AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting	Trust Board Meeting (Public)
Date	26th September 2024
Time	10.10 to 12.40
Venue	The Orchards, East Malling

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/24-25/54	1.	Welcome, Introductions & Apologies		Verbal	Chair	10.10
TB/24-25/55	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/24-25/56	3.	Personal Story – SUN (Service User Network) service in Thanet.	FN	Verbal	DHS	10.15
TB/24-25/57	4.	Continuous Improvement Story – Reducing DNA (Do Not Attend) Rates in the Community	FN	Verbal	AR	10.25
STANDING ITEMS						
TB/24-25/58	5.	Minutes of the previous meeting	FA	Paper	Chair	10.35
TB/24-25/59	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/24-25/60	7.	Chair's Report • Well-led review	FN FA	Paper	JC	10.40
TB/24-25/61	8.	Chief Executive's Report • KMPT Gap Analysis	FN	Paper	SS	10.45
TB/24-25/62	9.	Board Assurance Framework	FA	Paper	AC	10.50
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/24-25/63	10.	Strategy Delivery Plan Priorities Progress Report	FN	Paper	SS	11.00
TB/24-25/64	11.	MHLDA Provider Collaborative Board Progress Report	FN	Paper	SS	11.10
TB/24-25/65	12.	Trust Name Change	FA	Paper	KH	11.15
TB/24-25/66	13.	Violence and Aggression Update	FN	Paper	AR	11.20
OPERATIONAL ASSURANCE						
TB/24-25/67	14.	Integrated Quality and Performance Review	FD	Paper	SS	11.25
TB/24-25/68	15.	Finance Report	FD	Paper	NB	11.35
TB/24-25/69	16.	Workforce Deep Dive: Re-modelling and reshaping the workforce for the future	FD	Paper	AC	11.45
TB/24-25/70	17.	Improving how we engage patients and communities	FD	Paper	KH	11.50
TB/24-25/71	18.	Annual Freedom to Speak Up Report, with Management Response	FD	Paper	SS	11.55
TB/24-25/72	19.	Business Continuity and Emergency Planning Report	FD	Paper	AC	12.00
TB/24-25/73	20.	Medical Revalidation Report	FA	Paper	AQ	12.05
CONSENT ITEMS						
TB/24-25/74	21.	Register of interests	FN	Paper	TS	12.10
TB/24-25/75	22.	Use of Trust Seal	FN	Paper	TS	
TB/24-25/76	23.	Report from Quality Committee	FN	Paper	SW	

TB/24-25/77	24.	Report from Audit and Risk Committee • Terms of Reference	FA	Paper	SW/KL	
TB/24-25/78	25.	Report from People Committee	FN	Paper	KL	
TB/24-25/79	26.	Report from Finance and Performance Committee	FN	Verbal	Chair	
CLOSING ITEMS						
TB/24-25/80	27.	Any Other Business			Chair	12.15
TB/24-25/81	28.	Questions from Public			Chair	
	Date of Next Meeting: 28th November 2024					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Sean Bone-Knell	SBK	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Stephen Waring	SW	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Non-Executive Director
Dr Asif Bachlani	AB	Associate Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Tony Saroy	TS	Trust Secretary
Hannah Puttock	HP	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications and Engagement
Apologies:		
Catherine Walker	CW	Non-Executive Director (Deputy Chair & Senior Independent Director)

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

Peter Conway	PC	Non-Executive Director
Mickola Wilson	MW	Non-Executive Director

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.00 hrs on Thursday 25th July 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
	Peter Conway	PC	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	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:			
	Tony Saroy	TS	Trust Secretary
	Hannah Stewart	HS	Deputy Trust Secretary
	Wendy Dewhirst	WD	Service Director for North Kent (*for item TB/24-25/39*)
	Lucy Pope	LP	Acting Senior Manager (*for item TB/24-25/39*)
	Dr Elinor Bradley	EB	Consultant Psychiatrist (*for item TB/24-25/40*)
	Nicola Strudley	NS	Advanced Clinical Practitioner (*for item TB/24-25/40*)
Apologies:			
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Kindra Hyttner	KH	Director of Communications and Engagement

Item	Subject	Action
TB/24-25/37	**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/24-25/38	**Declarations of Interest** None declared.	
TB/24-25/39	**Personal Story – Fresh Start at Dartford Liaison Service** The Board welcomed WD, LP and Hannah, who is a service user. WD set out the role of the Liaison service based in Darent Valley Hospital. LP informed the Board of the 'Fresh Start' pilot run by Leeds University, which is open to those people who have presented to A&E more than once with a self-harm presentation. The work focusses on providing cognitive behavioural therapy, and acceptance and commitment therapy with the intention of preventing	

Item	Subject	Action
	repeat attendance to A&E. The results of the pilot will be released by the university at the end of the pilot. Hannah explained to the Board how the pilot had helped her, and that she had not self-harmed since December 2022.This was an achievement given that she had self-harmed since the age of 10. She has also been able to rebuild her relationship with her family members thanks to the therapy that she received. The Board expressed its gratitude for the presentation and noted Hannah's comments that access to services had been hindered by not being able to get a GP appointment.. The Board **noted** the Personal Story – Fresh Start at Dartford Liaison Service.	
TB/24-25/40	**Continuous Improvement - The Home Treatment Team Reasonably Adjusting for Service Users with Autism Spectrum Disorder (ASD)** The Board received the continuous improvement story from NS and EB. This project focussed on improving the experience of service users with autism when they are in crisis. The Trust developed a survey to obtain qualitative data. This identified some gaps in the way that service users' needs were met and the team worked together so as to make care planning more personalised. As a result of the work, the feedback received showed an improvement in the experience patients felt in the care given. The Board thanked NS and EB for attending the Board and reflected that this person-centred approach would benefit all patients, not only those with autism. The Board **noted** the continuous improvement story.	
TB/24-25/41	**Minutes of the previous meeting** The Board approved the minutes of the 30.05.24 (subject to a change in the next meeting date) and 19.06.24 (without change).	
TB/24-25/42	**Action Log & Matters Arising** The Board approved the minutes subject to the following change: • Action TB/24-25/11 – MHLDA Provider Collaborative Report – the date to be set is October 2024.	
TB/24-25/43	**Chair's Report** The Board **noted** the Chair's Report.	
TB/24-25/44	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted:	

Item	Subject	Action
	• Staff members have given great feedback about the Value in Practice awards and they are making use of the thank you cards, • The International Recruitment Welcome Event was well attended with 75 recruits there. SS found it to be a humbling experience to hear their stories. SG and her team were thanked for their work on the event, • The Executive Team recently went to Medway Foundation Trust and was inspired with the transformation work that is being undertaken at that trust. The Board reflected on the Chief Executive's Report: • The term 'leader' was discussed and the Board noted that historically that this was a staff member at Band 8A and above, but that the Trust is moving to expand that definition to local leaders, rather than to banding. The Board **formally delegated authority** to SS to approve the K&M NHS Joint Forward Plan as appropriate. The Board **noted** the Chief Executive's Report.	

TB/24-25/45	**Board Assurance Framework**
	
	The Board received the BAF and reflected on the following matters:
	• No risks have been added to the BAF since May
	• Two risks have changed their risk score since the BAF was last reported to the Board in March
	  ○ 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))
	
	The Board was updated regarding the general risk of cyberattacks, with the Trust carrying out a review of its third-party contracts; assurance has been received. The Trust has business continuity plans in place, which have also been tested.
	
	The risks around the Dover port were also discussed with the Board recognising that there was a risk of travel disruptions for staff in the performance of their duties.
	
	The Board noted the success of community psychological services, which had made good progress and commended the leadership of this change to waiting times. However, 35% of patients will still be waiting over four weeks for assessment, and 30% will be waiting over 18 weeks for treatment more generally. The Board was sighted on the realistic prospect of the Trust not meeting its target by the end of 2025.
	
	The Board also reflected on the Community Mental Health Framework, noting good progress on implementation. The description of the risk will be updated to reflect that risk has moved from achieving implementation to achieving objectives.	

Item	Subject	Action
	The Board **approved** the Board Assurance Framework.	
TB/24-25/46	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report** The Board received the MHLDA Provider Collaborative Progress Report. The Board requested that future iterations of the report include a 'plan on a page' for each of the workstreams. The Board noted that a clinical lead is being appointed in respect of the health inequalities workstream. In terms of the dementia workstream, the plan is to achieve a dementia diagnosis rate of 63% by March 2025. The Board questioned whether the Trust's expectations for the Provider Collaborative is evidenced by the report which does not provide assurance for timely progress on key objectives. AR assured the Board that the Trust was right to be ambitious in order to gain the traction needed to achieve the objectives. A discussion regarding the feasibility of achieving the memory assessment goals by March 2025 concluded that the improvements achieved thus far are unlikely to be sustained at the same rate going forwards, and the Trust is unlikely to achieve its target by year end. The Board noted that it will receive a seminar on the MHLDA Provider Collaborative in October. The Board **noted** the MHLDA Provider Collaborative Progress Report.	
TB/24-25/47	**Right Care Right Person Report** The Board was informed that the Right Care Right Person programme had been in operation for four months, was progressing fairly smoothly, and that the model was now transitioning to business as usual. The Board noted that the Quality Committee had requested that a future evaluation of the work includes a review of the costs of implementation. It was confirmed to the Board that the Right Care Right Person programme has had participation from the third sector and South East Coastal Ambulance Service. **Action: AR to produce an end of project evaluation report for the Right Care Right Person programme, which includes evaluation of the costs of implementation. The report is to be presented at the January 2025 Board meeting.** The Board **noted** the Right Care Right Person Report.	
TB/24-25/48	**Purposeful Admissions Programme**	

Item	Subject	Action
	The Board received the paper on Purposeful Admissions Programme, which evidences positive progress in a number of areas. This includes the service user network, the safe haven in Medway, inreach from the Home Treatment team, and the support for frequent users of services. The discussion focused on the two areas of current concern – Bed Management RiO module, and consistent support from social care. The bed management module has not been successful and the Trust is considering the purchase of a standalone bed management software. However, before this is done, further work on the RiO module will occur as it has been successfully been used in Berkshire Healthcare NHS Foundation Trust. The Board noted the impact of inconsistent social care support on the delayed transfers of care. The Trust is struggling to get support for appropriate discharge accommodation. The Board reflected on the Ashford safe haven which was deemed critical given that Ashford Liaison Service is the busiest Liaison service in the county. The programme has stalled due to delayed permission from East Kent University Foundation Trust (EKUFT).. Whilst there continues to be insufficient space for staff in the Liaison team, it was confirmed that the safeguarding issue in Ashford Emergency Department had been resolved. The Board reflected on the Trust's 85% bed occupancy target and whether this was realistic given the current occupancy rate of 95.8%. The Trust recognised that it was ambitious but it remained an appropriate target which sets the trajectory for the Trust. The Board **noted** the Purposeful Admissions Programme paper.	
TB/24-25/49	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR) and were informed that there were three areas of concern: 1) Dementia – performance continues to lag. The Board noted the new standalone service Memory Assessment Service (MAS) in the south east coast area led by John Lavelle. Lessons have been learned and will inform the future rollout of such services. However, the MAS pathway requires a system-wide solution in order for it to be sustainable. 2) Patient flow – the Board received a paper on Purposeful Admissions Programme 3) Liaison Service – the Trust is struggling to capture the appropriate data for 12 hour waits and DHS is leading the work to resolve this issue. The Board reflected on the IQPR as follows: • Although the IQPR shows the current state of affairs of services, there is a need to identify what are the Trust's actions to resolve the issues. • The inclusion of Equality, Diversity and Inclusion (EDI) data is important, but it was not clear what the EDI dataset this month meant.	

Item	Subject	Action
	• For the 'Care spell start to Assessment within 6 weeks (MAS only)' dataset, the variation across the directorates was due to the way different teams upload information onto RiO. A consistent approach to data entry across the directorates will lead to reduced variance. • The Trust should ensure that compliments are fed back to staff members given the good PREM scores that the Trust is achieving. **Action: By November 2024, AC to produce a thematic review of compliments for the Quality Committee.** **Action: By January 2025, AC to include commentary regarding compliments, along with appropriate level of compliments data, within the IQPR.** • The Board noted the BAME data that was focussed on staff employed under agenda for change. The Board was pleased to see that the BAME dataset had separated out medic data as that tends to skew some of the data. • Although Liaison Service data is difficult to reliably capture, the data shows a worsening 12-hour wait performance and concern was raised that the Trust's risk rating does not accurately reflect the situation. The plan will be presented to the Finance and Performance Committee in the first instance, with referral to the Board if necessary. **Action: DHS to produce a report for FPC in September 2024 setting out the Trust's plans to address the Liaison Service performance.** The Board **noted** the IQPR.	
TB/24-25/50	**Finance Report – Month 3** The Board received the Finance Report and noted the following: • The Trust's agency position has seen a reduction in spend, with the position to Month 3 a year-to-date 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 psychiatric intensive care unit (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 The Board was informed that there is a need to deliver a £720k surplus by year end. The Trust's cash position has improved since 01.07.24. The Trust is in the process of a benefits realisation exercise connected to the provider collaborative and forensics contract. **Action: NB to produce a Loss-Making Services Paper for the September confidential Board meeting.**	

Item	Subject	Action
	With respect to the continued usage of external beds, the Board delegated the matter to the Quality Committee for review. **Action: NB to produce a paper addressing the continued use of external beds for the September Quality Committee.** The Board **noted** the Finance Report – Month 3.	
TB/24-25/51	**Pay Band Profile Report** The Board received the Pay Band Profile Report. The Trust's workforce growth is based on establishment rather than budget. The growth is partly driven by the filling of vacancies within budget. 71% of growth was related to the Mental Health Investment Standard, 21% of growth was in corporate services and 8% was clinical. The growth has also driven by the creation of the central investigation team as well as the expansion of the Trust's Infection Prevention and Control team. The Board reflected on the benchmarking of the 893 support staff, with the Board noting that 50% of support staff are within the medical directorate and estates directorate. The Board was reminded that there is an expectation for business cases to be reviewed by the People Committee and Quality Committee before it is too far in the process. It was confirmed to the Board that outline business cases will be presented to relevant committees for early discussion. The Board **noted** the Pay Band Profile Report.	
TB/24-25/52	**Community Mental Health Framework – Progress report** The Board received the Community Mental Health Framework progress report and noted that there had been good progress of the setting up of teams. The largest proportion of staff was driven by the Mental Health Together. The Board was informed that by October there will be a better set of metrics, including paired metrics related to dialog+. The Trust intends to retire the use of the care programme approach, but recognises that it is a large piece of work that must be managed carefully. This would need to be done outside the Mental Health Together programme. Space utilisation across the Trust's community mental health teams is mixed, with good progress in the east of the county. The Trust is conducting some internal work regarding the maximising of the estate. The Finance and Performance Committee will receive a paper on the estate strategic workplan in September. The Board **noted** the Community Mental Health Framework – Progress Report.	
TB/24-25/53	**Annual Freedom to Speak Up Report, with Management Response**	

Item	Subject	Action
	This item was deferred to the Board's September meeting due to the Guardian's sick leave. **Action: TS to amend September Board agenda to include Annual Freedom to Speak Up Report, with Management Response.**	
TB/24-25/54	**Review of Committee Terms of Reference** The Board **approved** the Committees' Terms of Reference.	
TB/24-25/55	**Report from Quality Committee (incl. Mortality Report)** The Board received and **noted** the Quality Committee Chair's report.	
TB/24-25/56	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/24-25/57	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/24-25/58	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/24-25/59	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/24-25/60	**Any Other Business** SW highlighted the sudden death of a staff member. Tribute was paid to Dianne Hyatt, EDI practitioner. SS confirmed that she had written to the family and that SG was supporting the family.	
TB/24-25/61	**Questions from Public** None.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 26th September 2024 at the Orchards, East Malling.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/09/2024

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2024								
25.01.2024	TB/23-24/124	Finance Report – Month 9	AC to bring an update on zonal observations to the Quality Committee in May.	AC	May 2024	September 2024	This was discussed at the Quality Committee on the 17th September 2024	**IN PROGRESS**
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		This is on the agenda for discussion.	**IN PROGRESS**
25.07.2024	TB/24-25/49	IQPR	DHS to produce a report for FPC in September 2024 setting out the Trust's plans to address the Liaison Service performance.	DHS	September 2024		This is on the agenda for Finance and Performance Committee taking place on 24th September 2024.	**IN PROGRESS**
25.07.2024	TB/24-25/50	Finance Report – Month 3	NB to produce a Loss-Making Services Paper for the September confidential Board meeting.	NB	September 2024		This is on the Private Board agenda for discussion.	**IN PROGRESS**
25.07.2024	TB/24-25/50	Finance Report – Month 3	NB to produce a paper addressing the continued use of external beds for the September Quality Committee.	NB	September 2024	November 2024	This has been deferred to the November 2024 Committee meeting at the request of the Executive Management Team	**IN PROGRESS**
25.07.2024	TB/24-25/53	Annual Freedom to Speak Up Report	TS to amend September Board agenda to include Annual Freedom to Speak Up Report, with Management Response.	TS	September 2024		This is on the agenda for discussion.	**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	October 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			

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/09/2024

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
25.07.2024	TB/24-25/49	IQPR	By November 2024, AC to produce a thematic review of compliments for the Quality Committee.	AC	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			
25.07.2024	TB/24-25/47	Right Care Right Person Report	AR to produce an end of project evaluation report for the Right Care Right Person programme, which includes evaluation of the costs of implementation. The report is to be presented at the January 2025 Board meeting.	AR	January 2025			
25.07.2024	TB/24-25/49	IQPR	By January 2025, AC to include commentary regarding compliments, along with appropriate level of compliments data, within the IQPR.	AC	January 2025			
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
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			**Closed**
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			**Closed**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th September 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. This is a brief report due to my annual leave, and a full Chair's report will be provided at the next meeting.

2. Kent & Medway system and national activity

The Provider Collaborative Board met, and I also attended the Integrated Care Partnership Board, of which I am a member, as well as the system workshop on learning disability and autism.

3. Non-Executive Director Changes

The Board notes that this is Dr Asif Bachlani's final Board meeting with the Trust as an Associate Non-Executive Director. The Board is grateful for his work during the last two years and his knowledge relating to digital matters.

With the upcoming departure of Catherine Walker as a Non-Executive Director, the Trust has gone through a recruitment process with the help of NHS England and the Kent and Medway Integrated Care Board.

I am pleased to say that the recruitment process was successful and a formal announcement will take place in due course.

4. External Well Led Review

In 2023/24, the Trust underwent an external well led review, as recommended by the CQC and NHS England. It was pleasing to note that there were many strengths identified during the review, but as always, there are things that can be improved.

The Trust received 24 recommendations as a result of the review and the Executive Management Team has created an action plan which is attached to this Chair's report. It provides the Board with an up-to-date position regarding the actions, which are monitored by the Chief Executive with the support of the Trust Secretary.

The Board will need to approve the external well-led review action log.

5. Trust Chair and NED visits

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

Where	Who
August 2024	
Forensic Directorate QPS meeting	Dr Asif Bachlani

Where	Who
West Kent Transformation and Performance meetings	Mickola Wilson & Peter Conway
Annual volunteer lunch	Trust Chair
Maidstone Home Treatment Team	Trust Chair
September 2024	
Forensic Directorate QPS meeting – Operational	Dr Asif Bachlani

Dr Asif Bachlani, Forensic Directorate QPS meeting
I attended the meeting on 1st August 2024 which was chaired by Emma Bowler (Forensic Director of Nursing). I got to hear about the QI project running across the trust and the focus on reducing violence and aggression and safety culture bundles. I got to hear about the future communities of practice meeting where good practice and clinical innovations will be discussed and shared across the directorate. There was discussion about the opportunity for forensic directorate clinicians to attend the open dialogue training. We discussed how the use of digital ECGs that can be used to improve health checks of patients in forensic units.

Mickola Wilson and Peter Conway, West Kent Transformation and Performance Meeting
Peter Conway and Mickola Wilson attended a meeting of the West Kent Directorate (WKD), hosted by John Lavelle and attended by his senior team. The meeting reviewed the WKD Integrated Quality and performance Report (IQPR) for the West Kent Area. The report follows the same format as the FPC IQPR report and considers the Financials for the WKD, the response to staff/patient surveys, delivery of performance and waiting times.

The area is performing well in most areas but in common with the whole of KMPT, there is a shortage of permanent staff in the nursing and community teams and as a result the agency spend is above target. Data in the meeting pack demonstrates the increased referral demand at the front door of Mental Health Together (MHT) and subsequent demand for interventions, which the team are sighted on and working on mitigation

The response rate and satisfaction scores were down on previous surveys and this was being looked at by members of the team. The financial figures were broadly on track, except that there has been no progress on the CIP requirements and a separate meeting was set up to review ideas from the team to make savings in future.

Dr Asif Bachlani, Forensic Directorate QPS Operational meeting
I attended the meeting on 1st August 2024 which was chaired by Julie Anne Meadows (service director). I heard about the NHS People Promise Manager Programme which will be used in KMPT to support KMPT long term workforce plan.

This programme has an emphasis on staff experience and when piloted at other organisations has helped to develop a positive and inclusive culture, improve patient care and improve staff wellbeing, engagement and retention. Specific actions included the use of cultural inclusion ambassadors and how Forensic directorate will be supporting the launch of the KMPT Staff Council.

I was delighted to hear that for interviews for staff there is routinely a patient or carer representative on the panel. It was good to hear the discussion about how best to support neurodiverse patients within the forensic division and effects the division was making regarding the adaptions. At the end of the meeting, I heard the positive feedback from staff about other staff members via the appreciation station which is a great initiative where staff can show their appreciation of their colleagues in a quick and easy manner.

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 17/09/2024

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
Recommendation 1: Future board development activities should cover best practice in relation to challenge, style, scrutiny, and tone to support committees and the Board to operate in a unitary manner. This exercise would benefit from a 360-degree peer appraisal to customise feedback for individuals and to support content for a group workshop.						
1.	Board development planner to be adjusted to include matters of challenge, style, scrutiny, and tone	JC	May 2024		Ongoing. We will have the December development day devoted to exploring the meaning of the new trust values to us as a board. JC also contributes to all Executive appraisals as well as NEDs and covers this area.	**In Progress**
Recommendation 2: The CEO should ensure that executive team development plans specifically consider best practice in relation to cross portfolio executive working in board and committees and peer-to-peer challenge and scrutiny in preparation for board level forums. This would also be supported by the 360-peer appraisal. The CEO should also ensure that the weekly EMT meeting has sufficient time for EDs to scrutinise the content and robustness of assumptions being presented to the Board and committees.						
2.	Appraisals / objectives 24/25 include cross portfolio working alongside supervision discussions to ensure broader understanding of exec portfolios.	SS	September 2024			**Complete**
3.	EMT extended to ensure peer to peer challenge and scrutiny in prep for board level forums.	SS	September 2024		EMT has been extended since November 23, this includes prep for Board meetings.	**Complete**
4.	Executive Development to be scoped and CEO to procure support to develop the Executive team in the next year.	SS	August 2024		First Executive team development day with new company takes place in September.	**Complete**
Recommendation 3: The Board should consider the responses to our board survey with a view to taking additional measures aimed at improving board succession planning, including using this process to further build the diversity of board membership.						
5.	Review succession plans put in place earlier in year to ensure that: 1) Longer term (3-5 year) pipeline identified 2) Personal development plans are in place (including external mentors) for all staff in talent pool.	SG	October 2024		Succession plans in place for EMT, and we are currently working on updating these to reflect a longer term (3-5 year) pipeline is identified, including looking for successors into Executive Director posts who may not be current direct reports to Executive Directors. This work also includes establishing and strengthening PDPs for all staff identified through this work. We are also developing a talent programme specific for BME staff	**In progress**

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 17/09/2024

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
					which will identify a pool of BME talent and create direct access for staff in that pool to roles at Band 7 and above where they meet the essential requirements of the role.	
Recommendation 4: The Board should review the benefits of developing more granular enabling strategies to support delivery of the corporate plan, including greater emphasis on a clinical strategy, workforce strategy, estates strategy and digital strategy. This review should also consider the need for more specific executive responsibility for coordinating an integrated approach to the enabling strategies.						
6.	Support the clinical multi-disciplinary leadership (Medicine, psychology, nursing, Allied Health & Pharmacy) to develop a clinical work plan in line with the clinical elements of the strategy.	JC/SS	March 2025		There is only one strategy, but various departments will need to have a strategic work plan and this is what they will be called.	**In progress**
Recommendation 5: The Board should review the Terms of Reference and forward plans for the Board and committees to ensure that the agendas align with the Trust strategic objectives and that forums get the right balance between operational matters and strategic oversight.rich						
7.	Review of Terms of References for Committees to be completed, with recommendations to be presented to Committees in July 2024	TS	July 2024			**Complete**
8.	Amended Committees' Terms of References to be submitted to the Board by July 2024	TS	July 2024			**Complete**
Recommendation 6: The Board should consider whether the board has sufficient oversight of the People and Culture agenda or if forward plans need to be adjusted to provide enhanced coverage, especially in relation to getting some of the 'basics' right.						
9.	Prioritise this work within the organisation, and at board level – including adding to agendas for public board and board development and seminars.	KH/SG	May 2024		Culture, identity and staff experience is one of our 6 organisational priorities, and is being reported to board through strategy reporting. Agreed various touchpoints for next financial year to bring this work to board.	**Complete**

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 17/09/2024

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
10.	Share plans for this work with board for discussion and approval and agree timelines for updates.	KH/SG	April 2025		High level plans agreed with Board 30.5.2024. New proposed Trust identity discussed at June Board seminar. Board paper for September. Agree any further touch point dates.	In progress
Recommendation 7: The Trust should look at the possibility of consolidating available leadership development courses into a more structured leadership development framework that will serve the needs of divisional leaders and support the succession planning of service level leaders. In addition, going forward, the middle management leadership development programme should have a clear focus on compassionate leadership behaviours.						
11.	Implement the newly designed leadership and management competency framework and development programmes.	SG	September 2024		This is in hand just finalising the new values and the behaviours and contra behaviours and then will launch the programme	In Progress
12.	Scope options for commissioning discrete senior leadership programme for top 100 leaders – launch programme in organisation	SG	September 2024		Working through a tender process and the ICB double lock process. Plan for 1st session to be delivered at the end October 2024	In Progress
Recommendation 8: The Trust should assign responsibility for board and committee administration to a corporate secretariat with a view to improving consistency, alignment and sharing of good practice across board and committee meetings, including the consistent use of the BAF and TRR to guide agendas (see KLOE 5). This should be done alongside reviewing scope for streamlining papers, agendas and for introducing an 'Advise, Assure, Alert' model for escalation reports						
13.	Transfer of responsibility for full committee administration from Executive Assistants to Trust Secretariat to occur by July 2024	TS	July 2024		Complete and transition back to Trust Secretariat has taken place.	Complete
14.	Committee Terms of References and Committee workplans to be adjusted to ensure that all committees have a consistent approach to their agendas, with prominent positioning of BAF and TRR matters	TS	July 2024		Plan to take governance review to EMT on 08.05.24; ARC on 11.06.24; Board on 25.07.24	Complete
15.	Committee Chair reports to be reviewed, adjusted to adopt the 'advise, assure, alert' model	KL	May 2024		Trust Secretariat circulated email to Committee Chairs on 25.04.24, new reports in use at Board meetings.	Complete
Recommendation 9: The Trust should consider the commentary in this report to further enhance the effectiveness of directorate leadership teams. This includes clarifying individual accountabilities; carving-out enough time for Clinical Directors to perform their leadership role; and ensuring the right balance of resourcing for central support within directorates and at the corporate level. In addition, consideration should be given to a SLT, a more structured approach to engaging directorate leaders in board committees, building awareness regarding directorate objectives and empowering leaders at the service level to address leadership styles						
16.	Accountabilities for directorate leadership to be clarified with clear outcomes	SS	July 2024		Confirmation of accountabilities meeting took place in June. The Service Directors have the ultimate accountability for the Directorates.	Complete
17.	Time allocation for clinical directors for the purposes of leadership to be established	AQ	Aug 2024		Clinical Director time for role under consideration with recommendations due by the end of July	In Progress

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 17/09/2024

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
18.	New forum for senior leadership team to be created, with focus on strategy and cohesive leadership	SS	September 2024		A new Trust Leadership Team (TLT) meeting with be set up for EMT, deputies and Directorate and Corporate leadership to attend. The meeting will take place fortnightly, this starts from the 1st week of October. TOR drafted and ready for review and sign off at the first meeting.	**Complete**
Recommendation 10: The Board should ensure that the TRR and BAF are used as dynamic documents and that the risk management framework is comprehensively updated to reflect the move to InPhase and the creation of the directorates. This refresh should also incorporate the Trust position in relation to risk appetite.						
19.	The risk management framework to be reviewed, with Risk Strategy, Policy and Standard Operating Procedure to be presented to ARC in August/September.	AC	October 24		Interim review of the Policy and SOP to reflect the changes to InPhase and the Directorates, when the systems and structures changed over in March last year, completed in June 2023. This is being reviewed again in light of further experience of the InPhase system and to automate away from manual extraction of data from InPhase to ensure reports are timely and easy to access and cover risk descriptions and related actions. Due to complete end of September 24.	**In Progress**
20.	Re-evaluation of the Trust's risk appetite to be completed	AC	October 24		To discuss with Audit and Risk Committee in June and to explore options of external support in helping to set the risk appetite. Board seminar to be scheduled.	**In Progress**
21.	Create a process by which regular and timely updates to the Board Assurance Framework and Trust Risk Register may be achieved. Evaluation of the process to occur on a rolling bi-annual basis.	AC	October 24		To align the BAF and TRR (through the BAF Oversight meeting with Executives and going forward the TLT) so that movement is captured as near to real time as possible and that the quality of actions and controls is reviewed to ensure adequacy and credibility.	**Complete**
Recommendation 11: The Board should consider increasing its focus on digital with a view to accelerating progress with this critical agenda item. This would be aided by enhanced coverage from committees, a refreshed digital strategic work plan and dedicated executive digital leadership. The Trust should also use the opportunity as a mechanism for further promoting clinical engagement at the Trust.						
22.	Regular oversight of the Trust's digital plan to be carried out by the Finance and Performance Committee with escalation to Board where required.	NB	October 2024		No specific board oversight required, over and above current approaches. Responsibility delegated to QC and to FPC as appropriate, with escalation to	**In Progress**

WELL-LED REVIEW ACTION LOG
UPDATED AS AT: 17/09/2024

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	COMPLETE

No	Workstream	Lead	Due Date	Revised Date	Comments	Status
					board if there are significant delays/issues.	
Recommendation 12: The Board should review opportunities for further enhancing NED visibility, such as participation in webinars, improved use of directorate alignment or attendance at other staff forums. In addition, it should consider a 'You said, we did' framework to address perceptions that actions are not taken because of staff feedback and develop an engagement strategy to enhance engagement with its two Local Authorities and primary care colleagues.						
23.	Enhancement of NED visibility	KH	Nov 24		NEDs are aligned to directorates, with NEDs able to attend Staff Forums	**In Progress**
24.	'You said, we did' framework shall be rolled out, framed as CEO Blogs	KH	Nov 24		These are regularly published to staff	**Complete**
25.	Engagement with Local Authorities and Primary Care Colleagues	AR and AQ	May 2025		This work will be more particularised and rolled out in April 2025 as part of the Trust's new identity work	**In Progress**
Recommendation 13: The Trust should consider the benefits of more closely aligning and consolidating the QI portfolio with the transformation portfolio.						
26.	Transformation and QI portfolio now combined.	SS	May 24		The QI and Transformation teams merged to form the Improvement Team in April. It has resulted in a harmonisation of methodologies and further development and upskilling of the new form team is underway to assist in driving the organisational strategy and further improvements across the organisation. Closer work is now being achieved with the Research and Clinical Audit teams with a single point of access that will allow for closer tracking of interdependencies and benefits realisation.	**Complete**

Chief Executive's Board Report

Date of Meeting: 26th September 2024

Introduction

As I approach the end of my 11th month in post I can't help but reflect how quickly the time has gone. I continue to be out and visiting staff and our services which I always find heart-warming and their feedback is invaluable for me to ensure the strategic vision of the trust is taking us in the right direction. In August, I was invited to the Houses of Parliament to attend an event hosted by the Purpose Coalition. It was a great opportunity to network with leaders from across health and broader industries to discuss how we can work together to improve social mobility and health inequalities. We made some valuable contacts to build on the work we have started to be an anchor institution, including with Southeastern. We have already started working together on a number of initiatives and look forward to sharing more with the board in the coming months.

National and Regional Update

Riots – KMPT Response

I am sad to say the summer was a challenging time for the country, with the horrific acts of racism, violence and intimidation on our streets. The NHS was not immune to this and appallingly a number of our staff were targeted. I was very clear in my messages to staff that I will not tolerate racism and aggression and it has no place in our society, our NHS, or KMPT. We chose to close one of our buildings due to a potential threat to ensure the safety of our staff and patients. The riots have also triggered a lot of feelings, memories and experiences for many staff. As well as putting in support and safe travel for staff, we also held two equality, diversity and inclusion (EDI) listening events. The aim being to create safe spaces for everyone to come together and talk about what was happening. More than 200 staff attended the first two sessions in August to share their stories and experiences. Many said it felt supportive to share openly, and to listen and learn about each other's experiences. I was really saddened to hear from colleagues who have come from London trusts that racism is more prevalent in Kent, and this is something we will be mindful of and tackle through our EDI work. To truly become an anti-racist and inclusive organisation we need to do things differently. At times that will mean having uncomfortable conversations about the reality of each other's lives and perspectives, and encouraging equity over equality. It won't always be easy, but we won't grow as an organisation unless we live by our new values of being inclusive, and having the curiosity and confidence to learn and share the good and the bad more frequently with each other.

Nottingham Report

The Care Quality Commission (CQC) published its review last month into the treatment of Valdo Calocane (VC), after the tragic deaths of three people, and injury of three others, in Nottingham last June.

The review found "the risk he presented to the public was not managed well" and a "series of errors and misjudgements" led to him being discharged from services, despite repeatedly not taking medication, being guarded, showing signs of aggression and having little understanding or acceptance of his condition. Inconsistent risk management and poor care planning and engagement with his family were highlighted, as was the decision to discharge him to his GP. The government has rightly, called for the CQC's recommendations to be implemented by mental health services across the country.

I have reflected with staff following the report and our Chief Nurse has undertaken a gap analysis against the CQC recommendations which is appended to this report. The services we provide can often be high risk, there are important lessons for every mental health trust to learn and we will do this at pace.

National CEO Meeting

There was a national CEO meeting at the beginning of this month which our Chief Medical Officer attended on my behalf. The expectations from NHS England were set out very clearly that we must deliver on what we have committed to whether that is operational performance or financial plans. As we approach winter, there will be a big role for KMPT to play in supporting our local Acute Emergency Departments ensuring that mental health patients are seen and transferred into our care as swiftly as possible. This is why our patient flow priority is so important as we move into the autumn.

Lord Darzi's review of NHS performance

The newly elected government requested an urgent, independent review into the performance of the NHS in England. Lord Darzi undertook the review which was published earlier this month. It is an honest reflection of the challenges the NHS currently faces. There are 22 summary findings, with 7 themes that should be included in the new ten-year health plan and will lead to action for all trusts including ours. While the report is gloomy and concludes by stating the NHS is in a critical condition, it also acknowledges the *"extraordinary depth of clinical talent, and our clinicians who are widely admired for their skill and the strength of their clinical reasoning. Our staff in roles at every level are bound by a deep and abiding belief in NHS values and there is a shared passion and determination to make the NHS better for our patients."* I could not agree more with this. I am proud on a daily basis to lead KMPT and I am confident our staff are completely dedicated to providing the best services we can for our patients.

Integrated Care System and Provider Collaborative Update

Provider Collaborative (PC) Board Update

Following a national recruitment process the collaborative team is now fully recruited.

Acute partners are working together to agree service models for Ear Nose and Throat (ENT) and Endoscopy across Kent and Medway. There is also a focus on variation across the acute providers are to identify areas where improvements can be made in patient care and sustainability, a plan is due to be discussed at the October PC Board meeting.

The community, primary and social care collaborative is undertaking an effectiveness review which will include exploring scope for joint commissioning with local authorities and clarifying links with Health Care Partnerships and Federations. The short-term services and better use of beds work is being rolled out across Kent and Medway. This work aims to improve discharge and community support and will be measured by acute bed days saved. In October the provider collaborative board will review the outline plans for Integrated Neighbourhood Teams. A scoping exercise has taken place in relation to community EPR convergence and the board has asked for an overall vision for digital to be presented at the November board meeting.

From September, there will be a joint Head of Procurement post across Kent and Medway, this role will be working with colleagues to progress a shared savings plan. The provider collaborative team is also supporting Kent Community Health Foundation Trust colleagues in scoping a Health and Care Academy.

There is a paper on our Board agenda today setting out the work being undertaken as part of the MHLDA PC.

Operational Update

KMPT Update

New Staff Intranet

I'm thrilled to share that on the 10 September our new intranet, Staffroom, launched trust-wide. At our people's request, it's an 'app first, desktop second' tool, so whether they are on the go using their mobile phones or sitting at a desk using a personal or shared computer, they can securely connect with the trust and their team wherever they are. This is a unique solution for the NHS and something we are really proud of as we've created a solution led by and shaped by our people.

We have spent a lot of time listening to staff about how we can make our trust a great place to work and specifically make it easier for people to do their jobs and connect with each other. Staffroom will be a key enabler of this, but also a key enabler for our culture, identity and staff experience priority. It will support us to work differently and truly live by our new cultural values. From creating caring, inclusive communities to share learning and celebrate; to making our communications more inclusive and open and less isolating; to creating opportunities to be curious, ask questions and be open and honest about how we're all feeling.

The capabilities at launch and beyond will be too long for me to share here, but this is a massive step forward for us. We couldn't have achieved this without the dedicated expertise of our communications and engagement team who I would like to thank formally here too and say a huge well done.

Value in Practice Awards

We are now four months into our Value Practice Awards and these have been a great success and really appreciated by the staff. It is really important to me as Chief Executive, that we recognise and value our staff for their amazing efforts caring for our patients on a daily basis. In the appendix attached, are the winners from June, July and August. A massive well done to all!

Identity / New Name

I'm really excited that this month's papers for our Trust Board, include our formal request for board approval to change our Trust name. One of my priorities since I became CEO has been focussed on our identity, staff experience, patient feedback and engagement with external stakeholders. As the board and others will know, we have completed over 620 hours of listening and gathered extensive feedback to help us reset our identity and how we want to interact internally and externally with stakeholders and how we want to be seen.

What has become very apparent from this work, and the overwhelming feedback we heard, is that many stakeholders think our trust name is confusing and they do not know what we do. We never set out with the intention to change our name but the feedback has been something we cannot ignore as we position our organisation in the heart of our communities as we move forward. We are therefore proposing we rename the trust to Kent and Medway Mental Health NHS Trust. We have already had support from patients, partners and our people on the proposed new name and I'm confident it will be a positive next step in our journey.

Deloitte Well-Led Review

Deloitte carried out our well-led review earlier this year. The executive team have drafted an action plan which I have agreed with the Trust Chair. This action plan is appended to the Trusts Chairs report for sign off by the Board today. A number of the actions have already been completed.

National Awards

I'm delighted to let you know that we have been shortlisted for numerous awards as follows:

Dr Afifa Qazi - HSJ, Clinical Leader of the Year for her critical work she has been doing not just at KMPT but across the wider mental health sector.

