Kent Community Health
NHS Foundation Trust

# Agenda and Papers

# for the

# Formal meeting of the

# Kent Community Health NHS Foundation Trust Board

# to be held at 10am on

# Thursday 27 July 2017

# At

# The Committee Room
# Tonbridge and Malling Council Offices
# Gibson Building
# Gibson Drive
# Kings Hill
# West Malling
# Kent
# ME19 4LZ

Kent Community Health
NHS Foundation Trust

**Meeting of the Kent Community Health NHS Foundation Trust Board**
**to be held at 10am on Thursday 27 July 2017**
**in The Committee Room,**
**Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill,**
**West Malling Kent ME19 4LZ**

**This meeting will be held in Public**

---

## AGENDA

| | | | |
|---|---|---|---|
| **1.** | **STANDARD ITEMS** | | |
| 1.1 | Introduction by Chair | Chairman | |
| 1.2 | To receive any Apologies for Absence | Chairman | |
| 1.3 | To receive any Declarations of Interest | Chairman | |
| 1.4 | To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on<br>• 25 May 2017<br>• 29 June 2017 | Chairman | |
| 1.5 | To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on<br>• 25 May 2017<br>• 29 June 2017 | Chairman | |
| 1.6 | To receive the Chairman's Report | Chairman | Verbal |
| 1.7 | To receive the Chief Executive's Report<br>• Sustainability and Transformation Plan Update | Chief Executive | |

Agenda

## 2. BOARD ASSURANCE/APPROVAL

| | | |
|---|---|---|
| 2.1 | To approve the Sustainability and Transformation Plan Hurdle Criteria | Medical Director |
| 2.2 | To receive the Quality Committee Chairman's Assurance Report | Chairman, Quality Committee |
| 2.3 | To receive the Integrated Performance Report | Chief Operating Officer/Deputy Chief Executive<br>Chief Nurse |
| 2.4 | To receive the Monthly Quality Report | Chief Nurse |
| 2.5 | To receive the Finance Report – Month Three | Deputy Director of Finance |
| 2.6 | To receive the Workforce Report | Director of Workforce, Organisational Development and Communications |
| 2.7 | To approve the Community Hospitals Safer Staffing Review Report | Chief Nurse |
| 2.8 | Policy for Ratification<br>• Maintaining High Professional Standards | Director of Workforce, Organisational Development and Communications |

## 3. REPORTS TO THE BOARD

| | | |
|---|---|---|
| 3.1 | To receive the Infection Prevention and Control Annual Report 2016/17 | Chief Nurse |
| 3.2 | To receive the Seasonal Infection Prevention and Control Report – Summer | Chief Nurse |
| 3.3 | To receive the Equality and Diversity Annual Report<br>• To approve the Equality Objectives for 2017/18 | Director of Workforce, Organisational Development and Communications |

| | | |
|---|---|---|
| 3.4 | To receive the Medical Appraisal and Revalidation Annual Report 2016/17<br>• To approve the Statement of Compliance | Medical Director |

## 4. ANY OTHER BUSINESS

| | | |
|---|---|---|
| | To consider any other items of business previously notified to the Chairman. | Chairman |

## 5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

## 6. DATE AND VENUE OF NEXT MEETING

**Thursday 28 September 2017**
**Council Chamber, Sevenoaks Town Council Offices, Sevenoaks, Kent**

Kent Community Health
NHS Foundation Trust

**Unconfirmed Minutes**
**of the Kent Community Health NHS Foundation Trust Board**
**held at 10am on Thursday 25 May 2017**
**in Room 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 – 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford, Kent TN25 4AZ**

**Meeting held in Public**

---

| | |
|---|---|
| **Present:** | David Griffiths, Chairman<br>Pippa Barber, Non-Executive Director<br>Paul Bentley, Chief Executive<br>Peter Conway, Non-Executive Director<br>Richard Field, Non-Executive Director<br>Gordon Flack, Director of Finance<br>Steve Howe, Non-Executive Director<br>Louise Norris, Director of Workforce, Organisational Development and Communications<br>Dr Sarah Phillips, Medical Director<br>David Robinson, Non-Executive Director<br>Lesley Strong, Deputy Chief Executive/Chief Operating Officer<br>Ali Strowman, Chief Nurse |
| **In Attendance:** | Gina Baines, Committee Secretary (minute-taker)<br>Natalie Davies, Corporate Services Director |

**25/05/1** **Introduction by Chair**

Mr Griffiths welcomed everyone present to the Public Board meeting of Kent Community Health NHS Foundation Trust (the Trust).

Mr Griffiths advised that this was a formal meeting of the Board held in public, rather than a public meeting, and as such there would be an opportunity for public questions relating to the agenda at the end of the meeting.

**25/05/2** **Apologies for Absence**

Apologies were received from Bridget Skelton, Non-Executive Director and Jennifer Tippin, Non-Executive Director.

The meeting was quorate.

**25/05/3 Declarations of Interest**

No conflicts of interest were declared other than those formerly recorded.

**25/05/4 Minutes of the Meeting of 30 March 2017**

Audit and Risk Committee Chairman's Assurance Report – top of page 7 of 183 to read '… putting in place further contingencies…'

The Board **AGREED** the minutes, subject to the amendment.

**25/05/5 Matters Arising from the Meeting of 30 March 2017**

The Board **RECEIVED** the Matters Arising.

**25/05/6 Chairman's Report**

Mr Griffiths stated that there were no significant issues to report to the Board that month.

**25/05/7 Chief Executive's Report**

Mr Bentley presented the report to the Board.

Dr Phillips was welcomed as a new Executive Director of the Trust Board.
It was confirmed that there had been several members of the Trust elected as Governors to the Trust's Council. Mr Bentley was looking forward to working with the new, strengthened body in the future.

The Trust had not been directly affected by the recent cyber attack on NHS IT systems. However, additional security measures had been put in place to strengthen the resilience of the Trust's systems. Staff had responded well to the incident and this had led to the organisation returning promptly to business as usual the following Monday morning.
In order to raise awareness amongst staff, patients and visitors of good infection prevention and control (IPC) practice, Ms Strowman and the IPC Team were leading a Trust wide campaign. This included posters which had been widely distributed across the community hospitals and clinics.
The Executive Team had undertaken some work to address maximising patient–facing time. The outcomes would be implemented initially in west Kent.
The One Stop One You shop in Ashford was proving a success in reaching new users as well as an example of partnership working with district and county councils.
With regards to improving the delivery of end of life care, the Trust was collaborating with NHS Improvement (NHSI) to further improve practice. The Trust would be focussing on supporting patients to make their wishes known regarding their preferred place of death, as well as working closely with their families to support their discussions around end of life decisions.
Members from the Lord Carter's team had met the Executive Team earlier that month to discuss operational productivity and performance in

community services trusts. The discussions had gone well, particularly in the area of wound care management.

In response to a question from Ms Barber regarding improving the success of any future overseas recruitment campaign, Ms Norris explained that, to avoid any misunderstanding, the Resourcing Team would make it clear to the possible applicants that the roles offered were based in the community rather than the acute sector.

**25/05/8** **Quality Committee Chairman's Assurance Report**

Mr Howe presented the report to the Board for assurance.

The Committee had met in April and May 2017.

With regards to patient death monitoring and reporting, Dr Arokia Antonysamy, Deputy Medical Director, had been appointed as the Trust Lead. Ms Barber would be the Lead Non-Executive Director. Both had attended a national briefing and Ms Barber would continue to attend on a quarterly basis. With regards to the Dental Service's Never Event action plan, this was on track. The service had introduced the World Health Organisation check list as a preventative measure. With regards to committee effectiveness, although the committee's operation had been aligned to its Terms of Reference, there was general consensus to move to an alternative and more stream-lined approach. This had been supported by Mr Griffiths and Mr Bentley. The Committee would seek to learn from trusts rated Outstanding and over the coming months develop a Quality governance framework that met its own needs and the needs of the Board.

High Did Not Attend rates in prison dental services were an enduring issue. This was attributed to prison arrangements and prison staff pressures, rather than poor efficiency in the service. The Care Quality Commission (CQC) was aware and the service continued to work closely with the prison authorities to try and improve the situation. With regards to the recent Clostridium difficile cross-infection at Heron Ward, Queen Victoria Memorial Hospital, Herne Bay, the investigation had now finished. The committee would be reviewing the resulting action plan which would set out Trust-wide lessons to be learnt. No avoidable pressure ulcers had been reported since January 2017. The report set out the Trust's position on recorded deaths within community hospitals in February and March 2017. All had been classified as expected.

The Board **RECEIVED** the Quality Committee Chairman's Assurance Report.

**25/05/9** **Audit and Risk Committee Annual Report**

Mr Conway presented the report to the Board for assurance.

The Committee had met the previous week and had received the 2016/17 Annual Accounts, governance and controls. The annual report of the

committee reflected well the range of activity that had been undertaken during the year.

The Board **RECEIVED** the Audit and Risk Committee Annual Report.

**25/05/10 Charitable Funds Committee Chairman's Assurance Report and Annual Report**

Mr Field presented the report to the Board for assurance.

Mr Griffiths welcomed the active fundraising that was taking place for particular projects. It was acknowledged that this was a challenge but essential to ensure that there were sufficient funds available to replace money as it was spent. The Committee was keen that i care, the Trust's charity, had a high profile to encourage greater participation in fund-raising.

Mr Griffiths added that the Committee needed to be mindful that there would be constraints on infrastructure that was purchased using charitable funds. It was agreed that this would be fed back to the Committee.
**Action** – Mr Field

The Board **RECEIVED** the Charitable Funds Committee Chairman's Assurance Report and Committee Chairman's Annual Report.

**25/05/11 2016/17 Annual Report and Accounts**

Mr Flack presented the report to the Board for approval.

The Trust had met all its statutory financial duties. The accounts had been prepared on a going concern basis. The 2016/17 Annual Report and Accounts and Governance Statement including the Remuneration Report and Assurance statements had been reviewed by the external auditors and the Audit and Risk Committee. The External Auditors had given an Unqualified Opinion. The Accounts showed that the Trust had had an excellent year, although the margins had been small once the central Sustainability and Transformation Funding (STF) had been discounted. This additional funding would be invested in future infrastructure projects.

