AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 25th July 2024
Time 09.30 – 12.00
Venue MS Teams

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/24-25/29	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/24-25/30	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/24-25/31	3.	Personal Story – Fresh Start at Dartford Liaison Service	FN	Verbal	DHS	09.35
TB/24-25/32	4.	Continuous Improvement - The Home Treatment Team Reasonably Adjusting for Service Users with Autism Spectrum Disorder (ASD)	FN	Verbal	AR	09.45
STANDING ITEMS						
TB/24-25/33	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/24-25/34	6.	Action Log & Matters Arising	FA	Paper	Chair	10.00
TB/24-25/35	7.	Chair's Report	FN	Paper	JC	10.05
TB/24-25/36	8.	Chief Executive's Report	FN	Paper	SS	10.10
TB/24-25/37	9.	Board Assurance Framework	FA	Paper	AC	10.15
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/24-25/38	10.	MHLDA Provider Collaborative Progress Report	FN	Paper	AR	10.25
TB/24-25/39	11.	Right Care Right Person Report	FD	Paper	AR	10.30
TB/24-25/40	12.	Purposeful Admissions Programme	FD	Paper	AQ	10.40
OPERATIONAL ASSURANCE						
TB/24-25/41	13.	Integrated Quality and Performance Review	FD	Paper	SS	10.50
TB/24-25/42	14.	Finance Report	FD	Paper	NB	11.05
TB/24-25/43	15.	Pay Band Profile Report	FD	Paper	SG	11.10
TB/24-25/44	16.	Community Mental Health Framework – Progress report	FD	Paper	DHS	11.20
TB/24-25/45	17.	Annual Freedom to Speak Up Report, with Management Response	FD	Paper	SS	11.30
TB/24-25/46	18.	Review of Committee Terms of Reference	FA	Paper	TS	11.40
CONSENT ITEMS						
TB/24-25/47	19.	Report from Quality Committee (incl Mortality Report)	FN	Paper	SW	11.45
TB/24-25/48	20.	Report from People Committee	FN	Paper	KL	
TB/24-25/49	21.	Report from Finance and Performance Committee	FN	Paper	MW	
TB/24-25/50	22.	Report from Mental Health Act Committee	FN	Paper	SBK	
TB/24-25/51	23.	Report from Charitable Funds Committee	FN	Paper	SBK	
CLOSING ITEMS						
TB/24-25/52	24.	Any Other Business			Chair	11.50
TB/24-25/53	25.	Questions from Public			Chair	

	Date of Next Meeting: 26th September 2024, The Orchards

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
Dr Asif Bachlani	AB	Associate Non-Executive Director
Shelia Stenson	SS	Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer/ Deputy Chief Executive
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnership and Transformation
In attendance:		
Wendy Dewhirst	WD	Service Director for North Kent
Lucy Pope	LP	Acting Senior Manager
Tony Saroy	TS	Trust Secretary
Hannah Stewart	HS	Deputy Trust Secretary
Apologies:		
Kindra Hyttner	KH	Director of Communications and Engagement

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 12.00 hrs on Thursday 30th May 2024
Via MS Teams

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
	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:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Oliver Isaac	OI	Senior Operational Excellent Manager (QI Story)
	Daniel Lagadu	DL	Senior Operational Excellence Programme Manager (QI Story)
	Gemma McSweeney	GM	Interim Head of Nursing for Acute (QI Story)
	Sue Taylor	ST	Advanced QI Practitioner (QI Story)
	Claire Hursell	CH	Director of Digital and Performance (Data and Digital Update)
	Hannah Stewart	HS	Deputy Trust Secretary
Apologies:			
	Dr Asif Bachlani	AB	Associate Non-Executive Director
	Tony Saroy	TS	Trust Secretary (Minutes)

Item	Subject	Action
TB/24-25/1	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/24-25/2	**Declarations of Interest** None declared.	
TB/24-25/3	**Personal Story – Crisis Home Treatment Services** The Personal Story item was cancelled due to the service user being unwell.	
TB/24-25/4	**Quality Improvement (QI) – Violence and Aggression**	

Item	Subject	Action
	The Board heard the QI story from OI, DL, GM and ST, who set out details of the ongoing work between the Quality Improvement Team and the Transformation Team, across the acute inpatient wards regarding violence and aggression, including the introduction of a safety huddle and the safety culture bundle. The success of implementation of the pilots is currently being monitored via data collection and staff feedback is actively gathered to ensure staff can feel that there is a difference. It was agreed a further update on the Violence and Aggression work should brought back to the September Board meeting. **ACTION: AR to bring back a further update on the Violence and Aggression to the September Board meeting.** The Board thanked RS for attending, and **noted** the Quality Improvement – Electronic Observations.	
TB/24-25/5	**Minutes of the previous meeting** The Board **approved** the minutes of the previous meeting.	
TB/24-25/6	**Action Log & Matters Arising** The Board **approved** the Action Log. The zonal observations action was discussed, noting that the new due date for this action is September 2024. It was confirmed due to the number of changes taking place on the wards, it was agreed that the safety bundle for violence and aggression would be rolled out first, and then the zonal observation changes will follow on wards where appropriate. Regarding the not due actions, it was confirmed that the clinically ready for discharge seminar which was due for December 2024, would instead have half a day dedicated to this at the October Board Seminar day.	
TB/24-25/7	**Chair's Report** The Board received and **noted** the Chair's Report. The Non-Executive Directors gave updates on their recent visits that took place across the Trust.	
TB/24-25/8	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • SS recently attended the Senior Medical Staff Committee and presented her six priorities to them and shared feedback from her first 100 days including staff views. SS re-enforced how important it is to hear the medical voice more in the organisation and for them to be actively part of the transformation and improvements. • On 16th May KMPT held its first ever Data Conference for clinical colleagues across the Trust. The event was very well attended and feedback was really positive.	

Item	Subject	Action
	• The Board's attention was drawn to a paper later on the agenda regarding the culture of the organisation, which demonstrates how bold and ambitious the Trust is trying to be. The Board received and **noted** the Chief Executive's Report.	

TB/24-25/9	**Board Assurance Framework (BAF)**
	
	The Board received the BAF and reflected on the following matters:
	• 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))
	
	A discussion pursued around the removal of the industrial action risk given the recent announcement of further industrial action to take place in the future. Assurances were given, that previous industrial action had been well managed with minimal impact on the Trust and it was agreed that the risk should be still be removed.
	
	The Board reflected on Risk ID 02241 regarding compliance with food legislation, noting that there are no further actions and it was queried whether this need to remain on the BAF. Assurance was given that a process is currently being undertaken to ensure that the new contract has matured in the right way, with initial findings showing that it has, and following this review the risk may be recommended for removal.
	
	The Board **approved** the Board Assurance Framework.	

TB/24-25/10	**Strategic Delivery Plan Priorities - Year 2** The Board received the report, noting that no changes have been proposed due to the upcoming election period. The Board noted that this was a more focused strategic plan, with a number of actions moved into 'business as usual'. An update was given on the progress of each of the six priorities for year 2 of the plan, with a total of 28 outcomes due to be delivered. Vacancies were discussed, noting that the 3 year target has already been met, and it was noted that the Executive Management Team would receive a paper shortly to discuss the Trust's tolerance rate on vacancies and whether this should be revised further.	

Item	Subject	Action
	The Board **noted** the Strategic Delivery Plan Priorities Year 2 Update.	
TB/24-25/11	**Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report** The Board received the MHLDA update. It was noted that two additional sub-groups are due to be established; one focusing on improvements in dementia diagnosis rates through the system, and the second focusing on health inequalities to scope the potential opportunities and initiate improvements where necessary. Services users in out of area placements with learning disabilities or autism were discussed, and it was confirmed that the workstream on returning these service users from their placements is being hosted by the Trust as opposed to Kent County Council, as the Trust is the largest Mental Health provider across Kent. In order to aid this, some learning disability experts have been recruited to support this piece of work. The Board discussed the Provider Collaborative and the work done to date, recognising that the Integrated Care Board feels that work should have progressed further than it has done so far. However, positive feedback has been received with regarding the progress of the Mental Health work done to date. It was agreed that a Board seminar should be held in the future by the Programme Director of the Provider Collaborative, with a date to be agreed outside of the meeting, focusing on the three main areas of the collaborative. **ACTION: TS to arrange a Board seminar in the future, with a date to be agreed outside of the meeting, with the Programme Director of the Provider Collaborative, updating on the three main areas of the Collaborative.** The Board **noted** the MHLDA Provider Collaborative update.	
TB/24-25/12	**Community Mental Health Framework (CMHF) Transformation** The Board received the CMHF Update, recognising that the first phase of the framework has now gone live with seven new Mental Health Together (MHT) Service being implemented and existing resource being deployed from all current providers. The Board was advised that the cohort of Community Rehabilitation Services patients have complex mental health and comorbidity needs, and will therefore require a different approach on their care when it comes to MHT. The focus will be on outreaching to the service users, as opposed to bringing them into the service, and providing a more flexible service. It was noted that this will be crucial to the community services, but will be different to the MHT programme. The Board **noted** the Community Mental Health Framework Transformation.	
TB/24-25/13	**Integrated Quality and Performance Report (IQPR) – Month 1** The Board recognised the new format of the IQPR and it was agreed any feedback on this should be sent to SS outside of the meeting. The Board received the IQPR with the Board discussion focussed on the following:	

Item	Subject	Action
	• For the first time, this report includes the performance of the Trust's liaison teams across the county. There were 63 breaches of the 12 hours wait within April. However, this may not be fully accurate as the data continues to be worked through. This is an area of priority for the Trust and work is being undertaken to improve this performance across the six Liaison teams. • It is widely recognised both internally and externally, that the Trust needs a system solution for the dementia pathway. The first Provider Collaborative working group on dementia is due to meet for the first time at the beginning of June and they will report back to the Provider Collaborative that same week with a proposed timescale for a solution. • Work continues to progress to reduce violence and aggression on Trust wards, with staff continuing to be engaged with the work. • An independent report has been received on the Trust's Clinically Ready for Discharge patients (CRFD). 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, with KMPT contributing to the work. It was noted that the Trust is an outlier in this area compared to other Mental Health providers. The Board discussed the recent Deloitte External Well-Led Review, and their recommendation to use more benchmarking, and the need for this within areas of the IQPR, particularly the clinically ready for discharge data. The Board was further reminded of the need for pace on areas of improvement, and the importance of achieving all that is possible internally prior to looking to our external partners to support further improvements. The Board **noted** the IQPR.	
TB/24-25/14	**Finance Report – Month 1** The Board received the Finance Report and noted the following: • 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).	

Item	Subject	Action
	The Board was reminded that the system remains in a financially challenged position and due to this, the system has been asked to re-submit its financial plan by 12th June 2024. The Trust's position is not expected to change as to what was previously submitted and the Trust will continue to support the system in delivering their position. The Board **noted** the Finance Report.	
TB/24-25/15	**Equality Diversity and Inclusion (EDI) Plan/ Brand & Culture** Culture and identity is one of the Trust's six organisational priorities and to achieve the Trust strategy the Trust need to focus on creating the right internal culture and behaviours within KMPT, and do more to help service users, partners and the public understand what are the Trust's values and its role in Kent & Medway. Extensive engagement has been undertaken with staff, service users and partners, in addition to staff surveys, the external Well Led Review and Speak to Sheila sessions. All feedback has been themed into set responses, which will be used as the values for the culture change across the organisation. It was noted that the Board received a seminar session on this at its upcoming Board Seminar day in June and the People Committee would receive a further update on the equality and diversity work in July. The Board welcomed the ambitious plan which it supports, but recognised that this would take time to implement; it emphasised the importance of continuing to receive feedback as this is implemented to ensure frontline staff can feel the change. The Board further discussed the need to ensure the plan is appropriately resourced. There was a focus on equality and diversity and racial aggression, and the importance on getting this right first time. The Board **approved** the direction of travel within the report and appendix two regarding the cultural transformation programme. However, appendix one (the voice identity plan) was not immediately approved as it was agreed that this needed further discussion at the Board Seminar day in June.	
TB/24-25/16	**Patient Survey Results** The Board received and noted the disappointing results for the Care Quality Commission (CQC) Community Mental Health Survey 2023. The survey reflects the views of 270 people on the quality of care of KMPT, taken from a random sample of 1250 community patients. The Board recognised that the community services are currently in a state of transition with the introduction and roll out of the Community Mental Health Framework, which is expected to facilitate improvement in areas noted as worse than expected in this annual survey. The Board recognised the importance of triangulating feedback from the multiple ways in which it receives feedback from its service users, including the friends and family test. The Board discussed the Patient and Participation Strategy that was previously signed off by the Board, as well as the introduction of the Patient Engagement Council. It was felt that these could be better utilised to improve patient experience. It was noted that this would be moving to KH's portfolio in the coming	

Item	Subject	Action
	months and it was agreed that the Patient and Participation Strategy should be reviewed and refreshed, and brought back to the Board in November. **ACTION: KH to bring an updated Patient and Participation Strategy to the Trust Board in November.** The Board **noted** the Patient Survey Results.	
TB/24-25/17	**Safer Staffing Report** The Board **noted** the Safer Staffing Report.	
TB/24-25/18	**Social Value Update** The Trust has been incorporating social value and net zero requirements into its procurement processes from April 2022, and implemented the Trust's own model in September 2023. Further engagement on a social value plan is expected as the work is started by the system. The Board praised the progress made to date, but recognised more needed to be done, particularly with a focus on the Trust's Equality and Diversity work, the Trust's desire to become an anchor institution, and with a greater focus on health inequalities. It was agreed that the Board should receive a further update on the social value work in November, when the procurement plan will have been in place for a full year **ACTION: NB to bring an update on the social value work to the Board in November, with a focus on compliance, equality and diversity, health inequalities and the Trust's desire to be an anchor institution.** The Board **noted** the Social Value update.	
TB/24-25/19	**Data and Digital Update** The Board received an update on the progress against the Data and Digital Plan, noting that the one of the biggest issues remains the disconnect between the business and the Trust's patient record system, Rio. As the work for Mental Health Together has progressed, the digital team has standardised processes and worked with the team to co-design the Rio system with clinicians. The digital team worked with clinicians daily to really understand what they needed from the system and feedback from those teams indicate that Rio is now easier and quicker to use as a result. Following the success from Mental Health Together, the Trust is now considering how this can be carried out in other areas of the Trust with the appropriate digital and clinical resource. The Trust now has Digital Champions in place, with the first question and answer session having already taken place with them. This provides another feedback mechanism to the Digital team. Some Board members who recently attended the Data and Digital Conference within the Trust, praised the event and noted the positive feedback received from those in attendance. The Board **noted** the Data and Digital Update.	
TB/24-25/20	**Standing Orders & Standing Financial Instructions**	

Item	Subject	Action
	The Board discussed and **approved** the recommend changes to the Standing Orders & Standing Financial Instructions.	
TB/24-25/21	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/24-25/22	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/24-25/23	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/24-25/24	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/24-25/25	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/24-25/26	**Use of Trust seal** The Board **noted** the Use of Trust Seal Report.	
TB/24-25/27	**Any Other Business** Board members were encouraged to attend Canterbury Pride on 8th June 2024, noting that SG would be overseeing the recruitment stall.	
TB/24-25/28	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 30th July 2024, MS Teams	

Signed …….. (Chair)

Date ……..

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 08.30 to 08.50 hrs on Wednesday 19th June 2024
Via MS Teams

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Catherine Walker	CW	Deputy Trust Chair (Senior Independent Director)
	Sean Bone-Knell	SBK	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Dr MaryAnn Ferreux	MAF	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:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Tony Saroy	TS	Trust Secretary
	Hannah Stewart	HS	Deputy Trust Secretary
Apologies:			
	Peter Conway	PC	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director

Item	Subject	Action
TB/24-25/29	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/24-25/30	**Declarations of Interest** None declared.	
TB/24-25/31	**Annual Report & Accounts** NB confirmed to the Board that the Annual Report and Accounts had been reviewed by the Audit and Risk Committee. The Trust's External Auditors had reviewed the documents and made no material findings. There was one medium rated action related to the trust's MiCad system. The Board was informed that this was a data entry issue and the Trust was reviewing the system. The Board **approved** the Annual Report and Accounts.	

Item	Subject	Action
TB/24-25/32	**External Audit Report** The Board **noted** the External Auditor's Report.	
TB/24-25/33	**Letter of Representation** The Board noted and **approved** the Letter of Representation.	
TB/24-25/34	**Audit and Risk Committee Chair Report** The Board **noted** the Audit and Risk Committee Chair's Report.	
TB/24-25/35	**Any Other Business** None.	
TB/24-25/36	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 25th July 2024, MS Teams	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/07/2024

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JULY 2024								
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		On Agenda	IN PROGRESS
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		On Agenda	IN PROGRESS
ACTIONS NOT DUE OR IN PROGRESS								
30.05.2024	TB/24-25/11	Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report	TS to arrange a Board seminar in the future, with a date to be agreed outside of the meeting, with the Programme Director of the Provider Collaborative, updating on the three main areas of the Collaborative.	TS	TBC			
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		
30.05.2024	TB/24-25/4	Quality Improvement (QI) – Violence and Aggression	AR to bring back a further update on the Violence and Aggression to the September Board meeting.	AR	September 2024			
30.05.2024	TB/24-25/18	Social Value Update	NB to bring an update on the social value work to the Board in November, with a focus on compliance, equality and diversity, health inequalities and the Trust's desire to be an anchor institution.	NB	November 2024			
30.05.2024	TB/24-25/16	Patient Survey Results	KH to bring an updated Patient and Participation Strategy to the Trust Board in November.	KH	November 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			

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/07/2024

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
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			**Closed**
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			**Closed**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 25th July 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

I attended the Kent & Medway Provider Collaborative board, and noted the progress made. The potential for change is exciting but the pace of progress is still slow.

There have been significant changes to those in the position of NHS Chair in Kent & Medway. I would like to welcome my colleague, John Goulston, to his additional role as Chair of Medway NHS Foundation Trust, and welcome Annette Doherty as the new Chair of Maidstone & Tunbridge Wells NHS Trust.

I was invited to join a round table event for some NHS chairs and chief executives, hosted by the Chair of North West London Integrated Care Board, who has been tasked by the Cabinet Office to review the role of the Care Quality Commission. It seems likely that there will be some significant changes to way in which regulation is carried out, although this may be influenced by a new government now being in place.

3. Board Development Day

We held an excellent development day to which we invited the leadership team (Service Director, Clinical Director and Head of Nursing) of each of our five directorates. This was a great opportunity for increased dialogue with key leaders in the organisation, and an opportunity to share priorities and challenges in the year ahead. I am also grateful to my colleague, Mary Ann Ferreux (Non-executive Director) who led a presentation and discussion on health inequalities. The directorate leaders were as inspired as the members of the Board, and the Chief Executive and I will be discussing the way forward with this important topic over the coming year.

4. Trust Chair and NED visits

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

Where	Who
June 2024	
Trevor Gibbons Unit, Emmett's Ward and Willow Garden	Catherine Walker
Rosewood Mother & Baby Unit	Sean Bone-Knell
Brookfield Ward	Sean Bone-Knell
Research team	Jackie Craissati
Leader's event	Jackie Craissati
July 2024	
Complex Emotional Difficulties Physiological Therapies Service	Kim Lowe

Where	Who
Dartford, Gravesham & Swanley (DGS) Mental Health Together (and MHT plus)	Jackie Craissati
Medical committee meeting (Serious Incidents)	Jackie Craissati
North Kent Quality & Performance meeting	Jackie Craissati
Sevenscore & Woodchurch wards	Jackie Craissati & Kim Lowe (to be reported on at our next Board)

Chair visits
I was delighted to spend the morning with the Research director and the wider team. There is palpable energy in the team, and good progress being made, some grants coming on stream, a number of promising applications in the pipeline and the team expanding as a result. The key obstacle seems to be the ability to free up clinical staff to support research projects, despite the strong support from the executive team; in part this is a result of staff shortages, but also relates to the relative priority that research (and perhaps also quality improvement) is given by busy line managers.

Again, I spent the morning at the Leader's event, which is a great opportunity for a wider group of leaders to come together and contribute. In particular I enjoyed the presentation from our Director of Estates and his deputy who demonstrated the power of strong emotionally intelligent leadership.

I wanted to see Mental Health Together (our new community framework) in action: I am grateful to the team for hosting me and also allowing me to observe a pathway meeting. There is no doubt that staff are committed to implementing the model and are working hard. They are, however, hampered by considerable delays in the clinical leads getting into post, and difficulties in bedding in the partnership working with key third sector organisations. These seemed to be problems that perhaps could have been anticipated and tackled a little earlier? However, I was told that the latter problem was a consequence of significant delays in contracts being put in place and the finances released.

Finally, I spent time with the Consultant Psychiatrists in the Trust at their regular meeting, talking with them about learning from independent serious incident investigations and the implications for us at the Trust. As the most senior clinicians in the organisation, the doctors are important in ensuring that we have the right culture of continuous improvement and meaningful actions in response to patient safety concerns.

Catherine Walker - Trevor Gibbons Unit, Emmett's Ward and Willow Garden
I visited the Trevor Gibbons Unit and in particular Emmett's Ward and Willow Garden. It was good to see a refreshed and welcoming main reception area and a greater utilisation of the administrative blocks including a training and SIM room and quiet spaces for staff study and work. KMPT knows that the buildings on this site are aging which poses problems.

I was told that plans are afoot to construct a wooden fence. The electronic search scanner that I saw on my last visit is now an integral part of security in Emmett and staff welcome it as both time efficient and better in terms of patient dignity. Willow garden has had a partial makeover and the chickens and goats are a source of interest. More work is needed and the team hope to engage patients more in that project. Funds have been sourced from a local business to build a garden room which will be used for therapy sessions and quiet time.

Emmett was peaceful and I spoke to staff and patients about the food which seems to be improved with the new contract. Plenty of fruit was available in the lounge area. A source of

concern for staff was the slow refurb of three bathrooms which have been out of commission for a month.

Sean Bone-Knell - Rosewood Mother & Baby Unit
A lovely bright and modern building with motivated and caring staff. I was able to observe the multi-disciplinary team meeting at the unit. This was a very interesting experience and I was very comforted to hear the level of detail and care given to each of the patients. Updates were inclusive and focused on what was needed to get the patient ready to return home.

The unit were experiencing some medical staffing issues on the day with both the specialist doctor and consultant on special leave periods due to unforeseen circumstances.

The building was clean, smart and inclusive of many aspects to occupy and develop both mother and baby. The award-winning garden is well used and patients and staff get to appreciate this excellent facility.

Sean Bone-Knell – Brookfield Ward
All of the staff were polite, caring and motivated. Patients were moving around the ward and happy to show me the improvements to their accommodation.

It was pleasing to see that capital works had been taking place recently at Brookfield to replace bedroom doors, reduce ligature risks and improve bathroom facilities. The staff were very pleased with the new doors and electronic access features. Privacy panels that allow patients to control from inside their room have also been included and were well received. (as mentioned in recent CQC reports.)

Food and nutrition were a strong feature and there was plenty of information available on notice boards and fresh fruit readily available. The new catering contract was again seen as a positive step forward, especially the food delivery and service feature which was well received by staff.

It was disappointing that on such a hot day the outside area/garden was still not readily accessible to patients. This was reported in a recent CQC report but as yet only minor improvements have been made.

Kim Lowe – Complex Emotional Difficulties Physiological Therapies Service

I was invited to join a live session hosted by Lee Laurence with five patients who experience complex emotional difficulties. Lee recently came to the Board to share a patient story and I was curious to see how this 'home grown' service functions and to understand the benefits to our service users.

It comprises a two-hour meeting, three times a week, for 12 weeks. Patients are referred to this service from our Home treatment team. The results were impressive, with a very low return take up once people had been through the service. It was relaxed, positive and gentle with peer-to-peer support guided by Lee. Patients are very self-aware of their difficulties and take positive learnings and messages from the rest of the group. You could feel the benefits the service users were gaining from talking and sharing with each other, instilling self-worth, confidence, and a level of kindness that so many were not receiving from their home, educational or work situations.

When asked what more could we be doing in this new area of therapy for KMPT. It was a simple request of set up more groups across Kent & Medway, use peer support and include more MDTs e.g. pharmacy. Share this success with national teams and use this as an exemplar for a way forward to help our community's stay well as a mean full preventative tool. A great service.

5 Congratulations

I would like to send warmest congratulations to all staff who were awarded an inaugural 'Value in Practice' award this month. An employee and a team from each directorate was awarded, and it was delightful to have the opportunity to send each of them a personal thank you from me and the Chief Executive for the immense value they bring to our organisation.

Chief Executive's Board Report

Date of Meeting: 25th July 2024

Introduction

I am now 9 months into my new role as Chief Executive of KMPT. In the last month we have finalised our plan following all the engagement work we have been doing as part of our identity and staff experience priority. I am confident there are exciting times ahead for KMPT that will be to the benefit of our staff, patients, carers and partners.

Regional and National Update

NHS Confederation Conference

Donna Hayward-Sussex, our Chief Operating Officer, and I attended the NHS Confed conference in Manchester last month. We had a brilliant two days where we heard from Amanda Pritchard the CEO for the NHS on her aims for the NHS in the coming months. We also heard from Sir Clive Woodward who did a brilliant presentation on creating "Teamship", which really resonated with me as we aim to connect our staff and their local teams to team KMPT as part of our identity work. In addition, we joined a session on improvement in the NHS and how it is critical as we all move forward to ensure that staff and patients know their views are valued and considered as part of finding solutions for new ways of working or improving patient pathways. We will be discussing our patient engagement work at the September Board meeting.

Integrated Care System and Provider Collaborative Update

Provider Collaborative (PC) Board Update

We met as the PC Board last month with John Goulston as the new Chair for the PC Board. The Board received an update from all three PCs and the progress that is being made. At the next meeting, we will provide an update on risks to the PCs for delivery and how we are mitigating these. There are some ambitious plans that are designed to improve care for our patients and also support the system financial plans.

K&M NHS Joint Forward Plan (JFP)

NHS Provider Trusts and NHS Kent and Medway are legally required to publish a Joint Forward Plan (JFP) setting out how they will deliver the NHS elements of the Integrated Care Strategy. The draft plan spans 2024-2026 after which it will be refreshed.

The plan has been developed with a project group leading this piece of work, all organisations from within the patch have contributed to the content they considered most appropriate from their individual strategies. A summary is included in the appendix to this report, with the full version uploaded to the Diligent Reading Room.

The Board is asked to:

1) Note the partnership approach to co-producing a Shared Delivery Plan for the Integrated Care Strategy.
2) Note the reference style to the Shared Delivery Plan and the key, existing approved NHS plans which are included in the document.
3) In the case of revisions by other partners during the approval process, to delegate authority to the Chief Executive for final approval of the revised plan.

Operational Update

KMPT Update

Leaders Event in person

We had another face to face leaders' event towards the end of June, the event was well attended and engagement levels were high. I once again set out my expectations for the senior leaders in the organisation, encouraging them to look up and out of KMPT and Kent, in addition to this I summarised to them the discussions we had at our virtual leaders' sessions and what we are doing to support them as leaders moving forward. We had an excellent presentation from our Director and Deputy Director of Estates sharing their leadership journey as a directorate and how engagement has improved leading to an impressive improvement in their staff survey results last year. The first time in many years. We spent time discussing our new identity, trust values and the behaviours that must underpin these values. We finished the day sharing with the group the programme we are developing for them as leaders. This will commence in September.

Kent Surrey and Sussex (KSS) Higher Trainee Event

I attended the KSS higher trainee event in Chatham on Friday 7th June. This event was organised by our Medical Education department to support higher trainees in the region. It was very well attended and I met numerous Higher trainees placed in KMPT.

I heard that KMPT has started a new initiative with the appointment of a Chief Registrar post to support higher trainees to develop leadership skills which is a welcome step forward.

Our higher trainee posts have gone through significant expansion, our trainee posts are oversubscribed and in August 24 we will see 16 higher trainees placed across our teams. Our trainee retention has improved and all higher trainees who completed their training last year have been appointed to consultant posts at KMPT.

International Recruitment Welcome Event

I had the privileged of closing our international recruitment welcome event on Tuesday 25th June. The event was very well attended. It was inspiring to listen to six of our international recruits share their personal stories with us. All were extremely positive about their experience of the recruitment process and joining KMPT. I want to formally welcome all of our international recruits to KMPT and my commitment to them on the day was that we are here to support them and their development, I was very clear they are a big part of KMPT becoming a truly inclusive organisation.

Value in Practice Awards

I am excited to say that June was the first month where the Trust has its Value in practice awards, there was an employee of the month and team of the month in all five directorates and support services. We

had over 100 nominations which is remarkable. Well done too all of the winners who are listed in the appendix of this report.

KMPT Thank you Cards for Staff

We also launched this in June and when I have been out and about visiting teams' staff have been talking to me about the thank you cards and how they have been using them to send to colleagues to say a little thank you.

Culture and identity priority

Over June we engaged with our people, patients and partners on options for our new visual identity and our cultural values. As has been the case throughout all of this work, we have listened and adapted as a result of that valuable feedback we have heard. We presented the final draft to our senior Leaders and our Board, which I am pleased was well supported.

A lot of thought has gone into the new trust cultural values to ensure they are right for our staff, patients and partners. **Our new values will be;**

- **Caring**
- **Inclusive**
- **Curious**
- **Confident**

There is overwhelming evidence that shows engaged staff really do deliver better health care; and it is proven that leaders who help their organisations to develop a clear vision and a compelling narrative about their mission and priorities, achieve higher levels of staff engagement. They also attract more people to work for them and have higher levels of retention. This is absolutely why we have invested the time we have and taken this bold approach to develop a new vision and compelling narrative that connects with our people, partners and patients.

We have also heard that our current name is confusing and needs to better reflect who we serve, what services we provide and our legal status. We will therefore be consulting further with the public on changing our name to Kent and Medway Mental Health NHS Trust and I will be seeking board's formal approval following the consultation, when we meet again in September to take this forward. I am confident that our new identity and values will take us to the next level and give our patients and people what they deserve, and would like to thank everyone who has been involved in helping us shape this so far. This is vital work that will enable us to deliver on our priorities for our patients.

Executive Visit to Medway Foundation Trust - Patient First Programme

On 31st May the Executive team visited Medway Foundation Trust to experience the achievements of the Patient First Programme. The programme utilises Continuous Improvement throughout the organisation and is used as the delivery method for their core strategic objectives. The team visited individual team Improvement Huddles where they witnessed frontline teams taking ownership of local problems and opportunities as well as their contribution to the larger strategic objectives. We attended a divisional performance review from the Medical directorate which demonstrated their grasp on performance, problem solving and proactive planning and later saw from the MFT executive team how this then translates into the overall strategy objectives for the organisation.

It provided us with an opportunity to see how Continuous Improvement can drive change and improvement for both local opportunities and the wider organisational strategic objectives. Dr Adrian

Richardson, our Director of Transformation and Partnerships will be leading on the KMPT "Doing well Together" improvement journey.

Memory Assessment Service (MAS) Update

I am pleased to say that on Monday 17th June we started our new Standalone Memory Assessment model. This new way of working is to ensure that we have a service dementia patient can easily assess. The new model will use the 'front door' of the Mental Health Together service, to triage people who need a dementia assessment. The ultimate aim is to ensure that people referred to the MAS service are able to be assessed and diagnosed within a six-week time frame. Over the past few months the team in South Kent Coast, led by General Manager, Dan Lee have been preparing for the launch of this service.

The first operational step on developing this model starts with the 1-month trailblazer. We will be reviewing as an Executive Team at the end of July to agree next steps. This is the first stage of a radical review of dementia community services in KMPT. There will be a further 2 stages to this work to ensure that the Kent and Medway system has a clinical and operational model that is sustainable to meet demand for this service for the future.

Summary and Conclusion

I am delighted to include in my public board report today the four new values that KMPT will be adopting going forward. These values have been chosen by our staff, patients and partners to support us in reshaping our identity. The values are fundamental to our organisation and are what I want us all to role model everyday in how we work and behave. I believe it is vital we have a culture that continually supports growth, and opportunity, for all of us.

Sheila Stenson
Chief Executive

APPENDIX

Over the past six months work has been undertaken across the system to draft a Joint Forward Plan.

Joint Forward Plan

NHS provider trusts and NHS Kent and Medway are legally required to publish a Joint Forward Plan (JFP) setting out how they will deliver the NHS elements of the Integrated Care Strategy. As our Integrated Care System has developed, we have now incorporated the Joint Forward Plan into a Shared Delivery Plan with Kent County Council and Medway Council.

The development of the Shared Delivery Plan was overseen by a project group which included representatives from NHS Kent and Medway, Kent County Council and Medway Council. Each organisation contributed the content they considered most appropriate from their strategies and workplans. The project group linked with NHS operational planning leads to ensure consistency and reduce duplication. Provider partners were represented by Strategy Directors and drafts were reviewed as the plan developed.

In April the draft was shared with an extensive list of stakeholders including Health and Wellbeing Boards (this is a statutory requirement), NHS trusts, ICB subcommittee, leadership at KCC and Medway Council, Healthwatch, the Police and Crime Commissioner, HCPs, VCSE representatives and NHS England and as a result the draft addressed issues highlighted by stakeholders.

The Board is asked to:

1. Note the partnership approach to co-producing a Shared Delivery Plan for the Integrated Care Strategy.
2. Note the reference style to the Shared Delivery Plan and the key, existing approved NHS plans which are included in the document.
3. In the case of revisions by other partners during the approval process, to delegate authority to the Chief Executive for final approval of the revised plan.