Jag Bahia and colleagues in the Pharmacy Team – HSJ Medicines, Pharmacy and Prescribing Initiative of the Year for their work on the innovative Consultant Connect Project.

Shannon Paine and colleagues at the Tarentfort Centre - HSJ Patient Safety, Mental Health Safety Improvement Award for their brilliant, collaborative and innovative work in driving down sexual safety incidents within our Tarentfort Unit.

Nicole Jones - Mental Health Social Worker of the Year in the Social Worker of the Year Awards for her work with the Mental Health Homelessness Team and working alongside out partner organisations to challenge the systems they have in place and also our own processes.

Congratulations to each and every one of you for your nomination and Good luck!

Summary and Conclusion

As I said at the beginning of my report, the last 11 months have passed very quickly. We are making good progress on our Trust strategy, but there is still more to do. I am confident we are focussed on the right things that will ultimately improve patient care and experience and make a better day everyday for our staff. We are starting to see some improvements in access to dementia care and we have clearer patient pathways following the implementation of phase 1 of the community mental health framework (CMHF). We are seeing a substantial reduction in the number of violence and aggression incidents on our wards which is a brilliant achievement for all involved, as this will start to improve our staffs working days.

Our focus as we go into the autumn now has to be on patient flow and improving our ability to admit patients in a timely manner, balancing this with our level of readmission rates and patients who are clinically ready for discharge. An important continued focus for us will be the work we are undertaking on EDI across the organisation, we will continue to move forward with the six areas of focus from our independent report earlier this year and continue the listening forums we have held over the summer months. This work absolutely is underpinned by my comments earlier in this report that I will not tolerate racism and aggression and there is no place for this in KMPT.

Sheila Stenson
Chief Executive

APPENDIX

Executive Team Visits

Sheila Stenson:

Coleman House
Ash Eton
Folkestone Health Centre
CJLD Service
CIC Group
Thanet CHMSOP
Maidstone Liaison
Thanet Safe Haven
Canterbury Wards
Facilities staff, Canterbury
Willow Suite

Donna Hayward-Sussex
The Grove
Rivendale
Ethelbert Road
Rosebud
Highlands House
111 Tonbridge

Nick Brown:
The Beacon
Woodchurch and Sevenscore
Rosewood Mother & Baby Unit

Andy Cruickshank
Willow Suite
Canterbury Wards
TGU
The Beacon
Mother &Baby Unit

Kindra Hyttner
Britton House

Sandra Goatley

Willow Gardens
Rosewood Mother and Baby Unit

Dr Afifa Qazi:

Willow Suite
Cherrywood
Amberwood
Pinewood

Value in Practice Awards – June, July& August 2024

Directorate		June	July	August
North	Individual	Julie Williams	Sorcha Porter Support, Time, Recovery Worker	Kelly Tanner, SLT Administrator
	Team	Medway & Swale CMHSOP	Dartford Liaison Psychiatry	Medway & Swale CRHT
East	Individual	Poppy Hammond admin Ashford + Canterbury MHT	Christine Thompson Clinical Lead	Annie Jeffrey, Ambassador for Peer Supported Open Dialogue
	Team	East Kent Team of the month – Thanet LPS	Open Dialogue Team	Canterbury Community
West	Individual	Lisa Eagles Senior Mental Health Practitioner	Safraz Joomun, Patient Flow Matron	Pat Morgan, Deputy Lead AHP, West
	Team	Maidstone CMHSOP	Review & Resettlement Team	111 Tonbridge Road
Forensic	Individual	Aimee Daly – Senior Speech & Language Therapist	Daniel Brennan, Forensic Nurse	Darren Jacobs, Administrator
	Team	Mental Health of Learning Disability Services (MHLD)	Dr Randhir Singh, Specialty Doctor	Liaison, Diversion and Reconnect Admin Team.
Support services	Individual	Lee Mitchell Head of Estates	Danielle Anderson, Recruitment Manager	Asim Janjua, Head of Digital Communications and Brand
	Team	Porters at Priority House	Rio Team	ICT – Networking Technologies Team
Acute	Individual	Vicky Fernandez, Interim Ward Manager, Fern	Sharon James, Senior administrator Acute SMT	Cathy Dannahy, Ward Manager
	Team	Heather Ward	Sevenscore Ward	Physiotherapy Team

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Trust Board
Title of Paper:	CQC Review of Nottinghamshire Healthcare NHS Foundation Trust – KMPT gap analysis
Author:	Rachel Town, Compliance and Assurance Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Discussion/Noting
Submission to Board:	Regulatory Requirement/Board requested

Overview of Paper

This paper provides an overview of KMPT's response to the publication of CQC's review into the services provided by Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008. This was requested by the Secretary of State for Health and Social Care following the conviction of Valdo Calocane in January 2024 for the killings of 3 members of the public in June 2022.

Issues to bring to the Board's attention

Items of excellence:

- Of the 17 CQC recommendations, for 6 of these there are good systems, process and practice to provide assurance that we meet the requirements.
- Where gaps have been identified, these are already areas of focus as part of the strategic priorities or via learning that has been identified via serious incidents or complaints.

Significant improvements in matters that were previously an area of concern:

- Not applicable as this is the first time these recommendations have been reviewed.

Items of concern and hot spots:

- 11 gaps/areas for further development have been identified and these focus on:
  - reviewing policies following transformation of services,
  - strengthening engagement and involvement with families and carers,
  - improving the assurance around discharge processes,
  - having a robust system for monitoring waiting times using new national metrics,
  - strengthening the patient flow pathway so that there is an increase in bed availability,
  - having access to shared records that cross all healthcare services so that full risk history and family dynamics can be understood in greater depth

Version Control: 01

- to consider how to support patients that disengage with services via an assertive outreach approach
- to consider how regular reviews of treatment plans for treatment prescribed in line with key NICE guidelines can be reviewed on a regular basis in order to identify further learning
- to consult with GP practices to ensure that suitable structures are in place for support, advice and escalation.

Governance

Implications/Impact:	Failure to comply with the regulatory standards could result in an enforcement action being taken against the trust which may have financial and resource implications.
Assurance:	Trust Risk Register - Strategic risk 3756
Oversight:	Oversight by Quality Committee

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1. Introduction

Following the conviction of Valdo Calocane in January 2024 for the killings of 3 members of the public in June 2022, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008.

As part of CQC's review, they were asked to look at 3 specific areas:

1. A rapid review of the available evidence related to the care of Valdo Calocane
2. An assessment of patient safety and quality of care provided by NHFT
3. An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity

2. Publication of the reports

In March 2024, CQC published the first part of their review on the findings of their assessment of patient safety and quality of care provided by NHFT, and progress made at Rampton Hospital since the last inspection in July 2023.

In August 2024, CQC published the second part of their review. The issues identified in NHFT were noted as not unique to this trust as CQC found systemic issues with community mental health care and therefore made recommendations relevant to all providers.

CQC have stated that they are committed to looking in detail at the standard of care in community mental health services and have therefore requested that Trust Boards:

- Reflect on the issues and recommendations identified in the review
- Self-assess and/or audit community mental health services
- Identify areas for improvement in quality of care, patient safety, public safety and staff experience
- Put in place, or are putting in place, action plans and timescales to address the areas for improvement

3. KMPT gap analysis

A gap analysis has taken place to identify the current status of each of the recommendations, identify if there are any gaps and identify any further actions that may be required. The following gaps have been identified as follows and there are existing workstreams and actions in place already to support these:

CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
Review how it monitors and measures waiting times in community mental health services by setting measurable targets at team, service, and trust level. These	Waiting times are captured via monthly operational BI reports and monitored via the IQPR.	No target set for the new CMHF metric measure as there is no national target	1. Existing action in place to establish baseline data for measuring and monitoring

CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
targets must be monitored to ensure equity of care across services and that deterioration in people's		this year and so KMPT needs to establish a baseline.	purposes. There is no intention to consider a target for new CMHF measure this financial year. KMPT will await the publication of national data on this and future direction from NHSE before consider potential targets for 2025/26.
Improve their responsiveness to people's immediate needs by ensuring calls to the crisis line are answered and that 4-hour and 24-hour targets are met more often and consistently	There are national KPIs to meet as follows: • Emergency – 999 • Very Urgent - 4-hour Rapid Response • Urgent- within 72 hours • Routine - 28 days Continuous improvement is being consistently noted with meeting these. There is a SOP in place for NHS 111 which was produced and implemented in April 24. This is a working document and will be amended once all transformation work has completed.	No specific gap identified however the definition of urgent is causing confusion with the 72 stoppage of LPS/HTTT reviews with MHT. Service Director for West Directorate has conducted a review of the 72 hr follow-up process and streamlined this so that it is clearer for staff.	1. Updated process will feature as part of the transfer and discharge policy whereby the review is underway. Feedback is being received from the governance leads within the directorates with regards to the transfer and discharge policy monitoring compliance section and the policy review is underway. Policy to be in place by end of December 2024.
Ensure it reviews and amends its approaches to bed management to ensure beds are available when needed	Patient flow team in place that reviews and monitors the bed stock. Meetings are held daily to review this. A new escalation protocol has been drafted for those patients waiting in the HBPoS for a bed. KMPT is also working with system partners such as the ICB and local authorities to review approaches to decreasing the number of patients that are clinical ready for	At times the demand for a bed is high which leads to patients waiting for an admission (although high risk patients will always be a priority). This is due to blockages with the flow throughout the organisation. There are patients that are clinically ready	1. Existing patient flow workstream is reviewing this and have agreed 3 priorities which are understanding the data around those that are clinical ready for discharge, those that are re-admission and the older adult flow. This work is ongoing.

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CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
	discharge to move on. There is an external workstream focusing specifically on this and this is also a strategic priority for KMPT over the next 3 years.	for discharge which are delayed due to housing or social care.	
Ensure services do more to meet the needs of people who need care and treatment. This includes, but is not limited to, ensuring: a) patients receive timely access to care and treatment, b) patients can equitably access the full range of evidence-based care and treatment through multidisciplinary teams with clear pathways, including psychological therapies regardless of where patients live and c) services, including GP practices, are integrated and use shared systems to provide patients with seamless transitions in care and treatment	The implementation of CMHF will mean that patients are receiving timely access to care and treatment and will have access to the support they need such as psychological therapies – this is countywide. There are now 34 Primary Care Nurses in place to support patients that are transitioning across services.	Lack of shared records so that patient medical history including risks can be reviewed by multiple services.	1. Existing action is underway - KMPT's digital team are working with colleagues within the ICB to develop a shared record that all services can access. This work is ongoing.
Ensure that joint working protocols are in place with GP practices, which ensure that patients with complex mental health needs have joined up care	Shared care agreements are in place for high risk medications such as Lithium, Alzheimer's Type Dementia and Melatonin. These were developed with the involvement of GP practices. A further agreement has been developed for antipsychotic medication and the draft is to be reviewed at the LMC on 24/09/24. KMPT does not have a specific joint working protocol with GP practices for patients with complex mental health needs however there are a number of processes in place for support, advice and escalation. These include:	KMPT does not have a specific joint working protocol with GP practices for patients with complex mental health needs however there are a number of processes in place for support, advice and escalation. This will be queried further with GP colleagues via the LMC to understand if there are any wider gaps.	1. Liaise with GP practices via the LMC to understand if there are any gaps that require further action. The next meeting is taking place on 24/09/24.

CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
	• Urgent referrals can be made back to mental health services by contacting the mental health crisis line on 111 and select option 2 when prompted. • Medication advice and guidance support for GPs and PCNs is available in each CMHT. • Access to consultant connect		
Review treatment plans on a regular basis to ensure that treatment prescribed is in line with national guidelines, including from NICE (National Institute for Health and Care Excellence), specifically when it relates to treatment of schizophrenia and medicines optimisation	KMPT subscribes to the Prescribing Observatory for Mental Health (POMH) programme, allowing us to participate in all of their Quality Improvement audits. These audits focus on specific mental health prescribing topics and align with NICE recommendations and compare us with all the mental health trusts in the UK. KMPT has a NICE implementation policy in place however it is not clear if the processes outlined in this policy are adhered to. The current process is that a systematic review of the guidelines occur when they are published or when there are significant changes. There is a gap around regularly reviewing treatment plans in line with key NICE guidelines in order to identify further learning. A report on NICE related activity is	KMPT has a process and policy for the implementation of NICE guidelines that are led by a NICE Clinical Lead via the Trustwide NICE Group. There is a gap around regularly reviewing treatment plans for treatment prescribed in line with key NICE guidelines in order to identify further learning.	1. This has been added to the Trustwide NICE Group agenda for consideration so that a plan can be formulated and implemented. Timescales will need to be agreed for 2024/25.

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CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
	presented to CEOG on a 6 monthly basis each year as part of the reporting schedule.		
Ensure that, in line with national guidance and best practice, staff are aware of the importance of involving and engaging patients' families and carers and that they do so in all aspects of care and treatment, including at the point of discharge, with patient consent. The trust should ensure that where patients do not give consent, this is reviewed on a regular basis in line with best practice and on all the available information available to the multidisciplinary team	There are carers champions in place across the trust however more could be done to improve engagement with families and carers. SIs indicate that KMPT does not always take into consideration the views or concerns of family members.	There is no systematic approach to engaging with families especially at times when patients are stable and have capacity. Curious communication needs to feature as part of the conversations that staff are having with patients and their families to find out about their networks and friends.	1. Existing action in place to collaboratively consider what needs to change seeking the views of family therapy colleagues. A clear way forward will be in place by the end of November 2024. The formation of a working group will be in place by the end of September, with the aims and approach being established in October and the improvement approach will be developed in November.
Have a robust policy and processes for discharge that consider the circumstances surrounding discharge and whether discharge is appropriate	There is a policy in place however this needs to include a robust monitoring compliance section. A review is therefore underway.	A review of the transfer and discharge policy is underway and will be strengthened to include a robust monitoring compliance section.	1. Existing action is underway as the policy is being reviewed. Feedback is being received from the governance leads within the directorates with regards to the transfer and discharge policy monitoring compliance section and the policy review is underway. Policy to be in place by end of December 2024.
Ensure all practicable efforts are made to engage patients who have disengaged from the early intervention in psychosis service. This includes referring people who find it difficult to engage with	There isn't an assertive and intensive outreach service in Kent & Medway, however the expectation is that the level of support provided for EIP	No dedicated team to provide an assertive and intensive outreach service however processes are in	1. A review of the EIP operational policy is underway and will be completed by the review date of January 2025. To be tabled for

CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
services to a team that provides assertive and intensive support	patients who struggle to engage would mirror what this type of service would offer. A workshop occurred sometime ago and this touched on lack of engagement and the reasons why teams may struggle to engage such individuals. Each patient will have set review points and they would be discussed in team meetings and the risk forum to discuss solutions and further support that could be offered. The current EIP operation policy states: Non-Engagement with the Service (Including DNA) 18.7.1 In a situation where a person is reluctant to have contact with the team either for assessment or for ongoing treatment, actions will be determined by known level of risk and symptomatology and will be discussed with members of the multidisciplinary team and documented within RiO progress notes. 18.7.2 The EIP services focus on engagement and will apply assertive outreach principles when appropriate.	place as set out in the EIP operational policy to apply assertive outreach principles for patients that are disengaging.	discussion at the next Communities of Practice Meeting in September 24. 2. Consideration to be given as to whether an assertive outreach team is required and how this can be offered to patients who find it difficult to engage. 3. To agree a way forward for an outreach service in Kent & Medway, to be agreed by October and implemented by March 2025
Ensure there is a standard operating procedure in place for early intervention in psychosis and community teams to follow when a patient does not attend for appointments and follow-up actions are defined for care co-ordinators	There is currently a DNA policy and operational policies for CMHTs, CMHSOPs and EIP. Due to the transformation changes with the rollout of CMHF, new operational	No gap identified however there is the risk that staff may be interpreting processes in different ways whilst	1. An MHT and MHT+ policy is being drafted which will replace those for CMHTs and CMHSOPs. 2. There is a bespoke group that has

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CQC recommendation	Existing assurance	Gap identified	Action to be taken including estimated timeframe
	policies will be required for MH together and MH together +. A policy review group has also been established to review the DNA policy in light of the CMHF implementation and changes to practice.	transitioning between operational policies and new ways of working.	been setup to review the DNA policy and this is underway. Both policies will be in place by the end of December 2024.
Ensure that staff in community services are appropriately trained and that mandatory training is available to support staff in working with autistic people and people with a learning disability	Part one of tier 1 and 2 available currently of the Oliver McGowan Mandatory training. Part two of tier 1 and tier 2 should be available in April 2025. The ICB are leading on this and will be updating with further information when the contract progresses with the new provider. Current compliance for Part 1: • East Directorate = 94.1% • West Directorate = 93.4% • North Directorate = 91.3% The trust target for this training is set at 84% for a 3-year period. There are some teams operating at slightly lower than the trust target however this is routinely monitored within the directorates.	Part 2 of the Oliver McGowan training not yet implemented – This is with the ICB to progress and this should be available by April 2025.	1. Existing action in place for the implementation and rollout of part two of the Oliver McGowan Training. The target is for this training to be available from April 2025.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26 September 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 July 2024. It was presented to ARC on 10th September, and has since been updated.

- 7 risks have been added to the BAF since reporting to ARC in September:
  - Risk ID 04706 – Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford crossing) (Rating of 12 (High))
  - Risk ID 08065 – Inpatient Flow (Rating of 16 (Extreme))
  - Risk ID 08146 – Maintenance of a Sustainable Estate (Rating of 12 (High))
  - Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 16 (Extreme))
  - Risk ID 08173 – Delivery of a fit for purpose Estate (Rating of 16 (Extreme))
  - Risk ID 08174 – Delivery of Financial Targets (Rating of 12 (High))
  - Risk ID 08175 – Delivery of Underlying Financial Sustainability (Rating of 12 (High))

- One risk has changed their risk score since the BAF was reported to ARC in September
  - Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 8 (High) to 6 (Moderate))

- 4 risks are recommended for removal
  - Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 8 (High) to 6 (Moderate))
  - Risk ID 00410 – Increased level of Delayed Transfer of Care (DToC) (Rating of 20 (Extreme))
  - Risk ID 00256 – Long Term Financial Sustainability (Rating of 12 (High))

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- Risk ID 00119 – Capital Projects – Availability of Capital (Rating of 12 (High))

Governance

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

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The Board Assurance Framework

The BAF was last presented to the Board on 25th July 2024. It was presented to the Audit and Risk Committee on 10th September, and has since been updated.

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 ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 16 – Extreme)
- Risk ID 08173 – Delivery of a fit for purpose estate (Rating of 16 – Extreme)
- Risk ID 07891 – Organisational Management of Violence and Aggression (Rating of 15 Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 15 – Extreme)

Risk Movement
One risk has changed their risk score since the Board Assurance Framework was presented to Board in July and ARC in September:

- **Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 8 (High) to 6 (Moderate))**
  This risk has been reviewed and has reduced in risk score. The Community Mental health Framework has now been implemented. This risk is also being recommended for closure.

Risks Recommended for Removal
4 risks are being recommended for removal at this time:

- **Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway (reduced from 8 (High) to 6 (Moderate))**
  This risk has been reviewed and has reduced in risk score. The Community Mental Health Framework has now been implemented. This risk is also being recommended for closure as the focus moves to achieving the outcomes following implementation of the framework. This has been captured in a new risk. Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 16 – Extreme)

- **Risk ID 00410 – Increased level of Delayed Transfer of Care (DToC) (Rating of 20 (Extreme))**
  It is proposed that this risk is closed and incorporated in a new risk comprising all the work on improving patient flow. This will avoid duplication on the reporting of actions. Risk ID 08065 – Inpatient Flow (Rating of 16 (Extreme)) has been opened and is included as a new risk on the BAF this time.

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- **Risk ID 00256 – Long Term Financial Sustainability (Rating of 12 (High))**
  This risk has been reviewed within the Finance and Performance Committee. It is proposed that this risk is closed and a new risk opened. Risk ID 08175 - Delivery of Underlying Financial Sustainability

- **Risk ID 00119 – Capital Projects – Availability of Capital (Rating of 12 (High))**
  This risk has been reviewed at the Finance and Performance Committee. It is proposed that this risk is closed and a new risk opened. Risk ID 08173 - Delivery of a fit for purpose estate.

New Risks

7 risks have been added since the BAF was presented to Board in July and ARC in September

- **Risk ID 04706 – Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford crossing) (Rating of 12 (High))**
  This risk has been added to the BAF to provide assurance that the Trust is liked into the County planning arrangements for the change to the Entry and Exit system at the Port of Dover, due in November. This risk is being kept under review and updated regularly as the worst-case scenario is tested and plans are updated.

- **Risk ID 08065 – Inpatient Flow (Rating of 16 (Extreme))**
  This risk has been added to incorporate all elements affecting patient flow into one risk. This risk was originally focussed on Inpatient acute admission delays, but this has been widened to include community and place of safety. It also includes the work on clinically ready for discharge (CRFD), and it is recommended that Risk ID 00410 – Increased level of Delayed Transfer of Care (DToC) is closed to avoid duplication of reporting.

- **Risk ID 08146 – Maintenance of a Sustainable Estate (Rating of 12 (High))**
  This risk has been added to the BAF following discussion at FPC.

- **Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 16 (Extreme))**
  This risk has been added to the BAF to reflect the move to evaluating outcomes from the implementation of the Community Mental Health Framework. It is intended this risk replaces Risk ID 04347 – Implementation of the Community Mental Health Framework across Kent and Medway, which is recommended for closure.
  Currently an increase in referrals is being experienced in Mental Health Together as a result of the 'No Wrong Door' approach with approx. 40% of those referrals requiring a primary care response. This along with the continuous onboarding of new staff is leading to waiting lists for social interventions and treatments. To address this, amendments to the front door are underway, the interface with GP's is undergoing improvement and the voluntary sector are moving resources to entry points to enable improved triage.

- **Risk ID 08173 – Delivery of a fit for purpose Estate (Rating of 16 (Extreme))**
  This new risk has been added to the BAF and replaces Risk ID 00119 – Capital Projects – Availability of Capital.

- **Risk ID 08174 – Delivery of Financial Targets (Rating of 12 (High))**
  This risk has been added to the BAF following discussion at FPC. The Trust is currently on track for delivering the 2024/25 financial targets, but there are recognised cost pressures and it is uncertain if the Trust will deliver the surplus NHS England has instructed after planning a breakeven position.

- **Risk ID 08175 – Delivery of Underlying Financial Sustainability (Rating of 12 (High))**
  This risk has been added to the BAF following discussion at FPC and replaces Risk ID 00256 – Long Term Financial Sustainability which is recommended for closure. While the Trust has delivered its financial targets for the past couple of years, the wider system remains in a challenged position. Long term financial sustainability remains a concern especially with the known estates pressures. The trust has a long term sustainability programme in place, and directorates and corporate teams are required to meet cost improvement targets annually.

Emerging Risks

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

Other Notable Updates

- **Risk ID 05075 – Community Psychological Services Therapy Waiting Times**
  There has been progress with this risk in terms of both supervisory posts which were out to advert at the last report to ARC have now been recruited to. Postholders were due to start in July and August.

- **Risk ID 00580 – Organisational Inability to Memory Assessment Service Demand (Rating of 20 (Extreme))**
  This risk has been reviewed and updated. Action completion dates have been updated to reflect more realistic completion dates. Good progress continues to be made with all actions. Early data from the standalone Memory Services Assessment Pilot has shown a positive impact on diagnosis performance.

- **Risk ID 04232 – Management of Environmental Ligatures (Rating of 12 (High))**
  Work continues to address areas of concern identified through the Annual Ligature Audit. The remaining actions from the 2022 and 2023 ligature Audits have been reviewed and prioritised. Funding has been identified in the capital programme to address these areas and completion is planned by year end.
  This risk will continue to be reviewed and updated to ensure the controls and assurances remain accurate.

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.

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Updated: 13 September 2024

NHS
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Board Assurance Framework

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

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

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

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

Action status key:

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

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

1.1 - Improving Access to Quality Care

12/01/2022 — BAF Risk Opened

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

31/10/2022

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

15/05/2024

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

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)
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 — 01/10/2024 — A Phase 1: Pilot of standalone Memory Assessment Service in line with Community Mental Health Framework rollout — Director of Partnerships and Transformation — 13/09/2024 — A Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 24/12/2024 — 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	4	12	31/03/2026

30/08/2023 — BAF Risk Opened

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)
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 — Completed — G	Chief Operating Officer		1	2	2	30/08/2025

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)
							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.															
	12/06/2024 Risk Opened																					
ID 08065	Jun 2024	Chief Operating Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	3	15	Patient flow team jointly working with acute hospital colleagues, Liaison Psychiatry, Home Treatment and community services on case by case basis twice daily reports including the Place of Safety Breaches daily system calls review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts business case approved through ICB to move to CORE 24 across all acute hospitals CRFD programme of work underway to release capacity within the KMPT bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review CRFD Programme is a system wide programme in conjunction with the ICB Local Authority and supported through the Provider collaborative.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	3	5	15	NEW	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer		1	3	3	**12/09/2025**
													Accurate recording and reporting of 12 hour breaches	Director of Digital	30/08/2024	A						
													Countywide safe Haven Provision	Deputy Chief Operating Officer	30/12/2024	A						
													CRFD Programme	Deputy Chief Operating Officer	31/03/2025	A						
													High Intensity User Programme	Director of Psychological Therapies	31/03/2025	A						
													Implementtion of CORE 24 across all Hospital Liaison Services	Deputy Chief Operating Officer	30/06/2025	A						
													Crisis Houses across the County	Deputy Chief Operating Officer	28/07/2025	A						
	12/06/2024 Risk Opened																					
ID 08157	Aug 2024	Chief Operating Officer	**Community Mental Health Framework Achieving outcomes to evidence success** IF we don't complete enough paired DIALOG+ and are not able to meet the 4 week wait THEN we will a) not be able to assess outcomes for our service users and will b) delay commencement of treatment, RESULTING IN poor patient experience.	5	5	25	Fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. Team level daily management. Tactical groups in all localities monitoring waits and clinical risk to patients (1c). Monthly deep dive by programme management to each locality (1a) Dashboard in place (1d)	Robust team level management Dashboards Caseload management tool Partnership Forums	4	4	16	NEW	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Operating Officer		3	3	9	**28/03/2025**
													Review of Mental Health Together Processes	Deputy Chief Operating Officer	30/09/2024	A						
													Review of people currently waiting to be seen	Deputy Chief Operating Officer	30/09/2024	A						
													Integration of Provider workforce to aid skill mix and new ways of working	Deputy Chief Operating Officer	15/11/2024	A						

				Initial rating					Current rating						Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
1.2 - Creating safer and better experiences on our wards																			
04/12/2014 — BAF Risk Opened — 20/07/2023 — 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** Capital Expenditure on Environmental Ligature risk areas / Head of Capital Planning / 31/03/2025 / A	Chief Nurse		1	4	4	31/03/2025
04/12/2014 — BAF Risk Opened — 20/07/2023 — Risk returned to BAF																			
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF KMPT do not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance Violence Reduction Strategy PSS Strategy Use of Force Act CQUIN Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy	Incident reporting via InPhase Quality Improvement Data	5	3	15	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services. / Chief Nurse / 31/03/2026 / A	Chief Nurse		2	3	6	31/03/2026
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 — 08/08/2024 — Risk Recommended for closure. A new risk to be opened relating to achieving the outcomes from the CMHF.																			
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	3	6	↓	**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 / G Integration of provider workforce to aid skill mix and new ways of working / Chief Operating Officer / 15/11/2024 / 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.																			
00410	n 2022	Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available	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	Daily scrutiny of DToC data	4	4	16	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**	Officer		3	3	9	3/2025

				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)
ID	Jul	Chief Operating	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.				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. Actions following the external review being progressed.						ICB diagnostic analysis of reasons for DTOC	Deputy Chief Operating Officer	Completed	G	Chief Operating					300:
														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						
3.3 - Playing our role to address key issues impacting our communities																							
25/01/2019 Risk Opened 08/08/2024 Risk added to the BAF due to concern about the impact of the change to the entry and exit arrangement at Dover on the ability to deliver services																							
ID 04706	Jan 2019	Chief Nurse	**Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford crossing)** IF an incident occurs that affects the transport network of the county, including incidents of Civil Disturbance THEN this will have an impact on staff and patients travelling to their required locations RESULTING IN increased stress and delays in attending appointments, leading to poor service delivery and poor patient experience	4	3	**12**	Regular Highways updates on current status of situation [1h] Warning and Informing with targeted communications Virtual red board meetings (when appropriate/necessary) Business Continuity Plans [2e] Significant Incident plan [2e] Major Incident Plan [2e] Remote working available to a proportion of staff [1d] Directive - via ICB Director attendance at Kent Strategic and Tactical Co-ordination groups	EPRR Annual Assurance Programme (Significant Incident Plan and Business Continuity Plans) TWEPRRWG Minutes	4	3	**12**	⟷	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Nurse		2	2	**4**	**01/09/2025**
														Exercise against reasonable worst case scenario EES prior to October 2024	EPR Lead	Cancelled	G						
														Understand reasonable worst case scenario for Port Entry and Exit system go live - traffic impact	EPR Lead	Completed	G						
														Map and take assurance on new BCPs - Transformation in East Kent where KMPT is principle contractor	EPR Lead	15/11/2024	A						

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones				Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
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. → 14/03/2023 This risk is recommended for closure. A new risk to be opened relating to the Delivery of underlying financial sustainability																						
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						
25/06/2024 Risk Opened																						
ID 08174	Jun 2024	Chief Finance and Resources Officer	**Delivery of Financial Targets** IF the Trust is unable to deliver its financial targets THEN additional scrutiny will be attached to its financial position RESULTING IN sanctions from NHS England	3	5	15	Standing Financial Instructions Delegated budgets Agency recruitment restriction CIP Process Monthly statements to budget holders Budget holder authorisation Authorised signatories Trust Capital Group oversight Business Case review group	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	12	NEW	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		2	4	8	31/03/2025
													Finalisation of the Cost Improvement Plan and Timetable	Chief Finance and Resources Officer	31/07/2024							
													Forecast of the Trust Agency Position and Required Actions	Associate Director of Finance	31/10/2024	A						
													Review of the use of temporary staffing and identify appropriate mitigations	Chief Finance and Resources Officer	31/10/2024	A						
													Review of Trust Reporting Pack	Associate Director of Finance	20/12/2024	A						
													Alignment of Service line reporting (SLR) and Budget Reporting	Associate Director of Finance	31/03/2025	A						
25/06/2024 Risk Opened																						
ID 08175	Jun 2024	Chief Finance and Resources Officer	**Delivery of Underlying Financial Sustainability** IF the Trust does not focus on cost saving, productivity and efficiency to contain its run rate THEN funds will not be available to support the investment in services RESULTING IN the Trust potentially moving into financial deficit and unable to support the delivery of the Trust Strategy	3	4	12	Standing Financial Instructions Delegated budgets Agency recruitment restriction CIP Process Monthly statements to budget holders Budget holder authorisation Authorised signatories Trust Capital Group oversight Business Case review group	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	12	NEW	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		3	3	9	31/03/2025
													Finalisation of the Cost Improvement Plan and Timetable	Chief Finance and Resources Officer	31/07/2024							
													Forecast of the Trust Agency Position and Required Actions	Associate Director of Finance	31/10/2024	A						
													Review of the use of temporary staffing and identify appropriate mitigations	Chief Finance and Resources Officer	31/10/2024	A						
													Review of Trust Reporting Pack	Associate Director of Finance	20/12/2024	A						
													Alignment of Service line reporting (SLR) and Budget Reporting	Associate Director of Finance	31/03/2025	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																			

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6.2 - Invest in a fit for purpose, safe clinical estate																			
01/04/2020 Risk Opened → 04/06/2021: Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. → 06/09/2021: This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway → 17/01/2022: The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022. → 14/03/2023: The capital allocation for 2023/24 is severely limited across the system, which limits the ability of the Trust to invest in life expired buildings and equipment. → 08/08/2024: Risk recommended for closure. A new risk to be opened relating to delivery of a fit for purpose estate.																		
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	⟷	**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	Executive Director of Finance		2	3	6	31/03/2025
29/03/2024 Risk Opened																			
ID 01873	Mar 2024	Chief Finance and Resources Office	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	16	Identifications of neds of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership		4	4	16	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Identification of potential next steps steps on high cost estates development / Director of Estates and Facilities / 30/06/2024 Implementation of a rolling, multiyear estates capital programme / Director of Estates and Facilities / 30/09/2024	Chief Finance and Resources Office		3	3	9	31/12/2024
01/04/2020 Risk Opened																			
ID 01846	Aug 2024	Chief Finance and Resources Office	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	12	Robust design and specification processes and capital programme management Prioritise capital plan, review regularly with services and against backlog maintenance (2e) Trust capital group managing programme Programme delivery reported to SEG Management of Trust maintenance contract	Reporting to FPC TiAA Audit Contract Monitoring Minutes	3	4	12	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of the present hybrid working arrangements / Director of Estates and Facilities / Completed / G Review of the implementation of the new maintenance contract / Director of Estates and Facilities / 30/09/2024 Review of the present backlog maintenance position / Director of Estates and Facilities / 30/09/2024	Chief Finance and Resources Office		2	3	6	31/03/2025

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Strategy Delivery Year 2 Update
Author:	Adrian Richardson, Director of Transformation and Partnerships
	Sarah Atkinson, Deputy Director of Transformation and Partnerships
	Kindra Hyttner, Director of Communications 7 Engagement
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an update to the Board on progress against the trust three-year strategy 2023-2026 for the period 1 April – 30 September 2024 (the first six months of year two), with a focus on our six priority areas. It also includes a summary of progress across wider areas in our strategy and challenges.

Issues to bring to the Board's attention

As outlined in the paper to Board in May 2024, we are focusing on six priority areas, which are being measured through 28 driver metrics from our trust strategy. The remaining metrics outlined in the trust strategy are categorised as 'business as usual' or 'watch' metrics. Business as usual metrics are monitored through strategy deployment group (SDG) or as part of the trust integrated quality & performance whereas 'watch' metrics are monitored and progressed within business activity without the need for an improvement approach.

The paper highlights positive progress on a number of our priority programmes, notably:

- We are delighted to see the significant improvement on some of our wards to reduce violence and aggression. This follows the implementation of the safety culture bundle by our staff. A separate report to Board will give greater detail into the approach taken as well as the successes and lessons learned.
- We are also proud to have launched our new staff-app, staffroom, as part of our culture, identity and staff experience priority and our four new cultural values. All of which have received overwhelmingly positive feedback and engagement from our people.

We have also set out where there is still work to do and the challenges we are facing in overcoming complex problems. For example:

- On patient flow some good improvement work has happened but this is not being seen in our current data due to the complexity of the challenge and multiple contributing factors. To ensure

we meet our strategic targets, we are currently undertaking a review of the patient flow programme to narrow the scope. By focusing on 3 key projects - readmissions, older adult length of stay and clinically ready for discharge (CRFD) - we will better understand the impact of our improvements, enabling us to scale and spread effective improvements at pace. Our aim is to enact these focused improvements within wards in the coming months (Oct-Nov) ahead of the inevitable winter pressures.

- While our new memory assessment service has now successfully been rolled out across our directorates, and average waiting time for diagnosis has reduced from 189.9 days in July 24 to 155.5 days in August, we are not yet seeing consistent and sustainable reductions in times. We hope the benefits of the new model and our improvement approach will lead to faster reductions over the next six months and beyond.
- In Mental Health Together the volume of referrals received are outstripping the capacity we have to offer treatment within 4 weeks. Early indicators suggest that 40% of referrals would benefit from a primary care intervention with further engagement with GP's planned in the coming months.

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Strategy Deployment Group, IQPR and Board Sub-Committees

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Background

We agreed the 2023-26 trust strategy which sets the direction, with specific outcomes, that will need to be delivered by the organisation. The strategy is based on three strategic ambitions (our Patients, our People and our Partners) and three strategic enablers. Each ambition and enabler have a number of outcomes associated with it and as such require transformative change support to successfully implement.

Acknowledging the significant challenge of improving 73 outcomes all at once, in May 2024 the outcomes were separated into three groups:

Group	Number of Outcomes	Approach
Drivers	28 (6 of which are from strategic enablers)	Where an active improvement approach is supporting the strategic ambitions and enablers.
Business as Usual	25 (9 of which are UEC and Patient Experience)	Where the metrics/outcomes are monitored and reported frequently through the Strategy Deployment Group (SDG) or as part of the Trust Integrated Quality & Performance Report (IQPR) and Quality Performance Reviews (QPRs), without the need for an improvement approach.
Watch	20	Where monitoring and further progress will be made within a business as usual approach without the need for an improvement approach

Strategy Deployment Year Two

Priority Areas

In keeping with the prioritisation of year one, and phasing of our strategy delivery, we agreed to focus on six key priorities throughout year two of the strategy:

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

Governance

The reporting and governance structure established in the latter part of year one has continued into year two. The executive sponsors provide a monthly operational update to the rest of the executive

management team (EMT) to ensure clarity on progress, challenges and identify support where needed. Each programme also undergoes a deep dive with EMT and the Senior Responsible Officer (SRO) quarterly.

Year Two (first six months) Operational Delivery Update

Overview against operational plan

Progress across our six priority outcome measures is summarised in the following pages. We have provided specific details on the work to date, acknowledging that whilst there has been great improvement on many of the metrics, there is still work to do. While some metrics show as ‘off target’ this scoring approach does not reflect the substantial amount of work that is ongoing and the progress that has been made.

The table below captures progress against our priorities and their associated driver metrics. The latest trust scorecard is in Appendix A. Updates for watch outcomes are contained in Appendix B.

