responds to Key Lines of Enquiry. It is recognised that delays exist in nationally published data for a number of metrics, many as a result of being reflective of the annual staff survey results.

## NHS OVERSIGHT FRAMEWORK PERFORMANCE REVIEW

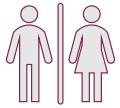
| | |
|---|---|
| Provider | KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST (RXY) |
| Data publication | 19 April 2024 |

| Theme | Sub-Theme | Oversight Framework Metric | Reporting Period | Current Performance | National Average | Target | Rank (National benchmark) | Quartile (National benchmark) | Improvement or Deterioration since previous period |
|---|---|---|---|---|---|---|---|---|---|
| **NHS England Programme Assessment** | | | | | | | | | |
| | | S000a: NHSOF Segmentation | 2024 03 | 2 | | | | | |
| **Leadership and capability** | | | | | | | | | |
| | **Leadership** | S059a: CQC well: led rating | 2024 03 | 3 - Good | | | 13/69 | Higher Quartile | |
| **People** | | | | | | | | | |
| | **Belonging in the NHS** | S071a: Proportion of staff in senior leadership roles who are from a BME background | 2022 | 13.1% | | 12% | 24/69 | Interquartile | Deterioration |
| | | S071b: Proportion of staff in senior leadership roles who are women | 2024 02 | 62.3% | | 62% | 35/45 | Lower Quartile | Improvement |
| | | S071c: Proportion of staff in senior leadership roles who are disabled | 2023 | 7.22% | | 3.2% | 12/69 | Higher Quartile | Improvement |
| | | S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age | 2023 | 57.5% | | | 49/71 | Interquartile | Deterioration |
| | | S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES). | 2023 | 1.9 | | 1 | 50/69 | Interquartile | Deterioration |
| | | S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES) | 2023 | 1.2 | | 1 | 54/69 | Lower Quartile | Improvement |
| | **Looking after our people** | S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers | 2022 | 7.62% | 11.1% | | 27/71 | Interquartile | Improvement |
| | | S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues | 2022 | 13.2% | 20% | | 27/71 | Interquartile | Improvement |
| | | S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public | 2022 | 29.8% | 27.8% | | 62/71 | Lower Quartile | Deterioration |
| | | S067a: Leaver rate | 2024 01 | 7.96% | 7.29% | | 54/71 | Lower Quartile | Improvement |
| | | S068a: Sickness absence rate | 2023 11 | 5.27% | 5.35% | | 26/71 | Interquartile | Deterioration |
| | | S069a: Staff survey engagement theme score | 2023 | 6.89/10 | 6.89/10 | | 61/71 | Lower Quartile | Deterioration |
| | **Compassionate and inclusive culture** | S133a: Staff survey - compassionate and inclusive theme score. | 2023 | 7.4/10 | 7.3/10 | | 55/71 | Lower Quartile | Deterioration |
| **Quality, Access & Outcomes** | | | | | | | | | |
| | **Mental health services** | S086a: Inappropriate adult acute mental health placement out of area placement bed days | 2024 01 | 0 | | 0 | 1/56 | Top Decile | |
| | | S125a: Adult Acute LoS Over 60 Days % of total discharges | 2024 02 | 13% | | | 7/53 | Higher Quartile | Deterioration |
| | | S125b: Older Adult Acute LoS Over 90 Days % of total discharges | 2024 02 | 34% | | | 18/53 | Interquartile | Improvement |
| | **Safe, high quality care** | S034a: Summary Hospital level Mortality Indicator | | | | | | | |
| | | S035a: Overall CQC rating | 2024 03 | 3 - Good | | | 13/69 | Higher Quartile | |
| | | S121a: NHS Staff Survey compassionate culture people promise element sub-score | 2023 | 6.9/10 | 7.1/10 | | 63/71 | Lower Quartile | Deterioration |
| | | S121b: NHS Staff Survey raising concerns people promise element sub-score | 2023 | 6.5/10 | 6.5/10 | | 54/71 | Lower Quartile | Deterioration |

Note: *As highlighted in the report some areas exist where KMPT does not recognise national data there is ongoing work with NHSE colleagues to align methodology. Within the SoF it is known that S086a, Inappropriate acute out of area placements, is under representing the accurate position due to issues faced with national reporting portals.*

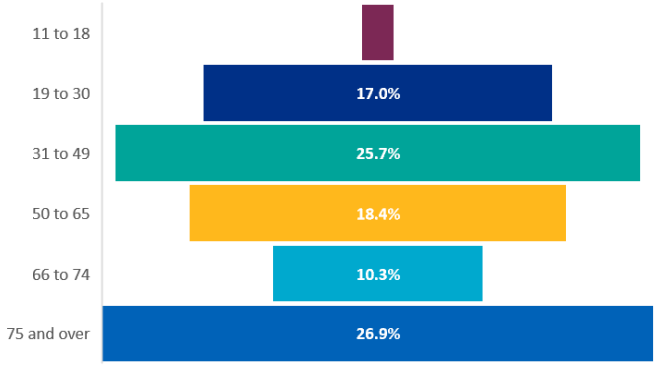
## Appendix 2: Demographic Profiles

The trust is committed to gaining a greater depth of understanding of how the performance levels reported within the IQPR carry across the patient population it serves. The following pages present some high-level statistics to highlight variances within the population, patients seen by KMPT and its workforce. More focussed work is underway to look as trust service delivery through this lens with updates brought to this appendix for any key findings. From such findings it is the intention to develop measures for the IQPR which help focus on identified inequalities.

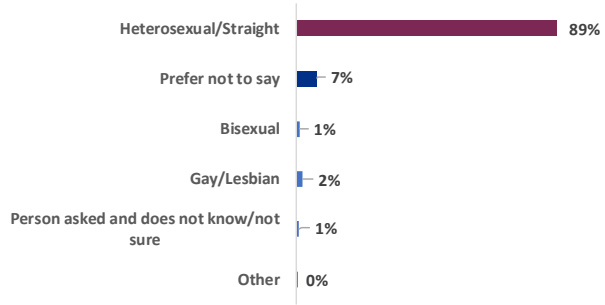
| | Kent & Medway Population | KMPT Service Users | KMPT Workforce |
|---|---|---|---|
|  **Population** | 1.85m | 70,000 per annum<br>22,000 active | 3,900 |
|  **Ethnicity: % Non White British** | 12.4% | 15.3% | 13.2% |
|  **Gender** | 48% Male<br>52% Female | 51% Male<br>49% Female | 42% Male<br>58% Female |
|  **Average Deprivation Score (IMD 2019)** | 5.38 | 4.83 | 5.29 |

# Service User Demographics

## Age Groups
Complete: 100%



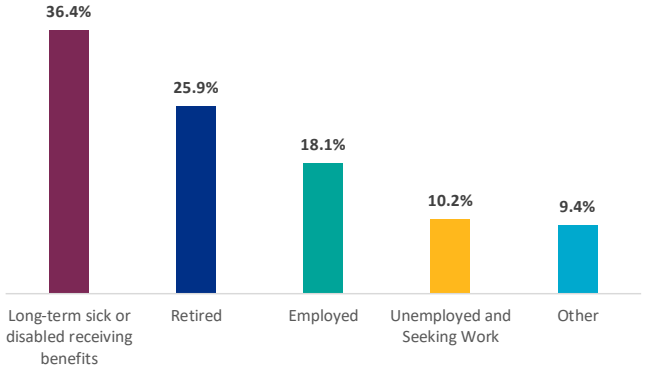

## Sexual Orientation
Complete: 9.3%
Incomplete: 90.7%



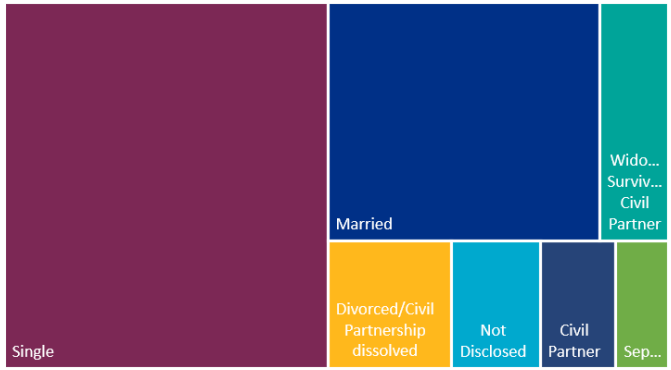

## Community
98.3%

## Inpatient
1.7%

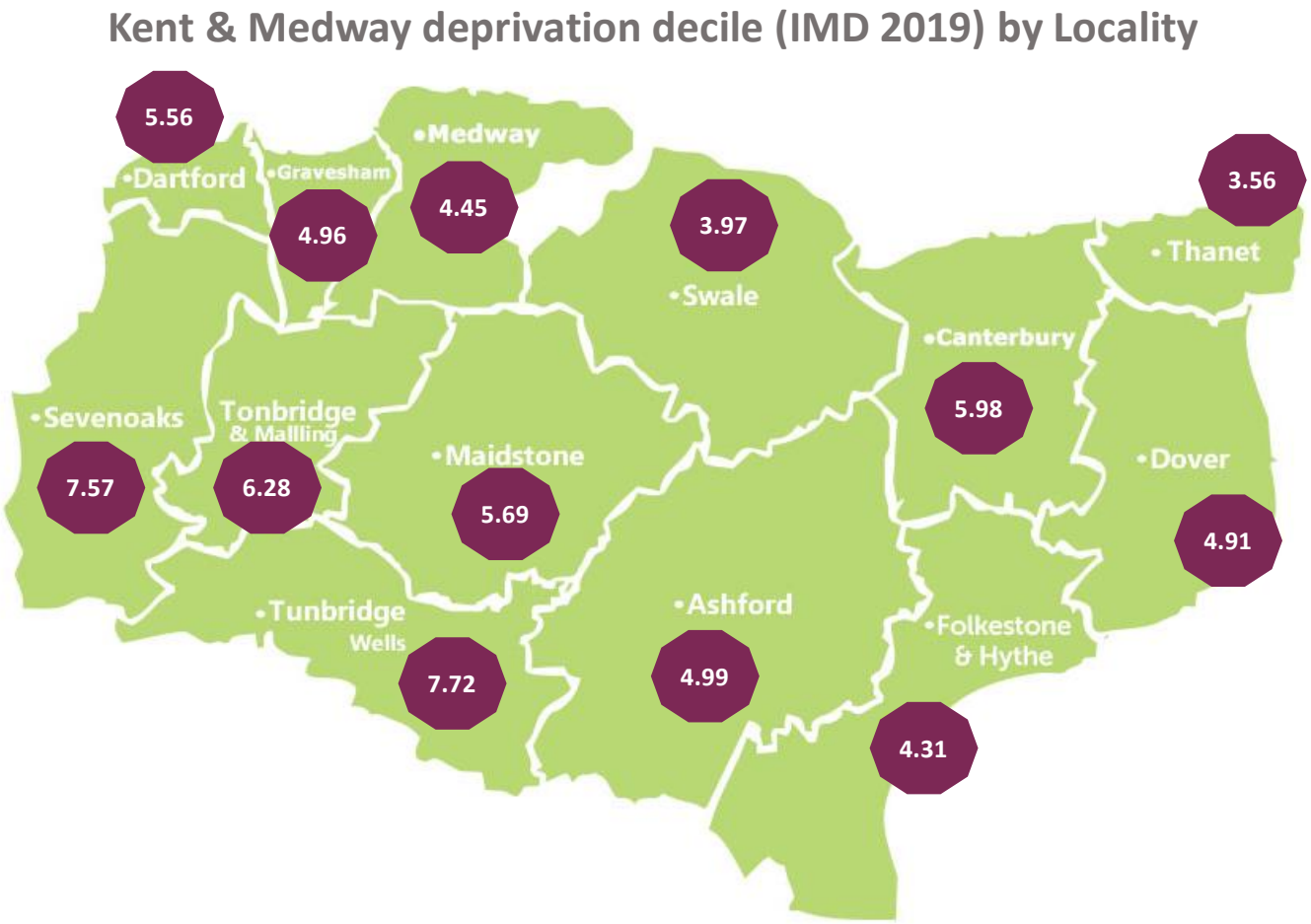
## Employment Status
Complete: 56.4%
Incomplete: 43.6%




## Marital Status
Complete: 60.8%
Incomplete: 39.2%

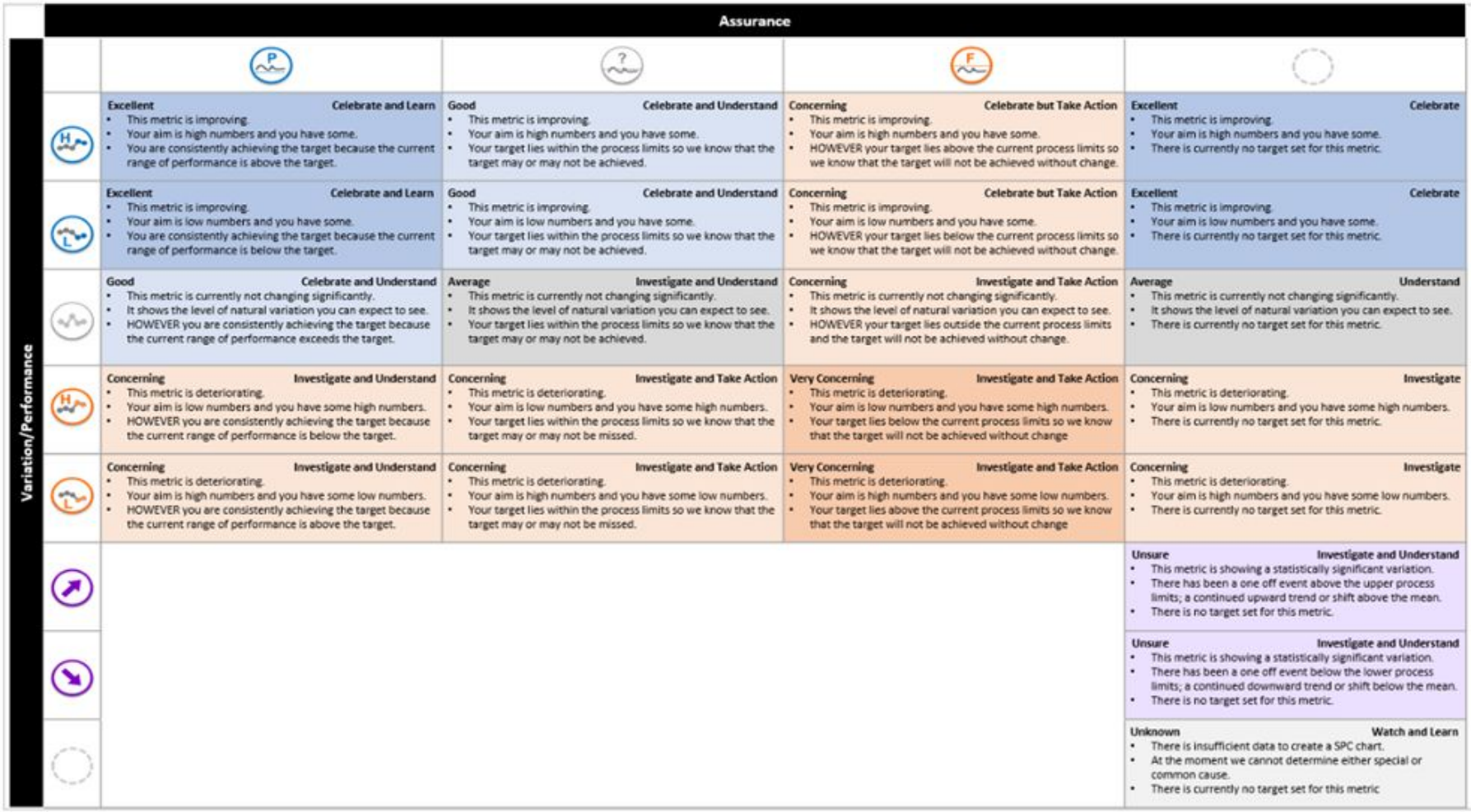


The map below highlights the variance in levels of deprivation within the population we serve, highlighting the importance of local consideration in the delivery of services. Indices of multiple deprivation (IMD) are widely-used datasets within the UK to classify the relative deprivation (essentially a measure of poverty) of small areas. Multiple components of deprivation are weighted with different strengths and compiled into a single score of deprivation.



## Appendix 3: Exception Reporting Guide

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



NHS
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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Finance Report for Month 1 (April 2024) |
| **Author:** | Nicola George, Deputy Director of Finance |
| **Executive Director:** | Nick Brown, Chief Finance and Resources Officer |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Regulatory Requirement |

## Overview of Paper

The attached report provides an overview of the financial position for month 1 (April 2024).

## Items of focus

For the period ending 30 April 24, the Trust is reporting a breakeven position against its financial plan, submitted to NHS England 2nd May 2024. This was in line with the plan provided to Board in March.

The board are asked to note,

- The Trust has an agency cap of £6.58m (c3.20% of its total pay bill). At Month 1, the Trust's spend on agency is below cap.

- The capital programme is at the early stages with spend phased to increase as the year progresses. Focus will be on ensuring schemes remain on plan with the main capital scheme relating to the development of the centralised Section 136 suite.

- The Trust has a £10.76m Cost Improvement Programme, and has identified schemes totalling 92.81% of this ask. The present risk assessed delivery is £6.15m. The Trust are working to close this gap to support delivery of the financial position.

- The cash position is below plan at £14.71m at the end of April 2024. This reflects additional payments for NHS Professionals and the impact of delays in the contracting round (this position is anticipated to be resolved by the end of Quarter 1).

## Governance

| | |
|---|---|
| **Implications/Impact:** | If the Trust fails to deliver on its 2024/25 financial plan then this could impact on the long-term financial sustainability agenda. |
| **Assurance:** | Reasonable |
| **Oversight:** | Finance and Performance Committee |

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# Finance Report
# April 2024

## Trust Board

*Brilliant care through brilliant people*

## Contents



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# Executive Summary

### Key Messages

For the period ending 30th April 2024, the Trust has reported a breakeven position against its budget; and this is expected to continue for the rest of the year.

The position is based on the Trust's final 2024/25 submitted to NHS England, 2nd May 2024. This position is in line with the plan provided to Board in March.

The key financial challenges for the Trust are:

- The Trust is expected to manage its agency spend below a 3.20% agency cap in year (of its pay budget). This is the equivalent of a £6.58m spend on agency, £0.55m per month. The Trust entered the year with a recurrent run rate of £0.59m per month. In month this has been reduced to £0.50m. This position will require close monitoring in the coming months.
- The continued usage of external beds, remains a continued pressure for the Trust. The budget has been set at the equivalent of 7 beds. In month, the trust has used the equivalent of 8 female PICU beds (3 of which attract additional funding), 1 Male PICU bed and 2 external Male Beds. The Trust has therefore utilised the equivalent of 1 bed above funding.
- The capital programme is at the early stages with spend phased to increase as the year progresses. Focus will be on ensuring schemes remain on plan with the main capital scheme relating to the development of the centralised Section 136 suite.
- The Trust has a £10.76m cost improvement programme and has identified schemes equating to 92.81% of this ask, with the risk assessed delivery presently £6.15m. Delivery of the Cost Improvement programme is imperative to delivery of the overall financial position.

### Income and Expenditure

Key points for April included the following:

- Agency spend continues and spend for the period was £0.50m which is equivalent to 2.95% of the Trust Pay bill , the target set nationally as part of planning was 3.20%. In month there has been a 14.67% reduction in spend, mostly within the Medical staff group.
- Bank spend decreased in month by 28.88% with WTEs utilised; 460 WTEs were utilised in month compared to March levels of 586 WTEs.
- In April, the Trust utilised 8 female external female PICU beds of which 5 are at contracted levels and 3 additional which are in relation to a patient with a complex care requirements. There was 1 Male PICU bed and 2 male acute beds utilised in month.

### At a Glance - Year to Date

| | |
|---|---|
| Income and Expenditure | ● |
| Efficiency Programme | ● |
| Agency Spend | ● |
| Capital Programme | ● |
| Cash | ● |

**Key**

| | |
|---|---|
| On or above target | ● |
| Below target, between 0 and 10% | ● |
| More than 10% below target | ● |

### Capital Programme

As at 30 April the overall capital position is £0.05m underspent, with a forecast total capital spend position of £11.90m, which is as per plan but excludes IFRS 16 spend (this position is being finalised at part of the NHS planning round, and will be available by the end of Quarter 1).

In month there was minimal spend transacted and spend will increase as the year and capital schemes progress.

In month spend on the section 136 Scheme is slightly over anticipated spend levels but full year spend is expected to be in line with the allocation.

### Cash

The closing cash position for January was £14.71m which was £2.79m below plan.

This was due to a higher payments to NHS Professionals in month due to high levels of bank and agency spend in March 2024; and the impact of the timing of contractual payments received from our Commissioners.

Income payments were also slightly below the planned level, with the contractual positions being finalised. We would expect this position to be resolved by the end of Quarter 1.

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# Income and Expenditure

## Statement of Comprehensive Income

| | Annual | Current Month | | | Year to date | | |
|---|---|---|---|---|---|---|---|
| | Budget | Budget | Actual | Variance | Plan | Actual | Variance |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Income | 270,020 | 22,784 | 22,761 | (23) | 22,784 | 22,761 | (23) |
| Employee Expenses | (205,185) | (17,204) | (17,046) | 158 | (17,204) | (17,046) | 158 |
| Operating Expenses | (59,483) | (5,134) | (5,347) | (213) | (5,134) | (5,347) | (213) |
| **Operating (Surplus) / Deficit** | **5,352** | **446** | **368** | **(78)** | **446** | **368** | **(78)** |
| Finance Costs | (5,352) | (446) | (368) | 78 | (446) | (368) | 78 |
| **System control Surplus / (Deficit)** | **0** | **(0)** | **(0)** | **0** | **(0)** | **(0)** | **0** |
| Excluded from System control (Surplus) / Deficit: | | | | | | | |
| Technical adjustments | 0 | 0 | (52) | (52) | 0 | (52) | (52) |
| **Surplus / (deficit) for the period** | **0** | **0** | **(52)** | **(52)** | **0** | **(52)** | **(52)** |

## Commentary

For month 1, there is an favourable pay variance to budget of £0.16m. This includes a significant underspend on substantive pay of £1.97m (due to the level of vacancies) being partly offset by agency and bank usage.

Agency spend in month 1 totalled £0.50m which represents a 32.04% reduction on the level of spend seen in April 2023/24. Spend in month is equivalent to 2.95% of the Trust Pay bill, the target set nationally as part of planning was 3.20%.

The highest levels of reduction in the 12 month run rate is within medical agency with spend 46% lower than spend in April 2023. Spend levels were highest in East Kent with 31.46& of the spend due to continued difficulties recruiting to vacancies..

Bank spend decreased in month by 28.88%; with 460 WTEs utilised compared to the previous month when 586 WTEs were utilised. Focus will be on rotas through the financial year so that annual leave is spread through the year

Other non pay includes a higher level of spend on External placements. In April, the Trust utilised 8 female external female PICU beds of which 5 are at contracted levels and 3 additional which are in relation to a patient with a complex care requirements.

There was 1 Male PICU bed and 2 male acute beds utilised in month. which reflects the pressured bed position seen operationally.

## Cost improvement plans 24/25

| Risk rating | RAG rated £000s | %of target | Risk Assessed Delivery £000s | %of target |
|---|---|---|---|---|
| Green | 2,600 | 24.21% | 2,600 | 24.21% |
| Amber | 7,168 | 66.74% | 3,555 | 33.10% |
| Red | 972 | 9.05% | - | 0.00% |
| **Total** | **10,740** | **100.00%** | **6,155** | **57.31%** |

## Commentary

The Trust submitted a breakeven financial plan for 2024/25 and this is predicated on the basis of delivering the CIP plan, which totals £10.74m, in full.

Plans which are currently risk rated as Green relate to initiatives already underway having been worked on as part of the loss making services review and include:

- EIP **£0.50m**
- Provider Collaborative Contract negotiation **£1.10m**
- MHLD service review **£1.00m**

Plans rated as Amber include schemes which have been identified and are being further developed to ensure deliver in year and include:

- Community services and productivity review **£2.00m**
- Crisis teams model review **£1.00m**
- Utilising Acute resource **£0.60m**
- Back office / corporate cost review **£3.57m**

Red rated schemes represent the financial gap in the savings programme and work is underway to identify further schemes in order to mitigate this shortfall.

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# Exception report

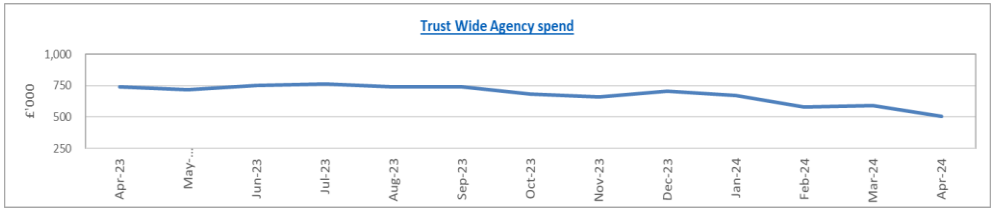
### Temporary Staffing Spend

As at the end of April the Trust reported a year to date underspend on pay of £0.16m. This consists of an underspend on substantive pay of £1.97m, offset by overspends on temporary staffing which total £1.81m; £1.31m on bank staff and £0.50m of agency spend.

### Agency

Agency spend in month 1 totalled £0.50m and spend is forecast to continue due to both vacancies and operational pressures. This month's spend is a 32.04% reduction on spend seen for the same period in 2023/24. The greatest level of reduction is within medical agency with spend 46% lower than spend in March 23.

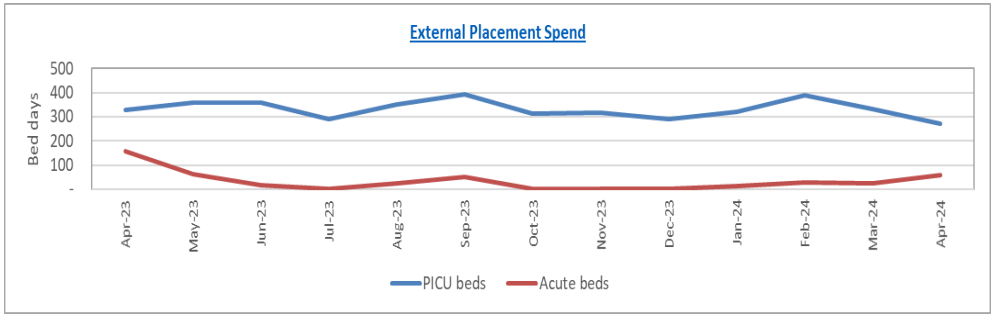
Overall agency spend levels were highest in East Kent (31.46%) due to the pressures within Crisis teams and Community teams. There continues to be focus and scrutiny on all agency spend as the financial year progresses to ensure spend is minimalised. The agency position is being closely monitored at an Executive Level.




### External placements

In April, the Trust utilised 8 female external female PICU beds of which 5 are at contracted levels and 3 additional which are in relation to a patient with a complex care requirements.

There was 1 Male PICU bed and 2 male acute beds utilised in month. which reflects the pressured bed position seen operationally.




### Bank

The Trust holds a budget for bank spend predominantly to cover the headroom in the rota. This is used to cover sickness absence, training and annual leave cover. Currently due to the level of vacancies and operational pressures there is a higher level of bank cover utilised than planned.

### Trust Wide Bank spend (£'000)

| | 22/23 Qtr 4 | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | 24/25 Apr |
|---|---|---|---|---|---|---|
| Nursing | 2,097 | 1,885 | 2,159 | 2,151 | 2,597 | 726 |
| HCAs | 2,768 | 2,760 | 3,342 | 3,086 | 3,568 | 989 |
| Other | 450 | 383 | 433 | 390 | 370 | 86 |
| **Total** | **5,316** | **5,028** | **5,934** | **5,627** | **6,535** | **1,800** |

### Trust Wide Bank Usage (WTEs)

| | 22/23 Qtr 4 | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | 24/25 Apr |
|---|---|---|---|---|---|---|
| Nursing | 153 | 125 | 145 | 141 | 156 | 148 |
| HCAs | 309 | 277 | 321 | 301 | 314 | 289 |
| Other | 43 | 34 | 38 | 37 | 33 | 24 |
| **Total** | **506** | **437** | **505** | **479** | **503** | **460** |

The Acute and Forensic Directorates report higher levels of bank usage due to the clinical requirements and the high level of observations of a specialist patient.

It is reported by the Directorates that there is a high level of observations required due to the acuity of patients with particular pressure seen within the Acute wards.