In response to a question from Mr Field regarding whether a more condensed version would be published, Ms Norris confirmed that the key messages would be published in the Trust's quarterly Community Health magazine. The magazine was distributed widely across the county. The full report would be laid before Parliament, consistent with the Trust's statutory duties.

In response to a comment from Mr Conway regarding producing a shorter document in the future in line with other government departments, it was agreed that Ms Norris would investigate this.
**Action** – Ms Norris

Mr Griffiths requested that the organisational structure within the Annual Report was amended for accuracy.

The Board **APPROVED** the 2016/17 Annual Report and Accounts

2016/17 Annual Quality Report

Ms Strowman presented the report to the Board for approval.

The report had been reviewed by the Quality Committee. It had also been circulated to the clinical commissioning groups (CCGs) and HealthWatch for comment. The report had also been reviewed by the External Auditors. The Quality Priorities for 2017/18 had received significant input from all stakeholders.

The Board **APPROVED** the 2016/17 Annual Quality Report.

Self-Certification with NHS Providers Licence

Ms Davies presented the report to the Board for approval.

As required by its Foundation Trust licence, the Trust was required to self-certify whether or not it had complied with the conditions of the NHS provider licence and had complied with governance requirements. The Board was asked to confirm that it was satisfied with compliance against Condition G6(3) and Condition FT4(8).

The Board **APPROVED** the Self-Certification with NHS Providers Licence.

**25/05/12 Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

There had been a spread of performance at 2016/17 year end with 60 per cent of the Trust's Key Performance Indicators (KPIs) achieved or exceeded. An update was provided regarding a number of KPIs including stop smoking, Clostridium difficile cases, sickness rate, delayed transfer of care, Never Event, Health Visiting assessments times, long term condition activity, length of stay, and preferred place of death. In 2017/18, Referral To Treatment Times performance which would need some monitoring included Advanced Health Professionals, Podiatric Surgery, Community Paediatrics, and the Kent Continence Service; although some of these services were showing some early improvement. KPIs that were showing good performance included health visiting assessments, therapy services, and health checks. Services had met all their national targets that month. Good quality services were being maintained and the harm free care measure was above the benchmark. The Trust had also met its financial duties as well.

In response to a question from Ms Barber regarding compliance for moving and handling training, Ms Norris suggested that there had been an

improvement which had enabled the Trust to meet its target that month. However, because of the specific challenges associated with this training, compliance would continue to be monitored and alternative methods of delivery considered.

Mr Griffiths suggested that at year end, those KPIs that were still rated amber should be reassigned as red as they had not hit their target. There was some discussion and it was agreed that the Executive Team would consider this and bring a response back to the Board.
**Action** – Mr Bentley/Mr Flack

The Board **RECEIVED** the Integrated Performance Report.

**25/05/13 Monthly Quality Report**

Ms Strowman presented the report to the Board for assurance.

There had been an improved fill rate in April for Registered Nurses and Health Care Assistants, although, the wards in the community hospitals in Herne Bay and Tonbridge had not met the fill rate standard. A higher number of patients had required one to one care in the community hospitals. There continued to be an improving position in respect of pressure ulcers and there had been no serious incidents in relation to falls. A national approach towards falls had been published that week and would be discussed by the Quality Committee. With regards to the recent Clostridium difficile outbreak that had been reported, an action plan was in place and the IPC Committee and the Quality Committee were both monitoring it. The Quality Surveillance Meeting had met on 11 May 2017. Three community hospitals were on minor concern and were being monitored by the meeting. Patient experience remained extremely positive.

In response to a question from Mr Howe regarding the continued high level of one to one care that was being provided, Ms Strowman explained that this was due to the changes in the acuity of patients that were coming into the system. Current practice in the community hospitals was being reviewed and guidance was being developed to address any identified variations. It was agreed that a report by the community geriatricians would be brought to the Quality Committee.
**Action** – Dr Phillips

In response to a request from Ms Barber regarding providing tracker data around patient satisfaction, it was agreed that a six month rolling position would be included in the report so that the trend could be observed.
**Action** – Ms Strowman

The Board **RECEIVED** the Monthly Quality Report.

**25/05/14 Finance Report (Month 12)**

Mr Flack presented the report to the Board for assurance.

The Trust had achieved a surplus for Month One which was slightly better than plan. The Trust was forecasting to reach a surplus which was in line with plan. Additional Sustainability and Transformation Funding (STF) had been received. With regards to the Finance dashboard, the Cost Improvement Programme (CIP) rating was amber, although a significant amount of the total annual CIP target had been removed from budgets in Month One which was encouraging. The Trust was meeting its other finance performance targets. With regards to the agency trajectories, these would be adjusted internally in order to encourage staff to drive down agency usage further.

The Board **RECEIVED** the Finance Report.

**25/05/15** **Workforce Report**

Ms Norris presented the report to the Board for assurance.

The presentation of the workforce metrics had been reviewed at the request of the Board. The targets for starters and leavers had been removed as the metric's performance was misleading when staff were TUPEd into services. A summary of the current workforce position was given. This included turnover which had increased slightly that month, due in part to the normal increase in retirement at that time of year. Reviewed over five years, the Trust was achieving its best turnover performance. With regards to vacancies, the Trust was performing slightly above the target which was an improvement on recent months. With regards to the sickness rate, this was still vulnerable to the impact of organisational change on staff's health and wellbeing. Work would be focussing on supporting staff and minimising the impact.

In response to a question from Mr Field regarding the welcome drop in agency usage and an improved vacancy position, Ms Strong confirmed that in addition to recruitment, vacancies which would had not been recruited to had been removed at budget setting.

The Board **RECEIVED** the Workforce Report.

**25/05/16** **Kent and Medway Sustainability and Transformation Plan (STP) Update Report**

Mr Bentley presented the report to the Board for assurance.

Mr Glenn Douglas, Chief Executive of Maidstone and Tunbridge Wells NHS Trust, had been offered the role as the Chief Executive for the Kent and Medway STP on a two year fixed term basis subject to NHS England and NHS Improvement approval. Dr Fiona Armstrong had been appointed as the STP Co-Clinical Chair, alongside Dr Peter Maskell.
Work continued on the local care model and the acute hospital model. These would be recommended to the Board when the work was complete.
With regards to the integration of the health and social care system, east Kent stakeholders were at the forefront of developments to establish a

more sustainable model.

Mr Griffiths added that the Chairs and Chief Executives of the STP organisations would be meeting the following week.

The Board **RECEIVED** the Kent and Medway Sustainability and Transformation Plan Update Report.

**25/05/17** **Terms of References of Committees**

Ms Davies presented the report to the Board for approval.

Each of the committees had reviewed and approved their Terms of Reference. There had been minimal changes. As the Quality Committee was reviewing its governance framework, its Terms of Reference would be brought back to the Board later in the year for approval. The Remuneration and Terms of Service Committee Terms of Reference had been withdrawn and would be submitted to the Board later in the year.

The Board **APPROVED** the Terms of References of Committees.

**25/05/18** **Seasonal Infection Prevention and Control Report - Spring**

Ms Strowman presented the report to the Board for assurance.

A summary of the Trust's performance in 2016/17 was provided. This included the final number of attributable Clostridium difficile infections which had been disappointing. However, the Trust had exceeded its reduction target for catheter acquired urinary tract infections (CAUTIs) and urinary tract infections (UTIs). With regards to 2017/18, there had been one case of Clostridium difficile in April 2017.

The Board **RECEIVED** the Seasonal Infection Prevention and Control Report - Spring

**25/05/19** **Quarterly Patient Experience Exception Report**

Ms Strowman presented the report to the Board for assurance.

The Quality Committee had previously received the report. The Trust's overall patient experience score for Quarter Four remained high. With regards to complaints, there had been an increase in the number compared to the previous quarter. Communication was cited as the issue in the majority of instances. With regards to complaints relating to changes in the supply of continence products, this had been anticipated and was being monitored. Complaints had been received by the Health Visiting Team regarding ante-natal letters and inappropriate visits by the staff. This was due to poor communication between the parts of the NHS. Ms Strowman had been in contact with the Chief Nurses at the acute trusts to identify a solution. There was currently one complaint case with the Ombudsman. With regards to the timescales for responding to each complaint, in the last

three months there had been a small number of complaints which had not met the timeline as set down by the Trust. This was largely due to a revision in the process to improve upon the quality of the response letters. The Quality Committee would be kept informed of progress. With regards to the table which showed the overall scores per locality based on a combined score across children's and adult services, the East Sussex Locality had been incorrectly rated as it was a new service.

In response to a comment from Mr Griffiths regarding interrogating the acute trusts' systems to help improve the co-ordination of midwifery and health visiting, it was agreed that this would be investigated.
**Action** – Ms Strowman

In response to a suggestion from Ms Barber regarding complaints trends, it was agreed that a trend line for each of the areas would be included in future reports.
**Action** – Ms Strowman

In response to a question from Mr Field regarding the low number of complaints per member of staff, Ms Strowman confirmed that work had been undertaken with the Complaints Team to increase awareness amongst patients as to how to complain. Staff were also better at dealing with complaints locally. She was confident that the numbers were an accurate reflection of customer satisfaction.

The Board **RECEIVED** the Quarterly Patient Experience Exception Report.

**25/05/20** **Mortality Annual Report**

Dr Phillips presented the report to the Board for assurance.

Dr Arokia Antonysamy, Deputy Medical Director, would be focussing on improving the oversight of mortality in the Trust alongside Dr Phillips. Currently, data quality needed further improvement. With regards the cohorts of patients, the available data was orientated to the acute rather than the community hospital setting.

In response to a question from Mr Conway regarding how the Mortality Surveillance Group (MSG) approached its review of deaths, Dr Phillips confirmed that every death in the Trust's community hospitals was reviewed and it was satisfied with the circumstances of each death. The approach the MSG took was under review. With regards the group's effectiveness, this had not been assessed. With regards how deaths at home would be captured, this was still to be agreed nationally.