Executive Team Visits

Sheila Stenson:

Laurel House
Ethelbert Road
CED Crisis Group

Donna Hayward-Sussex

Offender Personality Disorder Pathway
Dover Community Mental Health Team
Trevor Gibbens Unit
Early Intervention and Home Treatment Team – Canterbury
Folkestone Community Mental Health Team

Nick Brown:

Highlands House
St Martins – Bluebell, Foxglove, Heath, Fern Wards
ECT Priority House

Andy Cruickshank

Offender Personality Disorder Pathway

Kindra Hyttner

Coleman House, Community Mental Health Team
Priority House Ward Visit
Trevor Gibbens Unit – Come Dine with Me

Sandra Goatley:

Canterbury Older Adults

Folkestone, Community Mental Health Services for Older People
Trevor Gibbens Unit, all wards
Acute Director Team Leaders

Dr Afifa Qazi:

Britton House, Older Adult Team

Dr Adrian Richardson:

Bay Tree House
Offender Personality Disorder Service

Value in Practice Awards - June 2024

Directorate		Name
North	Individual	Rebecca Bourne, Occupational Therapist
	Team	DGS Community Mental Health Team
East	Individual	Charlotte Gosden – Community Mental Health Nurse working in the Rapid Transfer Dementia Service
	Team	Thanet Mental Health Team, Community, Older Adults, Early Intervention Psychosis.
West	Individual	Kimberley Lowe, Administrator
	Team	Early Intervention Psychosis
Forensic	Individual	Hayley Mason, Family Engagement and Liaison Lead for Forensic Inpatient Services
	Team	Allington Ward
Support services	Individual	Adrian Biernacki, Catering Compliance Manager
	Team	Organisational Development
Acute	Individual	Maria Elliot, HCA Amberwood Ward
	Team	Acute Governance Team

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 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 May 2024.

- No risks have been added to the BAF since May
- We are exploring our exposure to risk in light of the recent cyber-attack involving Guy's and St. Thomas' pathology system as well as the potential disruption that the entry/exit system controls at Dover may cause.
- Two risks have changed their risk score since the BAF was last reported to the Board in May
    - Risk ID 05075 – Community Psychological Services Therapy Waiting Times (reduced from 16 (Extreme) to 9 (High))
    - Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 12 (High) to 8 (High))
- One risk is recommended for removal
    - Risk ID 02241 – Compliance with Food Legislation – Temperature control checks of Food (Rating of 6 (Moderate))

Governance

Implications/Impact:	Ability to deliver Trust Strategy.
Assurance:	Reasonable Assurance

Version Control: 01

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

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 30th May 2024.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – 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 May:

- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times (reduced from 16 (Extreme) to 9 (High))**

  This risk has been reviewed and updated. A review of the waiting lists has shown a reduction of 50% over the first 4 months of data collection, which has enabled the reduction in risk score. This has been possible following changes to the clinical model to maximise resources and increase access to services. There has been a positive response to recruitment with postholders starting their positions in July and August 2024. Waiting times will continue to be monitored with the aim of halving them again by March 2025.

- **Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 12 (High) to 8 (High))**

  The Community Mental Health Framework is now being implemented at pace. The risk levels have reduced, which has been reflected in the reduction in risk score.

Risks Recommended for Removal

1 risk is being recommended for removal at this time:

- **Risk ID 02241 – Compliance with food legislation – Temperature control checks of food (Rating of 6 (Moderate))**

  The most recent data shows increased compliance with the recording of food temperatures. The mechanisms for monitoring the compliance with recording the temperature checks of food and contract in place to address any concerns seems robust. Therefore, this risk is recommended for removal from the BAF and closure.

New Risks

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

Version Control: 01

Emerging Risks

No new emerging risks have been identified for the BAF at this time.

Following the Cyber attack to the South East London pathology provider the Trust has undertaken to review its clinical systems to identify the processes and procedures in place within its 3rd party providers. An initial review of the contracts has provided the Trust with assurance that industry standards are in place, however further work is on-going to assure this position.

The change to Entry and Exit System controls at Dover in October has the potential to cause significant traffic disruption in the county and may affect the delivery of services. KMPT holds a risk already regarding significant traffic disruption which is managed as part of the Emergency Planning risks.
Risk ID 4706 - Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford crossing)
Included on this risk are some actions to ensure KMPT is linked into the county planning via the ICB and Kent Resilience Forum, understands the reasonable worst-case scenario and has tested any updated plans to ensure any disruption is minimal. This risk will be kept under review and updated regularly as we approach the change to the Entry and Exit system.

Other Notable Updates

- **Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand**
  Whilst there are some early signs of an improvement for this risk, more time is needed to see if this is a statistically significant improvement. This risk remains unchanged at the moment, but will be updated as more data becomes available.

- **Risk ID 04232 – Management of Environmental Ligatures**
  This risk is well understood and remains stable, there will be little change until the actions identified in the Annual Ligature Audit and planned through the Trust Capital group have been completed. 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 00410 – Increased level of Delayed Transfers of Care (DToC)**
  There are early signs that this is moving in the right direction, with a reduction in the number of DTOCs and patients who are clinically ready for discharge. However, more assurance is needed that the data is showing a sustained improvement, and considerations are being given to the point at which this will be at a tolerable level.

Recommendations

The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.
The Board are requested to note that work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

Version Control: 01

Updated: 15 July 2024

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Board Assurance Framework

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

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

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

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

Action status key:

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

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** If KMPT remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. 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: COVID Backlog Plan complete in November 2023 Demand and Capacity modelling completed for the new Standalone MAS Model in March 2024 Updated Triage guidance signed off in May 2024 New Imaging guidance signed off in May 2024 External: GPs with Enhanced rolls in place to support KMPT clinics (ICB commissioned) ICB Pilot for Diagnosis of Dementia in Care Homes - Diagnosing Advanced Dementia Mandate (DiADem) in place 1st Line Directorate level IQPR including Power BI functionality to drill down to team level as part of IQPR refresh from May 2024. Communities of Practice engagement events Q4 23/24 and Q1 and Q2 24/25. 2nd Line Stand-alone Memory Assessment Model design and rollout across KMPT started in Aug 2023 to work on a number of initiatives to address capacity and demand and diversifying diagnostic skill-mix. Waiting List Initiative, COVID backlog has come to an end in Nov 2023 Capacity Planning and demand modelling is in progress and will be informing new model of care to launch in alignment with CMHF. 3rd Line 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%. KMPT will support the development of community based diagnostic provision and provide advice and guidance for DiADem. Audit of referral to assessment scheduled 25/26.	2nd Line Highlight report to Strategy Deployment Group on internal standalone Memory Assessment Service 6 week performance reported to organisation IQPR to Trust Board ?Progress report and performance to FPC and QC 3rd Line As part of internal audit review for 25/26 planned Referral to Assessment Scoping clinical audit to be confirmed	4	5	20	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Power BI reporting to support Improvement — Director of Partnerships and Transformation — 31/05/2024 — A 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 Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 31/10/2024 — A 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** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1.Active Review is in place in each CMHT locality. This involves an understanding and review of risk on a regular basis for all patients who are waiting some form of intervention. Psychology Leads working with colleagues to move patients onto stepped care pathway. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3.PSYCHOLOGICAL SERVICES TO MAINTAIN SPREADSHEET DATABASE TO TRACK PATIENTS IN PATHWAY. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO. 6. Hybrid working in place as requested by patients needs 7. Expansion of psychological practice workforce use of Mental	Assurances from dashboard data	3	3	9	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Waiting list review for mental health together — Director of Psychological Therapies — 31/08/2024 — A Recruitment of new supervisory posts for Mental Health Together — Director of Psychological Therapies — 31/10/2024 — G	Chief Operating Officer		1	2	2	30/08/2025

				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)
							Health Wellbeing Practitioners, Clinical Associate Psychologists, Recruit to Train staff and Assistant Psychologists continues to grow. 8. Ongoing group interventions to reduce waiting times and parity of offer at place.												

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)
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 — BAF Risk Opened — 30/07/2023 — Risk returned to BAF																			
ID 04232	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee IQPR reporting to Board	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 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 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** IF Food temperatures are not being consistently recorded at point of food service in food safety log books THEN the risk to the Trust is non compliance with food safety regulations. RESULTING IN possible inappropriate food temperatures, prosecution for non compliance via environmental health (EHO), possibility of food poising, burns, death, impact on food quality, reputation, criminal action against the Trust and individual staff (Server of food)	5	4	20	1/ HACCP - Safety log books on all wards - daily sign off by nurse in charge, weekly sign off ISS supervisors, monthly sign off KMPT Catering compliance mgr. 1d 2/ Modern matrons discussing with wards & ward managers non compliance 1a 3/ Acute wards as part on counting in out cutlery also confirm and sign that HACCP sheet has been completed. 1f 4/ Policies and procedures in place 1f 5/ Monthly catering contract review meetings with care groups 1h 6/ Risk being monitored via Nutritional steering group 1h 7/ Sending Deputy Director of Nursing regular e-mails with concerns/non compliance 1f	Further training is being provided by Catering compliance Manager and ISS where required Being reported into Nutritional Steering group to feed into board report (6 monthly from November 2023) 08.02.2024 - ISS have taken over the HACCP completion as part of new contract - Draft SOP added to documentations 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																			
			No Risks Identified against this Strategic Objective																
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** IF the Community Mental Health Framework is not piloted with the appropriate governance and data systems in place, THEN it may not be possible for agencies to work effectively together RESULTING IN poor data quality for reporting to IQPR, Staff dissatisfaction and engagement with the pilot, continued capacity issues, lack of improved waiting times, inability to achieve parity of access regardless of patient age, reputational damage	4	4	16	CMHF Programme Board with Implementation group with associated plan, including 3 phases of implementation across county reporting in CMHF Programme Board with multi- agency digital workstream CMHF Programme Board dedicated communications lead Clear reporting lines established with clinical leadership and oversight of new models. Robust programme management in place with phases 1 and 2 review in place	Community Mental Health Framework Programme Board	2	4	8	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Digital Solution for Data Collection and Reporting to be identified and implemented — Deputy Chief Operating Officer — 31/01/2024 — A Integration of provider workforce to aid skill mix and new ways of working — Chief Operating Officer — 31/07/2024 — 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)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	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. Daily reporting Weekly check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events 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** / **Owner** / **Target Completion** (end) / **Status** ICB diagnostic analysis of reasons for DTOC — Deputy Chief Operating Officer — Completed — G Recruitment of social workers for inpatients — Deputy Chief Operating Officer — Completed — G Exploring Step down options for DTOC — Chief Operating Officer — 30/04/2024 — A	Chief OperatingOfficer		3	3	9	06/05/2024

				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)
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	Owner	Target Completion (end)	Status	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** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) has been launched in the organisation and is being led by the deputies. 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. Service Line reporting data has been utilitised to identidfy loss making services and to focus discussions on opportunities. Papers reported to FPC and Trust Board. SLR data reviewed routinely to ensure Directorates clear on the position.	3	4	12	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Executive Director of Finance		3	3	9	**31/03/2025**
													Identify CIP programme to meet 2024/25 savings target	Deputy Director of Finance	30/06/2024	A						
													Align SLR and Budgeting to give clearer service line on reporting	Deputy Director of Finance	30/09/2024	A						
													Implement 3 year planning Model	Deputy Director of Finance	30/09/2024	A						
22/08/2023 Risk Opened																						
ID 07557	Aug 2023	Chief Medical Officer	**Trust agency usage** IF the Trust fails to recruit to its establishment and relies on Agency staff THEN this could impact on the quality and safety of services 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] Reporting the NHSE [3b] QPR Meetings [2a] Monthly Exec led Directorate Management Meetings to review Agency Usage [2a] Finance and Performance Committee monitoring [2b] Standing financial instructions [2e] Agency recruitment restriction [1a] Budget holder authorisation and authorised signatories Weekly monitoring of agency spend 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**	Executive Director of Finance		3	3	9	**28/03/2025**
													Identify plan for address temporary staffing within Nursing	Associate Director of Financial Management	30/06/2024	A						
													Identify approach for Medical Staffing within East	Chief Medical officer	30/06/2024	A						
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																			

				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)
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** IF the capital programme is not delivered in full THEN the Estates Strategy agreed at Board may not be executed in the timescales set out RESULTING IN clinical and workplace environments which may not be fully fit for purpose.	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. 2. In addition, the Capital Development Team are working with key stakeholders such as Procurement and Finance colleagues to establish standardised processes, frameworks and design/material specifications to provide a common path for capital projects for efficient, timely and effective delivery against specifications ("build it right first time"). 3. To assist with design management, ensuring that specifications are fit for purpose, it has now been agreed through 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). Trust Capital group managing programme. Programme delivery reported to TCG.	IQPR dashboard and reporting, Board, FPC and Trust Capital Group Oversight Board, FPC and Trust Business case review group Capital Group Oversight Business case review group EFM Senior Management Team Dashboard and reporting	4	3	12	⟺		Executive Director of Finance		2	3	6	31/03/2025

Actions to reduce risk	Owner	Target Completion (end)	Status
Robust capital plan to be in place for 2024/25 (timings)	Director of Estates and Facilities	30/05/2024	A
Quarterly, In Year Review of Capital Programme and Priorities (half yearly review)	Director of Estates and Facilities	30/09/2024	A

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update
Author:	Adrian Richardson, Director of Partnerships & Transformation &
	Jane Hannon, Programme Director Provider Collaboratives
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 ambitions, objectives and established milestones.

Governance

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

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Provider Collaborative Board

The Provider Collaborative Board is 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/workstreams 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)

MHLDA Provider Collaborative Progress

The PC met in June and was chaired by the KMPT Chief Executive. Following April's meeting two subgroups were established:

Task and finish overview for driving improvements to dementia diagnosis rates through a system wide response.

The task and finish group has met and is working alongside the Ageing Well Board to accommodate a workshop at the end of July where using A3 methodology improvement opportunities will be established for both dementia diagnosis and other aspects of dementia care across Kent and Medway.

Health Inequalities sub-group to scope the potential opportunities and initiate improvements where necessary.

A proposal was brought to the meeting for some focused work at team level to develop an approach to population health inequalities that could be rolled out. This was agreed and a clinical lead will be identified. The board requested a piece of work to address health inequalities experienced by young adults in Medway in one of the collaborative's workstreams and a proposal will be brought back on proposed next steps for this.

Work is continuing with the SROs and programme teams to ensure the ambition and objectives of each workstream are clearly defined. An update is contained in table 1.

Table 1 – Workstream Ambitions and Outcomes

Workstream	SRO	Ambition	Objectives	Milestones	Savings?
Bring people with LDA back from out of area placements	Sheila Stenson	Eliminate our of area placements for people with LDA	• Reduce the number of autistic in-patients unsuitably placed outside the Kent and Medway geographical location by 25% • Reduce the number of all autistic in-patients by 10% through a comprehensive review and resettlement program that includes clinical reviews of every patient and quality review of every provider.	• To reduce the OOA cohort by 25% and the entire cohort by 10% by the end of the 12-month pilot • To reduce the unsuitable admission of Autistic people • To reduce the length of stay for Autistic people admitted to mental health in-patient settings • To realise any identified savings and reinvest them into community services.	£1m to be reinvested

Improve UEC flow and ensure people with mental health crisis cared for in the most appropriate environment	Louise Clack	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	• 5% reduction in KMPT bed occupancy
			• KMPT LOS 32 days
			• Reduction in primary mental health presentation to ED 1.85% of attendances to 0.85%
			• Reduction in primary mental health conveyance to ED by ambulance from 4.1% to 2.05%
			• Reduction in primary mental health conveyance to ED by police from 3.7% to 3%
			• Reduction in 12 hour waits in ED that are attributable to mental health from 3% to 1%
				• 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
				• Revised Section 136 crisis pathway standards.
				• Development of a 3 year Action Plan aligned to the NHSE
					TBC –savings in acute CIP assumptions need to be clarified

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			• 4-hour response to emergency assessment 80% • Increase footfall to safe havens from 2135 to 5885 contacts per quarter • Reduction in incidence of s136 by 10% • Reduction in time spent by police in ED for s136 • Increase in conversion rate of s136 to admissions • Reduction in clinically ready for discharge	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.	
Ensure there is an appropriate Dementia offer for local people	Adrian Richardson	Ensure patients are diagnosed and have access to necessary interventions in a timely manner	• Increase Dementia Diagnosis Rate to 63%	• Working in collaboration with Ageing Well programme develop opportunity matrix for community assessment and diagnosis – Aug 24 • Task group formation collaborative chair between Ageing Well and MHLDA PC to drive opportunities – Sept 24 – Mar 25 *(key milestones and interim objectives will be developed following initial workshop in July 24)*	Dependent on future models of assessment and care
Community Mental Health Transformation Programme	Donna Hayward-Sussex	To complete implementation of Mental Health Together and Mental Health Together +	• Implement Mental Health Together to improve mental wellbeing for older and younger adults across Kent and Medway through the provision of integrated mental, physical, and social care support that is designed with and for people in their local community	• East Kent Phase 1 MHT Go Live Jan 24 – April 24 • North Kent Phase 1 MHT Go Live May 24 • West Kent Phase 1 MHT Go Live May 24 • VS/TP Recruitment April – June 24 VS/TP Contract Award March 24 On Track VS • Phase 2 implementation commences Jul - Aug	No – improved effectiveness – enables UEC improvements

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			• Improved access to support with better experiences of care. Delivered via a place-based model with a multi-agency approach centred on an integration of primary care, secondary care, social care and the Voluntary, Community and Social Enterprise Sector (VCSE) able to respond to local demographics and address health inequalities.		

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Next steps

- An overview of governance is being undertaken to ensure programme governance is established and how the ODG and CPAB groups feed into both the MHLDA PC and other PCs. A workshop is being planned to establish the function and opportunities of CPAB and a paper is anticipated to be presented to PC in August for CPAB and ODG.
- The establishment and recruitment of the central team will continue to 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 joined at the end of February 2024 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 the Clinical Professional Advisory Board to ensure a clinically aligned and where possible clinically driven improvement within the workstreams.

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Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Right Care, Right Person - Update
Author:	Christine Hemmings, Quality Assurance Director
Executive Director:	Adrian Richardson, Director of Partnerships and Transformation

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested.

Overview of Paper

Right Care, Right Person is an approach developed originally by Humberside Police. The approach was implemented across Kent and Medway on 2nd April 2024, this report provides an update on the implementation, findings and next steps.

Issues to bring to the Board's attention

The Right Care, Right Person was implemented on 2nd April 2024 and the programme structure has continued to monitor implementation since then.

Risks and issues identified before implementation have continued to be reviewed and are regularly reviewed within the programme.

Work is now underway to evaluate the impact of the implementation across Kent and Medway and the programme continues to run with an aim of implementing as business as usual in the Autumn.

Governance

Implications/Impact:	As the programme transitions into business as usual further work will be necessary to embed oversight, training and monitoring into existing structures to reduce possible impact in the future.
Assurance:	Reasonable
Oversight:	Trust Wide Patient Safety and Mortality Review Group

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Right Care, Right Person Update

1 Introduction

The Right Care Right Person (RCRP) initiative was implemented in Kent and Medway on April 2nd. The goal of this initiative is to refocus police activities on core duties and reduce unwarranted police involvement. The approach, developed by Humberside Police, has been described by Kent Police as showing an initial reduction in calls. A system wide evaluation has been commenced and over the next few months, county wide data will be shared and made available. The police have continued to prioritise public safety and respond to immediate risks to life or serious harm, as well as prevent and detect crime during this time.

2 Work completed to date

2.1 Option Appraisal Paper

In January 2024, The Executive Management Team reviewed an options appraisal paper drafted by the RCRP Oversight Group. The purpose of this paper was to lay out the options to cover any potential gaps in resource that might arise following the implementation of RCRP.

The following decisions were made:

- For patients absent or absent without official leave (AWOL) from our inpatient wards, we will use current resources to respond to AWOL situations where there is no immediate risk to life. Existing patient transport services may be sought for patients who choose not to return independently. Following three months, there will be an evaluation of this usage which will help inform any change in demand that may need to be responded to.
- The existing proposal to extend Core 24 Liaison Services will be continued to be pursued. This is in line with the expectations of the NHS Long-Term Plan and aligns with current proposal and funding request whilst supporting accreditation against PLAN standards for mental health liaison services. Core 24 provides a skilled and enhanced multidisciplinary team to support assessment and intervention for mental health presentations to EDs alongside

improved mental health oversight and foot print at front door via triage. This will support the delivery of RCRP.

- A review of 72-hour follow-up practice in West Kent Directorate showed potential resource release by limiting follow-up to discharge from inpatient admission. Daily safety huddles and police liaison meetings are being developed will be implemented.

2.2 Impact on Practice

The main areas of impact are requesting police assistance to return patients and involving the police for service user home visits. The associated policies are being updated. These are currently in draft and a number of interdependencies have been identified. Therefore these are being clarified to ensure that the revised policy is future proof. In the interim, the existing policies are being utilised.

3 Right Care Right Person Oversight Group

3.1 Governance

The governance structure for the RCRP project has been developed, with identified Trust Executive, Strategic, and Implementation Leads. Support continues to be provided by the Operational Excellence Project Manager. The project is monitored by the Trust Wide Patient Safety and Mortality Review Group. The RCRP Oversight Group is transitioning to the RCRP Evaluation Group although it is recognised that this will feed into the system wide evaluation. This group will continue to provide oversight to the workstreams which will continue. They may need to evolve and repurpose although it is hoped that as RCRP transitions to business as usual they can be ultimately stood down.

3.2 Workstreams

3.2.1 Patients Absent Without Leave

Practices are being adapted to avoid contacting the police unless specific concerns are present. Ward staff are responsible for ensuring the safe return of AWOL patients, unless they are high risk or an immediate concern for their safety.

The group continues to meet on a monthly basis to review the action plan and lessons learned that are shared by Kent Police on a weekly basis. The AWOL policy was completed for presentation to Clinical Effectiveness and Outcome Group(CEOG) in March 2024 however this was cancelled due to significant IT issues. It was subsequently shared with the CEOG virtually and has been amended where appropriate, with one final piece of work to replace the references to risk stratification in accordance with new policy and NICE guidance on risk assessment and management.

There have been a number of communications in the Acute and Forensic & Specialist Services Directorates however there have still been occasions where staff on wards have defaulted to reporting AWOL patients to the police regardless of risk. Where this has occurred, the incident has been reviewed and communications cascaded accordingly.

3.2.2 Security

There are no current plans to propose an additional security function within KMPT currently. This will be monitored over the next three months to establish what the need is if any. At this stage, it seems unlikely that this is an appropriate way forward.

3.2.3 Concerns for Welfare

This workstream continues to meet and review any issues that have been raised. The duty function picks up any issues raised. The weekly learning shared from Kent Police has provided an opportunity to focus on any issues that have arisen. There have been examples whereby a multi-agency approach has been adopted and valuable learning shared.

3.2.4 Patients that walk out of the ED

There has been discussion in system meetings and lessons learned shared across in terms of response to issues that have occurred in Emergency Departments. Police will be able to share data over the coming months that will support deeper understanding of the issues.

3.2.5 Section S136

Multi-agency meetings are held monthly to discuss section 136 implementation and review, with a focus on refining services and policies.

Even though it is apparent that patients detained under section 136 typically require specific police attendance, it is also recognised that innovative approaches implemented by health and social services might create alternative treatment pathways. KMPT's 836 service plays a critical role in advising on these alternatives. This service effectively guides police officers to appropriate and supportive care options beyond immediate police intervention, ensuring that the response to the patient's crisis is as beneficial and appropriate as possible.

To coordinate these efforts and continually improve the system, a multi-agency meeting focusing on section 136 implementation and review is held monthly. This forum brings together representatives from various agencies including the Police and SECAMB to discuss current practices and outcomes. One of the main agenda items at these meetings is discussing the implementation so initiatives such as the 'See and Treat' and 'Hear and Treat' and crisis houses. These discussions are aimed at refining these services to ensure they meet the diverse needs of each patient group effectively. By examining real-world outcomes and feedback from all stakeholders, the group identifies gaps in service and opportunities for enhancement.

These meetings serve as a platform for reviewing the system-wide policies that govern the handling of section 136 cases. Currently, this includes a comprehensive review of the overarching policies, with specific focus areas like the RCRP being brought to the forefront of discussions. The goal is to ensure that policies remain

relevant and are adapted based on evolving needs and insights gained from ongoing service implementation and outcomes.

The overall aim of these efforts is to create a more responsive, humane, and effective system that not only meets legal mandates but also provides the best possible care and outcomes for individuals experiencing mental health crises.

3.2.6 Transport

Alternative methods for low-risk patient pickups, such as using taxis or public transport with staff escort, and existing patient transport for higher-risk situations are being utilised. The usage over the next three months will be captured and this will inform next steps regarding any additional provision that may be required.

3.2.7 Data

Trust data opportunities have been explored, and data from Kent Police is being analysed to assess the impact of the new approach. This has not currently shared with KMPT but will be within the next three months. However anecdotally it has been recognised that there has been a reduction in calls to the Police demonstrating potentially a decrease in unwarranted activity.

3.3 KMPT staff engagement

High-level communication has been shared with staff to inform them of the significant change in practice. RCRP project members have attended various meetings, including the Senior Nursing Leadership Forum, to discuss the changes. Weekly System wide meetings with Kent Police are held to evaluate cases and establish correct escalation processes.

3.4 Service user and carer representation

Service User and Carer Representation Scheduled meetings with carers and service users have been conducted to gather feedback and input on the RCRP approach

prior to implementation. Suggestions for mental health training for the police, concerns about confidentiality during staff visits, and the need for more safe havens have been noted.

4 Embedding the New Approach

4.1 Next steps

Agreement on evaluation metrics for the project period has been made and work is underway across the system to collate and review these. Evaluation of the effectiveness of the RCRP project will be conducted at 3 months and 6 months, with a transition to a sustainable business as usual model in October 2024.

4.2 Data analysis

Continued analysis of available trust data and collaboration with Kent Police for more accurate reflection of unwarranted police activity and map resource requirements. This will be available over the next three months.

4.3 Training

Training needs analysis is being conducted to address potential knowledge and skill gaps. This is being informed by feedback and lesson learned that are reviewed on a weekly basis. Trust policies and procedures are being reviewed and amended with stakeholder engagement.

5 Risks and Issues

Prior to implementation there were concerns that potential risks would include workforce requirements impacting patient safety concerns and service delivery gaps. Anecdotally this has not been evident as an issue. However there have been isolated incidents whereby the response from Kent Police has required some further discussion and learning.

Conclusion

Overall, progress has been made in implementing the Right Care Right Person initiative, with key decisions made, policies being updated, and stakeholder engagement ongoing.

Evaluation, data analysis, and training were identified early in the implementation and working groups are now being established to identify the ongoing training needs and to articulate the impact of the implementation to various stakeholders.

It is recognised that this is still relatively early stages of implementation, however there are currently no identified issues that are being raised other than isolated situations.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Purposeful Admissions Programme
Author:	Victoria Stevens, Deputy Chief Operating Officer
Executive Director:	Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The Trust Board ratified the Bed Strategy 2023-2026 in July 2023. This underpins the development and delivery plan for the Patient Flow Priority. This paper provides an update on the progress and delivery of initiatives since the last board discussion on this in January 2024.

Issues to bring to the Board's attention: Overall, the Patient Flow Priority is on track to deliver the Trust's strategic ambitions.

Current position*:* Inpatient bed occupancy is at 95.8% against a target of 85% by the end of 2025/26. The current occupancy is 0.1% off trajectory (target of 95.7% for June 2024 as per the initial trajectory).

Areas of concern:

- The proposed bed management RiO module has not progressed. The Digital Team have faced challenges with this and are working with the current supplier to look at software development options.
- Consistent support from social care, is required to ensure timely discharge of people from our in-patient services. Whilst they have engaged well with us, there has been a delay in agreed actions.

Item of excellence

- Crisis House (third sector run) and gate-kept by KMPT is running well in Medway. Safe Havens are being extended across the system supporting admission avoidance.
- Red to Green programme is running across all wards.
- Medicines optimisation initiative has been completed with all community teams having access to clozapine testing devices and Consultant Connect (App based support) live across all community teams.
- CMO led MADE events held in North, East and West with reducing trend in bed days lost to CRFD.
- High Intensity User pilot has demonstrated effective admission avoidance. Model is being scoped for roll -out across all community teams.

Governance

Implications/Impact:	Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board

Version Control: 1.0

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Patient Flow Priority Update: July 2024

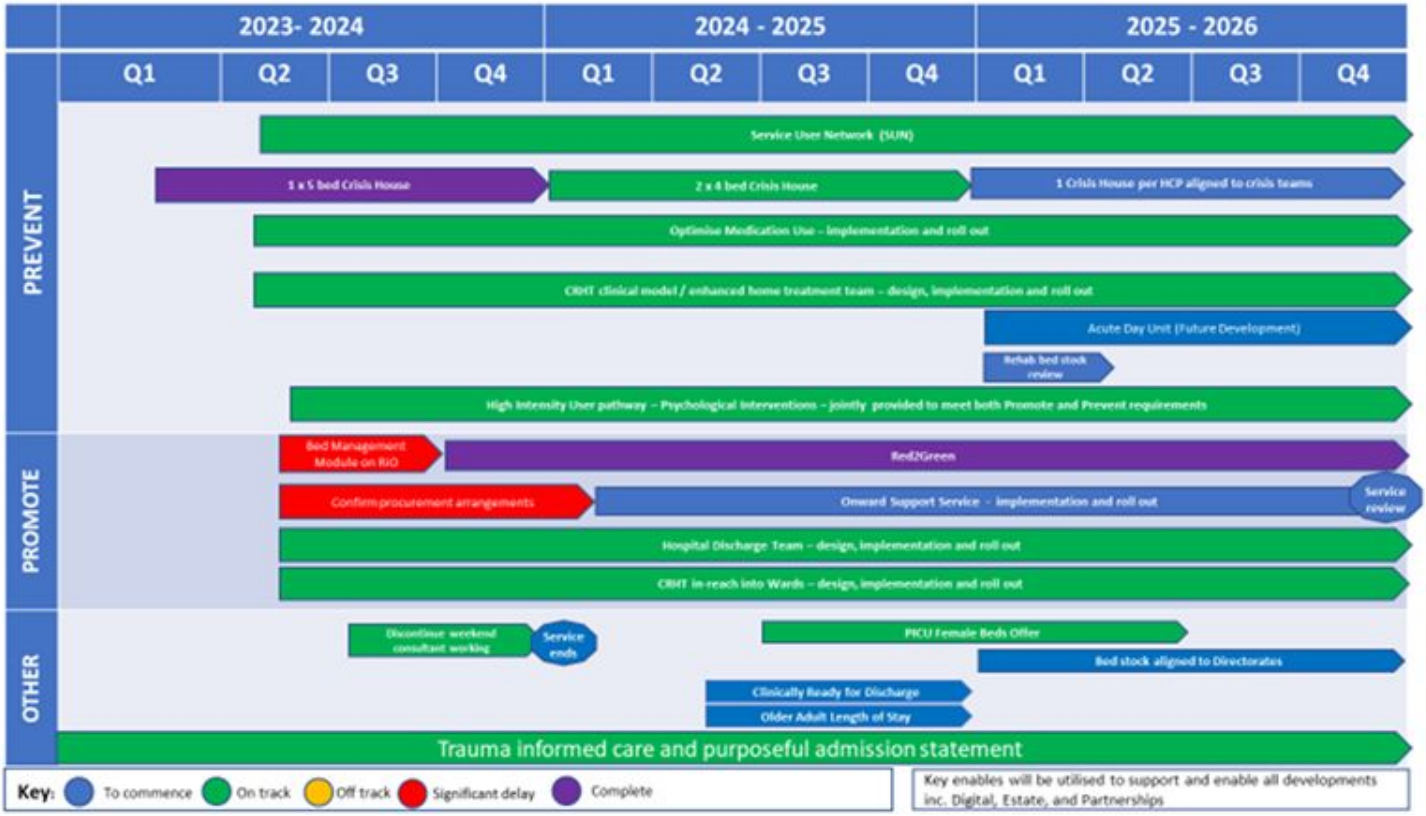
1 Purpose

1.1 The Trust Board ratified the Bed Strategy 2023-2026 in July 2023. This has been used to underpin the development and delivery plan of the Flow priority, which is one of the Trust's six priorities. This paper provides an update on the progress and delivery of the priority to June 2024.

2 Background

2.1.1 The Flow Programme supports our strategic ambition to deliver outstanding care that is safe, high-quality, and easy to access. It focuses on providing care close to people's homes in the least restrictive settings, in line with NHSE guidance on in-patient care in mental health settings[1]. The programme has been built around two key themes, **'preventing'** (avoidable admission) and **'promoting'** (timely discharge). The initiatives identified in the programme support the strategic ambition to reduce bed occupancy to less than 85% by 2025/26. Further details about these initiatives are outlined in Appendix One.