### Acute Inpatient HCA Bank Usage (WTEs)

| | Average | | | | | |
|---|---|---|---|---|---|---|
| | 22/23 Qtr 4 | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | 24/25 Apr |
| **Inpatient area** | | | | | | |
| Older Adult Wards | 40.07 | 40.40 | 42.46 | 41.09 | 48.68 | 35.28 |
| Willow Suite | 13.73 | 27.96 | 35.75 | 30.64 | 29.48 | 31.61 |
| Younger Adult Ward | 73.51 | 83.10 | 85.80 | 72.08 | 89.80 | 75.91 |
| **Total** | **127.31** | **151.46** | **164.01** | **143.81** | **167.95** | **142.80** |

### Forensics Inpatient HCA Bank Usage (WTEs)

| | 22/23 Qtr 4 | 23/24 Qtr 1 | 23/24 Qtr 2 | 23/24 Qtr 3 | 23/24 Qtr 4 | 24/25 Apr |
|---|---|---|---|---|---|---|
| **Inpatient area** | | | | | | |
| Low Secure Services | 56.77 | 59.76 | 63.43 | 62.34 | 65.79 | 67.28 |
| Medium Secure Services | 33.42 | 23.01 | 31.53 | 37.19 | 44.17 | 34.87 |
| **Total** | **90.20** | **82.78** | **94.95** | **99.53** | **109.96** | **102.15** |

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# Appendices

# Balance Sheet

## Statement of Financial Position

| | Opening | Prior Month | Current Month |
|---|---|---|---|
| | 31st March 2024 | 31st March 2024 | 30th April 2024 |
| | *Actual* | *Actual* | *Actual* |
| | £000 | £000 | £000 |
| **Non-current assets** | 169,254 | 169,254 | 170,524 |
| **Current assets** | 23,068 | 23,068 | 23,011 |
| **Current liabilities** | (29,558) | (29,558) | (28,900) |
| **Non current liabilities** | (47,291) | (47,291) | (49,221) |
| **Net Assets Employed** | **115,473** | **115,473** | **115,414** |
| **Total Taxpayers Equity** | **115,473** | **115,473** | **115,414** |

## Commentary

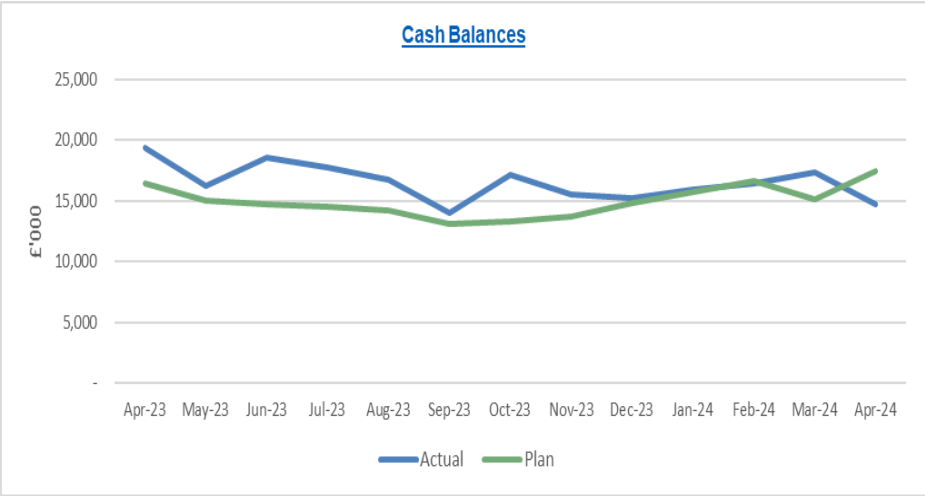
**Non-current assets**
Non current assets have increased by £1.27m in month, this relates to £2.19m of capital expenditure being offset by £0.90m of depreciation and amortisation.

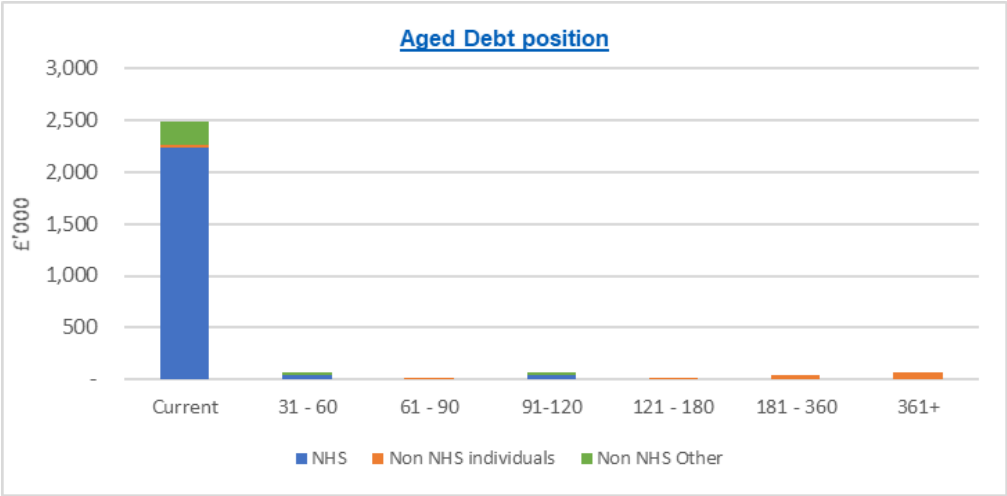
**Current Assets**
Within current assets the cash position remains strong at £14.71m.

Trade and other receivables increased by £2.60m primarily driven by new financial year invoicing.

**Current Liabilities**
Overall Trade and other payables decreased by £0.5xm primarily driven by a reduction in accruals and invoices being processed and settled.

**Aged Debt**
Our total invoiced debt balance is £2.80m, of which £2.50m is due within 30 days. This is a £1.30m increase on last month predominantly due to delays with billing for the KSS Provider Collaborative.

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# Capital Position

| Scheme | Full Year Plan £000 | Full Year Forecast £000 | Full Year Variance £000 | In Month Plan £000 | In Month Actual £000 | In Month Variance £000 | Year to Date Plan £000 | Year to Date Actual £000 | Year to Date Variance £000 |
|---|---|---|---|---|---|---|---|---|---|
| **System Capital Funding:** | | | | | | | | | |
| Information Management and Technology | 2,000 | 1,908 | 92 | 0 | 0 | 0 | 0 | 0 | 0 |
| Capital Maintenance and Minor Estates Schemes | 4,169 | 4,046 | 122 | 100 | 48 | 52 | 100 | 48 | 52 |
| Section 136 development | 948 | 995 | (47) | 17 | 20 | (3) | 17 | 20 | (3) |
| **Total System funding** | **7,117** | **6,950** | **167** | **117** | **68** | **49** | **117** | **68** | **49** |
| **PDC funding :** | | | | | | | | | |
| Front Line Digitisation | 1,736 | 1,828 | (92) | 0 | 0 | 0 | 0 | 0 | 0 |
| Mental Health Response Vehicle | 225 | 300 | (75) | 0 | 0 | 0 | 0 | 0 | 0 |
| Section 136 development | 2,708 | 2,708 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total PDC funding** | **4,669** | **4,836** | **(167)** | **0** | **0** | **0** | **0** | **0** | **0** |
| PFI 2024/25 | 117 | 117 | 0 | 10 | 10 | 0 | 10 | 10 | 0 |
| **Total Capital Expenditure** | **11,903** | **11,903** | **0** | **127** | **78** | **49** | **127** | **78** | **49** |

### Commentary

As at 30 April the overall capital position is £0.05m underspent, with a forecast capital spend against System Capital and PDC funding of £11.90m, which is as per plan.

The plan presented to Trust Board In March included capital spend for 24/25 totalled £13.20m which included the IFRS 16 position on leases.

At the time of writing the IFRS 16 position is being finalised as part of the planning process; this will be included within future reports.

### Year to date and forecast performance against Plan

In month the Capital Maintenance and Estates schemes marginally underspent by £52k. The Section 136 in month is slightly over anticipated spend levels but full year spend is expected to be in line with the allocation.

The capital programme is at the early stages with spend phased to increase as the year progresses. Focus will be on ensuring schemes remain on plan for delivery particular estates schemes and the Section 136 programme.

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Insights and plans for KMPT identity, culture and staff experience |
| **Author:** | Rebecca Stroud-Matthews, Deputy Chief People Officer |
| | Asim Janjua, Head of Digital Communications and Brand |
| **Executive Director:** | Sandra Goatley, Chief People Officer |
| | Kindra Hyttner, Director of Communications and Engagement |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Approval **-** The Board is asked to agree the direction of travel in the high-level plans at Appendix 1 and 2 |
| **Submission to Board:** | Board request |

## Overview of Paper

This paper captures what we have heard from extensive engagement with our people, our patients and our partners about what it feels like to work for KMPT, be cared for by KMPT and partner with KMPT. It sets out what action we will be taking to address these insights as part of our culture, identity and staff experience priority – ultimately to support the overall delivery of our organisational strategy.

## Issues to bring to the Board's attention

Culture and identity is one of our six organisational priorities. We recognise that to achieve our strategy we need to focus on creating the right internal culture and behaviours within KMPT, and do more to help our patients, partners and the public know who we are and what we do. In April 2024, we added 'staff experience' to the title of this priority to better reflect and integrate the focused work happening in this area.

As well as having the insights from our recent staff survey and well-led review, we commissioned two separate pieces of independent research and work looking specifically at equality, diversity and inclusion within the organisation, and our identity. Many of the themes have been shared with the board in advance of this paper.

The change needed to address this is significant, but our people and partners recognise change is on the horizon and feel optimistic. We need an identity akin to a 'north star' (also thought of as our 'why' and reason for being) to guide us, and our audiences, to address these challenges and harness the opportunities to develop.

To help us make this significant shift, we have developed plans on specific areas of focus, included here:

- For Board's discussion and approval: (1) our VOICE identity plan, including four new organisational values;
- For Board's discussion: (2) our high-level equality, diversity and inclusion (EDI) plan.

Following the engagement with our audiences, we are also proposing to change KMPT's name in the near future, with Board's approval, to provide a clearer sense of our remit and enable us to connect and communicate more effectively with our patients, partners and people.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Trust strategy; reputation; recruitment and retention |
| **Assurance:** | Reasonable |
| **Oversight:** | Board |

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## 1. Background to the importance of this work and what we did

**1.1.** It is widely accepted that high quality care hinges upon organisational culture – simply put, the way we do things around here, and the way that makes people feel. Culture plays a significant role in shaping the overall work environment, influencing employee behaviour and impacting organisational success.

**1.2.** As we began to deliver our ambitious three-year strategy in 2023, we recognised that more intentional work was needed to translate our strategy in a way that connects all of our audiences and to transform our culture. We knew we needed a culture that would facilitate our strategic ambitions and an identity that would help us improve our relationships and reputation with our patients, our people and our partners (our three Ps). The appointment of Sheila Stenson as our new CEO in November 2023 provided a critical time to make these improvements with her ambition to have a significant and positive impact on our three Ps.

**1.3.** The most thriving, high performing organisations have cultures and identities where their purpose, mission, and inclusive values are woven into the DNA of everyday work life. It has become apparent through the recent engagement work that this is sadly lacking in KMPT. We commissioned independent research, and expertise, looking at equality, diversity and inclusion within KMPT and opportunities to improve; and looking at our identity and how we connect with our three Ps. This work has informed and culminated in:

- a new identity, vision and values that unite our staff behind our strategy and connect us with our wider community;
- a clear position on who we are, our impact and the difference we make;
- a clear long-term plan for making and sustaining the changes required;
- immediate actions to address to the most urgent priorities.

**1.4.** It is intended that the above will lead to improved levels of engagement with patients, partners and our people; improved staff and patient experiences; and stronger relationships with our partners. Ultimately, it is expected that these changes will allow effective delivery of strategic goals, improved performance and quality of services, and ultimately greater impact on our community. We will measure this through existing national staff survey and patient survey metrics, as well as new local survey indicators.

## 2. How we engaged and listened to our three Ps

**2.1.** Between October 2023 and March 2024, we undertook extensive engagement with our people, patients and partners. This included an intensive series of listening activities (including interviews, workshops and surveys) to better understand our starting position, what our audiences want and the levers to creating that for them. In total, through these exercises, we had over 730 hours of listening time with staff, patients and partners in addition to the data from the surveys.

**2.2.** This activity took place alongside other established engagement mechanisms, including team, directorate and leadership meetings, CEO monthly sessions and executive visits. The work also formed a strong focus for Sheila Stenson's first 100-day engagement with our people, patients and partners.

**2.3.** We listened and engaged our audiences through four discrete programmes, as set out below.

| Programme | Purpose | Methodology |
|---|---|---|
| **Cultural Transformation (equality, diversity and inclusion)** | To understand the current situation in relation to equality, diversity and inclusion (including a specific focus on discrimination and racially motivated incidents) | • Survey responses from around 1,000 staff in relation to diversity and inclusion;<br>• Listening into action sessions for staff at Bands 2 to 7;<br>• Cultural competence assessment with 259 senior leaders. |
| **KMPT's identity** | To understand KMPT's current position and cultural impact internally and externally, across our three Ps. | • 3 x Brand and identity agency workshops and 15 focus groups with clinical and non-clinical staff (over 250 staff)<br>• Workshops with senior leaders<br>• 10 interviews with EMT, Board, senior leaders<br>• Interviews and surveys with external stakeholders and partners<br>• 3 x service user workshop and surveys<br>• A survey of staff in relation to KMPT's brand and identity, completed by 800 staff. |
| **Staff survey** | To understand current staff experience across a broad range of indicators, including benchmarking against similar organisations | • Survey responses from around 1,900 staff in relation to staff experience. |
| **Well-led review** | To understand the strengths and weaknesses of KMPT's leadership and governance arrangements | • Desktop review to understand the effectiveness of governance and leadership;<br>• Interviews with 15 Board members and senior leaders to understand the effectiveness of governance and leadership;<br>• A survey completed by 411 staff in relation to governance and leadership;<br>• Interviews with 7 stakeholders to understand external perceptions of governance and leadership;<br>• 2 focus groups with staff in relation to governance and leadership;<br>• Observations of a number of Board Committees to evaluate effectiveness of governance and leadership. |

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## 3. Insights from what we heard

**3.1.** Although there was commonality across all four programmes, the different focuses of the exercises resulted in a wide range of themes emerging with clear areas of focus.

**3.2.** The key themes that emerged are as follows:

- Our purpose, vision and mission lacks clarity and credibility;
- We talk about measures not outcomes, resulting in a transactional approach to care;
- There is no shared understanding of what we do and our role in the county's wellbeing is unclear;
- There is a focus on caring, but not always a caring culture;
- Racism exists towards staff by staff;
- There is a lack of fairness felt against our ethnic minority staff;
- Violence and aggression exists against our staff, perpetrated by patients;
- The lack of psychological safety is a constant pressure;
- We have ineffectual systems and processes which significantly impacts our people;
- Strong local teamworking plays out in silo working and fragmentation;
- There is a disconnect between staff and leadership, including EMT and the Board;
- The role of our leaders needs clarity, accountability and development;
- Command and control overshadows staff voice;
- We are risk averse which stifles innovation;
- Our people have a lack of pride to work for KMPT and need to feel celebrated;
- We can be seen as unresponsiveness and lacking apathy from our patients and partners because we are bogged down in complicated processes and perceived busyness;
- For the most part, we are friendly and supportive;
- There are good relationships between staff and line managers;
- Good training opportunities are in place.

**3.3.** A detailed version has already been provided to the board. These insights are valuable and have and will be put to use astutely as part of our culture, identity and staff experience priority work.

## 4. What we have done in response to what we heard

**4.1.** Participation from our people, partners and patients has been central to how we have developed our high level plans on our VOICE identity and EDI, reflecting our commitment to truly transform how we do things - taking a co-production approach and giving people the time and space to reflect and connect with this work and our ambitions. This will increase the likelihood of changes being embedded and sustained.

**4.2.** The insights highlighted the need for three main areas of change and action:

- **Repositioning ourselves through a new identity that connects with our stakeholders.** We have developed a one-page VOICE identity plan (Appendix 1) that covers the beliefs that guide us, the future we want to shape, why we exist, how we want to be seen in the market, the experience and value we provide, the proof points that demonstrate our offer, our image, our culture and our essence. This also includes our four new organisational values, shaped by our

engagement – inclusiveness, open, brave and curious. We will develop an activation plan that supports how we will reposition ourselves to better connect with our audiences over the next 3-5 years.

- **Transforming our culture through equality, diversity and inclusion**. As well as repositioning our identity and values, we have created a 2 month improvement roadmap aimed specifically at developing EDI within the organisation, eliminating discriminatory behaviours – especially related to racism – implementing leadership accountability and allyship, and tackling systemic inequalities that exist within the organisational culture (appendix 2). Tackling racially motivated violence and aggression, which also came out through our insights, is being addressed through our violence and aggression organisational priority, led by our Chief Nurse Andy Cruickshank. Learnings and recommendations from this insight have been shared with that priority.

- **Changing KMPT's name**. We heard from all stakeholders that our name presents a confused and unclear picture of what we do, who we are and who we serve. It no longer reflects our operational business – we are not a formal partnership trust and do not provide social care. We are proposing to change our name in the future with Board approval, in line with NHSE naming principles, to provide a clearer, accurate reflection of our remit and enable us to connect more effectively with the public, patients, partners and our people. The creative concepts for our new identity and our proposed new name will be discussed with the Board in June.

**4.3.** The below table brings together a number of significant, interconnected pieces of work that sit within the culture, identity and staff experience priority and complements the VOICE identity and EDI plans, and responds to the insights we heard. The Board is already sighted on much of this work, which will be completed this year. To note, this includes: a Staff Council; a new staff intranet which will include the ability to 'pulse survey' our staff; mobilising, developing and supporting leaders and managers through a new set of competencies developed in line with our new identity; developing our value proposition including our policy and practice around areas including recruitment, leave and flexible working; reward and recognition; and improved routes for speaking up.

**4.4.** Detailed communications and engagement plans are in development to support this work, and the culture, identity and staff experience transformation journey as a whole. This includes repositioning our narrative across our communications and channels, and being proactive and more intentional in this. As we found through our identity research and development, we have distinct organisational shifts to make from being insular to inclusive; ambitious to impactful; risk averse to brave; judgemental to curious. Communications and engagement will play a vital role in telling this story and helping the organisation make the shift it needs to have a more positive impact.

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# What we heard and how we are addressing it

Data and insights

| Name and identity | Engagement & staff voice | Leadership & management | Employer value proposition | Addressing concerns | Violence and aggression |
|---|---|---|---|---|---|
| Development of a unique core identity that clearly defines our mission, vision, purpose, values and position which influences our name, literature, comms, recruitment, culture, governance and strategic direction. | Introducing a new intranet and staff app, an Employee Council, and strengthening our staff networks. Also shifting internal and external communications reflect our impact and culture – and is aligned to our beliefs and core brand. | Introducing a new set of leadership and management competencies (including cultural competency), a new leadership and management development programme, and developing leadership accountability | Development of an innovative Employer Value Proposition which focuses on embedding our brand, embracing diversity and wellbeing through on refreshing policies, systems, processes and marketing. | Including improving incident logging systems (reducing time) and processes, so that the experience staff have of raising concerns is improved. This workstream will also focus on enhancing Quality Improvement capability across the Trust | Continuing to address violence and aggression, including rolling out allyship training for all staff in patient-facing roles, and embedding trauma-informed support. |
| • Care as a core value and transactional care<br>• Lack of clearly articulated purpose and vision<br>Lack of focus on impact<br>• Lack of clear identity/differentiation/unclear service offering<br>• Friendly and supportive culture | • Care as a core value and transactional care<br>• Lack of focus on impact;<br>• Lack of clear identity<br>• Friendly and supportive culture<br>• Command &control; lack of staff voice<br>• Ineffectual systems/processes<br>• Lack of fairness/ discrimination against ethnic minority staff. | • Silo working and fragmentation<br>• Disconnect between staff & leaders<br>• Lack of leadership role clarity, accountability and development;<br>• Blame culture and lack of psychological safety<br>• Risk aversion<br>• Lack of fairness/discrimination against ethnic minority staff<br>• Lack of local decision making | • Lack of focus on impact;<br>• Lack of clear identity/differentiation/unclear service offering<br>• Lack of pride/recognition of achievement<br>• Good training opportunities<br>• Lack of fairness/ discrimination against ethnic minority staff. | • Blame culture and lack of psychological safety<br>• Lack of fairness/ discrimination against ethnic minority staff<br>• Staff on staff racism | • Patient on staff V&A<br>• Lack of fairness/discrimination against ethnic minority staff. |

**Addressing**

**So that**

| *Patients* | | *People* | | *Partners* | |
|---|---|---|---|---|---|
| We have a clear position we communicate in the region and nationally<br><br>We have a clear service offering that manages expectations.<br><br>We make our care felt at all touchpoints of the organisation in a meaningful and measured way. | Staff have a voice and can communicate and engage with confidence.<br><br>Internal and external audiences understand our impact, who we are and what we do. | Leaders feel confident in their capability (as indicated through survey/appraisal)<br><br>Staff feel supported by their leaders (indicated through survey)<br><br>Leaders have clear accountabilities they deliver against (appraisal) | Staff of all backgrounds feel valued by the organisation (as indicated through survey)<br><br>Reduced turnover<br><br>More successful recruitment<br><br>Increase in minority staff in roles at B7 and above | Staff of all backgrounds feel confident raising concerns (as indicated through survey)<br><br>Concerns raised by staff of all backgrounds are effectively addressed (as indicated through survey) | The proportion of staff experiencing violence and aggression decreases (as indicated through survey)<br><br>The proportion of BAME staff experiencing violence and aggression decreases (as indicated through survey) |

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## 5. Risks, issues and mitigation

**5.1.** There are a number of possible risks to delivery of our cultural ambitions, described below:

| Risk | Impact | Mitigation |
|---|---|---|
| This is a significant transformation requiring leadership and engagement from our top 100 leaders. | This will affect the morale and engagement of our staff, which will ultimately impact on how we do things and the quality of care we deliver. | A whole organisation approach is needed led by our top 100 leaders, and a clear and robust communications and engagement plan will be put in place with realistic timelines.<br><br>We will clearly define our behavioural expectations for our leaders, and provide support and development where appropriate.<br><br>Robust QIA on new programmes of work, including anticipated impact on engagement and morale |

## 6. Conclusion

**6.1.** We are taking a radically different approach to transforming our culture and changing the way our people, patients and partners think about us. The extensive engagement we have done with our stakeholders, which we have never done before, gives us a solid foundation to make the right decisions and change the culture and identity of KMPT. This work is the start of our journey to build a high performing, inclusive and thriving organisation – one where our patients feel well cared for, where our people feel safe and can thrive, and where our partners want to actively collaborate with us to tackle the shared challenges that we face. It will look and feel different. The work of our People team and Communications and Engagement team, under the shared committed leadership of our executive team and top 100 leaders, will enable this significant change and take us to that truly outstanding organisation we aspire to be.

**6.2.** The board is asked to discuss and approve the approach to our VOICE identity and the high level EDI plan.

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# APPENDICES

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## Appendix 1: Voice identity plan

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# VOICE identity on a page

| | | | | |
|---|---|---|---|---|
| **Beliefs** | **Communities thrive when mental health care forms part of the fabric of life** | | | |
| | The more stressful life is the more our support is needed | Navigating help is hard so we must make it easy to access our services | When we are heard and cared for our life feels more meaningful and positive. | Empowering our staff is the only way to empower our patients |
| **Ambition** | **A world where mental health care helps transform living into living well,** where services are there at the right time for happier, more meaningful lives. | | | |
| **Purpose** | **Weaving mental health care into the fabric of our community** by listening, caring and guiding from crisis to calm | | | |
| **Mission** | **Being a proactive presence in the region, listening to patients and staff to create seamless care and a thriving workplace,** collaborating with partners to shape a mental health service for the collective well-being of comunities and the county | | | |
| **Positioning** | **We're a compassionate, collaborative multi-disciplinary team of clinicial professionals** driving new approaches and providing care for adults suffering from the most severe impacts of mental health illnesses across our region and beyond | | | |
| **Offer** | We provide highly specialised, acute clinical and community support for adults with serious mental health needs, dementia, perinatal psychosis, brain injuries, personality disorders and other complex psychological needs **through a network of specialist inpatient facilities across the county.** | | | |
| **Promise** | **To be an open, curious and supportive presence** showing compassion for those in need, confident in the postive impact we have on people's lives | | | |
| **Reasons to believe** | Essential Support \| Forensic Expertise \| Specialist Approaches & Empowering Spaces \| Regional Reach \| Inclusive Culture \| Willing Partners \| Research & Innovation \| Teaching & Training | | | |
| **Personality** | Determind \| Relatable \| Warm \| Visionary \| Expert | | | |
| **Cultural values** | Inclusive \| Caring \| Open \| Curious | | | |
| **Essence** | Doing well together | | | |

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# VOICE identity on a page – shorter version

| | | | | |
|---|---|---|---|---|
| **Beliefs** | **Communities thrive when mental health care forms part of the fabric of life** | | | |
| | The more stressful life is the more our support is needed | Navigating help is hard so we must make it easy to access our services | When we are heard and cared for our life feels more meaningful and positive. | Empowering our staff is the only way to empower our patients |
| **Ambition** | Helping transform living into living well | | | |
| **Purpose** | Weaving mental health care into the fabric of our community | | | |
| **Mission** | An active, united mental health service for our communities across Kent & Medway | | | |
| **Positioning** | A compassionate, collaborative multi-disciplinary team of mental health professionals serving Kent & Medway. | | | |
| **Offer** | **We provide highly specialised, acute clinical and community support for adults with serious mental health needs,** through a network of specialist inpatient facilities across the county | | | |
| **Promise** | **To be an open, curious and supportive presence** showing compassion for those in need, confident in the postive impact we have on people's lives | | | |
| **Reasons to believe** | Essential Support \| Forensic Expertise \| Specialist Approaches & Empowering Spaces \| Regional Reach \| Inclusive Culture \| Willing Partners \| Research & Innovation \| Teaching & Training | | | |
| **Personality** | Determind \| Relatable \| Warm \| Visionary \| Expert | | | |
| **Cultural values** | Inclusive \| Caring \| Open \| Curious | | | |
| **Essence** | Doing well together | | | |

rbl

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# Or to put it another way....

**Who we are**

A compassionate, collaborative multi-disciplinary team of mental health professionals serving Kent & Medway.

**What we do**

Weaving mental health care into the fabric of our community

**How we do it**

Being an active, united mental health service for our communities across Kent & Medway

**And why**

Because communities thrive when mental health care forms part of the fabric of life

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## Appendix 2: Cultural Transformation 12-month EDI plan

### Cultural Transformation Programme: Phase 2

Phase one of the Cultural Transformation programme was focused on gathering the baseline data necessary for making recommendations to progress the Equality Diversity and Inclusion plan. Data was collated via a bespoke Diversity Survey, Listening-into-Action [LIA] groups, and initial work on Cultural Competence with senior leaders. Based on the data analysis and insights from phase 1, 10 recommendations (scorecard) were initially proposed. These have now been consolidated into 6 workstream areas, which will guide organizational transformation over the next 3-5 years, beginning with the targeted improvements we aim to achieve in the next 12 months. Please see figure 1 below.

***Figure 1: Phase 2 Improvement Workstreams***


Each workstream has an allocated Executive Sponsor, Subject Matter Experts (SMEs) and a representative from each of the Staff Networks. Please see below Figure 2 below.

***Figure 1: Phase 2 Improvement Workstreams with Members.***


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## Context for the 6 Workstream Areas

**Workstream 1**
Addressing Racism, Violence & Aggression on Inpatient Wards.

Reducing the number of incidents against staff members relating to racism, violence, and aggression by raising patient awareness about Equity, Diversity, and Inclusion (EDI) values; encouraging respect for the diverse backgrounds of staff members who provide their care.

Rolling out Allyship Training to staff members by providing the insights and skills necessary to support and advocate for their colleagues, especially individuals from marginalised or underrepresented groups. This training will include a basic level of Trauma Informed Practice applicable to staff working directly with patients.

**Workstream 2**
Improving Leadership Accountability through Cultural Competence.

Empowering Senior Managers to be better equipped at recognising and addressing issues relating to EDI within their teams and creating environments where everyone feels heard, respected, and valued, to able to thrive in dynamic and diverse work settings. Key enablers include: -

- Cultural awareness: understanding and respecting diverse cultures and perspectives in individuals.
- Cultural inclusion: leading with equitable opportunities and inclusive communication.
- Cultural diversity: recognising and appreciating the cultural nuances among various cultures.
- Cultural diligence: using data to track demographic shifts in the workforce and inform decision-making.
- Cultural confidence: enhancing efficiency in managing diverse teams and resolving cross-cultural conflicts.

**Workstream 3**
Enhancing the EDI Strategy through Workforce Engagement & Diversity Data.

Re-energising the Staff Networks by revisiting their purpose and aligning with the current EDI plan, objectives, and goals. This process includes exploring creative approaches to boosting participation and introducing refresher training on the latest updates in EDI to ensure continued relevance and engagement.

Creating a Diversity Dashboard for tracking the demographic shifts through intersection lens in the workforce and patients; also helping to improve organisational decisions concerning people and services.

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**Workstream 4**
Reviewing People Policies, Staff Health Equities and Wellbeing.

Reviewing key people policies and practices that are essential for promoting a supportive, inclusive, and productive working culture while ensuring legal compliance and mitigating risks. demonstrating a commitment to improving employee satisfaction, engagement, and overall organisational success. The review of critical policies and practices, provides a safe platform for employees to raise concerns or grievances related to EDI and wellbeing issues.

**Workstream 5**
Connecting with the Workforce through Effective Communications & Engagement.

Improving connections with the workforce by regularly updating everyone on the Cultural Transformation programme to ensure transparency. This involves, promoting safe spaces to encourage participation and feedback, clearly articulating the goals and call-to-action of EDI initiatives, and ensuring everyone understands they have a role in helping to driving transformation within the organisation.

**Workstream 6**
Improving the Incident Logging System and Process.

Developing the InPhase Incident Management system by reducing the time required to raise an incident and ensuring the impact on staff is adequately captured. Enhancements include improving the user experience by creating a robust process for tracking incidents and reporting progress to the EMT on a monthly basis.