Ms Barber added that this would be a particular change for community trusts and that there would be learning across the system. The new national guidance required the Trust to strengthen its oversight.

The Board **RECEIVED** the Mortality Annual Report.

**25/05/21** **Clinical Audit Annual Report**

Dr Phillips presented the report to the Board for assurance.

The audit work that had been undertaken during the year had driven change in the organisation. The main areas of focus had been NICE guidance, local priorities and the KPIs. These had helped to drive the Trust's assurance process, measure the quality of care and identify risks. Areas of good practice and quality improvement had been disseminated across the organisation. The completion of actions and benchmarking against other Trusts had been regularly monitored. Work had been presented locally and national.

Mr Howe confirmed that clinical audit performance and outcomes had improved year on year. Mr Conway added that as there was a move towards delivering integrated models of care, the question of receiving assurance of the robustness of other organisations' clinical audit performance would need to be addressed.

The Board **RECEIVED** the Clinical Audit Annual Report.

**25/05/22** **Six Monthly Public Engagement and Equality Report**

Ms Norris presented the report to the Board for assurance.

With regards to engaging with young people, this had been difficult but work continued to identify appropriate engagement channels. Work to increase public membership continued well. There had been a Members event held with Governor involvement and in partnership with East Kent Hospitals University NHS Foundation Trust on the theme of diabetes. This had been well-attended and well-received by the Governors. A similar event would take place in the autumn in west Kent.

The Board **RECEIVED** the Six Monthly Public Engagement and Equality Report.

**25/05/23** **Annual Information Governance Report**

Ms Davies presented the report to the Board for assurance.

The Information Governance (IG) Toolkit Assessment provided a strong framework to measure the Trust's performance. It had indicated an excellent level of compliance for 2016/17. With regards to the annual IG audit, the Trust had received an overall opinion of substantial assurance with no further recommendations. At year end, the Trust was 90.3 per cent compliant with IG training. The number of IG incidents had risen that year as well as the number of near misses reported. The IG Team worked hard with clinical services and IG champions to promote good IG standards. There had been one Serious Incident during the year which was being investigated. This was a significant decrease on previous years.

In response to a question from Mr Field regarding the submission of the annual Caldicott Report to the Board, Ms Davies confirmed that this, along with a summary of actions, was included in the Annual IG Report. Dr Phillips was the Responsible Officer on the Board and Dr Raj Nandi was responsible for discharging the operational duties of the Guardian. Looking ahead, the duties of the Guardian would be changing but further guidance was awaited.

The Board **RECEIVED** the Annual Information Governance Report.

**25/05/24** **Emergency Planning and Business Continuity Annual Report**

Ms Davies presented the report to the Board for assurance.

The Trust was fully compliant with the standards for resilience assessment. Internally, there was a focus on lock down procedures and cyber security. There had been a number of incidents that the Trust had had to respond to over the year and wide ranging business continuity plans had been instigated.

The Board **RECEIVED** the Emergency Planning and Business Continuity Annual Report.

**25/05/25** **Standards of Business Conduct Report**

Ms Davies presented the report to the Board for assurance.

The Registers of Interests and Gifts, Hospitality and Sponsorship along with the Trust's declaration of Fit and Proper Persons were available on the Trust's public website.

The Board **RECEIVED** the Standards of Business Conduct Report.

**25/05/26** **Any Other Business**

There was no further business to discuss.

**25/05/27** **Questions from Members of the Public Relating to the Agenda**

There were no questions from the public.

The meeting closed at 12.05pm.

**25/05/28** **Date and Venue of the Next Meeting**

Thursday 29 June 2017 at 10am in the Thomas Keane Room, East Malling Research Station, New Road, East Malling, Kent ME19 6BJ

Kent Community Health NHS Foundation Trust

**Unconfirmed Minutes**
**of the Kent Community Health NHS Foundation Trust Board**
**held at 10am on Thursday 29 June 2017**
**in the Thomas Keane Room, East Malling Research Station, New Road, East Malling, ME19 6BJ**

**Meeting held in Public**

---

| | |
|---|---|
| **Present:** | David Griffiths, Chairman<br>Pippa Barber, Non-Executive Director<br>Paul Bentley, Chief Executive<br>Peter Conway, Non-Executive Director<br>Richard Field, Non-Executive Director<br>Gordon Flack, Director of Finance<br>Steve Howe, Non-Executive Director<br>Louise Norris, Director of Workforce, Organisational Development and Communications<br>Dr Sarah Phillips, Medical Director<br>Bridget Skelton, Non-Executive Director<br>Lesley Strong, Deputy Chief Executive/Chief Operating Officer<br>Ali Strowman, Chief Nurse |
| **In Attendance:** | Gina Baines, Committee Secretary (minute-taker)<br>Natalie Davies, Corporate Services Director |

**29/06/1** **Introduction by Chair**

Mr Griffiths welcomed everyone present to the Public Board meeting of Kent Community Health NHS Foundation Trust (the Trust).

Mr Griffiths advised that this was a formal meeting of the Board held in public, rather than a public meeting, and as such there would be an opportunity for public questions relating to the agenda at the end of the meeting.

**29/06/2** **Apologies for Absence**

Apologies were received from David Robinson, Non-Executive Director and Jennifer Tippin, Non-Executive Director.

The meeting was quorate.

**29/06/3** **Declarations of Interest**

No conflicts of interest were declared other than those formerly recorded.

**29/06/4 Chairman's Report**

Mr Griffiths stated that there were no significant issues to report to the Board that month.

**29/06/5 Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

The implementation of changes at the Kent and Canterbury Hospital had taken effect on 19 June 2017. The Trust's service teams had worked hard supporting an increased number of discharges. The performance data was showing no diminution in quality. This outcome was a testament to the hard work of the staff of the Trust and other local trusts.
The Executive Team continued to attend briefings with staff across the Trust to explain the Sustainability and Transformation Plan (STP) and local care provision. The views of the workforce were being helpful in shaping and raising awareness.
The Trust's Staff Awards had taken place on 23 June 2017. It had been an uplifting event and was a testament to the work that all the staff of the Trust carried out.

In response to a comment from Mr Howe regarding the 2017 Staff Awards, it was agreed to pass on the Board's thanks to the Communications Team for organising a successful event.
**Action** – Ms Norris

The Board **RECEIVED** the Chief Executive's Report.

**29/06/6 Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

The performance dashboard was healthy that month with three quarters of the Key Performance Indicators (KPIs) rated Green or Blue. The Stop Smoking KPI was Red rated although it was expected to turn Green in the near future. This was due to Kent County Council (KCC), the commissioner, agreeing a stretching but more realistic target for the year. With regards to the Delayed Transfers of Care KPI, achieving this target was challenging and had been recognised as such at a national level. Further work was underway nationally. The Trust would be in a position to agree a revised target by September 2017 and additional funding would be made available to help attain this. With regards to the Health Visiting KPI, there had been a step improvement and the expectation was that it would be rated Green in the near future. The Length of Stay, Allied Health Professionals Referral To Treatment Times (RTT) and Community Paediatrics RTT KPIs were all improving. With regards to the Safety Thermometer, some problems with recording had been identified and this had caused a dip in performance. This was now being addressed. With regards to occupied bed days, the published paper had indicated that there had been a weakening in recording activity performance. This was

incorrect; the KPI was over performing. It was agreed that the error would be amended and the correct information republished on the Trust's public website.
**Actions** – Mr Flack

The Board **RECEIVED** the Integrated Performance Report.

**29/06/7 Monthly Quality Report**

Ms Strowman presented the report to the Board for assurance.

A summary of the key performance areas for patient safety, patient experience and patient outcomes was given. This included fill rates, use of additional health care assistants in providing one to one care for patients suffering from dementia, the number of Registered Nurses per shift, clinical incidents, pressure ulcers, falls, medication incident reporting (SafeMeds), and infection prevention and control reporting including Sepsis.
With regards to pressure ulcers, the task force continued to meet monthly. Action plans were in place and there was good engagement from staff. Two category three pressure ulcers had been reported recently and the Board would receive an update the following month. There had been one avoidable Clostridium difficile infection reported in the month. This had occurred in a therapy-led unit and the subsequent investigation had considered the impact of this particularly skill mix for the outbreak. In response to the findings, the staff in the unit had been re-trained in the correct medicines management approach for such incidences.
With regards to the Early Warning Trigger Tool (EWTT), an update was provided to the Board around Hawkhurst Community Hospital which was on Moderate Concern.
Patient experience scores for the Trust continued to be positive at 96.91 per cent. Twelve complaints for services had been received in May 2017 which was the lowest number of complaints in a month for three years. There were a number of themes to the complaints and these were summarised.

In response to a question from Ms Barber regarding expediting the outstanding investigations of category three, four and ungradeable pressure ulcers to ensure that there was prompt learning in the services, it was agreed that this request would be passed to the Clinical Governance Team and operational teams.
**Action** – Ms Strowman

In response to a question from Ms Barber regarding receiving assurance that the NICE Quality Standard and the Royal College of Physicians improvement recommendations had been implemented in the community hospitals for each and every patient at risk of falls, it was agreed that a report would be brought to the Quality Committee in the near future.
**Action** – Ms Strowman

In response to a question from Ms Skelton regarding whether it was the same staff members who repeatedly made medicine administration errors

(SafeMeds), Ms Strowman suggested that it was unlikely as there was thorough retraining undertaken to ensure that the relevant staff were fully competent. Ms Strong added that the EWTT was a useful tool for highlighting any SafeMed themes to the Executive Team.

Mr Flack added that, overall, the Trust had seen a significant decrease in SafeMeds and he suggested that this should be highlighted through a communications campaign.
**Action** – Ms Strowman

In response to a question from Mr Howe regarding patient phone access to the Phlebotomy Service at Queen Victoria Memorial Hospital, Herne Bay, Ms Strong explained the new arrangements that had been put in place. It was agreed to check with the service as to whether there had been an improvement in patient experience since the introduction of additional telephony services.
**Action** – Ms Strong

The Board **RECEIVED** the Monthly Quality Report.