3 Programme Update



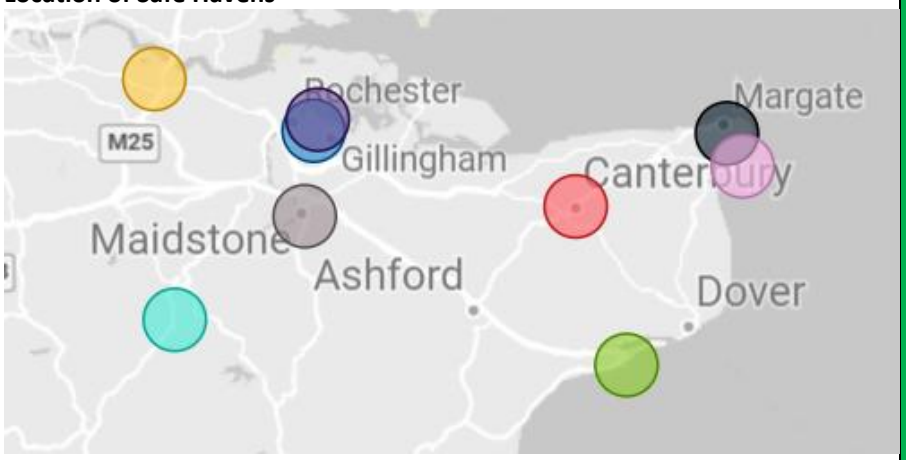
3.1 The total number of out-of-area bed days (acute plus non-contracted PICU) decreased from 493 in Quarter 1 2023/24 to 453 in Quarter 4 2023/24. This has risen to 529 from March to May 2024. This increase was due to OOA use related to two members of staff admitted to OOA beds.

3.2 Inpatient bed occupancy is currently at 95.8% against a target of 95.7% to reach a trajectory of 92% by March 2025. The Quarter 4 position was 96.2% (young adult acute = 95.5%, older adult acute = 97.7%). The last 3 months (March – May) position was 96.1% (young adult acute = 96.4%, older adult acute = 95.5).

Version Control: 1.0

3.3 As outlined in the IQPR, bed occupancy is high across all our sites with minimal variance. We are experiencing delays with CRFD patients relating to a number of internal factors that were highlighted in the MADE (Multi agency discharge event) that we are actively working to address. We are also working with our partners to address external factors relating to social care and housing.

3.4 **Progress of Programme Initiatives**

	Programme Initiative	Details of work completed	RAG Rating
Prevent	Service User Network (SUN)	Clinical staff have been recruited to the network and groups are now in place in North, West, and East Kent. North Kent Mind are the identified lived experience provider and recruiting to posts. KMPT volunteers with lived experience will continue to cofacilitate the groups until this recruitment is complete. Sign up from patients for groups has been lower than expected. This is being explored using the A3 improvement methodology. KPIs are being put in place which will inform an evaluation of this service. Early feedback from those who have attended is positive with people describing the groups as *"very understanding"* and a *"safe* [space]*".* They reported feeling *'lighter after the group'* and feeling able to *'change my life around'.*	Green (On Track)
	Crisis Houses and Safe Haven	Medway Crisis House (5 bedded unit) opened in April 2024. To date 35 individuals have used this service. The ICB have confirmed that there will be 4 crisis houses in Kent and Medway by 2025. The new Safe Haven contract came into effect in June 2024. Services have been extended across all areas and a new Safe Haven has opened in Dartford. Medway and Thanet Safe Havens now offer extended services including 24/7 in Medway. Discussions are underway to co-locate a haven at the William Harvey Hospital, 6am to 11pm, 7 days a week. **Location of Safe Havens** 	Green (On Track)

[1] NHS England » Acute inpatient mental health care for adults and older adults

	Medicines Optimisation	**Consultant Connect** is now live across all community services. All clinicians in CMHT's can access the Consultant Connect system. This App and web-based communication platform facilitates direct, real-time connections between our clinicians and national experts across 14 specialities, eliminating the need for referrals as well as by-passing GP and hospital switchboards. Positive feedback from our prescribers using this system has allowed immediate treatment initiation hence reducing onward referrals. and enables safe prescribing and treatment for patients. **Point of Care (PoCHi)** near to-patient blood testing machine for Clozapine patients, is now operational across all of the CMHTs. KMPT is currently conducting a patient evaluation audit to demonstrate improvements in patient experience.	Green (On Track)
	CHRT Clinical Model	The Enhanced Home Treatment Team model is on track with recruitment to the multi-disciplinary team underway.	Green (On Track)
	Acute Day Unit	This has been paused for future Development and will be reconsidered in Q1 2025	Not Started
	High Intensity User Pathway	The pilot has concluded. 14 patients were supported. The average number of admissions reduced from 11 to 4 per month for this cohort. The average LOS dropped to 48 from 127 days per month. This translated to reduction in bed use of 79 days per month for the duration of the pilot. The rollout across all CMHTs is being scoped.	Green (On Track)
Promote	Red to Green	Red to Green has been implemented and is live across all wards. This ensures that all patients receive an MDT discussion every day resulting in improved clinical care and discharge planning. This has transitioned to business as usual for the Trust.	Complete
	RiO Bed Management Module	This initiative is Red-rated. It has not been possible to implement the proposed bed management RiO module as per the original timeline. The Digital Team are working with the current supplier to look at development options to address identified issues but it is likely that an alternative digital solution will be required. Once implemented this would further help with improving flow.	Red
	Onward Support Services	The Trust and the ICB commissioned the bed usage assessment that has been published. The ICB, KMPT, and the MHLDA Provider Collaborative are now jointly working on the recommendations. Although this work is not due to complete until March 2026, this initiative has been RAG rated red due to a recurrent solution not being identified to date. In addition to this, the ICB has confirmed non-recurrent funding for Discharge to Access (D2A / step down beds. The D2A step-down bed model in East Kent is being scoped and developed.	Red
Promote	Hospital Discharge Teams	Recruitment of social workers will commence September 2024. Options to reconfigure patient flow team are being scoped with staff providing in-reach function to care homes to support with discharge of patients with complex needs.	Green (On Track)
	CHRT Clinical Model	CRHT in-reach into wards commenced January 2024. Home Treatment Teams are actively in-reaching into wards to support discharge. Every week there are a significant number of patients going home with CRHT input. 49% of discharges are attributed to HTT in-reach. Two weekly governance meetings are in place to monitor implementation and effectiveness.	Green (On Track)

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Other	Weekend Consultant Service	Weekend Consultant cover has been ended and consultant cover to inpatient wards is now only used as an exception particularly over bank holiday weekends and during periods of Industrial action.	Green (On Track)
	Segmented Beds	Scheduled to start in 2025-26.	Not started
	(New) Clinically Ready for Discharge	MADE events (chaired by CMO) have been held in West, East Kent, and North Kent. Actions from these events are being used in conjunction with the Bed Usage report to support both discharge of individual patients identified in MADE and a system wide focused improvement initiative. The improvement initiative will focus on: a) Working with the system: Developing external relationships and improving processes between partners to support discharge. This is being supported by the Integrated Care Board b) Improving the continuous flow of people via internal ward-based process reviews and improvement in internal KMPT functions. The monthly number of acute clinically ready for discharge patients decreased from 59 in February 2024 to 38 in June 2024. During the same period clinically ready for discharge bed days reduced from 1903 in February 2024 to 1417 in June 2024. An escalation meeting that is jointly chaired with Kent County Council is now in place every Wednesday for people who have been inpatients for 30+ days or whose care needs are more complex in nature with no onward plan. This will use monthly SPC charts that monitor the impact of the system and internal improvement initiatives indicated above.	Green (On Track)
	(New) Older Adults LOS	Trust wide improvement initiative has commenced utilising the A3 improvement methodology. Additional scoping of a virtual ward offer in the East for older people providing support for both physical and mental health has commenced with KCHFT.	Green (On Track)

4 Conclusion

- Initiatives that focus on preventing avoidable admissions are progressing with access to Safe Havens extended across Kent and Medway, the introduction of the Medway Crisis House, and the rollout of the SUN model. The High Intensity User pilot has demonstrated a positive impact on admission avoidance and a full rollout is being scoped. Mechanisms to measure the benefits of these services are being put in place.
- Initiatives that promote safe, high-quality, and timely discharge are also progressing. Red to Green has been rolled out across the Trust with 49% of discharges attributed to in-reach from the Home Treatment Team. The recruitment of social workers to discharge teams is due to commence in September 2024. Three multi-disciplinary discharge events chaired by the CMO have been held to support the discharge of people who are clinically ready for discharge. Partners have committed to a system wide improvement initiative whilst KMPT is introducing ward level continuous improvement to support the discharge of people who are clinically ready for discharge.
- The monthly number of acute clinically ready for discharge patients decreased from 59 in February 2024 to 38 in June 2024. During the same period clinically ready for discharge bed days reduced from 1903 in February 2024 to 1417 in June 2024.

Version Control: 1.0

- There is a clear downward trend in bed days lost to CRFD over the last 3 months (March to June) however this is not yet translating into a proportionate reduction in Bed Occupancy. It is likely that as increased capacity is realised, it is quickly used by unmet need. Our next planned action is to analyse ward level data and triangulate our information to help us understand further how to address the unmet need.

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Appendix One: 10 Initiatives within the Purposeful Admission Programme

Service proposal	Outline details	Expected outcome
Onward Support Unit	A voluntary, community, and social enterprise (VCSE) sector run 20 bed residential Onward Support Unit to support planning and pathways to move people out of a hospital setting. To be reviewed in Year 3 with the intention to close as demand will have been reduced by other initiatives within the Purposeful Admission Plan.	Reduced delays in transfer of care/clinically ready for discharge for people waiting for placements with providers in the community Reduction in number of bed days
Crisis Houses	Short-term (7 days) 24/7 supported accommodation as an alternative to inpatient admissions Commissioned by the ICB, delivered via Voluntary, Community and Support Services Sector (VCSE) in partnership with KMPT providing the gate-keeping function. Model based on national best practice and co-produced with ICB NB: It must be noted that commissioning of this service falls within the remit of the ICB and is out of the direct control for KMPT	Prevent avoidable admissions of patients mostly with complex emotional needs presenting in a crisis situation Reduction in the number of bed days
Hospital Discharge Teams	Dedicated team for CRfD to achieve hospital discharge by working proactively with and supporting providers with placements of patients with complex mental health needs Workforce model achieved by remodelling of patient flow team	Promote timely discharge Reduced delays of transfer of care/clinically ready for discharge Reduced bed days
Bed Management system (Flow/Red to Green)	Red to Green is a process and set of principles to support patient flow within mental health inpatient settings; by focusing on resolving issues which prevent patients progressing on the discharge pathway	Promote timely discharge Reduction in bed days
CRHT Clinical Model	Home treatment teams to offer enhanced support to inpatient wards. Work towards an increase in the number of in-patients accepted for home treatment. Pilot clinical model to split ward/CRHT consultant model	Promote timely discharge Reduction in bed days

Acute day treatment units aligned to CRHTs	Acute Day Unit (ADU) in one Directorate initially to expand to one per HCP. Initial pilot developed to evaluate the provision The acute unit (CRHT staff) will offer a range of interventions including close monitoring and medication management. This will provide crisis focused and a time limited non-residential service	Prevent avoidable admissions Reduction in the number of bed days
High Intensity User pathway (Psychological interventions for people with Complex emotional needs)	Psychologically informed co- produced safety plan for reducing the number of admissions to hospital for people with complex emotional needs	Prevent avoidable admissions Reduction in the number of bed days
Service User Networks (SUN)	Service in the community which will support people with complex emotional needs and offer support to avoid going into a crisis situation and promote use of crisis houses where appropriate	Key enabler for the implementation and successful delivery of crisis houses across the county with focus on reduction in avoidable admission and reduced bed days
Optimise use of medication / anti-psychotics	Community Clozapine initiation to allow patients to access Clozapine treatment without requiring admission to an inpatient ward	Increase number of patients receiving Clozapine initiation in the community Reduction in avoidable admissions
Segmented beds aligned to Directorates	Inpatient beds aligned to Directorates in year 3. This will allow each Directorate to manage their own bed stock with community teams and CRHT working closely with acute services to admit people only when care in a bed becomes absolutely essential	Better ownership of flow through beds Prevent avoidable admissions and promote early discharge Reduction in the number of bed days

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25th July 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.

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)

July 2024

Contents

1. Chief Executive Overview

In the last IQPR report I set out the 65 measures that we are capturing and the activity that enables them. As this report shows, we are making progress to improve the reporting and quality of data across many of these measures, and in getting our people to recognise and own data to improve outcomes for patients. This is an ongoing focus for me and the executive team, and very much aligns to the work we are doing to transform our identity and culture and embed our new values. We all need be curious about what our data is telling us, and have the confidence to use this data to make better operational decisions and be open about areas where we can continuously improve.

This report highlights where performance has improved and also where continued, dedicated focus is required. Ultimately, we need to do things differently to improve access to our services and deliver the best outcomes for our patients. Notably, across dementia, mental health together and flow. That is why these areas continue to remain my priorities and the areas me and my executive team are focused on improving.

Dementia

Our dementia diagnosis times continue to be an area of concern. I am pleased that work we have done since our last report has increased the recording of the diagnosis of dementia on Rio, giving us a more accurate picture of how long patients are routinely waiting for a dementia diagnosis. Our team in Medway deserves credit for the work they have done to cleanse their data and to work together to spot gaps and find opportunities to improve, which is why we have seen an improvement in the diagnosis rates recorded there. We must now make sure this practice is sustained across all of our teams and much work is happening to do that.

However, we know we need to do things differently to solve this challenge which is why we are introducing a new standalone memory assessment service (MAS). This began, as planned, on the 17 June in the South East Coast and has already identified valuable learnings and improvements for us to take forward as we roll the service out across other areas in July and August, and ultimately our aim is to assess and diagnose within a 6-week period.

Mental Health Together

We are now routinely capturing the baseline outcome measure for Mental Health Together patients, which is telling us the main factors that are contributing to their poor mental health. Being able to track patients' progress through the service is limited at the moment due to it being a new service. As we and our

partners care for more patients through the service we will be able to monitor the quality of care being delivered over time, so that problems and opportunities for further improvement can be identified as soon as possible.

It's also too soon for us to be able to create a statistical process control chart but what we do know from the data, and from speaking to our people and partners, is that we are seeing a significant and increasing demand into the new service across all our teams. As of mid-June, 1,000 patients have attended an initial meeting, first assessment and completed a baseline outcome (Dialog+), which is positive - but they are now waiting for social or clinical interventions from us and / or our partners beyond the 4 week ambition. We are working closely with partners to recruit to new roles that will be delivering these interventions and to minimise waiting times for our patients.

On a positive note, the introduction of Mental Health Together has led to a reduction in calls to the 111 press 2 line. Calls still remain high, and additional support and training is being put in place to manage that, but we are pleased that the number of abandoned calls has reduced.

I'm also delighted to report that our rapid response teams have seen even more patients in crisis within 4 hours this month. We have exceeded 80% for the first time since August 2023, with North Kent at nearly 90%. I'd like to take this opportunity to say well done to these teams for their continued effort and focus on this.

Patient flow

Bed occupancy remains slightly above our target and with minimal variance across our hospitals. We remain focused on our agreed approach to prevent avoidable admission and to promote timely discharge. The focus and new approaches we continue to implement under this priority are having a positive impact on our performance. These are captured in detail in a separate paper for the board this month. I would like to recognise here that our focus on promoting timely discharges and working together with partners through our Multi Agency Discharge Events has helped us to reduce our clinically fit for discharge rates again this month, and I'm pleased to share that the new crisis house in Medway, received over 30 referrals in the first six weeks of opening supporting patients in a mental health crisis get support who may previously have been admitted to a ward. A further crisis house in East Kent should be available from late summer.

Liaison services

Our performance measures for liaison services are new and under review. We are currently measuring patients who are receiving a 'triage' assessment but not patients who have received a fuller assessment. It is important we see all patients entering A&Es as quickly as possible, regardless of the type of

assessment they have had, so while the data shows an improvement in the number of patients attending A&E that are triaged within 1 hour, I do not think this accurately reflects our position or the experience of our patients and have therefore asked for this to be reviewed.

Our acute colleagues report against two 12hr A&E waiting metrics. One covering the time from arrival to departure (whether that be admission, transfer or discharge) and one covering the period from a decision to admit (DTA) being made and the patient leaving the department for an admission. It is only possible for our psychiatric liaison services to reliably capture the point at which the patient is referred to Psychiatric Liaison and therefore all of our efforts are being concentrated on capturing this data across all our teams in the coming weeks.

Further areas I'd like to note

- Work is underway to retire the care programme approach (CPA) but until our new solution has been introduced, we will continue to monitor this. Overall, there is not significant variation in performance levels but variance does exist between community directorates. East Kent is performing 15% better than North Kent and West Kent. This is down to a number of factors including data capture, where letters are used instead of RiO forms; and more patients accessing medication depots in certain areas and therefore not requiring a care plan or personal support plan. CPA variation has been an area of focus for our West Kent teams over the last month to understand and drive improvements which they have done by 5%. Well done to all. North Kent is now adopting a similar methodology, and both directorates are aiming to reduce variation by 10% by September.

- Clinical appointments resulting in Did Not Attends (DNAs) have been steadily increasing in recent months. A deep dive analysis will be undertaken with findings presented by September.

- The percentage of patients presenting to CMHT and CMHSOP commencing treatment (second contact) within 18 weeks fell to its lowest position of the last two years in June. With Mental Health Together and MAS these metrics will be stood down nationally during 24/25, as we move to new measures that better reflect interventions delivered and patient outcomes - 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.

- Complainants are now consistently receiving a response within the 3-day target, with performance above 95% for seven successive months.

- Finally, I'd like to end my overview by celebrating the sustained effort and performance around our people work. We have continued to deliver improvements against our vacancy gap, essential training and leaver rate measures. I also recently learnt that we have one the fastest time to hire rates in the country for mental health trusts, it's now under 50 days, compared with the average in the NHS being over 75 days which is a significant achievement.

2. Report Guide

Statistical Process Control (SPC) is used to assist in the identification of significant change (see appendix for detailed information regarding this process), the tables within the next section of this report summarises variation in performance over time and assurance where targets exist. The intelligence from this analysis is used alongside wider intelligence within the organisation to highlight the areas of celebration and challenging within the Chief Executives Overview.

Section four presents a 12-month trend for all indicators by domain, within the summary tables levels of performance are colour coded against stated target (where they exist). Where an indicator is rated as amber, this denotes that the current level of achievement is within 10% of achieving its target. Red denotes a metric breaching the target and green where achieving.

Within each domain the indicators identified as subject to significant variation through the use of SPC are analysed further with supporting information regarding the definition, any known data quality and key variances across the directorates.

The latest published position for the Single Oversight framework is shown in the appendix. The majority of the indicators are annual measures and therefore not contained within the monthly IQPR, however it is important to ensure the trust continues to work to improve in these areas alongside those included within the IQPR.

3. Integrated Quality and Performance Summary

Variation Summary (where targets exist)

The following table summarises trends of variation and assurance for those indicators where targets are identified.

Variation	Assurance: Variation indicates consistently (P)assing the target.	Assurance: Variation indicates inconsistently passing and falling short of the target.	Assurance: Variation indicated consistently (F)alling short of the target.
Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	3.1.02: Vacancy Gap - Overall 3.1.03: Essential Training For Role 3.1.05: Leaver Rate (Voluntary)	1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	
Common cause – no significant change.	3.1.06: Safer staffing fill rates	1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral 1.1.13: Care spell start to Assessment within 4 weeks (Excl. MAS) 1.2.01: Average Length Of Stay (Younger Adults Acute) 1.2.02: Average Length Of Stay (Older Adults - Acute) 1.2.06: Unplanned Readmissions within 30 days (YA & OP Acute) 1.2.11: % Patients with a CPA Care Plan which is Distributed to Client 1.3.01: Mental Health Scores From Friends And Family Test – % Positive 1.3.09: Complaints responded to within 25 days (or agreed timeframe) 1.4.04: Restrictive Practice - No. Of Prone Incidents 2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge) 3.1.01: Staff Sickness - Overall	1.1.14: Care spell start to Assessment within 6 weeks (MAS only) 1.2.10: %Patients with a CPA Care Plan 1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans 2.1.04: Clinically Ready for Discharge: YA Acute 2.1.05: Clinically Ready for Discharge: OP Acute 4.1.01: Bed Occupancy (Net)
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.			1.1.15: Care spell start to Treatment within 18 weeks

Variation Summary (No targets)

The following indicators do not currently have an identified target nationally or locally and therefore can only be measured against trends in variation. Work is under way to establish local targets for an increased number of IQPR indicators.

Variation			
	Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	1.1.03: Assess people in crisis within 4 hours 1.1.04: People presenting to Liaison Services: triaged within 1 hour 1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks 1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)	
	Common cause – no significant change.	1.1.02: Open Access Crisis Line: Abandonment Rate (%) 1.1.06: Place of Safety LoS: % under 36 hours 1.1.09: % MHLD referrals commencing treatment in 18 weeks 1.2.03: Adult acute LoS over 60 days % of all discharges 1.2.04: Older adult acute LoS over 90 days % of all discharges 1.2.05: Patients receiving follow-up within 72 hours of discharge 1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) 1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end	1.3.02: Complaints - actuals 1.3.03: Compliments - actuals 1.3.04: Compliments - per 10,000 contacts 1.3.05: Patient Reported Experience Measures (PREM): Response count 1.3.06: Patient Reported Experience Measure (PREM): Response rate 1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly % 1.4.02: All Deaths Reported And Suspected Suicide 1.4.03: Restrictive Practice - All Restraints 4.1.04: In Month Budget (£000) 4.1.06: In Month Variance (£000)
	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	4.1.02: DNAs - 1st Appointments 4.1.03: DNAs - Follow Up Appointments	
	Special cause variation where movement is not necessarily improving or concerning	1.1.01: Open Access Crisis Line: Calls received 4.1.05: In Month Actual (£000)	

4. Trust Wide Integrated Quality and Performance Dashboard

People We Care For: Access

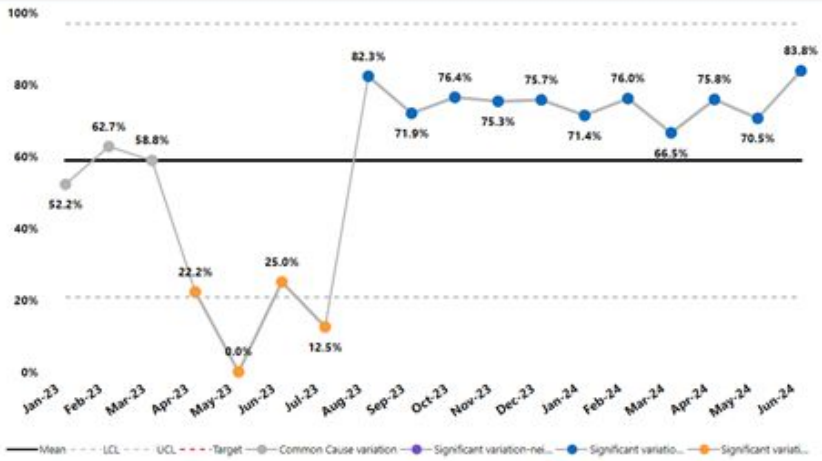
Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
1.1.01: Open Access Crisis Line: Calls received		5,245	4,910	5,248	5,249	5,473	5,380	5,842	4,737	4,900	3,604	3,258	3,022
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		35.2%	38.6%	45.4%	41.4%	44.9%	43.7%	42.3%	39.5%	42.3%	37.1%	34.1%	25.0%
1.1.03: Assess people in crisis within 4 hours		12.5%	82.3%	71.9%	76.4%	75.3%	75.7%	71.4%	76.0%	66.5%	75.8%	70.5%	83.8%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		0.0%	0.0%	0.0%	0.0%	0.2%	2.3%	4.4%	5.2%	9.9%	30.1%	46.0%	58.4%
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%	0.0%
1.1.06: Place of Saftey LoS: % under 36 hours		70.2%	66.0%	60.7%	82.5%	76.7%	78.6%	50.0%	56.0%	40.5%	60.5%	57.8%	74.5%
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%	52.2%	88.2%	65.2%	76.9%	64.7%	94.1%	71.4%	61.5%	66.7%	53.3%	76.5%	100.0%
1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks		8.1%	8.4%	7.6%	14.5%	15.5%	9.7%	4.6%	6.2%	7.5%	7.7%	8.8%	25.5%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		87.0%	89.4%	75.0%	72.7%	73.6%	60.0%	80.0%	67.7%	84.2%	62.5%	78.6%	79.3%
1.1.10: Perinatal assessments (against annual target)	2,103	171	153	146	158	163	118	145	139	113	485	138	157
1.1.13: Care spell start to Assessment within 4 weeks (Excl. MAS)	75.0%	60.5%	59.8%	58.6%	53.3%	63.7%	57.6%	54.5%	72.5%	72.5%	71.5%	71.0%	52.3%
1.1.14: Care spell start to Assessment within 6 weeks (MAS only)	75.0%	35.1%	38.2%	30.6%	36.6%	37.0%	34.4%	29.2%	37.9%	41.1%	41.7%	43.3%	47.2%
1.1.15: Care spell start to Treatment within 18 weeks	95.0%	76.5%	75.4%	71.9%	73.5%	75.2%	74.4%	73.2%	75.5%	77.8%	74.1%	72.2%	67.5%

Note: *1.1.10 Perinatal Access – Target is for annual position, national methodology results in a significantly larger figure reported in April compared to other months.*

Areas of Improvement

1.1.03: Assess people in crisis within 4 hours
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
	83.8%	96.9%	58.8%	20.8%		



Data Source
Rio

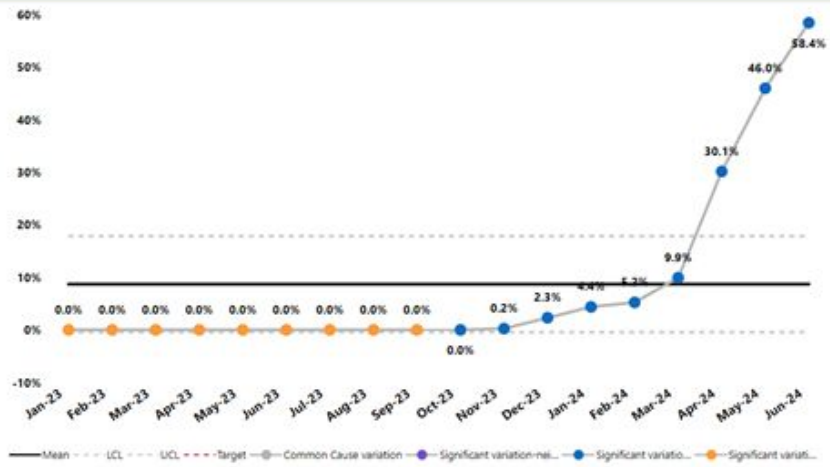
What is being measured?
Time from referral to 1st assessment, where the referral urgency is recorded as 'emergency'. This relates to Rapid Response and Home Treatment Teams.

Data Quality Confidence
Some issues identified with recording of referral urgency.

What is the data telling us?
There is an improving picture in terms of response to those in crisis, however, there remains variation across Kent and Medway. North Kent responded to almost 89.9% of 69 patients in crisis within 4 hours this month, East Kent 85% (107) and West Kent 73% (52).

1.1.04: People presenting to Liaison Services: triaged within 1 hour
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
	58.4%	17.8%	8.7%	(0.4%)		

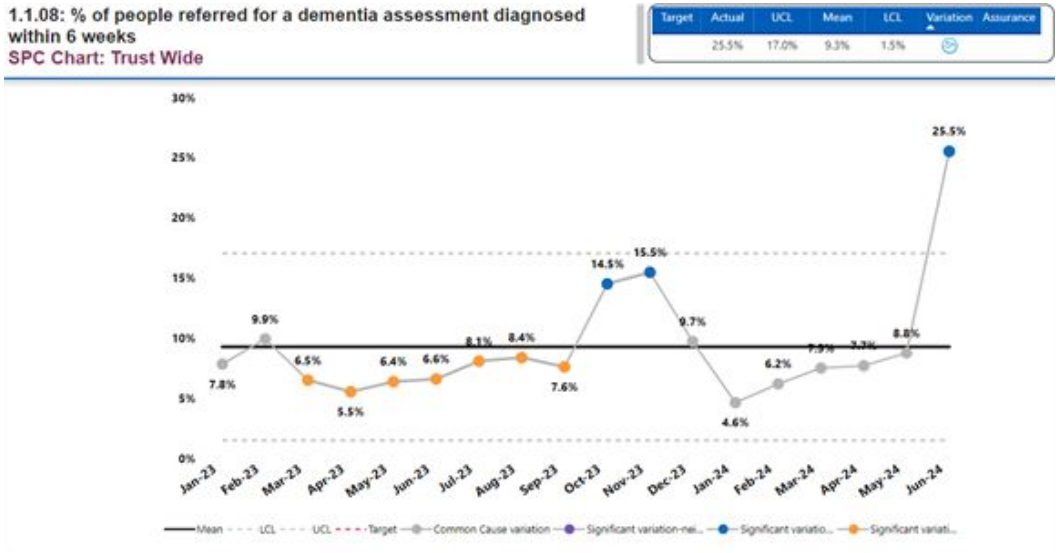


Data Source
Rio

What is being measured?
Time from referral to a 'triage' assessment within 1 hour.

Data Quality Confidence
A new code of 'Triage' was implemented to support a new model of care. However, not all clinicians are using the 'Triage' activity code on Rio for the initial assessment resulting in a lower than expected denominator.

What is the data telling us?
Whilst the use of the category Triage is increasing, as the chart shows, we do not consider this to be a fair representation of triage activity within Liaison Services. Regardless of the category used, all patients seen by a KMPT mental health professional within A&E settings will be triaged even when this is part of a fuller assessment. We are currently reviewing this measure with a view to propose a change for future months that extends triage to other categories recorded against activity on Rio.

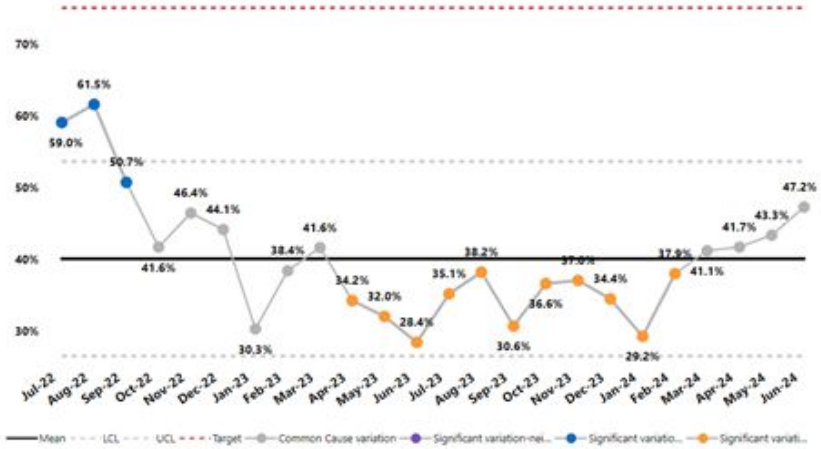


Data Source
Rio
What is being measured?
Time between a referral into the Memory Assessment Service and a confirmed diagnosis.
Data Quality Confidence
A confirmed diagnosis is not always recorded correctly on Rio, even though the diagnosis may have been confirmed with the patient and the GP via a letter. A letter has been sent to all medics by the CEO and CMO to encourage good practice.
What is the data telling us?
An improvement in the number of diagnosis recorded and % within 6 weeks. 333 diagnosis were recorded in June, compared to an average of 226 in the previous 6 months. Wait times for diagnosis (where this was recorded) was on average 20.1 weeks, this is an improvement on the previous month at 22.3 weeks. The increase in numbers of diagnosis and % of which that were in 6 weeks was driven by Medway CMHSOP following a focussed piece of work which is to be adopted within other teams. Increased levels of diagnosis were also observed in Ashford, Shepway and Maidstone teams

Areas of Concern

1.1.14: Care spell start to Assessment within 6 weeks (MAS only)
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
75.0%	47.2%	53.6%	40.0%	26.5%		



Data Source
Rio

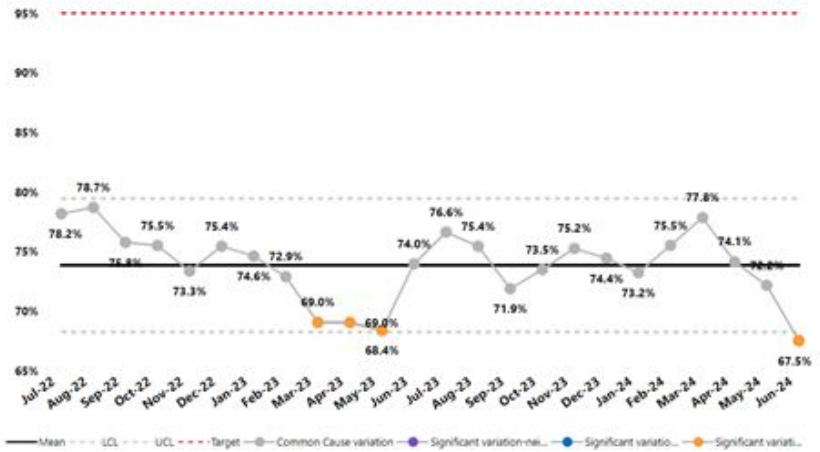
What is being measured?
Time from referral to 1st contact (initial assessment). Excludes the new Memory Assessment Service pilot in South Kent Coast.
This measure provides additional assurance alongside the wait for diagnosis whilst DQ is improved but will be retired upon full roll out of MAS services in all localities

Data Quality Confidence
No known issues

What is the data telling us?
Significantly under target, with less than half of patients starting an assessment within 6 weeks. There is significant variation across Directorates with North Kent above target (82%) and East and West significantly below target at 39% and 24% respectively. As backlogs are cleared % compliance will remain low

1.1.15: Care spell start to Treatment within 18 weeks
SPC Chart: Trust Wide

Target	Actual	UCL	Mean	LCL	Variation	Assurance
95.0%	67.5%	79.4%	73.8%	68.2%		



Data Source
Rio

What is being measured?
Referrals into CMHTs and CMHSOPs time to second appointment (start of treatment).