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | CQC Community Mental Health Survey 2023 – Recommendations |
| **Author:** | Julia Wilson, Strategic Lead for Allied Health Professions |
| **Executive Director:** | Andy Cruickshank, Chief Nurse |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Regulatory Requirement |

## Overview of Paper

This paper relates to the Care Quality Commission (CQC) Community Mental Health Survey 2023. The annual national survey reflects views on the quality of care from a random sample of 1250 service users in KMPT (who used services between 1st April to 31st May 2023). The CQC published the national benchmark reports on 18/04/2024. The content of this report provides a snapshot of the results. Recommendations for change are made for consideration by the board.

## Issues to bring to the Board's attention

The 2023 Community Mental Health Survey has reported some disappointing results in the following areas:

- Crisis care
- Support and wellbeing
- Overall experience

The community mental health survey reflects the views of 270 people on the quality of care of KMPT, taken from the random sample of 1250 community patients. It is important to note that the KMPT patient reported experience measures (PREM) and the family, friends and carers surveys (CREM) receive on average 611 monthly returns (around 541 PREM/ 70 CREM returns) This provides regular feedback and reflects that people that use our services report good patient experience – however, the details within the CMH survey highlight where improvement is necessary and that the current model of collecting feedback is not as focussed as it needs to be.

The roll out of the Community Mental Health Framework (CMHF) will facilitate improvement in areas noted as worse than expected in this annual survey. The CMHF promotes a new approach in which people are active participants in making positive changes to their health and wellbeing.

As part of the changes to the delivery of community mental health care, an improved infrastructure is required in order to involve, listen and respond to the experiences of people that use our services including family, friends and carers. A system redesign is required throughout local and central systems to enable this and to

ensure that coproduction is a core approach within all services. The first phase of this will happen in the next three months.

## Governance

| | |
|---|---|
| **Implications/Impact:** | The CQC National patient survey programme is part of the NHS Outcome Framework. The outcomes of the surveys are a major source of data for Care Quality Commission (CQC) and are used as part of the Inspection Regime, through Intelligent Monitoring. |
| **Assurance:** | N/A |
| **Oversight:** | Oversight by Quality Committee |

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## CQC Community Mental Health Survey 2023

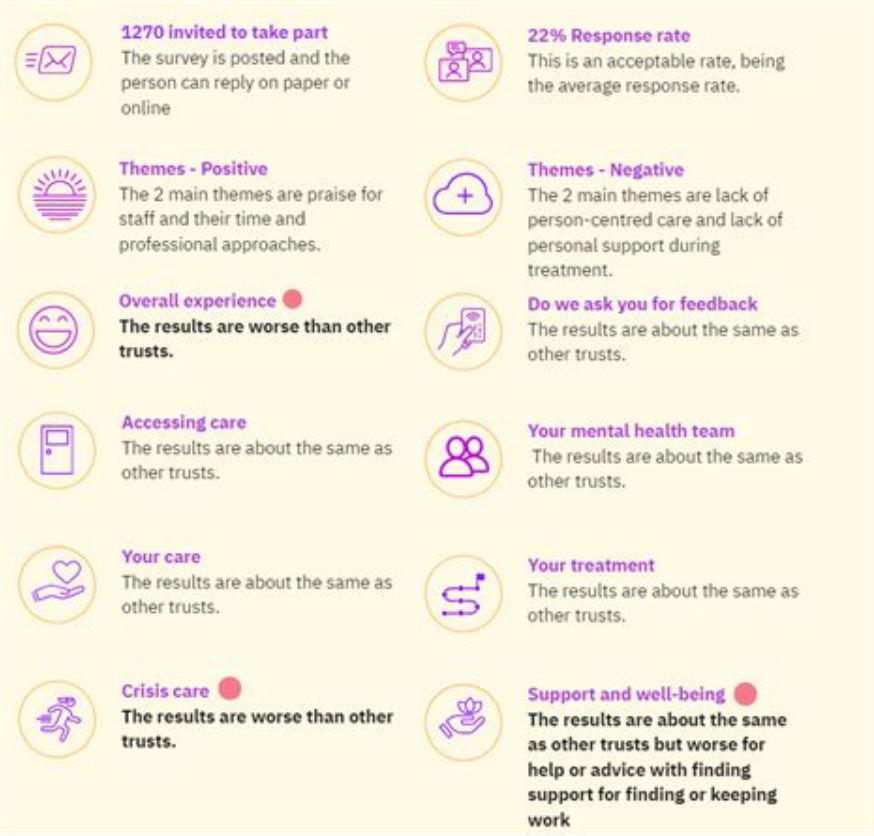
The Care Quality Commission (CQC) Community Mental Health Survey is completed annually. This national survey reflects views on the quality of care from a random sample of 1250 service users who used services with KMPT between 1st April to 31st May 2023. The CQC published the national benchmark reports on the 18th April 2024.

The content of this report provides a snapshot of the results. Recommendations for change are made for consideration by the board.

### Summary of results

The report noted five areas are at an acceptable standard when compared to other trusts partaking in the national survey.

- **Support while waiting**: between assessment and first appointment for treatment, the support offered was appropriate for services users and their mental health needs
- **Crisis care access**: service users knowing who to contact out of hours in the NHS if they had a crisis
- **Planning care**: service users having a care plan
- **Support while waiting**: between assessment and the first appointment for treatment, service users being offered support with their mental health
- **Support in accessing care**: support provided to access care and treatment met service users' needs



**Areas for improvement**

Analysis indicates that where performance is significantly low and worse than other trusts, it is particularly clustered in three areas for improvement as follows:

**Crisis Care – feeling that the help and support needed was received**

Q28. Thinking about the last time you contacted this person or team, did you get the help you needed? Worse than expected (5.0).

Most service users would know who to contact out of office hours in a crisis (8.2). KMPT is performing much better than other trusts at providing our service users with a named contact or contact information, however many people felt that when they have made contact, they did not receive the help that they needed particularly when in crisis.

**Crisis Care - family or carer support during a mental health crisis**

Q30. Did the NHS mental health team give your family or carer support whilst you were in crisis? Worse than expected (3.3).

Service users know who to contact in a crisis but many feel that their family, friends or carers are not getting the support that they need themselves during the crisis.

**Support and Wellbeing – support, help or advice for finding or keeping work**

Q32b. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for finding or keeping work? Worse than expected (1.4).

Services users did not feel that they were able to obtain support for other areas of their life including physical health, benefits, cost of living, support groups, support to stay working or returning to work.

**Recommendations and next steps for KMPT**

1. **Community Mental Health Framework**

Much of the narrative within the 2022/23 CMH survey reflects KMPT services before the roll out of the Community Mental Health Framework (CMHF).

The CMHF is now being rolled out in all areas across Kent and Medway. These changes to the provision of community mental health care and treatment started in Thanet and the last services to go live (on the 20th May 2024) are Dartford, Gravesham and Swanley and South West Kent. This new approach to mental health care promotes an approach in which people are active participants in making positive changes to their health and wellbeing.

As part of the CMHF, Dialog+ has been rolled out and training has been completed by community staff across East, West and North Kent. Dialog+ enables proactive conversations, supporting self-management and helping people to move forward with their recovery journey. It facilitates personalised conversations that identifies the needs of each individual, which could include therapeutic interventions or support provided by partner organisations such as employment or financial advice and support. Capturing this information through Dialog+ will allow KMPT to understand patient satisfaction levels and where focus for improvement is required. Dialog+ will be completed at the start of the episode of care, every three months during the journey with KMPT services and at the end of each intervention.

Retelling a personal story is also an area of dissatisfaction for people that access our services. The trusted assessment process will work to reduce this by ensuring that only one assessment is completed during an episode of care. Again, this will facilitate a more supportive, personalised approach, it will also ensure the right support and intervention is accessed at the right time.

Dialog+ and the trusted assessment process will allow a more focussed approach directed by the needs of the individual. There will be no 'wrong door' and services will be provided by KMPT and local partnership services.

Two surveys have been devised to review patient experience during the roll out of the CMFT which were co-produced with the CMHF Lived Experience Lead and KMPT engagement pool. The KMPT communication team are currently adding these to Google forms and the transformation team are establishing the delivery of these tools via text in line with GDPR rules. There will also be paper copies in reception areas available for people who are unable to access the surveys digitally.

Surveys - Attached

Appendix 3 – Trusted Assessment Patient Experience

Appendix 4 – Dialog + Patient Feedback

The KMPT Friends and Family test (FFT) and Patient experience reported measure (PREM) will continue to be monitored to look for changes as the CMHF continues to embed throughout community services.

**2. Patient experience with KMPT - current state**

Patient experience is currently led by the Allied Health Professions across the trust. The trust also has one data experience analysist who analyses the FFT/PREM data on a monthly basis. Patient experience qualitative data taken from the PREM is placed on a system called Gathr which is accessed by individual teams and discussed locally. Largely, this data has not been used for improvement in a systematic and testable way – there is not a standardised approach across the Trust and this largely relies on the AHP leads to manage this, which limits the scope of its use to really improve services.

**3. Patient experience/participation redesign**

It is clear that there is a need for a more dedicated resource to lead on People Participation/Patient Experience for the organisation. This will have to be achieved by repurposing some available resource. The current approach is fragmented and has a relatively narrow focus on particular workstreams – meaning that the influence of patient feedback, how this is used within teams for improvement and how people who use our services are involved in the design and testing of changes is not ambitious.

The development of a more substantial patient experience resource can be considered using internal resource through system redesign. The first of a series of planning/delivery meetings will be held in June (17th). The first of these is to get a full understanding of the different elements of work related to this from across the organisation and to agree a coherent model for services to engage with.

The group will be considering how to better use digital resource to help gather experience data – there are options other than Gathr that need to be considered that can help us track improvements over the course of the year.

The first phase of this work will be complete by end of August. It is important to note that this is a change in the culture of involvement of people who use our services in how they operate – so whilst the material changes can occur relatively quickly, the culture will take time to evolve. The adoption of the CMHF is an ideal moment to begin this process.

## Appendices

## Appendix 1

### Qualitative data themes

Analysis of the qualitative data reflects some of the results from the quantative data. There are positive comments especially praise for staff and their time and professional approaches. However, qualitative data findings reflect that many community service users express that their recovery is not being attained, they feel isolated and they are not being given enough support and consideration to access their care. The comments suggest that there are many longer term service users who do not feel supported to make decisions about their care and treatment and do not feel in control of their care.

Many feel that support needed to access their agreed care and treatment is not considered as part of the discussions around their care planning and recovery. They feel there is a lack of communication around the support needed to access their agreed care and treatment. They do not feel that the support provided meets their own specific needs and the support is elusive and impacted by staff shortages and problems getting through on the phone. Cancellation of appointments and lack of understanding to their own work and other time or personal commitments is a clear message. The findings indicate that the improvements needed are particularly clustered in the areas 'Your care' and 'Support & Wellbeing'.

### Qualitative data themes breakdown

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| | | | | | |
|---|---|---|---|---|---|
| Accessing care and treatment | Q1 When was the last time you saw someone from NHS mental health services? **Not scored**<br>Q2. Overall, how long have you been in contact with NHS mental health services? **Not scored** | Q4. How did you feel about the length of time you waited between your assessment with the NHS mental health team and your first appointment for treatment? | Q6. While waiting, between your assessment and your first appointment for treatment, were you offered support with your mental health? | **Appendix 1: CQC Community mental health survey**<br>**Questions**<br>**KEY**<br>Worse than expected<br>Somewhat worse than expected | |
| | Q3. How long did you wait between your assessment with the NHS mental health team and your first appointment for treatment? | Q5. While waiting, between your assessment and your first appointment for treatment, did you experience any changes in your mental health? | Q7. Was the support offered appropriate for your mental health needs? | | |
| Your mental health team | Q8. Were you given enough time to discuss your needs and treatment? | Q9. Did you get the help you needed? | Q10. Did your NHS mental health team consider how areas of your life impact your mental health? | Q11. Did you have to repeat your mental health history to your NHS mental health team? | Q12. Did your NHS mental health team treat you with care and compassion? |
| Your care | Q13. Do you have a care plan?<br>Q14. How has your care and treatment been delivered? **Not scored** | Q15. Have you and your team decided together what care you will receive? | Q16. In the last 12 months, have you had a care review meeting to discuss how your care is working? | Q17. Has your NHS mental health team supported you to make decisions about your care and treatment? | Q18. Do you feel in control of your care? |
| Your treatment | Q19. In the last 12 months, have you been receiving any medication? **Not scored**<br>Q20. Who prescribed medication for your mental health needs? **Not scored** | Q21. Have any of the following been discussed with you about your medication? □ Purpose of medication □ Benefits □ Side effects □ What will happen if I stop taking my medication | Q22. In the last 12 months, has your NHS mental health team asked you how you are getting on with your medication? | Q23. In the last 12 months, have you received any NHS talking therapies? **Not scored**<br>Q24. How do you feel about the length of time between assessment and 1st talking therapies appointment? | Q25. Thinking about the last time you received NHS talking therapies, did you have enough privacy to talk comfortably? |
| Crisis care | Q26. Would you know who to contact out of office hours within the NHS if you had a crisis? | Q27. In the last 12 months, have you contacted this person or team? | Q28. Thinking about the last time you contacted this person or team; did you get the | Q29. Thinking about the last time you contacted this person or team; how do you feel about the length of time it took you to | Q30. Did the NHS mental health team give your family or carer support whilst you were in crisis? |

| | | | | | |
|---|---|---|---|---|---|
| | | | help you needed? | get through to them? | |
| Support and wellbeing | Q31. In the last 12 months, has your mental health team supported you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)? | Q32. Did your mental health team give you help or advice with finding support for… □ Joining a group or taking part in an activity □ Finding or keeping work □ Financial advice or benefits □ Cost of living | Q33. Have mental health services involved a member of your family or someone else close to you as much as you would like? | Q34. Has your mental health team asked if you need support to access your care and treatment? | Q36. What support do you need to access your care and treatment? |
| | | | | Q35. Do you need support to access your care and treatment? | Q37. Do you feel the support provided meets your needs? |
| Overall | Q38. Overall, in the last 12 months, how was your experience of using the NHS mental health services? | Q39. Overall, in the last 12 months, did you feel that you were treated with respect and dignity? | Q40. Aside from this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care? | | |

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## Appendix 2 - CQC Community mental health survey results data

### CQC early release data summary 04/03/2024

### Overall experience

Overall, in the last 12 months, how was your experience of using the NHS mental health service?

| 2016 | 2017 | 2018 | | 2019 | | 2020 | | 2021 | | 2022 | | 2023 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6.4 | 6.6 | 6.5 | | 6.4 | | 6.7 | | 6.6 | | 6.4 | | 5.9 | |

### Banding

**Better**
Your trust's results were much better than most trusts for 0 questions.
Your trust's results were better than most trusts for 0 questions.
Your trust's results were somewhat better than most trusts for 0 questions.
**Worse**
Your trust's results were much worse than most trusts for **0** questions.
Your trust's results were worse than most trusts for **4** questions – listed below
Your trust's results were somewhat worse than most trusts for **6** questions - listed below
**Same**
Your trust's results were about the same as other trusts for **23** questions.

### Questions where banding is worse than expected

N.b. Much worse Worse Somewhat worse

Your mental health team

- Q9 Did you get the help you needed? – Somewhat worse

Your care - Planning care, Involvement in care

- Q18. Do you feel in control of your care? – Somewhat worse

Your treatment – Medication

- Q21b. Have any of the following been discussed with you about your medication? - Benefits of medication Somewhat worse
- Q21c. Have any of the following been discussed with you about your medication? - Side effects of medication Somewhat worse

Crisis Care

- Q28. Thinking about the last time you contacted this person or team, did you get the help you needed? Worse
- Q30. Did the NHS mental health team give your family or carer support whilst you were in crisis? Worse

Support and Well being

- Q32b. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for finding or keeping work? Worse
- Q32c. In the last 12 months, did your NHS mental health team give you any help or advice with finding support for financial advice or benefits? Somewhat worse

Overall

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- Q12. Did your NHS mental health team treat you with care and compassion? Somewhat worse
- Q38. Overall, in the last 12 months, how was your experience of using the NHS mental health services? Worse

**Response Rate**

**IQVIA initial response rate**

IQVIA delivers the survey alongside 52 other mental health trusts (there are 54 trusts).

The response rate for Kent and Medway NHS and Social Care Partnership Trust Total is 22%.

We achieved a response rate of 22% which is an acceptable rate, being the average response rate.

Most trusts achieved between 20% and 24%:

7 Trusts have a response rate between 25% and 29%

26 Trusts have a response rate between 20% and 24%

18 Trusts have a response rate between 15% and 19%

2 Trusts have a response rate between 10% and 14%

**CQC final response rate**

• 257 Kent and Medway NHS and Social Care Partnership Trust service users responded to the survey

• The response rate for Kent and Medway NHS and Social Care Partnership Trust was 21.05%

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**Appendix 3**

How are we doing?

**TRUSTED ASSESSMENT**

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| We want to hear about your experience of **Trusted Assessment** so we can change anything that isn't working and make it a good experience for everyone.<br><br>Please select one option for each statement |  |
|---|---|
| **1. Based on this meeting, I believe the team member from Mental Health Together understands what I need help with** | |
| **2. I am satisfied that I have been listened to and this is reflected in my Care Plan** | |
| **3. I am satisfied that my Care Plan has been developed with my input** | |
| **4. I am satisfied with how I was able to take part in this session (online or on the phone)** | |
| **5. Overall, how was your experience of the Mental Health Together service?** | |
| **6. What was good about your experience?** | |
| **7. What would make your experience better?** | |

**Thank you for your time and feedback.**

☐ Please tick this box if you do not wish your comments to be published in any reporting of the survey.

**Team:** **Date:**

**Appendix 3**

# How are we doing?

**TRUSTED ASSESSMENT**

NHS
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## About you

**This information will not be used to identify you. We use it monitor whether different people are having different experiences of NHS services. Your answers will be kept confidential and secure. All of the questions should be answered from your point of view.**

### Which of the following best describes your sexual orientation?

- ◯ Heterosexual / Straight
- ◯ Bisexual
- ◯ Gay / Lesbian
- ◯ Prefer not to say

Other orientation, please write in:

### What is your religion?

- ◯ Buddhist
- ◯ Christian
- ◯ Hindu
- ◯ Jewish
- ◯ Muslim
- ◯ Sikh
- ◯ No religion
- ◯ Prefer not to say

Other religion, please write in:

### Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

### If yes, does this reduce your ability to carry out day-to-day activities?

- ◯ Yes, a lot
- ◯ Yes, a little
- ◯ Not at all

### At birth your registered gender was...

- ◯ Male
- ◯ Female
- ◯ Intersex
- ◯ Prefer not to say

### Is your gender the same as the sex you were registered as at birth?

- ◯ Yes
- ◯ Prefer not to say

No, please write your gender below:

### What is your ethnic group?

**a. White**

- ◯ English / Welsh / Scottish / Northern Irish / British
- ◯ Gypsy or Irish Traveller
- ◯ Irish
- ◯ Roma

**b. Mixed / multiple ethnic groups**

- ◯ White and Black Caribbean
- ◯ White and Black African
- ◯ White and Asian

**c. Asian British**

- ◯ Indian
- ◯ Bangladeshi
- ◯ Pakistani
- ◯ Chinese

**d. Black / African / Caribbean / Black British**

- ◯ African
- ◯ Caribbean
- ◯ Arab

Any other ethnic group, please write in:

### How old are you?

- ◯ Under 18
- ◯ 19 - 29
- ◯ 30 - 39
- ◯ 40 - 59
- ◯ 60 - 80
- ◯ 80+

**Thank you for your time and feedback.**

☐ Please tick this box if you do not wish your comments to be published in any reporting of the survey.

**Team:** **Date:**

**Appendix 4**

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## How are we doing?

# DIALOG+

| We want to hear about your experience of **DIALOG+** so we can change anything that isn't working and make it a good experience for everyone.<br><br>Please select one option for each statement | Strongly Agree | Agree | Neither agree or disagree | Disagree | Strongly Disagree | Not applicable/ don't know |
|---|---|---|---|---|---|---|
| **1. I found it easy to find out about Mental Health Together** | ○ | ○ | ○ | ○ | ○ | ○ |
| **2. I found it easy to get help from Mental Health Together** | ○ | ○ | ○ | ○ | ○ | ○ |
| **3. At the meeting to talk about my support needs, I felt the team member from Mental Health Together understood what I need help with** | ○ | ○ | ○ | ○ | ○ | ○ |
| **4. I felt the team member from Mental Health Together was interested in what mattered to me most** | ○ | ○ | ○ | ○ | ○ | ○ |
| **5. I felt that the next steps following my meeting with Mental Health Together were clearly explained to me** | ○ | ○ | ○ | ○ | ○ | ○ |
| **6. I am satisfied with how I was able to take part in this session (online or on the phone)** | ○ | ○ | ○ | ○ | ○ | ○ |
| **7. I felt listened to, heard and was able to tell my story and what was important to me** | ○ | ○ | ○ | ○ | ○ | ○ |
| **8. Overall, how was your experience of the Mental Health Together service?** | Very good | Good | Neither good or poor | Poor | Very poor | Perfer not to say |
| **9. If you have used mental health services before, how does this time compare to your last experience?** | Much worse | Worse | Same | Better | Much better | Not applicable |

| **10. What was good about your experience?** | **11. What would make your experience better?** |
|---|---|
| | |

**Thank you for your time and feedback.**

☐ Please tick this box if you do not wish your comments to be published in any reporting of the survey.

**Team:** **Date:**

Kent and Medway NHS and Social Care Partnership Trust

**Appendix 4**

# How are we doing? DIALOG+

## About you

**This information will not be used to identify you. We use it monitor whether different people are having different experiences of NHS services. Your answers will be kept confidential and secure. All of the questions should be answered from your point of view.**

### Which of the following best describes your sexual orientation?

- ◯ Heterosexual / Straight
- ◯ Bisexual
- ◯ Gay / Lesbian
- ◯ Prefer not to say

Other orientation, please write in:

### What is your religion?

- ◯ Buddhist ◯ Christian
- ◯ Hindu ◯ Jewish
- ◯ Muslim ◯ Sikh
- ◯ No religion
- ◯ Prefer not to say

Other religion, please write in:

### Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?

- ◯ Yes ◯ No
- ◯ Prefer not to say

### If yes, does this reduce your ability to carry out day-to-day activities?

- ◯ Yes, a lot ◯ Yes, a little
- ◯ Not at all

### At birth your registered gender was...

- ◯ Male ◯ Female
- ◯ Intersex ◯ Prefer not to say

### Is your gender the same as the sex you were registered as at birth?

- ◯ Yes ◯ Prefer not to say

No, please write your gender below:

### What is your ethnic group?

**a. White**

- ◯ English / Welsh / Scottish / Northern Irish / British
- ◯ Gypsy or Irish Traveller
- ◯ Irish ◯ Roma

**b. Mixed / multiple ethnic groups**

- ◯ White and Black Caribbean
- ◯ White and Black African
- ◯ White and Asian

**c. Asian British**

- ◯ Indian ◯ Bangladeshi
- ◯ Pakistani ◯ Chinese

**d. Black / African / Caribbean / Black British**

- ◯ African ◯ Caribbean
- ◯ Arab

Any other ethnic group, please write in:

### How old are you?

- ◯ Under 18 ◯ 19 - 29
- ◯ 30 - 39 ◯ 40 - 59
- ◯ 60 - 80 ◯ 80+

**Thank you for your time and feedback.**

☐ Please tick this box if you do not wish your comments to be published in any reporting of the survey.

**Team:** **Date:**

NHS
Kent and Medway
NHS and Social Care Partnership Trust

# TRUST BOARD MEETING - PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Safer Staffing – MHOST Annual Establishment Review |
| **Author:** | Portia Aveling, Interim Deputy Director of Nursing and Practice |
| **Executive Director:** | Andy Cruickshank, Chief Nurse |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Committee:** | Regulatory Requirement |

## Overview of Paper

The aim of the paper is to provide a summary of the annual establishment review for all KMPT's Acute inpatient wards, forensic and specialist wards and community inpatient rehabilitation services. The review aims to support skill mixing, workforce planning and demonstrate any initiatives supporting safer staffing as well as meeting statutory requirements.

## Issues to bring to the Board's attention

The Mental Health Optimal Staffing Tool (MHOST) data collection occurred between 8th and 28th January 2024.

Some data accuracy concerns were identified which have highlighted the need for greater familiarity and fidelity with the use of MHOST. The process will be more regular through 24/25 once some additional training and systems work and training is complete.

Interpretation of Results:

The overall staffing picture is safe with continued improvements in key areas of missing charge cover (number of registrants on duty), and additional duties (covering observations and/or unplanned absence) through the roster review process. There are areas that require improvement to support consistency and efficiency but these do not pose safety concerns. These are:

1) Inpatient rehabilitation units and some older adult wards that are standalone geographically, are challenged with acuity and ensuring staffing is safe. New Ruby ward will resolve this for one older adult ward. It also creates opportunities for the Directorates to work differently to ensure a more efficient and patient focussed team-based way of working across hospital sites – which will need to consider patterns of activity such as patient leave, group activities and ways of working with distress and risk that are not wholly reliant on observations.

2) Clinically ready for discharge patients and wards functioning below optimal bed occupancy impact acuity and efficiency. This is anomalous in the current climate of high demand for beds but is better understood when the swing in demand for male or female beds is taken into account over the data collection period.
3) The current staffing model includes the changed shift pattern and roster reviews. Further work is needed to improve the organisations understanding of safer staffing and the rigour of local reviews of staffing demand and patterns of work in teams.

Please note that all detailed data is available on request.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Patient Safety: High numbers of vacancies and use of temporary staff can impact on patient care and safety. |
| **Assurance:** | Reasonable |
| **Oversight:** | Workforce and Organisational Development/Board |

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**Background and context:**

The annual inpatient establishment review is a statutory responsibility for the Chief Nursing Officer to complete on behalf of the Board. The review must comply with requirements set within the National Quality Board report (NQB) (2016) and updated (2018); Supporting NHS providers to deliver right staff, with the right skills in the right place at the right time.

Demonstrating sufficient staffing is one of the fundamental quality and safety standards required to comply with the Care Quality Commission (CQC) regulation. CQC Regulation 18; "To meet the regulation, providers must provide sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of the people using the service at all times".

Findings of the Independent review of Greater Manchester Mental Health NHS Foundation Trust identified workforce challenges as an area of learning linked to planning and managing risk. Low staffing particularly for nursing and support for newly qualified nurses were found to be significant areas of concern that Trusts should consider.

This MHOST establishment review collected data over a 21-day period from 8th January to 28th January 2024.

The review has fully considered multi professional contributions to inpatient care settings across all the directorates with exclusions for social workers, administration and matrons.

## 1. Methodology and data collection

The development of the MHOST was commissioned and funded by Health Education England (HEE). The tool is applicable in the following settings: Working age adult admissions wards; old age functional and dementia ward; forensic (High and Medium secure) wards; Perinatal Mother and Baby Units and Low Secure and Rehabilitation wards.

The collection of the data was supervised by the ward manager and matron of each unit/ward. Wards were provided with the guidance and the data collection tool. The Heads of Nursing and Quality along with the Matrons monitored application of the tool and the collection of the data.

The guidance set out the criteria for acuity levels 1-5 specifically designated for their service, with 1 being the lowest level of dependency and 5 the highest. The staff could use professional judgment in deciding the most appropriate level of acuity. Staff collecting acuity and dependency data must have had an insight into the patient's current care needs and clinical presentation within the last 24 hours and not just how the patient presented at the point of collection at 3pm.

Data was collected over a period of 21 days from 8th January to 28th January 2024. The MHOST was moved from December to January as the 2022 audit data was impacted by the festive period. Patients on extended leave more than 4 hours were not included. If they were on overnight leave, they were discounted. Long periods of escorted leave are already included in MHOST tool, they were not added separately.

The MHOST required that Full Time Equivalents (FTE) hours worked by substantive staff, NHSP and agency were included. Two sets of staffing data were used in the analysis and were supplied by Finance department and Eroster for the January 2024 period. This is the second time the Eroster data was used to look at the hours confirmed as being work on the wards through the roster as well as the finance actual worked hours. The use of the two data sets enables a more accurate picture and cross-

referencing role for inclusion or exclusion. This data excluded roster information for Covid-19 isolations, maternity leave and career breaks as this skews results. Absences such as annual leave and study leave are accounted for in the headroom which is used in the MHOST tool. Administrative and senior managerial roles such as matrons, ward administrators, service managers and related apprentices were excluded.

The headroom in the Trust varies, in Acute Care Group is 23% and the other are groups have 21%. The recommended headroom in the MHOST tool is not less than 22%. As the Trust moves to more frailty and needs led wards the headroom percentage will need to be reconsidered.

The Ready for Action (RfA) time is the percentage of time allocated to a staff member for their breaks. Time is set in the MHOST for the particular ward type, ranges between 8.6%-9.1% depending on the type of ward being analysed. This has been set at 8.3% for this review however this may need to be reconsidered as the long day shift patterns embed.