**29/06/8 Finance Report (Month 2)**

Mr Flack presented the report to the Board for assurance.

The Trust was ahead of its plan for 2017/18 at Month Two and was forecast to meet its surplus at year end with the support of central Sustainability and Transformation Funding. The Trust remained in the top risk rating category which positioned it with the top sixteen per cent of all trusts in the country. With regards to the Capital Plan, the Trust was for the first time ahead of its target. With regards to agency trajectories, these were being met for both agency staff and locum doctors.

The Board **RECEIVED** the Finance Report.

**29/06/9 Workforce Report**

Ms Norris presented the report to the Board for assurance.

An error in the report and cover sheet was highlighted and it was agreed that this would be amended and the correct information republished on the Trust's public website.
**Actions** – Ms Norris

A number of metrics had significantly improved including time to recruit and statutory and mandatory training. The Trust was reporting the highest appraisal compliance rate it had ever achieved. However, turnover was slightly up and this correlated with those services that were going out to tender and where there were planned restructures. Sickness as a percentage appeared to be high but this was due to the skewing effect of small teams on the figure.

The Executive Team had been receiving soft intelligence which suggested that there had been an increase in the number of staff leaving the Trust to work for local GP practices. This was particularly evident in east Kent. This situation would be investigated to establish what the current numbers were. The Trust intended to raise it with the clinical commissioning groups (CCGs) to discuss how more collaborative working could be encouraged instead. A joint recruitment campaign with other health agencies and KCC had been undertaken which had focussed on encouraging workers to work in east Kent. With regards to statutory and mandatory training, there was high compliance. There was a focus on improving the compliance of the Amber rated training.

In response to a question from Ms Skelton regarding the recent improvement in the time to recruit performance, Ms Norris explained that this was due to the Resourcing Team being back at its full complement following a period of staff sickness.

In response to a question from Mr Griffiths regarding the suggestion that there was an increasing number of staff leaving the Trust to join GP practices, Dr Phillips commented that this could be a reflection of the potential for the movement of services and models of care that was underway at present between various NHS providers. Ms Norris confirmed that an investigation would be taking place to establish the facts.

The Board **RECEIVED** the Workforce Report.

**29/06/10** **Recommendation In Response To The Edenbridge Public Consultation**

Ms Strong presented the report to the Board for approval.

The purpose for bringing the recommendation to the Board for its approval and its role in informing the CCG decision was explained. The outcome of the public consultation had been a high level of support for Option 1a, to build on a new site without inpatient beds. This option was favoured by the clinical commissioning group and the local GP practice. The Board was also asked to consider how the Trust would develop and support the staff at Edenbridge War Memorial Hospital during the development of the project and what role the Trust would play in developing the new service model.

In response to a question from Mr Conway regarding how congruent the Edenbridge model was with the STP, Ms Strong indicated that there was a strong fit. A discussion followed which considered the underlying premise of the proposal within the STP environment but it was agreed that the Board's role, at this time, was to receive the consultation exercise.

In response to a question from Mr Griffiths regarding why the consultation had been so successful, Ms Strong explained that the GP practice had supported Option 1a and this had been communicated clearly to the local community. Listening events had taken place which had been well attended and provided an opportunity for a full discussion by the local

community regarding the healthcare arrangements it wanted in Edenbridge. It was agreed to pass on the Board's thanks to the teams for managing a successful consultation exercise.
**Action** – Ms Strong

Mr Bentley would formally notify the West Kent CCG of the decision of the Board.

The Board **APPROVED** the Recommendation In Response To The Edenbridge Public Consultation.

**29/06/11 Policies For Ratification**

Ms Norris presented the following policy to the Board for ratification.

- Temporary and Agency Workers Policy

The Board **RATIFIED** the policy.

**29/06/12 Any Other Business**

There was no further business to discuss.

**29/06/13 Questions from Members of the Public Relating to the Agenda**

There were no questions from the public.

The meeting closed at 10.50am.

**29/06/14 Date and Venue of the Next Meeting**

Thursday 27 July 2017 at 10am in the Committee Room, Tonbridge and West Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

Kent Community Health NHS Foundation Trust

## MATTERS ARISING FROM BOARD MEETING OF 25 MAY 2017 (PART ONE)

| Agenda Item | Action agreed last meeting | By Whom | Current Status/Update |
|---|---|---|---|
| Charitable Funds Committee Chairman's Assurance Report | To feedback to the Committee the comments regarding constraints imposed on infrastructure purchased using charitable funds. | Mr Field | This has been fed back by email to Ms Tippin, Chair of the Committee, and will be discussed at its next meeting in July 2017. |
| 2016/17 Annual Report and Accounts | To investigate producing a shorter document in future years. | Ms Norris | Work is underway. |
| Integrated Performance Report Month One | For the Executive Team to consider reassigning amber rated KPIs at year end to red. | Mr Bentley<br>Mr Flack | This has been discussed and it has been agreed that an Amber rating would be set for a marginal under-performance. |
| Monthly Quality Report | To bring a report by the community geriatricians regarding the high levels of one to one care to the Quality Committee | Dr Phillips | Further information will be provided directly to Mr Howe as Chair of the Quality Committee. |

| Agenda Item | Action agreed last meeting | By Whom | Current Status/Update |
|---|---|---|---|
| Monthly Quality Report | To include a six month rolling position of patient satisfaction in the monthly report going forward. | Ms Strowman | Action complete. |
| Monthly Quality Report | To investigate whether the Health Visiting Service could interrogate the acute trust IT system in order to improve co-ordination with the midwifery service. | Ms Strowman | Liaison with the Directors of Nursing in the acute trusts. The Heads of Midwifery are addressing it at their forum. |
| Monthly Quality Report | To include a trend line for each of the areas for complaints in future reports. | Ms Strowman | Action complete. |

Kent Community Health
NHS Foundation Trust

## MATTERS ARISING FROM BOARD MEETING OF 29 JUNE 2017 (PART ONE)

| Agenda Item | Action agreed last meeting | By Whom | Current Status/Update |
|---|---|---|---|
| Chief Executive's Report | To thank the Communications Team for organising a successful Staff Awards event | Ms Norris | Action complete. |
| Integrated Performance Report | • To amend the error in the report.<br>• To republish the Board papers on the Trust's public website | Mr Flack<br>Ms Baines | Action complete.<br>Action complete. |
| Quality Report | To request the Clinical Governance Team and operational teams to increase the speed at which the outstanding investigations of category three, four and ungradeable pressure ulcers were completed. | Ms Strowman | Operational staff have been informed they need to increase the speed of the investigations and this is emphasised and tracked at the monthly Task Force meeting. Action closed. |

| Agenda Item | Action agreed last meeting | By Whom | Current Status/Update |
|---|---|---|---|
| Quality Report | With regards to falls, to bring a report to the Quality Committee regarding the implementation of the Royal College of Physicians improvement recommendations in the community hospitals. Date to be confirmed. | Ms Strowman | Discussion underway with Lead for Falls; dates to be confirmed. |
| Quality Report | To highlight the successful decrease in medicine administration errors through a communications campaign. | Ms Strowman | The Medicines Management Team has been asked to take this forward. Action closed. |
| Quality Report | To check with the Phlebotomy Service as to whether there had been an improvement in patient experience since the introduction of additional telephony services. | Ms Strong | Further changes have been made in response to patient feedback. Final report circulated separately to the Board. Action complete. |
| Workforce Report | • To amend the error in the report.<br>• To republish the Board papers on the Trust's public website | Ms Norris<br>Ms Baines | Action complete.<br>Action complete |
| Edenbridge Public Consultation | To thank the teams for managing a successful consultation exercise. | Ms Strong | Action complete. |

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 1.7 |
| **Subject:** | Chief Executive's Report |
| **Presenting Officer:** | Paul Bentley, Chief Executive |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | **x** |

| **Report Summary (including purpose and context)** |
|---|
| This report highlights key business and service developments in Kent Community Health NHS Foundation Trust in recent weeks. |

| **Proposals and /or Recommendations** |
|---|
| Not Applicable. |

| **Relevant Legislation and Source Documents** |
|---|
| |
| **Has an Equality Analysis (EA) been completed?** |
| No. Not Applicable. |

| | |
|---|---|
| Paul Bentley, Chief Executive | Tel: 01622 211903 |
| | Email: paul.bentley@kentcht.nhs.uk |

Kent Community Health
NHS Foundation Trust

# CHIEF EXECUTIVE'S REPORT
# JULY 2017

As previously I wanted to highlight to the Board the following significant developments since my last report which again is categorised into patients, our staff and partnership.

## Patients

### 1. CQC inspection

When Chief Nurse Ali Strowman and I met with senior officers of the Care Quality Commission (CQC) earlier this month, we were told that we will be inspected by them probably at the beginning of next year.

This is part of the regular programme of inspections and the CQC was very clear it is not in response to any concerns about our services. The inspection will be unannounced, so we won't know exactly when the inspectors are coming.

In 2014, when we were last inspected, it was trust-wide. This time, it will be a much smaller inspection, with fewer inspectors, and some core services chosen, alongside end of life care and a look at how well-led the organisation is.

The inspectors look at five domains – safe, caring, effective, well-led and responsive. To achieve, good or outstanding, we have to achieve a 'good' or higher in the well-led domain. The key lines of enquiry (KLOE) have been refreshed and we will be updating our information.

During the next six weeks, we will be filling out the CQC Provider Information Request (PIR) document.

### 2. Fire Safety

In response to the recent tragic event, the Trust has undertaken an additional review of Fire Safety across the properties we operate from, with particular emphasis on inpatient facilities. This has confirmed that the Trust has a robust system of controls and assurance surrounding Fire Safety. A current Fire Strategy, policy, risk assessment process and action follow up system is in place

and continually monitored. A trigger mechanism and escalation framework is in place for actions which are not completed in a timely manner or to a sufficient quality. Landlords are being vigorously pursued to ensure actions are taken and evidence provided within agreed timescales.