Priority	Exec Sponsor	Outcome	Status	Update
Patient Flow	Afifa Qazi	Decrease our bed occupancy to 85%	Off Target	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. 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. CRFD works have commenced (as above). This is not however translating into a reduction in bed occupancy. Inpatient bed occupancy remains high at 97.6%. A fresh bed modelling exercise has been completed, and two highest contributors to increased bed occupancy have been identified 1) High Readmission rate – 11.8% of patients were readmitted with 30 days in the last 12 months 2) High numbers of CRFD (currently 57 (4/9/24)) and additional impact on older adult wards from a long LOS, (average 102 days (6/9/2024) In light of this the Flow programme has been revised to focus on these three areas with enhanced support from the Improvement team.
		Reduce the length of stay for patients waiting onward transfer by 75%	Off Target	Extensive work in the form of external review plus three Multi-Agency Discharge Events (MADE) has been carried out to identify the root causes of patients clinically ready for discharge (CRFD) with both internal and external factors identified. External factors are mostly linked to housing which requires a new approach. This is being addressed via joint working with the ICB who have supported HACT (social housing charity), to work across system partners and also with social care to address delays in discharge from acute wards linked to their processes. Internal pieces of work are being picked up under the flow programme. Two new work streams have commenced to reduce CRFD. 1) Discharge to assess model in East Kent in partnership with HCP with discharge to community providers with support. 2) Internal improvements within in- patient services facilitated by an external consultant started on two inpatient wards in East Kent with plan for county-wide roll-out.
Dementia	Adrian Richardson	95% of people referred for a dementia assessment will be seen within 6 weeks	Off Target	Phase 1 of standardised model began rollout Q1/2 and will be complete by Q3. Phase 2 of multidisciplinary model of assessment will initiate in Q3 with recruitment and refinement of model. Phase 3 with wider system level response for scoping and implementation begins end of Q2. Average waiting time has reduced from 189.9 days in July 24 to 155.5 days in August.
		Patients receive treatment within 4 weeks of a referral into Mental Health Together	Off Target	MHT Dashboard now agreed and monitoring against target has commenced. Recruitment across all partners agencies now in train and will expected to have the majority of recruitment in place by November 2024, which will positively impact the MHT ability to comply with the 4 ww. It is noted that the referral rates to all new Mental Health Together services is outstripping capacity with some areas receiving over 60 referrals in one day with broadly 40% of referrals historically

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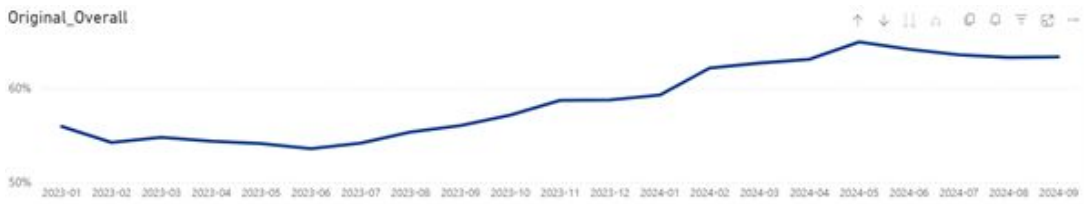
				managed within primary care. To enable patients to receive the right care at the right time, It is clear a revision to the model at the 'front door' is required along with a need to improve communication regarding who would benefit from the service.
Mental Health Together (MHT) **(*Community Mental Health Framework*)**	Donna Hayward-Sussex	Increase the number of patients accessing care in the Mental Health Together service to levels representative of the local population.	On Target	Progress is being made with regards to understanding the profile of patients accessing Mental Health Together with more work needed at 'place' to truly appreciate the impact on MHT within the local population. • 56% of presentations are female compared to local population of 52% • 91% of presentations are white (excluding not known/stated) compared to local population of 87.6% • Average level of deprivation 4.2 compared to local population of 5.5
		85% of people with a severe mental health illness presenting through Mental Health Together will have a physical health check	On Target	In Mental Health Together+, compliance is currently at 63.3%, an improving picture 
		See 85% of routine referrals within 4 weeks	On Target	All referrals are being seen within 4 weeks with the majority of patients seen within a few days of referral. Challenges in meeting the 4 weeks wait to treatment remain with recruitment critical to meeting the target as described previously.
		Forecast mental health capacity and meet demand	On Target	Initial demand and capacity work completed with the ability to forecast as MHT becomes established and referral profiles are better understood.
Violence and Aggression	Andy Cruickshank	Decrease violence and aggression on our wards by 15%	On Target	Following a refresh of the approach to analysing the data being produced by this work, we are now seeing strong signs of improvement – with the testing wards now tentatively approaching an average improvement of 85% when compared to baseline data from 22/23. As new teams on-board with this work we see increases – sometimes dramatic but the contrast between now and 22/23 is the equivalent of seeing 2-3 incidents per day on wards to 2-4 per week. Further work is being done to gather feedback form teams on the changes they are seeing but better engagement and change ideas generation are now an integral feature of the improvement work to further reduce violence.
		Reduce racist violence and aggression incidents	Of Target	Whilst the work on violence is proceeding well, which includes the capture of data around racial violence and abuse, the overall approach to addressing this requires further work to ensure the

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		to 15%, in line with the national average.		range of responses are being tested systematically and appraised as to their effectiveness. This forms the next phase of the overall work on reducing violence and aggression.
Culture, identity and staff experience *(two previous outcomes have been removed due to overlap)*	Sandra Goatley/ Kindra Hyttner	Increase percentage of BAME staff in roles at band 7 and above	Off Target	The first year of work focused on analysing the evidence to better understand the barriers to BAME staff at KMPT accessing or remaining in roles at Band 7 and above. Due to the sensitivity and complexity of this topic, this discovery phase took longer than originally planned. A BAME talent strategy has now been drafted and is engagement stage, to be presented to People Committee in November 2024. 26.5% of all BAME staff at KMPT are currently in roles at Band 7 and above or with equivalent salaries. This is above the target of 18.5% that was set originally for the end of Year 2. However, the evidence indicates that the greatest challenge exists in relation to Agenda for Change staff, with only 15.4% of BAME staff in Agenda for Change roles being in roles at Band 7 and above. The BAME talent strategy therefore focuses on this group of staff and a marked improvement is expected as a result of the specific interventions in the strategy by the end of Year 3 of the strategy. In addition to this we have 5 people attending the ICB's Aspiring Development programme which is designed for Band 5 nurses from diverse backgrounds to plan their careers, overcome barriers and move into Band 6 roles.
		Increase our raising concerns sub-scores from 6.6 to 6.9	Off Target	On track with work committed to, but this score was below target in Year 1, and we won't have access to outcome data until after next Staff Survey results are published in early 2025.
		Increase our burnout sub-score from 5.2 to 5.5	On Target	Target for Year 2 currently being achieved.
		Increase staff satisfaction with their line managers from 7.6 to 7.9 in our staff survey	Off Target	It was hoped that there would be an increase in this score in the first year, although with hindsight, given the scale of change required, this was ambitious. New leadership and management programmes starting in September.
		Reduce our agency spend to 3.7% of the trust total pay bill	On Target	All our AfC clinical and non-clinical rates below cap and there is 0 off-framework use. Medical agency use has also been alleviated as a result of recruitment into consultant vacancies. We continue to benefit too from the work of the K&M Temp Staffing Group and continue alongside K&M partners to see agency converting to less expensive bank.
		Our people feel KMPT is a supportive and compassionate employer	On Target	On track with work committed to, but won't have access to outcome data until after next Staff Survey results are published in early 25.
		Increase engagement score from 6.9 to 7.1	On Target	On track with work committed to, but won't have access to outcome data until after next Staff Survey results are published in early 25. Set corporate objective to reach 7.3 engagement score (one of the best in the country) over the next 5 years.

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		90% of leaders at Band 7 to have attended KMPT leadership and management development	On Target	New leadership and management programmes starting in September. This is later than anticipated at the outset due to significant OD support to CMHF transformation which did not originally feature in the strategy, however it is still expected that the target will be met by the end of the three-year lifespan of the strategy.
Getting the Basics Right*	Donna Hayward-Sussex	Reduce unwarranted variation in services	Off Target	Work is due to commence in October 2024 – establishment of workstreams with scoping underway.
		Reduction in time spent capturing and revalidating non-value adding data by 25%	On Target	Significant time savings have been felt across MHT through the new standardised ways of working created by the Business Analysts in conjunction with the clinical leads. These benefits are still be calculated to understand the full impact of the improvements. The Business Analysts have been fundamental in redesigning processes and the core functionality of Rio (in conjunction with the Rio Team) to enable KMPT and partners to co-manage patient journeys in an efficient manner. The navigation within the Rio platform has been streamlined and improvements to reporting have improved the user experience. This includes, but is not limited to, designing new workflows for the system, interactive in-built system reports that links to other parts of Rio, and refining the navigation tools.
		Process Re-Engineering of operational support systems	Off Target	Work is due to commence in October 2024 – establishment of workstreams with scoping underway.
	Adrian Richardson	Process Re-Engineering of corporate support systems	Off Target	Work is being scoped in September with a view to establishing workstreams around biggest contributors.

In addition to the driver metrics within the six priority programmes, there are six outcomes that form part of the strategic enablers that are driver metrics for 2024:

Outcome	Exec Sponsor	Status	Update
Clinical staff report that our Electronic Patient Records System is quicker and easier to use.	Nick Brown	On Target	Extensive work has been undertaken to deliver new streamline processes for MHT and MAS that have made it easier to ascertain what a patient is waiting for, which has saved time for clinicians. This is also supported by Power BI dashboards which provide further insight in relation to waiting lists for assessment and interventions. Whilst there is more work to do, this staff within MHT are reporting that it is easier to extract the information from Rio that they need.
Sharing information and data internally is smoother and quicker and we have one version of the truth		On Target	A new suite of Business Intelligence Reports has been delivered. The provision of data to support transformational activities has also increased including a new MHT dashboard which is being used to monitor waiting lists for assessments and interventions.

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Electronic solutions have been deployed for medicines, ordering investigations, patient safety alerts and bed management		Off Target	Electronic prescribing has been deployed to InPatient settings and a project is underway to deploy the solution to community teams. The product has been upgraded but there are changes that are needed before this product can be released to all community settings. Order investigations (pathology) is a ICS project that KMPT is actively engaged in. A PM has just been assigned to progress this work. The Rio FLOW module has been found to be not fit for purpose to manage planned admissions. A meeting with the supplier has occurred and we are awaiting urgent feedback from the supplier to determine how to progress. If the issues with the current product cannot be resolved, an alternative solutions will be sought
Electronic solutions have been delivered for referrals and consultations		On Target	Teams has been deployed across the trust to enable electronic consultations. This has provided a single solution for all staff, removing the Lifesize product, which was not available to all staff. The e-Referrals project is underway and engagement sessions with other trusts and GPS are currently underway
A service user portal has enabled access to personalised information and freedom to control their own care		On Target	The project to implement a patient portal is in planning. Supplier engagement is underway.
Embed hybrid working		Off Target	The Trust has implemented a hybrid working policy which seeks to balance the needs of the business with the flexibility of the new ways of working. As we move further away from the pandemic there is a need to review whether the trust's approach on this is meeting the business need, so a further review of the policy and approach is being undertaken
Secure shared clinical spaces with our partners		Off Target	Our partner organisations through the CMHF programme have confirmed they struggle with accommodation and have a greater need for space than they can accommodate. We therefore haven't progressed this work as intended. We continue to seek opportunities and are presently working with NHS Property Service looking at a hub initiative that could see us share accommodation with Primary Care and others.

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Wider progress and issues

Data and Reporting

Across our strategic priorities we are taking a more data driven approach. This is a more mature and improvement-led way of problem solving for our organisation and has meant the scoping phases have taken us longer so that we can benchmark effectively. It also ensures the improvements we continuously make are sustainable and will make meaningful impact to our strategic ambitions.

At the end of year one of the strategy, availability and quality of data was a recurring theme across the strategic programmes. Much of the issue was due to the culture around data within the organisation and our people understanding the importance of this, why it must be collected, and how it can be used to improve services. During Q1 and Q2 of this year further developments have been undertaken to improve the use of data across the major programmes as well as a refresh of the IQPR.

An example of how we have utilised data to inform our approach is within the culture, identity and staff experience priority. To increase the percentage of BAME staff in roles at band 7 and above, we have taken the time in year one of the strategy to really understand our performance data to better understand the barriers to BAME staff in accessing or remaining in roles at Band 7 and above. Due to the sensitivity and complexity of this topic, this discovery phase took longer than originally planned but has enabled us to now understand that 26.5% of all BAME staff are currently in roles at Band 7 and above or with equivalent salaries. This is above the target of 18.5% that was set originally for the end of Year 2. The evidence has however indicated that our greatest challenge exists in relation to Agenda for Change staff, with only 15.4% of BAME staff in Agenda for Change roles being in roles at Band 7 and above.

A BAME talent strategy has now been drafted and is in the engagement stage, to be presented to People Committee in November 2024. In response to the data discovery, the BAME talent strategy focuses on the aforementioned group of staff and a marked improvement is expected as a result of the specific interventions in the strategy by the end of year 3.

We will be utilising our own data from the first phase of the Mental Health Together service, alongside population data, to inform the roll out and improvements through MHT+. While it's too early in the programme to be 'on track' with the four-week to treatment we are receiving and processing significant numbers of referrals many who receive an assessment within a few days. This is positive for our patients and partners referring into the service to have a single front door, and work is underway to utilise this learning and data to improve waiting times overall and the number of patients accessing treatment through MHT+ and our partners.

Our approach to operational excellence and strategy delivery

We have already set out and agreed our ambition to execute an improvement approach that aligns with our strategy and supports implementation through creating a culture of continuous improvement.

We have been engaging with other trusts who are ahead of us on their operational excellence journey, including Medway Foundation Trust. In May and July, the executive management team (EMT), deputy directors and improvement team members visited Medway Foundation Trust to see their approach as part of their 'Patient First' programme.

During the first-year of our strategy, key elements of an operational excellence model were utilised to drive delivery of the strategic priorities. In the last six months we have also designed a high-level

approach to our own operational excellence programme called *Doing Well Together,* which aligns with our new identity.

In September 2024, we will partner with KPMG to assess our organisational readiness for an operational excellence programme. KPMG will work alongside the trust's improvement team and executive management team to carry out a 6-week information gathering exercise, including focus groups with frontline staff, directorate and corporate leaders, the improvement team and interviews with the executive team and non-executive directors.

This readiness assessment will look at criteria across 10 domains as outlined below:

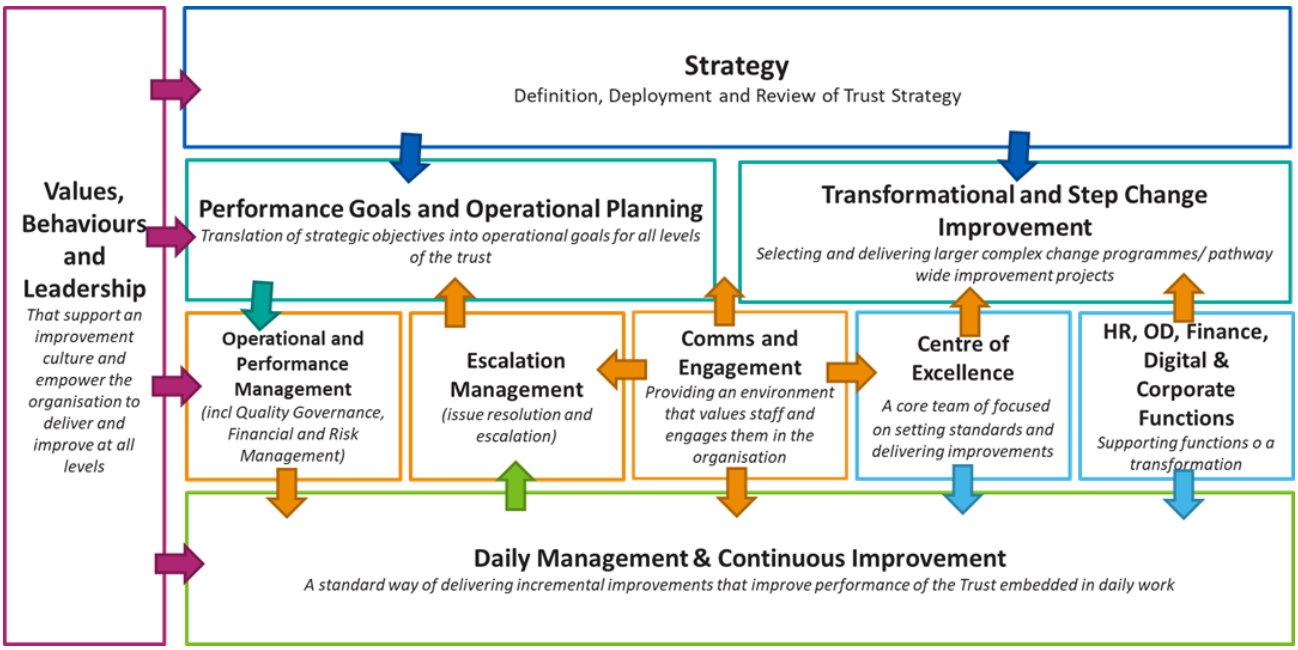

Figure 1: Adapted from KPMG OE readiness assessment document

The results of this will be shared with the executive team at a workshop which is planned for 23 October 2024. A second workshop in November will develop a plan to deploy our improvement programme across the organisation over the next few years, with work starting in Q3/Q4 this year.

In April this year, the transformation and QI team merged to form the new improvement team and will be responsible for the upskilling of the organisation and supporting the deployment of the new model in the coming years. A capability matrix has been developed within the team to understand any capability gaps in delivering operational excellence and work is underway to build capability both within the improvement team and across the wider organisation. This will be closely aligned to our leadership and development programme as we anticipate many of them will require this training.

In September 2023, we became accredited to deliver A3 Thinking (problem solving) training by the Lean Competency System. Since then 52 people have been trained in the methodology with 18 having become certified so far (13 of which are in the improvement team). We are now seeing this methodology being used to drive our strategic improvements. Over the next 12 months, this capability building will grow with the further deployment of operational excellence.

Our operational excellence approach will allow individual teams to understand how they are contributing to the priority areas and promote accountability throughout the trust, while also empowering frontline teams to make change in their own areas.

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Conclusion

We are now halfway through our three-year strategy and are confident the six areas we are focusing on will make the biggest difference to our people, partners and patients. The time we have already invested, and will continue to, in developing our data maturity and operational excellence approach will be significant, but without this we will not realise our potential or achieve long term sustainable improvements for our patients.

Against the challenges captured here, as well as previously with the board and through committees, we are proud of what we have achieved already against our strategy. Significant improvements are showing on some of our priorities, notably thanks to greater engagement with our people who are all essential in us achieving it. And we are seeing staff embracing our four new values, including curiosity which is essential if we want to grow as an organisation and learn and improve.

That said, we recognise our work so far on patient flow and dementia is not significantly improving outcomes for our patients, and that our staff are still telling us they are struggling with the amount of change, and our processes and systems. The work happening across these priorities will address this and we hope to report a marked improvement by the end of year two.

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Appendices

Appendix A – Trust Performance Scorecard (August 2024)

(In Reading Room)

Appendix B – Watch Metrics

Strategic Ambition	Outcome
Patient	All staff are trained on autism awareness
	Increase service user and public participation in local-led research projects by 10%
People	We will be ready to apply for formal teaching status
	Our joint working with Kent Medical School and University of Kent will be formalised
	Reduce Voluntary turnover to 14% or below
	Reduce sickness rates to 4%
	The number of minority ethnic staff involved in conduct and capability cases so that there is 0.5% variation against the numbers of white staff affected.
	Drive down our vacancy rate to 14%
Partners	Fulfil our role to deliver joint initiatives to reduce suicide and self-harm
Digital	Our leaders have increased access to reliable data and knowledge to help decision making
	All digital solutions are co-designed by clinical and digital staff
	Electronic solutions have been deployed for medicines, ordering investigations, patient safety alerts and bed management.
	Increase the digital literacy of our workforce
Sustainability	Increase the environmental quality of our green spaces by 2025
	Overhaul organisations governance
	Reduce carbon emissions from energy consumption by 80% by 2035
	Cut emissions associated with transport by 25% by 2025
	Reduce our overall waste volume by 5% every year
	Reduce water consumption by 5% every year
Estates	Release office space footprint and increase clinical space through hybrid working and new ways of delivering integrated models of care by 10%

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Appendix C – BAU Metrics

Strategic Ambition	Outcome
Patient	95% of people Presenting to EDs with a mental health crisis will be triaged within 1 hour
	Service users with autism report friendlier wards
	Increase service user's experience of receiving care
	Improve patient outcomes
	90% of all transformation and Qi projects involve service users, carers or loved ones
	95% of mental health patients in EDs will be admitted to a psychiatric bed or discharged within 12 hours
	Reduce Out of Area placements for patients requiring acute and PICU care
	Eliminate all inappropriate specialist out of area placements (including dementia)
	Increase satisfaction for in-patient experience by 10%
	Reduce inpatient harms relating to medicine incidents, self-harm, falls and sexual safety by 10%
People	95% of staff receive annual appraisals with their line manager
Partners	10% of women with severe perinatal mental health needs in community services will have access to specialist care
	85% of people in our care with learning disabilities (who may also be autistic) where identified are referred for an annual physical health check
	Improve social mobility and inequality through our commitment to deliver against the 14 levelling up goals
	Introduce agreed outcome measures to monitor patient care and experience
	Work with our partners to assess 95% of people in a crisis within 4 hours
Digital	Reduce the number of serious incidents, complaints and investigations associated with information sharing across the system and wider NHS
Sustainability	Achieve recurrent annual break-even financial position
	Devise new model for transformation
	Eliminate our underlying deficit
Estates	Improve the efficiency of our estate and invest in more maintenance
	Increased staff satisfaction with estates maintenance of office and clinical spaces
	Completion of Ruby Ward build
	We repurpose our estate to recycle back into our existing buildings
	Prioritise patient safety and backlog maintenance

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NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update
Author:	Jane Hannon, Programme Director Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

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).

Issues to bring to the Board's attention

The report outlines the overall governance arrangements for the Provider Collaborative, the key workstreams, progress and plans for three of its key programmes: Urgent and Emergency Care, Dementia and repatriation of people with autism from out of area placements.

The out of area placements work is exceeding its target for patients being discharged from hospital settings.

Governance

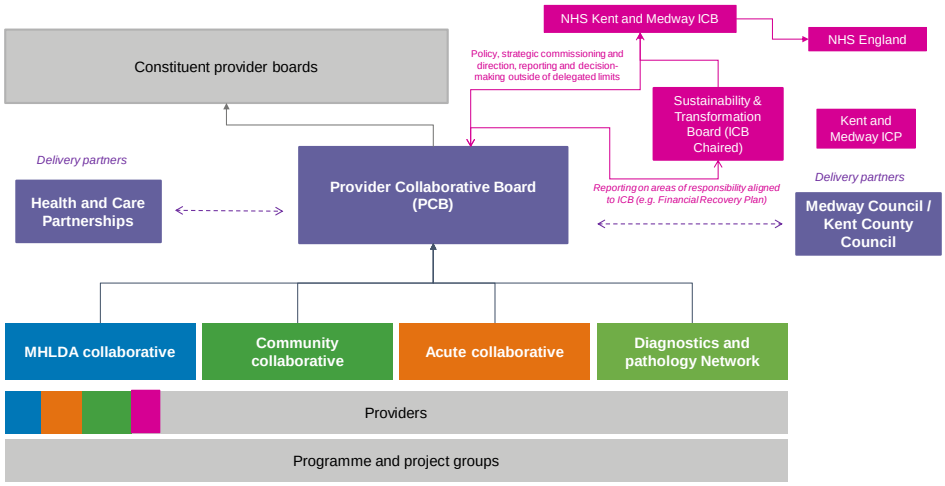
Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board and Provider Collaborative (PC) Board

Kent and Medway Provider Collaboratives - Update for KMPT Board

Provider Collaborative Board Structure

The Kent and Medway Provider Collaborative has been set up by the Chief Executives of the Kent and Medway Health Providers. It is chaired by John Goulston, Chair of KCHFT and MFT. The Executive lead is Sheila Stenson, Chief Executive for KMPT.

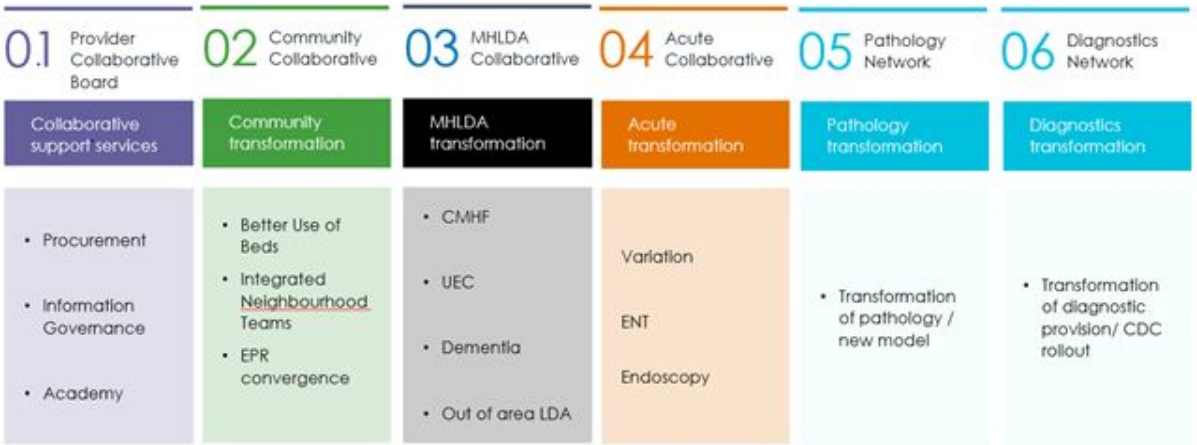
Governance Structure



The Collaborative includes three collaboratives and three further workstreams

- Community, Primary and Social Care Collaborative – Senior Responsible Officer (SRO) Mairead McCormick
- Acute Collaborative – SRO Jayne Black
- MHLDA Collaborative – SRO Sheila Stenson
- Corporate and Enablers Workstream – SRO Chris Wright
- Pathology Network – SRO Miles Scott
- Diagnostics Network – SRO Jonathan Wade

Overall Collaborative Portfolio



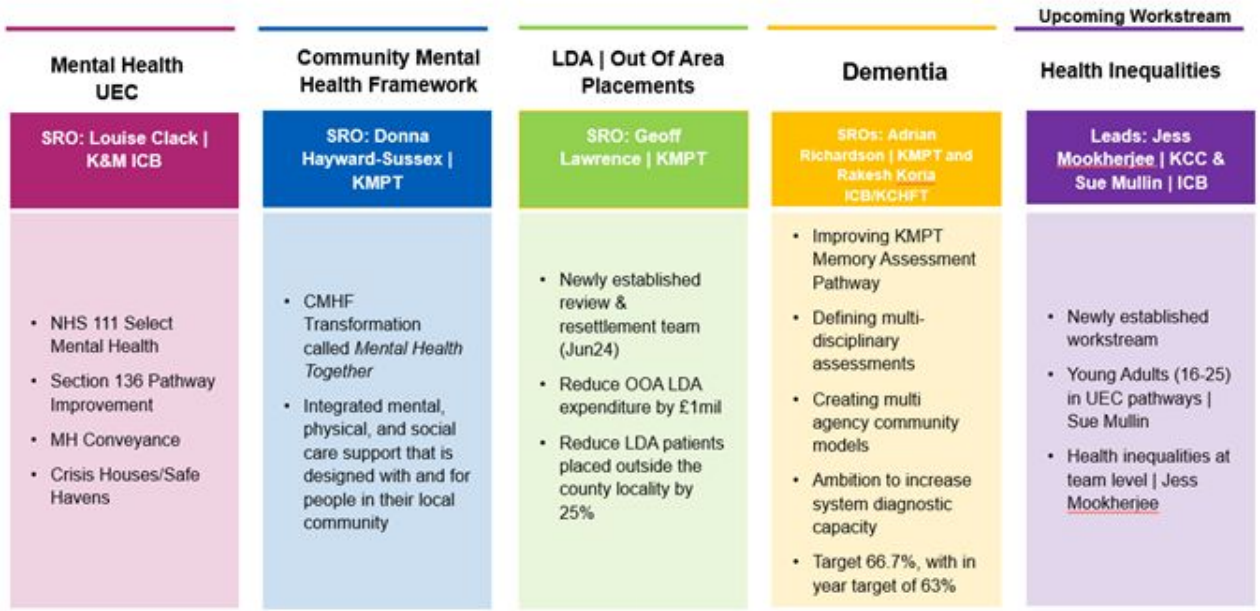
The Mental Health Learning Disability and Autism Provider Collaborative

This is the most mature collaborative and has strong engagement from health (acute, community, mental health, primary care, ambulance the ICB and HCPs), the voluntary sector, police and local authorities. The last meeting had 29 attendees from across 12 different organisations.

The MHLDA provider collaborative is chaired by Sheila Stenson and since August 2024 is serviced by the provider collaborative team. It meets every two months. A workshop took place on 3 September to review the terms of reference for the Clinical Professional Advisory Board, which will provide clinical input to the workstreams.

MHLDA Collaborative Portfolio

The current portfolio is shown below.



August 2024 meeting

The August meeting received an update on Mental Health Investment spending and there was an agreement to broaden the membership of the meetings that oversee this routinely.

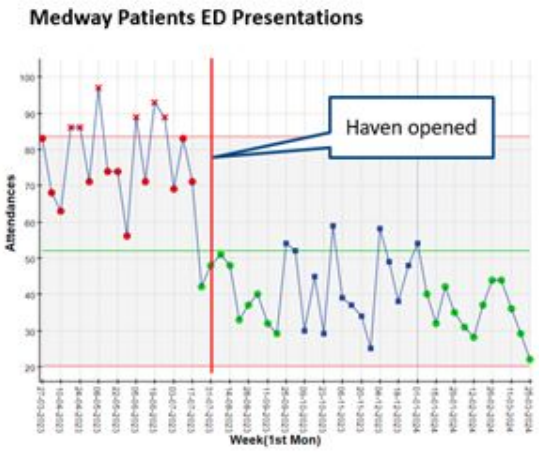
It also received updates on progress for urgent and emergency care, learning disability and autism out of area placements and dementia.

It heard about the new Mind and Body community of practice being set up by nursing colleagues in Maidstone and Tunbridge Wells and the ICB. We plan to work with the Mind and Body community of practice to achieve more shared standards on how people with severe mental health problems are supported when they are in acute hospitals.

Mental Health Urgent and Emergency Care (UEC)

The vision for this workstream is that every Kent and Medway resident requiring Urgent and Emergency Mental Health care or support will find access easy and timely, and experience high quality, therapeutic care and support, in the least restrictive setting possible and close to home.

Urgent and Emergency Care achievements to date include



- Completing the roll-out of safe havens across Kent and Medway with safe transfer between sites via a newly commissioned mental health conveyancing service.
    - Medway and Thanet (co-located with A&E, 24/7). Data shared by the ICB team shows an example of the positive impact of the Medway Haven opening.
    - Community safe havens in Canterbury, Maidstone, Tunbridge Wells, Dartford, Ramsgate and Folkestone
- A sit and wait offer as part of the conveyancing service, whereby healthcare workers relieve police officers in emergency departments when they bring in section 136 patients.
- Opening a crisis recovery house in Medway.
- NHS 111 select mental health service.
- Right person right care successful go live.
- Section 136 pathway improvement project.
- Hear and Treat telephone service offering mental health clinical advice to police and ambulance and phone interventions for the person they are with.
- See and treat, where rapid response staff are conveyed via mental health response vehicles to undertake urgent assessment. The vehicles are designed to enable therapeutic assessment to take place within them.

Teams are working together to finalise shared metrics across the ICB and KMPT for measuring the impact of the joint programme.

Implementation of further improvements planned include

- Co-located safe haven on William Harvey site in East Kent by early 2025.
- A&E Liaison meeting core 24 across all hospital sites by the end of March 2025
- NHS 111 Text Messaging Service: Ensure service users can access mental health support via NHS 111 by text by 2025.
- Crisis recovery houses for Ashford in November 2024 and Margate in May 2025
- Centralised health-based place of safety in May 2025

The ICB and KMPT are also working with the collaborative to bring together plans for housing and step down to support the KMPT programme to reduce the number of patients who are clinically ready for discharge.

Dementia

This programme reports to both the Ageing Well Board and MHLDA Provider Collaborative to improve the dementia diagnosis capacity and diagnosis rates across Kent and Medway to achieve a diagnosis rate of 66.7%, with an in year target of 63%.

The work includes internal KMPT work to improve the Memory Assessment Service diagnostic capacity and system work to increase overall diagnostic capacity.

Improving KMPT pathways within the Memory Assessment Service as a standalone service

The acute Memory Assessment Service (MAS) has been the main source of diagnostic capacity in Kent and Medway. It has experienced sustained high levels of demand since 2020 that outstrip capacity.

A stand-alone service is being rolled out with the intention of generating consistent capacity to support the diagnosis of patients who cannot otherwise be diagnosed in local care or via a community-based service.

- Between February and May 2024 demand and capacity modelling took place for the rollout.
- By early October 2024 the updated model will have been rolled out.
- Over the coming twelve months Plan Do Study Act cycles will take place across HCP areas to embed improvements.

Further funding will be required to strengthen provision and financial modelling and gap analysis are being completed.

Improving overall system capacity

System partners recognise that the scale of demand requires a broader response including strong input from community and primary care. A joint workshop took place in July 2024 between KMPT and the Aging Well Board to review system opportunities. Scoping has been carried out during August and a task force is meeting in September 2024 in order to develop a community pathway for assessment and diagnosis with a more robust model of care and increased capacity. This will be jointly chaired and report to Ageing Well and the MHLDA collaborative.

The joint steering group will agree a future pathway in partnership with clinicians to ensure that the system makes best use of specialist skills and grows capacity to meet the need. For example, General Practitioners with enhanced roles are already working with memory assessment services to bolster capacity and the Aging Well Board is keen to work in partnership with mental health professionals to provide further community based support to diagnosis.

Timescales for system wide work

Action	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Workshop									
Internal redesign									
Scoping									
Task and Finish									
System plan									
System delivery									

Reducing out of area placements for autistic inpatients

The Out of Area Autistic In-Patient Placements programme aims to significantly improve the care and placement of autistic in-patients within Kent and Medway.

There are 29 autistic placements in acute, rehabilitation and specialist placements, 10 of whom are currently placed out of area. We want people to be as close to home and in the least restrictive environment possible.

By the end of the pilot (April 2025), the team set out to reduce the number of autistic in-patients unsuitably placed outside the Kent and Medway geographical location by 25% and reduce the number of all autistic in-patients by 10% through a comprehensive review and resettlement programme that includes clinical reviews of every patient and quality review of every provider. This target requires approximately three patient moves altogether, which is a low number, but will have a high impact on patient experience and effective use of resources. The team has already exceeded this target, with four discharges to date, three of which were for patients in out of area placements.

These discharges provide significant opportunities to increase independence after long hospital stays. The programme is also aiming to reduce unsuitable admissions for autistic people and the length of stay for autistic people in inpatient settings. Efficiencies will be reinvested into community care.

Conclusion

This paper sets out the current picture for three of the MHLDA PC's programmes. A collaborative Urgent and Emergency Care workshop is taking place in early October to firm up joint working and metrics for this programme. We will continue to share updates here for these programmes and for new programmes as they come on board.

A more detailed board workshop is also planned in October as part of the Board seminar, where we will share outcomes, metrics and detailed timeframes for discussion.

Below are the programme charters for:

- Out of area autistic inpatient repatriation
- Mental Health Urgent and Emergency Care
- Community Mental Health Framework implementation
- Dementia

Appendix: Programme Charters

Project Name: Out of Area Autistic In-Patient Placements
Date: 08/04/24 Updated By: G.Matuska, G.Lawrence, A.Sigfrid

1. Governance

Exec Sponsors: Nick Brown (KMPT CMO)
Clinical leads: George Matuska
Information Lead: Holly Partridge
Finance Lead: Geoff Lawrence
Quality Lead: Alice Sigfrid
Project Managers: G.Matuska, G.Lawrence, A.Sigfrid, J.Kerrigan

Gateway

2. Description

Aim:
By the end of the implementation period (April 2025), reduce the number of autistic in-patients unsuitably placed outside the Kent and Medway geographical location by 25% and 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.

24/25 System Objectives:
- To reduce the OOA cohort by 25% and the entire cohort by 10% by the end of the 12-month period
- 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.

Currently resource:
For the project trial to succeed three additional roles (the complex care coordinator for autistic people) have been recruited with one co-Ordinator yet to commence working.

Key Interdependencies:
- The success of the trial is dependent upon working collaboratively and transparently with all system partners, to achieve the objectives set out. Communication is key.
- The Kent and Medway Dynamic Support System continues to flag and track autistic people with escalating needs

3. Timeline and key milestones

Lead	Milestone/ Target Description	Date	RAG
AS	Cohort complete and 50% of reviews undertaken	Jul 24	Complete
AS	100% of reviews undertaken and discharge plans completed	Sep 24	On Track
AS	5% of cohort either stepped down or EDD in next 3 months	Dec 24	On Track
AS	10% of cohort stepped down or EDD established.	Mar 25	On Track

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF the Kent and Medway Dynamic Support System do not maintain communication with all system partners as well as ensuring that the project team are kept informed of newly identified autistic people in inpatient settings **THEN** the team cannot review, the autistic person's needs, review the placement provider, support the planning for discharge **RESULTING IN** a further increase of autistic people potentially unsuitably placed in inpatient settings	20	The Deputy Director for Learning Disability and Autism in the ICB is part of the project team and joins all project planning/ review meetings providing a link between the trial team and dynamic support system. The trial team manager is also now part of the Dynamic support forum meetings, which are crucial to success.	4
IF the project is unable to recruit and retain the desired number of complex care coordinators **THEN** there may not be enough capacity during the planned trial period to review the autistic people's needs, review the placement provider, and support the planning for discharge **RESULTING IN** autistic people who might be ready to be discharged or are receiving poor quality care to remain inpatient and/or remain poor quality care	12	The RRT manager will continue to repost job advertisements as it is known from the RRT's previous setup trial for MH that it can take several rounds of recruitment to fill team posts	6
IF the trial project cannot evidence its effectiveness in assuring that autistic people are receiving good quality inpatient care and or can be supported to be successfully discharged **THEN** the commissioner of the trial will not have any evidence to support future developments **RESULTING IN** an end to the trial without becoming BAU	20	The collection of evidence re: the effectiveness is being collected from the trial start is being shared with commissioners regularly and will be shared as part of a report prior to the end of the trial	4
IF the Community Mental Health Framework transformation is not fully embedded across Kent and Medway **THEN** the CMH teams will not be in a position to ensure the smooth transition of patients from their inpatient setting **RESULTING IN** delayed transfers of care, inappropriate placements and poor patient experience	20	The RRT manager and Complex Co-Ordinator will ensure that community Mental Health processes and procedures are in place and will work with CMH to ensure a smooth transition upon step down/discharge	4

5. Impact Assessment

Impact Assessment	RAG	Date completed	Date approved	Review date	Key issues raised (if applicable)
Quality Impact Assessment		23/4/24	7/5/24		
Equality Impact Assessment		23/4/24	7/5/24		

6. Activity Assumptions

The caseload has now been collated and agreed. All patients have been prioritised with this placed in Out of Area providers given the highest priority. It is important to realise that activity can only be measured against those patients that are commissioned by Kent and Medway ICB and where provision of care is their responsibility and not the Provider Collaborative nor NHS England.
A report will be carried out monthly detailing the entire cohort and the elements within it so that senior management completely understand the scale of the project but simply and easily. It demonstrate performance against target, admissions, discharges, changes in diagnostic presentation, gatekeeping and monitoring length of stay.
As at July 2024 the cohort is at 29 patients. Those patients who are receiving S117 aftercare or are the commissioning responsibility of NHS England or the Provider Collaborative have been removed. Recruitment is now complete and the team has been fully staffed since 8th July. The first quarterly review took place at the end of August.

Project RAG

7. Financial Overview

Budget is monitored on a monthly basis and will be reported to the project group identifying surplus or shortfall.
For indicative purposes - Out of Area 24/25 FOT £5.8million | Kent and Medway 24/24 FOT £3.9million.
Since the start of implementation there have been 4 discharges, one from KMPT and 3 from out of area. Whilst there are costs to consider for ongoing care in the community the reduction in bed day costs for 24/25 is estimated to be £1,152,620.