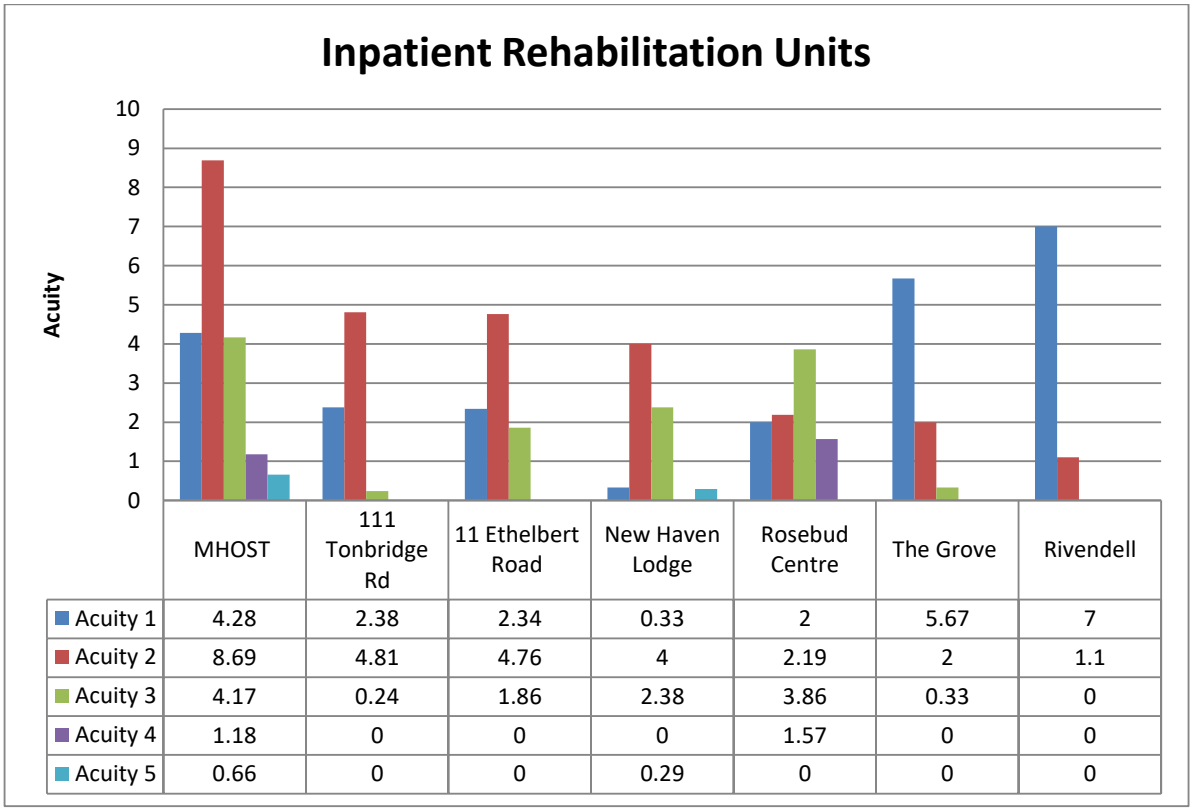
## 2. Results:

The results were collected in specialism or directorate and benchmarked against the corresponding MHOST specialist service.

## 3. Community Directorates Inpatient Rehabilitation Units

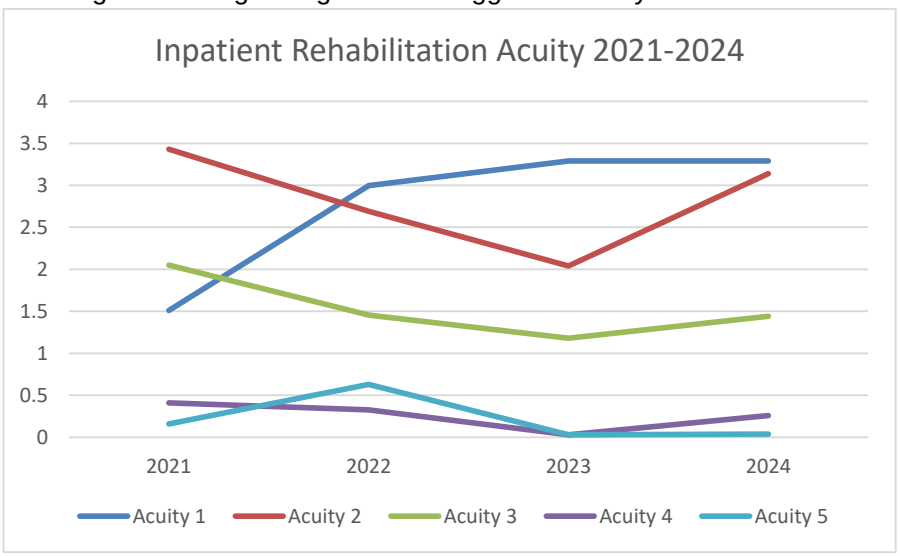
There is mixed support around the validity of the MHOST being used for inpatient rehabilitation units such as those that operate within KMPT. However, this is were the importance of using professional judgement and other data to review alongside the MHOST. In was noted during the collection period that there were no reported COVID or infection outbreaks or Inphase reports recorded linked to insufficient staffing.

Lower occupancy in these units has the effect of increasing the Care Hours Per Patient Day (CHPPD) but this can result in the establishments appearing inefficient. This can be good for patient experience but costly in relative terms. The requirements to meet safer staffing levels and safe acuity levels mean that there is not much room to flex staffing to accommodate this variation in need. The pace of discharge is slower, the units are standalone and the remote geographical areas impacts the ability to have higher acuity patients. Therefore, KMPT's units appear over staffed and costly. This will likely be a continued MHOST reporting pattern unless the rehabilitation delivery model changes.




| | MHOST | 111 Tonbridge Rd | 11 Ethelbert Road | New Haven Lodge | Rosebud Centre | The Grove | Rivendell |
|---|---|---|---|---|---|---|---|
| Acuity 1 | 4.28 | 2.38 | 2.34 | 0.33 | 2 | 5.67 | 7 |
| Acuity 2 | 8.69 | 4.81 | 4.76 | 4 | 2.19 | 2 | 1.1 |
| Acuity 3 | 4.17 | 0.24 | 1.86 | 2.38 | 3.86 | 0.33 | 0 |
| Acuity 4 | 1.18 | 0 | 0 | 0 | 1.57 | 0 | 0 |
| Acuity 5 | 0.66 | 0 | 0 | 0.29 | 0 | 0 | 0 |

All 6 inpatient rehabilitation units have reported lower acuity for the for the application of the tool in comparison to benchmark wards. Previous reports have identified contributing factors as delayed transfers of care (DTOC) now known as clinically ready for discharge (CRFD) along with the units running with vacant beds. However, on this analysis, low bed occupancy appears to be the biggest contributor to the lower acuity and this therefore increases the care hours per patient day (CHPPD). Rivendell reported all 7 patients at acuity level 1 which would be reflective of patients nearing discharge but also goes against the suggested acuity for rehabilitation units.




The standalone style of these units means that they cannot vary staffing to reflect a reduction of occupancy or acuity due safety requirements. It however notable, that the staffing is lower in terms

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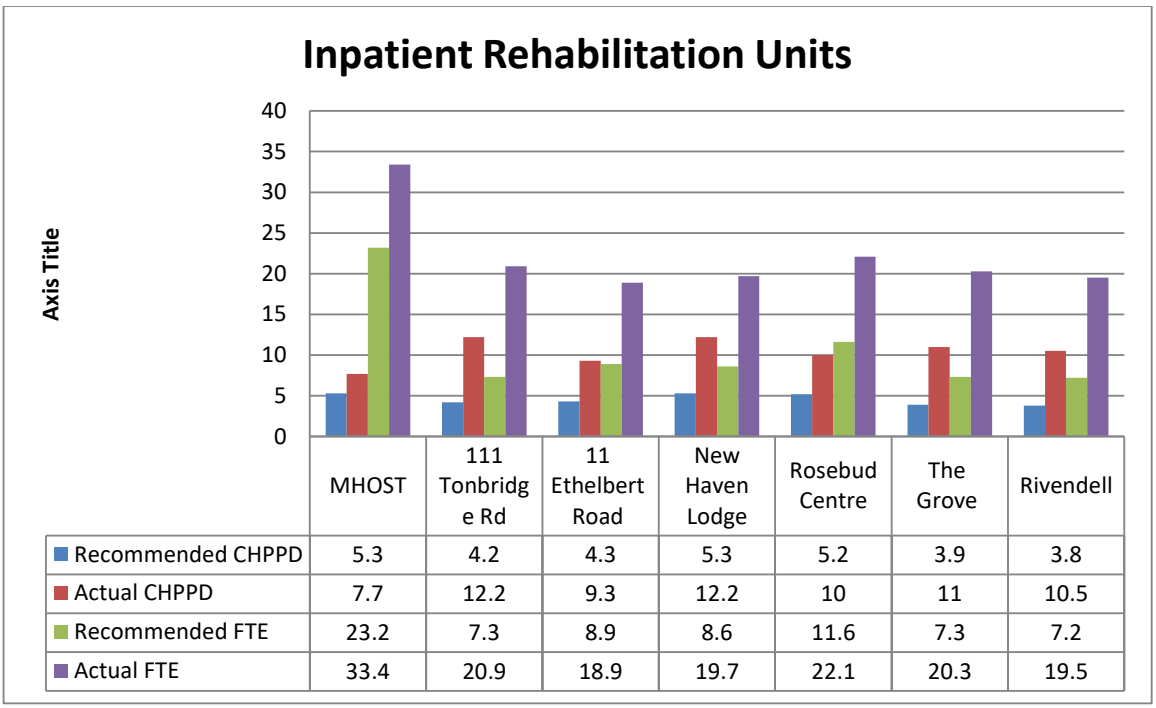
of FTE for these units. This suggests that the nature of the model is the issue here with lower acuity and underoccupancy being the primary factors.




| | MHOST | 111 Tonbridge Rd | 11 Ethelbert Road | New Haven Lodge | Rosebud Centre | The Grove | Rivendell |
|---|---|---|---|---|---|---|---|
| Recommended CHPPD | 5.3 | 4.2 | 4.3 | 5.3 | 5.2 | 3.9 | 3.8 |
| Actual CHPPD | 7.7 | 12.2 | 9.3 | 12.2 | 10 | 11 | 10.5 |
| Recommended FTE | 23.2 | 7.3 | 8.9 | 8.6 | 11.6 | 7.3 | 7.2 |
| Actual FTE | 33.4 | 20.9 | 18.9 | 19.7 | 22.1 | 20.3 | 19.5 |

**4. Forensics and Specialist Directorate:**

The forensic and specialist directorate (FSD) services are mapped against their identified MHOST with the exception of Bridge House. Bridge House is a substance misuse rehabilitation specialist unit which is a setting the MHOST is not validated for. During the MHOST collection period there was one reported COVID outbreak on Walmer Ward resulting in the ward closure and one InPhase recorded for Emmetts Ward in relation to insufficient numbers of healthcare professionals. This obviously impacts the results of data collection for those teams.

Data accuracy issues were identified within the FSD collection as patients on extended leave were recorded under acuity 1. Where possible these were amended.

**Rosewood Mother and Baby Unit (MBU)**

Mother and Baby Unit staffing levels are predetermined by Royal College of Psychiatry: Service Standards for Mother and Baby Units (2014) and NHSE/I. The multi-disciplinary team (MDT) staffing levels are not varied according to acuity, as they are set standards and include specialist roles. Other needs such as enhanced observations are met by increased staffing levels. Rosewood is operating within this guidance. During the data collection period the MBU did not record any covid or infection outbreaks requiring ward closure and there were no InPhase reports linked to insufficient staffing. However, the unit didn't run at full bed occupancy with an average bed occupancy of 5 out of 8 beds occupied. This will impact acuity and CHPPD figures when comparing with the MHOST averages.

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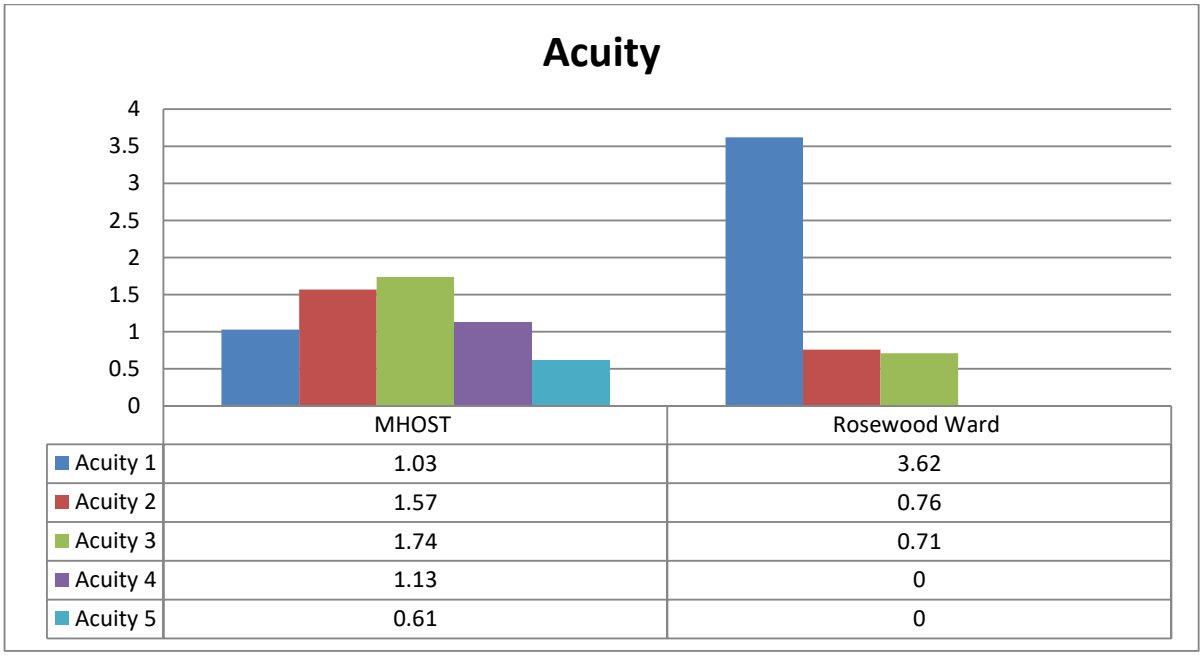
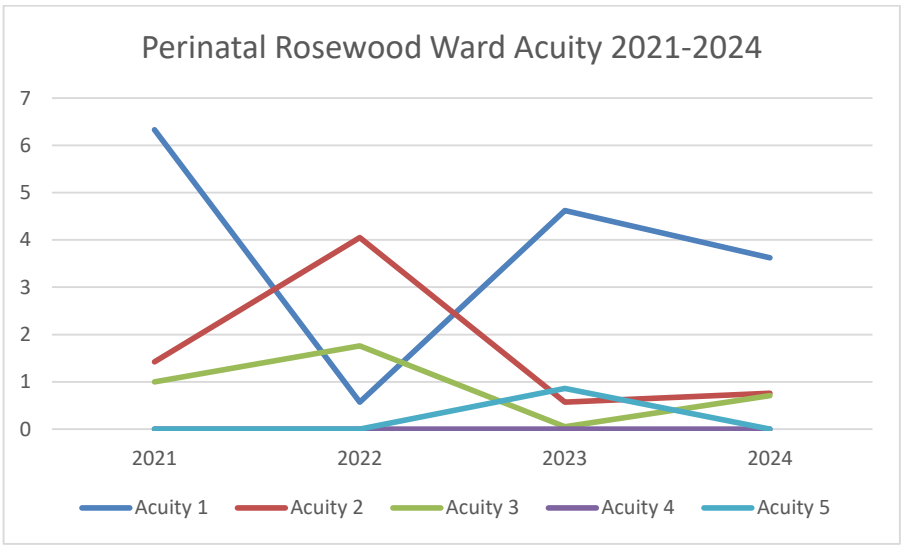



| | MHOST | Rosewood Ward |
|---|---|---|
| Acuity 1 | 1.03 | 3.62 |
| Acuity 2 | 1.57 | 0.76 |
| Acuity 3 | 1.74 | 0.71 |
| Acuity 4 | 1.13 | 0 |
| Acuity 5 | 0.61 | 0 |

Acuity continues to remain slightly lower that the MHOST wards with no Acuity 4 or 5 listed. This is consistent with previous MHOST reports with only 1 Acuity 5 mother being recorded for the first time in December 2022. Most patients were recorded as acuity 1, with no recorded level 4 patients. It is important to consider that although the mother may be recorded at acuity 1 the babies may require more intense support and resource.




Rosewood FTE and CHPPD figures are consistent with the previous MHOST results and continue to run higher than the recommended figures although this MHOST are more inline than last year's FTE calculations. This higher running pattern is seen in the benchmarking wards and is reflective of how the care for the mother and the baby are individually assessed with staff increasing as required to support the baby's needs. This often results in the service being perceived as expensive, however there may be opportunities to look at staff being utilised differently or using short notice annual leave options when the unit is running under occupancy. Some initiatives are already in place with the team to find some workable solutions to this.

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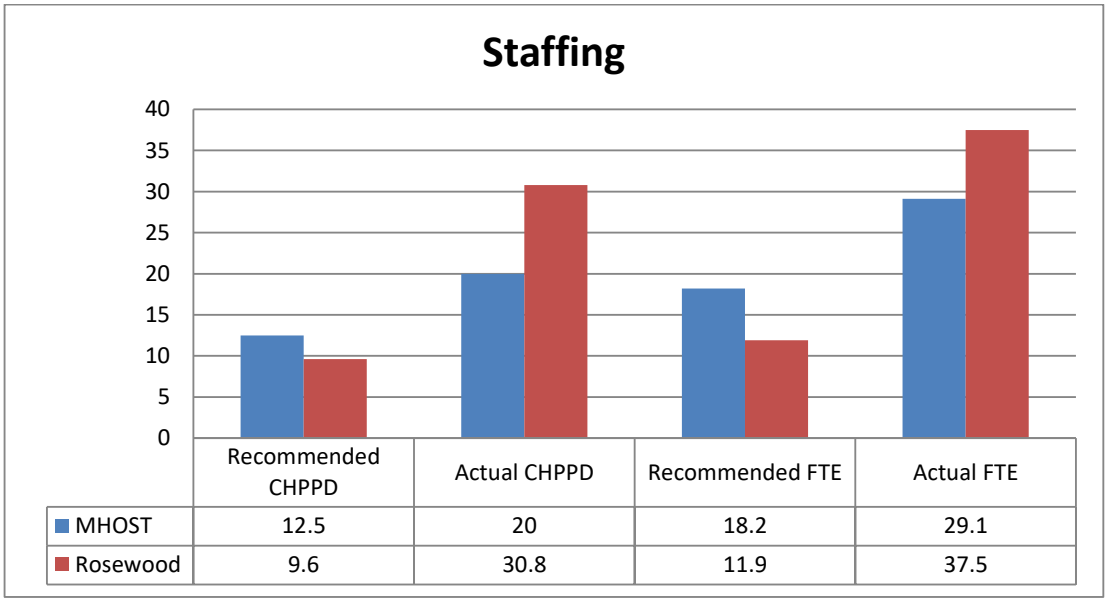
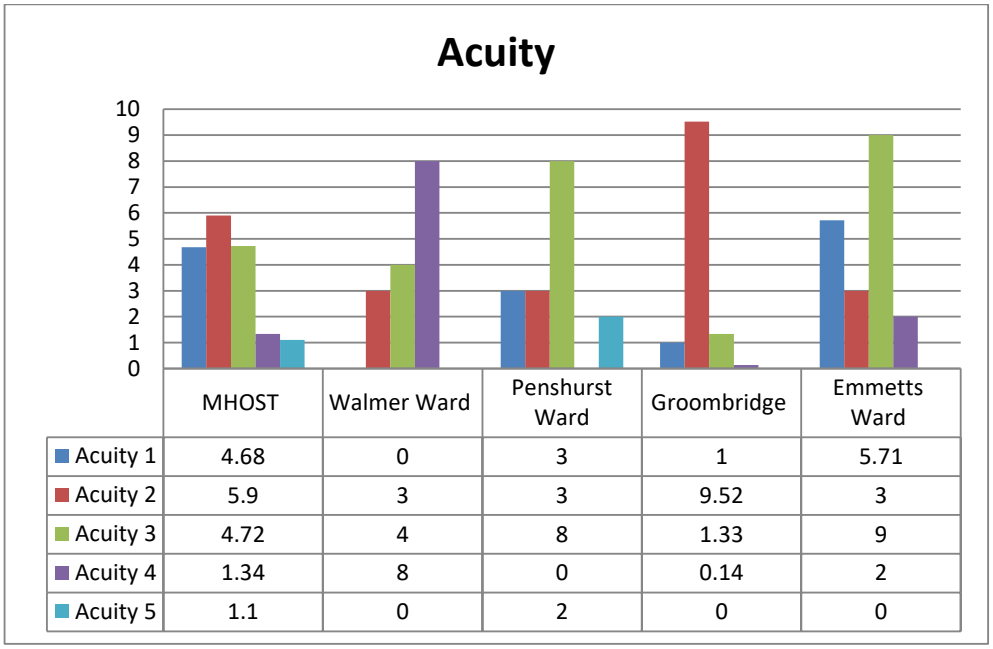


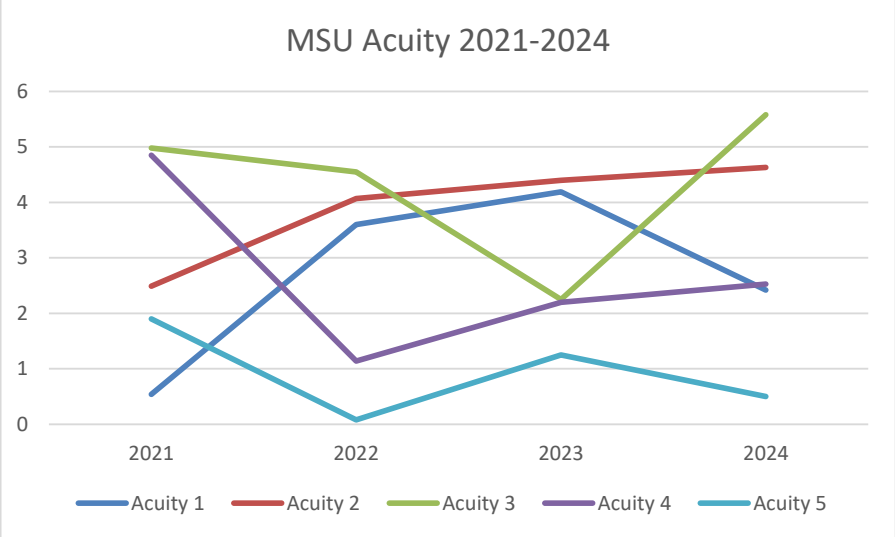

**Medium Secure Unit (MSU)**

KMPT's medium secure wards host patients under Ministry and Justice restrictions which by their nature means that the pace of progress is cautious before patients can move on or be discharged. Often this results in longer term inpatient stays, that could be seen in with the recording of low or repetitive acuity scores. During the data analysis for these wards it was noted that Walmer had a COVID outbreak, patients had been included when on leave and one InPhase was recorded for Emmetts ward related to insufficient numbers of healthcare professionals.

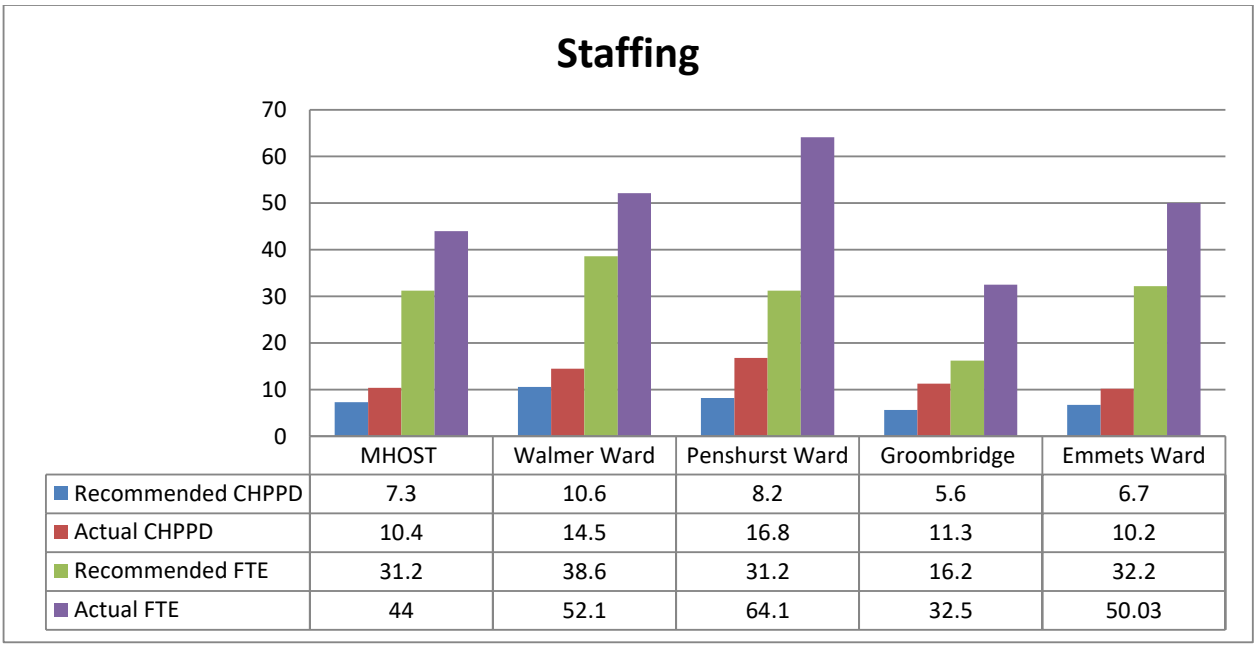



The acuity in the MSU did not follow previous or expected trends with only Penhurst having acuity 5 patients. This results in the overall higher patient acuity levels (4&5) coming down whilst the number of acuity 3 patients have increased. This is not the expected acuity pattern for these types

of ward when comparing to the MHOST benchmark wards and is an area for the directorate to review as this will impact the CHPPD and FTE recommendations.




The MSU wards are awaiting refurbishment or maintenance updates which were highlighted in the annual ligature audit. This means professional judgement around staff staffing and admissions is essential to mitigate against the environmental challenges. The recommended and actual CHPPD hours are more consistent with MHOST benchmark wards expectations although due to the lower acuity there is a bigger gap between the recommended and actual CHPPD. This is particular notable for Penshurst and is link to having no acuity 4 patients recorded.




| | MHOST | Walmer Ward | Penshurst Ward | Groombridge | Emmets Ward |
|---|---|---|---|---|---|
| Recommended CHPPD | 7.3 | 10.6 | 8.2 | 5.6 | 6.7 |
| Actual CHPPD | 10.4 | 14.5 | 16.8 | 11.3 | 10.2 |
| Recommended FTE | 31.2 | 38.6 | 31.2 | 16.2 | 32.2 |
| Actual FTE | 44 | 52.1 | 64.1 | 32.5 | 50.03 |

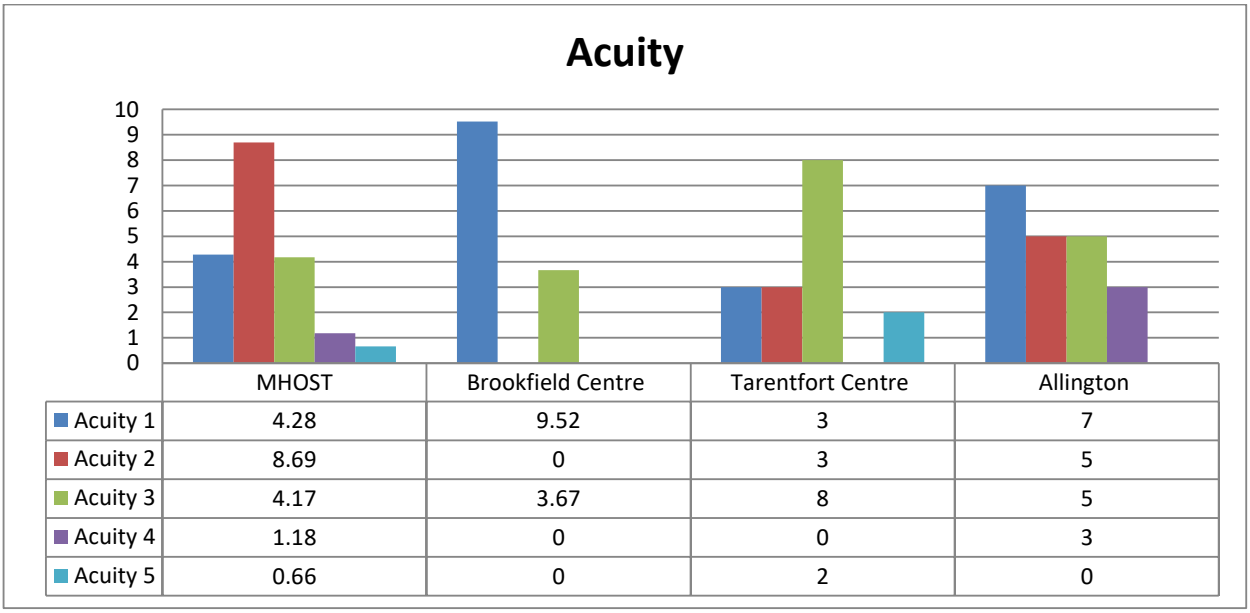
Previous MHOST reports identified the actual FTE for KMPT's MSU have been significantly high and an outlier. Although the data demonstrates an expected gap between the recommended and actual FTE, the MSU FTE gaps are significantly more that the recommended gap of no more than 10.8, with Penshurst (32.9) Groombridge (16.3) and Emmets (17.83). Emmet's ward is more

significant as during the MHOST collection period they recorded an actual FTE of 50.03, included leave patients in the acuity and recording an InPhase for insufficient numbers of healthcare professionals. This would indicate a deeper dive around roster management for this ward is required.

The Directorate meet daily to look at staffing resources and re-allocate staff based on the acuity along with the actual FTE on the day. This supports a more fluid approach to establishments but may not be picked up through the MHOST as this is unlikely to be recorded on KMPT's digital systems. In addition to this, the wards have a number of other roles assigned to them including social workers (not included in this MHOST), AHP, medics and psychology which are partially included in the calculations as MHOST recommends. However, these staff members may not be on the wards for the actual hours booked for each ward as they are not necessarily based on the ward. Therefore, this could be an opportunity for the daily staffing huddles to consider an MDT approach manage the acuity demand and redistribution of resource.