The Trust can be assured that in all of our sites and occupied locations no person is at serious risk in the event of a fire. The fire risk management system predicts and identifies fire risks to ensure fire safety and the avoidance of enforcement action. The monitoring and governance procedures carried out by the Fire Safety Manager and the Trust Compliance Manager ensures a regulatory compliant status is maintained with the appropriate audit capabilities to provide assurance of performance.

### 3. Inspiring Improvement 2017

Our Medical Director attended the event ‘inspiring improvement on 11 July, high quality speakers including Jim Mackey, Chief Exec of NHS Improvement, the event enabled lots of sharing of best practice and a real focus on QI approach within organisations. The event reaffirmed our need to fully adopt a QI approach, and to learn from other community trusts doing outstanding quality work.

## Staff

### 1. Clinical Director for Community Paediatrics

I am delighted to be able to report that since the Board last met we have appointed Dr Chandra Hedge to position of Clinical Director Community Paediatrics, and Dr Raj Hembrommy to take over from Emma Fox as Lead Medical Appraiser.

### 2. Accredited Finance Training

The Finance Department has been working with the Financial Skills Development Manager in the South East and with the Training Department to accredit the Trust as a formally accredited training organisation with the main accountancy bodies relevant to us (AAT, ACCA, CIMA and CIPFA). I am pleased to say that the Trust is now an accredited training organisation with AAT and with ACCA and is accredited for Continuing Professional Development with CIPFA. Whilst the Trust has always had qualified finance staff and has supported staff studying towards professional accountancy qualifications, this is a good stamp of approval from the accountancy bodies that they recognise us as an organisation that can support staff training in these qualifications and in continuing professional development. We are also working towards securing full accreditation for CIMA.

### 3. Sustainability and Transformation Partnership – engaging with staff

We have continued to engage with staff around the model of care for older people with long-term conditions.

Members of the Executive Team have now carried more than twelve road shows, listening to our colleagues about their views on the local care model and more broadly, nearly 300 colleagues have attended these workshops, we have also encouraged our teams to attend the public road shows on the partnerships.

We have also taken this opportunity to talk to colleagues about our quality improvements for next year, as well as get feedback on updating our mission and vision to reflect the changes needed in the health and social care services which are provided.

## Partnerships

### 1. Changes in NHSI and NHSE

Since the last time the board met NHS England (NHSE) and NHS Improvement (NHSI) have formalised that they are integrating their management structure, with Anne Eden undertaking the role of Regional Director on behalf of both organisations. Anne has previously undertaken the role on behalf of NHSI.

### 2. i care charity update

Following a successful fundraising appeal, we have secured sufficient donations through our charity i care to install a fully equipped sensory rom for children with disabilities at the Heathside Clinic in Coxheath (integrated children's therapies). This means that children attending the centre, for example, for weekly physio, speech and language therapy will also be able to benefit from an onsite sensory room in which they can play, learn and develop their skills.

The bulk of the donations came from the Maidstone Lions, which has bought all of the equipment needed for the room (up to £20,000). Other donations are being used to fund the installation and maintenance of the room, which is due to be opened in August 2017.

We plan to ask Edie Hughes who is a patient of the service and her family to open the room and we are in the process of ordering a plaque that will be installed next to the room. Each room in Coxheath Centre is named after an animal, at the moment the name of the room is the 'snake'; room but this will also be renamed the 'Lion' room. We are working on a promotional plan to maximise the opportunity to get publicity for the room (and as a consequence of that for the charity as a whole).

## 3. A different view

In May, we launched East Kent: A Different View, a joint recruitment campaign between:

East Kent Hospitals University NHS Foundation Trust
Kent County Council
Kent and Medway NHS and Social Care Partnership Trust
Kent Community Health NHS Foundation Trust
East Kent CCGs.

The aim is to encourage qualified health and social care professionals to move and then work in east Kent. The main focus of this campaign is the lifestyle opportunities afforded by this area to both individuals and families, in particular the proximity of the coast.

The campaign website is www.takeadifferentview.co.uk. The hashtag for the campaign is **#takeadifferentview.** Several case studies from all of the partner organisations have been collated and these are featured on the website.

KCHFT communications team has led on the campaign from the start, coming up with the title of the campaign, all resources, films and the website. We are also coordinating the social media for the campaign on Facebook and Twitter which includes paid-for advertising.

Each organisation has a section of the site which has links to job pages on their website (for primary care this is the LMC).

The campaign has received positive feedback from stakeholders including the executive team at EKHUFT and leading members of the STP.

Finally, it is a testament to our teams that when the pressures on services remain as so significant that the patient satisfaction remains so high, and I would like to formally thank all our teams on behalf of the Board.

**Paul Bentley**
**Chief Executive**
**July 2017**

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.1 |
| **Subject:** | Sustainability and Transformation Plan Hurdle Criteria |
| **Presenting Officer:** | Dr Sarah Phillips, Medical Director |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | **X** | Assurance | |

**Report Summary (including purpose and context)**

This paper summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway clinical commissioning group (CCG) governing bodies, trust boards and local authority committees.

The service models and hurdle criteria build on the Kent and Medway STP case for change (http://kentandmedway.nhs.uk/latest-news/kent-medway-case-change-published/)

The service models were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate and their feedback has been taken into account in preparing the final versions that are now being presented.

**Proposals and /or Recommendations**

The Trust Board is asked to consider the Kent and Medway:

- Local care model
- Emergency department service delivery model
- Acute medical service delivery model
- Stroke service delivery model
- Elective orthopaedic service delivery model
- Urgent care / elective orthopaedics and stroke hurdle criteria

STP Hurdle Criteria

| Relevant Legislation and Source Documents |
| --- |
| |
| **Has an Equality Analysis (EA) been completed?** |
| No. Not Applicable. |

| | |
| --- | --- |
| Sarah Phillips, Medical Director | Tel: 01622 211939 |
| | Email: sarah.phillips@kentcht.nhs.uk |

# KENT AND MEDWAY SUSTAINABILITY PARTNERSHIP

## Service Models and Hurdle Criteria

### Introduction

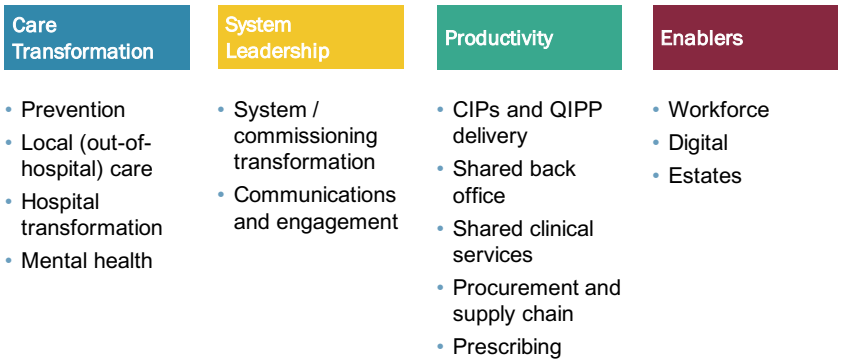
1. This paper summarises the service models and hurdle criteria that have been developed through the Sustainability and Transformation Partnership (STP) and asks for support for these from Kent and Medway clinical commissioning group (CCG) governing bodies, trust boards and local authority committees.
2. This paper accompanies the detailed information on service models that covers:
    i. Local care model
    ii. Emergency department service delivery model
    iii. Acute medical service delivery model
    iv. Stroke service delivery model
    v. Elective orthopaedic service delivery model
    vi. Urgent care / elective orthopaedics and stroke hurdle criteri
3. The service models and hurdle criteria were developed by the local care and hospital care workstreams. These have built on patient, public and carer insight over recent years about what is important to people about local services, with clinical leadership and involvement in the design and thinking, and some ongoing testing and discussion with wider stakeholder audiences and groups across Kent and Medway. The development and progress of the design phase has regularly reported to the STP Clinical Board, the Patient and Public Advisory Group (or its predecessor arrangement the Patient and Public Engagement Group) and onwards to the STP Programme Board. The draft service models have been presented to the South East Coast Clinical Senate[1] and their feedback has been taken into account in preparing the final versions that are now being presented.

### Context

4. Sustainability and Transformation Plans were proposed in the annual NHS planning guidance Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 issued in December 2015[2]. This outlined the triple aim of the plans was to address health inequalities; quality failings and under-performance against NHS Constitution targets; and financial challenges.
5. The further development of Sustainability and Transformation Plans, and a further recognition that these arrangements are about collective system leadership through the change of name to Sustainability and Transformation Partnerships, was outlined in Next Steps on the Five Year Forward View[3] published in March 2017. The October STP

[1] Clinical Senates have been established to be a source of independent, strategi advice and guidance to commissioners and other stakeholders. This includes reviewing proposed changes through bringing together a range of health care professionals, with patients, to review proposals presented to them. This is also part of the NHS England service change assurance process.
[2] https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

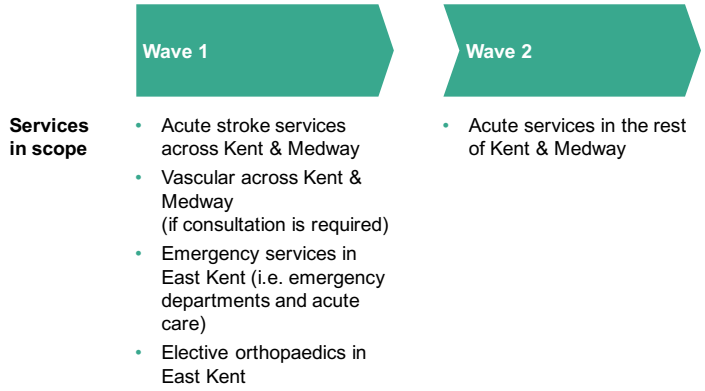
submission outlined the key themes of transformation that are being pursued across Kent and Medway. These were identified as follows:




6. Work streams were established to take forward each of the above areas, comprising clinicians, leaders and practitioners from across Kent and Medway NHS and local authority organisations. They have been meeting since the autumn of 2016, and test and discuss their work with the programme's Patient and Public Advisory Group (including its precedessor the PPEG) and the programme's Partnership Board as part of an ongoing programme engagement infrastructure and as one strand of engagement activity

7. The STP Programme Board took stock of the progress being made by these work streams in February 2017. It was recognised that different parts of the Kent and Medway area were at different stages in relation to their readiness and development.