Data Quality Confidence
No Known Issues

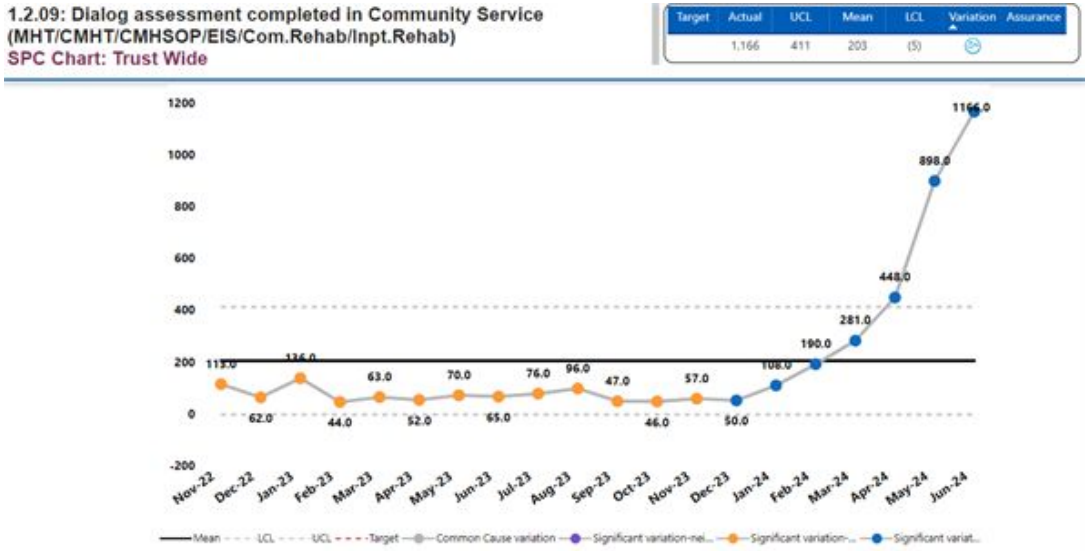
What is the data telling us?
As MHT and MAS services are implemented the inclusion in this indicator will reduce and in time it will be retired and superseded by CMHF waiting time measures and Dementia diagnosis waits.
All directorates experienced a decrease in month with variation remaining from 76.5% in NK to 55.1% in WK.

People We Care For: Care Delivery

Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	35.8	36.7	29.9	33.6	32.1	27.3	45.5	37.5	32.1	44.4	35.1	42.9
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	109.8	83.6	60.2	94.8	110.3	80.7	94.9	80.8	97.7	109.0	81.2	97.9
1.2.03: Adult acute LoS over 60 days % of all discharges		14.6%	16.5%	13.3%	16.2%	10.3%	9.2%	16.3%	12.8%	10.8%	17.5%	11.9%	15.3%
1.2.04: Older adult acute LoS over 90 days % of all discharges		52.4%	34.6%	29.2%	41.7%	45.5%	34.8%	32.0%	34.6%	46.2%	38.7%	29.0%	34.8%
1.2.05: Patients receiving follow-up within 72 hours of discharge		79.3%	72.3%	80.9%	81.3%	76.1%	82.0%	79.8%	83.0%	88.9%	83.4%	81.8%	72.8%
1.2.06: Unplanned Readmissions within 30 days (YA & OP Acute)	8.8%	9.7%	6.5%	3.8%	2.1%	5.2%	5.6%	1.7%	3.0%	5.1%	8.2%	3.9%	2.0%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		213	295	376	239	250	204	263	350	280	242	291	245
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end		6	12	8	8	5	8	9	12	9	9	8	9
1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)		76	96	47	46	57	50	108	190	281	448	898	1,166
1.2.10: %Patients with a CPA Care Plan	95.0%	80.9%	82.5%	81.7%	83.2%	83.1%	81.0%	81.6%	83.3%	85.4%	86.4%	86.0%	87.8%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	73.7%	75.6%	77.6%	79.0%	79.2%	77.4%	77.1%	77.4%	75.6%	76.8%	75.2%	73.8%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	68.8%	71.4%	70.9%	71.2%	73.3%	70.9%	69.8%	69.9%	68.6%	70.9%	68.8%	69.0%

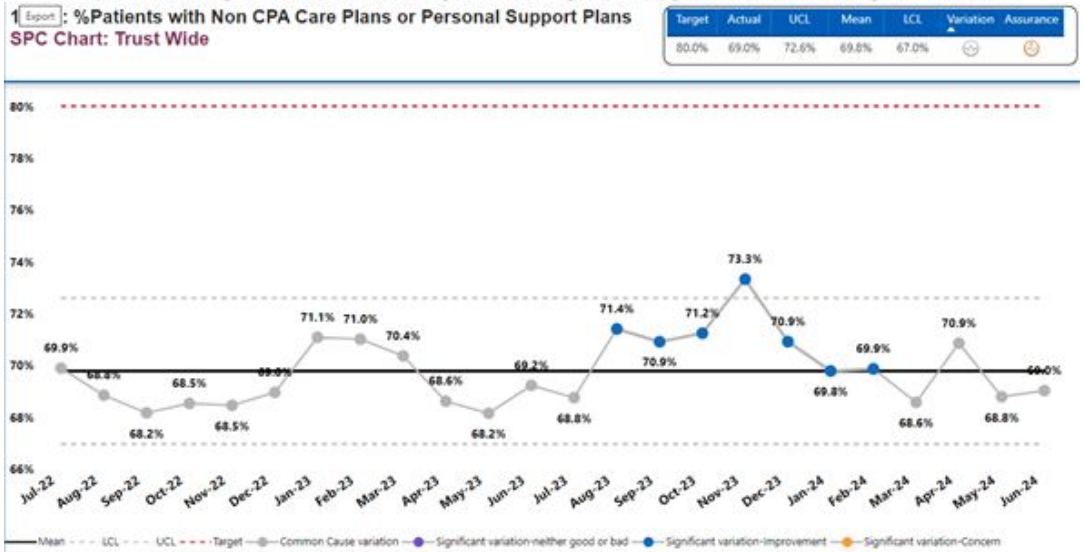
Note: *1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway.*

Areas of Improvement



Data Source
Rio
What is being measured?
The number of Dialog+ assessments recorded on Rio for all community teams.
Data Quality Confidence
No known issues.
What is the data telling us?
The ability to benchmark across teams is emerging now that MHT has been implemented in all localities. A significant increase in the number of Dialog+ assessments across community team was observed in June, it is yet to be identified what a consistent number will be as growth continues. Subsequent work is underway to monitor paired scores, insights into patient presentations and measurable improvements. These measures will become more robust as more Dialog+ roll out continues and more patients' complete interventions.

Areas of Concern



Data Source

Rio

What is being measured?

The % of patients where a CPA Care or Personal Support Plan created or updated in the last 6 months.

Data Quality Confidence

Care Plans and Personal Support Plans are not always recorded within the appropriate Rio Form and therefore not counted. Some are held as separate documents and uploaded into Rio.

Note: some patients are accessing depots and therefore do not require a Care or Personal Support Plan.

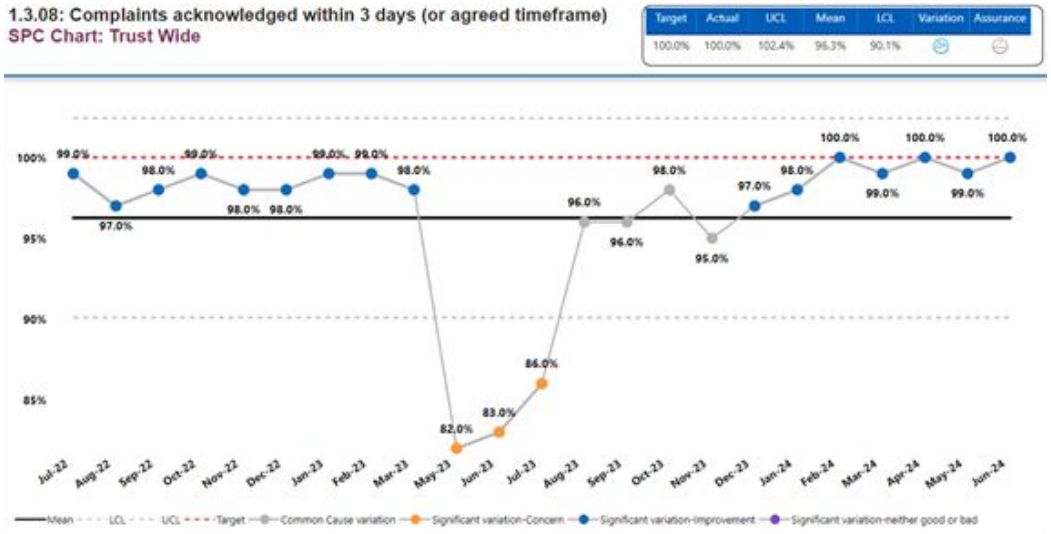
What is the data telling us?

KMPT is consistently and significantly below target and has been for the past 12 months for both measures. Forensic and Specialist Directorate performance has improved and is above target for the second month. Whilst levels of performance are not subject to significant variation, variance exists between community directorates EK are consistently within 10% of target.

People We Care For: Patient Experience

Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	86.4%	83.4%	88.3%	87.1%	89.2%	87.4%	85.9%	86.5%	87.9%	87.6%	89.8%	89.4%
1.3.02: Complaints - actuals		44	50	47	53	48	27	44	44	35	42	43	40
1.3.03: Compliments - actuals		115	112	117	106	131	115	112	82	126	120	110	119
1.3.04: Compliments - per 10,000 contacts		36.0	34.6	35.7	30.9	38.5	41.2	30.6	24.9	39.3	35.8	32.3	37.1
1.3.05: Patient Reported Experience Measures (PREM): Response count		675	512	460	510	631	532	417	452	496	596	674	538
1.3.06: Patient Reported Experience Measure (PREM): Response rate		4.7	3.6	3.2	3.4	4.2	4.0	3.0	3.1	3.4	4.0	4.5	4.0
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.3	8.4	8.4	8.1	8.6	8.5	8.3	8.1	8.5	8.4	8.4	8.5
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	86%	96%	96%	98%	95%	97%	98%	100%	99%	100%	99%	100%
1.3.09: Complaints responded to within 25 days (or agreed timeframe)	100%	84%	87%	73%	65%	79%	78%	87%	91%	100%	95%	96%	95%

Areas of Improvement



Data Source

InPhase

What is being measured?

The % of complaints that are acknowledged within 3 working days of receipt. An acknowledgement is a written response including advocacy information and a leaflet on the complaints process.

Data Quality Confidence

No known issues.

What is the data telling us?

Sustained improvement in acknowledging complaints for a period of 6 months following a change in process to address increased volume to prioritise acknowledgements.

Data relates to approximately 40-45 complaints a month as detailed in indicator 1.3.02 Complaints - actuals

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People We Care For: Safety

Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-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		85	130	420	230	127	135	117	113	105	115	114	113
1.4.03: Restrictive Practice - All Restraints		94	120	77	105	44	58	67	78	99	129	107	69
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	7	15	12	6	0	2	3	5	10	23	1	5
1.4.05: Decrease violence and aggression on our wards	(7.5%)	2.5%	5.7%	(18.1%)	2.5%	(20.7%)	(7.1%)	11.6%	23.8%	19.9%	36.7%	29.6%	29.0%
1.4.06: Medication errors		57	52	49	71	106	56	55	40	50	30	48	49

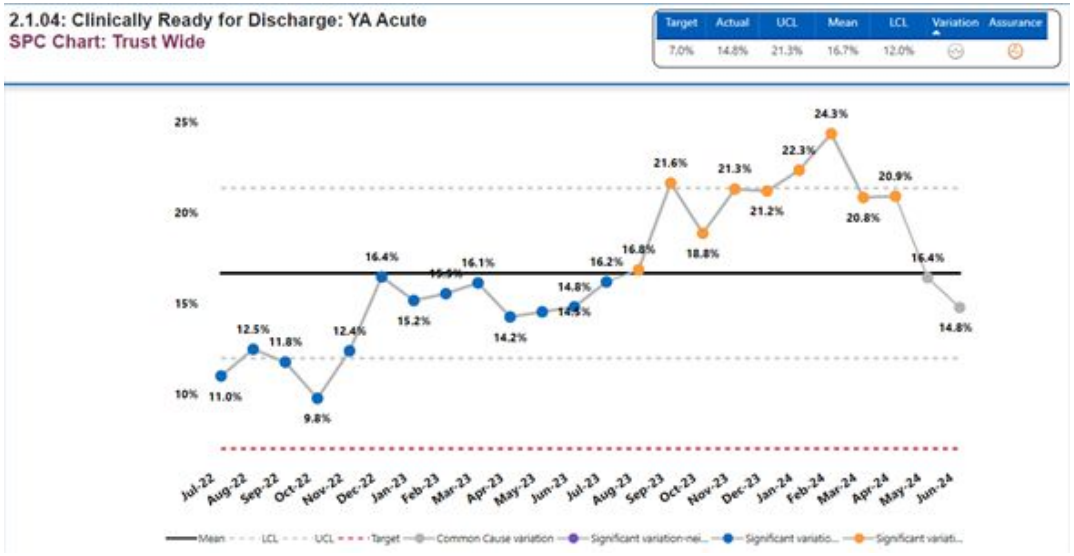
Note: ***Decrease violence and aggression on our wards*** *(1.4.05). An increase in reporting has been seen as staff awareness increases, this is a positive step and one we would expect as we focus on addressing this with our staff and patients. KMPT are promoting and moving towards a more open and speak up culture, 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*

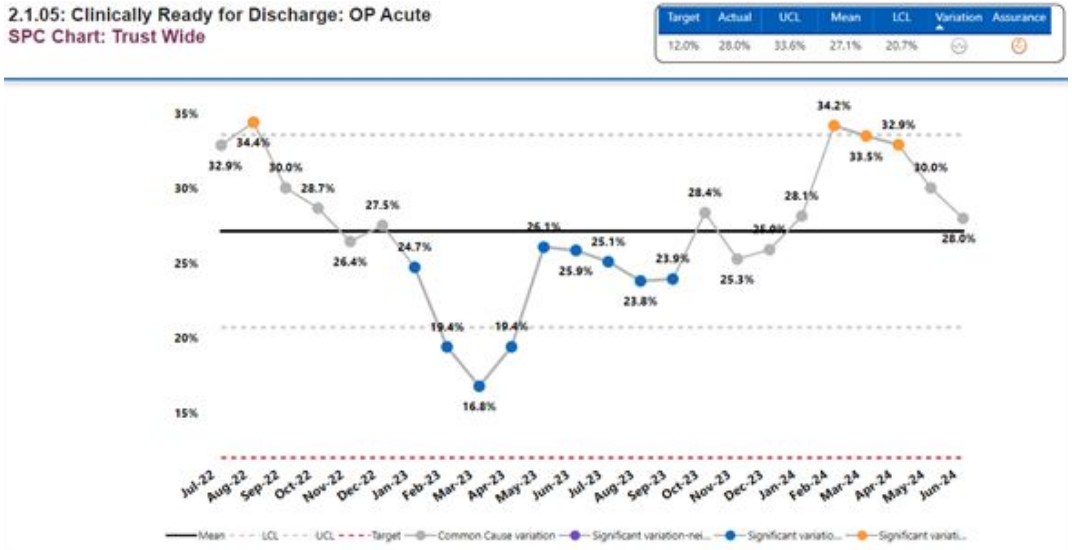
Partners we work with

Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
2.1.01: Referrals to MHT & MHT+ commence treatment within 4 weeks									100.0%	40.0%	32.6%	44.2%	30.9%
2.1.02: MHT & MHT+ waiting list size								49	193	387	772	1,624	2,210
2.1.03: MHT 2+ contacts		16,383	16,303	16,244	16,308	16,406	16,348	16,455	16,459	16,385	16,493	16,590	16,559
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	16.2%	16.8%	21.6%	18.8%	21.3%	21.2%	22.3%	24.3%	20.8%	20.9%	16.4%	14.8%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	25.1%	23.8%	23.9%	28.4%	25.3%	25.9%	28.1%	34.2%	33.5%	32.9%	30.0%	28.0%
2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge)	44.0	65.1	46.6	63.6	84.9	71.0	89.3	69.0	61.0	71.4	99.3	74.7	89.2

Note: *MHT 2+ contacts (2.1.03) 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, 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.*

Areas of Concern





Data Source

RiO

What is being measured?

% of bed days lost to CRFD's of all occupied bed days

Data Quality Confidence

No known issues.

What is the data telling us?

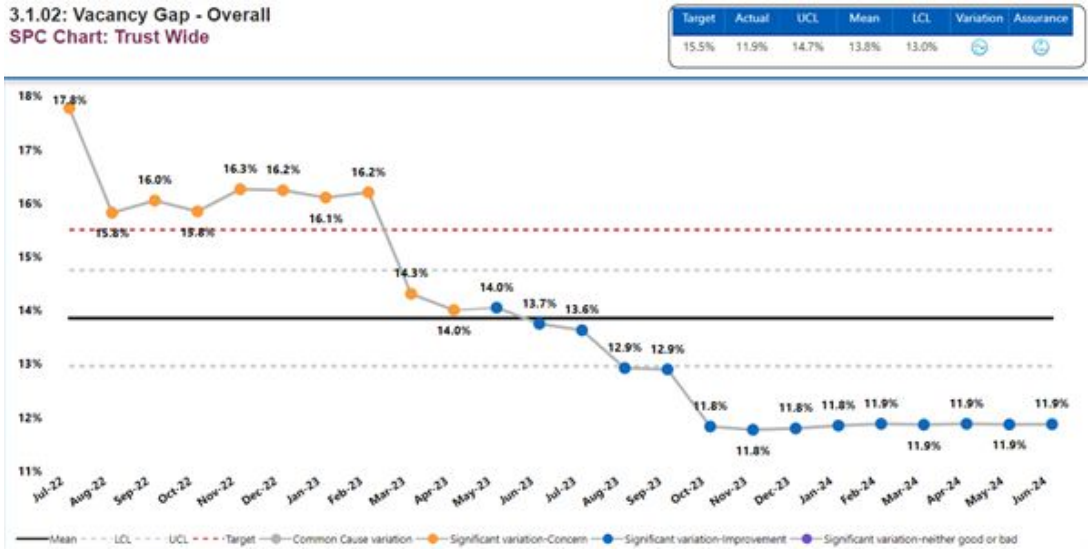
Third successive month of reduction in both YA and OP Acute bed CRFD, ongoing monitoring via SPC to establish if a trend of significance.

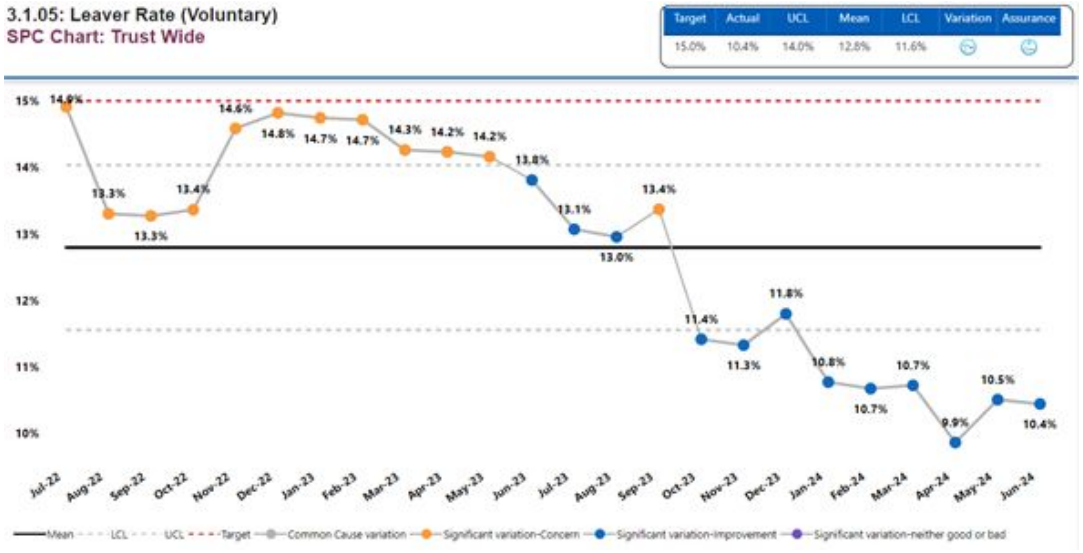
As of 11th June there were 47 CRFD's in acute beds of which 35 required support from Social Care. The main reasons for delays accounting for 80% of CRFD's are awaiting residential placements, public funding, care packages in patient homes and housing.

People who work for us

Section	Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
3. People who work for us	3.1.01: Staff Sickness - Overall	5.3%	4.7%	4.6%	4.4%	4.9%	5.1%	5.3%	4.8%	4.2%	4.5%	4.4%	4.5%	4.4%
	3.1.02: Vacancy Gap - Overall	15.5%	13.6%	12.9%	12.9%	11.8%	11.8%	11.8%	11.8%	11.9%	11.9%	11.9%	11.9%	11.9%
	3.1.03: Essential Training For Role	90.0%	93.6%	93.8%	93.4%	93.4%	93.7%	94.1%	94.0%	94.3%	93.9%	94.0%	94.2%	94.4%
	3.1.04: Leaver Rate	16.5%										14.7%	14.6%	14.6%
	3.1.05: Leaver Rate (Voluntary)	15.0%	13.1%	13.0%	13.4%	11.4%	11.3%	11.8%	10.8%	10.7%	10.7%	9.9%	10.5%	10.4%
	3.1.06: Safer staffing fill rates	80.0%	108.7%	108.7%	105.5%	108.8%	109.3%	106.1%	108.1%	112.5%	111.7%	112.4%	108.9%	103.7%
	3.1.07: Increase percentage of BAME staff in roles at band 7 and above	18.5%	15.3%	15.0%	14.9%	15.0%	14.7%	14.4%	14.6%	14.7%	14.0%	13.6%	15.5%	15.2%
	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%	0.5%	0.8%

Areas of Improvement





Data Source

ESR

What is being measured?

Vacancy- Calculated using in post FTE against the Vacant FTE on the 1st of each month.

Leaver Rate: For Voluntary Leavers we use a selected set of reasons. The calculation is average staff in post (FTE) against the leavers (FTE) in that same period (Usually reported as 12 Months).

Data Quality Confidence

No known issues.

What is the data telling us?

Sustain improvements below mean of last 24 months in both indicators.

Individual targets exist for each directorate based on historic performance, all directorates achieving their vacancy gap target with exception of East Kent who are within 1%.

All directorates achieving leaver rate targets with North Kent experiencing the lowest rates at 7.6% in June

Data Source

iLearn

What is being measured?

% of staff that are compliant with essential training overall.

Data Quality Confidence

No known issues.

What is the data telling us?

KMPT is consistently above the 90% target for essential training. The data combines all areas of essential training into one overall percentage. What the data does not highlight are the areas of essential training that are consistently below the required 95% target.

Levels of performance have improved further over recent months because areas of training that are below the 90% target, for example Basic Life Support and Immediate Life Support, have improved due to closer monitoring by Learning and Development and within the Directorates.

Efficiency

Section	Measure Name	Target	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
4. Efficiency	4.1.01: Bed Occupancy (Net)	92.0%	95.0%	95.2%	94.1%	92.1%	92.4%	93.4%	95.2%	96.9%	96.7%	95.8%	95.8%	96.5%
	4.1.02: DNAs - 1st Appointments		9.2%	9.6%	9.6%	10.0%	11.0%	9.8%	10.0%	10.1%	9.9%	10.2%	10.9%	11.6%
	4.1.03: DNAs - Follow Up Appointments		8.9%	9.3%	9.1%	9.3%	8.9%	9.3%	9.4%	9.3%	9.6%	9.8%	9.2%	10.0%
	4.1.04: In Month Budget (£000)	0	(13,739)	(13,651)	(14,390)	(13,607)	(13,941)	(13,756)	(13,746)	(13,746)	(13,754)	(13,524)	(13,619)	(13,850)
	4.1.05: In Month Actual (£000)		(13,669)	(14,063)	(14,108)	(13,362)	(13,702)	(13,581)	(14,226)	(14,201)	(14,630)	(14,080)	(14,655)	(14,437)
	4.1.06: In Month Variance (£000)		71	(411)	283	245	239	175	(480)	(456)	(876)	(556)	(1,035)	(587)
	4.1.07: Agency spend as a % of the trust total pay bill	3.2%	4.8%	4.3%	4.5%	4.1%	4.0%	4.2%	4.0%	3.4%	2.3%	3.0%	3.6%	2.9%

Areas of Concern

Data Source
RiO

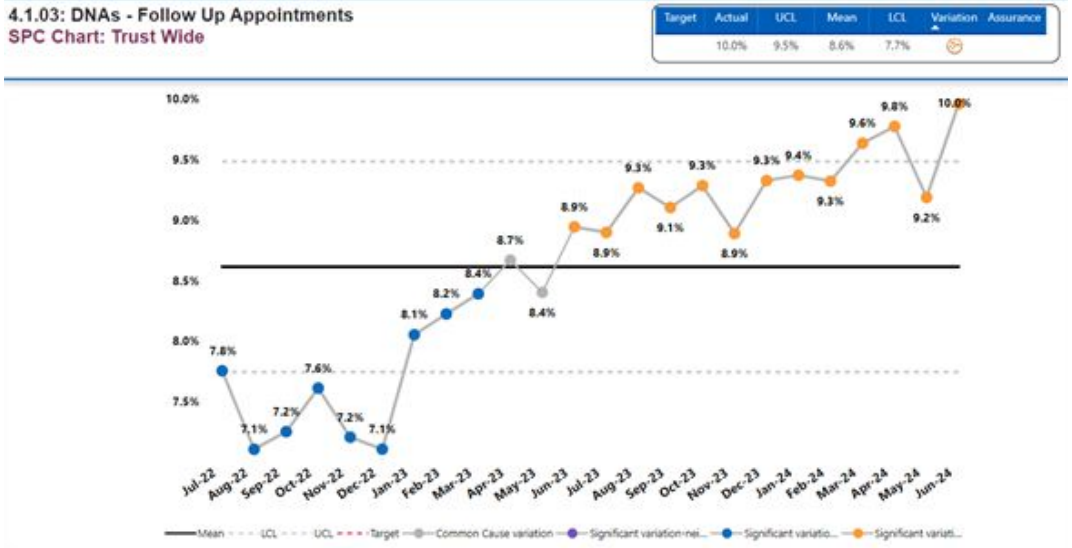
What is being measured?
Occupied bed days as a % of available bed days

Data Quality Confidence
No known issues.

What is the data telling us?
Levels of bed occupancy are driven by other aspects such as CRFDs, numbers of admissions and length of Stay.

The 92% target is the level the trust hopes to achieve by March 2025 requiring improvements in the remainder of 2024/25.

Level of occupancy are comparable between YA acute (96.4%) and OP Acute (96.7%)



Data Source

RiO

What is being measured?

% of appointments outcomed on RiO as DNA

Data Quality Confidence

No known issues.

What is the data telling us?

This equates to approximately 600 1st appointment and 2,750 follow up appointments being recorded as DNA's per month.

As is to be expected there is wider variation in DNA levels across different service types, MHT services are above trust average significantly with DNA rates for first appointments consistently around 19% in recent months and account for 42% of all 1st contact DNA's.

For follow up appointments CMHT's account for 43% of all DNA and have a DNA rate of 16%. MHT services recorded follow up appointments DNA rate of 36% in June which equates to 300 DNA's.

5. Equality, Diversity, and Inclusion

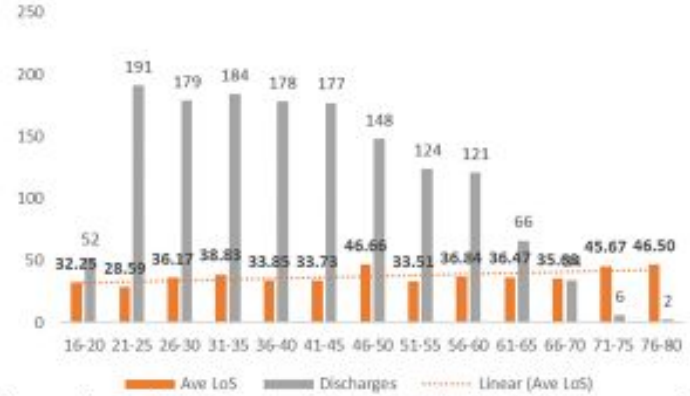
Indicator in focus: **Average Length Of Stay, Younger Adults Acute (1.2.01)**

(Analysis of period July 2023 – June 2024, inclusions where demographic information complete)

Levels of Deprivation

- The number of discharges decreases as deprivation reduces
- LoS increases as deprivation decreases
- Further analysis required to look at impact of clinical presentation

Age



- The number of discharges is greatest between the ages of 21 and 45
- LoS increases slightly with age with those aged 46-50 experiencing the longest lengths of stay

Ethnicity

- LoS discharges are 14.8% from BAME population, higher than local population (12.4%)
- LoS BAME = 37.57 days *(ethnicity defined as 'mixed' an outlier at 45 days in respect of 59 discharges)*
- LoS White = 36.19 days

Gender

- LoS discharges 48.74% male in line with the local population (48% male, 52% female)
- LoS male = 38.16 days
- LoS female = 33.47 days

6. Appendices

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. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues.	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.
4	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme

The following tables represent 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.

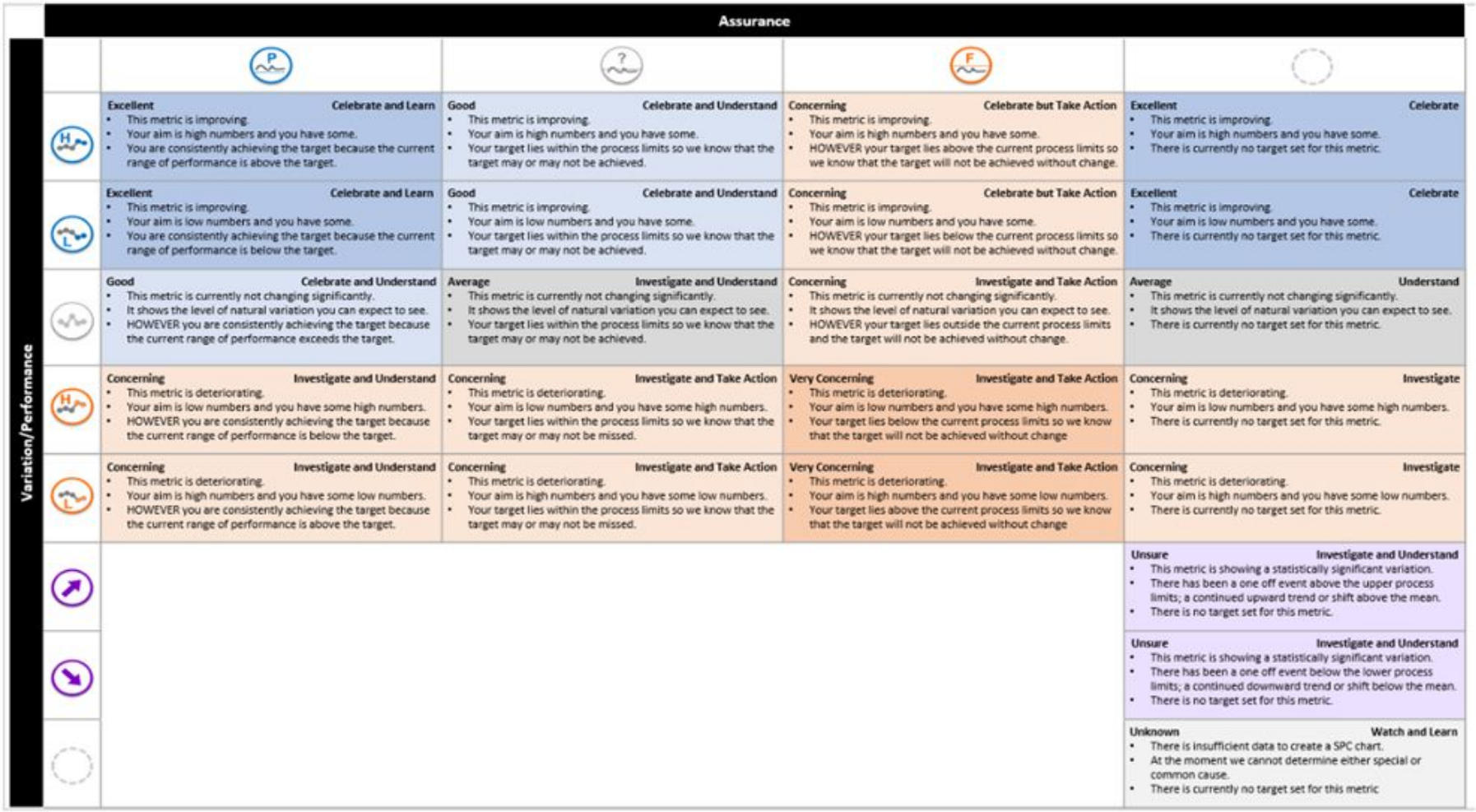
Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
S000a: NHSOF Segmentation	Month	2024 05	2:Flexible support					
S035a: Overall CQC rating	Month	2024 05	3 - Good					13/69
S059a: CQC well -led rating	Month	2024 05	3 - Good					13/69
S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual; calendar year	2023	10%	9.94%				2/71
S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual; calendar year	2023	20%	17.7%		↑		51/71
S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, .	Annual; calendar year	2023	30%	25.1%				51/71
S067a: Leaver rate	Month	2024 02	8.22%	7.25%		↑		55/71
S069a: Staff survey engagement theme score	Annual; calendar year	2023	6.89/10	6.89/10		↓	↓	61/71
S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2022	13.1%		12%	↓		24/69
S071b: Proportion of staff in senior leadership roles who are women	Month	2024 03	60.6%		62%	↓		37/45
S071c: Proportion of staff in senior leadership roles who are disabled	Annual; calendar year	2023	7.22%		3.2%	↑		12/69
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientatio.	Annual; calendar year	2023	57.5%			↓	↓	49/71

Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
S086a: Inappropriate adult acute mental health placement out -of-area placement bed days	Month	2024 03	0		0			1/56
S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual: calendar year	2023	6.9/10	7.1/10		↓		63/71
S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual: calendar year	2023	6.5/10	6.5/10		↓		54/71
S125a: Adult Acute LoS Over 60 Days % of tota discharges	Month	2024 03	13%					5/53
S125b: Older Adult Acute LoS Over 90 Days % of total discharges	Month	2024 03	38%			↑		21/53
S133a: Staff survey - compassionate and inclusive theme score.	Annual: calendar year	2023	7.4/10	7.3/10		↓		55/71
S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual: calendar year	2023	1.9		1	↑		58/63
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual: calendar year	2023	1.2		1	↓		54/63

Note: *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.*

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/.



Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: ○
H	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** — Celebrate and Learn • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** — Celebrate and Understand • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Celebrate but Take Action • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** — Celebrate • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
~	**Good** — Celebrate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** — Investigate and Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** — Investigate and Take Action • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** — Understand • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning** — Investigate and Understand • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** — Investigate and Take Action • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** — Investigate • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure** — Investigate and Understand • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
○				**Unknown** — Watch and Learn • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Finance Report for Month 3 (June 2024)
Author:	Jenni Grover, Deputy Director of Finance (Interim)
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 3 (June 2024).

Items of focus

For the period ending 30th June 2024, the Trust is reporting a breakeven position and this is as per the annual plan.

Points to note:

- The Trust's agency position. In Month, the Trust has seen a reduction in spend, with the position to Month 3 a YTD spend of £1.62m, this is slightly below cap. However, additional spend is expected in Month 4, with new medical staff coming on board in Acute, Forensics and East Kent. Further work will be required to maintain the present position.
- There is a continued usage of external beds, in particular usage of non-contracted Female PICU and Male Acute beds.
- The Trust is presently reporting delivery of its £10.76m Cost Improvement Programme. A more detailed review is being undertaken following the finalisation of Quarter 1 to ensure delivery remains on course.

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Finance Report
June 2024

Trust Board

Brilliant care through brilliant people

Contents

Brilliant care through brilliant people

Executive Summary

Key Messages

For the period ending 30th June 2024, the Trust has reported a breakeven position excluding technical adjustments.

Following discussions with NHS England, the Kent and Medway system was required to submit an improved financial plan in June. This has added a further efficiency ask on the Trust of £0.72m; with the Trust now being asked to deliver a £0.72m surplus in year. We are working with our system colleagues to identify appropriate ways to deliver this, and expect to see delivery from Month 5 onwards.

The key financial challenges for the Trust are:

- The Trust's agency position. In Month, the Trust has seen a reduction in spend, with the position to Month 3 a YTD spend of £1.62m, this is slightly below cap. However, additional spend is expected in Month 4, with new medical staff coming on board in Acute, Forensics and East Kent. Further work will be required to maintain the present position.
- There is a continued usage of external beds, in particular usage of non-contracted Female PICU and Male Acute beds.
- The Trust is presently reporting delivery of its £10.76m Cost Improvement Programme. A more detailed review is being undertaken following the finalisation of Quarter 1 to ensure delivery remains on course.

Income and Expenditure

The main highlights for June included the following:

- Agency spend continues and with £0.52m spent in month, equivalent to 2.94% of the Trust Pay bill , the target set nationally was to contain agency spend to within 3.20% of the overall pay bill. In month spend represents a decrease of 14.8% over May with decreases in medical and nursing costs.
- Bank spend decreased in month by 6.1%, however WTE usage remains above that seen in June last year (2.5% year on year increase).
- In June, the Trust utilised 9 external female PICU beds and 2 male acute beds. The Trust has funding for 7 external beds within its budget, and is presently received additional funding for 3 beds in relation to a patient with complex care requirements.

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 30th June the overall capital position is £0.04m underspent, with a forecast capital spend position of £15.38m, which is as per plan.

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.

Cash

The closing cash position for June was £13.14m which was over planned levels by £0.81m and represents an in month increase of £1.17m.

The main movement relates to a catch up on Kent & Medway ICB income of £1.1m in month. The cash position is expected to improve further in Month 4 when we will receive the outstanding funding relation to the provider collaborative contract (£1.9m).

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

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	272,540	22,874	22,914	40	68,354	68,062	(293)
Employee Expenses	(206,962)	(17,490)	(17,478)	12	(51,908)	(50,940)	968
Operating Expenses	(60,906)	(5,108)	(5,395)	(287)	(15,279)	(16,294)	(1,016)
Operating (Surplus) / Deficit	**4,672**	**276**	**41**	**(235)**	**1,168**	**827**	**(341)**
Finance Costs	(5,352)	(446)	(104)	342	(1,338)	(890)	448
System control Surplus / (Deficit)	**(680)**	**(170)**	**(63)**	**107**	**(170)**	**(63)**	**107**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	0	0	33	33	0	823	823
Surplus / (deficit) for the period	**(680)**	**(170)**	**(30)**	**140**	**(170)**	**760**	**930**

Commentary

As at the end of June the Trust reported a year to date underspend on pay of £0.97m. This consists of an underspend on substantive pay of £6.74m, offset by overspends on temporary staffing which total £5.77m; £4.15m on bank staff and £1.62m of agency spend.

Agency spend in June totalled £0.52m which represents a 31.5% reduction on spend seen for the same period in 2023/24 and a 14.8% decrease on spend in May. The highest level of reduction is within medical agency with spend 40.1% lower than in June 2024.

Spend levels were highest in East Kent with 31% due to medical vacancies but also West Kent (30%) and North Kent (24%) due to pressures with CMHTs and Crisis teams. Agency has ceased in Crisis Line. The current forecast is for total agency spend of £6.36m against a cap of £6.58m.

Bank spend decreased in month by 6.1%; with 459 WTEs were utilised compared to May when 491 WTEs were utilised. Run rates remain high in some areas with all Acute Inpatient wards using bank staff significantly above rostered levels to support International nurses and high levels of observations, and also on Penshurst and Allington wards where EPCs require additional staff.

Other non pay includes £0.50m spend on external placements and £0.31m overspend in estate maintenance. The estates overspend is in part due to a backlog of requests from the change of maintenance provider. Work is underway to identify opportunities to recover this position.

There were 9 external female PICU beds utilised in June of which 5 are at contracted levels and one is with an alternative provider. 3 additional beds are in relation to a patient with complex care requirements, funded by the ICB. There were 2 male acute beds utilised in month.

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Cost improvement plans 24/25

		RAG Rating		
	Savings £'000	Green	Amber	Red
Corporate services transformation	3,568		3,568	
Contract Review	1,100	1,100		
Establishment reviews	600		600	
Service re-design	4,700	1,600	4,700	
Unidentified	772			972
Total Pay Savings	**10,740**	**2,700**	**8,868**	**972**

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.

Subsequently a further efficiency of £0.72m (a proportion of the additional £14.00m efficiency challenge from NHS England to the Kent & Medway system) has been agreed which is being worked on at system level.

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.

Exception report

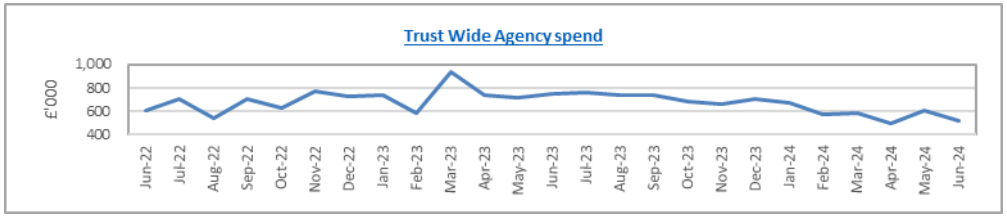
Temporary Staffing Spend

As at the end of June the Trust reported a year to date underspend on pay of £0.97m. This consists of an underspend on substantive pay of £6.74m, offset by overspends on temporary staffing which total £5.77m; £4.15m on bank staff and £1.62m of agency spend.

Agency

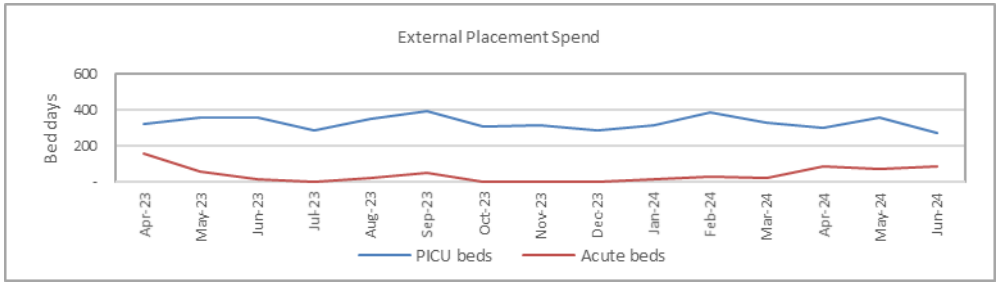
Agency spend in June totalled £0.52m which represents a 31.5% reduction on spend seen for the same period in 2023/24 and a 14.8% decrease on spend in May. The highest level of reduction is within medical agency with spend 40.1% lower than in June 2024.

Spend levels were highest in East Kent with 31% due to medical vacancies but also West Kent (30%) and North Kent (24%) due to pressures with CMHTs and Crisis teams. Agency has ceased in Crisis Line. The current forecast is for total agency spend of £6.36m against a cap of £6.58m.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

There were 9 external female PICU beds utilised in June of which 5 are at contracted levels and one is with an alternative provider. 3 additional beds are in relation to a patient with complex care requirements, funded by the ICB. There were 2 male acute beds utilised in month.



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	24/25 May	24/25 Jun
Nursing	2,097	1,885	2,159	2,114	2,560	713	826	800
HCAs	2,768	2,760	3,342	3,086	3,568	989	1,034	933
Other	450	383	433	390	370	86	95	101
Total	**5,316**	**5,028**	**5,934**	**5,590**	**6,498**	**1,787**	**1,955**	**1,835**

Trust Wide Bank Usage (FTEs)

	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Apr	24/25 May	24/25 Jun
Nursing	125.31	145.17	136.82	151.29	143.27	164.62	161.13
HCAs	277.30	321.18	300.67	313.59	288.53	300.91	271.53
Other	34.08	38.21	36.88	33.47	23.58	25.26	26.31
Total	**436.69**	**504.55**	**474.37**	**498.36**	**455.38**	**490.79**	**458.97**

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 (FTEs)

Inpatient area	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Apr	24/25 May	24/25 Jun
Older Adult Wards	40.40	42.46	41.09	48.68	35.28	47.31	51.04
Willow Suite	27.96	35.75	30.64	29.48	31.61	28.84	30.86
Younger Adult Wards	83.10	85.80	72.08	89.80	75.91	90.51	67.47
Total	**151.46**	**164.01**	**143.81**	**167.95**	**142.80**	**166.66**	**149.37**

Forensics Inpatient HCA Bank Usage (FTEs)

Inpatient area	23/24 Qtr 1	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Apr	24/25 May	24/25 Jun
Low Secure Services	59.76	63.43	62.34	65.79	61.49	46.32	39.35
Medium Secure Services	23.01	31.53	37.19	44.17	34.87	33.42	33.27
Total	**82.78**	**94.95**	**99.53**	**109.96**	**96.36**	**79.74**	**72.62**

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Appendices

Balance Sheet

Statement of Financial Position

	Opening	Prior Month	Current Month
	31st March 2024	31st May 2024	30th June 2024
	Actual	*Actual*	*Actual*
	£000	£000	£000
Non-current assets	169,254	170,591	170,721
Current assets	23,068	21,594	22,780
Current liabilities	(29,558)	(28,254)	(29,095)
Non current liabilities	(47,291)	(49,254)	(49,749)
Net Assets Employed	**115,473**	**114,677**	**114,657**
Total Taxpayers Equity	**115,473**	**114,677**	**114,657**

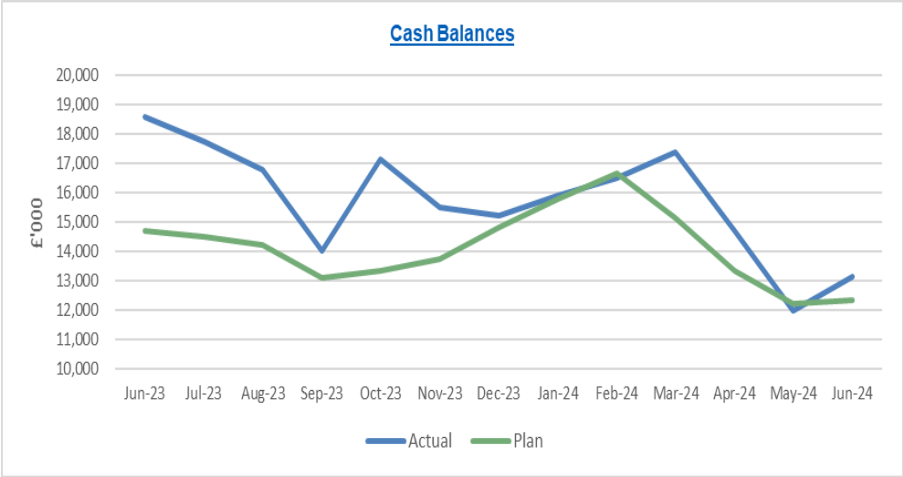
Commentary

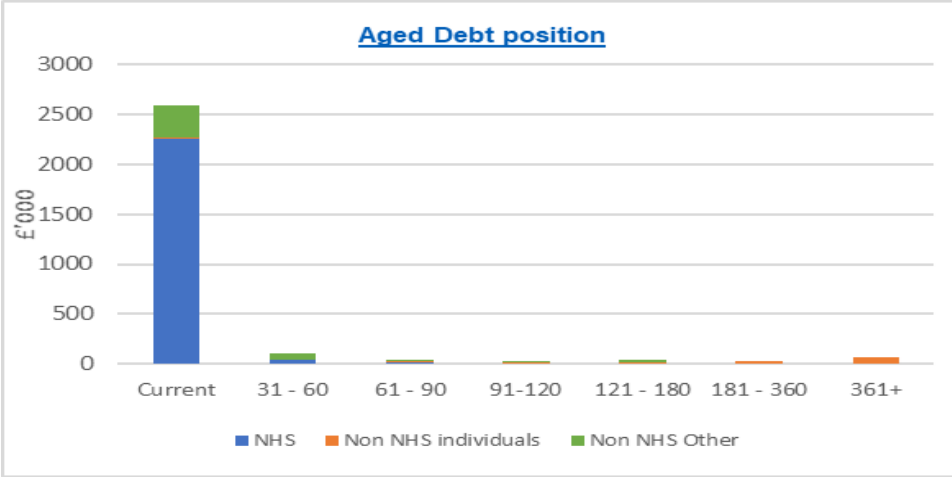
Non-current assets
In month, capital expenditure incurred of £0.86m was offset by depreciation and amortisation.

Current Assets
Following the receipt of the outstanding ICB contract funding, the cash position has improved by £1.17m in June, which is reflected in the overall current asset position.

Current Liabilities
Overall Trade and other payables increased by £0.84m reflecting an increase in accruals.

Aged Debt
Our total invoiced debt balance is £2.9m. This position includes £1.9m of current debt relating to the Trust's provider collaborative contract. Agreement of this position was delayed whilst the contracting position was agreed between the collaborative and NHS England. Payment was received 1st July 2024, and will be reflected in next month's cash position.





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Capital Position

	Full year			In Month			Year to Date		
	Plan	*Forecast*	*Variance*	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000	£000	£000	£000
System Capital:									
Information Management and Technology	2,000	1,908	(92)	0	57	57	54	112	57
Capital Maintenance and Minor Schemes	4,166	4,046	(120)	178	214	36	376	412	36
Section 136 development	3,656	3,703	47	46	30	(16)	73	57	(16)
Total System Capital:	**9,823**	**9,658**	**(165)**	**225**	**302**	**77**	**503**	**581**	**77**
PDC funding :									
DCF (EPR) IT	1,736	1,828	92	0	0	0	397	397	0
Mental Health Response Vehicle	227	300	73	0	0	0	29	29	0
Total PDC funding	**1,963**	**2,128**	**165**	**0**	**0**	**0**	**426**	**426**	**0**
Other Capital:									
PFI 2024/25	117	117	0	10	10	(0)	29	29	(0)
Leases New	605	605	0	0	0	0	34	34	0
Leases Remeasurement	2,872	2,872	0	0	548	548	2,872	2,757	(115)
Total Other Capital:	**3,594**	**3,594**	**0**	**10**	**558**	**548**	**2,936**	**2,821**	**(115)**
Total Capital Expenditure	**15,380**	**15,380**	**0**	**234**	**859**	**625**	**3,865**	**3,828**	**(37)**

Commentary

As at 30th June the overall capital position is £0.04m underspent, with a forecast capital spend against System Capital and PDC funding of £11.90m and total Gross spend of £15.38m, which is per the plan submitted to NHS England.

Capital Funding

The capital programme is made up of three main funding streams, primarily System Capital Funding from the ICB which is derived from our depreciation and amortisation plans, PDC Funding which is an injection of additional capital investment from NHS England, and other capital consisting of technical sources of non-cash funding such as the impact of IFRS16 on the Trust's eases.

Year to date and forecast

In month the Capital Maintenance and Estates schemes marginally overspent 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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NHS
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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	KMPT Band Profile
Author:	Nicole Moore, Workforce Planning Manager and Rebecca Stroud-Matthews, Deputy Chief People Officer
Executive Director:	Sandra Goatley, Chief People Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Requested

Overview of Paper

Following analysis of workforce growth earlier in the year, it was identified that there had been a change in KMPT's band profile over time. Specifically, a trend towards more senior roles was noted. As such, the Trust Board requested that a more in-depth review be undertaken in this regard and shared with the Board in July.

This paper summarises the findings of this review, drawing out:

- KMPT's current band profile
- The change in this band profile over time
- Comparisons of KMPT's band profile compared with that of other Kent and Medway Trusts and of other Mental Health Trusts.

Finally, the paper makes a number of recommendations.

Issues to bring to the Board's attention

The analysis of KMPT's band profile and that of comparators identifies that:

i) KMPT has a preference not to use Band 2 roles;

ii) There is some variation in nursing skill-mix when comparing KMPT and other Trusts;

iii) KMPT has seen growth in its senior workforce, particularly in Support Services roles and Operations and Directorate Management functions. However, benchmarking indicates KMPT's band profile in relation to senior roles to be broadly consistent with that of other mental health trusts.

Version Control: 3.1

In relation to the preference away from Band 2 roles, it is recommended that KMPT progress to the next stage of the review of the role of Healthcare Support Workers in the Clinical Model, aiming to enhance this role and reduce the reliance on Band 2 workforce.

In relation to the skill-mix variation at Band 3, 5 and 6 level, it is recommended that a review of the current nursing workforce model and skill-mix is undertaken. Additionally, it is recommended that focused work be undertaken to enhance talent management and career development in relation to Band 4 to 6 nursing roles.

Finally, it is recommended that new vacancy controls are implemented to allow greater scrutiny of new senior roles, and an evidence-based review is undertaken in six months' time of the effectiveness of these controls and of any growth in senior roles and in Support Services.

Governance

Implications/Impact:	Financial; recruitment and retention
Assurance:	Reasonable
Oversight:	Board

Version Control: 3.1

1. Background

1.1 In the context of the Kent and Medway health and care system's continued financial challenges, there is a need for every partner in the system to apply ongoing scrutiny to the efficiency and productivity of its workforce. As such, in January 2024, analysis was undertaken regarding workforce growth at Kent and Medway NHS and Social Care Partnership Trust (KMPT).

1.2 This analysis included a complete reconciliation of all staff increases and justifications for them, and concluded that the majority (around 71%) of KMPT's workforce growth was linked to the Mental Health Investment Standard and was well founded.

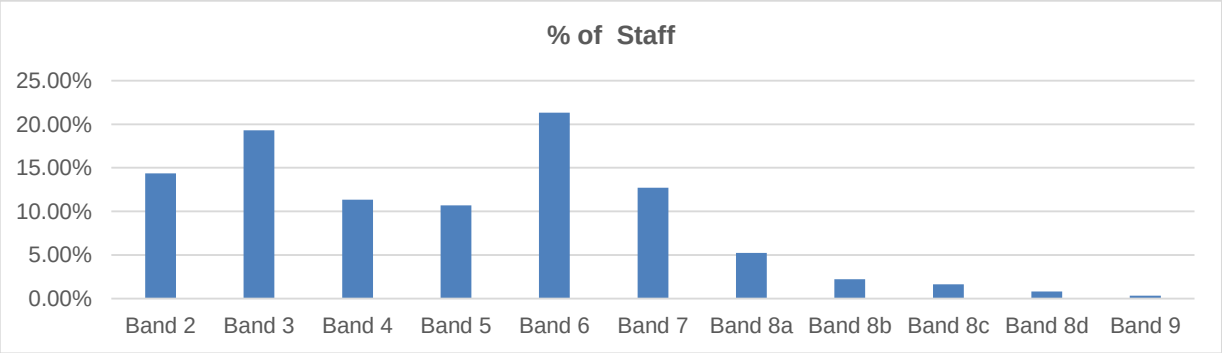
1.3 There was however a recognition that KMPT's banding profile had changed over the period, with a trend towards more senior roles and increases in numbers of senior roles in Support Services in particular. The Trust Board requested that a more in-depth review be undertaken of KMPT's band profile and band profile changes.

1.4 This paper summarises the findings of this review, including:

- KMPT's current band profile
- Changes in KMPT's band profile over time (since 2020)
- Benchmarking of KMPT's band profile against other Kent and Medway Trusts and other South East Mental Health Trusts.

2. Current band profile at KMPT

2.1 As at 31st March 2024, KMPT had a workforce of 3240 Whole Time Equivalent (WTE)[1]. The breakdown of the proportion of the total workforce comprised by each Agenda for Change pay band is shown below.



[1] This number does not include Very Senior Managers, Non-Executive Directors, Students or Medical staff. These groups were excluded to allow a focus on Agenda for Change banding as this was where the band drift was previously identified. However, further investigation into these groups, at a later date, can be completed should it be deemed useful.

Version Control: 3.1

2.2 This shows that, as might be expected, the higher-grade band (Band 8b - 9) constitutes the smallest proportion of the workforce, at just 5%. There is a similar distribution of the workforce across the middle grade band (Band 5 - Band 8a) at 50%, and the lower grade band (Bands 2 - 4) at 45%. The bands containing the largest proportions of the KMPT workforce are Band 3 (constituting 19% of the workforce) and Band 6 (constituting 21% of the workforce).

3. Changes to KMPT's band profile between 2020 and 2024

3.1 Over the past four years, there has been a small decrease in the proportion of KMPT's workforce comprised by the lower grade band (from 45.6% to 45%). Conversely, the proportion of KMPT's workforce comprised of the higher grade band has increased (from 4.5% to 5%). There has been negligible change in the proportion of the workforce made up by the middle grade band.

3.2 Although the change in the higher grade band is small in terms of WTE (around 38 WTE), this does represent a 30% increase on the original numbers and so warrants further exploration.

3.3 The growth in numbers has been mostly in Band 8c and Band 9 roles, where numbers have more than doubled from 25.5 WTE to 52.6 WTE and from 4.8 WTE to 10.9 WTE respectively. As was highlighted in the previous paper to Board, new senior roles have been introduced across a range of Support Services functions, but in the higher grade band, particularly in Operations and Directorate Support and Transformation. The subsequent section of this paper considers how the current position in relation to these higher bands and in relation to Support Services in particular compares with that of other Trusts.

3.4 As well as these changes in the higher grade band, it is worthwhile understanding a shift within the lower grade band. As previously stated, there has been a small decrease in the proportion of the workforce made up of posts at these lower bands. This is the result a significant decrease in the number of Band 2 roles at KMPT – with 466 WTE Band 2 roles now, compared with 520 in 2020 (meaning that Band 2 roles now constitute 14.4% of the workforce compared with 18.8% in 2020).

3.5 This largely reflects a trend of converting Band 2 roles into Band 3 roles. Although applicable across the workforce as a result of decreasing feasibility of Band 2 roles given cost of living increases, this shift has taken place predominantly in relation to the Healthcare Support Worker (HCSW) workforce, where there are additional contributing considerations around the clinical model. For example, in Rehabilitation and Medium Secure teams, additional responsibilities have been attached (in Rehabilitation teams, as a result of CQC guidance) to Healthcare Support Worker roles, prompting introduction of Band 3 HCSW roles in preference for Band 2 HCSW roles. This is considered further in the benchmarking later in this paper.

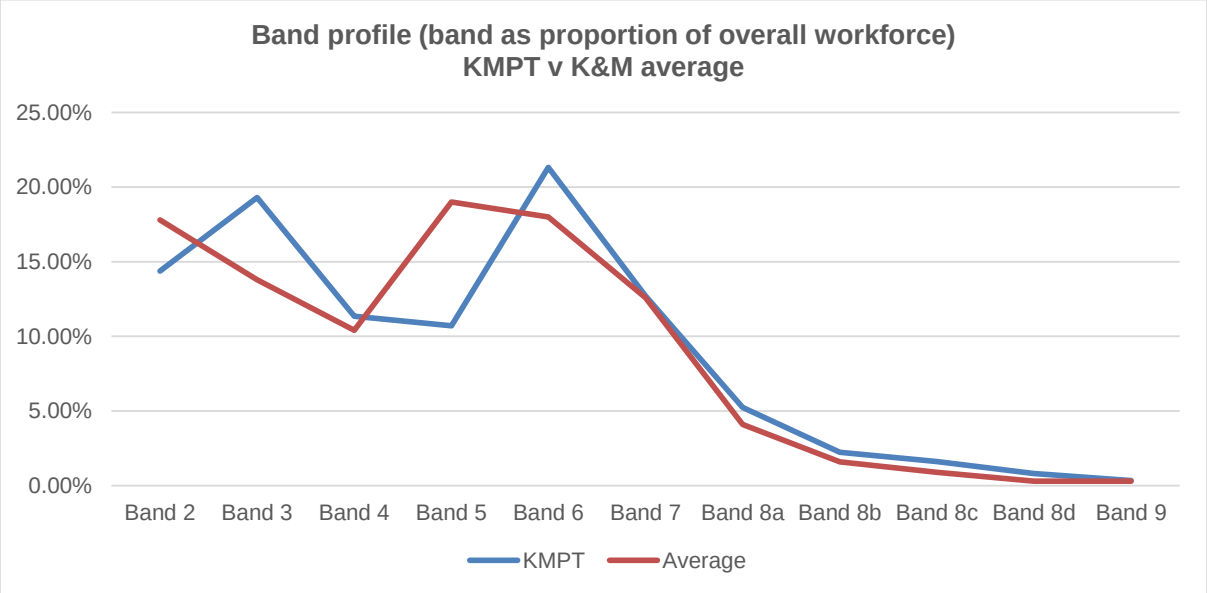
3.6 Separately, but also in relation to the lower grade band, there has been a very large increase in the number of Band 4 roles (from 210 WTE comprising 7.6% of the workforce in 2020 to 376 WTE comprising 11.3% of the workforce now – an increase of 75%). This growth is largely the result of increases in numbers of Nurse Associate and Registered Nurse Degree Apprentice roles. The benchmarking below suggests that KMPT still has lower numbers of these roles than

other Mental Health Trusts, although has the second largest proportion in Kent and Medway (behind only Kent Community Health Foundation Trust (KCHFT)).

3.7 To a lesser extent, a similar preference for more highly banded roles can be seen in the middle grade band with some increase in the proportion of roles at Band 7 and 8a level contrasted with a decrease in the proportion of roles at Band 5 and 6 level (although it should be noted that WTE has still increased at these levels). This reflects the introduction of higher banded roles such as Community Practice Nurses (CPNs), Clinical Nurse Specialists and Mental Health Practitioners into our clinical models within Community and Early Intervention Teams. The benchmarking below shows these proportions to be comparable both with other Kent and Medway Trusts and other Mental Health Trusts.

4. Comparisons with other Kent and Medway Trusts

4.1 The chart below compares the difference in band profile between KMPT and the average for the Kent and Medway Trusts.



4.2 The main areas of variation appear to be:

- KMPT's lower proportion of Band 2 roles and higher proportion of Band 3 roles;
- KMPT's lower proportion of Band 5 roles and higher proportion of Band 6 roles;
- KMPT's slightly higher proportion of roles at Band 8A and above.

4.3 KMPT's emerging preference for Band 3 Healthcare Support Worker roles over Band 2 Healthcare Support Worker roles was highlighted in the previous section of this paper. This trend appears to have been mirrored in neighbouring Trusts. In particular, KCHFT has seen a

21% reduction in Band 2 role and 19% increase in Band 3 roles, and East Kent Hospital University Foundation Trust (EKHUFT) has seen a 5% reduction in Band 2 and roles and 12% increase in Band 3 roles.

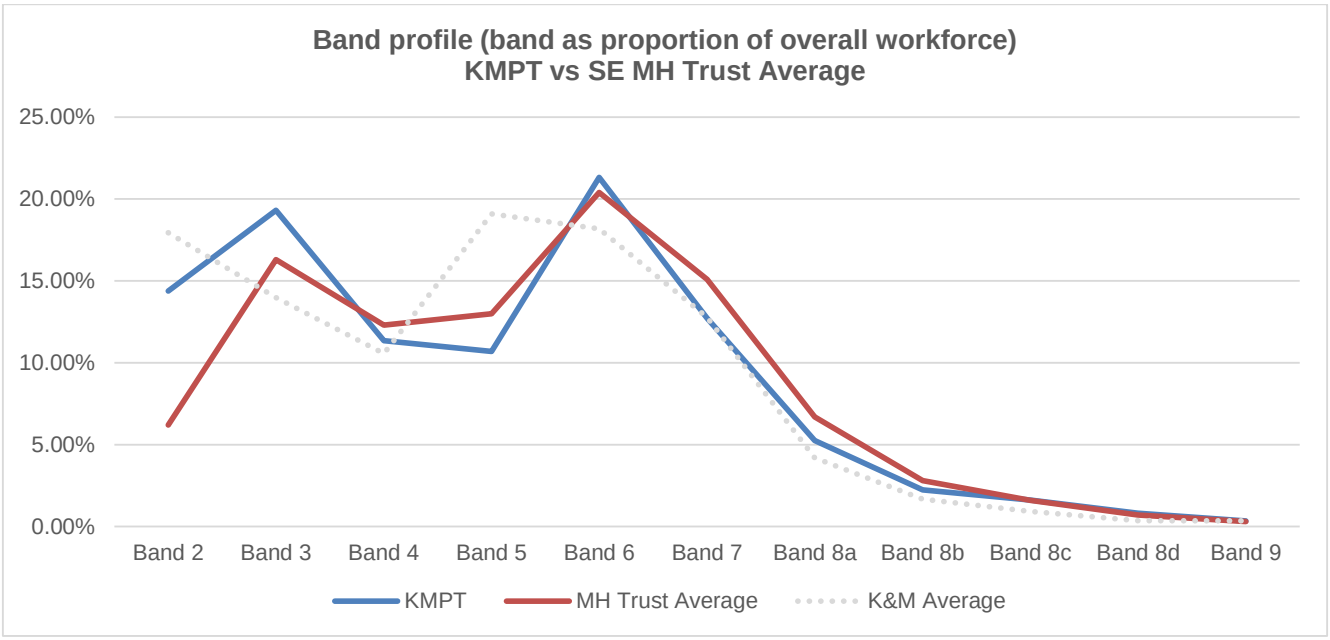
4.4 As it stands, KMPT has a lower proportion of the lowest banded (Band 2) roles in its workforce than is average for Kent and Medway Trusts, and the second highest proportion (19%) of Band 3 roles of any Kent and Medway Trust (KCHFT having the highest at 20%). The comparison with other Mental Health Trusts provides a different perspective and is considered in the subsequent section of this paper.

4.5 The benchmarking illustrates the utilisation in KMPT's clinical model of Band 6 nurses rather than Band 5 nurses. 11% of KMPT's workforce sits at Band 5 level, compared with an average of 19% in the wider Kent and Medway system. In contrast, KMPT has the largest proportion of Band 6 roles in the Kent and Medway system (21% compared with 18%). The mental health benchmarking also highlights KMPT as an outlier in this respect. This position has been consistent since 2020.

4.6 Across the higher grade band the growth highlighted earlier in this paper can be seen similarly across the Kent and Medway system, with KMPT's growth in fact being smaller than the average for the Kent and Medway system (27% for KMPT compared with 41% for the system). However, notwithstanding this, KMPT consistently has the highest proportion of higher grade banded posts in the system (5% at KMPT, compared with the next highest in the system of 3.6%). It should be noted however that KMPT appears not to be an outlier compared with other Mental Health Trusts. This is explored further below.

5. Comparisons with other South East Mental Health Trusts

5.1 Recognising that the different professional make-up of Mental Health Trusts may result in a different banding profile than might exist in an Acute or Community Trust, a comparison against other Mental Health Trusts in the South East of England has also been undertaken and can be seen below.