**Forensic Rehabilitation: Low Secure Units**

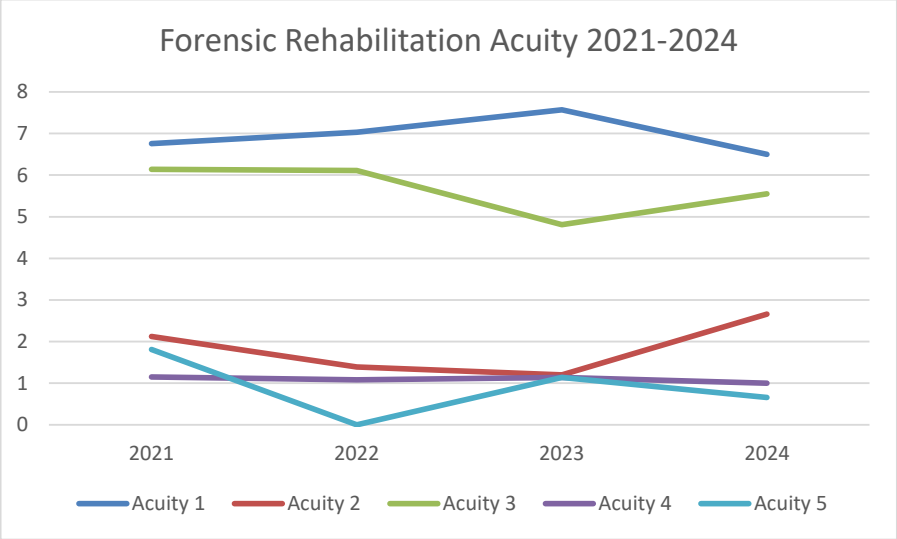
Similarly, to the MSU patient demographics LSU often support long term patients that have higher staff to ratio requirements and therefore the patients need specialist placements to support discharge that are challenging to find. During the MHOST collection period Tarentfort had individuals with commissioned extra care packages, which included increased staff to patient ratios. This impacts the FTE and CHPPD so is taken in to consideration in the reporting. The LSU didn't have any COVID or infection outbreaks or staff related InPhase reports recorded during the data period.




| | MHOST | Brookfield Centre | Tarentfort Centre | Allington |
|---|---|---|---|---|
| Acuity 1 | 4.28 | 9.52 | 3 | 7 |
| Acuity 2 | 8.69 | 0 | 3 | 5 |
| Acuity 3 | 4.17 | 3.67 | 8 | 5 |
| Acuity 4 | 1.18 | 0 | 0 | 3 |
| Acuity 5 | 0.66 | 0 | 2 | 0 |

The LSU wards have reported lower acuity than the MHOST recommended average with Brookfield and Allington as both have higher Acuity 1 levels than expected. For Brookfield this is the third MHOST report of low acuity with a higher number of acuity 1 patient levels although overall their acuity has increased slightly with more acuity 3 patients. Tarentfort's acuity 3 and 5 is slightly above the MHOST benchmark wards for the second MHOST. This is linked by a number of patients on 2:1 nursing care or extra care packages. The patients on extra care packages are considered

to be admitted outside the normal recommended service criteria and require specialist placements of which there is a National shortage. This was also identified in the previous two MHOST reports as a concern along with the challenges this presents when delivering safe quality care for all patients.




The LSU have consistently remained above the above the recommended FTE which is in line with the MHOST benchmarking pattern but the difference between the recommended and actual is significantly more than expected. The directorate has previously been impacted by admitting patients that are not within normal service criteria and require increased staffing support that impact FTE and CHPPD results. This level or type of care delivery may not be fully represented in the MHOST benchmarking wards and needs to be considered when reviewing the data. Tarentfort in particular is impacted as the actual FTE is 125.3 including all the additional commissioned extra care hours. If the extra care package staff are removed this figure reduces to would be 61.5 and is more inline, however the MHOST requires all substantive and temporary/additional staff to be counted within the process.

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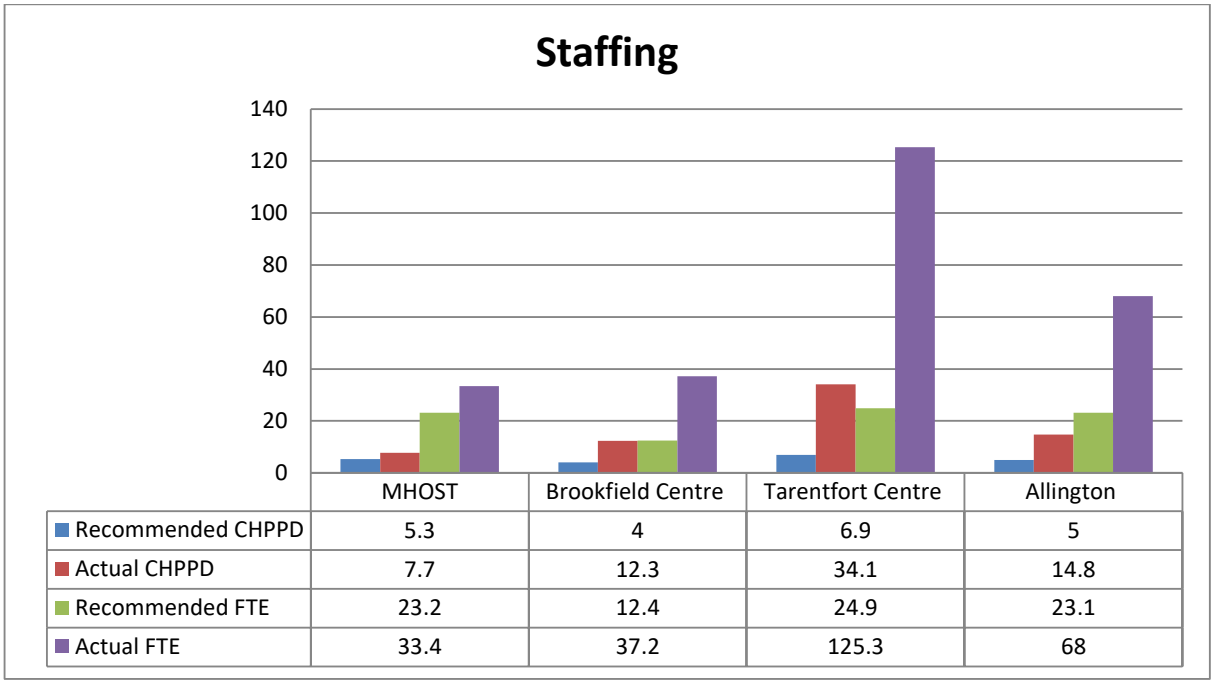


| | MHOST | Brookfield Centre | Tarentfort Centre | Allington |
|---|---|---|---|---|
| Recommended CHPPD | 5.3 | 4 | 6.9 | 5 |
| Actual CHPPD | 7.7 | 12.3 | 34.1 | 14.8 |
| Recommended FTE | 23.2 | 12.4 | 24.9 | 23.1 |
| Actual FTE | 33.4 | 37.2 | 125.3 | 68 |

**5. Acute Directorate:**

Historically the Acute Directorate only included younger adult wards with older adult wards aligned to another care group. All older adult and younger adult acute wards are under the Acute directorate but with the MHOST criteria applied they will continue to be reviewed separately against the relevant tool. The Willow Suite continues have the Psychiatric Intensive Care Unit tool applied. This will be reviewed for future MHOST collections as the wards move to needs led admission criteria which will include a frailty pathway.

There were no COVID or infection covid outbreaks, one ward was decanted with a reduced bed occupancy, three InPhase reports recorded insufficient numbers of healthcare professional and one ward's gender was changed for the MHOST period. At the time of the MHOST there were between 50 to 55 clinically fit for discharge, 11 patients placed in out of area PICU beds and 18 patients on the PICU Liaison caseload. This is also the first MHOST when the wards all provided single sex accommodation.

**Older Adult Wards**

Since the last MHOST the Older adult wards have evolved in the following areas admission criteria, single sex or gender wards, provide mixed models of care with organic and non-organic patient needs and have individual risk concerns linked to the estate. There were no covid outbreaks and Heather reported one InPhase for Insufficient numbers of healthcare professionals during the MHOST period.

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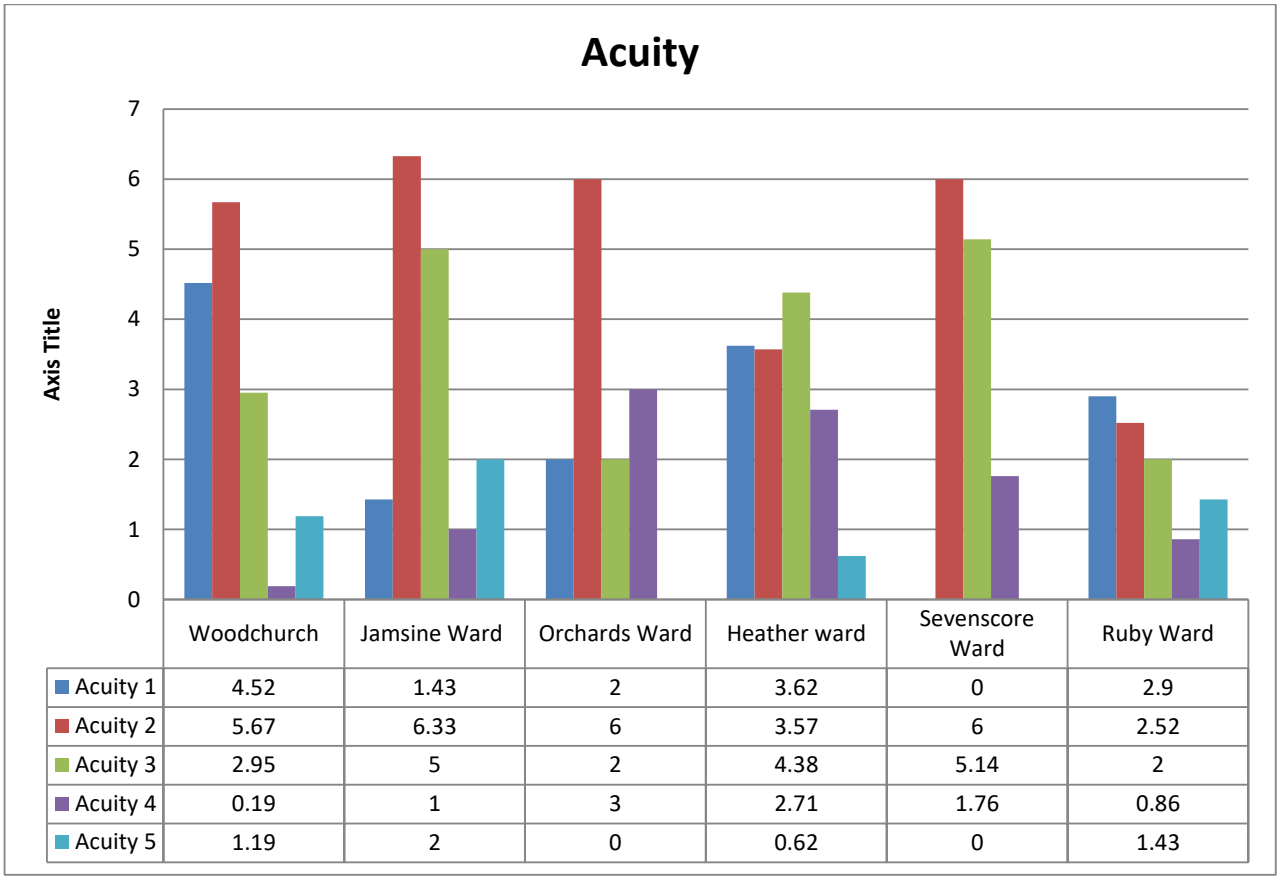
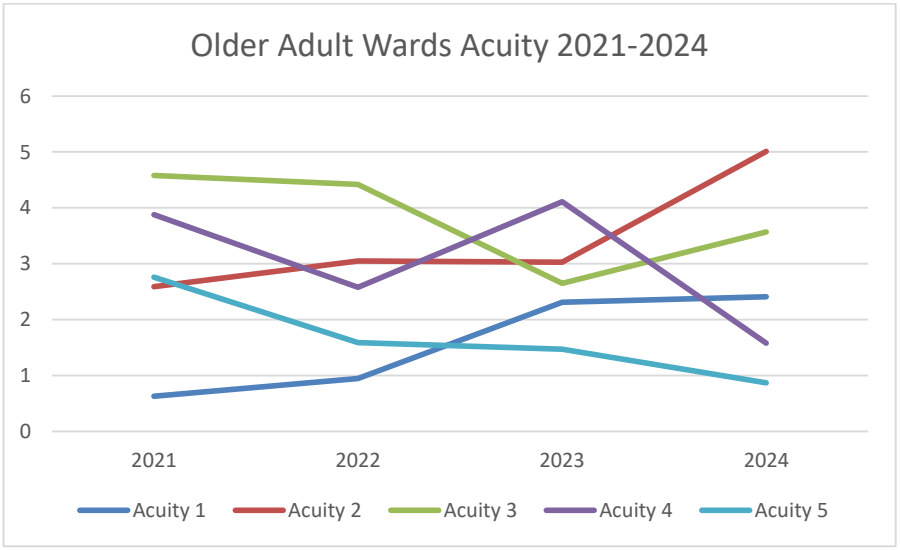



| | Woodchurch | Jamsine Ward | Orchards Ward | Heather ward | Sevenscore Ward | Ruby Ward |
|---|---|---|---|---|---|---|
| Acuity 1 | 4.52 | 1.43 | 2 | 3.62 | 0 | 2.9 |
| Acuity 2 | 5.67 | 6.33 | 6 | 3.57 | 6 | 2.52 |
| Acuity 3 | 2.95 | 5 | 2 | 4.38 | 5.14 | 2 |
| Acuity 4 | 0.19 | 1 | 3 | 2.71 | 1.76 | 0.86 |
| Acuity 5 | 1.19 | 2 | 0 | 0.62 | 0 | 1.43 |

Professional judgement is required alongside the MHOST as Sevenscore and Woodchurch have a number of ligature risks identified by the annual ligature audit that will be addressed through the Trust Capital prioritisation process and the interim introduction of ligature free rooms. Jasmine ward sits as a standalone unit with no neighbouring mental health support. Ruby ward decanted from Medway Maritime Hospital and into Littlestone with reduced bed occupancy whilst the 'new Ruby ward' build was completed. Each of these wards' admission criteria reflects the environmental and patient safety risks resulting in lower acuity or bed occupancy results. Despite this, all wards continue to sit above the MHOST bench marking with more acuity 3 and above patients recorded.

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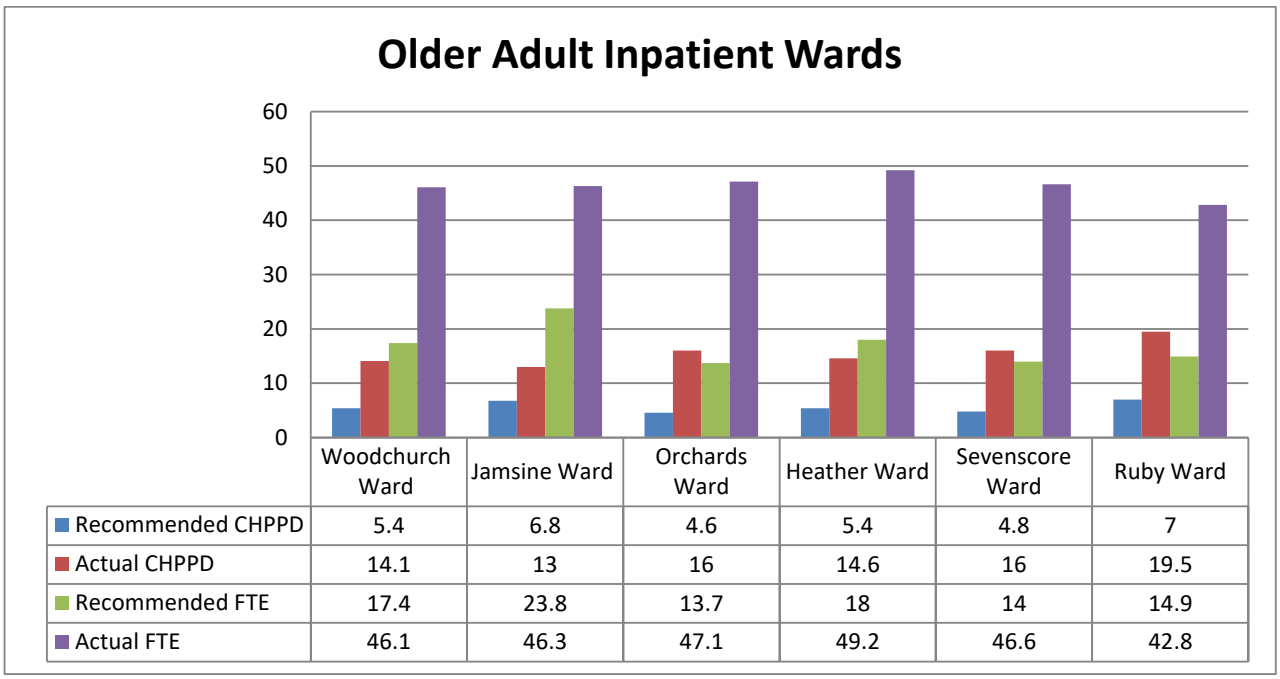
The directorate continues to be affected by Clinically ready for discharge patients for the fourth consecutive MHOST report. These patients are ready for discharge but awaiting appropriate placement or care packages. However, their acuity varies due to the complexity of the physical and mental illnesses related to old age.




| | Woodchurch Ward | Jamsine Ward | Orchards Ward | Heather Ward | Sevenscore Ward | Ruby Ward |
|---|---|---|---|---|---|---|
| Recommended CHPPD | 5.4 | 6.8 | 4.6 | 5.4 | 4.8 | 7 |
| Actual CHPPD | 14.1 | 13 | 16 | 14.6 | 16 | 19.5 |
| Recommended FTE | 17.4 | 23.8 | 13.7 | 18 | 14 | 14.9 |
| Actual FTE | 46.1 | 46.3 | 47.1 | 49.2 | 46.6 | 42.8 |

The recommended FTE for the wards, except for Jasmine and Heather, sit below the MHOST benchmark which reflects the reduced bed occupancy and admission criteria. This is also reflected in the CHPPD. It is worth highlighting that Jasmine despite being a standalone unit with a restricted admission criterion continues to sit above the other wards and MHOST benchmarking which indicates they are taking patients that are not suitable for the environment. Similarly, to the MHOST benchmarking pattern, the actual FTE for all wards is higher than recommended and the gap between actual and recommended aligns. This is reflective of the physical and mental health complexities of the older or frail patient.

**Psychiatric Intensive Care Unit (PICU): Willow Suite**

Willow Suite is the male only PICU ward however for the first two annual MHOST data collections the ward had out of scope admissions requiring extra care packages with higher nursing ratios and a temporary bed reduction to support this. This needs to be considered when comparing annual data sets. Female PICU is sourced outside of KMPT bed stock. At the time of the MHOST data collection there were 11 patients in out of area PICU's beds and 18 patients on the PICU Liaison caseload. There were no COVID or infection outbreaks, no InPhase reports for insufficient healthcare staff or any other notable areas that would impact acuity or staffing levels.

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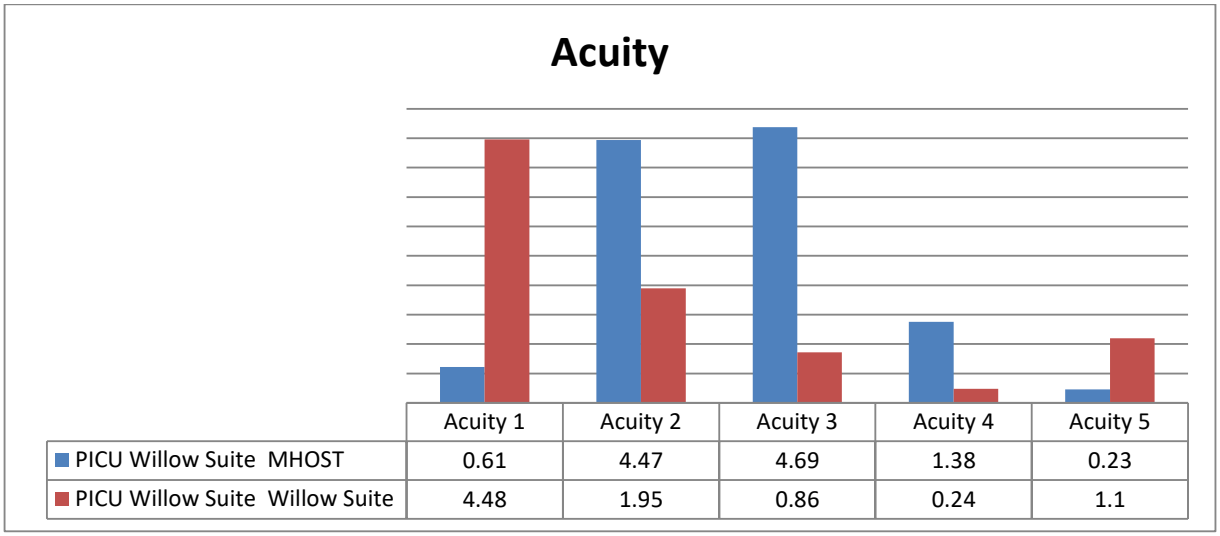
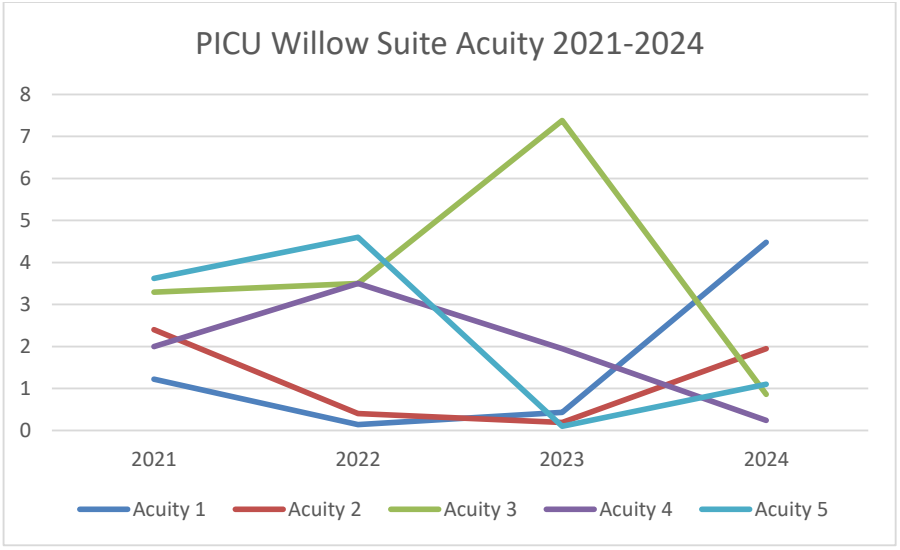



| | Acuity 1 | Acuity 2 | Acuity 3 | Acuity 4 | Acuity 5 |
|---|---|---|---|---|---|
| PICU Willow Suite MHOST | 0.61 | 4.47 | 4.69 | 1.38 | 0.23 |
| PICU Willow Suite Willow Suite | 4.48 | 1.95 | 0.86 | 0.24 | 1.1 |

Willow Suite operated under bed occupancy throughout the MHOST period with the exception of 1 day. The lowest bed occupancy of 7 or 8 was recorded for 16 of the 21 days. This will impact the overall acuity and staffing data as not operating at an optimum capacity level. This can be seen when comparing the MHOST averages with Willow's acuity which is lower than expected. When comparing Willows MHOST data year on year the overall acuity level has reduced.




Willow suite's actual CHPPD and FTE run above the MHOST benchmarking expectation and reflects the acuity and bed occupancy position. This can also be seen in the gap between actual and recommended for CHPPD and FTE. The recommended FTE sits at 58.9 (MHOST 46.6) with the recommended being at 16.1 (MHOST 28.9). A PICU ward requires a minimal level of staffing to provide a safe environment for patients and staff with the ability to adjust to unpredictable demand. However, reviewing the MHOST data from all annual reviews, it suggests an opportunity to review how different disciplines support the care on the wards across the site.

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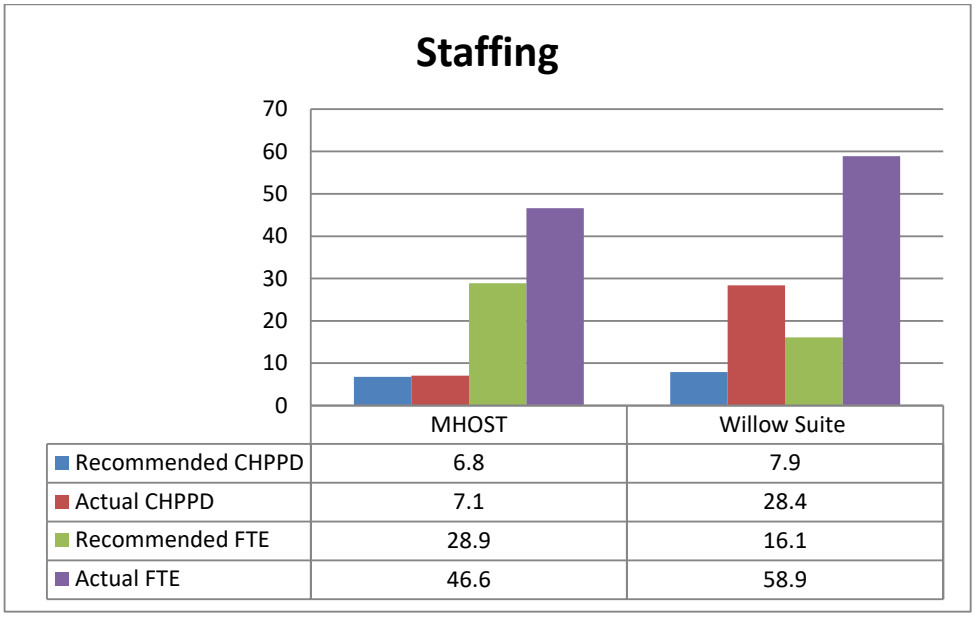
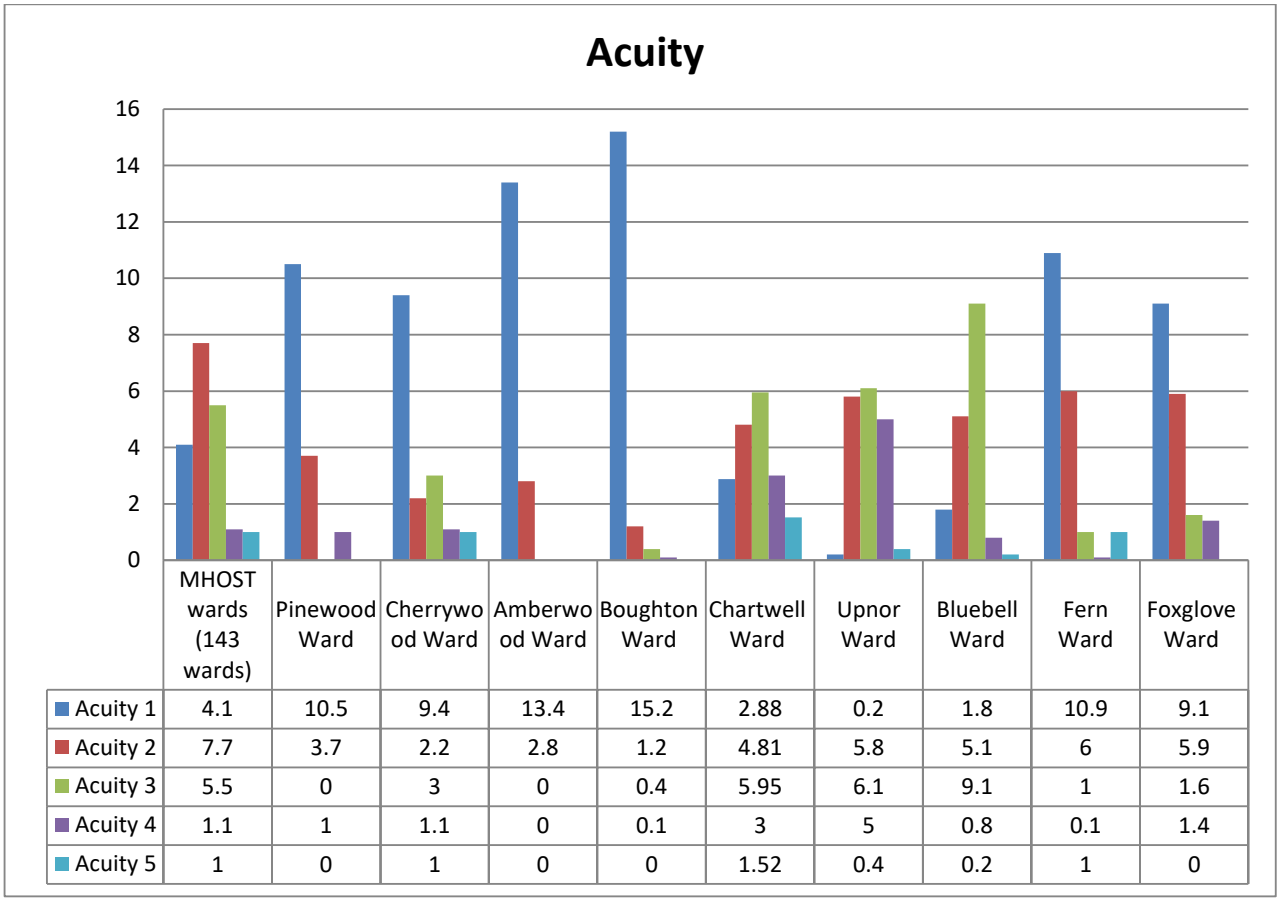



| | MHOST | Willow Suite |
|---|---|---|
| Recommended CHPPD | 6.8 | 7.9 |
| Actual CHPPD | 7.1 | 28.4 |
| Recommended FTE | 28.9 | 16.1 |
| Actual FTE | 46.6 | 58.9 |

**Acute (Younger adult) wards**

During the MHOST collection period Chartwell was changed from having female to male patients, the impact of this resulted in the ward operating at below bed occupancy for 10 days. There were no reported COVID or infection outbreaks and two InPhase reports were recorded for Insufficient numbers of healthcare professionals on Boughton Ward. Several data accuracy queries were identified around cutting and pasting with errors duplicated, no movement in patient's acuity, and incorrect acuity recording for leave patients or patients requiring 2 to 1 care or rapid tranquilization. This would suggest potential bias for under and over scoring on patient acuity was identified and this has been corrected with learning around quality checking identified for future MHOST data collections.