8. The STP stocktake concluded from an analysis of patient flows within Kent and Medway that there are negligible potential activity flows from East Kent to the rest of Kent and Medway. It was proposed that it is possible to consult on service changes in East Kent around urgent and emergency care alone, though the impact on future options in the rest of Kent and Medway will need to be considered. Therefore, two waves of public consultation are proposed but undertaken within a clear strategic framework for all of Kent and Medway:



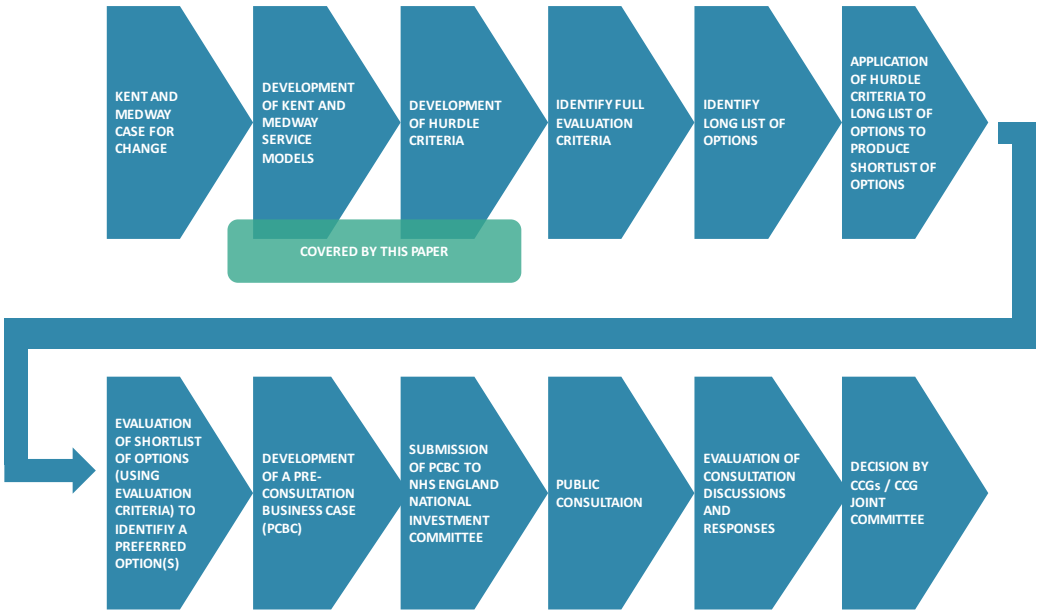

9. It had previously been hoped to consult on proposed wave 1 service changes in 2017 but a number of delays have been incurred, including the:

   - need to undertake more public engagement;

- need to put in place joint decision-making arrangements across the CCGs, which require a change to some of the CCG constitutions;
- impact of purdah due to the local and general election[4]; and
- not wishing to start any consultation too close to the Christmas holidays.

10. It is now envisaged that any required consultation would not take place until 2018.

11. In moving to consultation we are following a process that covers a number of stages as outlined in the following diagram (as outlined in the process diagram this paper covers the proposed service models and hurdle criteria):




**Case for change**

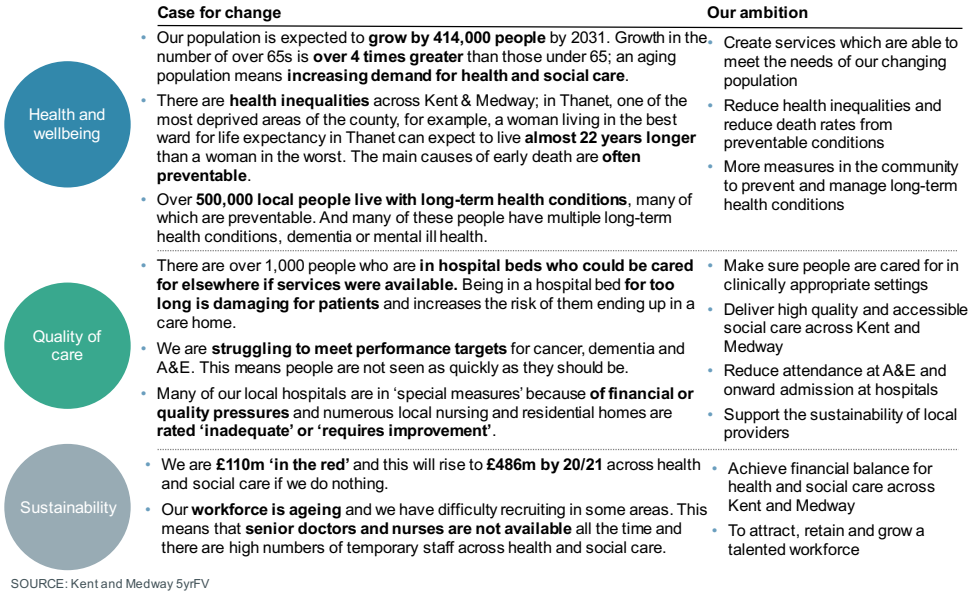
12. The Kent and Medway STP Clinical Board has prepared a technical case for change[5] which has been used to prepare a more accessible public facing case for change to support engagement with patients, carers, local communities and stakeholders[6].

13. These documents outline the strategic rationale for why change is needed. Whilst there is much to be proud of about health and social care services in Kent and Medway there are several issues that we need to tackle; there are long waiting times for some services and the quality of care is not always as good as it could be. We also need to focus on reducing the need for health and social care, through self-management, ill health prevention and earlier diagnosis. The following provides a summary of the case for change:

[4] The term 'purdah' is used across central and local government to describe the period of time immediately before elections or referendums when specific restrictions on the activity of civil servants and other public bodies are in place in order to ensure there is no breach of Section 2 of the Local Government Act 1986 (this states to "not publish any material which, in whole or in part, appears to be designed to affect public support for a political party")

[5] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/Kent-Medway-Case-for-Change-technical-doc-FINAL-UPDATED.pdf

[6] http://kentandmedway.nhs.uk/wp-content/uploads/2017/04/Kent-Medway-Case-for-Change-UPDATED-APRIL-17.pdf




SOURCE: Kent and Medway 5yrFV

14. The position outlined in the case for changes provides further details of the challenges against the triple aims of STPs (as outlined in Point 4, namely:

    i. health inequalities – there continue to be significant health inequalities within Kent and Medway, with the main causes of early death often being preventable:

    ii. quality failings and under-performance of NHS Constitution targets – with large numbers of patients not supported in the most appropriate setting of care, widespread non-delivery of NHS Constitution targets and a significant number of organisations facing quality challenges; and

    iii. financial challenges – a net over-performance on £110m in 2015/16 on the NHS total system budget which is projected to rise to £486m by 2020/21.

15. The challenges outlined above, and in more detail in the case for change, impact detrimentally on the health and lives of the population we service and on the sustainability of NHS and social care services. The strategic remit of the STP is to address these challenges.

**How our service models link together**

16. Through developing our local care services we will be able to offer care closer to the patients home. It is recognised that many elderly patients are supported in acute hospital settings inappropriately, when there needs would be better met in a non-acute setting (e.g. outside of a hospital). This is outlined in the Kent and Medway Case for Change and it is well documented that supporting these patients in an acute setting has a detrimental impact on their long-term outcomes.

17. Whilst it is vital to develop our local care services, we also recognise that there will always be circumstances where individuals need to access secondary care. We are therefore developing revised models for emergency care, covering emergency departments (accident and emergency departments) and acute medical care, as well as for stroke care. However, our aim is to minimise reliance on secondary care, including facilitating discharge from the acute setting at the earliest opportunity.

18. Where it has been necessary for an individual to be admitted to acute care our Local Care and acute medical model will facilitate timely discharge, as outlined below for the elderly frail:

| | 1. Upon admission | 2. Reduce time spent in a bed | 3. Optimise the discharge process | 4. Facilitate re-ablement and return to independence |
|---|---|---|---|---|
| Hospital care | • Assess patient for function and care needs on day 1<br>• Assessment needs to include cognition – early recognition of dementia/delirium | • Day 2 mobility plan<br>• Work on mobility every day<br>• Transparency within hospital to measure LOS >10 and medically fit<br>• Trigger reviews of long stays<br>• Early role of pharmacy in meds review | • Advance care plan<br>• Discharge process run by community (below)<br>• Early provision of discharge medication | • Enhanced transport offer |
| Interface | • Access to care record<br>• Ownership retained by community teams<br>• Direct link made between hospital team and community MDT to capture requirements<br>• Planned day of discharge agreed by MDT<br>• Determine social care means testing | • Daily MDT discharge meeting including community and care coordinators, nursing and medical team<br>• Ensure assessment of care need has been made<br>• Ensure funding decision is made | • Ensure rapid decision made about care packages required (e.g. within 2 hours)<br>• Ensure care record reflects needed details of ongoing care | • Single point of access that works across CCGs in STP<br>• Access to patient record<br>• Better use of telemedicine and tele care to manage people out of hospital |
| Local care MDT | • Carers consulted by MDT about support needed | • Discussion with self-funders for care needs<br>• Home environment assessed to see meets anticipated needs on discharge at the point of admission | • Discharge to assess<br>• Care package in place (self/public)<br>• Home modifications made<br>• Carers prepared for requirements | • Support carers to reable<br>• Provision of rapid response<br>• Shift therapy workforce to out of hospital<br>• Night sitting<br>• Support individual decision making |

19. We have also developed a revised elective orthopaedic service model. Whilst it is possible for elective orthopaedic services to operate on a standalone basis there are a number of interdependencies that need to be taken into consideration, in particular:

    - the critical clinical service co-dependencies for orthopaedic elective work are anaesthetics and access to simple diagnostics, which need to be available on the same site; and
    - the level of complexity of the procedures that can be undertaken is determined by access to Level 2 critical care facilities on site.