5.2 This illustrates clearly that, although KMPT's band profile differs from that of the other Kent and Medway Trusts, it is broadly aligned to the normal band profile for South East Mental Health Trusts.

5.3 In particular, it highlights that it is not unusual for Mental Health Trusts to have lower proportions of Band 2 roles in their workforce than other types of organisation. It is possible that this is a result of other parts of the South East region already having moved away from Band 2 HCSW roles ahead of Kent and Medway, or reflecting some of the additional complexities of HCSW roles in some areas of mental health services.

5.4 Similarly, it highlights that Mental Health Trusts tend to have higher proportions of Band 6 workforce than Band 5 workforce. This was another area in which KMPT was an outlier compared with the other Kent and Medway Trusts. This likely reflects the autonomous nature of the workforce providing community services (which make up much of the mental health workforce) compared with those working on acute inpatient wards with close supervision.

5.5 Finally, KMPT has a higher proportion of higher banded roles than the other Kent and Medway Trusts, but the Mental Health benchmarking highlights that KMPT is aligned with other Mental Health Trusts in this respect. This is likely due to the management structure in Mental Health Trusts featuring workforce from psychologies backgrounds, which attract higher salaries under Agenda for Change than nursing or other therapies backgrounds which are more likely to feature in acute or community services.

5.6 The comparisons above serve to provide rationale in relation to the main areas of variation between KMPT and the Kent and Medway system in relation to band profile and some assurance in relation to efficiency.

5.7 For completeness, albeit more linked to quality of care and workforce development than to financial efficiency, the Mental Health benchmarking does highlight KMPT's higher proportion of

Band 2 and 3 workforce, and lower proportion of Band 5 workforce compared with other Mental Health Trusts in the South East. This may warrant further consideration separately.

6. Conclusion

6.1 This piece of work has examined KMPT's banding profile from a number of angles. Firstly, it has considered the overall shape of KMPT's workforce. Secondly, it has considered how the profile of its workforce has changed over the past few years and why this might have happened. And thirdly, it has compared the profile of its workforce both with that of other Kent and Medway and with other Mental Health Trusts.

6.2 In summary, the review has found that:

iv) KMPT has a preference not to use Band 2 roles

KMPT has fewer Band 2 roles than most Kent and Medway organisations, and continues to reduce these numbers. This reflects a conscious decision to move away from Band 2 roles, which are notoriously hard to recruit and retain (and increasingly so given increases in cost of living over recent years, highlighted by the proximity of the Band 2 salary to national living wage). It is considered that this remains appropriate, and indeed numbers of Band 2 roles across Kent and Medway also continue to decrease. KMPT continues to utilise more Band 2 roles than other Mental Health Trusts.

v) There is some variation in nursing skill-mix when comparing KMPT and other Trusts

KMPT has a higher proportion of Band 3 roles than both other Kent and Medway organisations and other Mental Health Trusts. Conversely, it has a lower proportion of Band 5 roles than both other Kent and Medway organisations and other Mental Health Trusts. It is likely that this is a response to Band 5 nursing roles having been in very short supply over recent years.

KMPT also utilises a higher proportion of Band 6 roles than other Kent and Medway organisations and other Mental Health Trusts. This appears to be historical and has not materially changed over recent years. It is possible that the higher proportion of Band 3 roles and lower proportion of Band 5 roles cited above necessitates a higher number of more experienced Band 6 roles in the workforce model.

The analysis undertaken suggests that there is minimal cost impact associated with this workforce model, and indeed it has the benefit of creating a pipeline into Band 5 nursing roles and progression from Band 5 nursing roles.

However, whilst the model has clear merits it is considered that with some improvements in the availability of Band 5 nursing staff through university, apprenticeships and the international route, there may be an opportunity to explore alternatives. It is unlikely that conversion of Band 3 and Band 6 roles to Band 5 roles would yield financial benefit to the organisation, so the basis of any exploration in this area would relate more to clinical quality and workforce outcomes.

vi) KMPT has seen growth in its senior workforce

KMPT has seen growth in its senior workforce over recent years, particular in Support Services roles and Operations and Directorate Management functions. However this growth now puts KMPT on par with other mental health Trusts in terms of banding profile, albeit that Mental Health Trusts appear to have a greater senior profile than other types of organisation. The benchmarking indicates that the higher proportion of senior workforce in Mental Health Trusts generally is a result of the inclusion of higher salaried psychologies staff. Notwithstanding this, KMPT has seen growth in this area over recent years, and should pay close attention to further growth moving forward.

7. Recommendations and next steps

7.1 KMPT is committed to optimising its workforce whilst playing a part in tackling the system financial deficit. This review reflects the considerable attention KMPT is giving this area, and although it has provided reasonable assurance, some next steps are identified as below:

i) To progress to the next stage of the review of the role of Healthcare Support Workers in the Clinical Model, aiming to enhance this role and reduce the reliance on Band 2 workforce

ii) To review the current nursing workforce model and target skill-mix, considering current availability of Band 5 nursing staff through university, apprenticeships and international routes

iii) To embed a focus on talent management and career development for Bands 4 – 6 nursing into the plans for the new KMPT Academy (to be established in 2025)

iv) To introduce new vacancy controls to allow greater scrutiny of new senior roles ahead of recruitment, and to undertake a review in six months' time of the effectiveness of these controls and a further review of any growth in senior roles and in Support Services.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Community Mental Health Framework – Progress Report
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

Voluntary Community or Social Enterprise partners have commenced recruitment in all areas for newly established posts in Mental Health Together (MHT).

Business intelligence have developed a weekly dashboard to demonstrate activity and compliance and have developed a caseload management report to deliver patient level information across MHT and MHT+ which will enable safe and effective patient management and flow.

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

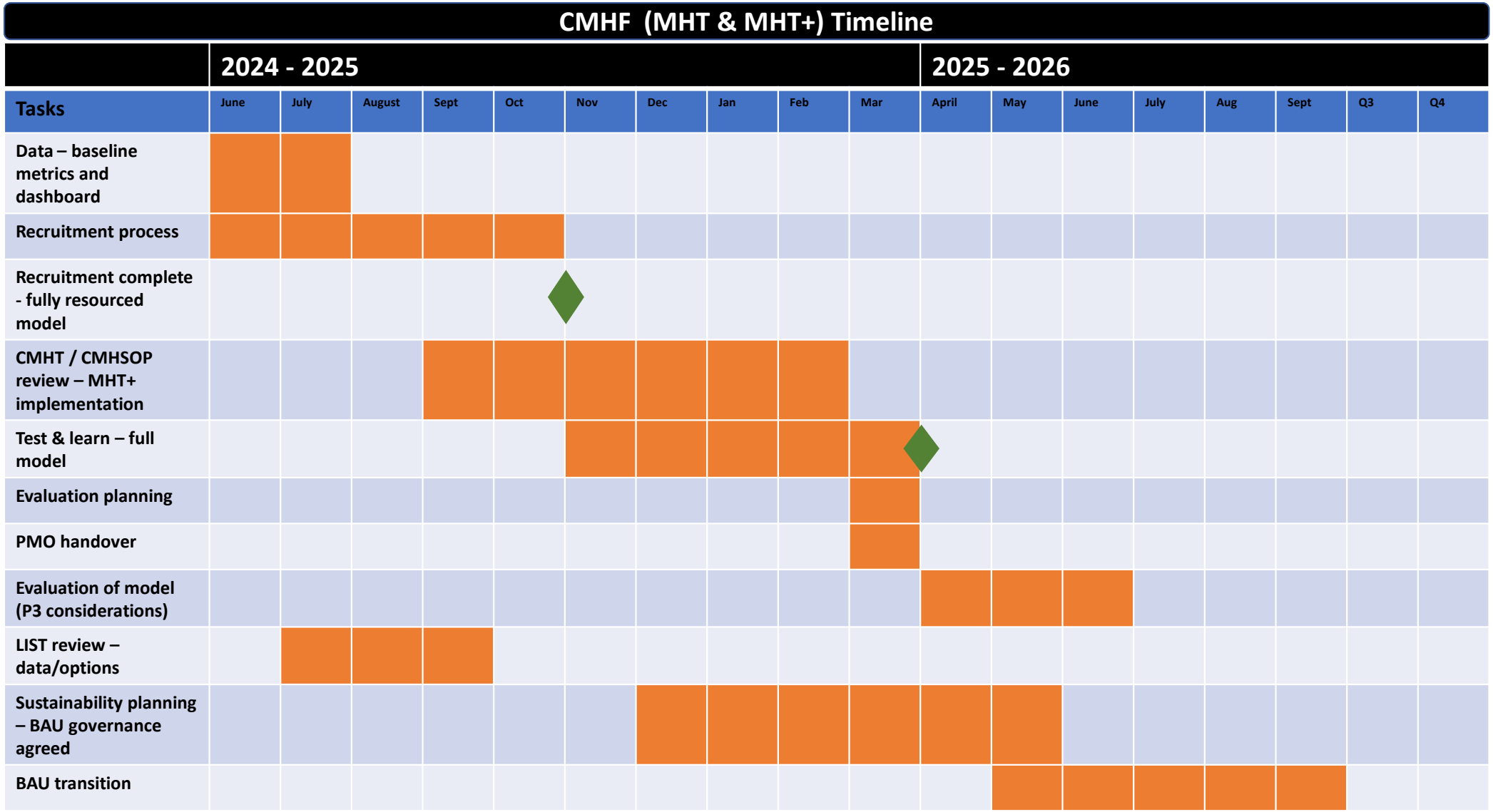
Oversight: Executive Management Team

Mental Health Together

NHS

Community Mental Health Framework

Trust Board Update – July 2024


CMHF (MHT & MHT+) Timeline
2024 - 2025
2025 - 2026
Tasks
June
July
August
Sept
Oct
Nov
Dec
Jan
Feb
Mar
April
May
June
July
Aug
Sept
Q3
Q4
Data – baseline metrics and dashboard
Recruitment process
Recruitment complete - fully resourced model
CMHT / CMHSOP review – MHT+ implementation
Test & learn – full model
Evaluation planning
PMO handover
Evaluation of model (P3 considerations)
LIST review – data/options
Sustainability planning – BAU governance agreed
BAU transition

Progress update

Locality Implementation

- Implementation groups in North, West and East continue with representation from all key stakeholders. The groups meet bi-weekly to track progress against agreed plans and monitor recruitment as designed for phase 2 of the mobilisation. Alignment with Memory Assessment Service (MAS) where this has gone live (South Kent Coast) and other key dependencies.

Finance & Contracting

- **Finance:** The 24/25 Integrated Care Board (ICB) contract includes £8.43m for 24/25 which KMPT is lead provider (Community Mental Health Framework) covering 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 and draft contracts are being reviewed by Shaw Trust and Porchlight; all three partners actively recruiting to posts with Lived Experience recruitment due to commence in July . A review of governance and reporting arrangements is underway with all partners.

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 has commenced with a focus on identifying estate in the area.
- **Performance and Outcomes**: 4 Week Wait process defined and now distributed to staff for use within local teams. Business Intelligence have developed a performance dashboard and a patient level caseload management report to support management of patient flow across MHT and MHT+.
- **Workforce:** Train the Trainer for Dialog+ has been developed and implemented.

Key Risks/Issues

Risk	Initial Rating	Current Rating	Aim	Mitigations
IF data required to measure and evidence programme effectiveness including wait times is not available within a reasonable timeframe **THEN** staff within MHT might not be able to monitor and manage performance effectively **RESULTING IN** an inability to revise the model to meet required changes as blockers/constraints will not be identified; carry out accurate demand and capacity modelling and manage caseloads to ensure patient safety	12	12	9	Ongoing discussions and task and finish meetings held with BI to specify reporting requirements and develop the right reports and dashboard, A toolkit has been developed to help with caseload management but is not yet ready for general use. BI via the Director of Digital and Performance have been requested to provide reports for discussion in MHT ODG from the 17 July 24. If the reports become available there will still be a requirement to have data stratified to partner level which does not have a current timeline.
IF the recruitment for additional staff in MHT is further delayed THEN there is a clinical risk to quality and safety for people waiting for interventions in MHT RESULTING IN delays to patient care and potential for clinical risk (also added to Issue Log)	16	16	8	Practice guidance issued for 'Reviewing Risk at the start of MHT' to incorporate assessing risk while waiting or if they need to step directly into MHT+ Review practice of directing patients to specific (historic) interventions and considering all of MHT support. Active review waiting lists to be reviewed immediately to ascertain if there is capacity within MHT+ to provide additional resource into MHT Weekly report demonstrating patient level data on who is waiting for what and the length of time they have been waiting VCSE partners prioritising localities with longest wait for recruitment Work has started to investigate the possibility of utilising the underspend to bring in temporary staff whilst substantive recruitment is underway.
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 may 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	9	•Digital colleagues identifying options for using Kent Medway Care Record (KMCR) instead of EMIS. 21/06/24 - EMIS group established to arrange access for key KMPT staff as an interim measure pending the outcome of the KMCR options work.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 25th July 2024
Title of Paper:	Freedom to Speak Up Annual Report
Author:	Rebecca Crosbie, the Guardian Service
	(Cover sheet authored by Sheila Stenson, Chief Executive)
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

A paper updating the Board on the annual performance of the Freedom to Speak Up (FTSU) Guardian Service.

The appendix to this paper also sets out the recommendations from the guardian service and the actions that the Trust are taking in response to these recommendations.

Issues to bring to the Board's attention

During the period of 1st April 2023 to 31st March 2024, a total of 101 concerns were raised with the FTSU Guardian (FTSUG). There is no noticeable increase from the previous period.

The 3 most prevalent themes were Systems & Processes, Behavioural/Relationships and Management Issues. Behavioural/Relationship concerns saw a 150% increase on the previous period and were also the least likely to be escalated due to fears of recrimination or judgement.

The staff group raising the most concerns in relation to the number of staff employed within that group is Additional Prof. Scientific and Technical. This period also saw an increase in Nursing staff speaking up.

With regards to concerns raised within directorates, North Kent saw the highest percentage of staff raising concerns (3.6%), followed by East Kent (2.6%). The directorate with the most concerns raised was Support and Corporate services, however this group has the highest staff count.

Within East Kent, Dover has continued to be the location with the highest percentage of staff raising concerns (20.70%). This is significantly higher than any other location and has risen from 5% in the first half of the period.

The main reason for staff contacting GSL was because they felt they had raised matters internally, but action had not been taken.

The appendix to this paper sets out the recommendations we are taking as an organisation to address the concerns being raised and the themes we are seeing. In summary a focus is needed on:

- Prioritising communication and training in relation to early resolution.
- Maintaining consistency in how concerns are handled – in particular avoiding disparity between handling of concerns relating to medical staffing and concerns relating to non-medical staffing.
- Feedback and follow up responsibilities of managers and senior leaders when concerns have been raised.
- Improving interdepartmental communication when handling or investigating concerns to reduce gaps in process and staff feeling that outcomes are insufficient or inconsistent.
- Raising awareness with managers and leaders around what constitutes whistleblowing and ensuring that this is appropriately tracked and logged in order to protect the staff member and ensure appropriate action is taken.
- Ensuring that robust pastoral support is available to staff raising concerns.

In addition to this we will be develop a 12-month communications plan in collaboration with the Guardian including internal plans for FTSU month which complement GSL speak up month promotions.

Governance

Implications/Impact:	Trust Strategy: Growing our capability to deliver
Assurance:	Reasonable
Oversight:	Oversight by People Committee/Trust Board

Version Control: 01

FTSU Action Plan 24/25

Area of Focus:	What has been highlighted:	Action Points:	Who:	Progress: On Track Yes/No	Date of Review:
Handling concerns relating to Medical Staffing	Consideration to review processes and responsiveness for the handling of concerns relating to medical staffing. To ensure that action is taken within reasonable timeframes and that there is no disparity between the handling of medical and non-medical staffing concerns.	• Full review of the DMU Process • Additional colleagues trained to undertake investigations in MHPS • Continually learnings to be shared as part of the CD and HoP CPD days	Afifa; Mohan; Marne; Jacqui	Yes	Oct 2024 Oct 2024 On-going
Communication around Organisational Change and transformation	Consideration to review the communication around organisational change and the support offered to teams going through transformation. Feedback from teams and managers has been that they don't feel informed and when asking for further information report not feeling heard.	• Feedback from Organisational Change to be gathered • Review feedback and ensure builds are implemented into Future plans	Marne/ HRBPs	Yes	As required As identified
Support for Managers Workplace incivility	To build on existing management programmes with consideration for focus on upskilling managers in compassionate leadership, communication skills and awareness, management style and impact, consistency and listening up. Support and training for middle managers to empower them to be able to inform and support teams through change, manage complex interpersonal relationships within teams and engage in difficult conversations. These are essential leadership skills which will support development of a positive workplace culture. Management and behavioural issues continue to be key themes within cases including incivility in the workplace. Consideration for a trust wide initiative into compassionate communication and respect. Inclusive of	• 6 new online workshops are being created for all to access at KMPT. Available from September 2024. We have aligned these to our strategic objectives and will be better placed to 'set the standard' of behaviour throughout KMPT. These subjects also respond to the areas of performance challenges/gaps we most commonly see across KMPT as evidenced by; requests for team interventions, feedback (ER/HRBP's) and FTSU learnings. ○ Acting with Compassion ○ Living the KMPT values ○ Professional Impact ○ Developing Self ○ Understanding myself & others	OD	Yes	Sept 2024

	communication towards both patients, colleagues, and compassionate leadership skills.	○ **Managing myself through Change** • **A new behavioural framework has been developed for managers and leaders. This framework will help us to set the standard of behaviour across KMPT and will be rolled out in September 2024. We have 3 areas of focus, each underpinned by competencies and behaviours:** **Leads the service** **Developing the knowledge and skills to provide an excellent service** **Leads the team** **Developing effective working relationships and strong team dynamics** **Leads with compassion** **Developing self-awareness to promote positive behaviour and interactions** • **To support the upskilling of managers we will be introducing new management development programmes from September onwards. These include:** **New manager Induction – in person and online** **Manager Foundations – will include workshops such as; Creating healthy Teams, Handling difficult conversations, Management skills and Performance management. Online and self-guided learning are also included. These will help give managers the skills needed and set the standard of best practice in line with our trust values and behaviour framework.** **Mary Seacole Programme – we are currently training 6 facilitators to deliver this programme for KMPT** **Senior leadership programme – this is about to be procured for delivery over the next 12/18 months**			

Whistleblowing and detriment	To review how the trust records and supports those who have made a protected disclosure and to investigate reports of detriment.	• Case management system to be used to record Whistleblowing • Better joined up approach to investigate and follow up on concerns raised and closed down accordingly	Employee Relations/ Patient Safety/ Safe guarding/ IG	Yes	September 2024

Early Resolution Policy	Since being published it has been reported that there has been a lack of communication and training around the new policy. For this policy to become effective and for those who engage it to have a positive experience it is a recommendation that the trust prioritise a communication and training initiative around this to ensure consistent use of the policy and best practice.	• Relaunch Policy in July 2024
		• Include Just learning Culture into Early Resolution Policy
		• Manager Training in:
		  ○ Investigations
		  ○ Disciplinary & Grievance
		  ○ Absence Management
			Marne/ Employee Relations	Yes	August 2024

Work related stress and Pastoral Support	Feedback from cases has been that individuals don't feel supported when they experience work related stress, with their perception being that the trust does not fully explore what led to the stress to mitigate any future experience. Recommendation to review processes for supporting staff with work related stress including monitoring of situations leading to work related stress to mitigate sickness absence and resignation. Pastoral support has been raised as a recurring theme within cases. It is a recommendation to ensure sufficient resources and clear expectations for pastoral support for those undergoing a formal process or those on long term sickness absence due to work related stress.	• New Pastoral support guide has been built • Pastoral support and line management support to be separate people • Review the Staff Support policy	Employee Relations	Yes	August 2024
Consistency of formal processes	A recurrent theme within cases has been a lack of consistency across formal processes – this includes timeframes, practice, and feedback delivery. Although there is the new central investigations team in post there will still be processes which fall outside of this team. Consideration to explore how	• All cases have a process to follow, start of case meeting; investigation; end of case meeting; outcome meeting	Employee Relations	Yes	September 2024

	consistency can be achieved and maintained across internal processes is recommended.				
Follow Up training for senior leaders	To consider making the NHSE Follow Up FTSU training for senior leaders mandatory to promote all elements of the speaking up experience and process within KMPT.	• Launch module 3 of the FTSU training incorporating Follow Up • Ensure that all Top 100 leaders complete the course	FTSU Guardian/ L&D	No	To be actioned when a full review of mandatory training has taken place this year (2024). To be signed off by CEO.
Board reflection and planning tool	For the board to collaborate with the Executive Lead for FTSU; to complete the NHSE Board Reflection and Planning tool at least once every two years to identify the trusts current position on FTSU and high-level actions for the organisation.	• Has been completed already and another will be planned for in 2025	Secretariat	Yes	2025
Addressing Concerns	Colleagues feel that when they raise concerns with managers they are not heard or dealt with properly.	• Hold monthly HR Clinics for colleagues to come and address concerns that they have, ask questions and give feedback	HRBP's, HR Advisors, HR Officers	Yes	To be in place by Sept 2024

NHS
Kent and Medway
NHS and Social Care Partnership Trust

The Guardian Service
Here to listen

Annual Report
1 April 2023 to 31 March 2024

Main point of contact:
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Prepared by:
Rebecca Crosbie
Lead Guardian
The Guardian Service Ltd.

20th June 2024

The Guardian Service
Here to listen

Contents

1. Executive summary

This report presents the Freedom to Speak Up (FTSU) Guardians' Annual Report for the period 1 April 2023 – 31 March 2024 and provides an overview of the activity and themes that took place during this period.

- 101 concerns were raised during this period. There is no noticeable increase from the previous period.

- The 3 most prevalent themes were Systems & Processes, Behavioural/Relationships and Management Issues. Behavioural/Relationship concerns saw a 150% increase on the previous period and were also the least likely to be escalated due to fears of recrimination or judgement.

- The staff group raising the most concerns in relation to the number of staff employed within that group is Additional Prof. Scientific and Technical. This period also saw an increase in Nursing staff speaking up.

- Medical Staffing and Estates/Ancillary are the least likely group to speak up.

- The directorate with the most concerns raised was Support and Corporate services however this group has the highest staff count. In relation to staff count North Kent saw the highest percentage of staff raising concerns (3.6%), followed by East Kent (2.6%).

- Dover has continued to be the location with the highest percentage of staff raising concerns (20.70%). This is significantly higher than any other location and has risen from 5% in the first half of the period.

- The main reason for staff contacting GSL was because they felt they had raised matters internally, but action not been taken (42%) and 35% due to the independence of the service sought impartial support.

- 11 Red concerns were raised during this period. 2 remain open due to feedback and follow up being outstanding. This is actively sought by the Guardian to gain closure and reassurance that further risk has been mitigated.

- 3 cases of detriment were reported during this period. One upheld as part of an external investigation and two were not investigated fully as staff did not wish to pursue the matter.

- Since the service went live there has been focus on empowering staff to speak up, but an equal amount of attention is now required for Line Managers to listen up and follow up – **see priority recommendation**.

- The organisation has completed the Reflection and Planning tool for the next 2-year period with high-level actions relating to Speaking Up culture within the organisation. The trust could benefit from identifying dates for this to be reviewed up until February 2026 when it will be completed again in full.

- Formal processes are now seeing a positive decrease in timeframes due to the implementation of the Central Investigations Team.

2. Purpose of the paper

The purpose of this paper is to give insight to the progress and development of the service and a summary of themes arising from the cases received by the FTSU Guardians.

This report provides an overview from 1 April 2023 to 31 March 2024. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include: Assessment of cases, Action taken to improve speaking-up culture, Recommendations.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in KMPT on 6th June 2022.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

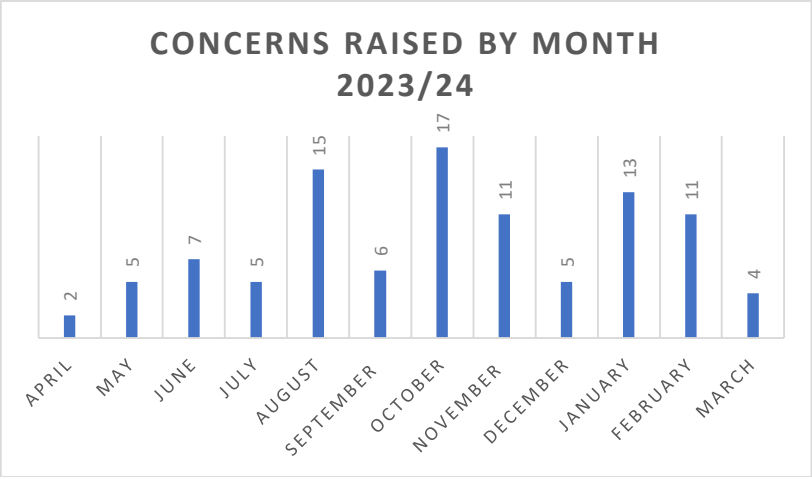
Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

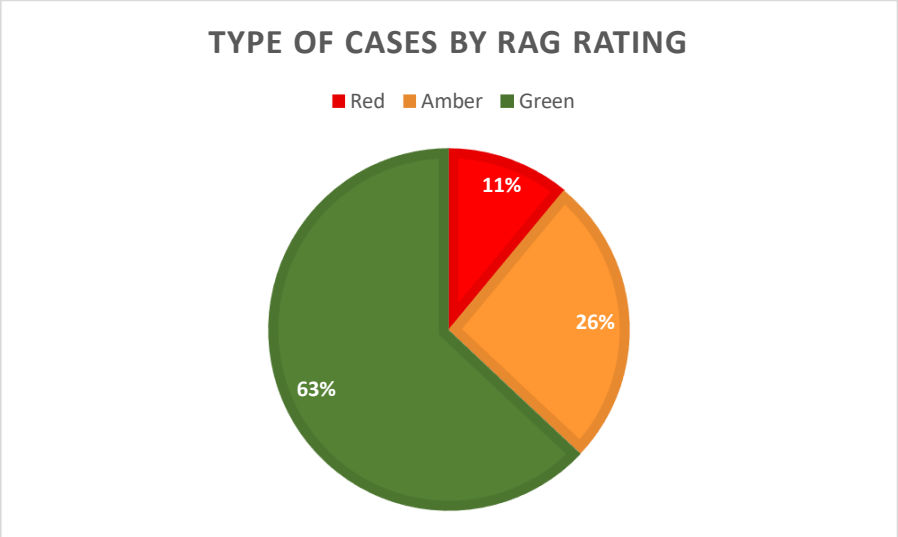
Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

For the period April 2023-March 2024 101 concerns were raised through The Guardian Service (GSL). This does not include concerns raised by other internal routes. In comparison to the previous year where 81 concerns were raised there has been a slight increase however for the 2022/23 year the service was only live for 10 months of the year. This shows only a slight increase on monthly average from 8.1 to 8.4. October saw the highest number of cases (17) and April saw the fewest (2). With Speak Up Month taking place in October, increased promotions may have contributed to confidence in coming forward to raise concerns.



Of the 101 concerns raised the majority (63%) were rated as green concerns. 26% were Amber and 11% were Red. 9 out of the 11 concerns rated as Red have been closed but two remain open due to an absence of feedback or follow up to those who have raised the concerns which the guardian is actively chasing though has faced some challenges. This will inform one of the recommendations within this report due to ongoing challenges with achieving the best practice 'Follow Up' aspect of the FTSU process.



8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	35	34.65%
Permission to escalate with names	43	42.57%
Permission to escalate anonymously	1	0.99%
Permission to escalate without name	22	21.78%
Total	**101**	**100**

Reassuringly 42.5% of staff raising concerns felt comfortable with these being escalated with full disclosure and only 1 staff member remained completely anonymous to both the guardian and the trust. In total 65% of the concerns raised were escalated into the organisation seeking resolution which is a positive figure. The remaining 35% used the service to seek impartial or emotional support without a need for of escalation.

Of the 101 cases 81 were closed within the period and 20 carried over into the next period whilst being proactively case managed by the guardian to seek resolution and feedback. The guardian carries out weekly cases reviews and actively chases or challenges any delays which may be perceived as unnecessary or to be exacerbating the concern itself. Delays in action or resolution can lead to formal processes, resignations or further concerns being raised.

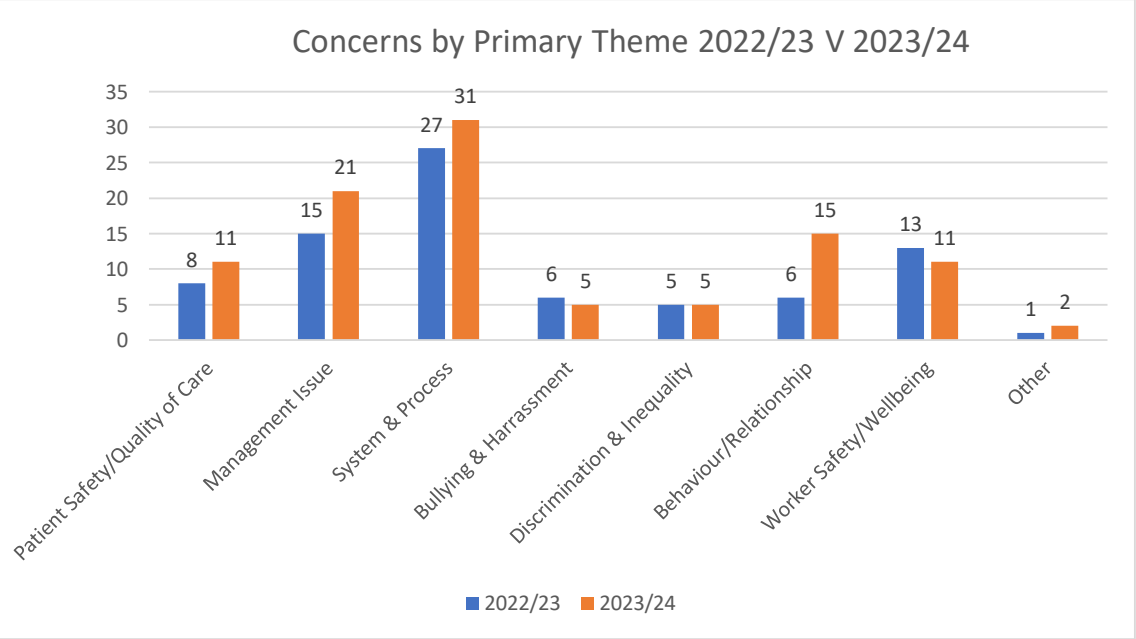
9. Themes

Concerns raised are broken down into the following categories;

Primary Theme	Total
A Patient Safety / Quality of Care	11
B Management Issue	21
C System Process	31
D Bullying and Harassment	5
E Discrimination / Inequality	5
F Behavioural / Relationship	15
G Other (Describe)	2
H Worker Safety or wellbeing	11
Grand Total	**101**

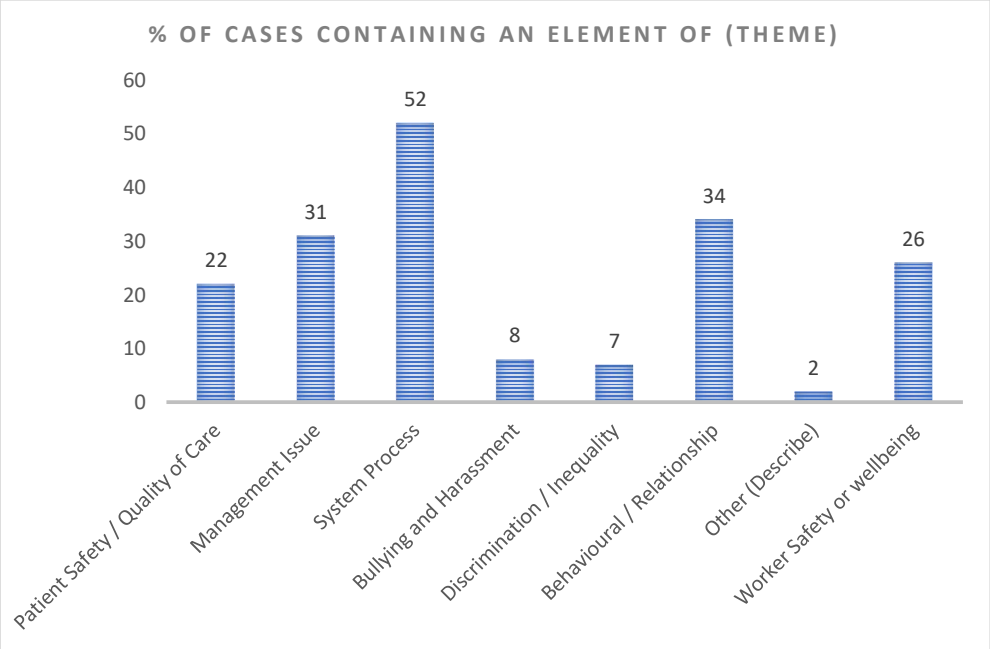
Multi Theme Occurrences	Total
A Patient Safety / Quality of Care	22
B Management Issue	31
C System Process	52
D Bullying and Harassment	8
E Discrimination / Inequality	7
F Behavioural / Relationship	34
G Other (Describe)	2
H Worker Safety or wellbeing	26

10. Trends in Cases



If we compare themes from the 2022/23 period to the more recent 2023/24 period, we can see an increase in cases relating to behaviours/relationships, systems & processes, management issues and a slight increase in patient safety/quality of care concerns. The cases relating to behaviours/relationships

have seen a significant increase of 150% for this period and when we look at the multi theme occurrences 33% of cases contained an element of behaviour or relationship related concerns and 50% of cases contained an element relating to systems & processes.