Version control: 1

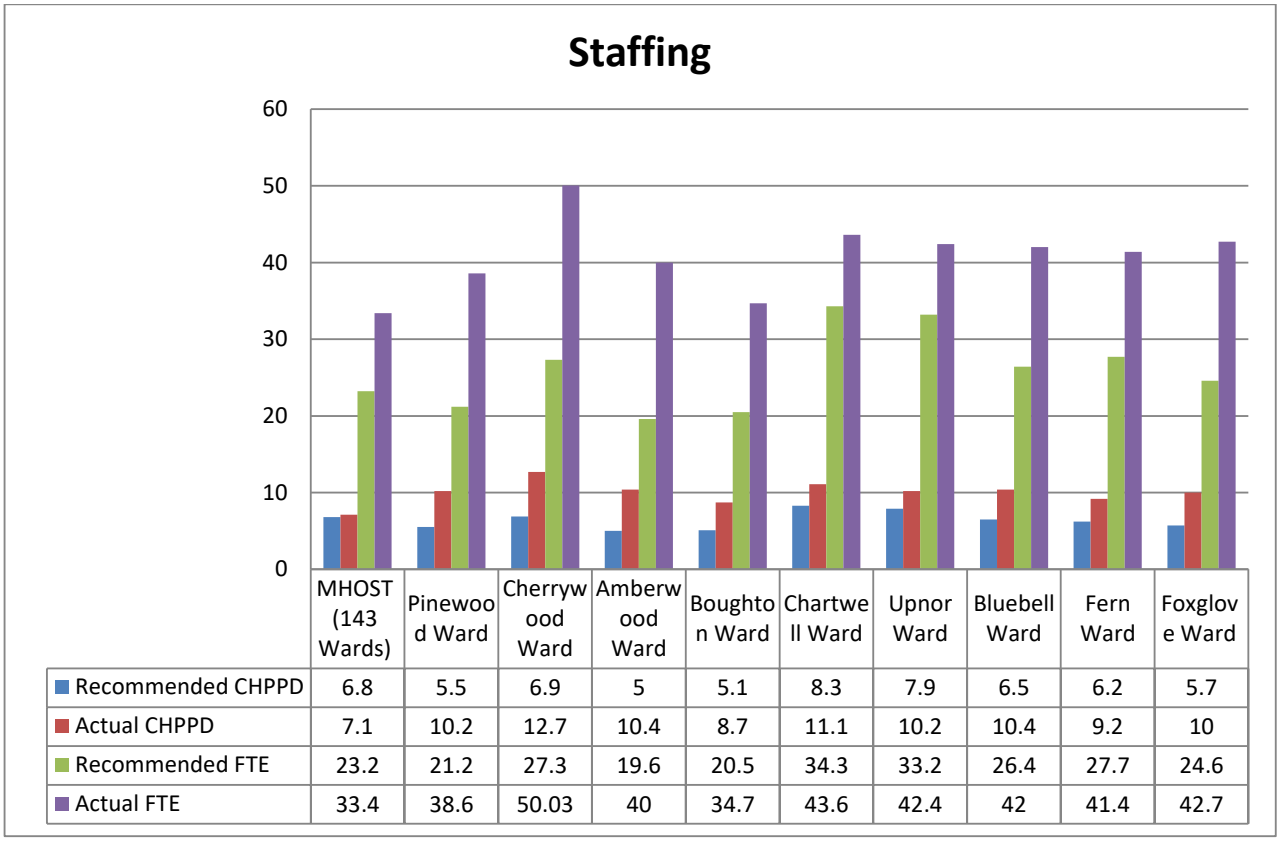



| | MHOST wards (143 wards) | Pinewood Ward | Cherrywood Ward | Amberwood Ward | Boughton Ward | Chartwell Ward | Upnor Ward | Bluebell Ward | Fern Ward | Foxglove Ward |
|---|---|---|---|---|---|---|---|---|---|---|
| Acuity 1 | 4.1 | 10.5 | 9.4 | 13.4 | 15.2 | 2.88 | 0.2 | 1.8 | 10.9 | 9.1 |
| Acuity 2 | 7.7 | 3.7 | 2.2 | 2.8 | 1.2 | 4.81 | 5.8 | 5.1 | 6 | 5.9 |
| Acuity 3 | 5.5 | 0 | 3 | 0 | 0.4 | 5.95 | 6.1 | 9.1 | 1 | 1.6 |
| Acuity 4 | 1.1 | 1 | 1.1 | 0 | 0.1 | 3 | 5 | 0.8 | 0.1 | 1.4 |
| Acuity 5 | 1 | 0 | 1 | 0 | 0 | 1.52 | 0.4 | 0.2 | 1 | 0 |

Overall the acuity of the Acute wards is lower than expected with no acuity 4 or 5 patients in some areas and higher than expected acuity 1 patients. This was the case for Pinewood, Cherrywood, Amberwood, and Fern for the second consecutive MHOST. This is reflective of the clinically fit for discharge patients with 50 to 55 recorded across the Trust during this period. It was also noted that some wards were operating under capacity during this period with four wards operating below capacity for 2 consecutive days or more. This is not a major concern as wards should be aiming for circa 85% occupancy – but when combined with lower acuity, this indicates that there are patients on the wards who may not require ongoing hospital care.

Most wards CHPPD aligned closely to the MHOST benchmarked CHPPD of 6.8. Similarly, the expected gap between recommended and actual was even for all wards but was larger than anticipated. Again, this reflects low acuity and operating below bed capacity during the data collection period.

Version control: 1




| | MHOST (143 Wards) | Pinewood Ward | Cherrywood Ward | Amberwood Ward | Boughton Ward | Chartwell Ward | Upnor Ward | Bluebell Ward | Fern Ward | Foxglove Ward |
|---|---|---|---|---|---|---|---|---|---|---|
| Recommended CHPPD | 6.8 | 5.5 | 6.9 | 5 | 5.1 | 8.3 | 7.9 | 6.5 | 6.2 | 5.7 |
| Actual CHPPD | 7.1 | 10.2 | 12.7 | 10.4 | 8.7 | 11.1 | 10.2 | 10.4 | 9.2 | 10 |
| Recommended FTE | 23.2 | 21.2 | 27.3 | 19.6 | 20.5 | 34.3 | 33.2 | 26.4 | 27.7 | 24.6 |
| Actual FTE | 33.4 | 38.6 | 50.03 | 40 | 34.7 | 43.6 | 42.4 | 42 | 41.4 | 42.7 |

All the wards actual FTE is higher than the MHOST benchmarking actual FTE of 33.4 with the wards recording between 34.7 to 50.03. However, compared to the MHOST recommended FTE of 23.2 the wards recorded a lower range of 20.5 to 34.3. The gap between the actual and recommended varied significantly. This is likely to reflect the higher number of acuity 1 and lower numbers acuity 4 and 5 along with vacant beds during this period.

The FTE incorporated roles that might not be based on the ward like AHP, Psychology and Medics. The variation of acuity, bed occupancy and staffing levels creates an opportunity for the directorate to look at more site base MDT working that is able to respond to the patient population demands across the wards.

## 6. Safer Staffing:

The National quality board, NHS England, CQC and NHS Chief nurse (in 2014 revised in 2016 and 2018) required all hospitals to publish information about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safer staffing guidelines. This was part of the response to the Francis report and the figures are published on our external facing website for public viewing. When considering the safer staffing data against the MHOST findings we can need to take in to account a number of factors. Ward managers, AHP's, psychology, social workers and medics are not included in the RN and HCA fill rate for safer staffing so although there are areas below 80% there could be a ward manager, matron and AHP staff supporting the ward and patient care at the time. This is supported by the low number of InPhase reports submitted for Insufficient numbers of healthcare professionals across the directorates during the MHOST period and 76 reported in the 12 months. However, from the data available there appears to an under

reporting of Inphase and this is why we are developing the 'Red Flag' system on eroster for 'less than 2 RNs on shift' with an identifier if the RN on duty is a preceptorship nurse.

It is anticipated a number of wards being outliers on the safer staffing report, such as Tarenfort with a 254.4% fill rate for HCA's at night due to extra care packages but other areas fill rates are unprecedented when the acuity and bed occupancy levels are considered. There are some other anomalies such as Chartwell, as they would require additional staff to support the ward gender swap, or for other reasons such as additional staff used for ECT inpatients, and increased observations. Often wards use known HCA staff as emergency cover if a second RN cannot be secured.

Some of the safe staffing data indicates low staff numbers in line with the reduced bed occupancy such as the MBU with 39% RN day fill rate, but the fill rate is set on the establishment need for a fully occupied ward and doesn't reflect flexing of staff.

**Safe Staffing Comparison January 2024**

| | | Day | | Night | |
|---|---|---|---|---|---|
| Care Group | Ward | RN | HCA | RN | HCA |
| Acute | Amberwood | 75.3% | 98.5% | 98.7% | 95.8% |
| Acute | Bluebell | 74.7% | 95.4% | 98.3% | 111.4% |
| Acute | Boughton Ward | 116.8% | 93.8% | 100.8% | 110.7% |
| Acute | Chartwell Ward | 93.9% | 102.3% | 102.0% | 129.6% |
| Acute | Cherrywood Ward | 66.7% | 188.5% | 99.2% | 257.2% |
| Acute | Fern | 84.3% | 110.3% | 98.5% | 153.6% |
| Acute | Foxglove | 83.3% | 110.7% | 84.9% | 203.8% |
| Acute | Heather | 90.6% | 110.5% | 100.4% | 140.3% |
| Acute | Jasmine | 73.0% | 114.6% | 98.6% | 116.3% |
| Acute | Pinewood Ward | 100.9% | 134.8% | 97.1% | 142.2% |
| Acute | Ruby Ward | 88.9% | 85.5% | 98.2% | 104.6% |
| Acute | Sevenscore | 123.3% | 98.1% | 87.4% | 117.4% |
| Acute | The Orchards | 92.3% | 83.4% | 100.6% | 103.8% |
| Acute | Upnor Ward | 83.2% | 121.2% | 99.5% | 159.5% |
| Acute | Willow Suite | 94.9% | 217.0% | 152.3% | 235.4% |
| Acute | Woodchurch | 66.3% | 101.6% | 101.8% | 117.6% |
| East Kent | Ethelbert Road | 105.2% | 74.9% | 102.5% | 100.0% |
| East Kent | Rivendell | 83.0% | 111.5% | 100.2% | 106.5% |
| East Kent | The Grove | 64.9% | 87.4% | 107.5% | 113.7% |
| Forensic & Specialist | Allington Centre | 97.6% | 155.4% | 100.7% | 148.5% |
| Forensic & Specialist | Bridge House | 97.6% | 104.6% | 100.8% | 100.7% |
| Forensic & Specialist | Brookfield Centre | 101.6% | 98.0% | 100.6% | 100.4% |
| Forensic & Specialist | Emmetts | 76.2% | 104.6% | 100.3% | 99.8% |
| Forensic & Specialist | Groombridge | 117.2% | 102.5% | 100.8% | 100.2% |
| Forensic & Specialist | Penshurst | 119.4% | 139.9% | 94.7% | 176.9% |

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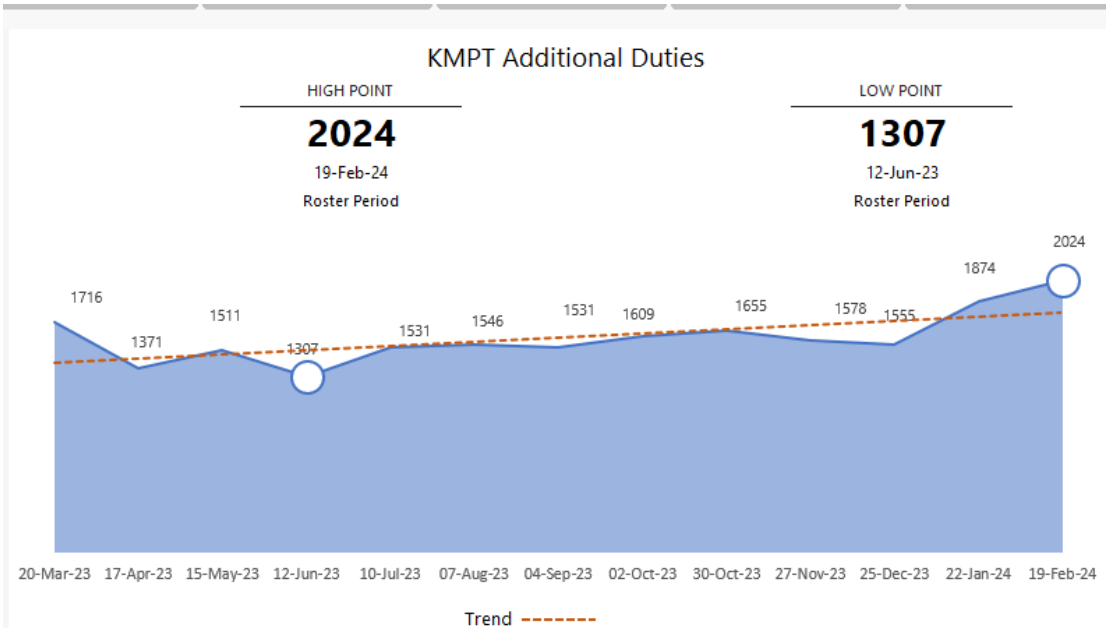
| | | | | | |
|---|---|---|---|---|---|
| Forensic & Specialist | South Central EDMBU | 39.0% | 72.7% | 50.4% | 88.0% |
| Forensic & Specialist | Tarentfort Centre | 98.7% | 175.6% | 100.8% | 254.4% |
| Forensic & Specialist | Walmer | 83.8% | 103.3% | 76.0% | 122.1% |
| North Kent | Newhaven Lodge | 94.3% | 129.9% | 100.1% | 128.6% |
| West Kent | 111 Tonbridge Road | 126.6% | 159.1% | 99.3% | 102.8% |
| West Kent | Rosewood Lodge | 102.7% | 181.2% | 100.5% | 130.9% |
| **Grand Total** | **Grand Total** | **86.23%** | **118.37%** | **95.76%** | **139.15%** |

## 7. Roster Reviews:

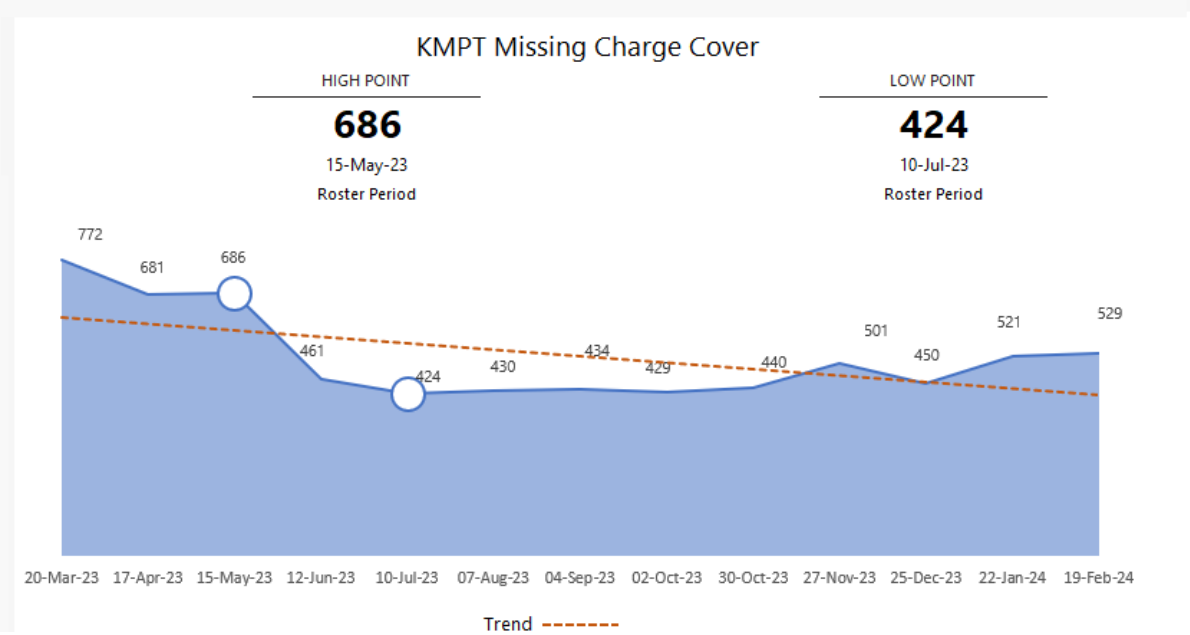
All directorates are required to review safe care and safer staffing through their patient safety governance structures as well as completing monthly roster reviews led by the Head of Nursing and Quality or matrons. The reviews were initiated across the Trust in September 2022 and supported by HR business partners, finance business partners, and ward or unit manager. Together they considered a number of key performance indicators around efficiency, skill mix and resource distribution. This has seen a number of improvements across the Trust with the biggest impacts on additional duties, shifts missing charge cover and unfilled roster %.

Initially this saw a reduction in additional duties, missing charge cover, unfilled shift cover, roster lead time and temporary staffing lead times demonstrating a sustained improvement towards safe and effective rosters. However, with the changes in shift patterns, directorates and key staffing roles changing we have started to see an impact on the performance trajectories. Additional duties were recorded in January 2024 as 1874 this is an increase from the previous MHOST and there is an upward trend is starting to emerge.

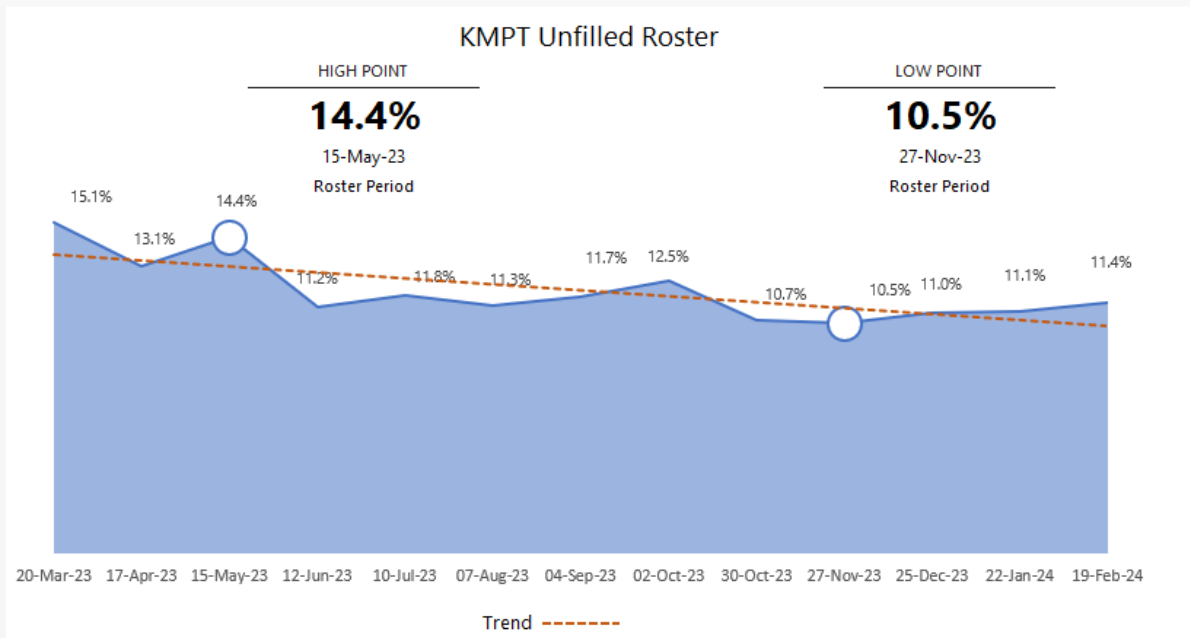



Missing charge cover was recorded as 326 at its lowest in the last MHOST and although this has increased slightly with 521 recorded in January 2024 we are seeing an overall reduction trend in this area.

Version control: 1




Unfilled rosters continue to be on a downward trajectory with January 2024 being recorded at 11.1%. However, this is not necessarily represented in the safer staffing figures for January 2024 but demonstrates a balance between specific roles not being included and these roles being used to support patient safety gaps.




Safecare and NHSP compliance has dropped significantly since the last MHOST report with only Jasmine Ward being 100% and Orchards, Sevenscore and Allington compliance at or above90%.

For the NHSP Interface compliance, most wards are recording 90% or more compliance. There are a number of roster initiatives starting that are linked to Safecare and therefore there the plan is to refresh Safecare for staff with additional training.

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SafeCare Compliance

| | | | | 27 Nov Roster Period | | | | 25 Dec Roster Period | | | | 22 Jan Roster Period | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Group | Short Name | Total | Comparison | 27-Nov | 4-Dec | 11-Dec | 18-Dec | 25-Dec | 1-Jan | 8-Jan | 15-Jan | 22-Jan | 29-Jan | 5-Feb | 12-Feb |
| Acute | Amberwood | 27% | | 50% | 14% | 21% | 0% | 0% | 0% | 0% | 71% | ✓ | 14% | - | - |
| Acute | Bluebell | 20% | | 36% | 21% | 36% | 36% | 0% | 0% | 0% | 29% | 21% | 21% | - | - |
| Acute | Boughton Ward | 37% | | ✓ | ✓ | ✓ | 71% | 0% | 0% | 0% | 0% | 0% | 0% | - | - |
| Acute | Chartwell Ward | 11% | | 7% | 0% | 43% | 7% | 0% | 14% | 43% | 0% | 0% | 0% | - | - |
| Acute | Cherrywood Ward | 69% | | 57% | 79% | 57% | 57% | 71% | 64% | 71% | 79% | 64% | 93% | - | - |
| Acute | Fern | 88% | | ✓ | ✓ | ✓ | 79% | 43% | 57% | ✓ | ✓ | ✓ | ✓ | - | - |
| Acute | Foxglove | 46% | | 50% | 50% | 50% | 43% | 50% | 50% | 43% | 50% | 50% | 29% | - | - |
| Acute | Heather | 66% | | 64% | ✓ | 64% | 71% | 64% | 79% | 64% | 57% | 71% | 29% | - | - |
| Acute | Jasmine | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | - |
| Acute | Pinewood Ward | 28% | | 36% | 36% | 36% | 36% | 21% | 29% | 36% | 14% | 0% | 36% | - | - |
| Acute | Ruby Ward | 65% | | 64% | 50% | 64% | 79% | 71% | 50% | 64% | 71% | 86% | 50% | - | - |
| Acute | Sevenscore | 96% | | 93% | ✓ | ✓ | ✓ | 93% | ✓ | 93% | 86% | ✓ | ✓ | - | - |
| Acute | The Orchards | 99% | | ✓ | ✓ | 93% | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 93% | - | - |
| Acute | Upnor Ward | 74% | | 79% | ✓ | ✓ | 50% | 0% | 86% | 86% | ✓ | ✓ | 36% | - | - |
| Acute | Willow Suite | 87% | | 71% | 71% | 86% | 79% | 93% | 93% | 93% | 93% | ✓ | 93% | - | - |
| Acute | Woodchurch | 10% | | 14% | 21% | 21% | 0% | 21% | 0% | 0% | 0% | 21% | 0% | - | - |
| Forensic & Specialist | Allington Centre | 92% | | 64% | 93% | 79% | ✓ | ✓ | ✓ | 93% | 93% | ✓ | ✓ | - | - |
| Forensic & Specialist | Bridge House | 9% | | 7% | 21% | 0% | 14% | 21% | 21% | 0% | 7% | 0% | 0% | - | - |
| Forensic & Specialist | Brookfield Centre | 72% | | 64% | 57% | 86% | 71% | 57% | 86% | 64% | 86% | ✓ | 50% | - | - |
| Forensic & Specialist | Emmetts | 50% | | 14% | 21% | 43% | 29% | 43% | 29% | 21% | 21% | 29% | 50% | - | - |
| Forensic & Specialist | Groombridge | 59% | | 43% | 64% | 57% | 64% | 71% | 50% | 64% | 57% | 50% | 71% | - | - |
| Forensic & Specialist | Penshurst | 8% | | 21% | 14% | 7% | 0% | 0% | 0% | 7% | 0% | 21% | 7% | - | - |
| Forensic & Specialist | South Central EDMBU | 77% | | 79% | 36% | 43% | 64% | 64% | ✓ | ✓ | ✓ | ✓ | 86% | - | - |
| Forensic & Specialist | Tarentfort Centre | 66% | | 57% | 64% | 64% | 64% | 79% | 86% | 57% | 71% | 64% | 57% | - | - |
| Forensic & Specialist | Walmer | 51% | | 64% | 36% | 50% | 57% | 50% | 71% | 57% | 36% | 57% | 36% | - | - |
| Total Compliant Wards | | | | 4 | 7 | 5 | 4 | 3 | 5 | 4 | 5 | 10 | 4 | - | - |

NHSP Interface Compliance

| | | | | 27 Nov Roster Period | | | | 25 Dec Roster Period | | | | 22 Jan Roster Period | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Care Group | Short Name | Total | Comparison | 27-Nov | 4-Dec | 11-Dec | 18-Dec | 25-Dec | 1-Jan | 8-Jan | 15-Jan | 22-Jan | 29-Jan | 5-Feb | 12-Feb |
| Acute | Amberwood | 94% | | 97% | 97% | 90% | 88% | ✓ | 98% | 93% | 94% | 91% | 90% | 96% | ✓ |
| Acute | Bluebell | 96% | | 94% | 93% | 97% | ✓ | ✓ | 93% | 89% | 96% | 94% | ✓ | ✓ | ✓ |
| Acute | Boughton Ward | 96% | | 97% | 91% | ✓ | 98% | 97% | 93% | 96% | 96% | ✓ | 86% | ✓ | ✓ |
| Acute | Chartwell Ward | 91% | | 79% | 87% | 94% | ✓ | 90% | 88% | 91% | 79% | 93% | 97% | ✓ | 98% |
| Acute | Cherrywood Ward | 91% | | 75% | 80% | 87% | 94% | 97% | 88% | 93% | 97% | 85% | 93% | ✓ | ✓ |
| Acute | Fern | 90% | | 88% | 77% | 80% | 77% | 88% | 88% | ✓ | 91% | 97% | ✓ | 93% | ✓ |
| Acute | Foxglove | 90% | | 97% | 91% | 90% | 89% | 80% | 90% | 81% | 87% | 93% | 89% | ✓ | 93% |
| Acute | Heather | 99% | | 96% | 97% | 98% | 98% | 98% | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Acute | Jasmine | 99.5% | | ✓ | ✓ | ✓ | 98% | ✓ | 97% | ✓ | 98% | ✓ | ✓ | ✓ | ✓ |
| Acute | Pinewood Ward | 74% | | 67% | 68% | 63% | 73% | 72% | 68% | 45% | 89% | 89% | 79% | 87% | 94% |
| Acute | Ruby Ward | 88% | | 87% | 97% | 87% | 92% | 94% | 81% | 94% | 71% | 73% | 76% | ✓ | ✓ |
| Acute | Sevenscore | 80% | | 65% | 83% | 63% | ✓ | 80% | 91% | 62% | 77% | 55% | 95% | 96% | 93% |
| Acute | The Orchards | 98% | | ✓ | 94% | 92% | ✓ | 95% | 95% | 97% | ✓ | ✓ | 97% | ✓ | ✓ |
| Acute | Upnor Ward | 94% | | ✓ | 93% | 89% | 98% | 85% | 87% | 95% | 94% | 90% | 94% | ✓ | ✓ |
| Acute | Willow Suite | 94% | | 91% | 97% | 95% | 94% | 94% | 91% | 92% | 94% | 89% | 97% | ✓ | ✓ |
| Acute | Woodchurch | 90% | | 94% | 89% | 91% | 95% | 85% | 81% | 79% | 92% | 93% | 87% | ✓ | 95% |
| Forensic & Specialist | Allington Centre | 98% | | 99% | 95% | 98% | 98% | 98% | 99% | 97% | ✓ | 99% | ✓ | ✓ | ✓ |
| Forensic & Specialist | Bridge House | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Forensic & Specialist | Brookfield Centre | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Forensic & Specialist | Emmetts | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Forensic & Specialist | Groombridge | 99% | | ✓ | ✓ | 96% | ✓ | ✓ | 90% | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Forensic & Specialist | Penshurst | 98% | | ✓ | ✓ | 99% | 94% | 98% | 96% | 98% | 98% | 93% | 99% | ✓ | 98% |
| Forensic & Specialist | South Central EDMBU | 80% | | 87% | 82% | 88% | 93% | 84% | 91% | 81% | 71% | 89% | 97% | ✓ | 0% |
| Forensic & Specialist | Tarentfort Centre | 99.6% | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 98% | 98% | ✓ | ✓ | 99% | ✓ |
| Forensic & Specialist | Walmer | 98% | | ✓ | 98% | 93% | ✓ | ✓ | 97% | ✓ | 98% | 98% | 98% | ✓ | ✓ |
| Total Compliant Wards | | | | 10 | 7 | 6 | 10 | 9 | 5 | 8 | 7 | 9 | 10 | 20 | 18 |

Further work is needed to ensure roster reviews triangulate data between safe care, safer staffing, eroster and the planned use of MHOST moving forward. KMPT have been working on a digital solution to support this and collection of MHOST data in an accessible, regular way. We, have purchased a module through Allocate to digitally collect the data required for MHOST. However, this requires Allocate and KMPT to reconfigure and load our Safecare system before it can be used. The erostering team are supporting this work as well as the relaunch and training. It is important to understand the digital solution will only be accurate and beneficial if wards are Safe care compliant.