**Service model for local care**

20. The STP has prioritised the development of local (out-of-hospital) care. This is in recognition of the vital role these services play, including the current challenges they face as outlined in the case for change. This is also in response to what local people have said they want in recent years' insight work about more joined up services, better access to primary care and more support with staying well and managing their own care, and, importantly, in recognition that it is difficult to make change to the way hospital care is delivered without developing these services.

21. The Kent Integrated Dataset[7] has been used to interrogate spend and this has identified that approximately 32% of resources are used on 12% of the population, namely the elderly frail population, with multiple complex needs:

[7] Kent is one of the early implementers of the linked dataset initiative in England. The KID is possibly the largest linked dataset of its kind and one of the very few programmes with ambition to link data across the wider public sector. The Information Governance (IG) agreement behind the KID is that it can only be used for planning purposes, and cannot be used for informing direct patient care.

Spend per head, £
Population, Thousands
Spend, £ Millions

2015/16 population size, total spend and spend per head by condition and age band

| Age | Mostly healthy | | Chronic conditions (1-3) | | Cancer | | Neurological disorders | | Dementia | | Serious and enduring mental illness | | Chronic conditions (4+) | | Learning disability | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-15 | 426 | | 942 | | 9,849 | | 3,805 | | | | | | 2,767 | | 3,378 | |
| | 257.2 | 109.4 | 28.5 | 26.8 | 0.2 | 1.6 | 1.5 | 5.8 | | | | | 0.1 | 0.2 | 0.5 | 1.6 |
| 16-69 | 349 | | 985 | | 2,362 | | 3,796 | | 11,772 | | 15,565 | | 2,764 | | 26,855 | |
| | 501.9 | 175.2 | 404.1 | 398.0 | 14.1 | 33.4 | 12.6 | 48.0 | 0.4 | 4.9 | 5.1 | 78.8 | 92.8 | 256.5 | 5.3 | 143.5 |
| 70+ | 1,901 | | 1,782 | | 2,420 | | 4,262 | | 7,681 | | 24,943 | | 4,576 | | 42,310 | |
| | 21.8 | 41.4 | 79.1 | 141.0 | 8.5 | 20.6 | 4.1 | 17.6 | 3.6 | 27.8 | 0.5 | 12.3 | 84.8 | 388.2 | 0.4 | 15.7 |

Notes: KID data covers 55% of population and 32% of spend for scope area. Populations have been scaled to account for population registered to practices not flowing data into the KID. Spend has been scaled to match CCG data returns to account for data not included in the KID (e.g. non-PbR acute activity). Children's social care, CAMHS, prescribing costs and continuing care costs are not included. People registered to GP surgeries which flow into KID but had no activity in 2015/16 have been added to "mostly healthy" segments. KID data quality issues cause some people with long term conditions (incl. physical disability and SEMI) to be categorised erroneously as 'mostly healthy', artificially raising those segments' spend and populations.

Source: Kent Integrated Dataset; Carnall Farrar analysis; latest version as of 31/03/2017

22. Therefore, the focus of the work around local care has been on developing new service models to support this group of individuals but is now looking at how other groups of patients and users are now supported, e.g. children with complex needs, the mostly healthy with urgent care needs, adults with chronic conditions.

23. Our proposed service model for older people with complex needs model has been built around eight key interventions:

| | | |
|---|---|---|
| Supporting people to be healthy and independent | 1 Care and support planning with care navigation and case management | Care navigators and case managers integrate health and social care service delivery, and work collaboratively with a wide range of community care colleagues, and also the people they care for, in order to coordinate care and support |
| | 2 Self-care and management | Support people and their carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention and engagement |
| | 3 Healthy living environment | Work to ensure a healthy living environment to preserve long-term health & wellbeing e.g. falls prevention, housing improvements and alterations |
| Coordinated care for people who need it | 4 Integrated health and social care into or coordinated close to the home | Person centered, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have care plans assigned dependent on their needs |
| | 5 Single point of access | A number called by the person, the GP, community services and acute staff to support people with their care by gaining more efficient, coordinated access to services |
| | 6 Rapid Response | The ability within an MDT to respond rapidly to people with complex needs who are experiencing a health or social care need that left unattended would result in a possible hospital admission |
| | 7 Discharge planning and reablement | A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating |
| Supporting services | 8 Access to expert opinion and timely access to diagnostics | The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to diagnostic services and the ability to ensure diagnostic results are full and timely will reduce the need for multiple outpatient appointments |

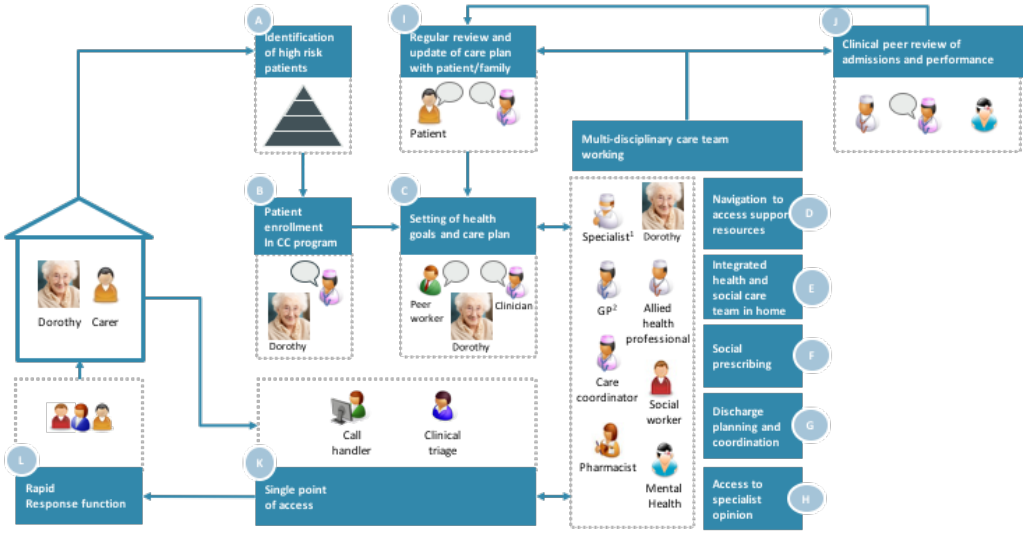
Source: K&M STP Local Care workstream, Carnall Farrar

24. These interventions will be delivered through a revised service model that sees the integration of primary and community services working in multi-disciplinary teams. Key components of this working arrangement include:

| PROCESS STAGE: | | DESCRIPTION: |
|---|---|---|
| A | Identification of high risk patients | • Patients are identified through a monthly KID data refresh, highlighting their appropriateness to be cared for by the "older person complex care and support model", and are placed on their local MDT list to be assessed<br>• Alternatively, patients are identified by clinicians in the community or in hospital care they are in contact with and are placed on their local MDT list to be assessed |
| B | Patient Enrollment in complex care programme | • Patients are informed of the older people with complex needs model and asked if they would like to enroll, informed of what the model requires and what the initial steps will be to ensure efficient inclusion |
| C | Setting of health goals and care plan | • There are two conversations, one with a peer and another with a clinical MDT member, ensuring personal goals and care and support needs are identified in partnership with the patient and their carers<br>• Peer and clinical conversation outputs are captured in a care and support plan owned by the patient<br>• The plan is used as the primary focus for the holistic care of an individual and is accessible to all teams interacting with the patients and by the patient themselves |
| D | Navigation to access support resources | • Case managers and care navigators support condition management, integration of services and care according to the patient's care plan and are supported by "social prescribing" |
| E | Integrated health and social care team in home | • MDTs deliver integrated care and support to both the patient and their carer |
| F | Social prescribing | • The MDT uses a highly accessible and user friendly digital directory of community resources for the patients, their carers and health and social care professionals, facilitating robust social prescribing practices<br>• The MDT also work to empower people to become or remain highly engaged regarding their own health and wellbeing |
| G | Discharge planning and coordination | • The community MDT (led by the patients care navigator or case manager) in-reach into the hospital to assist with and speed up the discharge process using a patient's care and support plan to determine change in need and plan for additional care and support requirements in the community upon discharge |
| H | Access to specialist opinion | • MDT GPs, community nurses and consultants can access specialist healthcare professionals through various communication channels, who have time dedicated to answering questions regarding specific patients<br>• MDT clinical staff have rapid access to diagnostic services (diagnostic and result) to quickly inform a clinical decision about a specific patient |
| I | Regular review and update of care plan with patient/ family/peer | • Annually, patients review their care plan with their peer supporter and with their CM/CN, ensuring their personal goals and care and support needs are still being fully and effectively addressed<br>• The care and support plan is updated as a result of these reviews<br>• MDTs meet regularly and when needed, to discuss and review the needs of specific individuals within the patient cohort |

| | | |
|---|---|---|
| J | Peer review of admissions and performance | • Any admissions are clinically peer reviewed to understand the reasons and to learn for the future |
| K | Single point of access | • Patients with a care plan, their carer, the GP and community services have access to a single number (SPoA) that can be used when patients are experiencing an urgent health or social care need, and that provides individualised support through access to their care and support plan |
| L | Rapid response function | • The SPoA is used to access the MDT rapid response function, which guarantees a 2-hour response time when required, 24 hours a day<br>• Patients receive and initial assessment by an MDT first responder who determines their short-term needs<br>• When required, the patient and their carers will be supported for a short time period post-intervention, including a telephone and home visiting service<br>• People requiring further clinical care will be transferred to the appropriate service quickly and efficiently |

25. The above components of the service model are depicted below as a flow diagram that outlines the model of how it is intended that local care would be delivered:




1 Specialists in both inpatient or outpatient settings 2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

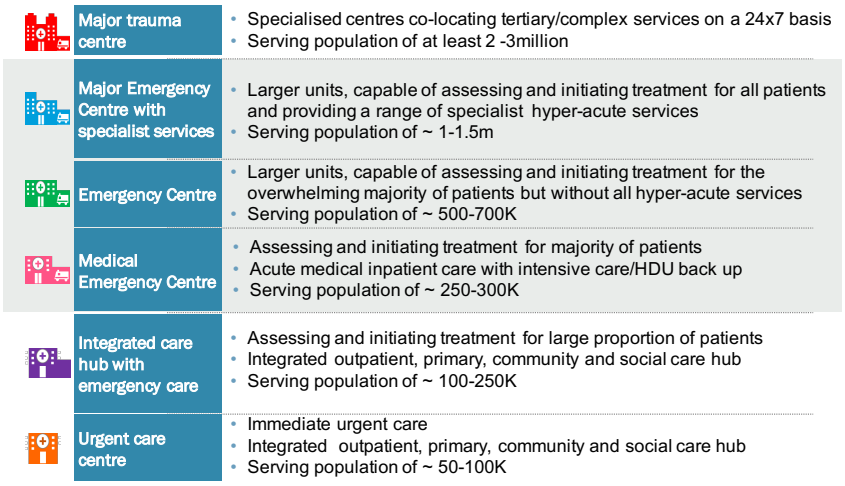
**Emergency department clinical model summary**

26. At present emergency department (ED) services are delivered at all seven acute hospitals sites in Kent and Medway. In 2015/16 there were 219,812 major emergency department attendances (including 254,441 adults and 57,507 children) and 311, 948 minor emergency department attendances (including 156,084 adults and 63,728 children). Emergency department attendances have grown by 3.6% per year over the last three years in Kent and Medway (the national average is 2.6%). Conversely, performance on the four-hour waiting target has deteriorated over the last two years; in

2015/16 on average 86% of people were discharged from emergency departments within four hours, compared to 92% nationally.