8. Non Financial Benefits and Quality Metrics

- Reducing or assuring the length of stay for treatment of a MH need
- Facilitating discharges of autistic people unsuitably placed in inpatient settings
- Gain assurance of the quality of placement providers that are out of area
- Autistic people experience and or report a better outcome for them
- Autistic people with escalating community needs are better support to prevent the need for inpatient admission for assessment and or treatment
- Length of Stay metrics to be reported.
- Patient Experience surveys to be introduced during stay and upon step down/discharge

9. Communication and Stakeholder Engagement

- A steering group including all system partners will be introduced to discuss and report the months activities and also any issues that arise from conducting reviews or where the Complex Care Co-ordinators have experienced issues with Providers.
- A full report of the months activities will be circulated to all stakeholders including the MHLDA PC, the ICB and KMPT, ensuring good governance is maintained.
- Stakeholder communication will be promoted by undertaking several sessions with teams in KMPT to explain the role of RRT and the processes that we have put in place . This also included a a session on "how to do an application to OATS panel" . Link workers from CMHTs who are partnered with each Care coordinator from RRT are encouraged on a monthly basis to discuss any matters of concern.
- In Q2 of the project the neurodiversity directorate leads will be introduced to the Complex Care Coordinators .

Programme Name: Mental Health UEC

Date: 08/07/24 Updated By: Louise Clack

1. Governance

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

Gateway

2. Description

Service Users experiencing mental health crisis/illness can contact NHS 111 Select Mental Health via a text messaging service (in addition to telephone) by 2025.
80% of Service Users experiencing a mental health crisis that requires clinical assessment will wait no more than 4 hours to receive this
- 100% of Acute Trust Hospitals will be CORE 24 compliant by 2024
Service Users experiencing a mental health crisis or illness can access a suite of community crisis alternatives including Safe Havens and Crisis Beds over a 24hr period.
Service Users requiring primary conveyance to a hospital following a community mental health act assessment will be conveyed safety and with dignity by a bespoke transport service.
80% Service Users experiencing acute mental illness who cannot be cared for at home, will be admitted to a bed within 12 hrs of the decision made to admit.
Service Users admitted to an inpatient bed will experience a purposeful and trauma informed, therapeutic admission and wait no longer than 48hrs to be discharged once clinically ready for discharge.
Service Users contacting SECAMB with primary mental health crisis will receive mental health intervention at home by mental health clinicians either March 2025 by telephone or face to face, or conveyed to a Safe Haven to avoid conveyance to an Emergency Department
Service Users with mental health crisis and in contact with Kent Police will receive mental health intervention by mental health clinicians either by telephone or face to face or conveyed to a Safe Haven; incidence of Section 136 will reduce by 30%.
Service Users detained on Section 136 will be conveyed to a Health Based Place of Safety by Ambulance 80% of the time, and on arrival in a HBPoS and will be looked after solely by health care professionals within 1 hr of arrival and will be discharged from the HBPoS within 24hrs of arrival.

3. Timeline and Key Milestones

Lead	Milestones	Date	Target
ICB	Ashford Crisis Recovery House planned Go Live	Sep-24	Nov 2024
ICB	Bespoke conveyance and sit and wait planned Go Live	Sep-24	Launched
ICB	See and Treat 2 hr response planned	Mar-25	On Track
ICB	Full Recruitment to CORE 24 in all Hospitals	Mar-25	On Track
ICB	Publishing of revised Crisis 136 Standards	Mar-25	On Track
ICB	Margate Crisis Recovery House Planned Go Live	Apr-25	May 2025
ICB	Centralised HBPOS Go Live	May-25	On Track
ICB	Maidstone Crisis Recovery House Planned Go Live	Oct-25	Confirming Update

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF there are increased numbers of inpatients clinically ready for discharge **THEN** people are waiting for admission in environments that are not able to meet their clinical and safety needs and at times have their deprivation of liberty deprived, **RESULTING IN** possible major injury and poor patient experience and corporate risk to Providers and Commissioners within the Provider Collaborative	16	Crisis Recovery House, Safe Havens, Step Down bed procurement, MH and Housing Strategy devpt. Use of private beds clinical risk assessment and clinical management of individual patients	16
IF there are insufficient number of trained AMHPs then there will be delays in the AMHP Service to respond to requests for MHA Assessments, resulting in challenges to timely patient flow for patients accessing the right care at the right place, for example in the Health Based Places of Safety..	12	Training request made to KMPT.	12
If the hard of hearing line , and crisis text service is not made available via the Urgent Crisis Line (NHS111 select mental health option), the service will not comply with NHSE requirement and will not meet the needs of some service **users or meet NHSE requirement.**	16	Plans afoot to implement both hard of hearing and crisis text service by Q4	12

5. Impact Assessment

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

6. Activity Assumptions

The Provider Collaborative is working with Kent and Medway ICB to agree on final metrics for this programme. The workshop is taking place on the 2 Oct to finalise these.

Project RAG

7. Financial Overview

Adult Safe Havens	£3.7m
Crisis Recovery Houses	£1.2m
Mental Health and Housing Consultancy	£70K
Liaison Psychiatry	TBC
Liaison Psychiatry uplift	£1.4m
Patient flow enablement (e.g. step down beds)	£1m
Mental Health Conveyance	£1.2m
External consultant to lead on a mental health and housing strategy	£70K
Hear and Treat/See and Treat	£800K

8. Non Financial Benefits and Quality Metrics

- Right Care delivered by the Right Person
- Improved service user experience
- Improved patient safety
- Improved Carer experience
- Least restrictive care provision
- Enhanced system integration and innovation

9. Communication and Stakeholder Engagement

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

Programme Name: CMHF

Date: 18 Mar 2024 Updated By: Tanya Parker

1. Governance

Gateway

Exec Sponsors: Donna Hayward –Sussex (KMPT)
Clinical leads: James Osborne
Information Lead: Nigel Lowther
Finance Lead: Nicola George
Quality Lead: James Osborne
Project Managers: Sophie Brett, Rosie Lawson

2. Description

Aim: CMHF transformation, which is called Mental Health Together, will respond to all mental health referrals in a timely and knowledgeable manner, providing an appropriate, responsive and safe outcome. Outcomes are focused on the needs of the person and includes both urgent and routine responses, along with onward transition to more appropriate services when required. MHT teams also provide interventions for people with complex mental health conditions; ensuring people are put on the right pathway using a stepped care approach.

24/25 System Objectives: 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; 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.

Not currently resourced: Full model will not be implemented until contract award and recruitment of additional staff has been carried out.

Key Interdependencies:
MAS Roll out; NHS 111 roll out; HCP Estates strategies; Collaborative working with PCNs; Interoperability of digital systems

3. Timeline and key milestones

Lead	Milestone/ Target Description	Date	RAG
Sam Gray	East Kent Phase 1 MHT Go Live	Jan 24 – April 24	Complete
Shurland Wilson	North Kent Phase 1 MHT Go Live	May 24	Complete
John Lavelle	West Kent Phase 1 MHT Go Live	May 24	Complete
VS	Phase 2 implementation commences	Jul - Aug 24	Started

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF it is not possible to recruit to new roles due to existing workforce issues **THEN** MHT may not be able to deliver agreed interventions **RESULTING IN** patient's not receiving a mental health service within 4 weeks that meets their presenting needs		• A system wide recruitment drive to promote job roles to be flexible and attractive to candidates. • Working closely with stakeholders to establish and utilise existing staff to avoid unnecessary recruitment. • Skill-mix interventions model, which includes Lived Experience roles.	
IF staff do not engage with the new PROMs mandated by **NHSE** **THEN** take up will be low **RESULTING IN** low numbers of clinical outcome measures which will limit the efficiency of trailblazer evaluation		DIALOG+ training has commenced and has good feedback and take up. Roll out plan developed. DIALOG+ guidance to be developed	
IF KMPT is not able to establish the right contracting mechanism **THEN** it may not be possible to fulfil the role of Lead Provider and sub-contract with partners **RESULTING IN** delays to recruitment for trailblazers and the wider roll out of MHT		• Scope of KMPT's Lead Provider responsibilities now clarified. • Governance structure for contracting being established. • Contract award to partners anticipated end of March 2024	

5. Impact Assessment

Impact Assessment	RAG	Date completed	Date approved	Review date	Key issues raised (if applicable)
Quality Impact Assessment		TBC			Seeking update
Equality Impact Assessment		TBC			Seeking update

6. Activity Assumptions

The work is being underpinned by recruitment in each area. The PC team are confirming with CMHF team which of the IQPR measures will be used.

Project RAG

7. Financial Overview

£2.6m from ICB 2023/24. 24/25 will be the remaining £8m. Spend will be driven by contract award and subsequent recruitment. Spend will not limit delivery. First contract signed off end of March 2024. Next steps with VCSE partners will be confirmed following this.

8. Non Financial Benefits and Quality Metrics

- Dialog+ and 4 Week Wait are the metrics used for quality and performance measures.
- Benefits realisation to be developed

9. Communication and Stakeholder Engagement

Planned: KMPT community staff – x3 online sessions scheduled in coming few weeks (4,9,23 April)
•Series of meet and greet events for staff who will work as part of MHT from across the system – x2 complete (Thanet, Ashford & Canterbury), x4 in the diary – aligned to dates ahead of the go-live of MHT in each area
Complete/ongoing from 2023:
x3 Local Mental Health Network events cross county, GP's Protected Learning time presentation (approx. 300+ GPs in attendance), and Primary care training hub sessions.
•Submissions on progress of the roll out featured regularly in system-wide newsletters, including the ICB GP update newsletter and regional HCP newsletters
•Visibility of MHT at all KMPT Big Conversation events at the end of 2023
•MHT stand at KMPT and ICB AGM's (September 2023)

Programme Name: Dementia

Date: 23/07/2024 Updated By: Adrian Richardson

1. Governance

Exec Sponsors: Adrian Richardson (KMPT)
Clinical leads: Rakesh Koria (Ageing Well) Efiong Ephraim (KMPT)
Information Lead:
Finance Lead:
Quality Lead:
Project Managers:

Gateway

2. Description

Aim: The overarching aim of the Kent and Medway Dementia Programme is to increase the level of pre and post-diagnostic support for people affected by dementia by 1) Supporting people to live healthy lives, 2) Supporting people with dementia to receive their diagnosis, 3) Improving the care for people with dementia or suspected dementia, and 4) Providing support for carers and families.

24/25 System Objectives: Increase diagnostic capacity across the system towards a rate of 66.7%, with in year target of 63%. This programme will collectively report to Ageing Well and MHLDA PC to look at ways to improved the dementia diagnosis rates across Kent and Medway.

Not currently resourced:
Scoping to be confirmed pending identified opportunities

Key Interdependencies:
- KMPT Dementia Improvement Programme (sitting internally within KMPT) looking at stand-alone Memory Assessment Services and novel model for diagnosis.
- Mental Health Together, Mental Health Together +
- Ageing Well Dementia Programme (additional three themes will be impacted

3. Timeline and key milestones

Lead	Milestone/ Target Description	Date	RAG
AR/RK	Dementia workshop in collaboration with Ageing Well	Jul 24	Complete
AR/RK	Scoping Opportunity	Aug 24	Complete
AR/RK	Task and Finish Group	Sep 24	On Track
tbc	Delivery Plan (for further expansion)	To Mar 25	On Track

4. Key Risks

Risk	PRE-MITIGATING SCORING	Mitigating Action	POST-MITIGATING SCORING
IF the programme is not appropriately resourced **THEN** it will not be possible to deliver **RESULTING IN** regional reputation damage and patients unable to access ongoing treatment and support services	16	Collaboration between MHLDA PC and Ageing Well Board and discussion on resourcing to occur	
IF the DDR rate is not achieved **THEN** People living with dementia will not have access to appropriate treatment and support services **RESULTING IN** harm to patients and carers, increasing pressure of resources outside of dementia services	12	System-wide plan is being developed to support mitigation.	
IF the waiting list is not reduced **THEN** the 6 week to diagnosis ambition will not be met, leading to patients not receiving cholinesterase inhibitors that will delay the progression of dementia **RESULTING IN** lack of effective management of symptoms, not maintaining independence in own homes and a rise in crisis situations leading to avoidable hospital/care home placements	20	KMPT BI to produce trajectory to understand backlog and recovery plan. There are weekly activity updates and we are starting to see the impact of the work reflected in the figures.	
IF recurrent funding is not approved **THEN** a community-based MAS will not be possible **RESULTING IN** insufficient diagnostic capacity in K&M, loss of skills developed in primary care, and reputational risk	15	Financial modelling has taken place to understand the gap. Preparations are underway for future funding.	

5. Impact Assessment

Impact Assessment	RAG	Date completed	Date approved	Review date	Key issues raised (if applicable)
Quality Impact Assessment		TBC			
Equality Impact Assessment		TBC			

6. Activity Assumptions

Achieve 66.7%: 1,865 additional people need to be diagnosed.
Sustain 66.7%: Estimated flow 110 diagnosis per week or 150 diagnostic appointments

Dementia Diagnosis Gap: As of May 24 the dementia diagnosis rate is 59.6%. An estimated 25,124 people in Kent and Medway will have dementia There is currently 1664 people undiagnosed within Kent and Medway. Of these, only 15.173 people or 59.6% are on the Dementia Register. Compared to other ICBs, Kent and Medway is 16th out of 17 organisations .

Diagnostic Capacity:
Acute MAS services are currently the main source of diagnostic capacity in Kent and Medway. It has experienced sustained high levels of demand since 2020 that outstrip capacity. The combined service responds to both organic and functional needs.
A stand-alone service is being rolled out with the intention of generating consistent capacity to support the diagnosis of patients who cannot otherwise be diagnosed in local care using DiADeM or via a community based service.
GPwERs are currently working within the acute MAS to support service capacity. The community-based model proposed should deliver 50% of the required diagnostic capacity, releasing pressure from acute MAS services and sustaining the DDR.

Project RAG

7. Financial Overview

The acute MAS model is built into the CMHSOP block contract that services both functional and organic activity.

DiADem in care homes is built into the EHCH contract but it is not felt that funding is sufficient to mobilise.

8. Non Financial Benefits and Quality Metrics

We want to increase diagnosis rates, so we can ensure people receive the right care and treatment.

9. Communication and Stakeholder Engagement

Joint programme of engagement with the Ageing Well Board and other partners.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Trust name change
Author:	Kindra Hyttner, director of communications and engagement
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose:	Approval
Submission to Board:	Board request

Overview of Paper

This paper seeks board approval to apply to the Department of Health and Social Care (DHSC) change the name of the trust from Kent and Medway NHS and Social Care Partnership Trust (KMPT) to Kent and Medway Mental Health NHS Trust (KMMH), and to give the Chief Executive delegated authority to respond to any DHSC consultation on the name change.

Issues to bring to the Board's attention

Culture, identity and staff experience is one of our six organisational priorities. We have done extensive listening, research and engagement with our patients, people and partners as part of this work, which the board has seen and discussed in full, along with our plans. This feedback has led to:

- A new identity, vision, and set of cultural values to unite staff and connect with our stakeholders
- A clear position on who we are and our impact
- A recommendation to change our name to accurately reflect our services and better connect with the public

While we did not start this programme of engagement with the intention to change our name, we heard consistently from all stakeholders that our name presents a confused and unclear picture of what we do, who we are and who we serve. We also haven't been a social care partnership trust since 2019. Our name is a big part of our identity and is something we should all be proud of, it is important we name ourselves based on the core service we provide - mental health.

We are seeking board approval to change our name to provide a clearer, accurate reflection of our remit and enable us to connect more effectively with the public, patients, partners and our people.

The formal change is subject to the Department of Health and Social Care amending our trust establishment order and ministerial sign-off. They have signalled that if we request the change after board, this is likely to be completed in 2025 and that we should realistically aim for 1 April 2025 as ‘go live’. We have planned to spread out the costs over the remainder of 24/25 and into 25/26 so we can effectively manage the financial and resource implications.

Governance

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

Why we are changing our name

We heard consistently from all of our stakeholders, through extensive engagement for our culture, identity and staff experience priority, that our name is confusing and shares little connection with how people describe us. There is an overwhelming belief, both inside and outside the organisation, that people don't know what KMPT does and so their first impression is one of confusion or misunderstanding.

Staff member: "Whenever you have to say where you work, there's absolutely no point in saying KMPT or Kent and Medway NHS and Social Care Partnership Trust because nobody knows what that is."

Patient: "I don't even know what KMPT means, it's confusing."

Partner: "It makes no sense why KMPT has partnership and social care in its name when it's a mental health trust."

In addition to what we heard from our stakeholders, our current name does not reflect our legal status or service provision. We haven't been a social care partnership trust since 2019.

Changing our name is an exciting and unique opportunity to create a much-needed new identity – one that is clearer, enables us to connect more effectively with our stakeholders and that we are proud of. Every part of our name should be treated as valuable real estate that can support our strategy and our new identity. The first step is to improve and increase recognition of the trust, and the way to do that is to use a descriptive name based on the core service we provide - mental health.

Constructing our name

Our options are limited due to NHS naming conventions and guidelines. We must include:

- Who we serve: the people of **Kent and Medway**
- What we provide: specialist **mental health** services
- Our legal status: an **NHS Trust**

Our new name would be: **Kent and Medway Mental Health NHS Trust (KMMH)**

We would maintain our site and ward names, which are localities from across Kent and Medway and already well known and recognised by our stakeholders.

Changing our name is exclusively about ensuring effective communication and clarity of purpose among our stakeholders. It does not signify any change in the status of power of our organisation or delivery of services. Therefore, we are not required, beyond the extensive engagement already carried out, to run a formal public consultation. We have engaged stakeholders on the proposed name to check it is clear and understood, and received no objections (stakeholder captured in Appendix 1).

The formal process

We have spoken with both NHS England and the Department of Health and Social Care regarding the name change and understand the formal process. This is set out below, along with the steps we have already completed. We do not need to run a statutory public consultation as there is no change proposed to our status or service, and the reason for the change is based on extensive engagement with our patients, partners, people and public. We have the full support of our system partners, including the Kent & Medway Integrated Care Board, and NHSE South East region.

1. Check with your regional NHS England communications team that your proposed new name follows NHS naming principles – *actioned and agreed.*

2. Check with NHS stakeholders that your proposed new name won't conflict or be confused with the names of neighbouring NHS organisations or services – *actioned and agreed.*

3. Engage with patients and the public to check your proposed new NHS name is clear and understandable – *actioned. We have tested our new name, alongside our new visual identity, with all stakeholders, including our staff, and there were no objections to its clarity (a list of those we engaged with is in Appendix 1).*

4. Seek board approval – *for board approval today.*

Assuming the board approves the name change today, we must then:

5. Contact the Department of Health and Social Care with the reason for the change and demonstrating your engagement – *We are prepared to do this immediately following board approval.*

6. If agreed, the department will draft the change to the NHS Trust's Establishment Order, via an Amendment Order, for our NHS Trust board to approve.

7. The Amendment Order then has to be approved and signed by the minister.

8. Inform key stakeholders as soon as possible of our new name so they can update their records (e.g. Care Quality Commission, MPs, local authority and Healthwatch organisations) – *We have already established a working group across the trust to map out and prioritise what activity needs to happen, when, so that we are prepared.*

We have been informed by the department that stages 5 to 7 can take a minimum of three months at least but they have suggested a 1 April 2025 change date would be realistic for us to aim towards.

Rolling out the name change

We will minimise any associated costs in changing our name and deliver value for money by being pragmatic about how we roll it out, and by capitalising on improvements we need to do regardless. For instance, a lot of our trust signs, and indoor areas patient areas are out of date and in poor condition, and our public facing website and patient literature needs modernising to make them more effective and accessible for patients and the public.

We have sought feedback and lessons learned from a number of trusts and NHS colleagues who have gone through changing a trust name. All have shared a phased roll out is the most cost and resource effective way of doing this.

A name change working group, consisting of key trust departments, has been established. It has mapped out the required changes and estimated costs of circa £400,000 over two years. However, this

is taking into consideration the changes and modernisations that already need to be completed. We therefore estimate the costs simply in relation to change the name would be closer to £250,000

Assuming the name change formally happens in 2025, we plan to utilise funding we have ringfenced across both 24/25 and 25/26 to deliver this, and we will roll out the changes in priority order so we can effectively manage the resource implications. We will continue to work closely with partners, staff and patients to agree the timings and nature of these changes.

The communications and engagement team will have a continued, critical role in communicating effectively with our stakeholders in advance of the change taking place and when it happens. We had hoped to launch the new name and trust values together, but it isn't necessary, so we will go ahead with the formal launch of the values in January 2025.

Risks and mitigations

Risk	Impact	Mitigation
We are told we have to stop due to ongoing system financial challenges and further controls.	This will affect the morale and engagement of our staff, and our reputation with our stakeholders, which will ultimately impact on how we do things and the quality of care we deliver.	We can afford this change and have built it into our financial position. Many of the expensive changes required as part of the name change were planned to do regardless e.g. signage and website. We will continue to work with the system to develop a longer term plan for any additional controls. A unified approach, and a clear and robust communications and engagement plan will be created. We have a trust working group established and dedicated resource, as well as robust governance in place to monitor and successfully deliver this work.
We will have two names running concurrently as we phase roll out.	This could lead to confusion among our stakeholders, and staff feeling less valued in areas where we don't change their site straight away.	We have mapped out the changes required and will be focusing on priority changes from day 1 with a phased roll out, and a focus on patient facing materials. Targeted messaging will explain this. For example, on day one we will explain to staff why we will need to prioritise high patient footfall sites (like the main hospitals), over staff-only sites (e.g. Magnitude). We will run a communications campaign ahead of the change to inform all stakeholders it's happening and what it means for them. We have been conducting an audit of our patient facing materials (e.g. leaflets) and will hold back printing non-urgent leaflets to reduce the amount of 'KMPT' branded collateral in the public domain.
Vulnerable patients might think KMPT is no longer in existence	Confusion and anxiety among our patients.	Our communications and engagement plan will mitigate this.
A name change alone won't change our culture	We won't see immediate changes to our strategic outcomes.	Our name is one important part of our identity, but we have a number in plans in place across the culture, identity and staff experience priority to grow our culture which complement the name change.

Our stakeholders don't like the name change	They will feel disengaged and unhappy.	As with any change, people will come on the change curve journey at different points. Our communications and engagement activity will reflect this, and continue to explain why the name change is happening – which ultimately has been driven by our stakeholders' request. The chosen name follows NHS naming principle guidelines and clearly explains who we are, what we do and who we serve.

Indicative high- level timeline for the name change

Conclusion

We never set out to change our name as part of this work to transform our culture, identity and staff experience. The extensive engagement we have done with our stakeholders, which we have never done before, gave us a solid recommendation and mandate to change our name to something that is clearer and allows us to connect more effectively with our audiences. It also gives us a platform to be proud of what we do and who we are, which we heard is very important to our people too. It is vital we listen to all the feedback we heard and act on it. Changing our name is a critical part of our new identity and a step forward for us on our journey to be the outstanding organisation we aspire to be.

Appendix 1

Who we engaged with

The decision to change our name was a direct outcome of the extensive engagement we completed with staff, patients and partners about our identity totalling over 730 hours ranging from surveys to workshops, events and 121 interviews. Ongoing engagement has taken place with key stakeholders as we have developed our thinking and ideas to shape our new identity, which has included testing the visual and written identity, name change and values with all of our audiences and responding to their feedback.

Engagement on and informing our identity	Engagement on the proposed name
Cultural transformation (equality, diversity and inclusion): • Survey responses from around 1,000 staff in relation to diversity and inclusion • Listening into action sessions for staff at Bands 2 to 7 • Cultural competence assessment with 259 senior leaders **KMPT's identity** • 3 x identity agency workshops and 15 focus groups with clinical and non-clinical staff (over 250 staff) • Workshops with senior leaders • 10 interviews with EMT, board, senior leaders • Interviews and surveys with external stakeholders and partners • 3 x service user workshop and surveys • A survey of staff in relation to KMPT's identity completed by 800 staff. **Staff survey questions added on identity** • Responses from around 1,900 staff **Deloitte well led review** • Desktop review to understand the effectiveness of governance and leadership • Interviews with 15 board members and senior leaders • A survey completed by 411 staff in relation to governance and leadership; • Interviews with 7 stakeholders to understand external perceptions of governance and leadership; • 2 focus groups with staff in relation to governance and leadership; • Observations of a number of Board Committees to evaluate effectiveness of governance and leadership.	• CEO wrote to 108 stakeholders and partners - including all Kent and Medway MPs, council leaders and health leads, HOSC and HASC chairs, voluntary sector organisations, community groups (with a focus on harder to reach communities), and members of the Kent and Medway system (including police and SECAmbs). These received little feedback other than acknowledgments of receipt of the letter (positive verbal feedback shared) • CEO presented to all system CEO colleagues and spoke to NHS SE region to seek approval. • CEO blog issued to all staff. No objections to clarity of name change. • Social media posts issued – which achieved more than 15,200 impressions (opportunities to see) encompassing members of the public, some staff and patients/their families. 47 comments received with the significant majority supporting the change of name and name chosen and none objecting that the new name is clear and understandable.

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Violence and Aggression Update
Author:	Ilias Rentoulis, Head of Operational Excellence
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an update to the Board, on the progress of the Violence and Aggression Strategic Priority, specifically for the period since we have implemented the Safety Culture Bundle. The number of overall incidents will be explored, as well as the experience of staff in using this approach.

Issues to bring to the Board's attention

We are seeing that in most teams, when compared to rates of incident reporting in 22/23 there are strong early signals of improvement. However, improvement can be initially overshadowed by the increase in reporting that is a feature of sensitising staff to the issue of violence.

Sustaining gains is largely characterised not only by the way the tools and techniques are used by the testing teams in terms of their reliability, but the engagement and leadership within these teams. Where these have not been so strong, we can see that a combination of under reporting, a lack of rigour around the use of the tools at their disposal – in this case the Safety Culture Bundle – can make judgement about improvements harder to verify. This is why both measurement and the stories of the staff involved in this work is so important. There are really heartening improvements, but it is still early days and the work on this area continues.

Governance

Implications/Impact:	Patient and staff safety
Assurance:	Reasonable
Oversight:	Strategy Deployment Group and Board Sub-Committees

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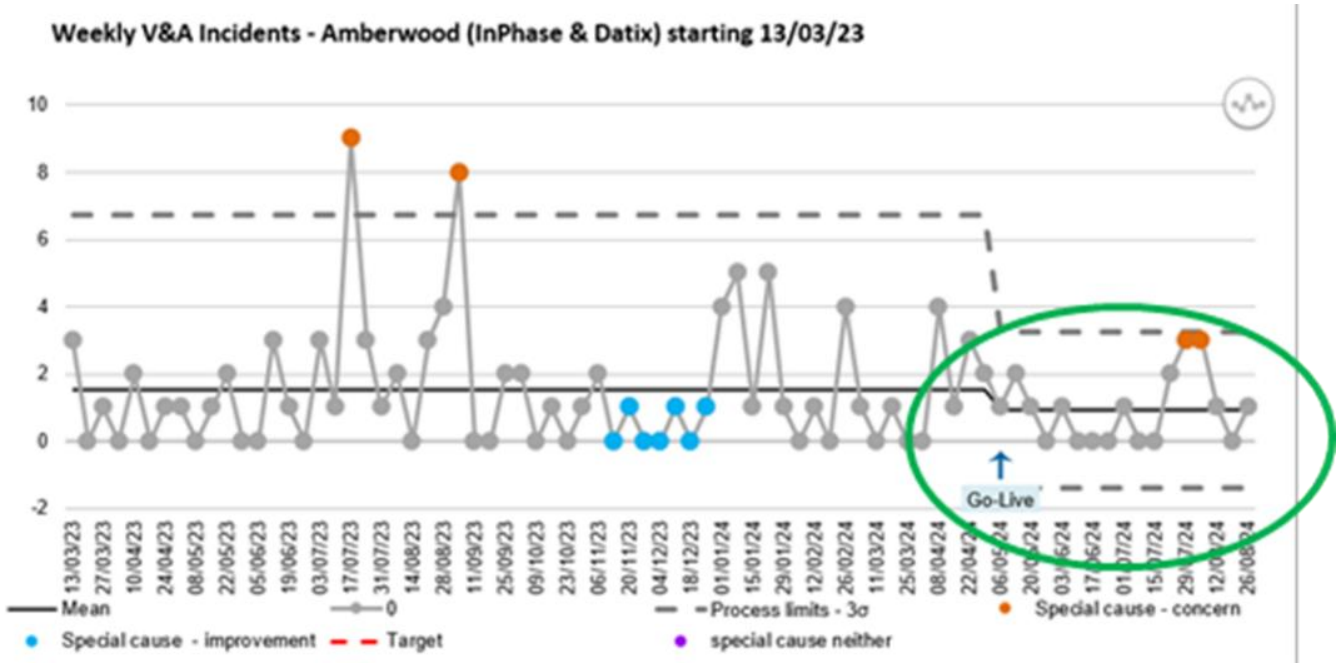
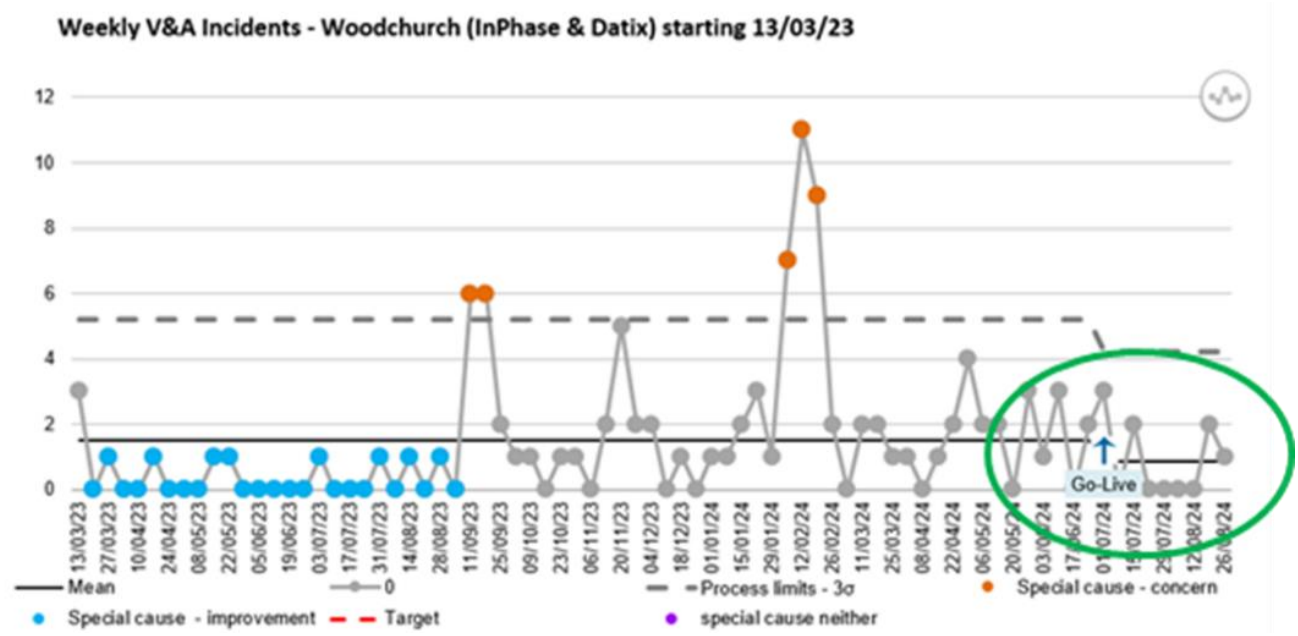
1. Introduction

This paper provides an overview of the work that has happened so far with the Violence and Aggression Strategic Priority, the introduction of the Safety Culture Bundle (SCB), and demonstrates why sometimes it can be difficult to demonstrate improvements using aggregated data and present the impact in staff experience since we started supporting them with Violence and Aggression work.

Positive Impact of the SCB

Amberwood and Woodchurch are good examples where we can see a reduction in the mean number of incidents since the 'go-live' with the SCB.





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2. Early indications of Improvement

In the chart below, you can see just how much improvement has been made against the baseline data from 22/23. There are some teams showing a now broader consistency in improvement with others only recently joined the work. This means that although the figures shown in Mean Variance to baseline below are really impressive, it is highly likely that over time, this will change and we will see, once these teams mature in this work (by sustaining the gains over 6 months), that we will have a more realistic picture of the scale of improvement. On the current trajectory this may settle as an overall improvement of between a 60-70% reduction in violence.

Ward	Prv. Month	Current Month	Baseline Mean (Average No. of Incidents in 22-23)	Current Mean (Since go-live)	Mean Varience to baseline
Bluebell	12	26	69.8	12.4	82%
Upnor	12	0	55.3	12.4	78%
Chartwell	14	9	58.9	10.1	83%
Boughton	8	6	64.6	10.2	84%
Orchards	3	6	35	7.2	79%
Fern		55	53.6	55.0	-3%
Foxglove	6	6	63	5.3	92%
Sevenscore	8	0	72.5	5.0	93%
Cherrywood	8	6	56.4	5.3	91%
Pinewood	5	7	36.4	6.3	83%
Amberwood	1	3	41.8	2.3	94%
Willow	20	13	60.2	15.3	75%
Ruby	1	5		3.0	
Jasmine	11	4		7.5	
Heather		25		25.0	
Woodchurch		4		2.0	
Bubble					

We can see that now, some teams are having several of weeks without incidents, when that was not the case before. It is the combination of several days/weeks without incident and the decline in overall conflict on the wards (including verbal aggression) that is a signal of the maturity of the work.

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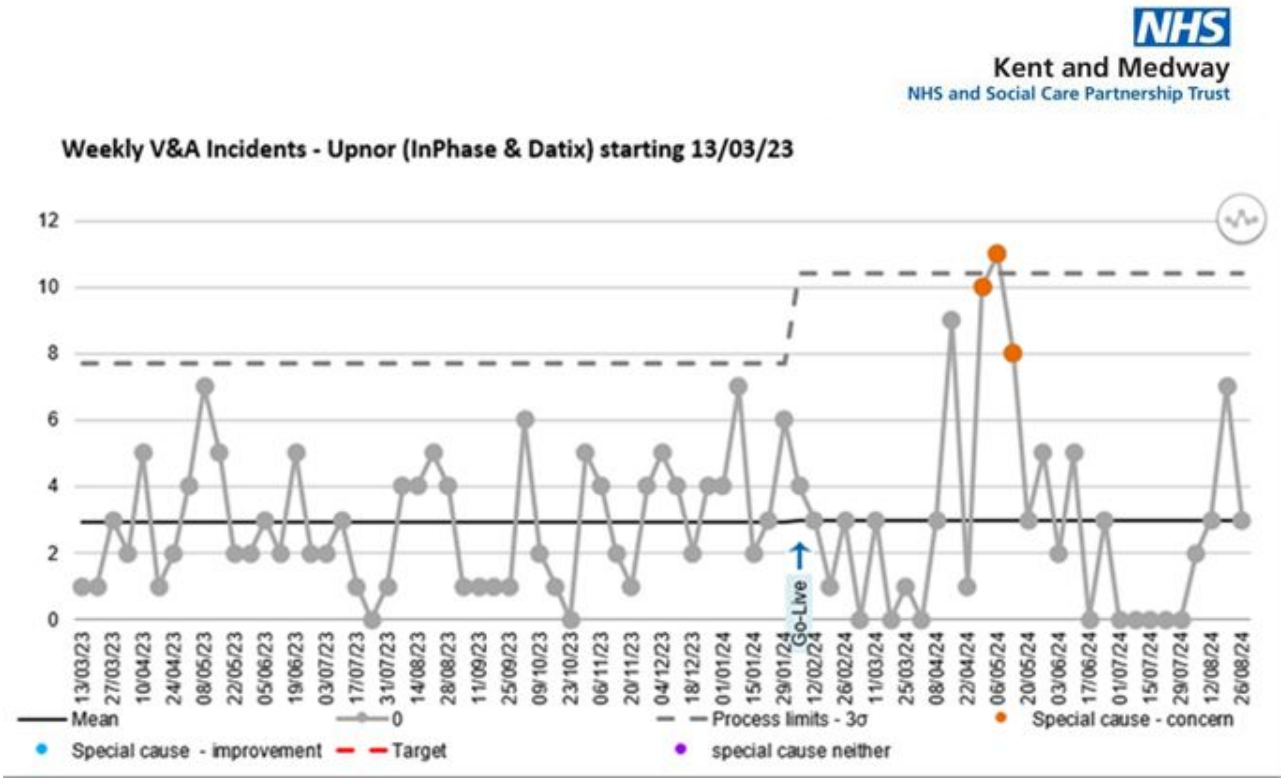

3. Staff Feedback Since the Beginning of the SCB Roll-Out

Alongside the improvement in incidents, we have seen improvement in the experience that our colleagues are having within the testing teams.

From our colleagues that have completed our survey (51):

- Over 70% agree or strongly agree the SCB has made an impact on communication between staff and patients
- Around 73% agree or strongly agree the SCB has made an impact on transparency about incidents
- Over 68% agree or strongly agree the SCB has made an impact on gaining patient views on what triggers agitation

Also, in their own words, our colleagues told us that SCB:

- Raising awareness of patients and their current presentation
- Provides a clear action plans to reduce risk
- Aids reflection and communication
- Helps with quick identification of issues
- Improves team work

Not all feedback is positive - it is worth noting that those who have been impacted by violence have to negotiate the sequelae of that – meaning their views on both their own agency in reducing violence and aggression and how the events have affected them, inevitably influence how they see and engage with this work. Other themes are around capacity, huddle frequency, staff turnover and not seeing the value of the SCB.

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4. The general expected trend of improvement

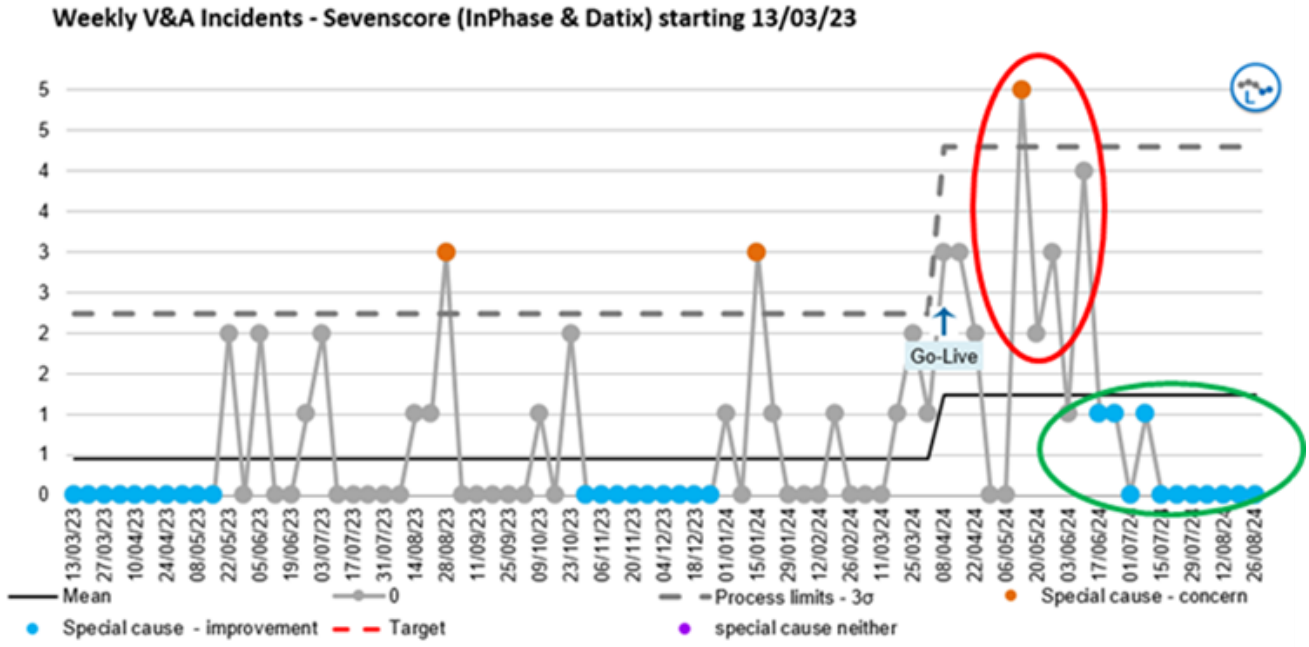
Below is an example, in this case of Sevenscore Ward that demonstrated what we expect to see when we start the SCB roll out. This is:

- A spike in the incidents, demonstrating that colleagues in the wards are reporting more/all the incidents.