Red flags will be introduced and used to further support this work and understand when there are ‘less than 2 RNs on shift’ with an identifier for if the RN on duty is a preceptorship nurse. Again, this will support the triangulation required to have robust establishment reviews and reduce the data inaccuracy found.

Version control: 1

## 09. Recommendations and Next steps

- Each directorate to consider the MHOST findings
- Directorates to review site delivery of safe staffing and movement of staff to support varying demands and acuity
- A review of outlier wards resources and function in comparison to MHOST recommendations
- Clinically fit for discharge and admission criteria to be reviewed as part of the bed occupancy work in the Trust.
- Inpatient rehabilitation model to be reviewed
- Roster reviews to triangulate safer staffing, safe care and MHOST data (when available).
- Implementation of Red flags and the MHOST Safecare module with training for staff
- Safer staffing and MHOST training to be developed for key senior nursing staff responsible for establishment reviews. Safer staffing module are already available on iLearn
- Planning for regular establishment reviews once the MHOST module is functioning
- Closer monitoring of roster data and compliance in particular safe care and MHOST by Heads of Nursing and Quality, Matrons and Governance Leads
- Review of headroom and RFA data sets used for MHOST

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Delivering Social Value and Net Zero |
| **Author:** | Jo Newton-Smith, Associate Director of Procurement |
| **Executive Director:** | Nick Brown, Chief Finance and Resources Officer |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Noting |
| **Submission to Committee:** | Board requested |

## Overview of Paper

The Trust has been incorporating social value and net zero requirements into its procurement processes from April 2022 and the Trust's own model in September 2023. The paper seeks to provide an initial update of the impact of this approach.

## Issues to bring to the Board's attention

Whilst still in early stages of implementation the Trust has seen some quantified commitments made by the supply chain across the life of the contract such as charitable donations by supplies; and suppliers creating employment opportunities.

Due to the nature of the procurement process, specific deliverables are only achieved when the Trust undertakes a competitive tender process.

The social value impact represents only 10% of the procurement specification meaning that the impact is not a main determining factor in contract award.

The Trust's approach to implement Social Value in its procurement process is in its early stages, further refinement is proposed to the process.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Engagement and consultation |
| **Assurance:** | N/A |
| **Oversight:** | N/A |

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## Executive Summary

Within NHS Procurement there is a requirement to reduce carbon emissions and drive social value through our contracts, ensuring that we deliver more for our communities, whilst safeguarding our patients and staff by ensuring our supply chain are responsible and ethical employers. In April 2022 this became a mandatory requirement with the inclusion of social value and net zero evaluation criteria in all applicable procurement processes with a minimum weighting of 10%.

The Trust has implemented this requirement, however commitments made by suppliers were often broad and organisational wide rather than specific to the Trust and our ambitions. In August 2023, the Trust agreed an enhanced approach to delivering social value and net zero through our supply chain (details set out in Appendix 1) in order to deliver social benefit to the community of Kent and Medway.

This report sets out progress on embedding the approach, lessons learnt, impact and deliverables, and next steps.

## The Trust's Social Value and Net Zero Approach

KMPT's approach to embedding social value & net zero into its procurement processes was adopted in August 2023 and has been utilised in our procurement processes since September 2023.

The Trust sets out its ambition to its supply chain using its Social Value and Net Zero Guide, outlining its overall ambition for delivering on social value and net zero emissions linked with the Trusts Corporate Plan, Green Plan, the wider Greener NHS ambitions and local community needs.

The ambition "to work collaboratively with our supply chain to reduce health inequalities" is supported by four targeted themes; fighting climate change, healthier and more resilient communities, being a fair and responsible employer with a diverse workforce; and tacking economic inequalities and supporting business growth. Each theme is supported by several priorities.

This is intended to give clarity and areas of focus to our suppliers and internal stakeholders, and to ensure that social value and delivering net zero becomes embedded in our procurement practice. It also allows the Trust to monitor and track progress.

The benefit of this approach is that it is flexible yet a robust structure which can be adapted to meet the organisations needs on a contract by contract basis so we can ensure that our requirements for suppliers are relevant and proportionate to the scale and scope of the contract.

## Update on Progress

Whilst the Trust has been incorporating social value and net zero requirements into its procurement processes from April 2022, the Trust's own model was implemented in September 2023, since then only a few open tenders or mini competitions have been undertaken where the new model has been utilised, it is therefore too early to determine whether it has been successful.

Overall 15 contracts were procured incorporating social value and net zero evaluation criteria since April 2022. This number is low in comparison to the number of contracts the Trust entered into at this time. This is because requirements can only be incorporated when undertaking a competitive tender process.

At the present time the requirement does not apply to any quotation processes (contracts below a value of £50k) or when we are direct awarding a contract via a framework agreement or through a Single Tender Waiver which lessens the opportunity to incorporate the social value and net zero evaluation criteria.

Whilst framework agreements have already incorporated social value and net zero requirements into the contracts with suppliers generally these are organisational wide commitments, for example aiming to meet net zero by a certain date, publishing carbon reduction plans, or fair recruitment. Whilst this does deliver social benefits to the community, the commitments are not specific to our contract or the area of Kent and

Medway. The Trust does also not apply criteria to any contract extension negotiations or retrospectively to contracts tendered prior to April 2022.

The Trust is keen to ensure that commitments made by suppliers during the tender process are actioned and reported on. The Trust is now is requesting data from its suppliers on what they have delivered over the last 12 months and is expected to have this information collated during June. It is the intention that the Trust will collate this data on an annual basis so that it can be tracked and reported to Trust Board as part of our comprehensive contract management approach.

### Commitments and Deliverables

We have undertaken an analysis of the commitments made by suppliers and are currently working with them to collate data on what has been delivered.

Detailed below are some highlights of quantified commitments made by the supply chain across the life of the contract:

- A total of 5-6 apprenticeships per year
- 62+ hours per year of career support to local job centres and schools (mentoring, career advice, CV workshops)
- A total of c £3,500 in charity donations
- 1 tree planted for every 8,333 pages printed
- Recruitment of 3 long-term unemployed people
- Recruitment of a least 15 previously unemployed people
- 3 12-week work experience placements for KMPT service users in catering retail outlets
- A total of 7-8 work experience placements per year
- A total of 1,812 hours volunteering per year to local communities/charitable causes
- 2 afternoon cookery classes per quarter for service users
- 25 hours per week of meaningful activity/therapeutic input (e.g. self-care, baking skills etc)
- Fleet used for the contract to be replaced with electric vehicles
- Creation of c 50 new local jobs
- 100% of subcontractor works delivered by Kent based businesses
- 100% electricity from renewal sources
- Various waste reduction, reuse and recycling targets
- Social value and net zero commitments valued at £130,757[i1] over a 3-year contract

The Trust is working with suppliers to collate data on what has been delivered over the past year. Some of the Trust's most strategic contracts, for example our Hard FM and Catering contracts have not yet been in place for a year, therefore deliverables and impact will be limited at this time. We do however have some initial data which shows that our supply chain has delivered:

- The employment of 3 long-term unemployed people
- The employment of 15 previously unemployed people

[1] This is based on the Social Value Portal TOMs Framework which uses financial proxy values to measure value delivered.

## Lessons Learnt / Observations

During the past two years the Trust's procurement team have been assessing each procurement process to test the impact of incorporating social value and net zero requirements. Some lessons learnt and observations are:

- Deliverables specific to Kent & Medway are only achieved when undergoing a competitive tender process or mini competition via a framework. It has not been incorporated into any direct award contracts, or retrospectively for contracts already in place. Due to this there have been limited opportunities to test the model and deliver social value and net zero impacts. The Trust is very reliant on utilising direct award for procurement of contracts, particularly for IT and capital programme, this is due to a number of factors including cost of change, and timescales.
- Since April 2022 only 15 number of contracts have been out to open market and therefore social value and net zero ambitions have limited impact across our supply chain portfolio.
- The supply chain in some market areas lacks maturity and ambition on delivering social value and net zero.
- Commodity based suppliers, including IT software/infrastructure are poor at demonstrating deliverables particularly specific to Kent & Medway
- Most suppliers tend to focus on their past deliverables rather than what they intend to do in the future
- Most suppliers are vague in their commitments and they are not specific to the Trust
- Suppliers who provide a good response on delivering social value and net zero do not necessarily win the contract leaving the Trust with a supplier who has been relatively poor in this area.

## Next Steps

Based on lessons learnt we will be making some modifications to our model and how we communicate this to our supply chain. This includes:

- Adapting the wording within our tender documentation to provide further clarity on the Trust'
- Providing a template delivery plan for completion – this ensures information submitted by suppliers is more consistent and focussed making evaluation and future monitoring easier.
- Providing suppliers with examples of what 'good' looks like, particularly in less mature markets.
- Holding supplier virtual events during the tender phase to ensure suppliers understand the requirements and our expectations.
- Ensuring pre-tender market research includes consideration of social value and sustainability
- Refining approach to embedding social value and sustainability KPIs and associated reporting mechanisms within our contracts.

Collating and reporting data is key to ensure we hold our suppliers to account in order that progress and impact is made. We will be working with our suppliers and contract managers to ensure that progress is made and work towards a standardised approach for collecting information. The Trust is currently exploring options for how best to do this, using technology to support, for example whether we can utilise our e-sourcing platform Atamis or whether to utilise a specific industry know platform called the Social Value Portal.

Appendix 1

# Delivering Social Value & Net Zero through our Procurement

# Information for Suppliers

## Introduction & Background

The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services which support and help improve patient outcomes, while increasing value from every pound spent in the NHS.

The Social Value & Net Zero Information for Suppliers has been developed to provide clarity to our supply chain on our social value and net zero requirements and priorities within our procurement processes. Our aim is to ensure that organisations working with the Trust are responsible and ethical employers who are committed to supporting the economic, social and environmental wellbeing of Kent & Medway.

While the main function of the NHS is to provide health services, we can also play an active role in supporting partner organisations, communities and our supply chain to address the physical, social and environmental factors which can cause ill health (often known as the wider determinants of health). Studies have proven that 80% of health outcomes are determined by non-health related inputs, with examples including education, employment, income and access to green space.

KMPT has adopted its own Green Plan which sets out ambitions for the Trust, including a target of achieving net zero carbon emissions by 2040. It has also incorporated the ambition to become one of the first net zero NHS Trusts by:

- Reducing carbon emissions from energy consumption by 80% by 2035
- Cut emissions associated with transport by 25% by 2025
- Reduce our overall waste volume by 5% every year
- Reduce water consumption by 5% every year
- Increase the environmental quality of our green spaces by 2025

Delivering a net zero NHS has the potential to secure significant benefits across the population, by reducing health in equalities, drive better environmental performance and delivery more value from contracts. Procurement and contract management will play a key role in achieving this goal, with 60% of NHS carbon emissions occurring within the supply chain.

## Our Trust's Mission

Kent & Medway NHS and Social Care Partnership Trust (KMPT) is a provider of mental health care across Kent & Medway with a mission to deliver brilliant care through brilliant people. The Trust recognises the vital role we have beyond delivering outstanding care, and works with our partners to help people in our communities live well and to make sure mental health is recognised to be just as important as physical health.

Each year across the UK, around 1 in 4 people will experience mental ill health. Mental illness is the second largest source of Burden of Disease in England, and we know that for people with serious mental illness, 2 in 3 deaths are caused by physical illnesses that can be prevented.

KMPT provide a wide range of adult mental health and learning disability services to our local population of 1.8 million people in Kent and Medway, as well as specialist services for adults in Sussex and Surrey. Each year we care for over 2,000 people in our hospitals and 54,000 people in the community.

## Social Value and Net Zero Procurement Requirements in the NHS

The Public Services (Social Value) Act 2012 requires public bodies to give due consideration to the inclusion of Social Value when commissioning goods, services and works to which the Public Contracts Regulations 2015 apply.

Central government's Procurement Policy Note (PPN 06/20) has been adopted by NHS England and adopted by NHS Trusts from 1st April 2022, this requires all NHS procurements to include a minimum 10% net zero and social value weighting in their evaluation of tenders

In addition, in support of the delivery of net zero carbon across the NHS, from April 2023 all contracts above £5 million per annum required suppliers to publish a carbon reduction plan for their UK Scope 1 and 2 emissions as a minimum (building on the requirements set out in PPN 06/21). From April 2024, the NHS will extend the requirement for a carbon reduction plan to cover all procurements.

In support the delivery of social value and net zero carbon across the NHS, the NHS published a 'Applying Net Zero and social value in the procurement of NHS goods and Services' guidance. As per the requirements of the guidance document, the Trust incorporates the theme 'Fighting Climate Change' as an evaluated element of procurement processes.

The Trust also has a requirement to work to eliminate modern slavery across our supply chain. If you are a large supplier, you may be caught by the provisions of the Modern Slavery Act and will be asked within a procurement process to confirm that you comply with the Act. For smaller companies who are not required to publish information in response to the Requirements of the Act; however, modern slavery can impact smaller contracts as well as larger ones, and we therefore believe it is still worthwhile to publish this information in consideration of the moral code which lies behind this stipulation.

## Evergreen Self-Assessment for Suppliers

In June 2023 the NHS launched Evergreen. The Evergreen Assessment is an online self-assessment and reporting tool for suppliers to engage with the NHS on their sustainability journey, and to understand how to align with the NHS net zero and sustainability ambitions (including those set out the NHS Net Zero Supplier Roadmap). It provides a single route for communication and data gathering between NHS suppliers and the NHS.

After completing the assessment suppliers will receive a sustainability maturity score against NHS priorities, signposting their current position and pathway to progress. The assessment has not been designed to be included as a scored/evaluated requirement in procurement, and is therefore is not mandated; however, the benefits of using Evergreen for suppliers are:

- **Benchmarking against current and future NHS priorities** – suppliers can see how they align to the NHS's long-term sustainability priorities
- **One conversation with the NHS** – suppliers have a standardised way of communicating their sustainability information to all NHS buyers

- **Supporting sustainability ambitions** – suppliers can use the assessment to help inform internal planning and decision-making, such as developing business cases for sustainable investment or target setting

The assessment can be completed by any supplier which provides or plans to provide goods or services to the NHS. It is recommended that suppliers complete the assessment at least annually. Details of how to access and complete the assessment can be found at NHS England » Evergreen Sustainable Supplier Assessment

## Social Value & Net Zero Ambition and Priorities

The Trusts overall ambition for delivering on social value and net zero emissions, linked with the Trusts Corporate Plan, Green Plan, the wider Greener NHS ambitions, and local community needs, is as follows:

**Ambition**

| **To work collaboratively with our supply chain to reduce health inequalities** |
|---|

Using the guidance and requirements set out in the Public Services (Social Value) Act 2012, Central government's Social Value Model (PPN 06/20), and NHS England's guidance, the Trust has broken down its ambition into 4 targeted themes, supported by several key priorities which we aim to achieve through our procurement and contract management processes.

**Themes**

| | |
|---|---|
| Fighting Climate Change | Healthier and more resilient communities |
| Being a fair and responsible employer with a diverse workforce. | Tackling economic inequalities and supporting business growth |

**Priorities**

| | |
|---|---|
| **Fighting Climate Change** | • Reduce carbon emissions<br>• Reduce air pollution to protect the environment<br>• Avoid the creation of waste (especially single use plastics) and promote reuse and recycling supporting circular economy principles<br>• Reduce water consumption<br>• Protecting natural habitats and biodiversity. |
| **Healthier and more resilient communities** | • Provide programmes to support physical or mental wellbeing for communities and staff<br>• Provide volunteering in the community<br>• Support local community projects<br>• Make a local impact by enhancing facilities / open spaces<br>• Deliver initiatives to support those who have experienced mental ill health, or long-term health condition to build stronger community networks |
| **Fair and Responsible employer with a diverse workforce** | • Demonstrate action to identify and manage the risk of modern slavery including within the supply chain<br>• Operate fair, transparent and inclusive recruitment and working processes and practices that safeguard users<br>• Provide fair and equitable wages for staff and support in-work progression<br>• Increase the workforce representation of disabled people or those with long-term health conditions; and<br>• Adhere to ethical and responsible sourcing practices |
| **Tackling economic inequalities and supporting business growth** | • Provide employment opportunities, particularly for those who face barriers to employment and/or who are located in deprived areas<br>• Provide apprenticeship and training opportunities, particularly for those who face barriers to employment and/or who are located in deprived areas<br>• Ensure a diverse and resilient supply chain by providing opportunities to local businesses (where possible), SMEs and third sector organisations.<br>• Raise career aspirations within the community and help to ensure people are equipped with the right skills to match the labour market. |

## Applying the Guide in our Procurement Processes

The Trust regularly undertakes procurement processes for the supply of goods, works and services.

We are aware that public sector procurement can often appear overwhelming to organisations wanting to bid for contracts, that is why we have put together this information to act as a tool for assisting potential suppliers to navigate social value and net zero procurement requirements, and to understand the NHS and the Trust's priority areas of focus.

For each individual procurement process the Trust will determine which themes and priorities are relevant and proportionate and will communicate this in the Specification and Information for Bidders document. Please note that the Theme of Fighting Climate Change will be incorporated into all procurement processes.

During the procurement process, the Trust is looking for suppliers to set out how they can support the Trust in delivering against the priorities within each theme. The Trust is looking for additionality that will be delivered through the contract, rather than business as usual responses or policies. By this we mean for suppliers to identify what they will be delivering over and above their normal business practice, specifically as a result of the contract.

The table below sets out the broad approach to evaluating suppliers against social value and net zero. Each procurement process is unique, and in some sectors, we appreciate that it might be difficult to deliver on some of the priorities directly across Kent & Medway. The Trusts approach to social value has therefore been developed to be flexible and ensure that a proportionate and relevant approach is taken.

Specific details of the evaluation methodology included in the Tender documents will always take precedence; therefore, you should make sure to read this information thoroughly when preparing your submission.

*Table 2: Social Value and Net Zero Example evaluation approach*

| Theme | Minimum Evaluation Weighting | Scoring Criteria | How it will be evaluated |
|---|---|---|---|
| **Fighting Climate Change** | 5% | Responses awarded a score based on set evaluation criteria in the tender documents. | This will be evaluated as a qualitative element of the tender submission via a net zero question. Suppliers will be expected to include a SMART delivery plan and where applicable a Carbon Reduction Plan. Our expectation is that all priorities within the theme are responded too. |
| **Healthier and more resilient Communities** | 2.5% | Responses awarded a score based on set evaluation criteria in the tender documents. | This will be evaluated as a qualitative element of the tender submission. The Trust does not wish to stifle innovation; therefore, the supplier can choose which priorities in this theme to respond to, and can choose to incorporate additional relevant areas outside of those defined in this Guide. A SMART delivery plan will also be required to support your response. Where relevant and proportionate, the Trust may determine some mandatory elements of this theme within the Tender Specification which must be responded to and delivered upon during the contract. |
| **Fair & Responsible Employers with a diverse workforce** | Pass / Fail | Responses must meet the mandatory criteria detailed in the tender documents, or be rejected from the tender process. | Suppliers are required to respond to all priorities within this theme, demonstrating you're your organisation complies with the Trust's requirements. |
| **Tackling Economic Inequalities and supporting business growth** | 2.5% | Responses awarded a score based on set evaluation criteria in the tender documents. | This will be evaluated as a qualitative element of the tender submission. The Trust does not wish to stifle innovation; therefore, the supplier can choose which priorities in this theme to respond to, and can choose to incorporate additional relevant areas outside of those defined in this guide. A SMART delivery plan will also be required to support your response. Where relevant and proportionate, the Trust may determine some mandatory elements of this theme within the Tender Specification which must be responded to and delivered upon during the contract |

## Contract Management and Reporting Progress

Suppliers who have committed to deliver against the Guide through a successful procurement process must report progress through contract management reporting. This will help the Trust to understand what has been achieved, and also what is planned for the future. The carbon data that is provided by suppliers through the Carbon Reduction Plan (where relevant) will form part of the Trust's reporting on its carbon emissions.

The delivery plans submitted as part of the tender process will be used to track and monitor progress, and suppliers will be expected to report progress at least annually. For our larger contracts, it is likely that quarterly reporting will be required. Annual data from all suppliers will be collated so that the Trust can produce an annual report of key achievements, and the impact that has been made.

For some contracts, KPIs and reporting measures will be incorporated and detailed as part of the tender process within the Specification. An example of some of the measures that might be used are detailed below:

| Theme | Possible Measures |
|---|---|
| **Fighting Climate Change** | • Savings in CO2e emissions on contract achieved through de-carbonisation<br>• Total volume of reduced plastics<br>• Hard to recycle waste diverted from landfill or incineration<br>• Reduce waste through reuse of products and materials<br>• Volunteering time for environmental conservation & sustainable ecosystems<br>• Car miles saved as a result of green transport programme |
| **Healthier and more resilient Communities** | • No of hours of volunteering time provided to support local community projects.<br>• Initiatives taken to support older, disabled and vulnerable people to build stronger community networks<br>• Initiatives taken or supported to engage people in health interventions or wellbeing initiatives in the community<br>• Donations or in-kind contributions to specific local community projects |
| **Fair & Responsible Employers with a diverse workforce** | • Initiatives to strengthen the identification, monitoring and reduction of risks of modern slavery and unethical work practices<br>• No of employees from under-represented groups<br>• Evidence of targets and initiatives to promote diversity and inclusion |
| **Tackling Economic Inequalities and supporting business growth** | • No of weeks of apprenticeships provided on the contract<br>• No of staff hours spent on local school and college visits supporting pupils<br>• No of hours of 'support to work' assistance provided to unemployed people<br>• Meaningful work placements that pay min or national living wage<br>• Total amount spent in local supply chain through the contract<br>• Evidence of initiatives to lowering barriers to employment |

If you have any queries about the information contained within this document, please email the Procurement Team at kmpt.procurement@nhs.net.

NHS
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NHS and Social Care Partnership Trust

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Data and Digital Update |
| **Author:** | Claire Hursell, Director of Digital and Performance |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Approval |
| **Submission to Board:** | Board requested |

## Overview of Paper

To provide the Board with progress against the Data and Digital Plan and also answer the question posed by Trust Board last month with regards to digital resource.

## Issues to bring to the Board's attention

- Digital resources are sufficient but dedicated clinical resource is needed to review standard operating procedures across the Trust.
- A new suite of Business Intelligence Reports are available to all staff via the Intranet but we recognise there is more to do to take this data and have meaningful conversations regarding what it is telling us and what actions we need to take off the back of it.
- Business Analysts are a new specialist resource within KMPT and have remodelled processes for MHT which have led to improvements for clinical staff.
- 41 staff have so far expressed an interest in becoming a Digital Champion.
- Getting the Basics Right will be used to engage all staff and communicate digital changes in a meaningful way to clinicians, and will focus on improving processes, standardising practice and implementing digital solutions. Some improvement work has already been completed.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Identification of additional resource requirement to deliver the digital portfolio in the form of clinical staff to support the creation of new standard ways of working. |
| **Assurance:** | Assurance is provided via the monthly Data and Digital Strategy Board which reports into Strategy Deployment Group in relation to the Digital Enablers within the Corporate Strategy. |
| **Oversight:** | Board and FPC |

Version Control: 01

NHS
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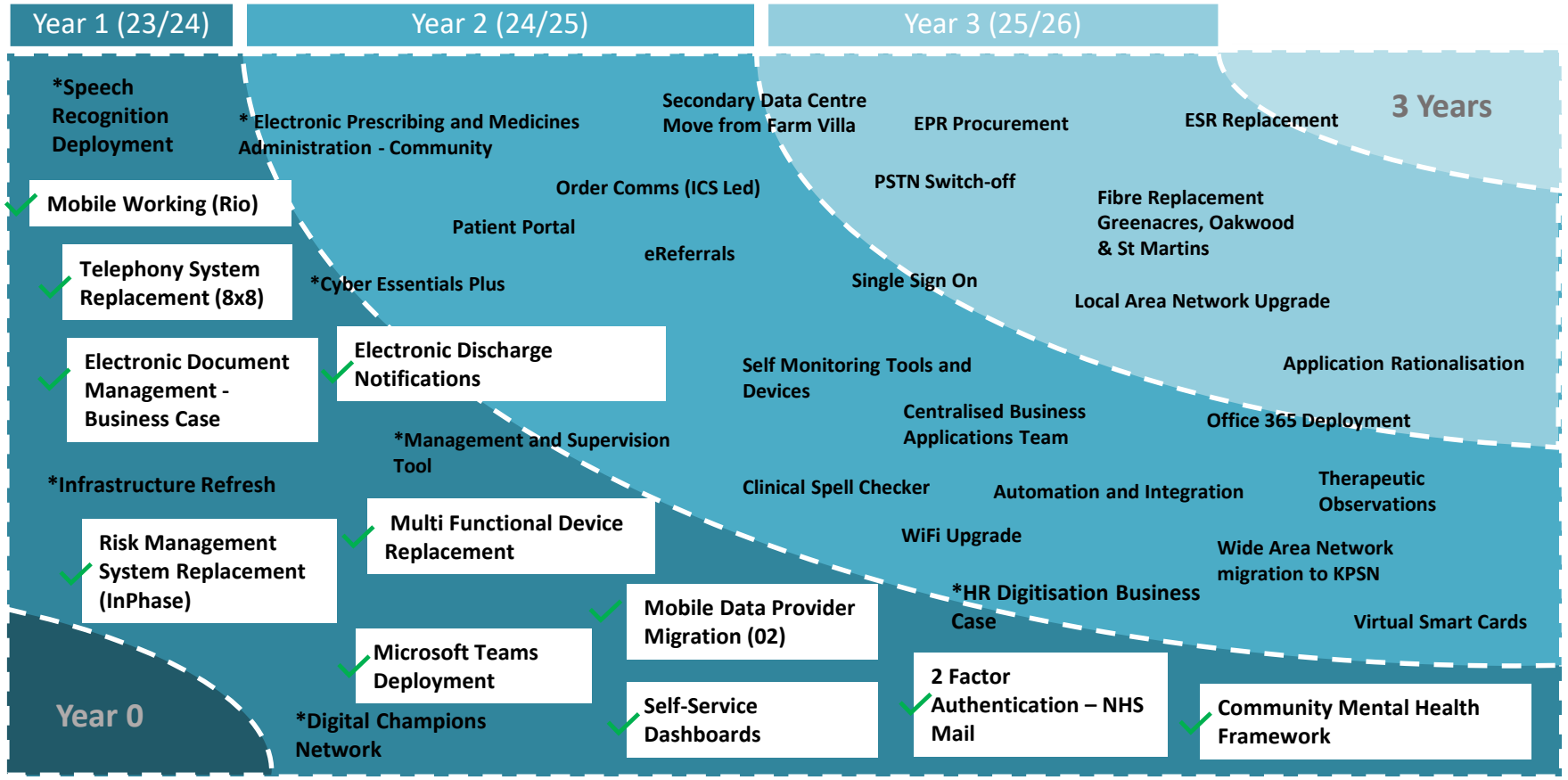
# Digital Transformation Project Map




* In-flight Projects

✓ Complete

*Brilliant care through brilliant people*

RESPECT · OPEN · ACCOUNTABLE · WORKING TOGETHER · INNOVATIVE · EXCELLENCE

NHS
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**Digital and Data Update**: May 2024

Introduction

Following last months Trust Board there was an action for the Chief Executive, Chief Finance Officer and Director of Digital and Performance to review the need for additional resource to support the Trusts digital and data agenda so we can go further faster. This report sets out where we are in regard to our digital and data agenda and addresses the ask of the Board regarding additional resource.

We are prioritising the need to remove barriers which are currently adding burden onto clinical staff to free up time to care for patients. There is an urgent need to implement solutions that work in practice and integrate to reduce the time wasted entering the same data multiple times. We also need to reach a point where the data used can be trusted because it is of good quality and consistently recorded in Rio and also the need to be able to triangulate the Rio data with other Trust systems and external partners.

We recognise that barriers need to be removed which create additional work for clinicians and prevent them caring for patients.

**Digital Resources**

The Digital and Performance Directorate has been reconfigured and it now comprised of clearly defined Business Intelligence, Technology, Business Applications and Digital Transformation functions. Posts within each team are sufficient to undertake the current scheduled work, however, there remain vacancies within project management and business analysis, with business analysis presenting as a particular challenge to recruit into. Business Analysis is new to KMPT and provides specialist resource to digitise and streamline processes – these resources are fundamental to the work to remove the burden on staff and have already shown their value in the implementation of the Community Mental Health Framework since their introduction in October last year.