Benchmarking data is not yet published for the 2023/24 period. The data below makes comparisons to the data in the NGO annual report for 2022/23. It is important to note that there are many factors which impact case numbers including but not limited to: Geographic spread, CQC rating, leadership style, organisational culture, type of organisation.

For Mental Health and Learning Disability Trusts the average number of cases per submission* nationally for 2021/22 was 22.4 and for 2022/23 increased to 29.3. This average is collected across all trust sizes.
**Submission refers to one quarter of a year*

Mental Health and Learning Disability Trusts	
Year	**Average number of cases**
2022/23	117.2
Year	**KMPT**
2023/24	101

NGO data shows that KMPT is below average for Mental Health and Learning Disability Trusts on the average number of cases per half year period. This differs if we compare average figures by trust size.

Figure 4. Average number of cases per submission by NHS Trust size (2022/23)

The average number of cases for a small trust for a 12-month period is 69.2. KMPT had 101 cases for this 12-month period.

Small Trusts (up to 5,000 Workers)
Average number of cases (12-month period)
69.2
KMPT
101

11. Assessment of Cases

The overall top three themes for the period when looking at multi theme occurrences are:

1. Systems & Processes
2. Behaviours/Relationships
3. Management Issues

Highlights and themes from these areas are as follows:

Systems & Process

The most recurrent concern within this theme related to processes around transformation and restructure. Staff felt that communication was inconsistent or in some cases lacking. Staff reported that their managers didn't have the information to answer their questions or offer reassurances. Staff reported a negative impact on wellbeing, did not feel valued and were seeking transparency and information. In one instance a live FAQ document was created for staff which was well received and could be similarly beneficial in other times of transition.

Second to this was a recurrent theme around formal processes. Staff reported feeling that processes lacked dignity and felt impacted negatively by their experiences. Staff felt that communication from the organisation could be more compassionate and often felt judgement was being made about them without consideration for an understanding of their perspective and experiences. Staff continue to raise that timeframes feel unreasonable and that internal processes lack consistency in approach. The launch of the Central Investigations Team has started to improve timeframes in some cases.

Behavioural/Relationships

It is important to note that despite there being a significant increase (150%) in cases under this theme for this period that 66% of them were not escalated due to fear of how these would be managed internally. There was also a perceived risk of the situation becoming worse including potential impact on career or reputation.

The large majority of these concerns related to interpersonal issues between colleagues or staff with managers. Individuals felt that microaggressions, communications and behaviours were negatively impacting their wellbeing and the work environment. Individuals felt unsupported in trying to resolve these internally often reported feeling their experiences were minimised or not believed.

Consistently staff felt that the organisation did not have robust mechanisms to resolve these situations and that the early resolution policy, in the cases it was requested, did not meet the needs of the concern or have a positive impact.

Awareness around personal impact and microaggressions in the workplace could be beneficial trust wide with the continued increase in concerns of this nature.

Management Issue

Within this theme staff were predominantly reporting a perception of poor management style, behaviour or communication. Staff were seeking support due to the impact of this on their wellbeing, experience in the workplace and impact on team/service culture.

Within this theme were several unconnected cases where staff members had independently approached their senior management for support with a challenge with a line manager. The consistent experience here was that the senior manager was reluctant to take action due to managing the line manager themselves. In some of these cases interventions such as mediation were declined, and senior managers suggested staff go off sick or make a formal complaint. Generally, staff try to avoid formal processes and sickness absence rather seeking support, guidance and early resolution from the senior manager in the first instance.

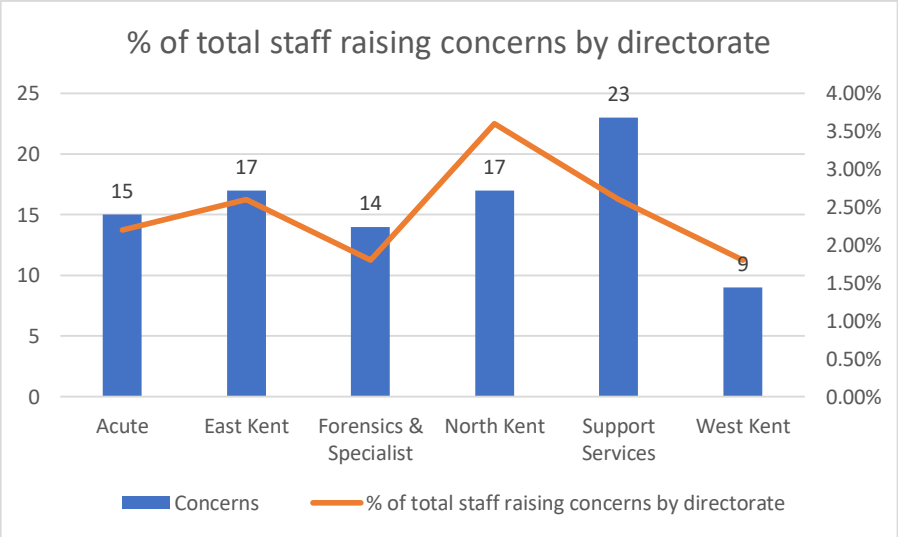
Other key recurring highlights from this theme were:

-Ineffective management
-Micromanaging
-Lack of meaningful or infrequent supervision
-Management minimising risk or a perception of management not taking risk seriously
-Abuse of power
-Workplace friendships impacting managerial responsibilities

The ongoing project being developed to support leadership development should positively impact on concerns being raised within this theme.

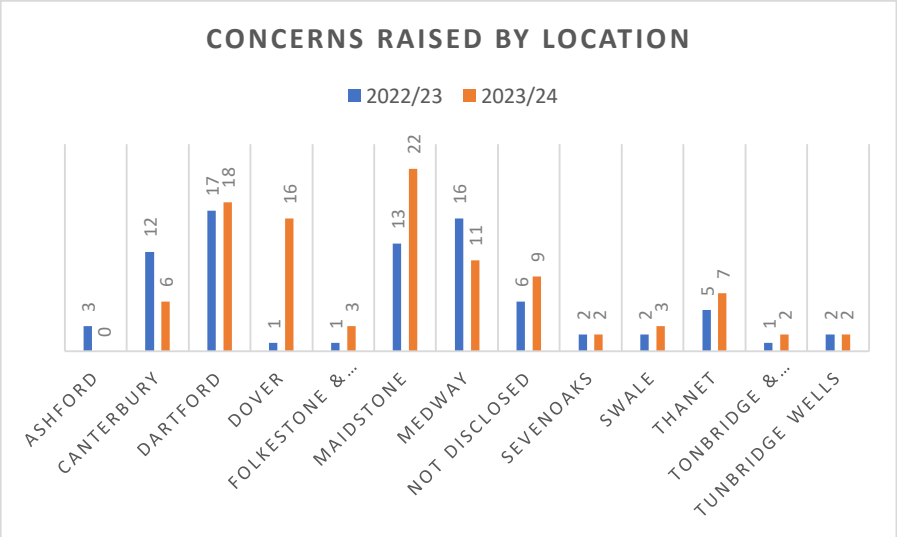
12. Statistical Graphs

Concerns raised by Directorate



Support services continued to see the highest number of concerns raised for this period however it is important to note that this directorate also has the highest number of staff employed within it at 893 employees. If we look at the total number of staff raising concerns in relation to the number of staff employed in each directorate North Kent is the prominent area with 3.6% of staff raising concerns followed by East Kent and Support Services with 2.6% of staff raising concerns.

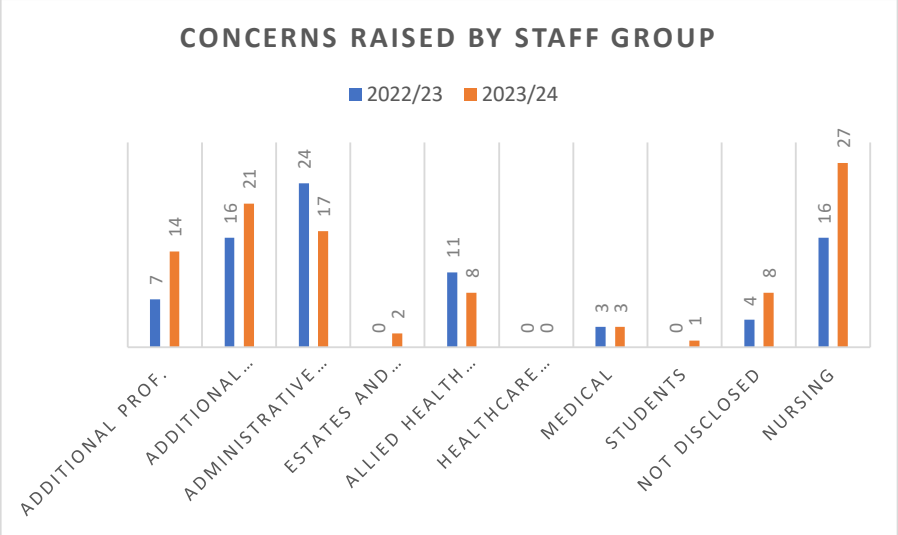
Concerns raised by Location



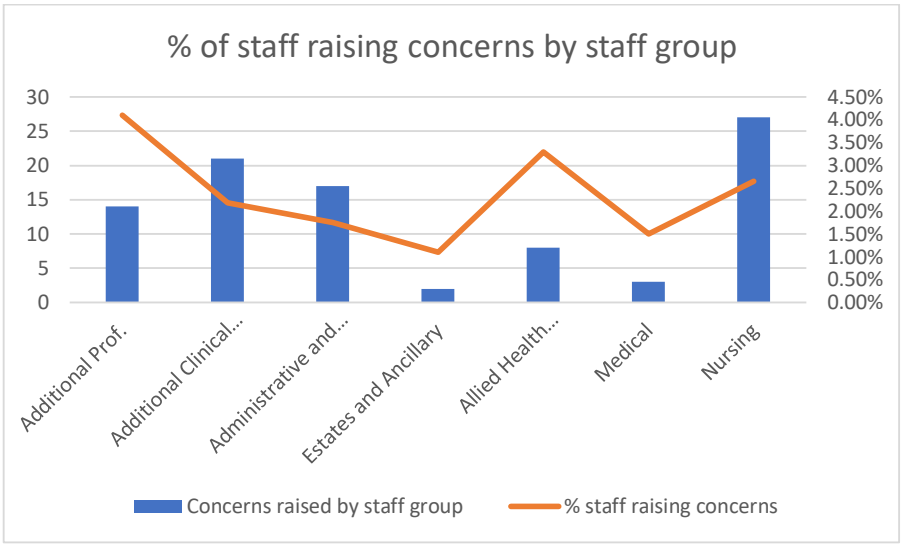
Location	Employee Count	Concerns	% of staff
Dartford	718	18	2.50%
Gravesham	4	0	0%
Sevenoaks	44	2	4.50%
Tonbridge and Malling	179	2	1.11%
Maidstone	975	22	2.25%
Tunbridge Wells	85	2	2.35%
Swale	151	3	1.98%
Ashford	122	0	0%
Canterbury	719	6	0.80%
Folkstone and Hythe	102	3	2.90%
Dover	77	16	20.70%
Thanet	304	7	2.30%
Medway	280	11	3.90%
Unspecified	46		
Not disclosed		9	
Grand Total	**3806**	**101**	

If we look at the percentage of staff raising concerns by employee count in each location Dover rates the highest with 20.7% of staff raising concerns. This has increased from 5% in the first half of the period. **(note staffing figures were provided by the organisation in January and are not due to be updated until July 2024. Looking at outtake and intake, figures should not change significantly)**

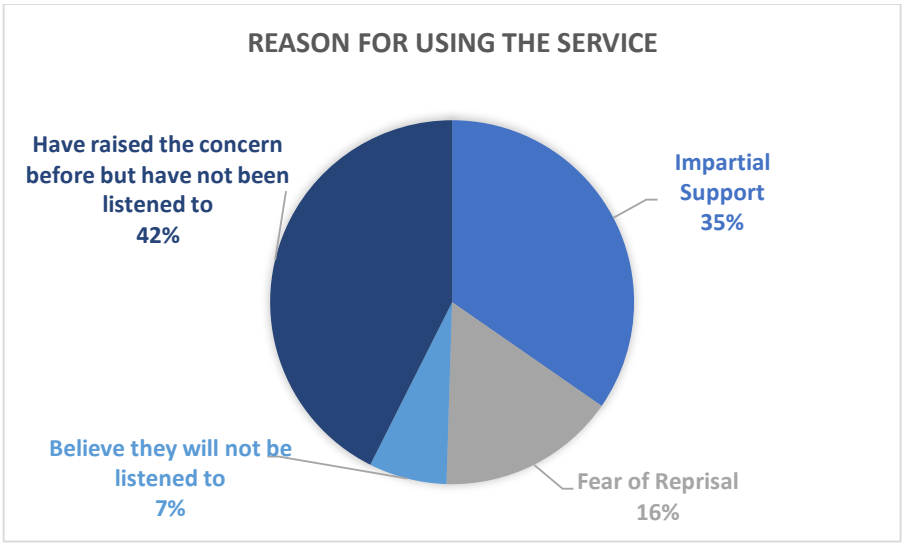
Concerns raised by Job Group



When comparing data from the previous period we can see there has been an increase of 68% in nursing staff raising concerns. This could imply that there is increased trust and open culture developing which could impact staff feeling more empowered to speak up. There has also been a 100% increase in staff raising concerns from the Additional Prof. Scientific and Technical staffing group. When looking at the number of staff employed within this group, we can see this group has the highest number of staff raising concerns at 4% followed by allied health professionals at 3.3%.



13. Why do staff use The Guardian Service?



We continue to see that the prevalent reason for staff using The Guardian Service being that they believe they 'Have raised the concern before but have not been listened to'. The theme of futility was emphasised as the National Guardian's Office conference in 2024 and how this can have a significant impact on the overall culture of an organisation. If staff don't feel heard which can include not receiving feedback or follow up, then they may be less likely to raise concerns in the future as well as discouraging colleagues by sharing their negative experiences.

35% report using the service for impartial support and value the independence of The Guardian Service.

16% share a fear of reprisal and although it is a smaller percentage it is still important for the organisation to continue to break down any fears and barriers staff may have around speaking up. This can be done by ensuring the full Speak Up, Listen Up, Follow Up process is a positive experience for those who do raise concerns.

14. Detriment

There were 3 reported cases of detriment within this period. One case was logged when closing a concern, the staff member felt that following escalation they were treated with hostility from management from which the impact led to their resignation. They declined further follow up or communication on this due to their experience. Dialogue took place between senior management and the guardian to explore learning and prevent further instances of this experience in that area.

The second instance was a staff member who approached The Guardian Service to share their perception of experiencing detriment following raising a protected disclosure internally. This case became part of a wider external investigation where the alleged behaviours and experiences were upheld. The individual was able to continue in their post and has seen improvements but felt there were gaps in receiving follow up and feedback on their case of which they used GSL to prompt the trust for.

The third case concerned a staff member who felt their hours were reviewed following raising concerns about a perception that management weren't taking risk seriously enough. This staff member was empowered to manage this situation independently and did not wish to take further action.

15. Action taken to improve the Freedom to Speak Up Culture

The organisation has now completed the Freedom to Speak Up Reflection and Planning Tool at board level. This contains high level actions to bring about improvement to FTSU. Progress will be reviewed by the Executive Lead for FTSU periodically and is due to be completed again in February 2026.

The organisation includes FTSU in all corporate inductions and are looking to include FTSU into local induction handbooks.

With the introduction of a new CEO the organisation has hosted many, trust wide, 'Speak to Sheila' events to encourage staff to have a voice and share any concerns or experiences.

The organisation has introduced a new staff council.

The organisation supports the Guardian to have free access to all services across the trust to ensure that FTSU promotions can take place and there is good visibility of the service for all staff.

The Guardian meets quarterly with the NED from FTSU and Monthly with the Executive Lead. Monthly meetings are also held with the Deputy Director of Workforce and the Guardian will now attend the HR BP team meeting quarterly to give an update on themes and trends. Other monthly and quarterly meetings take place with HR BPs and Service Directors individually as needed to discuss hot spot areas and ongoing case progress within the remit of confidentiality.

16. Learning and Improvements

The organisation is defining and developing a plan around a just and learning culture which will include addressing concerns.

Management & Leadership Development programme is being finalised by organisational development.

Timeframes for formal processes are reported to be starting to decrease with the launch of the new Central Investigations Team in place. This should also offer more consistency within formal processes.

17. Comments & Recommendations

Priority Recommendations

1. Since the service has been live within KMPT there has been a focus on empowering staff to raise concerns. A focus is now needed on the feedback and follow up responsibilities of managers and

senior leaders. Lack of action, feedback and follow up has become increasing challenging when managing cases during this period.

2. Consideration to be taken on how interdepartmental communication can be improved when handling or investigating concerns to reduce gaps in process and staff feeling that outcomes are insufficient or inconsistent.
3. Consideration on raising awareness with managers and leaders around what constitutes as whistleblowing and ensuring that this is appropriately tracked and logged in order to protect the staff member and ensure appropriate action is taken.

Other Comments

Consideration to develop a 12-month communications plan in collaboration with the Guardian including internal plans for FTSU month which compliment GSL speak up month promotions.

The organisation has completed the Reflection and Planning tool for the next 2-year period with high-level actions relating to Speaking Up culture within the organisation. The trust could benefit from identifying dates for this to be reviewed up until February 2026 when it will be completed again in full.

It would be beneficial to have a live action plan of ongoing recommendations which can be reviewed quarterly with the Exec Lead in their meetings with the Guardian.

18. Staff Feedback

- My journey has not been smooth, but at every step, the guardian has been informative, polite, respectful, very kind to my needs and at times a needed friend.
- I have been involved in a very complex situation and have really valued Rebecca's advice and support when I have been under a lot of stress.
- Very thankful for quick response and action taken by Rebecca. Escalated concerns which I did not know where else to go with.
- This service proved invaluable in my particular experience.
- I cannot express my thanks enough for the amazing instant support and of being listened to.
- Thank you for your service. Unfortunately, I had the worst job experience of my career, and thanks to your service I have not left my job as other colleague with the same problem did before me.
- Thank you for the support and help offered and liaising with senior staff to help resolve the problem.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	25 July 2024
Title of Paper:	Review of Committee Terms of Reference
Author:	Tony Saroy, Trust Secretary
Executive Director:	n/a

Purpose of Paper

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

Overview of Paper

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

Issues to bring to the Board's attention

Trust Secretariat has been charged by the Trust to review the governance structure within the Trust and make recommendations to the Audit and Risk Committee, and then Board. The work undertaken has been done in parallel with the independent well-led review by Deloitte.

Trust Secretariat is focussed on achieving three main aims: 1) reducing friction in governance 2) reducing meeting preparation time and 3) reducing meeting length. Trust Secretariat has identified some mission creep in the terms of references for committees, as well as a mixing of assurance and executive functions.

The Board Committees have completed reviews of their respective adjusted Terms of References and as a result of these reviews are proposing some changes to their Terms of Reference for Board approval. Where Committees have requested changes, these are highlighted in the attached paper.

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

Governance

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

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Committee Terms of Reference

1 Context

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

As part of the Trust Strategy delivery, the Trust identified that there needs to be a refresh of the governance regime. Two outcomes were identified:

a) There needs a higher degree of assurance delivered to the Board, either directly or through sub-Board committees; and
b) There must be more effective decision making.

To achieve those two outcomes, three main aims were set so as to:

a. Reduce friction in the governance process;
b. Reduce preparation time for meetings; and
c. Achieve a proportionate length of meeting.

The outcomes and aims of the governance refresh align with the matters discussed within the Deloitte Well-Led Review.

Reducing friction

At the start of the refresh, the Trust had 40 assurance/decision making groups. This has already been reduced to 34 during the refresh process. Currently there is:

a. 1 x Board
b. 7 x sub-Board committees
c. 14 x trust wide groups
d. 12 x sub groups.

A review has been undertaken, with the starting point being the standing orders and the appropriate delegation down through the various levels to the sub-groups. The key aspects for sub-board committees fall into three main areas:

a. Assurance regarding the Committee's area of concern,
b. Assurance regarding structures, systems and processes
c. Assurance that risks are being overseen properly.

The review has so far identified some mission drift when comparing the 'ask' from the Board as detailed in the Standing Orders with the matters contained within Committees' Terms of Reference. Some Terms of References have blurred the line between assurance and executive function, with approval of policies just one area which used to occur but has been rectified.

In order to ensure that Committees are appropriately sighted on matters, it is anticipated that each committee meeting has an Exec Lead Report which not only highlights key areas of progress and concerns within the jurisdiction of that Committee, but also allows for Exec-Lead commentary on

papers that will be received later in the agenda. This was used effectively during the July Quality Committee meeting where the inaugural Chief Nurse report was well received, and has been used effectively at the Mental Health Act Committee to the extent that the pace of meeting often leads to shorter meetings, releasing senior officers' time.

Reducing Preparation Time

As from 1st July 2024, governance support for all committees will fall to Trust Secretariat. The team will also be providing additional governance support to Exec Leads so that they can discharge their duties as Board/Committee members. This was one of the recommendations from the Deloitte Well-Led Review as there was a finding that meetings that were supported by Trust Secretariat operated at a higher level than those that were not supported by Trust Secretariat.

Accordingly, the actions will be tightened with there being greater oversight and stricter compliance requirements, with a significant reduction in the number of papers that are deferred. This will give Committee Chairs more confidence that they are leading a committee that is discharging its duty to the Board, as per standing orders and terms of reference.

With the centralisation of governance support, there will be a stronger monitoring of cross-referred matters. It is anticipated that one area of change may occur on the coversheets for Board and Committees, with papers being produced for a 'primary' committee, but added to the reading room for a relevant 'secondary' committee. This should reduce the number of report submissions an Executive must make.

Proportionate length meetings

With governance support being provided by Trust Secretariat, reports will be monitored so that they provide clearer interpretation of the data and that they provide an answer to the question raised by the Board or Committee. This should reduce the number of re-submitted reports and follow-up papers being sought.

Training will be provided to relevant individuals regarding report production and Diligent will be rolled out to additional users to avoid the need for PDF production of meeting packs. This reduces the confusion that can occur when Diligent users can see live documentation, but other users see static documentation

Clean copies of the new Terms of References have been uploaded to Diligent. Committee workplans will be adjusted following Board approval of the Terms of References.

2 Proposed Changes for Approval

1 Quality Committee

The Quality Committee is proposing changes to membership so as to reduce the number of members, which will allow for swifter approval of matters. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

2 People Committee

The People Committee seeks to change its membership to include the Director of Communications and Engagement and to remove the Chief Operating Officer. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

3 Mental Health Act Committee

The Terms of Reference were adjusted so as to remove references to trust wide groups no longer in existence and tightening up the methodology of the Committee. Adjustments were made to the language within the terms of reference so as to focus on the matters as delegated by the Board through the Standing Orders.

4 Audit and Risk Committee

The Audit and Risk Committee will be adopting, in most part, the Terms of Reference as recommended by the Healthcare Financial Management Association. The Chair of the Audit and Risk Committee has requested a paper from the Trust Secretary, which will be received by the Committee at its September meeting, that addresses queries raised.

5 Conclusion and Recommendation

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

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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th July 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 • Digital Champion Network Update	• Quality Digest • Quality Impact Assessments • CQC Report • Mortality and Serious Mental Illness Report • Culture of Care Programme • Annual Complaints Report	• Risk Register • Annual Controlled Drug Report • Quality Committee Terms of Reference

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.**
Chief Nurse's report	The inaugural report updated the Committee on key themes from the other committee papers as well as main items of concern and success since the last committee meeting. The Committee was updated on the rollout of Patient Safety Investigation Review	Reasonable	

	Framework as well as he Band 5-6 development programme.		
Referral from other committees	The Committee was informed of concerns about the delay on preparing reports and reviewing patients who are discharged on conditional discharge. The Committee also sought assurance regarding the appropriate use of private PICU beds. The Committee was informed of the reasoning behind the use of private beds over and above the block contract.	Reasonable Reasonable	The Trust is actively addressing this issue with local leadership teams. The Trust is implementing its action plan to improve the pace of reviewing patients and preparing reports. The Committee requested the issue to be addressed in the forthcoming patient flow report that it shall receive.
Quality Digest	There are a number of Root Cause Analyses that have breached the deadline for completion. The ICB is not extending any deadlines as it prepares for the Patient Safety Investigation Review. The Trust recognises the breached deadlines but continue to complete Root Cause Analyses with pace and with discussion with the ICB.	Reasonable	The Committee will receive a further update on the Root Cause Analysis data when it next receives the Quality Digest.
Quality Committee Terms of Reference.	The Committee endorsed the amended Terms of Reference.	Reasonable	The Committee recommends that the Board approves the amended Terms of Reference.
The Committee welcomed the introduction of a regular overview report from the Chief Nurse, and recognised it as a valuable addition to the standing agenda. The Committee also noted progress in reshaping the Quality Risk Register report towards one that reflects the significant risks to quality in the organisation. Further work was underway to improve reporting and closure of risks where appropriate, to support closer focus on the issues of significant concern. On Quality Impact Assessments (QIA), a more meaningful report to committee, going beyond reporting on process would be brought to future meetings. The Chair would be attending a QIA meeting in August to observe.			

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MORTALITY REPORT – Q1 – 2024/25

1. INTRODUCTION

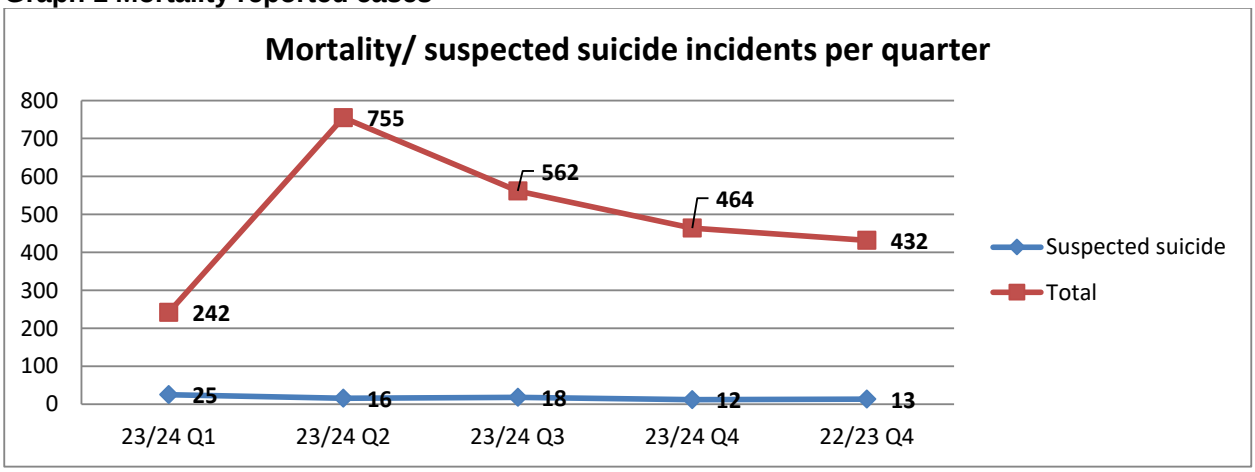
1.1 The purpose of the report is to fulfil the expectations in relation to reporting, monitoring and the Board's oversight of mortality incidents, as set out in the National Quality Board's 'Learning from Deaths' guidance (March 2017). This builds on the recommendations made by the MAZARS investigation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

2. HOW MORTALITY IS REVIEWED IN KMPT

2.1 The Trust-Wide Serious Incident and Mortality Review Panel (TWSIMRP) meets once a week to review all potential serious incidents, including mortality. The Governance team within each directorate ensures that every death is reviewed and scrutinised, to determine if the current serious incident framework criteria is met and to identify areas of learning.

3. ANALYSIS OF INFORMATION

Graph 1 Mortality reported cases

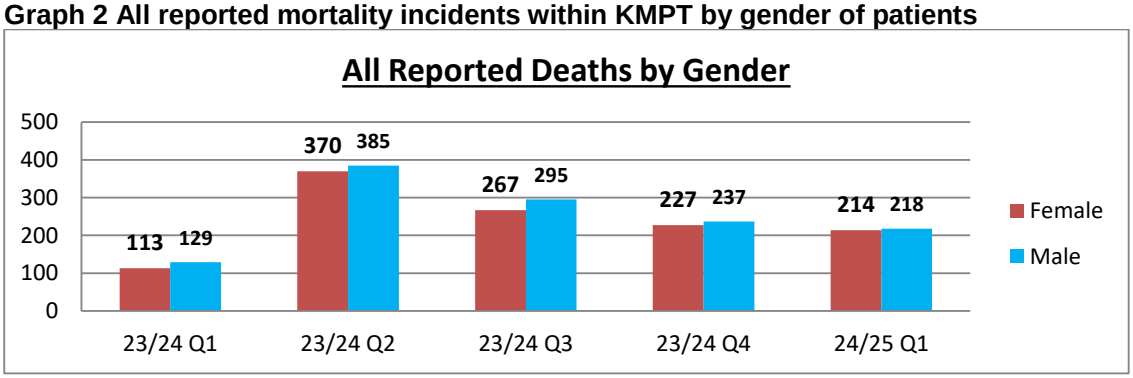


3.1 In Q1, 432 mortality incidents were reported on InPhase. There has been a 7% decrease in mortality reported incidents compared to Q4.

3.2 Although the mortality figures have slightly decreased, mortality data is higher than 2022/23 reports. After careful review of the data, the increase is more than likely due to historic death data work, that has been ongoing since July 2023. 178 (41%) of the mortality incidents reported in Q1 are recorded as Death Notifications, as part of the ongoing historic death work.

3.3 298 (69%), of all patient deaths reported in Q1 were of patients under the care of older adult community mental health services, most of whom died of natural causes and where no learning was identified. The number of mortalities in older adult patients is consistently higher than any other service.

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



3.4 The rates of male and female deaths are monitored to identify differing trends to that of national data. The 2023 Office for National Statistics report (for deaths registered in England and Wales 2022), shows that historically, female mortality were higher. Since 2020, the mortality rates shifted, with male deaths marginally higher than females.
Therefore, KMPTs mortality data is in line with current national mortality rates in males and females.

Mortality review by ethnicity
Table 1 Deaths by ethnicity

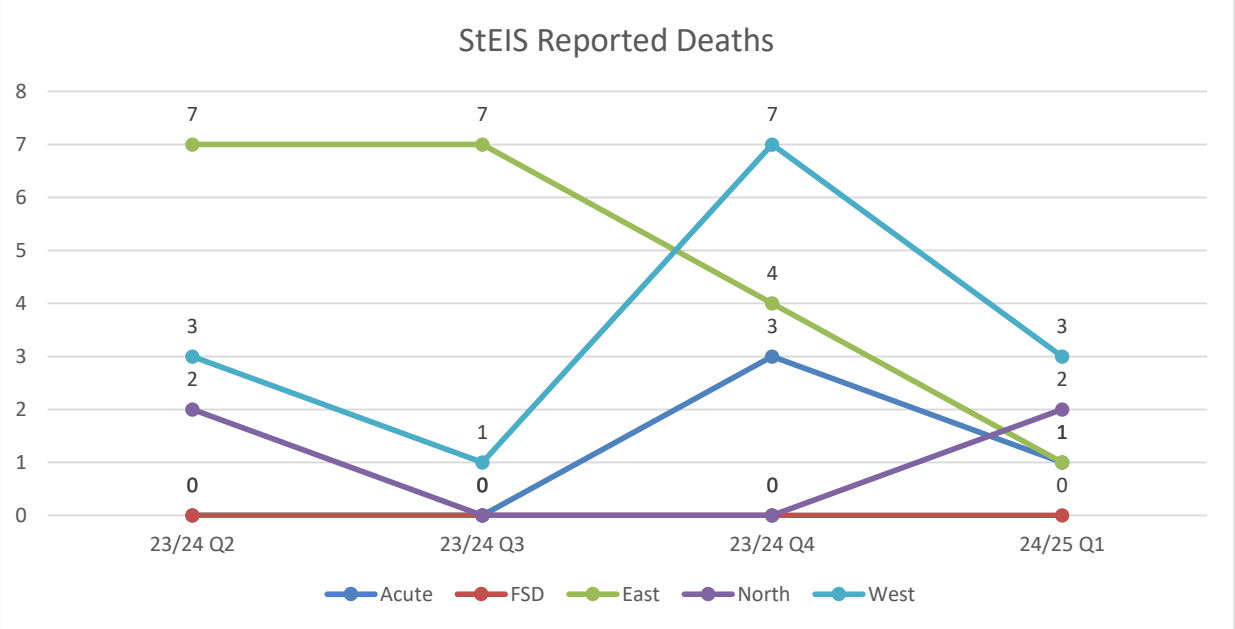
	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	24/25 Q1	Total
Asian or Asian British - Any other Asian background	1	0	3	2	0	6
Asian or Asian British - Indian	1	0	4	2	1	8
Asian or Asian British - Pakistani	0	1	0	1	0	2
Bangladeshi	0	2	0	0	0	2
Black, African, Caribbean or Black British – African	2	3	0	1	0	6
Mixed or Multiple groups - White and Asian	0	0	1	1	2	4
Mixed or Multiple groups - White and Black Caribbean	0	0	0	2	0	2
Mixed or Multiple groups - Any other mixed or multiple ethnic background	2	3	1	1	0	7
Mixed white and black African	1	0	0	0	0	1
Not stated / Unknown	28	175	81	117	83	484
White - British	207	563	466	329	341	1906
White - Irish	0	0	0	2	2	4
Any other ethnic group	0	0	0	0	1	1
White - Any other White background	0	8	6	6	2	22
Total	242	755	562	464	432	1559

3.5 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British, and what our national data tells us. We continue to see low numbers of deaths of patients of

ethnic minority, however there is a persistent theme of incomplete recording of ethnicity within InPhase (not stated/unknown). There are inconsistencies in the recording of patient ethnicity in InPhase, compared to the health record, RiO.