- The data to stabilise and slowly start reducing over time.

It is worth noting that this fluctuation will, as a consequence, increase the mean for a period of time.

Also, when we are comparing the period before and after SCB implementation, it is noted that around March 2023 was when we changed from Datix to InPhase this resulted to a period of under-reporting as our colleagues familiarised themselves with the new system.



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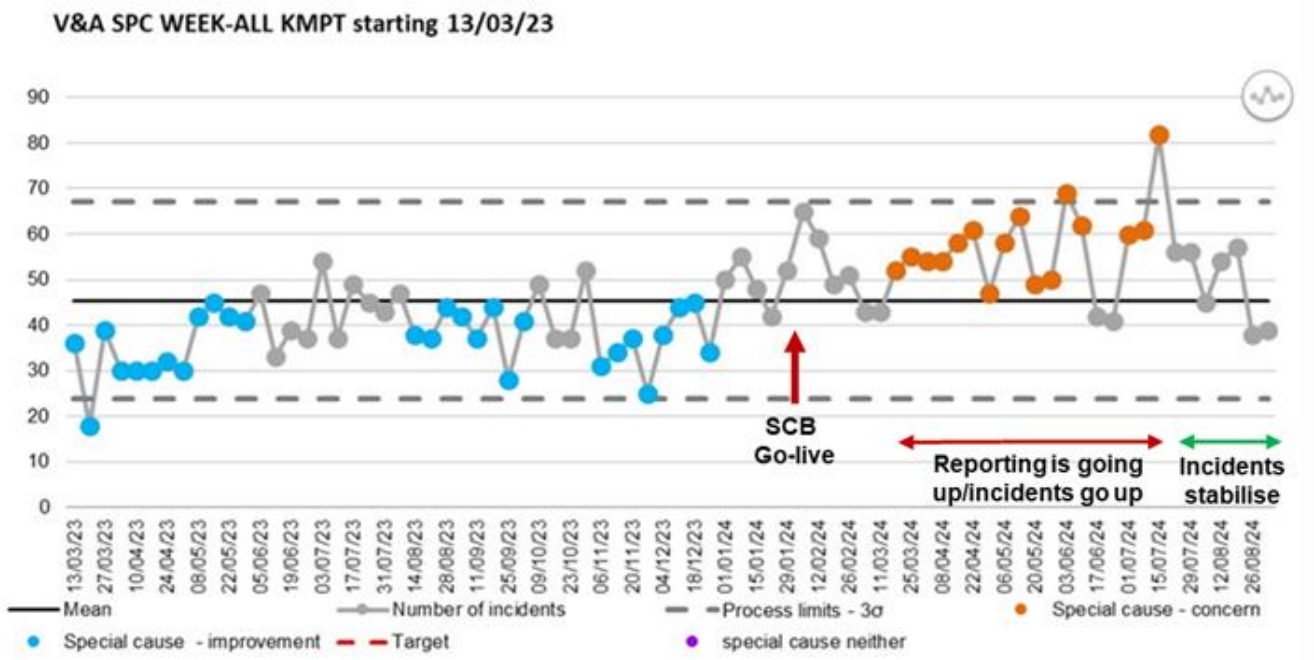
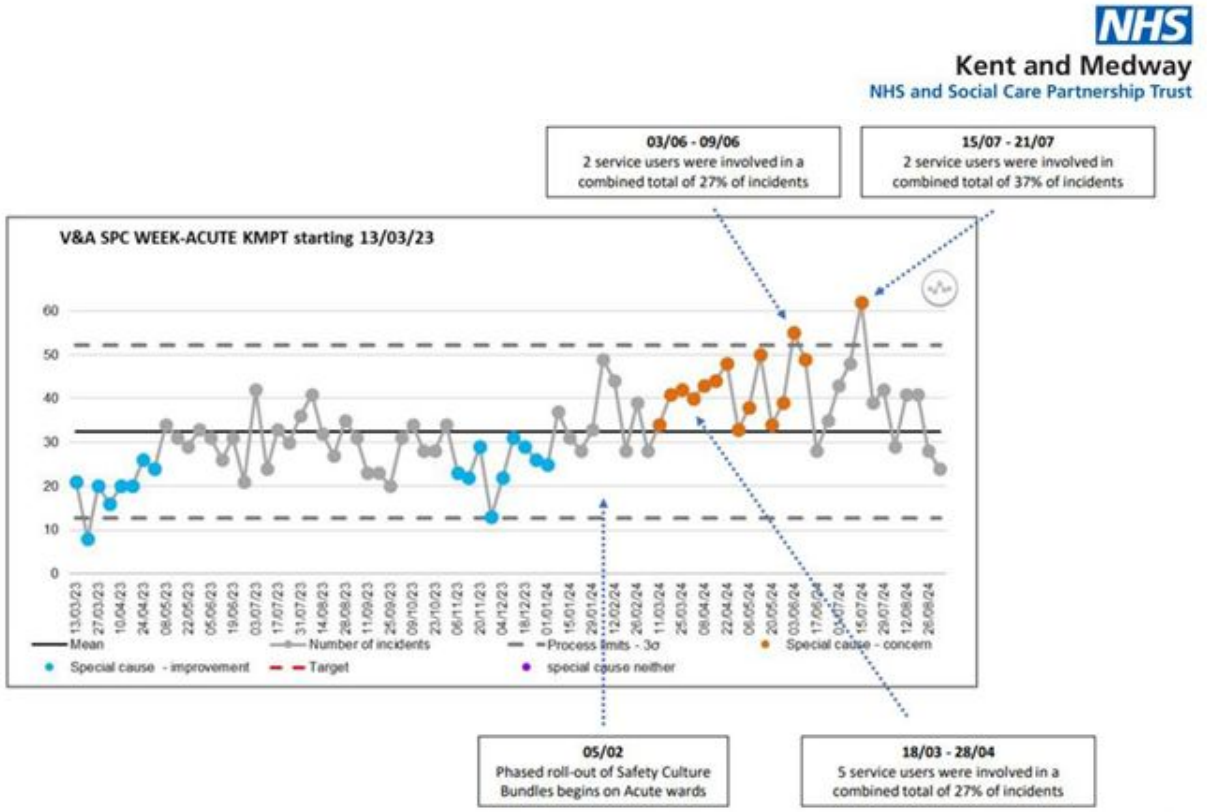
On a bigger scale and looking at the overall data we can see a similar pattern but the increase is sustained as more teams join the programme. It is anticipated that the overall improvement will be detectable in the aggregated data in the next couple of months.



It is sometimes difficult to demonstrate consistent improvement as incidents that involve a small number of patients can skew the overall data resulting in peaks for certain teams – this effect is amplified when several teams have a patient who requires lots of intervention to manage conflict.

From analysing ward level data we can see some teams that have been making great progress have a sudden increase in incidents and that this is usually attributable to a single patient. This can mask underlying improvements and when the incident data for that individual is removed from the calculations, we often see a reducing incidence of violence and aggression on those wards.



In

Targeted Improvement Work

A trial of a 'Rapid Improvement Event' specifically for incidents of racial abuse, was undertaken with the team on Willow Suite.

This is a targeted work in a short period of time where the problem, current state (data) and target are presented initially and then the root causes of the problem are identified.

In Willow's case, the team used a fishbone diagram to identify factors contributing to incidences of racial abuse. We then split the factors to controllable and non-controllable, and focusing on the controllable ones.

For every route cause identified, we have collectively decided on a target action point, called countermeasure. This is a blend of quick wins and things that we need to test using the Plan-Do-Study-Act (PDSA) approach.

Whilst it is early days to track the overall effect of this work – it is a good way to get teams focussed on what they can do to reduce these incidents.

5. Next Steps

Now that we understand the challenges around V&A, work is being undertaken with the Business Intelligence team, to explore how to provide the services with a more sophisticated dashboard that the team can see an interact with to understand how they are doing.

This dashboard and improvement huddle will have 4 elements:

1) Alongside the overall data, will also have the specific for the service incidents on a Statistical Process Control (SPC) format as well as the breakdown by incident.

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2) Balancing measures, like bed occupancy, staffing levels, rapid tranquilisation, admission rates and so on.

3) Maturity of SCB – which will focus on the use of the tools and learning from them.

4) The space to discuss the change ideas that each service is testing and their impact.

This will help to move this to business as usual, with arms-length support to help them sustain their gains and adjust as the prevailing needs of their patients requires.

Finally, in September we are happy to announce the SCB roll out to the Forensics and Specialist services, starting with Tarentfort Unit in Dartford and proceeding to all wards over the coming 2 months.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 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.

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 where performance has improved and also where continued focus is required to ensure we improve at pace. There are a number of areas where we need to do things differently to improve access to our services and deliver the best outcomes for our patients. My six priorities are these areas of focus, but as we move into the autumn, the 3 areas that will need relentless focus are dementia, mental health together and flow.

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)

September 2024

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1. Chief Executive Overview

This report highlights where performance has improved and also where continued focus is required to ensure we improve at pace. There are a number of areas where we need to do things differently to improve access to our services and deliver the best outcomes for our patients. My six priorities are these areas of focus, but as we move into the autumn, the 3 areas that will need relentless focus are dementia, mental health together and flow.

Patient flow

As we move into the autumn / winter this priority will be of significant importance. Managing flow has become increasingly difficult over the last month or so. The executive team have agreed that we will re-focus the patient flow programme to focus on 3 main areas, if we can make progress on these areas we will see an improvement in managing flow as we move into winter. The 3 areas are; CRFD including our internal discharge processes, OA LOS and Readmission rates. We have re-run the data that supports the patient flow programme and improvement in these 3 areas equate to 18 beds. This is where our focus will be in the coming months.

We have undertaken a review of readmissions over the summer and we have sadly noticed that we have been mis-reporting our readmission rate. The metric contained within this report has been counting unplanned readmissions only. There is an underlying issue with the use of and recording of admissions codes and this is being led clinically to ensure this is corrected moving forward. Therefore, our total readmissions rates are 12%, which is 3% above the national average. Hence this is now a focus area as part of the patient flow programme. We can see in the data that the Dartford site has the highest readmission rates across our three acute sites.

Dementia

Our dementia diagnosis times continues to be an area of concern. It is too early to tell at this stage the impact the new Memory Assessment Service (MAS) model will have on the diagnosis rate as we have not yet finished rolling this out across all the teams. Following a monthly high of 642 diagnosis being recorded in July, compared to 195 in April, there was a reduction to 338 in August. There is still a lot of data cleansing going on and the continued roll out of the new model which will be completed by the end of September. Weekly reporting is in place to the executive team on progress.

A recently published National Audit of Dementia from the Royal College of Psychiatrists shows that our challenges in this area are comparable to the national picture and provides valuable insights into the challenges we are all facing and potential solutions. We will be using this audit to help inform phase 2 and 3 of this work.

Mental Health Together

We are now routinely capturing the baseline outcome measure for Mental Health Together (MHT) 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.

We know from the data, and from speaking to our people and partners, that we are seeing a significant and increasing demand into the new service across all our teams. This is approximately 10% higher than comparable levels pre MHT and has resulted in a waiting list exceeding 5,000 as at mid-September. It is recognised that reducing thresholds into services has also had an impact on people being accepted for a mental health Together social intervention or treatment.

Voluntary sector organisations are now recruiting to all new roles, once onboarded we expect to see a decrease in waiting times for interventions. Continuous learning recognises that the process at the front door can benefit from further modification to improve efficiency and waits, this work is being urgently taken forward.

On a positive note, the introduction of Mental Health Together continues to result in 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 percentage of abandoned calls is now 50% lower than a year ago.

Further areas I'd like to note;

- Clinical appointments resulting in Did Not Attends (DNAs) have been steadily increasing in recent months. A deep dive analysis has taken place which has identified a wide range of factors that impact DNA's including patient's preference for one to one sessions as opposed to groups they are offered and delays in appointment letters, however the greatest factor was data quality and ensuring DNA's are recorded accurately. Instances of

cancellations being recorded as DNA's were identified as were inconsistencies in how unsuccessful telephone calls were recorded. There is a DNA policy review group commencing this month which will look at service specific approaches alongside the overarching policy, these initial findings will contribute to this work. MHT will be the initial focus of this work due to it having greatest impact on the DNA figures accounting for 52% of first appointment DNA's and 38% of follow ups across the trust.

- We continue to have a daily focus on 12 hour waits in our liaison services. If we can make real progress in the coming months on our patient flow priority this will support us in enabling timely admission to our inpatient services, this is critical for us to maintain flow. We continue to work with our acute trust colleagues to support the joint management of patients in emergency departments. In the short term we may see a slight increase in out of area bed usage to ensure we admit patients in a timely manner where appropriate.

- On a positive note, there are some areas of performance to be celebrated. Firstly, our vacancy gap continues to be below the target we have set ourselves and we are seeing continued progress in recruitment. Importantly our leave rate (voluntary) is passing our target, which is an encouraging sign linked to all the culture work we are undertaking across the organisation. I also wanted to reference the work being undertaken on reducing violence and aggression on our inpatient wards, early data capture is indicating that we are seeing a significant reduction of violence and aggression on our wards following the work that we have undertaken in the past few months. This is fantastic news, there is a separate report on today's Board agenda that highlights our progress with this priority.

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.	Variation indicates inconsistently passing and falling short of the target.	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) 3.1.06: Safer staffing fill rates	1.3.08: Complaints acknowledged within 3 days (or agreed timeframe) 3.1.01: Staff Sickness – Overall 4.1.07: Agency spend as a % of the trust total pay bill	
	Common cause – no significant change.		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)	1.1.14: Care spell start to Assessment within 6 weeks (MAS only) 1.1.15: Care spell start to Treatment within 18 weeks 1.2.10: %Patients with a CPA Care Plan 2.1.04: Clinically Ready for Discharge: YA Acute
	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.		3.1.07: Ince percentage of BAME staff in roles at band 7 and above	1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans 1.4.05: Decrease Violence and aggression on our wards 2.1.05: Clinically Ready for Discharge: OP Acute 4.1.01: Bed Occupancy (Net)

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.	1.1.02: Open Access Crisis Line: Abandonment Rate (%) 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.	1.1.01: Open Access Crisis Line: Calls received 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 1.4.06: Medication errors 2.1.03: MHT 2+ contacts 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	4.1.04: In Month Budget (£000) 4.1.05: In Month Actual (£000)	

4. Trust Wide Integrated Quality and Performance Dashboard

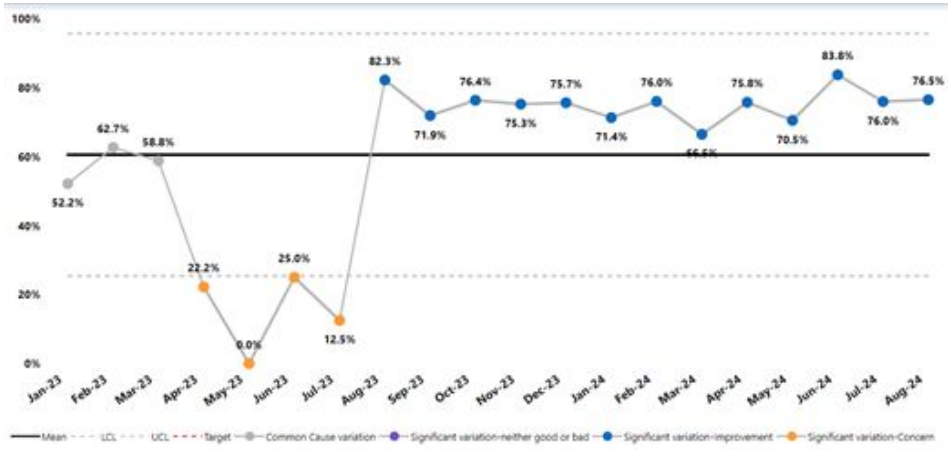
People We Care For: Access

Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
1.1.01: Open Access Crisis Line: Calls received		5,248	5,249	5,473	5,380	5,842	4,737	4,900	3,604	3,258	3,022	3,640	3,415
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		45.4%	41.4%	44.9%	43.7%	42.3%	39.5%	42.3%	37.1%	34.1%	25.0%	28.1%	22.5%
1.1.03: Assess people in crisis within 4 hours		71.9%	76.4%	75.3%	75.7%	71.4%	76.0%	66.5%	75.8%	70.5%	83.8%	76.0%	76.5%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		0.0%	0.0%	0.2%	2.3%	4.4%	5.2%	9.9%	30.1%	46.0%	58.4%	69.5%	77.4%
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%	1.4%	0.0%
1.1.06: Place of Safety LoS: % under 36 hours		60.7%	82.5%	76.7%	78.6%	50.0%	56.0%	40.5%	60.5%	57.8%	74.5%	69.8%	79.7%
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%	65.2%	76.9%	64.7%	94.1%	71.4%	61.5%	66.7%	53.3%	76.5%	100.0 %	61.1%	60.0%
1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks		7.6%	14.5%	15.5%	9.7%	4.6%	6.2%	7.5%	7.7%	8.8%	25.5%	11.1%	16.9%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		75.0%	72.7%	73.6%	60.0%	80.0%	67.7%	84.2%	62.5%	78.6%	79.3%	67.7%	78.1%
1.1.10: Perinatal assessments (against annual target)	2,103	146	158	163	118	145	139	113	485	138	157	160	114
1.1.13: Care spell start to Assessment within 4 weeks (Excl. MAS)	75.0%	58.6%	53.3%	63.7%	57.6%	54.5%	72.5%	72.5%	71.5%	71.0%	52.3%	58.9%	60.2%
1.1.14: Care spell start to Assessment within 6 weeks (MAS only)	75.0%	30.6%	36.6%	37.0%	34.4%	29.2%	37.9%	41.1%	41.7%	43.3%	47.2%	46.2%	45.5%
1.1.15: Care spell start to Treatment within 18 weeks	95.0%	71.9%	73.5%	75.2%	74.4%	73.2%	75.5%	77.8%	74.1%	72.2%	67.5%	66.8%	70.3%

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 & Sustained Achievement of Target

1.1.03: Assess people in crisis within 4 hours



Target	Actual	UCL	Mean	LCL	Variation	Assurance
	76.5%	95.8%	60.6%	25.4%		

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.

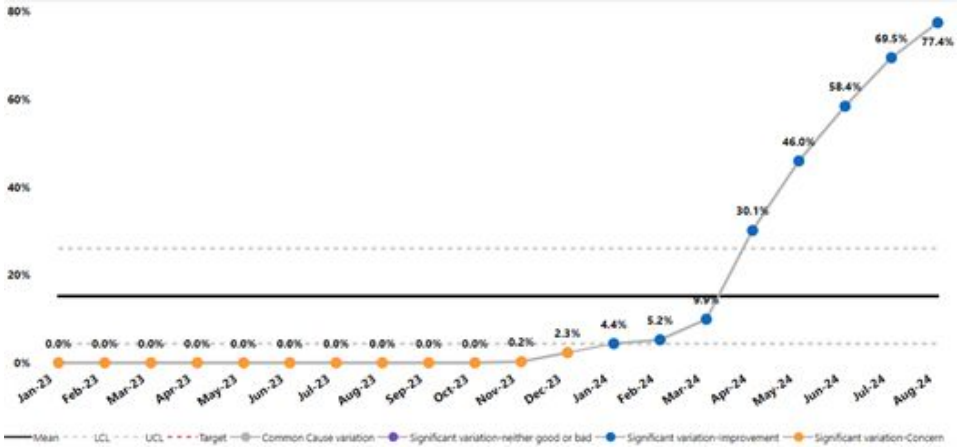
Data Quality Confidence

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. In August North Kent responded to almost 85.9% of 99 patients in crisis within 4 hours, East Kent 80.3% (122) and West Kent 60.5% (86).
There were over 300 assessments in August which is the highest number this year for any given month, the average was 249 for the previous 4 months.

1.1.04: People presenting to Liaison Services: triaged within 1 hour



Target	Actual	UCL	Mean	LCL	Variation	Assurance
	77.4%	26.0%	15.2%	4.3%		

Data Source

Rio

What is being measured?

Time from referral to a 'triage' assessment within 1 hour.

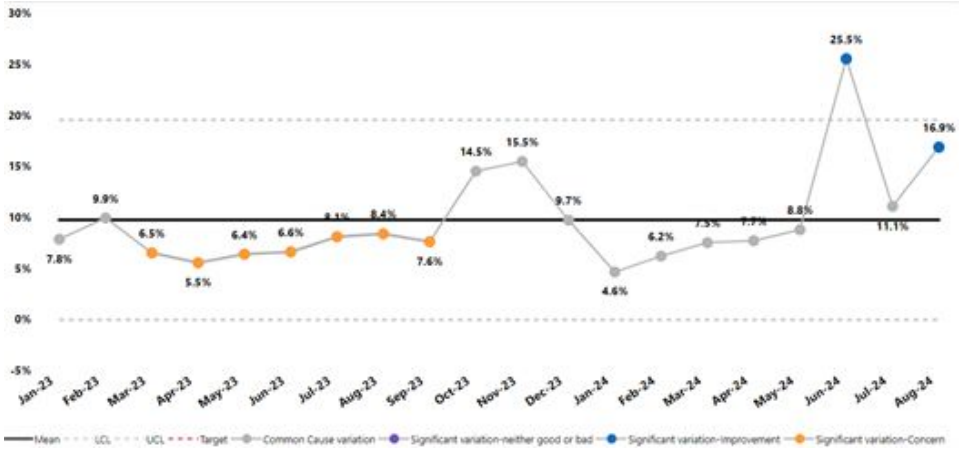
Data Quality Confidence

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?

The use of the category Triage has increased significantly, increasing the confidence that the measure is an accurate 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.

1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks



Target	Actual	UCL	Mean	LCL	Variation	Assurance
	16.9%	19.5%	9.7%	(0.1%)		

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.

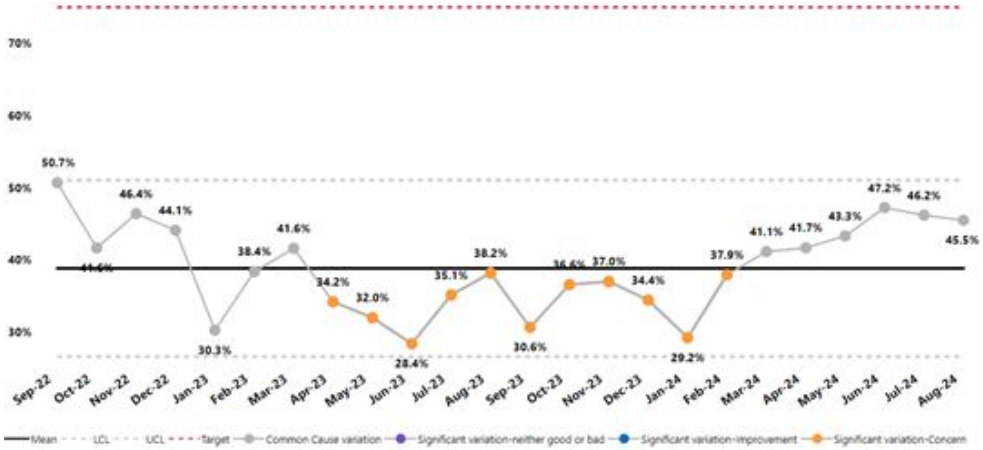
What is the data telling us?

An improvement in the number of diagnosis recorded and % within 6 weeks. 338 diagnosis were recorded in August, compared to a high of 642 in July. Wait times for diagnosis (where this was recorded) was on average 23.9 weeks, slightly above the year to date average of 23.3 weeks.

Areas of Concern

1.1.14: Care spell start to Assessment within 6 weeks (MAS only)

Target	Actual	UCL	Mean	LCL	Variation	Assurance
75.0%	45.5%	51.0%	38.8%	26.6%		



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

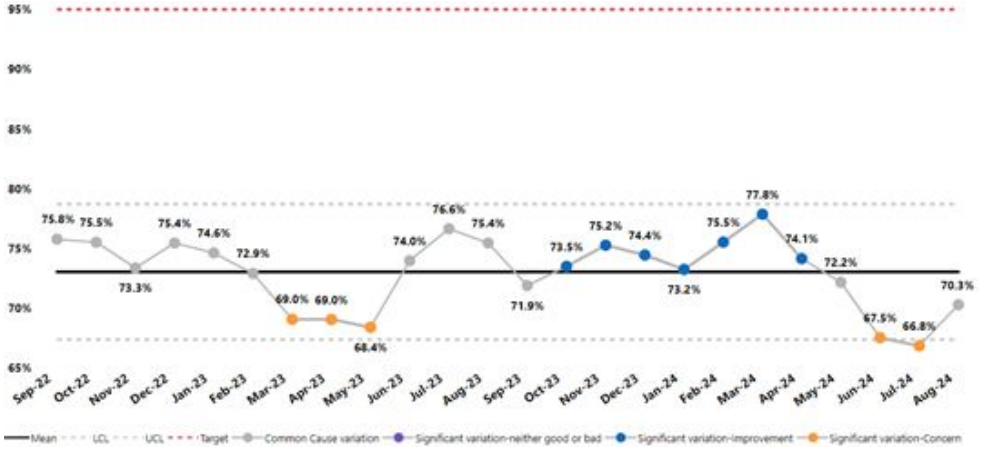
No known issues

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 achieving 66.3%) and East and West significantly below target at 35.1% and 51.9% respectively. As backlogs are cleared % compliance will remain low.
On full implementation of MAS this indicator will be retired with focus on time to diagnosis.

1.1.15: Care spell start to Treatment within 18 weeks

Target	Actual	UCL	Mean	LCL	Variation	Assurance
95.0%	70.3%	78.7%	73.0%	67.3%		



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.

People We Care For: Care Delivery

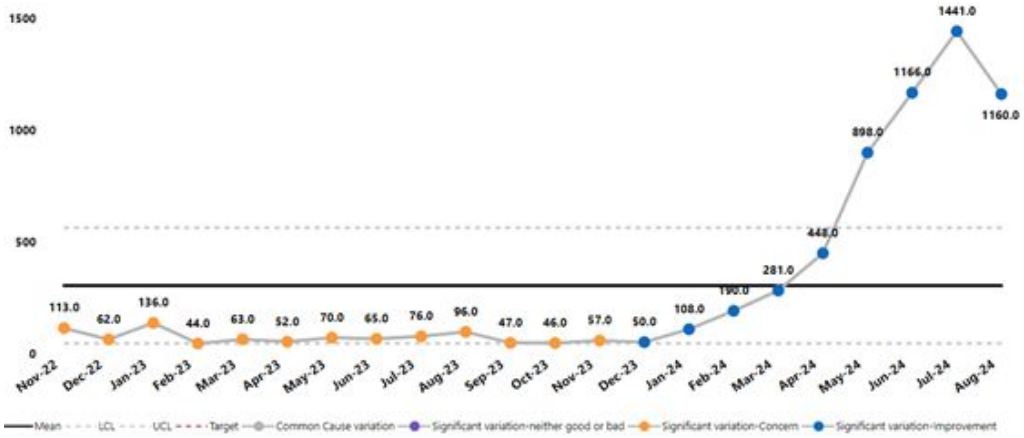
Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	29.9	33.6	32.1	27.3	45.5	37.5	32.1	44.4	35.1	42.9	35.2	42.3
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	60.2	94.8	110.3	80.7	94.9	80.8	97.7	109.0	81.2	97.9	102.1	79.8
1.2.03: Adult acute LoS over 60 days % of all discharges		13.3%	16.2%	10.3%	9.2%	16.3%	12.8%	10.8%	17.5%	11.9%	15.3%	15.5%	14.9%
1.2.04: Older adult acute LoS over 90 days % of all discharges		29.2%	41.7%	45.5%	34.8%	32.0%	34.6%	46.2%	38.7%	29.0%	34.8%	37.0%	44.4%
1.2.05: Patients receiving follow-up within 72 hours of discharge		80.9%	81.3%	76.1%	82.0%	79.8%	83.0%	88.9%	83.4%	81.8%	72.8%	83.0%	81.5%
1.2.06: Unplanned Readmissions within 30 days (YA & OP Acute)	8.8%	3.8%	2.1%	5.2%	5.6%	1.7%	3.0%	5.1%	8.2%	3.9%	2.0%	3.6%	5.4%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		376	239	250	204	263	350	280	242	291	245	340	377
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end		8	8	5	8	9	12	9	9	8	9	13	13
1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)		47	46	57	50	108	190	281	448	898	1,166	1,441	1,160
1.2.10: %Patients with a CPA Care Plan	95.0%	81.7%	83.2%	83.1%	81.0%	81.6%	83.3%	85.4%	86.4%	86.0%	87.8%	86.6%	85.6%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	77.6%	79.0%	79.2%	77.4%	77.1%	77.4%	75.6%	76.8%	75.2%	73.8%	73.7%	72.9%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	70.9%	71.2%	73.3%	70.9%	69.8%	69.9%	68.6%	70.9%	68.8%	69.0%	67.0%	65.0%

Notes: *1.2.06 Unplanned readmissions: Measure under review due to identified issue with recording of unplanned admission codes. Total readmissions within 30 days is approximately 12% compared to a national average of 9% with work underway to further analyse and address.*

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. 377 bed days were used in August 2024, 288 were female PICU patients within contracted beds resulting in 89 out of area placements days as an accurate reflection of trust performance.

Areas of Improvement & Sustained Achievement of Target

1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)



Target	Actual	UCL	Mean	LCL	Variation	Assurance
	1,160	562	303	45		

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 up to July with August seeing the first reduction. There was a reduction across all three directorates.

This will be closely monitored to establish if this reduction is temporary and seasonal or reflects natural variation as we establish a baseline of this new practice.

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.

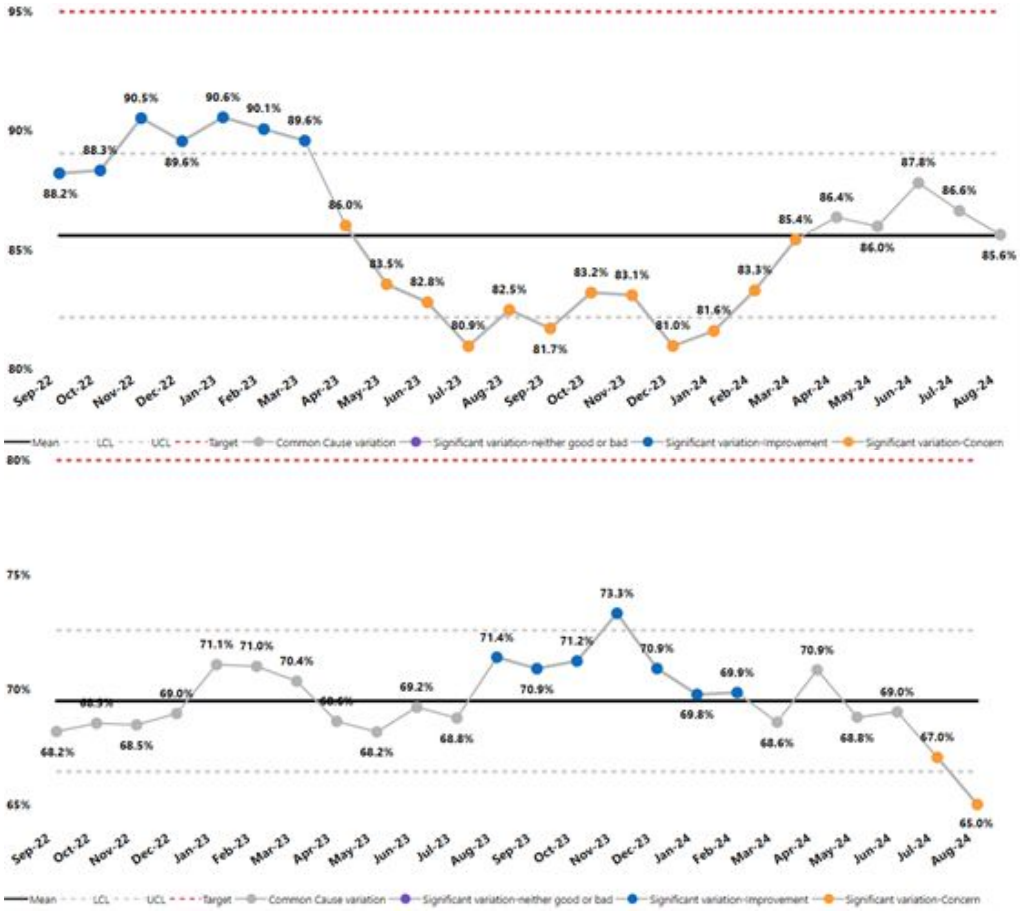
Areas of Concern

1.2.10: %Patients with a CPA Care Plan

Target	Actual	UCL	Mean	LCL	Variation	Assurance
95.0%	85.6%	89.0%	85.6%	82.2%		

1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans

Target	Actual	UCL	Mean	LCL	Variation	Assurance
80.0%	65.0%	72.6%	69.5%	66.4%		



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 targets set by ourselves 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.

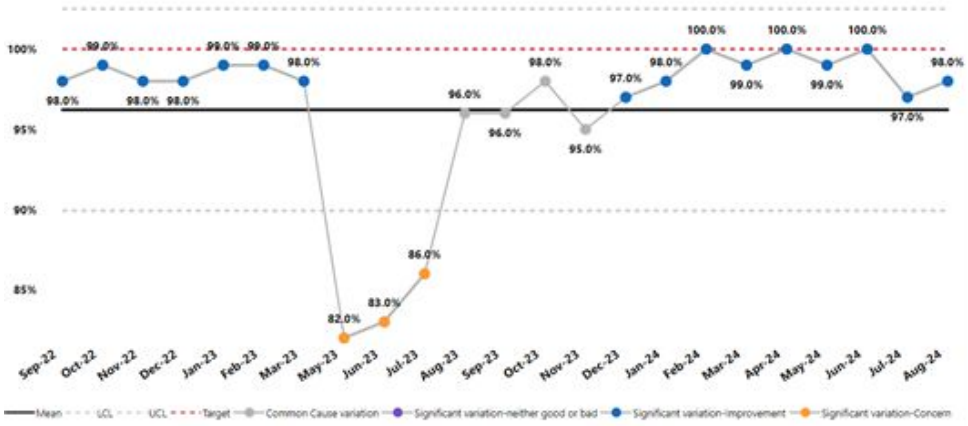
An event is taking place on 20th September to shape the future of the approach to CPA and care planning, on design of the new ways of working supporting metrics will be developed in partnership with clinical leads.

People We Care For: Patient Experience

Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	88.3%	87.1%	89.2%	87.4%	85.9%	86.5%	87.9%	87.6%	89.8%	89.4%	89.0%	89.5%
1.3.02: Complaints - actuals		47	53	48	27	44	44	35	42	43	40	46	56
1.3.03: Compliments - actuals		117	106	131	115	112	82	126	120	110	119	133	110
1.3.04: Compliments - per 10,000 contacts		35.7	30.9	38.5	41.2	30.6	24.9	39.3	35.8	32.3	37.1	37.9	34.8
1.3.05: Patient Reported Experience Measures (PREM): Response count		460	510	631	532	417	452	496	596	674	538	721	542
1.3.06: Patient Reported Experience Measure (PREM): Response rate		3.2	3.4	4.2	4.0	3.0	3.1	3.4	4.0	4.5	4.0	4.7	3.8
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.4	8.1	8.6	8.5	8.3	8.1	8.5	8.4	8.4	8.5	8.5	8.5
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	96%	98%	95%	97%	98%	100%	99%	100%	99%	100%	97%	98%
1.3.09: Complaints responded to within 25 days (or agreed timeframe)	100%	73%	65%	79%	78%	87%	91%	100%	95%	96%	95%	95%	89%

Areas of Improvement & Sustained Achievement of Target

1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)



Target	Actual	UCL	Mean	LCL	Variation	Assurance
100.0%	98.0%	102.5%	96.2%	89.9%		

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. It is positive that performance was maintained in August despite and increase in complaints (56)

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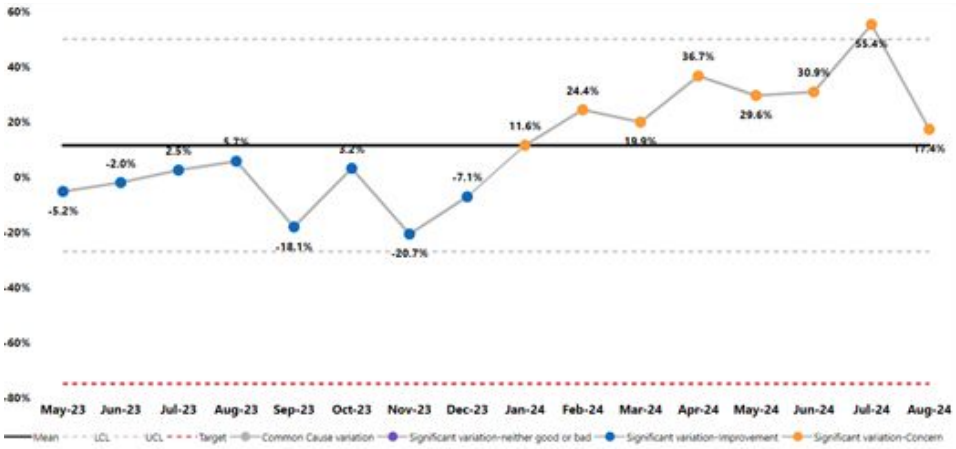
People We Care For: Safety

Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-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		544	231	159	173	162	154	150	159	142	126	144	96
1.4.03: Restrictive Practice - All Restraints		77	105	44	58	67	78	99	129	107	69	78	61
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	12	6	0	2	3	5	10	23	1	5	2	4
1.4.05: Decrease violence and aggression on our wards	(7.5%)	(18.1%)	3.2%	(20.7%)	(7.1%)	11.6%	24.4%	19.9%	36.7%	29.6%	30.9%	55.4%	17.4%
1.4.06: Medication errors		49	71	106	56	55	40	50	30	49	53	60	34

Areas of Concern

1.4.05: Decrease violence and aggression on our wards



Target	Actual	UCL	Mean	LCL	Variation	Assurance
(75.0%)	17.4%	50.0%	11.5%	(27.0%)		

Data Source

InPhase

What is being measured?

The number of incidents recorded as a % variance against the baseline (2022/23 data)

Data Quality Confidence

No known issues.

What is the data telling us?