There is a bottleneck within the Rio Development Team, but there is the opportunity to increase capacity via procuring support from the market. (It is a Gartner recommendation that Digital Teams make use of the market to provide specialist skills and flex resources).

Clinical leadership is key for a number of transformation projects and there is a need to make sure that there is clinical buy-in to the digital agenda partly through the effective use of the Digital Champions Network to co-design solutions.

We currently do not have a comprehensive set of standard ways of working across the Trust which is causing significant variation in the way work is undertaken and local manual processes are being put into place to try to help teams. If we are to remove the admin burden on staff, there is an urgent need to identify clinical resource to work alongside digital in the creation of Trust-wide Standard Operating Procedures (SOPs). I would estimate that we need a Band 8A and 2 x Band 6 clinical resources to design a new set of SOPs.

Version control: 1

## Business Intelligence

We need to be able to quickly answer important questions, such as;

- why are people referred to KMPT;
- how quickly are patients assessed;
- how quickly do patients receive an intervention or a diagnosis;
- and does that intervention make our patients better.

In the past we have not been able to answer these questions easily but we now have a suite of reports that are providing data, however we now need to be able to take this data and have meaningful conversations regarding what it is telling us and what actions we need to take on the back of it. Although we still have a long way to go in relation to data quality and consistency of recording within Rio, we are making progress. Importantly, we now have a report which monitors outcomes so it is possible to understand which interventions are making a difference for patients. The next steps for this will be to get clinical buy-in to this data and start to monitor patients' outcomes and the effectiveness of our interventions taking corrective proactive action where we can see the intervention is not have the desired impact/outcome.

The Business Intelligence Team have been working on a new suite of Business Intelligence reports, using the Microsoft Power BI platform as the delivery tool. The Business Intelligence reports are available through a link on the main page of the Intranet. Where appropriate, these reports can be filtered by Directorate and/or Service Type. These include:

- Referrals (Broken down by cluster)
- Assessment Waiting Times
- Mental Health Together – Intervention Waiting Times
- Memory Assessment Service – Diagnosis Waiting Times
- Outcome Monitoring (Dialog +)
- Physical Health Checks
- Equality, Diversity and Inclusion
- Workforce

## Digital Transformation

The new transformation team structure provides a permanent team structure as we recognise that digital improvement will be on-going. The team is designed to support strategic initiatives, bringing skills to digitise and streamline processes to reduce the burden on frontline staff and deploy new technologies to increase productivity.

An experienced Head of Digital Transformation is joining the team in June. They will be responsible for driving the digital projects forward and ensuring that benefits are delivered on time, within budget and to an acceptable level of quality.

Business Analysts are an important addition to this team sitting between the business and digital teams to reform business processes and design digital solutions that are aligned to business need. The team of business analysts are mainly supporting clinical activity but dedicated resource has also been assigned to reforming back office processes, assigned to HR

initially. The Business Analysts have already supported the Community Mental Health Framework and have been instrumental in redesigning processes and Rio (in conjunction with the Rio Team) to enable KMPT and partners to co-manage patient journeys in an efficient manner. As a result, Mental Health Together (MHT) has moved to a single way of working across all teams, (which includes external partners) with the patient journey now visible to all stakeholders through the development of new business processes, Rio reports and a migration away from progress notes. Significant time savings can already be evidenced across the management of MHT and staff are reporting that Rio is quicker to use.

A Digital Clinical Safety Officer was appointed in December and hazard logs have already been created for new products.

A full-time Chief Nursing/AHP Information Officer started in April. This is a key role to bring the voice of our largest workforce through into Digital, so projects and initiatives can be clinically led by nurses and AHPs. The campaign to recruit Digital Champions has been successful with 41 expressions of interest already received. Work to increase digital literacy across KMPT has started with a digital literacy framework which is in production using the template provided by the Royal College of Psychiatrists. We will be benchmarking the workforce against this framework in the next couple of months to identify the gaps, and we will be using the framework as a mechanism to monitor improvement in literacy year on year.

**Business Applications**

As part of our robust digital agenda, the focus of the Business Applications Team will be to redesign Rio so that the interface is less cluttered and easier for clinical colleagues to navigate. One of our neighbouring Trusts (NELFT) receive positive feedback from their Rio users and so we have been working with them on a new design for Rio to restructure the product to make it easier to use. A new design for Rio will be presented to the Rio Steering Group in September 24.

A system integration plan will be developed, and will be available by October to determine which applications could be integrated and how. This will enable the Trust to have a single source of truth for patient and staff data. An implementation plan will then follow led by the new Head of Business Applications. The team is already assessing if it is possible to integrate InPhase with Rio and ESR.

An application rationalisation plan will also be developed for clinical and corporate systems. This will be a review of all the applications that are used, with a view to reduce these to a minimum. The rationalisation plan for clinical systems will be produced for January 25. A business case to rationalise HR systems will be presented in June 24.

**Technology**

A technology roadmap based on Microsoft Office 365 through the central NHSE offering has been created which will consolidate products to maximise the value of the Office licence whilst simplifying the toolset. This workstream started with the retirement of Lifesize, which has now been replaced with Microsoft Teams.

We are actively working with suppliers to enrol their products onto the NHS England Single Sign On (single password) solution so that the number of logins and passwords staff need start to reduce. However, there are a number of existing products that cannot integrate with the NHS E system and alternative solutions are being explored.

**Digital Transformation**

Getting the Basics Right ✓

KMPT does not routinely have defined standard ways of working across the Trust. The work we have undertaken as part of Mental Health Together (MHT) has identified that teams work in silos and have created their own unique way of working. This means that not all patients will receive the same service from KMPT as we have multiple ways of doing the same thing. For example, we have identified that some teams use text messaging to inform and remind patients of appointments whereas other teams do not have this capability. We have completely redesigned MHT processes, making it much easier to track a patient through referral, assessment, treatment to discharge and enabled consistency on how information is recorded onto Rio to improve data quality. A standard, simplified and streamlined way of working across all teams has been well received by clinical colleagues who are stating that Rio is easier to use, patient information is quicker to access and processes are more efficient.

However, there is more work to be done to standardise how we work. We need a sustained, methodical and structured programme of work, that examines each part of the patient journey with a view to streamlining our ways of working for the benefit of staff and patients, with a focus on community services initially. This programme of work will focus on:

- Creating a comprehensive standard set of digitised SOPs that are easy to use.
- Redesigning efficient processes, digitising and automating as much as possible.
- Removing duplication within Rio and removing the overuse of progress notes.
- Redesigning Rio to make it easier for staff to navigate and record data in the correct place.

There will be a focus on improving ways of working across community teams with a view to easing the burden on staff to free up time to care. The programme will focus on standardising ways of work, and removing unnecessary variation in how work is done. However, rather than focus on IT systems as has been done traditionally, it will look at ways to improve an area of work, including procedures and processes as well as improvements that can be made through the use of technology (including changes to Rio).

Once these projects have been delivered, the next grouping of projects/workstreams will then be identified.

The work is complex and multifaceted but will be messaged to staff under a single '*Getting the Basics Right ✓*' tagline which will focus on communicating improvements to colleagues in a meaningful way. For example, rather than speak about the work that is happening in relation to the implementation of new digital solutions we will talk about improvements that will be

introduced to make it easier for colleagues to manage appointments, caseloads, referrals, medication and FLOW etc.

Frontline Digitisation – Minimum Digital Foundation

53 Core Capabilities have been set by NHS England with a deadline of March 2025. £3.8m capital funding is provided over 2 years to enable KMPT to meet this minimum standard. There is real synergy between the outstanding capabilities that have been funded by NHS England and the priorities of clinical colleagues. These include digital solutions for the following:

- Patient engagement/Appointment Management
- Medical spell checking
- eReferrals
- Bed Management
- Management of Medicines
- Decision Support
- Patient Tracking for Inpatients
- Electronic recording of therapeutic observations

The delivery of digital projects is governed by the Data and Digital Strategy Group and currently spans the 2 years of the Trust strategy.

A number of projects have already been delivered. The largest of these is the deployment of Electronic Pharmacy and Medicines Management to Inpatients. Clinical colleagues have reported improvement in patient safety and efficiency as a result of this deployment. The next phase of this project is currently in flight, and we aim to deploy the solution into Community Teams by April 25. We are actively deploying speech recognition software and aim to have 500 clinical staff using the software by end June, to reduce the time currently taken to write letters and record patient notes into Rio. We have also deployed tablet devices to Crisis Teams make it easier to record information straight onto Rio when in a patient's home and we are awaiting the feedback from this project to inform how we proceed with mobile solutions across community teams.

We are currently writing business cases for the procurement of a caseload management tool, which integrates with Rio, making it much easier for clinical colleagues to manage risk on their caseload and to ensure that leadership have a greater visibility of caseload and risk management across the organisation. These tools make use of algorithms to determine if a patient is likely to need to be stepped up, or if they can be stepped down or even discharged. But even without the algorithm, the presentation of caseloads in an easily accessible format has been a significant improvement for the Trusts we have spoken to. These trusts have reported that it is likely that it will take approximately 18 months to implement the tool, with approximately 6 months working on improving data quality within Rio. We held a number of demonstrations of a caseload management tool to clinicians to gauge interest in the product. 74% of those who attended, felt that a tool would greatly support teams to optimise resources when managing community caseloads. Once a business case is approved, we will be able to move forward to procure a suitable solution and plan for implementation.

Now that we have a single front door through Mental Health Together we can now make use of the Electronic Referrals Service which enables GPs to refer patients to KMPT through their EMIS system rather than via email, which will improve the quality of referrals as well as streamlining the process. We have just started this project and hope to have this capability by March 25.

In terms of patient portals, we want patients to have access to a single product across Kent and Medway which can be used to communicate, manage physical health, access care plans and provide self-management tools. Acute Trusts received funding to deliver patient portals and are therefore ahead of Mental Health in Kent with most Trusts using 'Patients Know Best' product which is accessed via the NHS App for ease of use. Learning from others suggests that many trusts found it useful to start with managing appointments, sending letters and documents as their first step as a way of reduce DNAs. A project manager is joining in June who will be responsible for implementation and integration with Rio. However, we currently have a lead clinician on this project who is exploring the capabilities of these products and speaking to other Trusts about their experiences in deploying these products.

Another important project is the implementation of the Rio FLOW module to migrate the current manual process (FLOW spreadsheet) used to admit patients to Acute services. The project is currently in-flight and is due to be implemented in July. This will give greater visibility across the Trust of the number of patients that are currently waiting for beds. We will then look to make better use of the FLOW product for discharge planning.

The key for all these projects will be working with clinical colleagues to create standard ways of work and redesigning processes to ensure these are efficient. Therefore, we have dedicated business analyst resource as well as project managers to ensure change are embedded and we create sustained positive change. However, clinical input and engagement is vital.

Appendix A, shows an up to date Digital Transformation Project Map.

**Conclusion**

To conclude, Digital and Performance Teams are making progress to deliver changes which are making a difference to the work of our front-line teams and provide managers with easily accessible data on which to base decisions.

The need at this stage is for clinical resource and leadership to ensure we make a success of our plans not for further digital staff. The introduction of a new skill set in the form of business analysts have been fundamental in the standardisation of working practices across Mental Health Together Teams but clinical resources are required to create a suite of standard operating procedures to support the migration to efficient processes which change clinical processes in relation to how work is done.

We are making significant process with business intelligence reporting, and whilst data quality is still of concern, we now have reports which measure outcomes for the first time. We have been successful in delivering new digital capabilities in the form of speech recognition, mobile

technology and eMeds and we have a number of projects that are just getting underway to bring further capabilities.  These projects will be aligned under the ‘Getting the Basics Right’ banner which will focus on streamlining processes, removing duplication, making changes to Rio, standardising practices and bringing in new digital solutions to increase productivity and ultimately improve services provided to patients and reduce the burden on staff.

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Changes to Standing Orders and Standing Financial Instructions |
| **Author:** | Jo Newton-Smith, Associate Director of Procurement |
| **Executive Director:** | Sheila Stenson, Chief Executive, and Nick Brown, Chief Finance and Resources Officer |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Approval |
| **Submission to Board:** | Statutory |

## Overview of Paper

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

## Items to bring to the Board's attention

Following the November update to the Trust's Standing Financial Instructions and Scheme of Delegation, it has been noted that the approval of contract awards over £500k require Finance and Performance Committee approval.

This sits outside the wider scheme of approval where the limits were adjusted to allowing Executive Management Team approval on non-pay up to £999,999. This change brings the contract award decision in line with these limits. The procurement process is supported by the Trust's Spending the Trust's money policy which was updated last year.

## Governance

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

## Key Changes Requested for Approval

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

| SO/SFI number | Current wording | | New wording | | Reason |
|---|---|---|---|---|---|
| Scheme of Delegation<br><br>Post tender contract award approval | Up to £2,500 | Level 1 | Up to £2,500 | Level 1 | Adjustment to the Post Tender Contract Award Approval in line with the Trust Spending the Trust Money policy. |
| | £2,500 - £14,999 | Level 2 | £2,500 - £14,999 | Level 2 | |
| | £15,000 - £49,999 | Level 3 | £15,000 - £49,999 | Level 3 | |
| | £50,000 - £74,999 | Level 4 | £50,000 - £249,999 | Level 4 or 5 | |
| | £75,000 - £249,999 | Level 5 | N/A | N/A | |
| | £249,999 - £499,999 | Level 6 | £249,999 - £999,999 | Recommendation report to EMT (min of two Executives) or for Capital Schemes, Trust Capital Group (Level 6) | |
| | £500,000 - £999,999 | Level 7 | £1,000,000 + | Recommendation report to Finance & Performance Committee and Trust Board for Approval (Level 7 and 8) | |
| | £1,000,000 + | Level 8 | | | |

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|---|---|
| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **30th May 2024** |
| Title | **Quality Committee Chair's Report** |
| Author | **Stephen Waring, Non-Executive Director** |
| Presenter | **Stephen Waring, Non-Executive Director** |
| Executive Director Sponsor | **Andy Cruickshank, Chief Nurse** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance & Governance items** |
|---|---|---|
| • Violence and Aggression Report<br>• Immediate Life Support and Basic Life Support Training Compliance<br>• Patient Safety Incident Response Framework (PSIRF)<br>• Right Care Right Person (RCRP)<br>• Safer Staffing – MHOST Annual Establishment Review<br>• Child Protection Conference Attendance | • Update on Deaths at Littlebrook Hospital<br>• Suicide Thematic Report<br>• CQC Community Mental Health Patient Survey<br>• Quality Digest<br>• Quality Impact Assessments<br>• CQC Report<br>• DPIC Annual Report and Declaration<br>• Mortality Report<br>• Delivering Same Sex Accommodation Annual Declaration | • Risk Register<br>• Quality Accounts |

| **Agenda Items by exception** | **Assurance narrative by exception.**<br>**Key items to be raised to the Board.** | **None**<br>**Limited**<br>**Reasonable**<br>**Substantial** | **Actions, mitigations and owners**<br>**Refer to another committee.** |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Suicide Prevention Approach | Previously discussed at the Quality Account priorities workshop, the document was formally approved by the Committee. | Reasonable | |
| Quality Risk Register | Particular concerns were raised about risks that had remained on the register for some considerable time, or that were poorly controlled. Questions were raised about estates-related issues (such as temperature controls and soundproofing), and whether there were any financial or programming barriers to resolving these. The Committee was assured that all directorates continue to give a high level of scrutiny to risks on their register. | Limited | The committee will continue to pay close attention to the detail of the content of the risks and link closely with the IARC. |
| Immediate Life Support and Basic Life Support Training Compliance | Responsibility for ensuring high levels of compliance with training has passed from the Chief People Officer to the Chief Nurse. As an 'extreme risk' on the Trust Risk Register, significant effort is being made to ensure compliance. The Committee noted its concerns, should a situation arise and staff were not sufficiently equipped. | Limited | Additional places procured and work underway to increase attendance.<br>Owner: Andy Cruickshank, Chief Nurse<br>People Committee consulted. Will continue to ensure link between committees on this issue. |
| Violence and Aggression Report | Committee members acknowledged that significant work was underway and that the Trust had specific, national expertise in the Chief Nurse, though there was much work still to do. | Reasonable. | Committee to keep this area of work under regular review. |
| Right Care, Right Person | One month into the implementation of RCRP, which has the potential to improve the experience of patients and carers by ensuring police involvement is warranted, the police are seeing reduced calls on their time, and no systemic adverse issues have been seen. | Reasonable | Requested a further report in six months once the policy is more firmly embedded to enable the Committee to understand the impact, drawing from the system-wide evaluation that is underway. |
| Director of Infection Prevention and Control | This is a nationally mandated report. The committee commended the overall report, and | Reasonable | Active, visible leadership (at different levels) required to increase flu vaccination uptake |

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|---|---|---|---|
| Annual Report and Declaration | the fact that there had been zero outbreaks of Norovirus, C. Diff or MRSA bacteraemia during the year, but noted the low uptake of flu vaccination (recognising this was similar in other MH trusts). | | together with learning from organisations with higher compliance. |
| **Free Text -**<br>[commentary box for any additional comments] | | | |

| | |
|---|---|
| Title of Meeting | **People Committee** |
| Meeting Date | **30th May 2024** |
| Title | **People Committee Chair's Report** |
| Author | **Kim Lowe, People Committee Chair, Non-Executive Director** |
| Presenter | **Kim Lowe, People Committee Chair, Non-Executive Director** |
| Executive Director Sponsor | **Sandra Goatley, Chief People Officer** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance items** |
|---|---|---|
| • People Committee Main Report which covered Strategic Delivery Plan Priorities<br>• HR Risk Register<br>• Deep Dive – Culture Report<br>• Deep Dive – Gender Pay Gap<br>• Employment Tribunal Annual Report<br>• Annual Policy Report<br>• HR Policies and Procedures | • | • |

| **Agenda Items by exception** | **Assurance narrative by exception. Key items to be raised to the Board.** | **None Limited Reasonable Substantial** | **Actions, mitigations and owners Refer to another committee.** |
|---|---|---|---|
| Menopause Network Report | • The menopause café started in 2021.There are currently 300 members. | Reasonable | N/A |

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| | • In May 2023, KMPT became part of the Integrated Care System's (ICS) bid to become a menopause friendly accredited employer and they are also fully involved within the Kent and Medway ICS Community of Practice which meet quarterly for all stakeholders.<br>• The Network Chair explained there is a 12-month plan in progress which will also incorporate the Male Menopause known as "the Andropause".<br>• The Network is working hard to increase the number of trained advocates and champions and will be looking at train the trainer approach as part of the on-going ICS Community of Practice Work.<br>• KMPT has signed up to the NHS eLearning menopause training, and this has been introduced as part of Staff Induction as of January 2023 with additional training added to the Managers' Toolkit.<br>• The Committee noted the Network Chair will be following up with Clinical Leads to gain a better understanding on what KMPT is doing for our patients. Having a dedicated Clinical Lead to work along-side the Network would be really beneficial. | | |
| People Risk Report Mandatory Training | • The Committee wanted to give assurance to the Board that essential Training for Immediate Life Support (ILS) and Basic Life Support (BLS) is being monitored as compliance is not meeting the target. A report from the Chief Nurse will be presented to People Committee in July 2024.<br>• The Committee would welcome a conversation on essential training versus risks and can some of the updates to training be done at less frequent intervals. A paper will be presented at the September People Committee to enable the discussion. | Limited | Chief Nurse to present a report on essential training for ILS/BLS at next PC Committee in July 2024. |
| People Committee Main Report | The report set out KPI's for the Trust and the People Plan for 2024/2025 Key points are: | Reasonable | N/A |

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| | • The Committee wanted to give assurance to the Board that additional system-levels controls are likely to be introduced in relation to substantive and temporary staffing due to financial projection for 24-25. The internal controls that we have in place are being reviewed to ensure they are robust.<br>• The Committee ask the Board to note that there are still pressures on agency spend, although we are beginning to see a downward trend, which is an achievement.<br>• Work is being done on the workforce plan for the next 3 years to understand where the gaps are likely to be and this will include retirees. This work is important as we have an ageing workforce.<br>• In the most recent cohort of International Recruitment, we successfully recruited 52 Nurses and 7 Occupational Therapists, the offer of pastoral care was a key to this being a success. It was noted that the pastoral care funding ceases in October 2024. We have achieved 100% retention of Registered Nurse Degree Apprentices.<br>• The Equality and Diversity Culture Transformation Programme has reached the second phase. Feedback from Phase 1 outlines 6 focus areas which will form the plan for the next 12 months. A joint Identity, culture and staff experience paper will be presented at May Board and will cover the high-level plans for both the identity and culture work. The detailed plans for the culture work will be completed by the end of June 2024 and will be presented to the People Committee in July 2024. | | |
| Guardian of Safe Working House Q4 Report | The Committee received the report from the Guardian of Safe Working which reviews the safe working hours and adequate supervision for Doctors in Training | Reasonable | |

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| | • There are 10 exceptions reported during the period of November, December 2023, January 2024, which only two of them were upheld. This was due to some exception reports being completed by trainees who have left the Trust and accidentally used our reporting system instead of the appropriate system in their new Trusts. No fines were raised. The Guardian regularly attends monthly meetings with Medical staffing to discuss any issues arising. | | |
| **Free Text -**<br>N/A | | | |

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|---|---|
| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | 30th May 2024 |
| Title | Finance and Performance Committee |
| Author | Mickola Wilson, Non-Executive Director |
| Presenter | Mickola Wilson, Non-Executive Director |
| Executive Director Sponsor | Nick Brown, Chief Finance and Resources Officer |
| Purpose | Noting |

**Agenda Items**

| **People items** | **Patient items** | **Finance items** |
|---|---|---|
| • | • IQPR<br>• Dementia Diagnosis<br>• Patient Flow | • Financial Plan and CIP (update)<br>• Month 12 Finance Update<br>• KSS Provider Collaborative<br>• BAF Risk Updates - Finance Risks |

| **Agenda Items by exception** | **Assurance narrative by exception. Key items to be raised to the Board.** | **None Limited Reasonable Substantial** | **Actions, mitigations and owners Refer to another committee.** |
|---|---|---|---|
| IQPR - Dementia Diagnosis | The Dementia Diagnosis model requires a whole system approach with Primary Care being pivotal to support demand management. This will be supported by the ICB | None | The Committee noted that the Trust Board had received assurance through the MHLDA Board that this work was underway and the pilot would be completed by the end of 2023 but this is not the case. It was noted that the Director of Transformation would be |

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|---|---|---|---|
| | | | providing a report to the Committee in June 2024 |
| Patient Flow | Patient flow is restricted by the lack of suitable accommodation for patients ready for discharge. The provision of accommodation is controlled by other members of the system and therefore not within KMPT's control. Work is underway with system partners including the ICB to improve flow including 'step down' options for patients. | Limited | Crisis Houses form part of the Patient Flow Programme with one established in Medway with another planned later this year. |
| Finance Items | Financial position of the Trust is strong, with the exception of the spend on Bank/Agency with is expected to continue to breach the targets set by the NHS | Substantial | The Executive continue to work with the teams to reduce the Agency spend. |
| **Free Text -**<br>It was noted that The Estates Strategy and Digital programme would be a standard agenda item for this Committee | | | |

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|---|---|
| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **30th May 2024** |
| Title | **Mental Health Act Committee (MHAC) Chair's Report** |
| Author | **Sean Bone-Knell, MHAC Chair** |
| Presenter | **Sean Bone-Knell, MHAC Chair** |
| Executive Director Sponsor | **Dr Afifa Qazi, Chef Medical Officer** |
| Purpose | **Assurance** |

**Agenda Items**

| **People items** | **Patient items** | **Finance items** |
|---|---|---|
| • MHA/MCA Training Report | • MHLOG Report<br>• Mental Health Act Compliance and Assurance Report<br>• Chief Medical Officer's Report<br>• CQC Actions Arising from MHA Monitoring Visits Report<br>• MHA CQC QIP Action<br>• Bi-Annual CTO Report<br>• Associate Hospital Managers Report | • |

| Agenda Items by exception | Assurance narrative by exception. Key items to be raised to the Board. | None Limited Reasonable Substantial | Actions, mitigations and owners Refer to another committee. |
|---|---|---|---|
| Mental Health Act Compliance and Assurance Report | An illegal section was addressed as it was noted that bed pressures across the Trust caused the bed on a named ward on section papers to be used, resulting in admission on a different ward. There have been eight Section 135s implemented over the last quarter by AMHPs which had to be stood down due to lack of admitting beds available across the Trust. The impact showed reassessment was required at a later stage causing added pressures to workload of staff and further delays to patient care. | Reasonable | The bed flow programme will improve capacity on beds across the Trust. There is a cohort of about 70 clinical ready for discharge patients and there are Multi Agency Discharge Events (MADE) to be held in May to try and rectify the problem and release capacity. |
| Chief Medical Officer's Report | A newly appointed Hearing Co-ordinator has been successfully recruited and has allowed for a streamline approach to all AHM reviews across the localities. The streamlining has already been very effective and has already halved the number of reviews the Trust previously had outstanding. Since the Hearings Co-ordinator came into post in February the reviews outstanding across the three locations has reduced from 58 to 26. Previously the Maidstone locality had been an area of concern due to the number of outstanding reviews and had been escalated via the MHAC report to Board. | Reasonable | |
| Bi-Annual CTO Report | Unknown data was recorded by BI as CTO transfers into localities and as at the point of transfer the inputter had no knowledge of location. AMHPs will not complete the CTO unless there is a specific place of residence as this forms part of the CTO.<br><br>Patients are effectively discharged from the CTO as soon as the statutory criteria ceases and a number of lapses | Limited | The Mental Health Act Manager will carry out an exercise to try and establish the addresses for the unknowns in the report.<br><br>A piece of work is to be carried out to understand why patients have lapsed rather than been discharged. The CTO report has |

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| | are due to the patients coming to end of the sections and they do not need to be renewed so they lapse rather than being discharged. | | been shared with the Clinical Directors to be discussed at the Directorate meetings. |

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|---|---|
| Title of Meeting | **Board of Directors (Public)** |
| Meeting Date | **30th May 2024** |
| Title | **Charitable Funds Committee Chair Report** |
| Author | **Sean Bone-Knell, Non-Executive Director** |
| Presenter | **Sean Bone-Knell, Non-Executive Director** |
| Executive Director Sponsor | **Dr Adrian Richardson, Director of Transformation and Partnerships** |
| Purpose | **Noting** |

**Agenda Items**

| **People items** | **Patient items** | **Finance items** |
|---|---|---|
| • Charity Strategic Update<br>• Charity Impact Quarterly Report<br>• Charity Strategy | • | • Charity Finance Report |

| **Agenda Items by exception** | **Assurance narrative by exception. Key items to be raised to the Board.** | **None Limited Reasonable Substantial** | **Actions, mitigations and owners Refer to another committee.** |
|---|---|---|---|
| Charity Strategic Update | The Charity's performance has improved recently. The Charity has benefited from the interim Charity Manager's work, which includes successfully recruiting the new Charity and Volunteers Lead on a substantive basis. | Reasonable | N/A |
| Charity Impact Quarterly Report | The Charity was unsuccessful in obtaining funding from the NHS Charities Together Green Fund, but future bids will be made. | Reasonable | N/A |

| | | | |
|---|---|---|---|
| | The Charity was pleased to hear of effective use of funds which directly benefited patients. | | |
| Charity Strategy | A new Charity Strategic Plan has been formed, which includes the potential re-branding of the Charity. The income generation targets were pleasing to see. | Reasonable | TS to circulate the Charity Strategic Plan to the Charity's Trustees for approval. |
| Charity Finance Report | The Charity continues to declare a surplus position, which is positively underpinned by the corporate donation from the Trust. | Reasonable | NB to present the Charity's budget for 2024/25 at its next meeting. |
| **Free Text -**<br>[commentary box for any additional comments] | | | |

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# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | Thursday 30th May 2024 |
| **Title of Paper:** | Trust Sealing Report |
| **Author:** | Nicola Legge, Legal Services Manager |
| **Executive Director:** | Sheila Stenson, Chief Executive Officer |

## Purpose of Paper

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|---|---|
| **Purpose:** | Noting |
| **Submission to Committee:** | Standing Order |

## Overview of Paper

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

## Issues to bring to the Committee's attention

Two documents have been signed and sealed as a deed during from Q4 23/24. This process has been undertaken by Legal Services as per the Trust Standing Orders.

## Governance

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| **Implications/Impact:** | No risks/impact |
| **Assurance:** | Substantial Assurance |
| **Oversight:** | Board |

Version control: 1

| Number | Date of Sealing | Description | Signatures | Comments |
|---|---|---|---|---|
| 152 | 23.10.2023 | Lease Renewal of Chris Ellis Centre | Helen Greatorex<br>Jackie Craissati | The existing lease expired in June 2023. The renewal lease is for five years with a two year break clause. |
| 153 | 19.02.2024 | Lease Renewal of St Michaels House | Sheila Stenson<br>Jackie Craissati | Extension to lease until 19 April to allow for the vacation of the property. |
| 154 | 18.03.2024 | Heathside Lease Renewal | Sheila Stenson<br>Jackie Craissati | Lease renewal for the National Death Service |
| 155 | 28.03.2024 | Magnitude Lease Renewal | Sheila Stenson<br>Jackie Craissati | Renewal of existing lease |
| 156 | 28.03.2024 | Magnitude Licence to Underlet | Sheila Stenson<br>Jackie Craissati | Licence to between superior landlord, landlord and KMPT to underlet KMPT space at Magnitude. |

Version control: 1