3.6 From previous analysis, (as demonstrated in the KMPT health inequalities report), it is unlikely that the 83 records where ethnicity is not stated or known, are of patients of ethnic minority. However, at this stage, it is paramount that the Trust work to determine how we can gain an understanding of the under-represented data. In order to achieve this, there will be a focus within the mortality review group meeting (which is in infancy), of the feasibility in pulling mortality data from RiO.

Graph 3, STEIS reported deaths



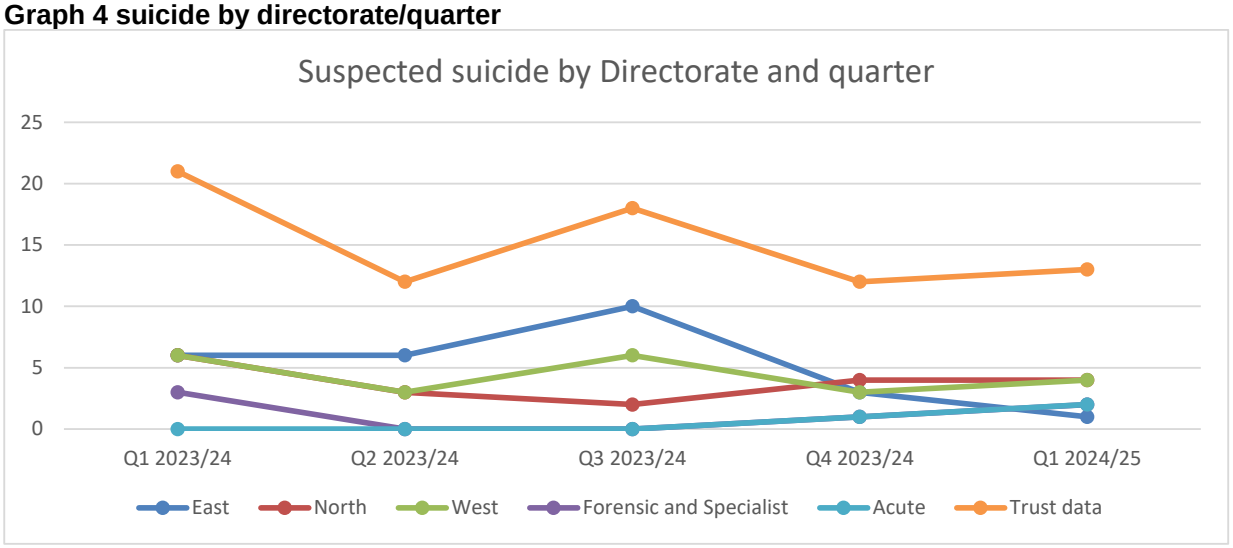
3.7 STEIS reported mortality incidents are included in this mortality report, as this could be an indication of gaps in care or treatment.

3.8 The number of STEIS reported incidents is known to fluctuate each quarter, and numbers can vary according to each Directorate (typically with Acute and FSD reporting smaller numbers of STEIS reported deaths).

3.9 STEIS reported mortality incidents have reduced in Q1 2024/25, with a total of 7, compared to 14 in Q4. The serious incident process as we know it is changing. As KMPT move towards the Patient Safety Incident Response Framework (PSIRF), it is anticipated that the trust will see a reduction in STEIS reported incidents if existing improvement work is in place to address learning. This approach is captured within the PSIRF transition plan.

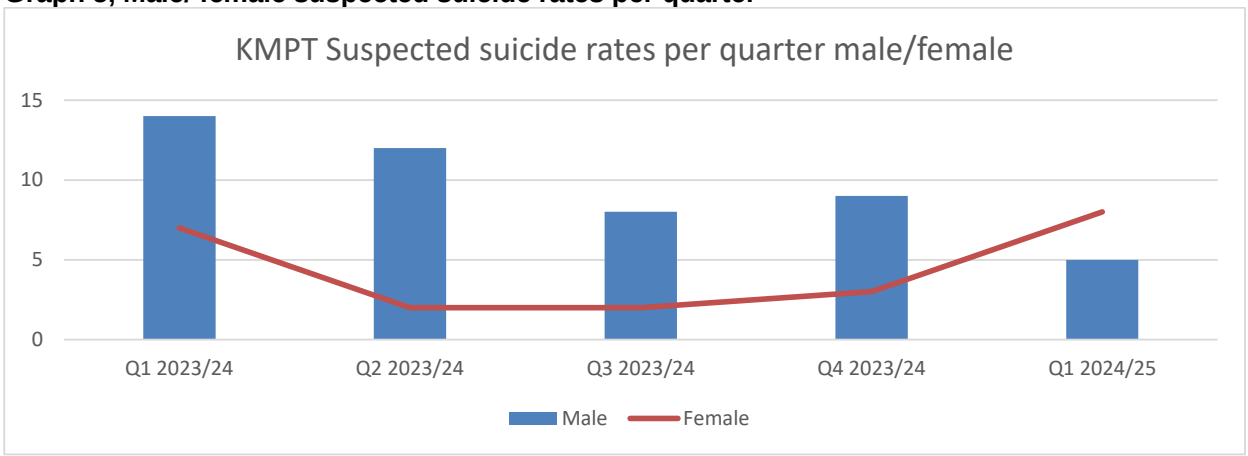
4 KMPT SUSPECTED SUICIDES

Graph 4 suicide by directorate/quarter



4.1 With the implementation of InPhase in April 2023, the way in which we record suspected suicides changed, to include all suspected suicides (previously, these were not captured due to the NRLS reporting requirements). This explains the peak in Q1 2023/24. However, suspected suicide numbers however have fluctuated over the financial year, and will continue to be monitored.

Graph 5, Male/ female suspected suicide rates per quarter



4.2 The 2023 Kent and Medway Real Time Surveillance data, provided by KCC's suicide prevention team, revealed higher numbers of suspected suicide in middle aged males, between 40-54 years.

4.3 Suicide rates in England and Wales are known to be higher in males. This is represented at each annual National Confidential Inquiry into Suicide and Safety in Mental Health (NciSH) report. The 2024 annual NciSH report[1] however, highlighted that the number of

[1] display.aspx (manchester.ac.uk)

female suicides increased in 2020, driven by an increase in the number of suicides by hanging/strangulation.

4.4 For the first time, suspected suicide figures in KMPT are higher in females than males. There are possible differences in patterns and trends, that would need to be explored further, such as:

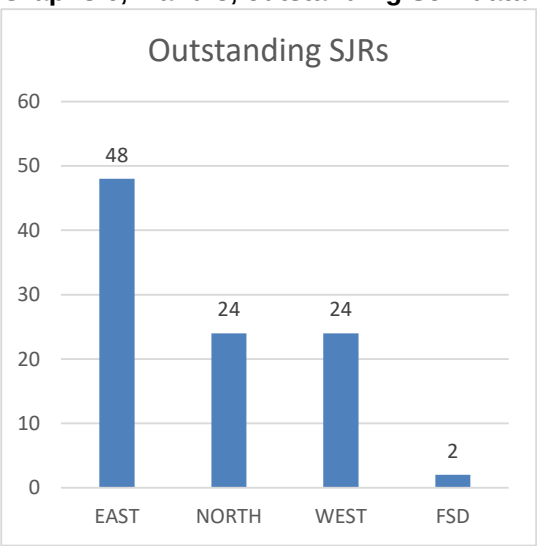
- Increase in female suspected suicide, comparing to Kent-wide Real Time Surveillance data
- Change in pattern of male and female age (previously middle aged in line with national data).
- Fluctuation in numbers of reported suspected suicide each quarter.

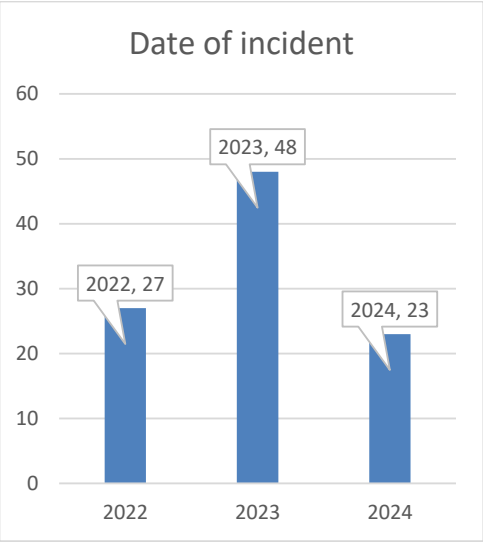
Table 2 Suspected suicides by age and gender

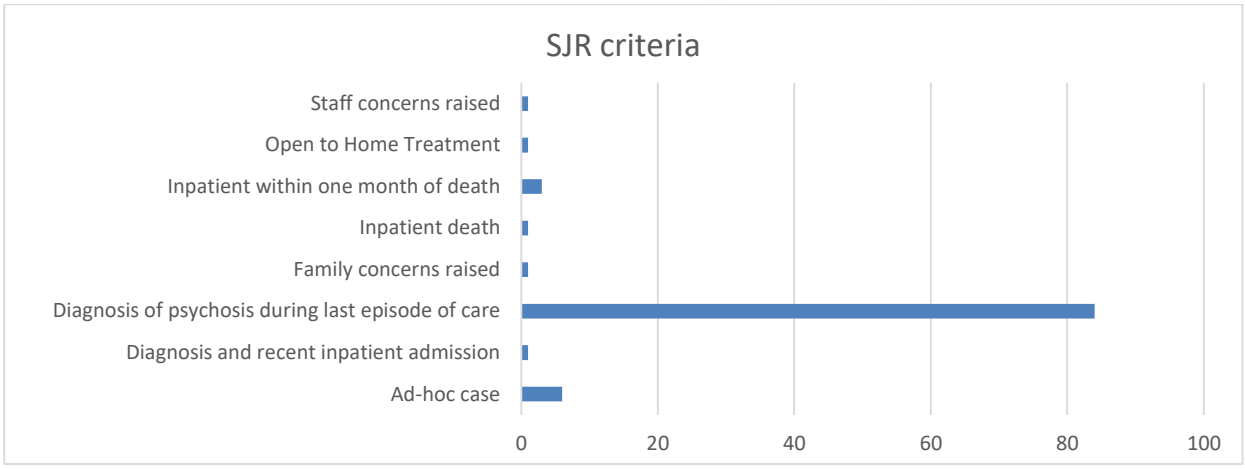
	Q4 2023/24		Q1 2024/25	
	Male	**Female**	**Male**	**Female**
18-19	0	1	1	0
20-29	0	1	1	0
30-39	3	0	1	2
40-49	4	0	0	1
50-59	1	0	1	0
60-69	0	0	1	2
70-79	1	1	0	3
80-89	0	0	0	0
90-99	0	0	0	0
Total	**9**	**3**	**5**	**8**

5. STRUCTURED JUDGEMENT REVIEW

Graphs 6, 7 and 8, outstanding SJR data







5.1 There are 98 unallocated, outstanding Structured Judgement Reviews, dating back to 2022. The majority have met the criteria due to diagnosis of psychosis during last episode of care.

5.2 There have been capacity issues for trained staff to undertake SJRs, since training was provided by the Improvement Academy in September 2020.

5.3 There is a plan in place to clear the backlog. A Learning from Deaths risk has been added to the Trust Risk register, to improve how we measure from learning from deaths.

5.5 Actions have been set within this risk (ID 7668):

Action	Owner	% Complete	Start Date	Due Date	Completion Date (est)
Mortality App report *(within InPhase to monitor progress of SJR's)*	Mortality Review Manager	0%	21/06/2024	30/08/2024	30/08/2024
Mortality Review Group Terms of Reference	Mortality Review Manager	0%	21/06/2024	31/07/2024	31/07/2024
To reduce and remove the Structured Judgement Review backlog	Mortality Review Manager	0%	21/06/2024	02/01/2025	02/01/2025
Training of staff to undertake Structured Judgement Reviews (Total 10)	Mortality Review Manager	50%	24/04/2024	30/08/2024	30/08/2024

We are 50% compliant in SJR training. The Central Investigation Team (CIT) received training in April 2024.

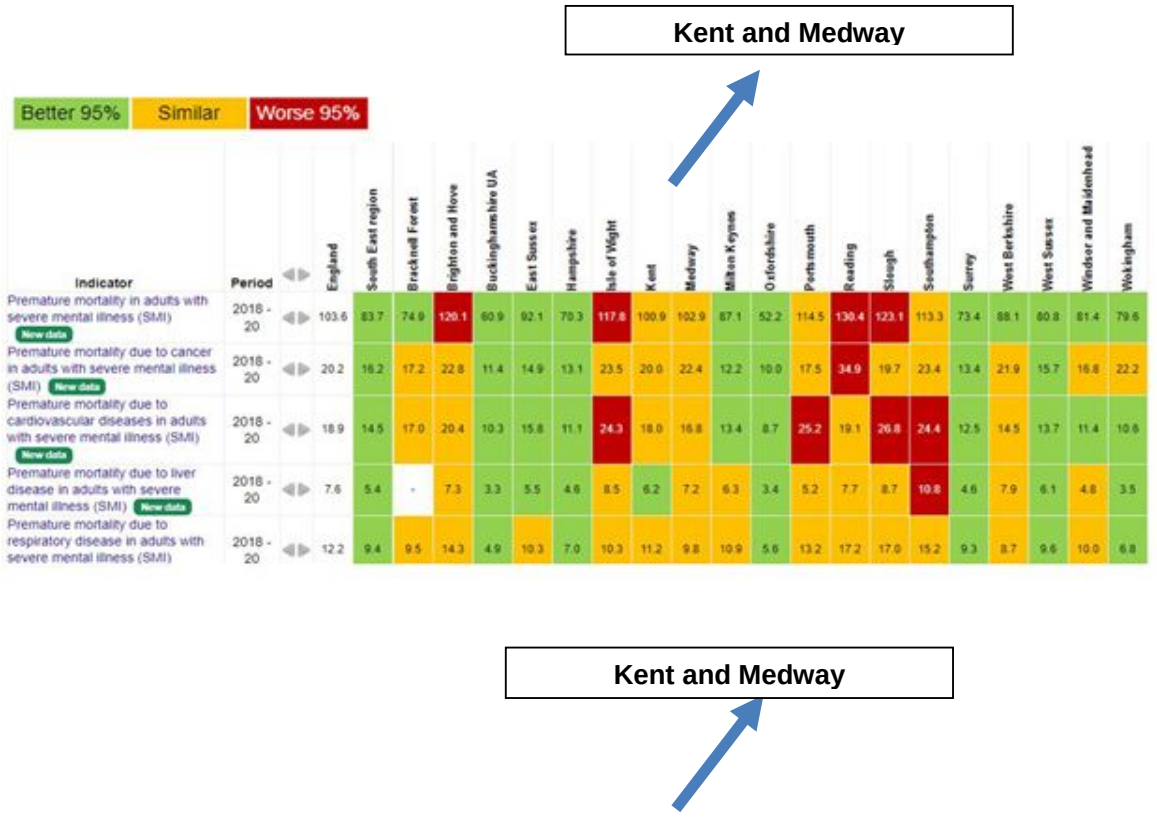
6. SERIOUS MENTAL ILLNESS (SMI) MORTALITY DATA

6.1 A review was completed to explore the deaths of KMPT patients with a Serious Mental Illness. The review included mortality incidents over a two year time period, between 2021 and 2023. 197 mortality incidents were reviewed.

6.2 The review linked in with the Office for Health Improvement and Disparities (OHID) Mental Health network data, for Kent and Medway. They stated that;

- Kent is not an outlier of SMI deaths, when compared to rates nationally. Kent has a premature mortality rate for people with SMI of 100.9 per 100,000 people, which is similar to the England rate. However, when compared to the South East Region rate, Kent is significantly higher for 4 of the 5 indicators, excluding due to liver disease which is similar
- Adults with SMI in Kent have an excess risk of dying before the age of 75 of 391.6, which means that they are nearly 5 times more likely to die prematurely than the general population
- Medway however, sit within the better 95%, and are less at risk of dying before the age of 75.
- The percentage risk of excess mortality for adults with SMI in Kent is statistically similar to England for all indicators
- When compared to the South East region, the overall percentage excess mortality for Kent is significantly lower; other indicators are similar.

Graphs 9 and 10, OHID data on SMI mortality



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Indicator	Period	England	South East region	Bracknell Forest	Brighton and Hove	Buckinghamshire UA	East Sussex	Hampshire	Isle of Wight	Kent	Medway	Milton Keynes	Oxfordshire	Portsmouth	Reading	Slough	Southampton	Surrey	West Berkshire	West Sussex	Windsor and Maidenhead	Wokingham
Excess under 75 mortality rate in adults with severe mental illness (SMI) New data	2018 - 20	389.9	425.0	439.2	433.7	416.8	424.1	485.1	458.3	391.8	329.3	342.0	330.8	360.2	331.4	320.1	334.8	523.7	518.3	407.2	422.6	549.6
Excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) New data	2018 - 20	125.8	123.3	130.2	121.9	104.2	96.5	135.7	148.0	120.4	131.5	50.2	86.6	61.9	170.4	88.5	105.9	143.1	241.6	105.5	122.2	302.8
Excess under 75 mortality rate due to cardiovascular disease in adults with severe mental illness (SMI) New data	2018 - 20	306.6	346.3	548.6	377.0	379.4	374.0	346.1	410.7	337.6	232.7	240.7	279.0	353.8	183.6	263.5	330.2	410.0	390.1	322.0	273.5	277.3
Excess under 75 mortality rate due to liver disease in adults with severe mental illness (SMI) New data	2018 - 20	550.2	542.8	-	366.0	473.4	441.8	704.3	566.9	529.0	509.1	501.6	388.5	243.7	262.4	310.7	563.2	677.7	1148.7	603.4	423.6	587.0
Excess under 75 mortality rate due to respiratory disease in adults with severe mental illness (SMI) New data	2018 - 20	559.5	625.7	861.5	642.7	526.7	603.8	673.2	726.9	475.5	323.0	513.6	491.9	443.9	626.2	489.0	492.1	998.2	551.7	804.4	843.3	858.7

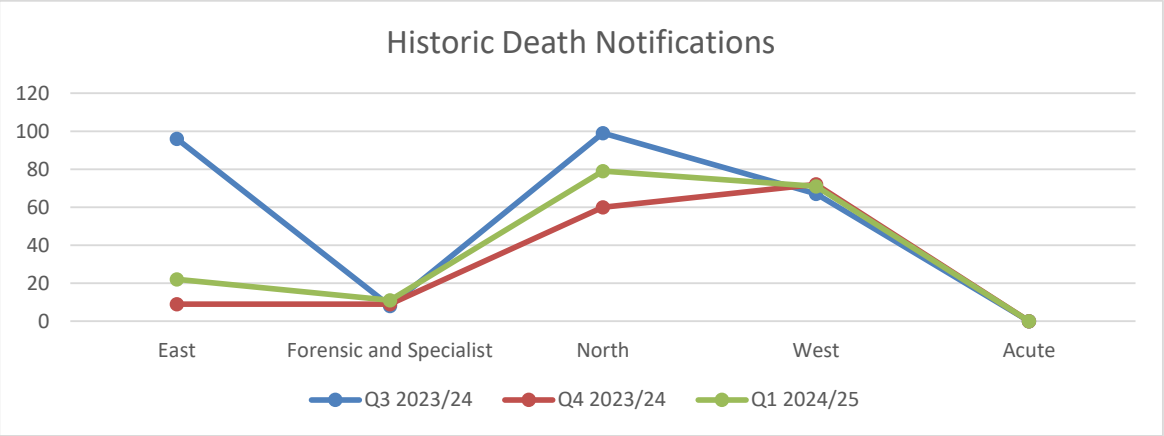
6.3 KMPT data on SMI mortality, showed the following:

- SMI mortality was more common in patients in their **fifties**, **sixties** and **eighties.** Males in their fifties were particularly higher.
- The male to female percentage for KMPT SMI mortality is almost on par (52% male, 48% female). This differs to the national OHID data (Premature mortality is significantly **higher in males** with SMI compared to females with SMI (124.4 per 100,000 compared to 83.6 per 100,000).
- The majority of patients were of **White-British ethnicity**. This fits with national data. There are small numbers of ethnic minority deaths, therefore it's not possible to determine any outliers
- Deaths of patients with a SMI between 2021 and 2023 were higher in the **Medway** and **Canterbury** area, with **Medway** equating to 15% of all SMI deaths reported. Medway has a higher population of 279,000, and high areas of deprivation[2].
- The most common cluster types in the majority of districts were, **ongoing recurrent psychosis** (low, symptoms), and, **ongoing or recurrent psychosis** (high disability)
- Although small numbers (**Maidstone** 4 and **Sevenoaks** 3), **dual diagnosis** featured more commonly in these areas.

[2] The Index of Multiple deprivation (IMD2019): Headline findings for Kent

7 KMPT HISTORIC DEATH WORK

Graph 12, Historic Death Notifications



7.1 The number of historic death notifications reported each quarter is reducing. This is expected as the directorates report to be in a much better position with regards to incident identification and reporting. A death monitoring report has been developed within Power BI, allowing this to be a more effective and accurate process. There were no STEIS reported historic death records in Q1.

7.2 It is a likely hypothesis that the reduction in mortality incidents reported in Q1, is a result of the reduction in historic death notifications.

8 THE MEDICAL EXAMINER

8.1 KMPT continue to engage with the Medical Examiner as necessary. The Medical Examiner process within KMPT is included as an appendix in the Learning from Deaths Policy.

8.2 NHS England have published guidance that, *"from 9 September 2024, all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. The changes, which form part of the Department of Health's Death Certification Reforms, were announced by the government on 15 April 2024, and come into force on 9 September 2024. As part of the changes, there will be a new medical certificate of cause of death (MCCD). From 9 September 2024, medical practitioners will be able to complete an MCCD if they attended the deceased in their lifetime. This represents a simplification of the current rules, which before 9 September require referral of the case to a coroner for review if the medical practitioner had not seen the patient within the 28 days prior to death or had not seen in person the patient after death".*

8.3 The number of mortality incidents within KMPT where a medical examiner referral is required, are minimal. There have been no mortality incidents where KMPT have been required to inform the Medical Examiner Office.

8.4 With the role out of this Medical Examiner process and full implementation in September 2024, there will be an educational piece with the doctors via CPD over the course of the coming two quarters, to ensure that the medical examiner process is embedded into Trust practice. Guidance within the Learning from Deaths policy, will also be shared with staff.

Title of Meeting	**Public Board Meeting**
Meeting Date	**25th July 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**
Sexual safety Identity, Culture and Staff Experience Leaders development Investigations team Mandatory Training WRES & WDES Violence and Aggression		

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.
International Nurses Recruitment	We successfully recruited 52 nurses. The Committee welcomed 2 nurses who shared their story about their experience and recruitment journey. It was uplifting to hear their stories and how smoothly the transition has been for them and how they feel KMPT has supported them, which is where our pastoral care is crucial. They felt without the support of the pastoral care team the programme would not be as successful as it has been.	Substantial	TO ADVISE There were 3 keys areas which we need to improve on: Accommodation Timing of the completion of the OSCE exam Mental Health training. This learning needs to be factored into any future international recruitment
People Committee Report	The Committee received assurance that the team are keeping abreast of any political changes and scoping the impact this may have on KMPT.	Reasonable	
Sexual Safety **Violence and Aggression Deep Dive Report**	The committee were updated on our sexual safety plans. The Trusts zero tolerance stance was welcomed and fully supported. The Chief Nurse updated the Committee on the work on violence and aggression on our wards. The introduction of safety culture bundles to the Acute Directorate has now concluded. It was recognised that some wards are doing this well and there is some improvement required on other wards. The safety bundles are now being rolled out in Forensics and Specialist Services.	Reasonable	ALERT Feeling safe at work is a priority and sexual safety needs to be included in the EDI, violence and aggression wrapper and our approach must be a holistic one.

	The key thing is to ensure we are learning from the data so we can identify what is working and what isn't working, so this can be addressed. The Chief Nurse is happy with the progress and informed the Committee we are aligning in the right way promoting safer care groups and feeling more confident about reporting.		
Identity, Culture and Staff Experience	**EDI Plan:** The Committee noted the progress on the Equality and Diversity Culture Transformation Programme which is now has 6 focus areas. The Committee is supportive of the ambition. The team will work on some interim milestones so that progress can be monitored along the journey and also looking to ensure that the work is embedded and sustainable	Reasonable	ADVISE This needs to be brought together into one culture, identity and staff experience plan and shared with the People Committee. We have too many work streams and strands in play.
Identity, Culture and Staff Experience	**Leaders Development Programme:** The Committee acknowledge the plans for developing a Leadership Development programme. To achieve our strategy, we need to focus on creating the right internal culture and behaviours. Leaders being equipped with the right tools, will ensure that the change process will be effectively embedded and sustained. The Committee felt assured we are in the right place and it is the right time for the step change to happen as this will inspire, motivate and guide teams through the transition, addressing resistance and fostering acceptance of the new culture. The Committee is excited about the next steps which involve identifying an external partner to work with us to co-design the programme (July/August) and to start delivery in September. The focus of the development will be across 4 key areas: • Self • Team	Reasonable	ASSURE Consider creating a new physiological contract for leaders to sign up to.

	• Organisation • External		
Investigation Team Update	Since the Central Investigation Team (CIT) was recruited time to handle complex cases has reduced for the cases that the CIT team has investigated. This has significantly improved the experience of colleagues involved in those cases. There have been a total 67 cases that have closed since Jan to May 2024, of which 11 (16%) have been handled by the Investigation Team. Majority of the cases have been complex grievances and dignity at work complaints. We have seen a significant increase in cases that have been resolved through early resolution rather than a formal process, 25 in total (37%), which support our just and learning culture.	Reasonable	ASSURE There is an opportunity for growth within the CIT team to handle more cases internally and there is also an appetite across the county for other providers to buy this service from KMPT. A full evaluation will be conducted into the service to consider a business case for growing the service Check that this is linked into FTSU themes
Mandatory Training	The Committee received a report on essential training for the role compliance. The Committee is concerned where we are not meeting our compliance targets on some elements of clinical training. The Committee has asked the Chief Nurse to provide assurance through a further paper on this matter. The Chief Nurse assured the Committee that due to a change in our rostering approach we now can ensure that we always have someone who is BLS trained on every shift.	Limited	ALERT The organisation needs to review what it considers is mandatory training then We need to agree our risk appetite attached to each item eg frequency, target compliance and comply with those targets at a higher than we are achieving today.
WDES/WRES Report	The paper was for noting and was approved for publishing on the KMPT website by the Committee. The paper highlighted the overview of the Workforce Racial Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) results for 2023/2024 for KMPT. The data was submitted as required to NHS England on the 31st May 2024 and the report will be published on KMPT Website September 2024.	Substantial	

	The new approach for Reasonable Adjustments went live April 2024 and to date, we have had 40 staff members requesting reasonable adjustments.		
AOB	FTSU scheduled paper was postponed as it is going the the Board for consideration All policies were noted and the topic for the next PC Seminar was agreed and would cover the new KMPT values		ALERT- the governance and process map surrounding FTSU would benefit from a refresh as it is not clear what is required for A&R and PC since the responsibility moved to CEOs office.
Free Text – N/A			

NHS
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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th July 2024**
Title	**Finance and Performance Committee Chair's Report**
Author	**Peter Conway, Non-Executive Director**
Presenter	**Peter Conway, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
•	• IQPR • Dementia Diagnosis Update • Psychology Waiting List Update	• Finance Report and Forecast • BAF Risk Updates – Finance Risks • Loss Making Services Update • Digital and IT • Estates Plan Update

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	The new mandated measure of "People presenting to Liaison Services: admitted to a psychiatric bed within 12 hours where required" considered unachievable. Poor performance under the access domain gives rise to the limited overall assurance rating.	Limited	Fuller explanation and options to be presented to Board given risks to patients after 6 hours and the impossibility of achieving target

Dementia Diagnosis	No Assurance as: • The new Memory Assessment Service system has only just commenced via a trailblazer. • Demand and capacity modelling not yet finished • The Integrated Care Board led community-based solution remains at early stage • KMPT performance is well adrift of 6 weeks wait target, unlikely much improvement by March 2025 before full remediation by March 2026	None	Board to receive updates at every meeting for these three areas.
Psychology Waiting Lists	Significant improvements and progress made under leadership of Sara Casado but 35% of patients will still be waiting more than 4 weeks for an initial assessment and 30% more than 18 weeks for treatment by 3.2025	Reasonable Assurance	IQPR monitoring going forward.
Estates Strategic Plan	• Sustainability funding requires KMPT to find £800k this year not currently budgeted • Community Estate ambition needs to be greater and involve non-NHS stakeholders as well as KCHFT and other neighbouring NHS Trusts. • Woodchurch, Sevenscore and TGU are all considered not fit for purpose. In-year maintenance budgets are insufficient to mitigate the repair/remedial work needed. Rebuilding would involve £130m+ of capital and full business cases to NHS/Treasury but the likelihood of success is low. In the meantime, there are operational and safety risks.	Limited Assurance	FPC to receive a paper in September quantifying these risks, options for mitigation and alternative clinical solutions that do not require re-builds

Finance Report – Month 2	• Agency spend above target and bank spend 9% up on previous month. We will breach targets if these levels continue • Psychiatric Intensive Care Unit (PICU): volumes nearly 50% above contracted level. • KMPT's cash position has reduced significantly since March y/e by £5m to £12m. This level is considered satisfactory but options for the Littlebrook lease may have implications for cash-flow.	Reasonable Assurance	FPC recommends Quality Committee review the provision of external beds and consider options given the open-ended financial implications. FPC will further consider the Trust's liquidity in September, in light of the Littlebrook lease.
Free Text -			

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th July 2024**
Title	**Mental Health Act Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Dr Afifa Qazi, Chief Medical Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance items**
•	• Report from MHLOG & MHLOG Attendance List • Summaries of learning from serious incidents with a MHA element • Mental Health Act Activity Data Quarterly Report • Chief Medical Officer's Report • Reports on CQC Actions Arising from MHA Monitoring Visits • Bi-Annual Deprivation of Liberty Safeguards (DoLs) Audit Report • Report from Associate Hospital Managers • Legislation Update • Annual Policy Report • Review of Terms of Reference	•

Kent and Medway NHS and Social Care Partnership Trust

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.
Report from MHLOG & MHLOG Attendance List	There are a number of items that require digital intervention in order to improve the recording of compliance under the Mental Health Act. Although assurances have been given these are in motion, deadline dates are yet to be set.	Reasonable	MHAC to receive update on use of digital solutions to address Section 132 compliance.
Mental Health Act Activity Data Quarterly Report	A total of 15 scrutiny visits took place within the last quarter. A number of the visits showed low compliance with the reading of the Section 132 rights on admission, which is similar to other Mental Health Trusts. Assurances were given work is ongoing with the matrons to improve compliance across the wards.	Reasonable	The Quality Committee to seek assurance on the improvements in the Acute Directorate with the matrons, includes work around eth the use of the MHA and in particular regarding Section 132 compliance upon admission and follow up to ensure compliance, ahead of the next meeting.
Reports on CQC Actions Arising from MHA Monitoring Visits	During a CQC Visit in 2021, concerns were raised regarding the estate of the Thanet Mental Health Unit, with assurances given that refurbishment would take place. The CQC have since re-visited those wards, with no further improvements taking place. A long term solution is yet to be sought, but will likely require a business case. In addition, following a recent CQC visit, the Trust is now looking to move to single gender rehabilitation units within the next three months, after feedback was provided that current mixed-sex units did not meet the necessary requirements for female only toilets and loungers, that provide privacy and dignity.	Limited	The Finance and Performance Committee to seek assurance on the estates issues raised within the recent CQC visit regarding the Thanet Mental Health Unit.
Free Text - The Committee will receive a report at its next meeting, on health inequalities with a focus on the Mental Health Act.			

The Committee were made aware of a recent number of delays in reviews for services users within the community on conditional discharge, being sent to the Ministry of Justice, which the Trust has never seen before. Assurance was given that a number of steps have been taken to avoid further delays, including a CMO letter detailing actions to be taken to all doctors. The Committee requested a further update is provided at the next meeting.

NHS
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Title of Meeting	**Board of Directors (Public)**
Meeting Date	**25th July 2024**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
•	• Quarterly Impact Report	• Finance Report • Appointing Accountants • Benefits of NCVO membership • Charity Operational Meeting Draft Minutes June 2024

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.**
Finance Report	The Charity Strategy was circulated virtually for approval and it was noted that Trustees require the Charity to be self-financing by year 2025/26.	Limited	The Charity Strategy will go to November Trustee meeting for further discussion, which will include discussions on funding.
Appointing Accountant	Due to its size, the Charity is required to appoint an accountant to finalise its Annual Report and Accountants. The Committee will receive an update at its next meeting, and	Reasonable	The Committee will receive an update on the appointment of the accountant at its next meeting.

	ahead of this the Chief Finance and Resources Officer will identify an accountant for Committee approval, that provides value for money.		
Free Text -			