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	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
2.1.01: Referrals to MHT & MHT+ commence treatment within 4 weeks							100.0%	40.0%	32.6%	44.2%	30.9%	25.6%	12.6%
2.1.02: MHT & MHT+ waiting list size						49	193	387	772	1,687	2,493	3,705	4,280
2.1.03: MHT 2+ contacts		16,244	16,308	16,406	16,348	16,455	16,459	16,385	16,493	16,590	16,559	16,627	16,684
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	21.6%	18.8%	21.3%	21.2%	22.3%	24.3%	20.8%	20.9%	16.4%	14.8%	12.2%	15.2%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	23.9%	28.4%	25.3%	25.9%	28.1%	34.2%	33.5%	32.9%	30.0%	28.0%	31.9%	31.1%
2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge)	44.0	63.6	84.9	71.0	89.3	69.0	61.0	71.4	99.3	74.7	89.2	89.9	45.1

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.*

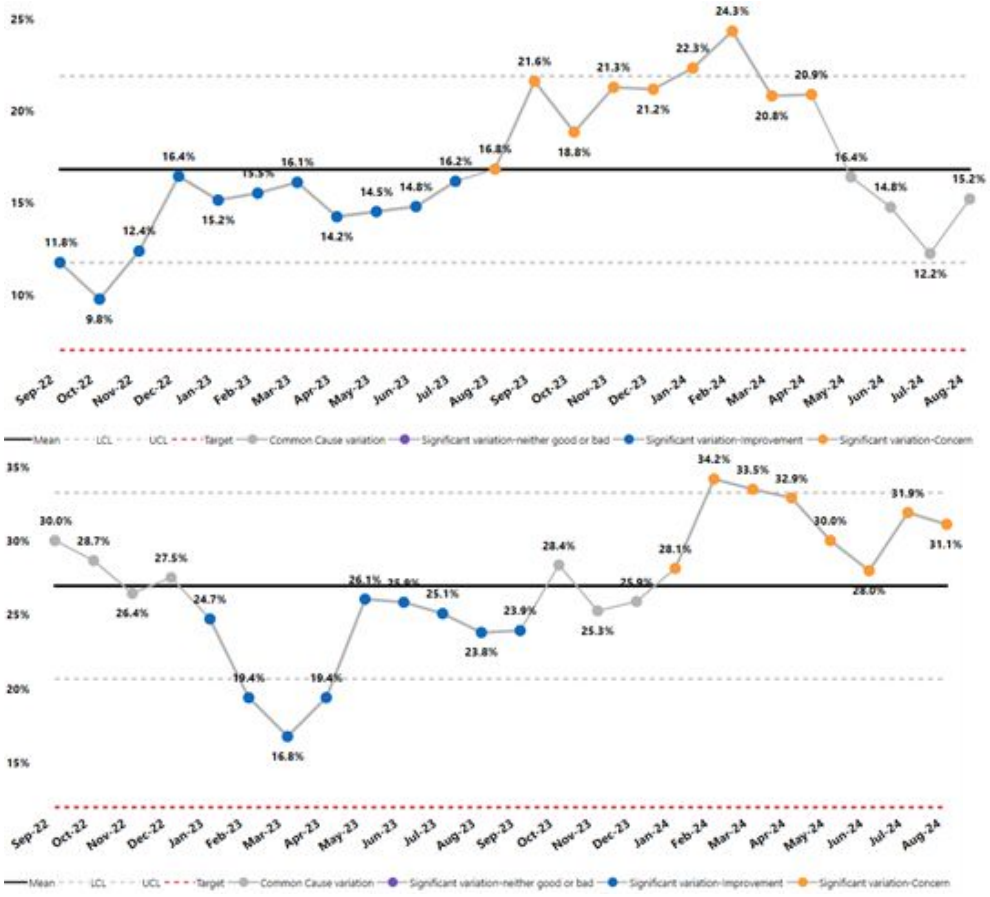
Areas of Concern

2.1.04: Clinically Ready for Discharge: YA Acute

Target	Actual	UCL	Mean	LCL	Variation	Assurance
7.0%	15.2%	21.9%	16.8%	11.8%		

2.1.05: Clinically Ready for Discharge: OP Acute

Target	Actual	UCL	Mean	LCL	Variation	Assurance
12.0%	31.1%	33.3%	27.0%	20.7%		



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?

Fourth successive month of YA being below mean. 714 bed days were lost in August (23 beds per day), the greatest impact continues to be housing

OP Acute bed days lost was above the mean for the eighth successive month. 846 bed days were lost in August (27.3 beds per day), the greatest impact continues to be those awaiting nursing home placements and funding decisions.

As of 13th September there were 62 CRFD's in acute beds of which 44 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

Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
3.1.01: Staff Sickness - Overall	5.3%	4.4%	4.9%	5.1%	5.3%	4.8%	4.2%	4.5%	4.4%	4.5%	4.4%	4.5%	4.4%
3.1.02: Vacancy Gap - Overall	15.5%	12.9%	11.8%	11.8%	11.8%	11.8%	11.9%	11.9%	12.5%	12.6%	12.6%	12.8%	12.2%
3.1.03: Essential Training For Role	90.0%	93.4%	93.4%	93.7%	94.1%	94.0%	94.3%	93.9%	94.0%	94.2%	94.4%	94.7%	94.8%
3.1.04: Leaver Rate	16.5%								14.7%	14.6%	14.6%	14.6%	14.6%
3.1.05: Leaver Rate (Voluntary)	15.0%	13.4%	11.4%	11.3%	11.8%	10.8%	10.7%	10.7%	9.9%	10.5%	10.4%	10.3%	10.4%
3.1.06: Safer staffing fill rates	80.0%	105.5%	108.8%	109.3%	106.1%	108.1%	112.5%	111.7%	112.4%	108.9%	103.7%	114.8%	116.4%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	18.5%	14.9%	15.0%	14.7%	14.4%	14.6%	14.7%	14.0%	13.6%	15.5%	15.2%	26.2%	26.7%
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%	0.4%	0.3%

Notes:

3.1.02: Vacancy Gap, there was a discrepancy identified in the establishment that was being used to calculate the Vacancy and has therefore been recalculated and backdated. Variance was <1% in all cases.

3.1.07: Increase percentage of BAME staff in roles at band 7 and above. At the Board's request, a revised figure has been provided to reflect the totality of the workforce, rather than just those staff on Agenda for Change terms and conditions as was previously the case. A refreshed target is to be agreed by the Executive to take into account this change in calculation.

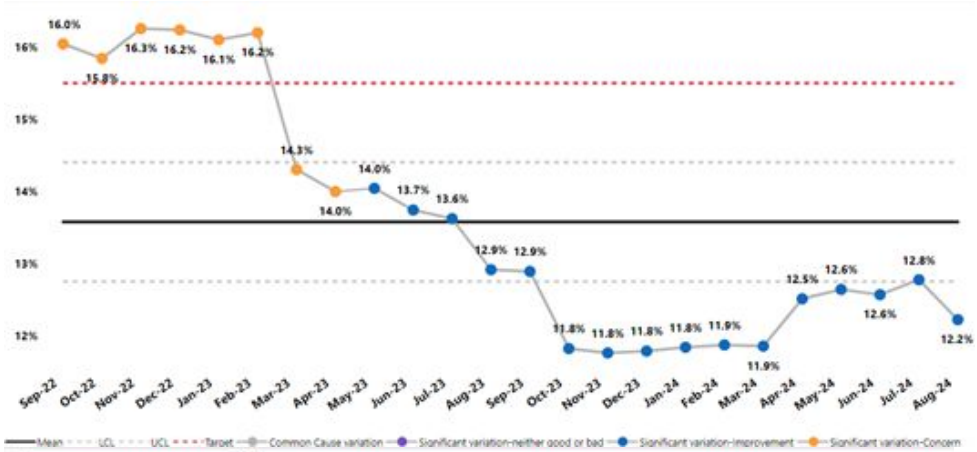
Areas of Improvement & Sustained Achievement of Target

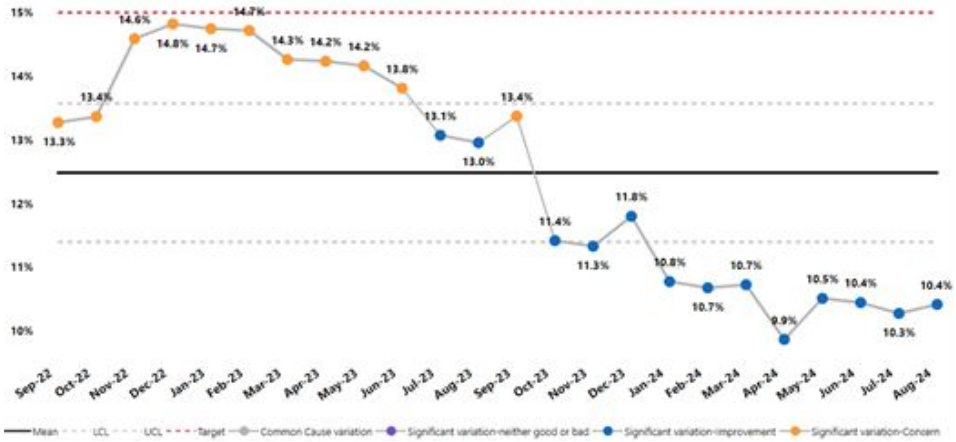
3.1.02: Vacancy Gap – Overall

Target	Actual	UCL	Mean	LCL	Variation	Assurance
15.5%	12.2%	14.4%	13.6%	12.8%		

3.1.05: Leaver Rate (Voluntary)

Target	Actual	UCL	Mean	LCL	Variation	Assurance
15.0%	10.4%	13.6%	12.5%	11.4%		





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.

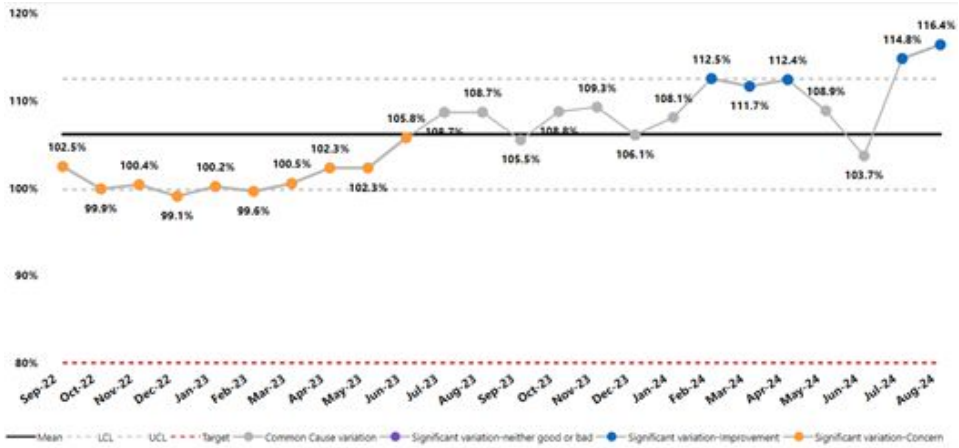
What is the data telling us?

Sustained 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

3.1.06: Safer staffing fill rates



Target	Actual	UCL	Mean	LCL	Variation	Assurance
80.0%	116.4%	112.5%	106.2%	99.8%		

Data Source

Eroster & NHSP

What is being measured?

Planned vs Worked hours

Data Quality Confidence

Difficulty obtaining data from NHSP between May and July in a timely manner due to a reporting platform closing. This has now been resolved.

What is the data telling us?

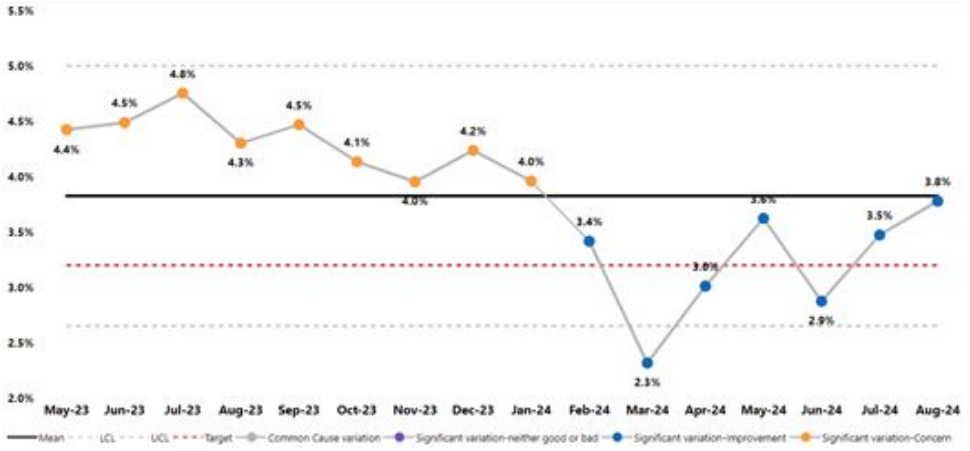
An increase in fill rates since February. The target of at least 80% fill rate for the safe staffing return is met throughout.

Efficiency

Measure Name	Target	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24
4.1.01: Bed Occupancy (Net)	92.0%	94.1%	92.1%	92.4%	93.4%	95.2%	96.9%	96.7%	95.8%	95.8%	96.5%	97.6%	95.9%
4.1.02: DNAs - 1st Appointments		9.6%	10.0%	11.0%	9.8%	10.0%	10.1%	9.9%	10.2%	10.9%	11.6%	10.5%	10.4%
4.1.03: DNAs - Follow Up Appointments		9.1%	9.3%	8.9%	9.3%	9.4%	9.3%	9.6%	9.8%	9.2%	10.0%	9.9%	9.6%
4.1.04: In Month Budget (£000)	0	(14,390)	(13,607)	(13,941)	(13,756)	(13,746)	(13,746)	(13,754)	(13,524)	(13,619)	(13,850)	(13,767)	(13,735)
4.1.05: In Month Actual (£000)		(14,108)	(13,362)	(13,702)	(13,581)	(14,226)	(14,201)	(14,630)	(14,080)	(14,655)	(14,437)	(13,900)	(14,555)
4.1.06: In Month Variance (£000)		283	245	239	175	(480)	(456)	(876)	(556)	(1,035)	(587)	(133)	(820)
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	4.5%	4.1%	4.0%	4.2%	4.0%	3.4%	2.3%	3.0%	3.6%	2.9%	3.5%	3.8%

Areas of Improvement & Sustained Achievement of Target

4.1.07: Agency spend as a % of the trust total pay bill



Target	Actual	UCL	Mean	LCL	Variation	Assurance
3.2%	3.8%	5.0%	3.8%	2.6%		

Data Source

Finance ledger system

What is being measured?

The percentage of our total pay bill that is an agency cost

Data Quality Confidence

No known issues.

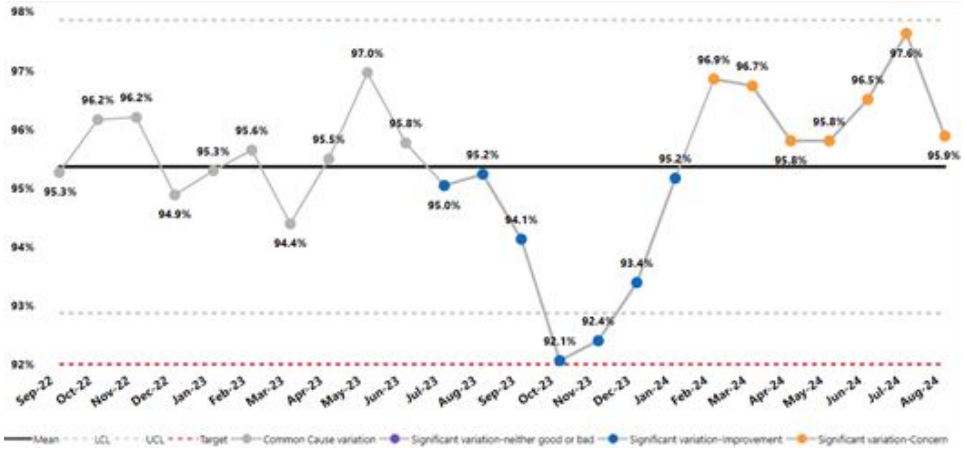
What is the data telling us?

As part of the NHS's approach to reduce its reliance on agency staff, the Trust was set an agency spend cap of 3.2% of its pay bill.

The agency metric gives us an indicator of health. In month the trust is above cap, and action is required to reduce this spend.

Areas of Concern

4.1.01: Bed Occupancy (Net)



Target	Actual	UCL	Mean	LCL	Variation	Assurance
92.0%	95.9%	97.9%	95.4%	92.9%		

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. All wards were above target in August with the exception of Fern and Sevenscore

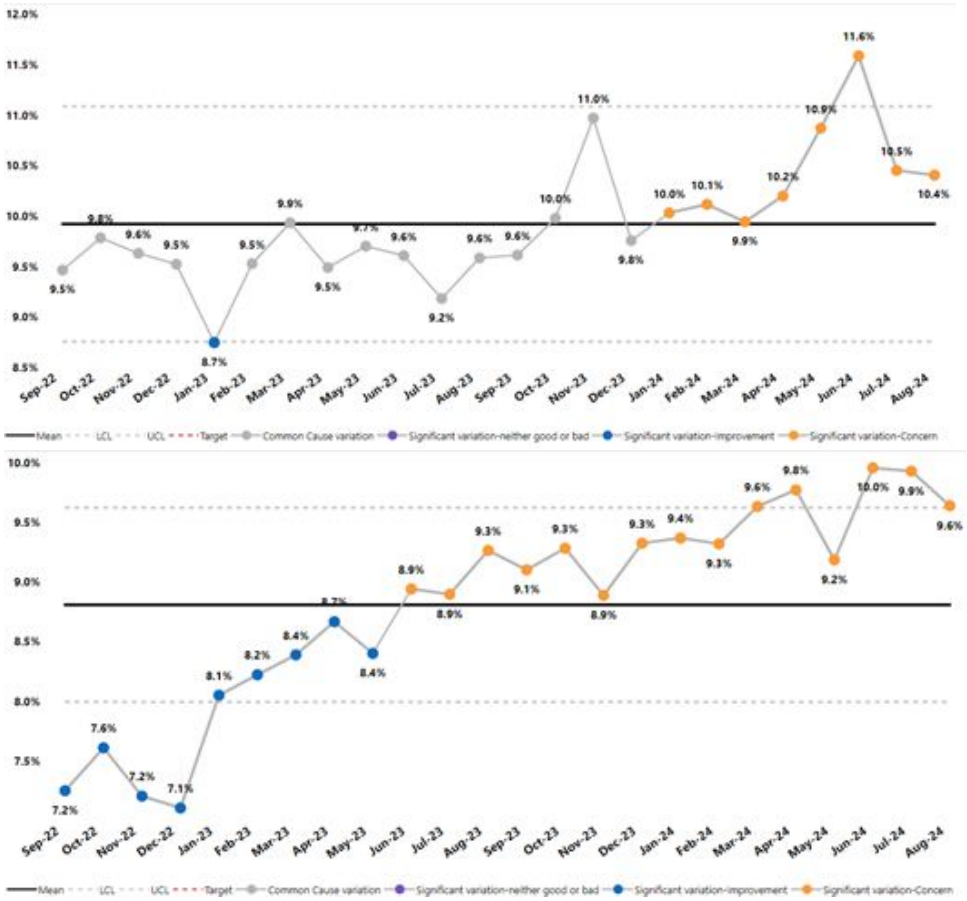
Level of occupancy are comparable between YA acute (95.6%) and OP Acute (96.3%)

4.1.02: DNAs - 1st Appointments

Target	Actual	UCL	Mean	LCL	Variation	Assurance
	10.4%	11.1%	9.9%	8.8%		

4.1.03: DNAs - Follow Up Appointments

Target	Actual	UCL	Mean	LCL	Variation	Assurance
	9.6%	9.6%	8.8%	8.0%		



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 appointments 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 accounted for 52% of 1st contact DNA's in August and are above trust average significantly with DNA rates for first appointments consistently around 19% in recent month. This is being investigated and could correspondent with large volumes of referrals of which approx. 40% being experienced as inappropriate. Inappropriate in so much as referrals not detailing reason for referral or in some circumstances, could have been managed within primary care.

For follow up appointments CMHT's account for 38%of all DNA and have a DNA rate of 14%. MHT services recorded follow up appointments DNA rate of 27% in August which equates to 404 DNA's.

5. 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 07	2:Flexible support					
S035a: Overall CQC rating	Month	2024 07	3 - Good					13/67
S059a: CQC well -led rating	Month	2024 07	3 - Good					13/67
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	8.88%	9.94%		↑		53/71
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	15.2%	17.7%		↑		53/71
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	28.1%	25.1%		↓		63/71
S067a: Leaver rate	Month	2024 05	8.18%	7.15%		↑		59/71
S068a: Sickness absence rate	Month	2024 03	4.07%	4.79%		↓	↓	11/71
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 06	61.1%		62%	↓		36/45
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%	56.4%		↓	↓	49/70

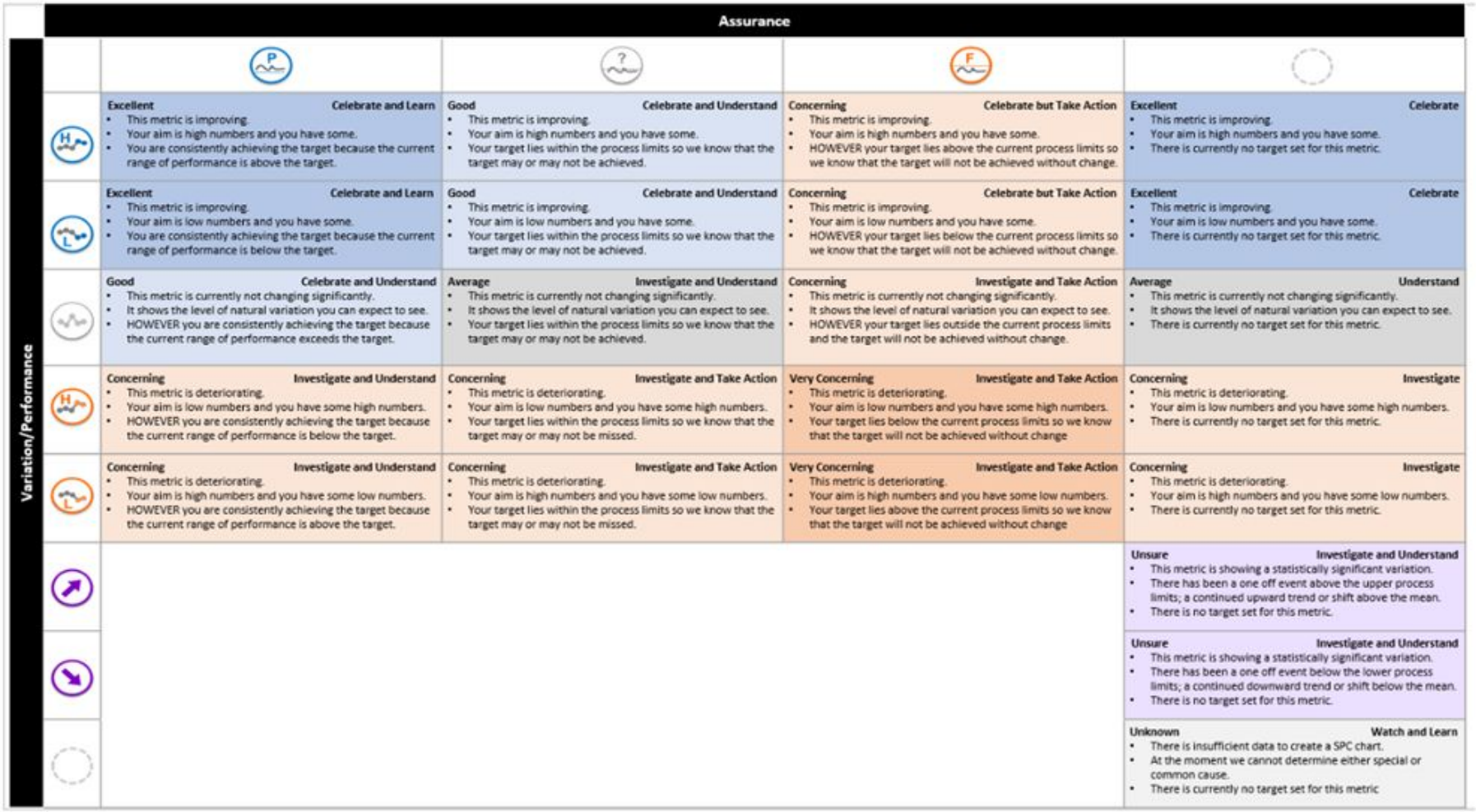
Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
S086a: Inappropriate adult acute mental health placement out -of-area placement bed days	Month	2024 03	0		0			1/56
S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2023	6.88/10	7.09/10		↓		66/71
S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2023	6.5/10	6.46/10		↓		56/71
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	7.42/10	7.3/10		↓		57/71
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	↑		50/69
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1.2		1	↓		54/69

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.*

Following a national consultation an updated version of the Single Oversight Framework is expected in late 2024.

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/.



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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Finance Report for Month 5 (August 2024)
Author:	Jenni Grover, Deputy Director of Finance
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 5 (August 2024).

Items of focus

For the period ending 31 August 2024, the Trust is reporting delivery against its financial plan. The board are asked to note,

- The Trust continues to see a higher than planned level of temporary staffing; in Month the Trust has seen a slight increase in agency spend (£0.04m), with the main increase in nursing spend. The Trust is also seeing increased use of bank nursing spend. One of the main areas of spend is within inpatient nursing, the Chief Nurse is actively reviewing the ward rotas to ensure appropriate controls are in place.

- The trust continues to use external beds, in particular the use of non-contracted Female PICU and male acute beds. The Trust's financial plan is based on no male acute beds being used, and this represents a financial pressure.

- The Trust's capital programme remains on plan; however, a potential delay has been identified in the s136 redevelopment programme. This position is being reviewed.

- The Trust's cash position has improved in month, with its cash balance £18.10m. The improvement relates to VAT receipts received in month.

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
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Finance Report
August 2024

Trust Board

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Executive Summary

Key Messages

For the period ending 31st August 2024, the Trust has reported a surplus of £0.09m excluding technical adjustments, in line with a revised financial plan of £0.72m surplus for the financial year.

The key financial challenges for the Trust are:

- Use of agency staffing continues and spend increased in August by £0.04m, with nursing spend increasing by 34.9% (£0.08m). YTD the Trust has spent £2.92m, this equates to a 3.37% compared to an agency cap of 3.20% for the year.
- The continued usage of external beds, in particular usage of non-contracted Female PICU and Male Acute beds. The Trust does not hold a budget for Male Acute beds and therefore any spend in this area creates a cost pressure.
- The Trust's capital programme remains on plan; however, a potential delay has been identified in the s136 redevelopment programme which will require further review.
- The Trust is presently forecasting to deliver its efficiency programme in full although £0.97m remains unallocated, with delivery assumed through non-recurrent actions.

Income and Expenditure

Key points for August included the following:

- Agency spend was £0.67m in month. This equates to 3.78% of the Trust Pay bill (in month); the target set nationally as part of planning was 3.20%. The Trust has planned to reduce spend through the year, and present run rate needs to be reduced by £0.15m over the coming quarter to meet the anticipated trajectories.
- Medical agency spend has increased slightly over the last quarter, work is on-going to address this with recruitment in place for the majority of roles except for the East directorate (where recruitment has historically been challenging).
- In month spend represents an increase of 6.4% over July with increases in nursing costs in Liaison, CMHT and Crisis. These budgets are under review to identify and address the drivers.
- Bank spend increased in month by 6.1% with HCA usage increasing across inpatient areas; with nursing spend increasing in Liaison and Crisis.
- In month, the Trust utilised 7.5 external female PICU beds and 2.6 male acute beds. This is 3 beds above the funded level. In month the Trust discharge one patient with complex care requirements (separately funded by the ICB).

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 31st August the overall capital position is £0.09m underspent, with a forecast capital spend position of £15.38m, which is as per plan.

The trust is reviewing the delivery of its s136 Development capital programme. The full year plan for this scheme is £2.7m. Any funds not used during 2024/25 will need to replaced by other capital schemes, and place a demand on the 2025/26 capital allocation.

Cash

The closing cash position for August was £18.10m which was an increase in month of £0.91m. This movement related to an increase in monthly VAT reclaims as well as the receipt of VAT reclaims which relating to last financial year.

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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	273,251	22,744	23,244	500	113,999	114,264	265
Employee Expenses	(207,000)	(17,310)	(17,773)	(463)	(86,505)	(86,888)	(383)
Operating Expenses	(60,899)	(4,988)	(5,050)	(62)	(25,264)	(25,834)	(570)
Operating (Surplus) / Deficit	**5,352**	**446**	**421**	**(25)**	**2,230**	**1,543**	**(687)**
Finance Costs	(5,352)	(446)	(330)	116	(2,230)	(1,452)	778
System control Surplus / (Deficit)	**0**	**(0)**	**91**	**91**	**0**	**91**	**91**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	0	0	35	35	0	(404)	(404)
Surplus / (deficit) for the period	**0**	**(0)**	**126**	**126**	**0**	**(313)**	**(313)**

Commentary

The Trust has a small, planned surplus of £0.09m for the period ending 31st August 2024.

To month 5, there is an adverse pay variance to budget of £0.38m. This includes a significant underspend on substantive pay of £9.65m due to the level of vacancies, which is offset by agency and bank usage.

In month there was increased spend on agency, reflecting additional nurse cover across the Crisis, Liaison and Community Teams. A partial driver the community position is the agreement for the CMHF teams to use agency staff whilst substantive recruitment is undertaken by our partners. This is intended to mitigate waiting list pressures, and is agreed for a maximum 3 months.

Medical agency remains high, particularly within East Kent which accounts for 50% of the medical agency spend.

If current spend levels continue the Trust will exceed the annual agency cap (of £6.58m) by £0.27m.

The Trust utilised 499 bank WTE in month, 11.6% higher than usage in August 2023. This is partly due to the acuity of patients seen in all inpatient wards, additional short term support to international nurses and Extra packages of Care (EPCs) within the Forensic wards.

Non-pay

Other non pay includes a higher level of spend on external placements compared to budget, with additional PICU & Acute beds utilised.

In month the external bed usage was above contracted levels with 7.5 female PICU beds being utilised. 2.6 external male acute beds were utilised in month.

Cost improvement plans 24/25

Risk rating	RAG rated	%of target	Risk Assessed Delivery	%of target
	£000s		£000s	
Green	2,400	24.20%	2,400	22.35%
Amber	7,168	66.70%	3,584	33.37%
Red	1,172	9.10%	-	0.00%
Total	**10,740**	**100.00%**	**6,155**	**55.72%**

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 **£0.80m**

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

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

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

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Exception report

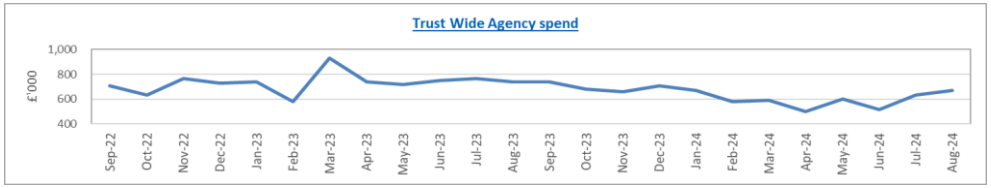
Temporary Staffing Spend

As at the end of August the Trust reported a year to date overspend on pay of £0.38m. This consists of an underspend on substantive pay of £9.65m, offset by overspends on temporary staffing which total £10.03m; £7.11m on bank staff and £2.92m of agency spend.

Agency

Agency spend to month 5 totalled £2.92m and this is forecast to continue due to both vacancies and operational pressures. Agency spend increased in month by £0.04m. The highest level of spend remains within the East Kent Directorate due to 6.1 WTE agency medics. Nursing agency spend increased by £0.08m with increased cover in Crisis, Liaison and Community teams. The current forecast outturn for agency is £0.27m above the 3.2% spending cap.

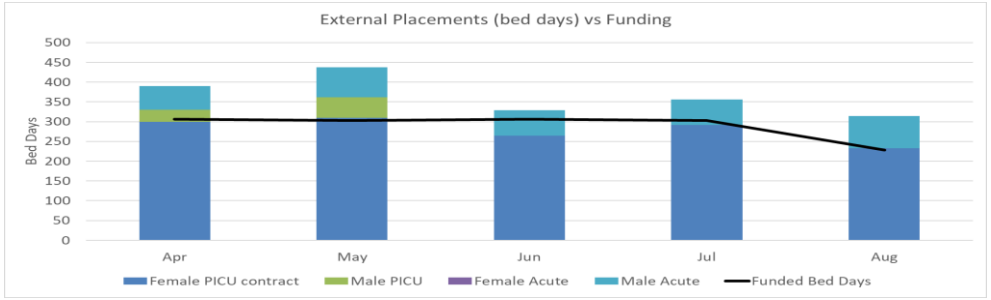
There continues to be focus and scrutiny on all agency spend as the financial year progresses to ensure spend is minimalised. The agency position is being closely monitored at an Executive Level.



External placements

Female PICU bed use has been stable at or just below funded levels however consistent use of 2 or 3 male acute beds have resulted in the cost pressure.

The decrease funded and actual bed days in August is due to a long term patient with complex care requirements (separately funded by the ICB) being discharged in early August.



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.

Bank spend in month was higher when compared to July levels but is lower than at the same time last year and in line with the 12 month average.

Trust Wide Bank Usage (WTEs)

	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Qtr 1	24/25 Jul-Aug
Nursing	145.17	135.76	150.64	156.31	162.04
HCAs	321.18	300.67	313.59	286.99	296.45
Other	38.21	37.94	34.13	25.08	27.94
Total	**504.55**	**474.37**	**498.36**	**468.38**	**486.43**

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

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

Acute Inpatient HCA Bank Usage (WTEs)

	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Qtr 1	24/25 Jul-Aug
Inpatient area					
Older Adult Wards	42.46	41.09	48.68	44.54	58.36
Willow Suite	35.75	30.64	29.48	30.44	22.06
Younger Adult Wards	85.80	72.08	89.80	77.96	73.89
Total	**164.01**	**143.81**	**167.95**	**152.94**	**154.31**

Forensics Inpatient HCA Bank Usage (WTEs)

	23/24 Qtr 2	23/24 Qtr 3	23/24 Qtr 4	24/25 Qtr 1	24/25 Jul-Aug
Inpatient area					
Low Secure Services	63.43	62.34	65.79	49.05	41.13
Medium Secure Services	31.53	37.19	44.17	33.85	41.53
Total	**94.95**	**99.53**	**109.96**	**82.90**	**82.66**

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Appendices

Balance Sheet

Statement of Financial Position

	Opening 31st March 2024 *Actual* £000	Prior Month 31st July 2024 *Actual* £000	Current Month 31st August 2024 *Actual* £000
Non-current assets	169,254	169,701	169,091
Current assets	23,068	25,628	25,520
Current liabilities	(29,558)	(30,684)	(29,775)
Non current liabilities	(47,291)	(49,619)	(49,682)
Net Assets Employed	**115,473**	**115,027**	**115,153**
Total Taxpayers Equity	**115,473**	**115,027**	**115,153**

Commentary

Non-current assets

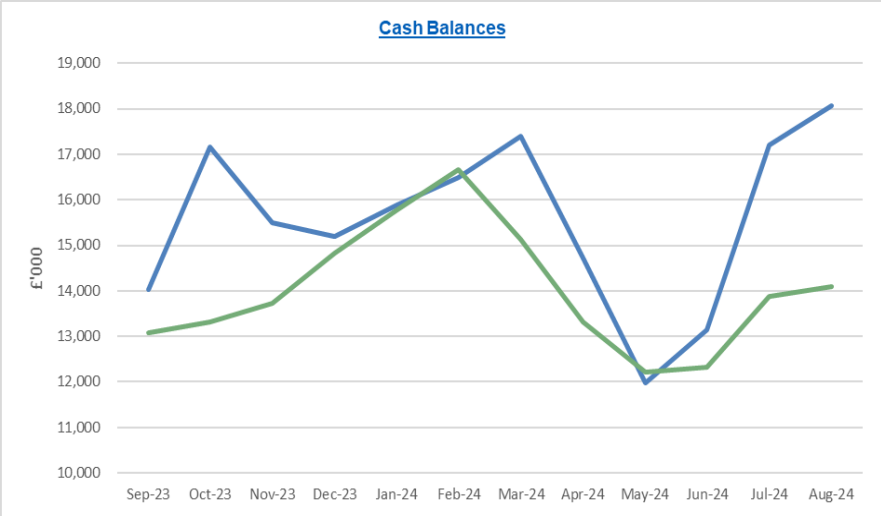
Non-current assets have decreased by £0.61m in August made up of an increase in capital expenditure of £0.26m, reduction due to depreciation of £0.87m.

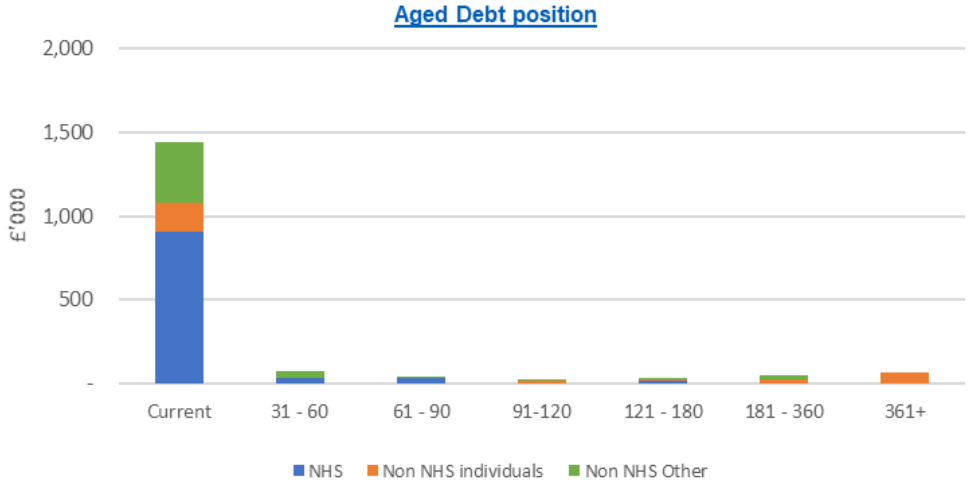
Current Assets

Current assets has remained stable in August as the cash position has increased by £0.86m and trade and other receivables have reduced by 0.97m.

Current Liabilities

Overall Trade and other payables increased by £0.90m primarily driven by the release of deferred income that relates to the Kent and Medway ICB and NHS England.





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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 Funding:									
Information Management and Technology	2,000	1,908	(92)	0	0	0	108	112	4
Capital Maintenance and Minor Schemes	4,166	4,046	(120)	230	131	(147)	717	613	(105)
Section 136 development	948	995	47	18	88	69	141	236	95
DCF (EPR) IT	0	92	92	0	0	0	0	(5)	(5)
Mental Health Response Vehicle	29	102	73	0	0	0	29	29	0
Total System funding	**7,144**	**7,144**	**(0)**	**248**	**219**	**(30)**	**996**	**985**	**(11)**
PDC funding :									
Section 136 development	2,708	2,708	0	0	0	0	0	0	0
DCF (EPR) IT	1,736	1,736	0	0	2	2	397	399	2
Mental Health Response Vehicle	198	198	0	0	0	0	0	0	0
Total PDC funding	**4,642**	**4,642**	**0**	**0**	**2**	**2**	**397**	**399**	**2**
Other Capital Funding:									
PFI 2024/25	117	116	(1)	10	10	0	49	48	(0)
Leases New	605	609	4	0	0	0	34	44	10
Leases Remeasurement	2,872	2,869	(3)	0	26	26	2,872	2,779	(93)
Total Other Capital Funding:	**3,594**	**3,594**	**0**	**10**	**35**	**26**	**2,955**	**2,871**	**(84)**
Total Capital Expenditure	**15,380**	**15,380**	**0**	**258**	**256**	**(2)**	**4,348**	**4,255**	**(93)**

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.

In Month

The Capital Programme in August 2024 is under spent by £0.02m which made up underspends in the previous month bringing the overall year to date position to a £0.093m underspend, 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.

Year to date and forecast

In month the Capital Maintenance and Estates schemes underspent by £147k. The Section 136 in month is slightly over anticipated spend levels but full year spend is expected to be in line with the allocation. Focus will be on ensuring schemes remain on plan for delivery particular estates schemes and the Section 136 programme.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Workforce Deep Dive: Re-modelling and reshaping the workforce for the future
Author:	Dr Mohan Bhatt, Deputy Chief Medical Officer
	Dr Sara Casado, Director of Psychological Therapies
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board update/Deep Dive

Overview of Paper

This paper covers the main areas of concern for staffing in KMPT, where there have been historic gaps without permanent remedy and where there are new developments such as the Community Mental Health Framework (CMHF), that require considerable workforce remodelling to ensure the services are fit for the future. In order to do this, teams have had to work to address historic vacancies, looking to the medium to longer term pipeline issues for new staff and address the issue of reliance on temporary staffing and develop plans that tackle the underlying issues that have created these gaps in staffing. Alongside this has been the development of new roles in psychological therapy and medicine.

Issues to bring to the Board's attention

Across all disciplines, there has been good progress on recruiting to posts within the disciplines of medicine, nursing, psychology, Allied Health Professionals and Social Work. Where needed, we have looked at the staffing models and redesigned the development trajectory for staff. . There will be further remodelling required to ensure our services meet and exceed the national standards in a range of clinical settings. Ensuring timely recruitment is not only essential for KMPT but also our partners in the Community Mental Health Framework.

This is working well for Band 5 nurses with KMPT set to be over-established at Band 5 for the first time. Over time, this will positively impact the gaps at Band 6 within community services. Nevertheless, even with these developments, this will still mean that there will be circa 50-60 vacancies in these teams. Further work is needed to look at the longer-term conversion of agency into substantive posts and the kinds of offers, in terms of stability, future prospects and advancing clinical careers that will make working for KMPT more attractive.

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Good progress has been made on recruitment to the medical and psychology workforce and although the East of Kent has been a difficult area to recruit to, there is progress in this area and a county wide ambition to reduce medical agency locums by 50% by the end of this financial year.

Governance

Implications/Impact:	Recruitment and Retention
Assurance:	Reasonable
Oversight:	Workforce Committee and Trust Board

Introduction

This report sets out the work that has been undertaken in the last year to re-model the Trust workforce and ensure that we could recruit to historic vacancy gaps which did not have a permanent remedy and where new developments such as the CMHF, have led to workforce remodelling to ensure the services are fit for the future.

The paper is structured based on staffing discipline with an overview for CMHF.

1. Community Mental Health Framework

The Community Mental Health Framework was an opportunity for the introduction of a more diverse workforce with an emphasis on 'new roles delivering a stepped care model in a community setting'. Over the last twelve months much of the transformation programme has been focused on creating a new workforce model in partnership with the Voluntary, Community & Social Enterprise (VCSE) sector. A summary of the new roles introduced is described below.

It is important to note that the clinical model is predicated on lower intensity interventions being mainly delivered by VCSE unregistered staff with supervision, training and support delivered by KMPT registered clinicians, such as psychological practitioners. Thus, allowing the registered practitioners to focus on providing care and treatment to people who require a more intensive offer due to their complex needs. This also supports the need to expand the workforce and attract staff from all disciplines and negates the need to attempt to recruit to clinical posts where the critical mass of staff is not available.

The new workforce across Mental Health Together (MHT) include Link Workers (Band 4) who provide low intensity interventions utilising DIALOG+, and care connectors (Band 4) who remain engaged with patients working across the stepped care model. Some Mental Health Together roles are registered mental health professionals delivering Clinical Pathway leadership (B7) and Operational Team management (B7) are provided by Invicta an organisation that is well established in Primary Care. The KMPT workforce will be extended to include Clinical Associate Psychologists (CAPs) (Band 6) and Mental Health Wellbeing Practitioners (Band 4/5). These roles will deliver low intensity psychological interventions across MHT.

Lead Consultant Psychiatrists across each of the 7 Mental Health Together + Services are being appointed with additional responsibility of working closely with Primary Care Networks (within in their area) to aid smother transitions between services and improved communication regarding complex case management.

New Mental Health Pharmacists (Band 8a) have been recruited and exist across all localities. A key element of this role is working alongside GP's supporting education and prescribing where required.

The Service User Network (SUN) is a recognised model of care for people who are experiencing difficulties with complex emotions often associated with Personality Disorder. New roles have been introduced to deliver the peer-support groups and have been recruited via our Voluntary Sector Partners. Registered existing KMPT staff work alongside the Lived Experience Practitioners offering supervision and pathway management as required.

Registered Mental Health Practitioners in Primary Care Networks (under the Additional Roles Reimbursement Scheme - ARRS) have been recruited across the majority of networks in Kent & Medway. These roles support practices in the management of patients with moderate to complex mental health needs interfacing closely with MHT and MHT+. Further expansion of these roles is expected in the coming months.

2. Nursing Workforce

The Trust has historically had a vacancy challenge for registered nurses at Band 5-6. Whilst the volumes of these change as services change, there is an underlying vacancy deficit that has never been resolved.

Current Establishment:

The registered nurse workforce totals: 1078 with 155 vacancies (14%)

The registered Nursing Associates, Apprentices, Support Time and Recovery Workers, Healthcare Workers totals: 625

The main concern has historically been high vacancies at Band 5 in inpatient services and Band 6 in the community teams. The table below shoes the pattern of these vacancies over 2022/2023 and 2024 to date (negative values are numbers over initial establishment – usually new roles, 8c for example is for the Heads of Nursing which were 8B prior to the move to Directorates).

Nursing	Vacancies (WTE)		
Band	2022	2023	2024
Nurse Band 5	95.24	68.95	59.91
Nurse Band 6	61.79	266.9	90.57
Nurse Band 7	7.65	7.94	-4.25
Nurse Band 8A	2.8	0.77	11.9
Nurse Band 8B	3.31	-1	1
Nurse Band 8C	0	-3.99	-4
Nurse Band 8D	-1	0	0
Nurse Consultant	-0.3	-0.3	-0.3
Grand Total:	169.49	337.47	154.83

The current position for Band 5 is set to improve due to 2 main areas of focus.

International recruitment of nurses has meant that the traditional problem of a shortage in Band 5 inpatient roles has been significantly impacted with 52 new nurses joining – the majority of these have now achieved their registration with the NMC and will move over into Band 5 positions (Band 4 until registration is achieved). Once this and other recruitment initiatives are considered, this means that the Acute Directorate and Forensics and Specialist Directorate will have either no band 5 vacancies or will be over-established for a period of time. This has not been achieved for many years in KMPT.

Newly qualifying students (approx. 70) will further reduce the vacancies in this group, with inpatient wards becoming temporarily over-established to ensure we can employ these nurses. Each of the community directorates is taking on circa 10 new registrants, into development posts (designated as Band 6 roles currently) created within community services to ensure they have the competencies for these roles and to aid in reducing the vacancy factor at Band 6. This is not without risk, inasmuch as the caseload management of these teams is complex and it will take time for the new registrants to gain the skills and confidence in these roles. We will be ensuring that they are receiving the help, support and development they need and Heads of Nursing have created a development programme for nurses in community services that is focussed on the clinical knowledge and skills required for these roles.

The Band 5-6 Development course starts in November once recruitment has concluded.

Bands 2/3:

The unregistered workforce (Band 2/3 Healthcare Workers) are key to the success of inpatient care and treatment. Currently, the acute directorate have 19 vacancies across Band 2/3 (8%) but this is balanced by an over-establishment at Band 4 – as this is where Nursing Associates are banded, where new nurses awaiting their registration with the NMC and Registered Nurse Degree Apprenticeships are banded, the latter after year 2 of their course.

Pipeline:

The domestic pipeline is an improving picture in the medium to longer term, with Canterbury Christchurch University doubling their intake of Mental Health Nursing students this year. It remains to be seen if this increase will persist but it is encouraging to note. KMPT aims to recruit at least 90% of any student cohort.

International recruitment remains an option but the central funding to assist with further cohorts has now ceased and would have to be funded by KMPT.

Apprenticeships:

Annually, KMPT employ 10 Trainee Nursing Associates (TNA) and 10 Registered Nurse Degree Apprentices (RNDA). These apprenticeships are now financed centrally, so that there is not the pressure on local budgets that has previously been a constraint, due to the need for back-fill for these posts when the apprentices are on placement or in University. The distribution of apprenticeships has to be managed each year, so that services can develop their staff without negatively impacting the core business of care by having too many staff out at any one time. TNAs take 2 years to train and RNDA's 4.

Retirement:

Based on the retirement age of 65, we can anticipate that between 47-48 nurses will retire in the coming year, with 30 of those being at Band 6. There may be some difference in actual retirals but planning for these volumes is prudent. The main area of concern is the community services where the majority of these posts are – and so the development programme is going to be crucial in managing this number. Likely estimates are that those undertaking this will account for 30% of community vacancies in the next year but this could increase as there will inevitably be further movement from Band 5s in the inpatient services to community teams.

As part of this work, we are reviewing the establishments in the community teams to ensure the development posts become a permanent feature in services to create a more sustainable pipeline.

Advanced Clinical Practitioner (ACP) and Nurse Consultant Roles:

KMPT has a cohort of 29 ACPs either in post or in the final stages of training, and these roles range from advanced practice and consultant roles in dementia, psychiatric liaison, independent prescribing as well as the development of Approved/Responsible Clinicians. A key factor for the development of these roles, is the support and supervision of consultant psychiatrists. KMPT has faired well in this regard and have an increasing cohort of these practitioners across inpatient and community services. They cannot replace consultant roles as such, but where there are gaps in clinical leadership and delivery in teams they are a vital element in ensuring care can be delivered to a high standard with the support of consultant colleagues.

Further workforce design changes:

We are exploring the use of a pool/floater nurse approach across sites, to better use temporary staffing and to ensure that we have a pool of staff who are supervised and developed in their roles. This can be attractive for staff who have commitments that mean they can't always work for us but it is also helpful for those returning from maternity or long-term sick leave to be able to work more flexibly. This proposal will be further developed into 2025 as we ensure we have grip and control of the substantive rotas.

Bank/Agency Use:

Bank: Most of the bank spend is within in-patients. There are 4 main areas of spend:

1) Observations – usually 1:1 and 2:1
2) Covering vacancy/sickness
3) Covering registered nursing shifts where the new registrants have training needs or have not received their PIN yet.
4) Rota efficiency and adherence to the shift patterns model.

On 1) A new control process will be in place at the end of September, led by the Chief Nurse, to address the use of observations (which are considered a form of restrictive practice). So far, work on this has not reduced the use of observations as intended and so greater scrutiny and challenge around this is required.

On 2) This is being monitored via Quality and Performance Review each month

On 3) This is a picture that will begin to resolve as the international nurses get their PINs and can take up their band 5 post.

On 4) the Heads of Nursing for Acute and Forensic and Specialist services are leading on this with their teams. Agency spend as a part of the total is reducing but bank spend remains high in certain teams. There are monthly rota review panels, where the hours, leave, adherence to the shift patterns and additional staffing concerns are addressed. As the new recruits settle into posts then we anticipate bank spend to reduce commensurately.

Summary: The nursing establishment has been a concern for KMPT for several years. Over the past 18 months several steps have been taken to address some of the underlying staffing pipeline problems through meaningful international recruitment and formal partnership with Christchurch Canterbury University to increase the volume of learners and improve the experience of students. The aging nursing workforce means that we will need to further increase the numbers of learners but also be able to prevent bottlenecks at Band 5 by having a clear development trajectory for new nurses to work in the community. Apprenticeships have been stabilised as part of routine annual planning. ACP development will continue and future opportunities explored. Rotas are being managed to tackle inefficiency in clinical staffing and to promote best practice.

3. Psychological Practice Workforce

This section summarises the current position and initiatives taken to improve the position of substantive psychological practice establishment in KMPT and demonstrates the changing profile of this workforce to meet the needs of the population and provide evidence-based interventions at the scale required with the supervision and development in place to be assured this occurs as planned.

The recruitment strategy has two main strands:

Expansion of junior workforce to create a pipeline for future in addition to covering current gaps

As the CMHF work matures, the range of psychological interventions, with varying degrees of intensity and complexity means that more junior posts have been designed nationally, to deliver these at scale and to open up development opportunities for those wishing to pursue a career in psychological services. These roles are designed to help those with a degree in psychology or related field, step into the clinical arena under the close supervision of a qualified psychology practitioner. These roles have their own qualifications or route to it and as such, offer a broader range of entry points and roles for graduates in psychology who wish to enter the field. The roles are:

- Clinical Associate Psychologists (CAPS) – 25 new posts created with support and supervision in place to develop
- Mental Health Wellbeing Practitioners (MHWPs) -12 in total 9 completed 3 are still in training.
- Recruit to Train (RTT) - 4 from first cohort in second year of training, another 7 to commence September 2024.

Increase in senior (band 7) psychology posts to support delivery of care under the new CMHF model (MHT and MHT+)

This will ensure specialist therapy supervision for the junior workforce expansion and CMHF partners.

Summary: There has been an improvement in the psychological practice recruitment across all bands but in particular junior workforce. It is crucial to ensure adequate support and supervision so that quality and safety of services is maintained at a high standard. Our forecast is that we will continue to monitor and expand our substantive workforce. We will not use any agency staff by the end of this financial year.

4. Medical Workforce Report

This section summarises the current position and plans to improve the position of substantive medical establishment in KMPT.

Current medical establishment

Consultant Psychiatrists **n=106**, Speciality Doctors **n= 48,** Specialist Grade Doctor (newly established grade nationally) **n=2** and Trainee Doctors (Foundation trainees, GP trainees, Core trainees, Higher trainees) **n=134**Out of 106 Consultant Psychiatrists, 77 (72.5%) are substantive appointments. Only 10 (9.5%) of the vacant posts are currently covered by agency locum doctors. Out of the 48 SAS Doctors in the Trust, 24 are substantive recruitments. Only 1 of the vacant posts is covered by agency locum. Low level of agency cover for vacant posts has been achieved by innovative practices around covering posts detailed in Section 2 below.

All our 134 trainee posts are filled. There are 4 MTI (international trained doctors) trainee doctors and 9 float locum doctors who also provide cover at junior doctor level.

Innovative ways of addressing vacancies

Conversion of 6 SAS posts to Higher Trainee posts: Additional funding from HEE and using finance from converting internal posts allowed us to increase our higher trainee numbers. We now have 34 higher trainees compared to 19 trainees 2 years ago. This has increased pipeline of higher trainees for taking on consultant posts in KMPT. Conversion rates to consultant positions shows a healthy forecast for the next 4 years.

Conversion of 4 consultant vacancies into newly created specialist grade posts: these posts have proved to be easier to recruit.

Nurse Consultant appointments: We have 3 non-medical (nurse) consultants in suitably medically supported posts in Priority House acute ward, and two posts in Liaison Psychiatry in Ashford and Thanet.

Non-medical clinicians: We are continuing with testing each consultant and SAS vacancy for non-medical recruitment. Where the requirements for supervision are met we are going ahead with conversion. We have identified a non-medical position for Liaison Service in North Kent and are working on developing this. We have also considered this as an option for CRHT East Team. However, we did not get a suitable applicant.

Academic posts: In the East Kent Directorate we are working with KMMS to fill consultant gaps. We have been successful in securing funding from KMMS for an academic post which is being recruited to and further joint posts are being developed.

Retire and return: We have supported post-retirement consultants to return to work within the Trust.

We have employed 6 MTI (international medical doctors) to support our vacancies at junior doctor level. We have also recruited 7 international doctors to consultant and SAS posts.

The following illustrates our approach to medical recruitment in KMPT. In summary we are attracting new talent from outside the organisation and also strengthening our offer to trainees to improve progression to consultant posts. This approach supports recruitment to current vacancies and securing a pipeline of consultants for future.

Impact of medical recruitments on medical agency spend (April 2023 to Jun 2024)

	Apr 23	Aug 23	Jan 24	Jun 24
Agency cost	425254	352500	312923	221852
Substantive underspend (due to vacancies)	264770	244611	500212	189315

- Medical agency costs have almost halved (reduced by £203k) over the last year
- Agency Consultant posts have reduced from 14 to 10 in year, there are more substantive consultants joining the Trust in the next couple of months as they are on the onboarding process and this figure will drop further.

Summary: There has been a steady improvement in the medical recruitment for Consultant and SAS vacancies in KMPT. Our current agency locum usage is at 9.5% of the total consultant establishment and 2% for SAS doctors. With the various initiatives described above, our forecast is that we will appoint to half of all posts covered by agency locum consultants (10 posts) and all locum cover for SAS position will be covered by the end of this financial year. Plans will be refreshed at the beginning of the next financial year and initiatives that bring the highest return will be taken forward.

Allied Health Professionals (AHP):

In KMPT, there are a variety of AHP roles, mainly Occupational Therapy (OT), but also including Physiotherapy and Sports Therapy Technicians, Dietetics, Speech and Language Therapy and Prosthetics, and a number of affiliated assistant roles.

We do not have any concerns about vacancies for these roles and most substantive posts are recruited to. The increase in OT on the wards has been a welcome addition – with each ward having a small dedicated team. Further work is underway to ensure the activity and outcomes of this work can be better reflected in patient records as well as within performance data.

There is a small-scale rotation between Dartford and Gravesham Trust and ourselves for Occupational Therapists on the Littlebrook site that will be evaluated with a view to scaling this up across the county if deemed successful.

Summary: OT have taken on significant areas of work around improving inpatient care but are very capable of taking on more advanced leadership roles in community settings (we have team managers who are OTs and 1 physio in an Operational Management role). The core offer of AHPs is one that will gain prominence

over the next year, as they are to set to develop and lead work on self-harm, violence and racism, women's health and a number of other areas of care. By bringing AHPs fully into this work, there are opportunities for improving patient experience, new learning and research, and ensuring that AHPs are considered more prominently in our offer to the community.

Social Work (SW):

In KMPT, social work has been quietly developing over the past couple years and there are now 49 SWs in KMPT in a variety of settings. The most established of these is within Forensic and Specialist services, where they are a core part of the clinical team and offer the range of assessments, interventions and knowledge that the profession can bring to mental health care.

Areas for further development are within the Acute Directorate, where the Inpatient Lead Social Worker roles will be pivotal in ensuring that patients retain and build their connections and helping networks within the community and that their recovery is focussed on building upon their strengths and capabilities to create a better quality of life as they recover.

Summary: Social Work, although strong in its identity within Local Authorities, has often been diluted through a pull towards generic clinical work, that does not necessarily accord with the training, skills and at times, code of social work – a criticism that has, amongst other issues, resulted in the removal of social work from teams within healthcare. To address this, the Trust Principle Social Worker will be working closely with both social workers and their managers to ensure the roles are in keeping with the identity and objectives of the profession and not being directed to regular activity that may detract from professional impact. The task for this year is to create a clearer social work voice within the Trust to help in understanding the nature of this work and what it offers to inter-professional practice, to ensure that the new roles can fully function as a real social work offer – and not simply as an adjunct to social care, as necessary as elements of this are – and to focus on improving outcomes for patients, primarily through the increased understanding of context, strengths and barriers to living well that our service users face.

Conclusion

We know that we need a strong substantive workforce to deliver good patient care. We will ensure that we have robust workforce planning in place to identify our future gaps. We will review our workforce model in line with the gaps. We will look at retention through the Culture, Identity and Staff Experience priority to ensure that staff are offered support to progress their careers. We will also look up and out to see what alternative workforce models are being used outside of KMPT and will continue to be ambitious with our approach to ensuring we maintain a strong workforce, which will include retaining our staff and recruiting to existing or new roles where the workforce model needs to adapt. We know we will have a very different potential workforce available in the next 5 years. We will need to work to ensure all generations have a place in KMPT and we don't have a one size fits all model and we fully understand the drivers for people joining and working for us.

Across all disciplines, there has been good progress on recruiting to posts within the disciplines of medicine, nursing, psychology, Allied Health Professionals and Social Work.

Therefore, our ambitions for next year are:

We will be aiming to reduce community Band 6 vacancies by 50% at least, over the coming year by increasing the development pipeline for those nurses. Bank and agency use within inpatient care will be reduced through increased stability and effectiveness in team rotas and the reduction of clinical dependency on wards.

We will focus on ensuring that the junior psychological workforce is appropriately supervised and that the wait times for psychological interventions continues to reduce.

We will recruit to at least 50% of all posts currently covered by locum consultant psychiatrists by the end of the financial year.

We will raise the profile of AHPs to lead on tackling complex clinical challenges such as violence and racism, and ensure that what the professions offer is prominent in all services and that this has greater visibility and understanding in practice.

We will ensure that Social Work has greater presence and that in partnership with the Local Authority, there can be greater coherence and consensus around how SW in KMPT can positively impact the lives of service users and increase the professions' identity as boundary spanning, to improve quality of life.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26 September 2024
Title of Paper:	Improving how we engage patients and communities
Author:	Kindra Hyttner, director of communications and engagement
Executive Director:	Sheila Stenson, chief executive officer

Purpose of Paper

Purpose:	For discussion
Submission to Board:	Board request

Overview of Paper

As an organisation we have not achieved our ambition to better involve patients, carers and communities in driving improvement. This paper is focused on the role the engagement council has had in supporting that ambition and how well we, as an organisation, have created the conditions needed for success.

It makes recommendations to the board on immediate next steps including:

- The replacement of the council with a new involvement and engagement team with responsibility for growing, diversifying and embedding patient and community involvement across the trust.
- Developing a co-creation framework.
- Increasing the diversity and scope of those we involve and engage, bringing together all of our involvement and engagement needs into one engagement pool.

Issues to bring to the Board's attention

The trust launched the participation and involvement strategy 2020-2025 in April 2020, which included establishing an engagement council in July 2020 as an enabler of that strategy. An update on delivery against that strategy was provided to the quality committee in January 2024 with an action that a new, co-produced plan was required to take this work forward.

Since then, the executive team portfolios have changed and engagement will move under the director of communications and engagement's leadership. The executive team has agreed that patient engagement needs a more prominent and renewed focus in the organisation, and that patient experience will continue to sit with the chief nurse. A new, engagement and involvement team will be established, utilising existing resources, and will move under the leadership of the director of communications and engagement, from transformation and partnerships.

Our overarching aims of new plan will remain the same. We want to be a patient-led, clinically-enabled organisation where patients, alongside our staff, drive improvements to patient quality and experience; where the patient and carer voice is listened to and acted upon in everything we do; and where we have trusted and enduring relationships with communities to improve services and outcomes for people.

The council has been involved in a lot of activity with positive intent, and members have had opportunities to share their views and experiences. Ultimately the council hasn't achieved measurable change that can be evidenced or quantified. The reasons why are outlined in this paper, along with the next steps we need to take and what will be different.

We have also heard from partners and patients we spoke to as part of the culture, identity and staff experience priority that many feel unheard by us and that our relationships with them are not consistently meaningful. We will therefore use what we do next as an opportunity to build trusted and enduring relationships with communities that start with people, and focus on what really matters to them to improve services and outcomes.

We are extremely grateful to the council and pool members for their commitment over the last four years, many of whom have done so voluntarily and given up significant amounts of time. These recommendations have been discussed with them. Many members are supportive of continuing to work with us in this new way, but some are not.

Governance

Implications/Impact:	Trust strategy; reputation;
Assurance:	Reasonable
Oversight:	Board

Why involvement and engagement matters

Listening to patients, carers and our communities is critical to the successful delivery of our organisational strategy. We can't improve what we do without listening to and involving the people who use our services. Their experience is a powerful tool for us to drive up quality, improve our services and identify new and better ways to meet their current and future needs.

NHS trusts also have a legal duty to involve people and communities in the design and delivery of services. This statutory 'involvement' can be done in a variety of ways. But ultimately working with people and communities supports the wider NHS objectives of integration, including population health management, personalisation of care and support, addressing health inequalities and improving quality.

It is our ambition as a trust to be a patient-led, clinically-enabled, organisation:

- where patients, alongside our staff, drive improvements to patient quality and experience;
- where the patient and carer voice is heard in everything we do; and
- where we have trusted and enduring relationships with communities to improve services and outcomes for people.

Defining patient engagement

Patient engagement and patient experience can often be confused. This happens both within and outside the organisation. While interlinked and sharing similarities, they are not interchangeable and will remain separate functions within the organisation, with the latter remaining under the direction of our chief nurse.

A description of the two is as follows:

- **Patient experience** is focused on delivering excellent service throughout a patient's entire journey and looks retrospectively at opportunities to improve. It includes the environment, making patients feel valued and ensuring every patient has a positive experience. Ultimately for us, it is about focusing on safe and friendly care that leads to positive patient outcomes.

- **Patient engagement** is forward looking and encompasses a variety of approaches such as partnership, participation, involvement, coproduction and consultation. Ultimately for us, it is about focusing on listening to and working side by side with patients, carers and communities to drive improvements to what we do, including the patient experience.

Our journey so far

The participation and involvement strategy 2020-2025 recognised the importance of involving patients, carers and communities in driving improvements.

The engagement council was established in July 2020 to be an enabler of that strategy. The role of the engagement council, as defined in its terms of reference, is:

> *To work with the trust at a strategic level and the wider engagement pool to determine priority areas for service development and improvement to specifically and meaningfully benefit those using our services and their loved ones.*

The council has been involved in lots of activity, and members have had the opportunity to share their views. However, it hasn't achieved measurable change that can be evidenced or quantified.

While the importance and ambition of the participation and involvement strategy still remains, the implementation needs to change.

The engagement council and pool have been a positive starting point on our journey. We need to learn from what has happened so far and take this forward differently.

Approach to reviewing where we are

It is recognised by our people and some council members that the council has not achieved what it intended to do, so the focus of this review is on why that is the case.

This review is based on engagement with the council, pool members, patients, partners and our people. It is not a scientific assessment and this paper is not exhaustive of the widespread feedback heard.

This review intends to act as a summary of the common themes heard. It is also informed by learning and wider experience from other trusts across the country who are further ahead on their journey.

Similar themes were heard across all audiences, which have been captured against 4 categories:

- **People** – factors related to anyone involved in patient engagement e.g. patients, carers, staff, training and skills.
- **Process** – factors related to how patient engagement is performed.
- **Purpose** – factors related to the purpose, objectives and measurement of engagement.
- **Material** – factors related to IT / information and communication / guidance.

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Review on a page

Guiding principles for assessing our current position

1 Our ambition is to be patient-led, clinically enabled, where patients, alongside our staff, drive improvements to patient quality and experience	**2** We have a responsibility to provide staff and those engaging with us with clarity of purpose, information, skills, time and tools they need to coproduce work to expected outcomes	**3** We are seeking to grow our culture and to create an environment where involving patients, carers and communities is heard in everything we do	**4** Our existing approach is open to review and continuous improvement

Key findings

People

- Staff and council not equipped to work together or coproduce
- Culture of involvement and coproduction doesn't exist
- Lots of listening but council not felt heard as action not taken
- Council is not diverse or representative of patients and communities we serve and largely inactive
- Some council members over-utilised without reimbursement
- Patients and partners outside council not felt heard or represented

Process

- Lots of activity, but not set up to support strategic priorities or drive improvement work
- Too bureaucratic, focused on governance and accountability rather than outcomes
- Inconsistent approach to engagement and co-creation
- Lack of process and clarity for decision-making
- Inefficient, unfair reimbursement approach
- Fixed-term council appointments not actioned
- Don't co-ordinate, track or measure involvement of various groups with similar aims

Purpose

- No clarity of purpose, outcomes or measurements of success
- Activity is discreet, not part of strategic endeavours or service-level improvements and largely driven by trust at tactical level
- Multiple engagement pools and community engagement overlapping across the trust and not aligned – some engagement outsourced at additional cost to trust
- Visibility is low and not given voice with senior leaders and board
- No specific roles, expectations or competencies
- Meetings lack focus on outcomes

Material

- Phones and IT not provided, support to access and train on our systems limited
- No clear guidance or rules for engagement
- Poor information sharing between trust and council
- Lack of administrative and onboarding support to council
- Inaccessible systems, environments and use of language

Proposed way forward

We propose four initial steps are taken in priority order:

1. **The replacement of the council with a new involvement and engagement team** with responsibility for growing, diversifying and embedding patient and community involvement across the trust. We will redeploy existing resources and embed new lived experience roles assigned to directorates. This will require a consultation and recruitment process. Members of the council will be encouraged to continue working with us as a member of the pool or to apply for an employed role.	By February 2025
2. **Increasing the diversity and scope of those we involve and engage**. We will bring together all of our siloed pools and engagement routes into one involvement and engagement pool that serves all our trust needs. From supporting our strategic priorities, to improving patient experience or taking part in research. The pool will be managed and developed closely under the new function to ensure equity of involvement and representation – all of which will be voluntary.	By February 2025
3. **Developing a co-creation framework.** The council has started some activity around co-creation. We will work together to develop a co-creation framework that sets out our purpose for engagement and involvement and how our people, patients, carers and communities will work together. This will be aligned to our new cultural values. We will also learn from our NHS partners' frameworks to inform ours.	For March 2025 board
4. **Develop a new engagement and involvement plan** that sets out our ambitions, the outcomes we hope to achieve, how we will achieve this and how we will measure success. Within the plan we will explain how we will align and track engagement and improvement across our six strategic priorities, Qi and improvement projects. We will also enable the new team to drive locally-led improvements and support health inequalities. We will set out how engagement and involvement will work together with patient experience colleagues to improve patient outcomes – notably we want to launch a patient-led accreditation.	For March 2025 board

What will be different?

We will create the conditions whereby service users, carers and community voices are not only heard but shape and drive the future of our services.

Engagement and involvement work will run through our governance, our operations and our clinical practice so that patient, carers and community voices drive action and improvements in what we do at a system, trust and local level.

We will shift the power to create equal partnerships with people who use our services, carers, our people, partners and our communities so that we can do well together to improve services and health inequalities for our local communities.

In practice this will mean:

- A patient-led, clinically-enabled organisation that can demonstrate the benefits of a disciplined application of good involvement and engagement practice.

- A thriving and diverse engagement and involvement pool that supports delivery of our strategy, and improvements to our services and trust business from policy to research, recruitment to improvement, and reducing health inequalities.

- Through our new 'doing well together' improvement approach, we will establish a way to measure, monitor and evaluate whether what we are doing is working. We want to learn, identity gaps and barriers, model what's working well and evolve what we do to affect change that leads to improvement.

- Lived experience 'engagement and involvement' roles actively involved in all aspects of our strategic priorities and services, working in partnership with our people (e.g. directorate leadership teams, service leads and corporate teams) and the pool to drive improvements at a system, trust and local level.

- An active pool and lived experienced roles working together to identify opportunities for co-production and involvement aligned to the trust strategy. We won't be able to co-create everything so for each piece of activity we will identity what level of involvement is needed to prioritise and be transparent and fair (our co-creation framework will set out how we will assess and identity levels of involvement in more detail).

- Our people hear, understand and act on the views of local service users, carers and local communities.

- We have established forums for engagement and involvement, and an approach to building trusted relationships, that allow us to reach all of our diverse communities, including patients, carers and partners, but also those who have not already used our services and whose voices we do not hear from. For example, traveller communities, religious groups and global majority communities.

- We have trusted relationships with our partners that enable us to work more collaboratively and help us shift perceptions of the trust so we are known for our new identity and values.

- An engagement and involvement team working side by side with our nursing directorate to improve the patient experience, and ensure it reflects our new identity and values.

- A new patient-led accreditation to recognise excellence, support improvement in patient experience and develop key markers of quality that matter most to our patients.

- More opportunities to involve a diverse range of patients, partners and communities in our research studies.

- Developing a culture where co-creation is embedded into everything we do and where 'doing well together' is the norm.

We will do this because we know that engagement and involvement improves services and the overall health and wellbeing of people experiencing mental health issues, learning disability or autism in our region.

Conclusion

'Doing well together' will be our new organisational mission, but not one we are consistently living now when it comes to involving and engaging our patients and communities. We heard - through our culture, identity and staff experience engagement - that patient, partner and community voices are not sought out, listened to and acted on at every level in our organisation. Our approach has not led to the measurable change we hoped to achieve, has not created the conditions needed for

success, and has also created frustration among our people and our engagement council. With scarce resources and the imperative to improve, we have to make informed decisions and do things differently.

Finally, we would like to thank and recognise the significant effort and time our engagement council members have given us. We look forward to working alongside them under this new approach, which will give them greater opportunities to meaningfully make a difference.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	Thursday 26th September 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

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Annual Emergency Planning, Resilience and Response Report
Author:	Jessica Scott, Emergency Preparedness and Resilience Lead
Executive Director:	Andy Cruickshank, Chief Nurse (Accountable Emergency Officer)

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Statutory

Overview of Paper

This paper has been submitted to give assurance that the Trust is assured against the Civil Contingencies Act (CCA), 2004 and fully aligned to the NHS England Emergency Preparedness, Resilience and Response Framework/Core Standards Assurance Programme of 2023/24 and 2024/25.

Issues to bring to the Board's attention

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

Confirmation of compliance with the Civil Contingencies Act (2004): The Trust is audited against the NHS EPRR Core Standards on an annual basis via a Kent and Medway Integrated Care Board (ICB) with submission to NHS England (NHSE).

The NHSE 2023 audit assurance confirmation was received in the fourth quarter (Q4), denoting that the Trust had maintained a status of 'Substantially Compliant' at an increased percentage score of 94.5%.

The 2024 NHS EPRR Core Standards self-assessment process, which was conducted in July 2024, will be again validated via ICB audit and the results ratified by NHSE and submitted to Audit and Risk Committee in Q4 2024/25 to confirm a maintained status of 'Substantial Compliance' at an increased percentage score of 98.3%.

Please:

- Note the closing of the 2023/2024 EPRR work plan.
- Note the EPRR 2023/24 Statement of Compliance (Appendix 1)
- Note the EPRR Improvement Plan 2024/25 (Appendix 2).

- Note the EPRR Policy (Appendix 3)
- Note the content of the 2024/2025 EPRR work plan commencing 1 September 2024 (Appendix 4).
- As requested by NHSE; Board are requested to share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Governance

Implications/Impact:	The Emergency Preparedness, Resilience and Response (EPRR) Policy is owned by the Board. The portfolio of EPRR has an Accountable Executive Officer (AEO): The Chief Nurse. The EPRR work plan runs annually from 1 September, following the July self-assessment and adheres to the governance principles; that the work is undertaken via a Trust-wide EPRR working group chaired by the Accountable Emergency Officer. The work plan is assured in its delivery to the Audit and Risk Committee (ARC) via the Trust-wide Health, Safety and Risk Group.
Assurance:	Significant assurance equating to 'Substantially Compliant' against NHSE EPRR Core Standards.
Oversight:	Oversight by Audit and Risk Committee

Emergency Preparedness, Resilience and Response – Annual Report to Board (Period September 2023 – August 2024)

Background and context

1. The Civil Contingencies Act (2004)

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

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

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

2. Assessing and documenting compliance

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

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

2.3 In 2023 KMPT was requested to submit evidence within the self-assessment for the audit against 55 lines of inquiry. Of those 55 the Trust was fully compliant with 52 and scored 94.5%.

2.4 The 2023 self-assessment data sets were audited by the ICB and the regional results collated and submitted for ratification by NHSE. NHSE confirmed the ratified position via a confirmation letter. In May 2024 the letter was received and presented to the Audit and Risk Committee, where it was noted as receiving 'Substantial' rating.

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

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

2.5 The gap in assurance, set out in the EPRR Improvement Plan was addressed via the agreed EPRR Work plan for 2023/24.

2.6 For 2024 KMPT have been requested to submit evidence within the self-assessment for the audit against 58 lines of inquiry. Of the 58 the Trust is fully compliant with 57 and has self-assessed at 98.3%.

2.7 The remaining 1.7% is rated at 'partially compliant' and accompany this report on the prescribed EPRR Improvement Plan template (appendix 1) for Board approval and noting of inclusion into the EPRR Work plan for 2024/25 (appendix 2)

3. Risk assessment

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

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

4. Develop emergency plans

4.1 Within 2023/24 all existing plans due for review have been republished or reformatted as required, no new plans have been created outside of briefing notes on the Entry and Exit System and Civil Unrest.

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

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

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

6. Warning and informing

6.1 Via the Trust Communications Team, arrangements are in place to make available information on resilience and response to the public and staff. Examples of this in the 2023/2024 work plan have in in relation to summer and winter preparedness, planned and unplanned Information Technology down

time potentially requiring IT System Business Continuity Plan activation, planned motorway closures, Met office forecasts, South East Water outages and the continued mitigation changes from European legislation culminating in the Entry and Exit System reforms in 2024.

7. Sharing information

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

7.2 The KMPT page on Resilience Direct is in place as a resilient EPRR repository; this has given on call staff a designated point of truth for plans, templates and briefings as the 'Master on call file' and allows for sharing of information in response across the Kent Resilience Forum such as common information pictures.

7.3 Throughout any national level 4 and regional level 3 Industrial Action planning and response the trust has been fully compliant with command and control arrangements. Situation Reports (SITREPs) flowed to the Kent and Medway Operational and Incident Control Centres and briefings, instructions and information has been received; as briefings and items for action.

8. Co-operation with other local responders.

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

9. Training programme

9.1. During 2023/24 and to date, training has been given to KMPT staff by EPRR Team on:

- Induction via eLearning
- Loggist training
- Staff entering onto the Director on call rota, Manager on call rota and Clinical Leads and refresher training sessions.
- Those requiring support with writing and reviewing Business Continuity Plans.
- Management of self-referrals with a hazardous material contamination, at reception areas across the Trust via eLearning

9.2 EPRR Team members

- 1 x Diploma Health Emergency Preparedness, Resilience and Response
- 1 x CBCI update to current standard

9.3 Externally EPRR Team members have provided training

- In conjunction with the ICB for Border Force on Loggist Training
- In conjunction with the Kent and Medway Resilience Team on Risk Assessment for members of the Risk Assessment Group and for Incident Commanders.

10. Exercise programme and Incidents

10.1. The duty placed on the Trust within the NHSE Core Standards is that it performs a communications cascade bi-annually and a table top exercise annually with a live exercise tri-annually. These elements have all been achieved in the 2023/24 work plan.

10.2 Internally communication and multiple table top exercises were undertaken, to allow for learning in support of service business continuity plans and incident plans:

Communication

- Exercise Melville ICB Communications Exercise 26/10/2023
- Exercise Toucan National NHS Communication Exercise 23/05/2024
- Exercise Activate Communications Exercise 17/06/2024

Table Top

- Exercise Arrow – Tarentfort Unit 14/09/2023
- Exercise Globe – Trevor Gibbens Unit 05/04/2024
- Exercise Hydro – (Critical Utilities) Greenacres site with PFI Estates provider May 14/02/2024
- Exercise Apollo – 111 Tonbridge Road 19/04/2024
- Exercise Ragdoll – Mother and Baby Unit/ Infant Abduction 11/07/2024 (Multi-agency)

10.3 Externally the trust has attended a local exercise and specialist briefings which have allowed for the review, validation and adaptation of response plans:

- Cold Weather Preparedness Programme Webinar 07/09/2023
- UK Power Networks Winter Resilience Briefing 07/11/2023
- Exercise Melville (Full acute hospital evacuation) 24/04/2024
- Cabinet Office National Threat and Risk Assessment Briefing April 2024
- KMRF Sink Holes Webinar 27/04/2024
- KMRF Coal Authority Webinar 07/02/2024
- UKHSA Summer Resilience Briefing 09/05/2024
- NHS Southeast EPRR Conference 18/04/2024

10.4 Within 2023/2024 the trust responded to the following Business Continuity/ Regional Incident declarations which have allowed for further validation of current plans and procedures where recommendations are project managed via a corrective action database:

- Junior Doctors/Consultants Industrial Action 02/10/2023, 20/12/2023, 03/01/2024, 24/02/2024, 27/06/2024
- Microsoft IT Business Continuity Incident 26/03/2024
- Ethelbert Road (Utility failure) Business Continuity Incident 19/05/2024

11. Methodology on opening of the 2024/2025 EPRR work plan

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

11.2 The NHS Core Standards Framework self-assessment has been undertaken and is used to generate the EPRR Improvement Plan (2024/25).

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

11.4 Identification of Plans, Policies and Standard Operating Procedures for 2024/2025 is set against master index held by the Trust Policy Manager.

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

11.6 Trust Business Continuity Programme baselines at 31 August 2024 and is forward planned against the priority of a plan and the transformation agenda.

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

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

12. Workforce Resource 2024/25

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

Chief Nurse	Accountable Emergency Officer
Deputy Director of Quality and Safety	Deputy Accountable Emergency Officer
Emergency Preparedness and Resilience Lead	Subject Matter Expert (RGN, DipN, DipHep, CBCI)
Emergency Preparedness and Resilience Officer	Non-Clinical Subject Matter Expert (DipHEPRR)
Resilience and Risk Administrator	Office functions

13 Action required from Board

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

- Note the closing of the 2023/2024 EPRR work plan.
- Note the EPRR 2023/24 Statement of Compliance (Appendix 1)
- Ratify the EPRR Improvement Plan (Appendix 2).
- Note the EPRR Policy (Appendix 3)
- Note the content of the 2024/2025 EPRR work plan commencing 1 September 2024 (Appendix 4).
- Share the NHSE ratified EPRR audit outcome on an annual basis with stakeholders and service users via the Trust Annual Report or appropriate mechanism.

Appendix 1.

Emergency Preparedness, Resilience and Response 2023/24 Statement of Compliance.

EPRR Statement of Compliance

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

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

As part of the national EPRR assurance process for **2023/24**, Kent and Medway Social Care Partnership Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 58 of the core standards which are applicable to the organisation, Kent and Medway Social Care Partnership Trust

- is fully compliant with 57 of these core standards;

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

- The overall rating is: Substantially Compliant

Andy Cruickshank
Kent and Medway Social Care Partnership Trust
15/08/2024

NHS England South East EPRR Assurance compliance ratings

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

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

Appendix 2.

Emergency Preparedness, Resilience and Response 2024/25 Improvement Plan

EPRR Improvement Plan:
Version: 1.0

Kent and Medway Partnership Trust (KMPT) has been required to assess itself against the NHS core standards for Emergency Preparedness, Resilience and Response (EPRR) as part of the annual EPRR assurance process for 2023/2024. This improvement plan is the result of this self-assessment exercise and sets out the required actions that will ensure full compliance with the core standards.

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

Core Standard	Current self-assessed level of compliance **(RAG rating)**	**Remaining actions required to be fully compliant**	**Planned date for actions to be completed**	**Lead name**	**Further comments**
58	Partially compliant	Exercise of CBRN incident with partners, debrief and report with recommendations flowing back to Hazardous Material Standard Operational Procedure via the Corrective Action Database.	July 2025	EPR Lead	Engagement with Kent Fire and Rescue against availability on their exercise programme.

Appendix 3

Emergency Preparedness, Resilience and Response Policy

(In Diligent Reading Room)

Appendix 4

Emergency Preparedness, Resilience and Response 2024/25 Work Plan

Action ID	CCA Duty	Item	Frequency	Governance	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
1	Duty to co-operate	Local Health Resilience Partnership - Executive Group	Three times per work plan	Reporting to NHSE and UKHSA who Co-chair			X				X				X	
2	Duty to co-operate	Local Health Resilience Partnership Delivery Group	Bi-monthly	Reporting to LHRP Executive Group		X		X		X		X		X		X
3	Duty to co-operate	Local Resilience Forum - Risk Assessment Group (LHRP DG Work Plan)	Bi-Annual in person Group Meeting and all risk work via TEAMS to a site held by KCC.	Reporting to KMRF Delivery Group	X							X				
4	Duty to co-operate	Local Resilience Forum - Deputy Chair of Risk Assessment Group/ Chairs and Deputies Meetings, National Meetings and Work planning Meetings.	No more than 1 day per month.	Reporting to KMRF Delivery Group	X	X	X	X	X	X	X	X	X	X	X	X
5	Duty to co-operate	LHRP Delivery Group appointed KMRF Meetings (as per LHRP DG work plan)	As detailed by Local Resilience Forum (KMRF) to attendees	Reporting via Exception Reports to the LHRP Delivery Group	X	X	X	X	X	X	X	X	X	X	X	X
6	Duty to co-operate	Southeast Community Providers EP Meeting	Quarterly	Exception report to LHRP DG	X			X			X			X		
7	Duty to co-operate	ICB EP Leads Meetings	Fortnightly	ICB Notes	X	X	X	X	X	X	X	X	X	X	X	X
8	Duty to co-operate	Medway Safety Advisory Group	Monthly and via Event App	Minutes held by Medway Council - Events Team	X	X	X	X	X	X	X	X	X	X	X	X
9	Duty to co-operate	Swale Safety Advisory Group	Bi Annual and High Risk Events Adhoc Meetings and via Event App	Minutes held by Swale Borough Council - Resilience Team	X	X	X	X	X	X	X	X	X	X	X	X

10	Internal Governance	Report to Audit and Risk Committee (EPRR Annual Report/Work Plan, Post NHS E Audit of Core Standards for Annual Governance Statement) and EPRR policy to ARC reading room.	Bi-Annual	ARC report to Board.	Annual Report						NHSE outcome letter					
11	Internal Governance	Trust wide Health, Safety and Risk Group (EPRR Sub-group Highlight Report and Plan/Policy ratification)	Quarterly	Bi- Annual Report from TWHS&RG to ARC and by exception.	X			X			X			X			
12	Internal Governance	Trust wide Emergency Preparedness, Resilience and Response Working Group. (Feedback from LHRP/ARC and Workplan maintenance)	Quarterly	Highlight Report to TWHS&RG	X			X			X			X			
13	Duty to risk assess	National Threat and Risk Assessment/ LRF - KMPT Risk and Capability Review.	Annual and Adhoc as Cabinet Office releases updates.	Official Sensitive information held on Resilience Direct									X				
14	Duty to risk assess	EPRR Risk - Action reviews to close gaps in controls and provide greater assurance.	Monthly, with Report Quarterly	Report to TWEPRRWG and TWHS&RG	X	X	X	X	X	X	X	X	X	X	X	X	
15	Core Standards Improve	Core Standard 58	Once	Reporting to TWEPRRWG and TWHS&RG											X		
16	Duty to maintain plans	Maintaining existing Plans/Policy and SOPs	As defined against each published Plan/Policy or SOP or as corrective action or regulatory changes impact.	Highlight report for those SOPs ratified at TWEPRRWG, with Plans and Policies ratified at TWHS&RG. BCPs are ratified at a Service level only and check by EPRR prior to publication..		Death of a patient COVID19 SOP BCPs due	Electricity Disruption Plan Water supply Disruption Plan Management of Industrial Action SOP Temporary Logo scheme BCPs due	Fuel Crisis Plan BCPs due	Leaflet- Staff Support following a Major Incident Leaflet psychosocial reactions to Major Incident BCPs due	Major Incident Plan Significant Incident Plan BCPs due	BCPs due	BCPs due	Summer Resilience Plan Structured debrief SOP BCPs due	BCPs due	BCPs due	Winter Resilience Plan, Cyber Resilience Plan BCPs due

17	New Plans	Based on a gap in capability assessment- Create Plans and check BCPs	N/A	TWHS&RG		Armed Forces Reservist List SOP	Gas Disruption - BCP reviews	KMPT - Full Site Evacuation Plan - Medway Hospital (As first of suite of docs)	Isle of Grain (COMAH) Incident SOP		Sewage Failure SOP	Medical Gas BCP		Telecommunications Resilience and Response Plan		
18	Exercise Programme	To comply with Exercise requirements in NHS EPRR Framework (at a minimum) 2x Communication 1x Table Top 1x Live (3 yearly) and 2x MOJ Assurance Table Top 2025 Cyber Resilience Exercise	Annual	TWHS&RG and Corrective Action Database	TT Ex Arrow	ICB Led Comms EX TT Ex Globe	TT Ex Willow			TT Ex Cyber Ex Internal Comms				ICB Led Communication EX Live Ex Chemical Ex Internal Comms		
19	Training Programme	Directors on call/ Managers on call/Clinical Leads	Provide for 2 sessions per month	TWEPRRWG	X	X	X	X	X	X	X	X	X	X	X	X
20	Training Programme	Key Operational staff MBU Switchboard Estates on call Digital on call TGU and LS on call	Provide for 2 sessions per month	TWEPRRWG	X	X	X	X	X	X	X	X	X	X	X	X

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Medical Revalidation Report
Author:	Dr Mohan Bhat, Deputy Chief Medical Officer for Workforce
Chief Medical Officer:	Dr Afifa Qazi, Chief Medical Officer

Purpose of Paper

Purpose:	Approval for Submission to NHS England
Submission to Board:	Regulatory (Responsible Officer Regs 2010 (as amended 2013)

Overview of Paper

Annual Organisation Audit Report and Statement of Compliance to Board for approval prior to submission to NHS England (2023/24).

Report is submitted to Board to provide assurance on appraisal and revalidation of doctors employed by the organisation and following approval will be submitted to NHSE as a statutory requirement.

Issues to bring to the Board's attention

1) 100% of KMPT Doctors (136/136) completed their appraisal in the year or within the first quarter of the next year. In addition to this there were 11 doctors who had approved exemptions for the appraisal year, 1 on a career break, 7 new starters, 1 on maternity leave and 2 on long term sick leave.
2) In line with GMC requirement and Responsible Officer Protocol, KMPT has a robust process in place to ensure recommendations to the GMC are timely and our doctors are revalidated in line with GMC requirements.
3) All actions raised from 2022/2023 Annual Organisation Audit Report on medical revalidation have been completed.

Governance

Implications/Impact:	KMPT meets the regulatory requirement for designated bodies (Responsible Officer Regs 2010 (as amended 2013) to ensure all Doctors employed by the organisation are fit to practice. There are no Resource and Financial Implications.
Assurance:	The paper is to provide assurance on compliance with the Responsible Officer (RO) regulations submission of the Annual Organisation Audit Report to NHS England.
Oversight:	Chief Medical Officer

Version Control: 01

Briefing Note:

Revalidation and appraisals are carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop, so care continuously improves. All Responsible Officers, who are the people responsible for helping doctors with revalidation, are required to complete the Annual Organisational Audit (AOA) on behalf of their organisations or 'designated bodies'. The collective results from the exercise provides a level of assurance about the consistency of the appraisal process supporting medical revalidation to patients and the public; and to doctors, Responsible Officers and the organisations in which they work; to higher level Responsible Officers in NHS England's regional teams, the General Medical Council and Ministers on the value that medical revalidation brings.

Our Annual Organisational Audit (AOA) for 2023/24 has concluded that as an organisation we have fit for purpose processes in place to ensure our doctors are appraised and revalidated in a timely manner in line with RO Regulation. We are assured that all our doctors are fully engaged with the appraisal and revalidation process.

Version Control: 01

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

The board/executive management team of Kent and Medway NHS and Social Care Partnership Trust can confirm that:

1A – General

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes / No:	Yes
Action from last year:	None
Comments:	Chief Medical Officer is our RO.
Action for next year:	None

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	None
Comments:	We have an established Medical Revalidation Team and the Deputy Chief Medical Officer also supports the RO in this function.
Action for next year:	None

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Yes / No:	Yes
Action from last year:	None
Comments:	The Medical Revalidation Team keeps an updated record of all the licensed medical practitioners with a prescribed connection to KMPT.
Action for next year:	None

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes / No:	Yes
Action from last year:	The revalidation and medical policy to be submitted to LNC for ratification.
Comments:	This has been completed.
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Yes / No:	Yes
Action from last year:	None
Comments:	TIAA audited our revalidation processes and all the recommendations have been completed and have been reaudited by TIAA.
Action for next year:	None

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Yes / No:	Yes
Action from last year:	None
Comments:	
Action for next year	None

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Yes / No:	Yes
Action from last year:	To ensure all doctors are aware of the changeover to version 7 MAG form.
Comments:	The layout for the new version on the IT system SARD is still being agreed upon and once agreed the doctors will be moved to the new version. This however does not affect the quality of the appraisal and also does not affect the revalidation of any doctors.

Action for next year:	To agree the layout of the version 7 MAG on the IT system SARD by end of this year.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	None
Comments:	
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes / No:	Yes
Action from last year:	
Comments:	
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes / No:	Yes
Action from last year:	Continue the annual refresher training for appraisers.
Comments:	This has been completed.
Action for next year:	None

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Yes / No:	Yes
Action from last year:	None
Comments:	
Action for next year:	None

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes / No:	Yes
Action from last year:	None
Comments:	TIAA audited the appraisal system last year (2022-23) and all the recommendations have been completed and confirmed by TiAA via reaudit (2024)
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	To continue processes
Comments:	Recommendations to GMC are made in a timely manner. There have been no delays in the recommendations for revalidations.

Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Yes / No:	Yes
Action from last year:	To continue processes
Comments:	
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Yes / No:	Yes
Action from last year:	None
Comments:	There is a robust line management and supervision structure for all doctors in KMPT.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Yes / No:	Yes
Action from last year:	To continue processes

Comments:	This is via the rigorous monthly Decision-Making Unit (DMU) chaired by the CMO.
Action for next year:	None

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Yes / No:	Yes
Action from last year:	To continue processes
Comments:	The Medical Education and Medical Revalidation Team support the doctors with this.
Action for next year:	None

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Yes / No:	Yes
Action from last year:	To continue processes
Comments:	This is via the DMU.
Action for next year:	None

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	None
Comments:	This is being monitored at the DMU.
Action for next year:	We will report these figures annually from this year (2024-25) to the People Committee in the “managing concerns around doctors”.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Yes / No:	Yes
Action from last year:	To continue processes
Comments:	This is supported by the Medical Revalidation Team.
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor’s practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Yes / No:	Yes
Action from last year:	None
Comments:	This is will be monitored by the annual report on “managing concerns around doctors” to the People Committee.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Yes / No:	Yes
Action from last year:	To continue processes
Comments:	This is supported by Medical Education and Clinical Effectiveness and Outcome Group (NICE guidance, research, clinical audit and clinical policies are monitored via this group).
Action for next year:	None

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	To continue processes
Comments:	We have a digital appraisal system for all staff. Clinical Directors have oversight of the professional standards for all healthcare professionals within their respective directorates.
Action for next year:	None

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Yes / No:	Yes
Action from last year:	To continue processes

Comments:	This is maintained by the Medical Staffing Department.
Action for next year:	None

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Yes / No:	Yes
Action from last year:	
Comments:	Job planning is used to ensure consistency and delivery of expectations for clinical activity, ensuring high professional standards with a culture of transparency and collaboration. The Trust implemented monthly excellence awards called 'Values in Practice Awards' in May 2024 which supports recognising excellence in care. We have also implemented the Patient Safety Incident Response Framework meeting the four key aims the framework sets out to provide.
Action for next year:	None

(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Yes / No:	Yes
Action from last year:	
Comments:	The Trust has undertaken an in-depth review of our culture and identity over the past 12 months. As a result, we have chosen to update our trust values to better reflect the work we do and the service we provide. These

	have been launched recently and are Caring, Inclusive, Confident and Curious. Included in this work we have had a focus on EDI and have substantive plans and actions across the trust to reduce violence, aggression and racism. To further support this work, we are about to embark on a leadership and culture development programme for our 'Top 50' leaders which will further enable them to lead the culture journey and improve cultural competence.
Action for next year:	None

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Yes / No:	Yes
Action from last year:	
Comments:	The new Trust Behaviour Framework provides our values and behaviours. We are supported by a Freedom to Speak up Guardian (external service) who helps colleagues to raise concerns safely when they do not feel they can use the local mechanisms we provide and encourage. Learning from concerns is key to improving patient safety and quality of care. Our CEO provides regular 'Speak to Sheila' sessions for all staff who are able to raise and discuss any topics they feel of relevance, ask questions and discuss matters of importance to them. We are trialling a new 'staff council' within one of our directorates which will further support staff with a mechanism to raise questions and concerns, offer ideas on improving patient and staff experience and enhance our learning culture. The ambition is to learn from this trial and roll out across KMPT in 2025.

Action for next year:	None

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards process by its connected doctors (including the existence of a formal complaints procedure).

Yes / No:	Yes
Action from last year:	
Comments:	We have a framework for management supervision for all doctors where these can be raised. The organisation provides access to a freedom to speak up guardian and there is a clear whistle blowing policy.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Yes / No:	Yes
Action from last year:	None
Comments:	This will be reported annually to the People Committee via the "managing concerns around doctors" report.
Action for next year:	As above in the comment

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	To continue processes
Comments:	The RO and Deputy RO attends the network meetings and high-level RO meetings.
Action for next year:	None

Section 2 – Metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024. .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	147

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	136
Total number of appraisals approved missed	11
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	39
Total number of late recommendations	0
Total number of positive recommendations	33
Total number of deferrals made	6
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	**5**
Total number of trained case managers	**3**
Total number of new concerns registered	**14**
Total number of concerns processes completed	**11**
Longest duration of concerns process of those open on 31 March	**4 years 4 months** (the delay was caused due to involvement of external agencies in the investigations)
Median duration of concerns processes closed	**6 months**
Total number of doctors excluded/suspended	**0**
Total number of doctors referred to GMC	**1** (self-referral made by the doctor)

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	11
Number of new employment checks completed before commencement of employment	10 (One overseas doctor placed in a non-clinical role whilst awaiting checks)

2F Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	1
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
At KMPT in the last year we had a total of 136 doctors had their appraisals. The 11 doctors who did not have the appraisal had agreed exceptions. We are continuing the annual refresher training for all the appraisers in the Trust to standardise the quality of appraisals. Since the last board report we had 2 actions arising from the TIAA audit on our appraisal and revalidation system. In response to this, we have updated our Medical Revalidation Policy taking into account the recommendations from the audit and has now been ratified. We have also produced reassurance to the Board about the improved practice of the revalidation process by conducting a re-audit which confirmed that that actions plans of improvement had been successfully implemented.

Actions still outstanding
None.
Current issues
No current issues identified.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
To agree the layout of the version 7 MAG on the IT system SARD by end of this year.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
We have had another successful year with regards to Doctors having their annual appraisals completed. We have also taken steps to support the doctors in this process and also ensured that the current appraisers are trained to improve the quality of appraisal experience of our doctors. We are committed to maintain and continually improve this overall process.

Section 4 – Statement of Compliance

The Board/Executive Management Team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body [(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	

Name:	
Role:	
Signed:	
Date:	

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Register of Board Members Interests – September 2024
Author:	Tony Saroy, Trust Secretary
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

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

Issues to bring to the Board's attention

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

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

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

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

Governance

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable
Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee

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Register of Board Members Interests – September 2024

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

Interests fall into the following categories:

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

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

REGISTER OF BOARD MEMBERS INTERESTS
September 2024

Director	Position	Interest declared
Dr Jackie Craissati	**Trust Chair**	Jackie is Director of Psychological Approaches CIC, which is on the NHS England framework for Independent Serous Incident Investigations. However, the company does not undertake investigations relating to KMPT. Jackie is chair of Crohn's & Colitis UK. The charity works closely with the NHS but is not commissioned to deliver services. Jackie is Independent Governor on the Board of the University of East London. There is the unlikely possibility that a particular serious safeguarding incident in relation to Lasting Power of Attorney has links to Kent & Medway. Jackie is Chair at Dartford and Gravesham NHS Trust
Catherine Walker	**Non-Executive Director** (Deputy Chair & Senior Independent Director)	Catherine is Chair of the Advisory Appointments Committee at Kings College Hospital NHS Foundation Trust, London Catherine holds judicial appointments in the Social Entitlement Chamber of the First Tier Tribunal and the Health Service Products (Pricing Cost Control and Information) Appeals Tribunal.

Kim Lowe	**Non-Executive Director**	Kim is a Non-Executive Director and Deputy Chair at Kent Community Health Foundation Trust.
Mickola Wilson	**Non-Executive Director**	Director of Seven Dials Fund Management and advisor to private investors in Real Estate. Former CEO of Teesland plc and MD of Guardian Properties. Non-Executive director of Mailbox REIT. Member of the Property Committee of the Mercers Livery Company. Member of the Council for Essex University Non-Executive Director BBRC (NFP Residential Company specialising in Key Worker Housing Member of the Chartered Surveyors Livery Company
Sean Bone-Knell	**Non-Executive Director**	Associate Inspector for His Majesty's Inspectorate of Constabulary and Fire and Rescue Services (From January 2024)
Peter Conway	**Non-Executive Director**	Independent Member of the West Kent Housing Association Audit Committee (until 24/09/24) Non-Executive Director of the West Kent Housing Association (from 25/09/24)
Stephen Waring	**Non-Executive Director**	Board Trustee and Vice-Chair of Trustee Board (unremunerated) of The Disabilities Trust (a charity offering specialist community-based and residential support for adults with acquired brain injury and complex physical disabilities). Employed (on an interim basis) at Greater London Authority, Health and Wellbeing Team.
Dr MaryAnn Ferreux	**Non-Executive Director**	Trustee - Royal College of Physicians Edinburgh Doctoral Researcher – London School of Hygiene and Tropical Medicine Medical Director at Kent, Surrey & Sussex Academic Health Science Network Non-Executive Director at Kent Community Health Foundation Trust.
Dr Asif Bachlani	**Associate Non-Executive Director**	Director of Company – AMB Psychiatry Limited that provides ADHD/ASD assessments for patients at Priory Woking hospital. Consultant Psychiatrist for Priory Woking Hospital providing care for private mental health patients NHS Benchmarking Reference Group Vice Chair– Mental Health, LD and Autism Mental Health Governance Lead for London Wellbeing Care.

Sheila Stenson	**Chief Executive Officer**	Sheila is the Chair HFMA Kent, Surrey and Sussex
Donna Hayward-Sussex	**Chief Operating Officer & Deputy CEO**	None declared
Dr Afifa Qazi	**Chief Medical Officer**	None declared
Andrew Cruickshank	**Chief Nurse**	None declared
Nick Brown	**Chief Finance and Resources Officer**	Spouse is an employee of KCHFT
Sandra Goatley	**Chief People Officer**	Member of the Remuneration Committee and People Committee for University of Kent
Dr Adrian Richardson	**Director of Partnerships and Transformation**	Spouse is an employee of Frimley ICS

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 26th September 2024

Title of Paper: Trust Sealing Report

Author: Nicola Legge, Legal Services Manager

Executive Director: Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose: Noting

Submission to Committee: Standing Order

Overview of Paper

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

Issues to bring to the Committee's attention

Two documents have been signed and sealed as a deed during from Q1 24/25 This process has been undertaken by Legal Services as per the Trust Standing Orders.

Governance

Implications/Impact: No impact

Assurance: Substantial Assurance

Oversight: Board

Version control: 1

Number	Date of Sealing	Description	Signatures	Comments
157	16.05.2024	Centralised Health Based Place of Safety	Sheila Stenson Jackie Craissati	Project Scheme Agreement for the building of the Centralised Health Based Place of Safety

Version control: 1

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th September 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**
• Acute on Violence Reduction Presentation • Violence and Aggression Report	• Digital 6L ECG and QTC instant QT Update • Zonal Observations • Section 136 Breaches/CNO Report • CMHS New Model of Care • Quality Digest • Quality Impact Assessments	• Chief Nurse's Quality Report • Quality Risk Register • Research Strategy • Clinical Audit Annual Report – National Audits and Accreditation • DPIC Annual Report and Declaration

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.**
Acute on Violence Reduction Presentation	The Committee recognised the positive work being undertaken regarding violence and aggression, which will be taken into the new financial year. As time progresses, the changes made will need to be reviewed to	Reasonable Assurance	Quality Committee will continue to receive regular updates on violence and aggression and will monitor progress.

	ensure these are sustainable and fully embeded as staff change.		
Chief Nurse Report	There have been recent concerns regarding bedroom seclusion in certain areas of the Trust. It was agreed that this should be referred to the Mental Health Act Committee for oversight. Following the three homicides that took place in Nottingham, the Trust has completed a mandated gap analysis issued by the CQC. The Integrated Care Board have also been asked to complete a separate gap analysis by NHS England and this is underway. Workplans will be produced following the gap analysis.	Limited Assurance Reasonable Assurance	To be referred to the Mental Health Act Committee for oversight. The Board will receive the CQC gap analysis at their Private Board meeting.
Research Strategy	The Board delegated oversight of the Research Strategy to the Quality Committee. Reasonable assurance can be taken that this is progressing well, with movements in the right direction to this becoming a self-sustaining model. However, despite this the scale of the challenge remains large.	Reasonable Assurance	Quality Committee will continue to receive regular updates on the Research Strategy.
Section 136 Breaches	The Committee noted the report and agreed that this should be referred to the Mental Health Act Committee for oversight.	Reasonable Assurance	To be referred to the Mental Health Act Committee for oversight.
Zonal Observations	Following the Board action, the Committee received a verbal update on the zonal observations project, noting that roll out will begin from December 2024.	Reasonable Assurance	Board action to be updated as completed.

CMHS New Model of Care	Following the roll out of Mental Health Together, there has now been a large number of referrals to the Trust, which has caused a waiting list with over 5000 patients on it. It is suggested up to 40% of those referrals do not need to sit with the Trust, and are better suited to Primary Care.	Limited Assurance	This will be highlighted to the Trust Board via the IQPR and will be included on the Board Assurance Framework.
Clinical Audit Annual Report – National Audits and Accreditation	For the last 10 years, the Trust has been participating in the prescribing observatory for Mental Health UK, for the Pompeii GK AUDITS. This year the Trust has been acknowledge by the Royal College of Psychiatrists around good practices and this has been shared with other Trusts as well particularly around clozapine prescribing.	Substantial Assurance	
Quality Digest	The Trust is performing well in the NHS Patient Friends and Family Test, with 88% of responses received being positive about their overall experience. This is above the national average for mental health trusts. The Committee praised the recent HSJ award nominations for Dr Afifa Qazi for Clinical Leader of the Year and the Pharmacy team for medicine prescribing.	Reasonable Assurance	
DPIC Annual Report and Declaration	The Committee reviewed and endorsed the DPIC Annual Report and Declaration for approval.	Substantial Assurance	The Board is asked to approve the DPIC Annual Report and Declaration, which is available in the reading room.
Free Text - [commentary box for any additional comments]			

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th September 2024**
Title	**Audit and Risk Committee Chair's Report**
Author	**Peter Conway, Audit and Risk Committee Chair**
Presenter	**Stephen Waring and Kim Lowe, Audit and Risk Committee Members**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Board to endorse/amend the actions proposed**

Agenda Items

Finance and Regulatory items

- Board Assurance Framework
- Trust Risk Register
- Risk Deep Dive – Increased level of DToC
- Risk Strategy and Risk Policies Review
- External Audit Report
- Internal Audit Report
- Anti-Crime Report
- Effectiveness and VFM of Auditors Review
- Director of Finance Items
- Single Tender Waivers Update
- Losses and Special Payments April-June 2024
- Digital and Data Update
- Digital Risks Report
- Health and Safety Reviews
- Fire Safety Report
- Emergency Preparedness and BRP Reviews
- ICS Governance Issues
- Audit and Risk Committee Terms of Reference & Committee Workplan
- Committee Effectiveness Review

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.
Action Log and Matters Arising	Reporting issues continue with the current InPhase system, with a large amount of manual work having to be carried out. A Risk Appetite Seminar is due to be scheduled with an external facilitator. Until this seminar takes place, the Trust will not meet the recommendations set by the External Well Led Review and the External Auditors. The Risk Management Framework 2024-27 will be published without the risk appetite statement for now.		InPhase has been bought by Ideagen. The Trust has met with the new owners, and it is estimated it will take up to 6 months to get the system to where it needs to be. In the meantime, work is underway with the Business Intelligence Team to design a bespoke reporting mechanism Seminar to be scheduled into the Board Programme. Date to be confirmed.
Board Assurance Framework (BAF)	BAF risks are broadly the right ones but the detailed content is a bit mixed. The key areas that need focus are (1)better descriptions of the risks, (2) actions being taken and by when and (3) better triangulation between these actions, the current risk rating and the target position after mitigations	Limited Assurance	Exec, risk owners and risk team to address
Trust Risk Register (TRR)	The Trevor Gibbons Units Boundary Fence Risk was discussed in detail. The TRR narrative is difficult to follow. Assurance was received that we are not in statutory breach, a workaround (a fence lower than the prescribed height) is being progressed while a longer term solution plus funding is pursued.	Limited Assurance	The risk will be updated ahead of the next meeting to describe the precise risks and their mitigations plus detail and timings of longer term measures
Risk Deep Dive – Increase levels of Delayed Transfers of Care (DToC)	The current risk for DToC is being revised, and in future will form part of the wider Patient Flow Programme. Social care and housing continue to be	Limited Assurance	The risk to be redescribed, updated and reflect a trajectory of likely delay levels over the next 6-9 months. Improvement from

	challenges. Dialogue is ongoing with the Integrated Care Board and other key partners		current levels of DToC is unlikely in the short-term
Internal Audit Report	The Trust received two limited assurance reports, one on the post implementation of E-Meds and the second on 8x8 Cloud Telephony Services.	Reasonable Assurance	Both audits are receiving prompt management attention with a number of the higher priority recommendations already remediated (will be subject to further audit)
Data and Digital Update	The IT team continues to focus on the cyber security position where assurance remains reasonable	Reasonable Assurance	It was agreed that the business continuity exercise taking place in February 2025 should consider the implications of RiO being unavailable for an extended time (ie. longer than 1 week).
Digital Risks Report	It was felt that the key digital risks were not fairly reflected in the Register given the strategic significance of digital/IT to the Trust as a whole.	Limited Assurance	The Digital Risks Register will be overhauled and re-submitted to the next ARC
Emergency Preparedness and BRP Reviews	The Committee discussed and endorsed the Emergency Preparedness Report.	Substantial Assurance	It is recommended the Board approved the Emergency Preparedness Report. The Board should note that a risk appetite statement is yet to be formulated.
Terms of Reference	The Committee endorsed the Terms of Reference for approval by the Trust Board, subject to clarification of the Freedom to Speak Up requirement		The Trust Secretary to provide a framework to the Trust Board on the oversight of Freedom to Speak Up across Committees and the Board

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th September 2024
Title of Paper:	Audit and Risk 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.

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 reviewed their Terms of Reference at their September meeting and recommended them for approval by the Trust Board subject to two amendments. The first amendment was for clarification around the Freedom to Speak Up governance process across the Board and its Committees. The second was for the removal of the equality statement, as this is already addressed in the NHS England standards for NEDs and within Trust policies for KMPT staff.

Governance

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

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Terms of Reference

Name of Committee	**Audit and Risk Committee (ARC)**	
Date	**11 July 2024**	
Version	**V23.1**	
Approval	**ARC**	
	Trust Board	
Next review due		

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1.0	Draft	29.07.11	Val Woodin	
V1.0	Draft	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11for implementation January 2012
V1.1	Draft	21.11.11	Simon Muir Internal Audit	Review requested by IAC re NHS Trust Audit Handbook requirements for incorporating Risk element
V1.2	Draft	15.03.12	Val Woodin	Minor amendments mainly related to the name of the Committee
V1.3	Approved	27.09.12	Val Woodin	Additional duty to oversee strategic objective
V1.4	Approved	04.09.14	Val Woodin	Minor amendments agreed by IARC
V1.5	Approved	03.03.16	Rosanna Roughley	Addition of role of Panel for Appointment of External Auditors
V1.6	Approved	18.04.17	Sheila Wilkinson	Annual review – no changes recommended
V1.7	Approved	08.03.18	Sue Manthorpe	Annual Review – Addition of EPRR
V1.7	Approved	28.06.18	Trust Board	Approved by the Trust Board 28.06.18
V1.8	Draft	05.09.19	IARC	Review and approve
V1.9	Draft	02.07.20	IARC	Addition of explicit reference to review of Board Assurance Framework twice a year
V1.9	Approved	30.07.20	Trust Board	Approved by Trust Board 30.07.20
V2.1	Draft	08.01.21	TS/PC	Amended to reflect HM Treasury Audit and Risk Assurance Committee Handbook
V2.1	Approved	25.02.21	Trust Board	Approved by Trust Board
V2.1	Approved	01.03.22	ARC	Reviewed by the Committee and agreed no changes required.

V2.1	Approved	02.03.23	ARC	Reviewed by the Committee and agreed no changes required.
V3	Draft	11.07.24	Trust Secretary	Updated in line with HFMA Guidance and the Trust's internal governance refresh

1. Constitution

The board hereby resolves to establish a committee of the board to be known as the audit (and risk/ risk assurance) committee (the committee). The committee is a non-executive committee of the board and has no executive powers, other than those specifically delegated in these terms of reference.

Any amendments to these Terms of Reference can only be approved by the Trust Board. The Terms of Reference will be reviewed annually.

2. Purpose

The Audit and Risk Committee provides assurance to the Board that governance, risk management, financial reporting and internal controls are effective across the Trust.

3. Authority

The committee is authorised by the board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise, if it considers this necessary.

4. Membership

The committee shall be appointed by the board from amongst its independent, non-executive directors and shall consist of not less than three members. A quorum shall be two of the three independent members. One of the members will be appointed chair of the committee by the board. The chair of the organisation itself shall not be a member of the committee.

The Chief Finance and Resources Officer and appropriate internal and external audit representatives shall normally attend meetings.

The counter fraud specialist (LCFS) will attend a minimum of two committee meetings a year.

The trust secretary may attend meetings.

The accountable officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

Other executive directors/ managers should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director/ manager.

Representatives from other organisations (for example, the NHS Counter Fraud Authority (NHSCFA)) and other individuals may be invited to attend on occasion, by invitation.

A nominated person shall be secretary to the committee and shall attend to take minutes of the meeting and provide appropriate support to the chair and committee members.

At least once a year the committee should meet privately with the internal auditors, external auditors and LCFS either separately or together. Additional meetings may be scheduled to discuss specific issues if required.

5. Quorum

A quorum shall be two members.

6. Behaviours and Conduct

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's standing orders, and standards of business conduct policy.

7. Frequency of meetings

The committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. A benchmark of four to five meetings per annum (with a possible additional meeting to specifically review the annual report and accounts) at appropriate times in the reporting and audit cycle is suggested. The chair of the committee, board, accountable/ accounting officer, external auditors or head of internal audit may request an additional meeting if they consider that one is necessary.

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To assist in the management of business over the year an annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

8. Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist, as well as the security management specialist (where they do not report elsewhere).

9. Responsibilities

The committee's duties/ responsibilities can be categorised as follows:

Governance, risk management and internal control

The committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHSCFA.

In carrying out this work the committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the committee will have effective relationships with other key committees (for example, the quality committee, or equivalent) so that it understands processes and linkages. However, these other committees must not usurp the committee's role.

Internal audit

The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, accountable/ accounting officer and board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resources
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

The committee shall review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses

- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other assurance functions

The committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter fraud

The committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the local counter fraud specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Management

The committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Financial reporting

The committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation
- explanations for significant variances.

System for raising concerns

The committee shall review the effectiveness of the arrangements in place for allowing staff (and contractors) to raise (in confidence) concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters) and ensure that any such concerns are investigated proportionately and independently, and in line with the relevant policies.

Governance regulatory compliance

The committee shall review the organisation's reporting on compliance with the *NHS Provider Licence*, *NHS code of governance* and the fit and proper persons test.

The committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

10. Accountability and Reporting

The committee shall report to the board on how it discharges its responsibilities.

The minutes of the committee's meetings shall be formally recorded by the secretary and available for the board. The chair of the committee shall draw to the attention of the board any issues that require disclosure to the full board, or require executive action.

The committee will report to the board at least annually on its work in support of the annual governance statement, specifically commenting on the:

- fitness for purpose of the assurance framework
- completeness and 'embeddedness' of risk management in the organisation
- effectiveness of governance arrangements

- appropriateness of the evidence that shows that the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how the committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual committee effectiveness evaluation will be undertaken and reported to the committee and the board.

The audit committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

7. Secretariat and Administration

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The committee shall be supported administratively by its secretary. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging meetings for the chair: for example, with the internal/ external auditors or local counter fraud specialists
- maintaining records of members' appointments and renewal dates and so on
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

Title of Meeting	**Public Board Meeting**
Meeting Date	**26th September 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 & Governance items**
• People Committee Main Report • Equality, Diversity and Inclusion (EDI) Plan) • Embedding our new Trust Values • Senior Leadership Programme • Essential Training Compliance Update • Medical Clinical and Management Supervision Update • Guardian of Safe Working Hours Report		• HR Risk Register • Strategic Delivery Plan Priorities • HR Policies and Procedures • Committee Effectiveness Review

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.
Essential Training Compliance Update	There are 9 areas of essential training that do not meet the required 90% compliance.	Limited Assurance	This non-compliance with essential training to be discussed by the Executive Management Team and the risk appetite agreed, and will also be referred to the Quality Committee by the People Committee.
Main Report	The new government have stated that they will make changes to employment legislation which are likely to impact on us e.g. employees' rights from day one, no probation period(s) and our future approach on flexible working.	Reasonable Assurance	Action - Current workforce to be educated on cultural changes in place. Action - Looking at inclusion for different generations of staff who will have differing priorities.
Main Report	Most key performance indicators within the report are in a good place, there is evidence of increased summer sickness which is forecasted to continue over winter, partly due to Covid and Covid like symptoms. There has been a success in medical vacancies with the help of social media and flexibility roles. KMPT non-medical agency rates are within the NHS England caps and we do not use off framework agencies	Reasonable Assurance	To establish the position for COVID vaccinations for staff. Further work is required to improve the medical rate cards.
HR Risk Register	The Electric Files risk has been removed and has been mitigated by Information Governance work.	Reasonable Assurance	

Strategic Delivery Plan Priorities	Outputs and actions for year 2 are in place. We are on track with the actions, and the impacts will be measured once the staff surveys results are in.	Limited Assurance	
Equality, Diversity and Inclusion (EDI) Plan	There is now one plan in place, which has clear timelines, owners and outputs. However, it was felt more work needs to be completed on the inclusion element of the plan.	Reasonable Assurance	The Committee to receive a further update at a future meeting on the inclusion element of the EDI Plan. Generation A will be joining the workforce in 5 years, we need to be ready to receive this new generation and understand how the Trust can build effective multi-generational teams
Senior Leadership Programme	The Committee was assured and are supportive of the work going into the Senior Leadership Programme.	Reasonable Assurance	The Committee will continue to receive updates on the Senior Leadership Programme as it progresses.
Free Text – N/A			