27. Some providers in K&M have amongst the worst patient satisfaction scores in the country. Patient stories show the current system is characterised by long waits, multiple contacts with health care professionals, and poor patient experience. A range of interventions are being developed to avoid emergency department attendances, as outlined in the previous section on our local care model. A new model for emergency departments will incorporate triage to the most appropriate pathway.

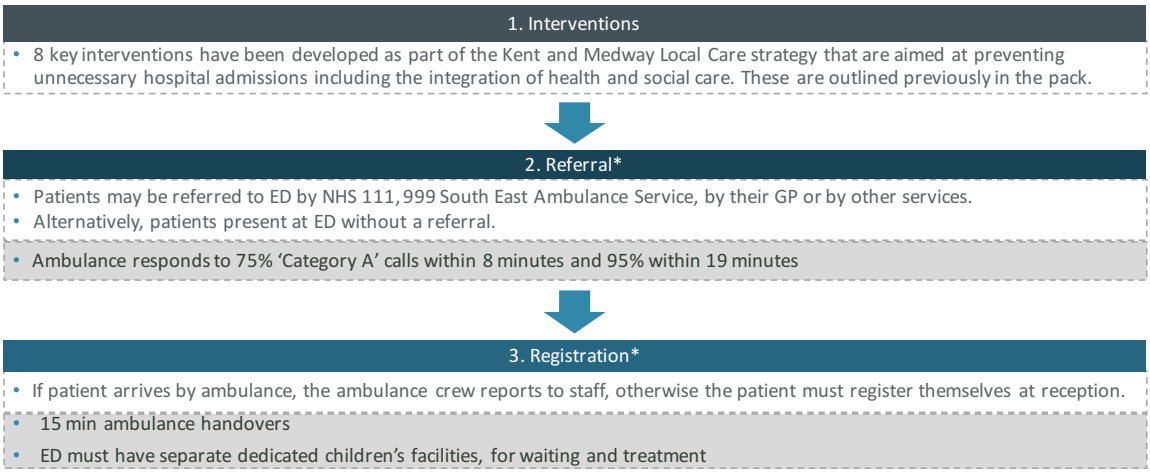
28. The models in the Keogh report have been used as a basis for developing building blocks of services (i.e. the service models we would see our current hospitals develop to become):




Source: Sir Bruce Keogh, Transforming Urgent and Emergency care services in England, End of Phase 1 Report, 2014

29. The South East Clinical Senate has undertaken work to understand the co-dependencies between services and these have been used to further describe the Keogh models.

30. The following diagram outlines the standard process that patients attending an emergency department would expect to experience:



**4. Assessment**

- Patients undergo a comprehensive** pre-assessment by a nurse or doctor before further actions are taken. This is called triage and will ensure people with the most serious conditions are seen first. Sometimes further tests need to be arranged before a course of action can be decided.
- No patient waits >12 hours on a trolley
- Presence of a senior ED doctor (ST4 or above) as a clinical decision maker 24/7

**5a. Treatment or transfer**

- Treatment or transfer: If situation is complicated, the patient my be seen by an ED doctor or referred to a specialist unit.
- 24/7 On site senior support within the core specialties
- Presence of a named paediatric consultant with a designated responsibility for paediatric care
- Availability of a surgeon at ST3 level or above, or a trust doctor with equivalent ability Interventional radiology services for highest acuity patients are available within one hour of referral

**5b. Discharge***

- Discharge: If nurse or doctor feels situation is not a serious accident or emergency, the patient may be sent home and asked to refer themselves to a GP, referred to a nearby urgent care centre, minor injuries unit or referred to a GP on site.
- Consultant accredited in Emergency Medicine [CCT holder] on the Emergency Floor Consultant between 08:00 and 24:00, 7 days per week

* Category A calls relate to immediately life-threatening incidents

* Many places across Kent and Medway are introducing a first step based on the Barking, Having and Redbridge (BHR) 'Redirection' where the eyeball 'streaming' takes place by a GP or Consultant who in less than 4 minutes will assess the patient and redirect out to community services, GP's, Pharmacy, Minors/UCC, or hot clinics'. Those that remain go through the comprehensive triage.

** The detail of these aspects of the model is being developed as part of the local care work stream.

**Acute medicine**

31. At present acute medical care is delivered at all seven acute hospital sites in Kent and Medway and there were 115,626 medical admissions in 2015/16.

32. The population registered with GPs in Kent and Medway is 1.8 million (i.e. includes patients from outside the area registered with local GP practices). The population is forecast to grow over the next five years, with a majority of growth occurring in the elderly population. Partly linked to this there are rising numbers of emergency admissions and bed occupancy across Kent and Medway.

33. In a recent bed audit, there were 1,007 patients in hospital beds who are medically fit to leave their current setting of care (as at 22nd November 2016). The vast majority of patients who were medically fit for discharge were delayed for a reason outside of the control of the hospital.

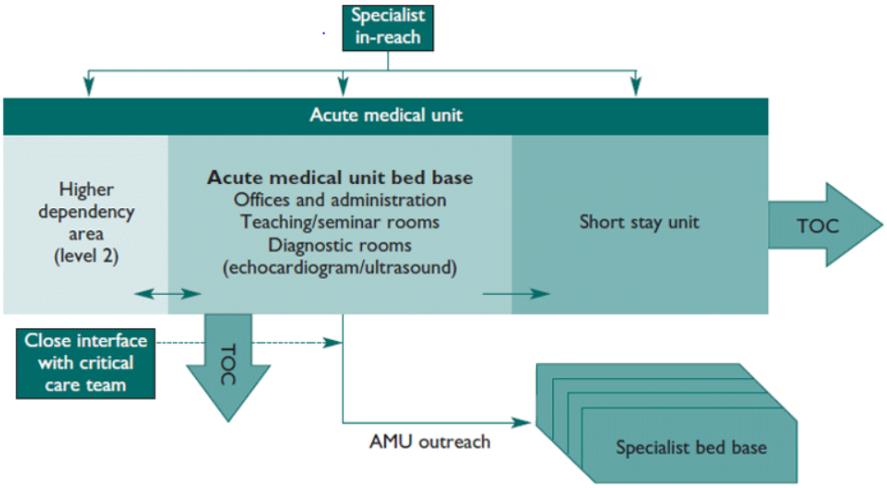
34. In line with national policy, the NHS aspires to provide seven day services but workforce constraints are challenging the delivering of this, including the inability to put in place 24/7 consultant cover in hospitals across Kent and Medway for those who need acute medicine.

35. The Kent and Medway acute medical care model is partially consolidated, but is still largely based on historic dispersal of services. Acute emergency medicine is currently delivered from seven sites using a variety of models. All Trusts aspire to deliver best practice models but constraints with capacity, estate and workforce only allow this to happen to varying degrees.

36. Our proposed service model covers:

- streaming to a fully functioning acute medical unit to reduce acute admissions;
- timely and appropriate discharge from the emergency department supported by schemes (e.g. such as occurs in the voluntary sector Take Home & Settle service in East Sussex);
- reduced non-elective length of stay, incorporating the NHS England pathway for people with dementia;
- Rapid Assessment Interface and Discharge (RAID) & Integrated Psychological Medicine Service (IPMS) models; and
- delivery of 7-day services in acute medicine to allow timely access to a senior specialist medical opinion.

37. The term Acute Medical Unit (AMU) has been defined by the Royal College of Physicians (RCP)[8] as 'a dedicated facility within a hospital that acts as a focus for Acute medical care for patients that have presented as medical emergencies to hospitals.' The report provides a detailed description of the rationale and requirements for an AMU but allows for local design. The structure of an AMU is schematically represented below:




38. Ideally an AMU should be co-located with other acute and emergency services as part of an emergency floor incorporating the ethos of Emergency Ambulatory Care. Strong clinical (medical and Nursing) and operational leadership is essential for an AMU to function successfully.

39. In delivering the acute medical take through an AMU a number of key principles need to be adopted:

- Assessment of acutely ill patients by competent clinical decision makers supported by appropriate levels of diagnostic support
- All areas follow the ethos of treating patients in an ambulatory model unless deemed otherwise by exclusion criteria
- Nominated medical, nursing and operational leads are in place working in the department on a regular basis

[8] Royal College of Physicians. *Acute medical care. The right person, in the right setting – first time.* Report of the Acute Medicine Task Force. London: RCP, 2007.

- Integration and collaboration of key acute services e.g. emergency department, critical care, AMU and key support services e.g. pharmacy and therapies
- Consistency of quality medical care 24 hours a day, 7 days a week
- Specialist medical in-reach when required in a timely way 7/7

**Stroke services**

40. In 2015/16 approximately 2,500 acute stroke patients were supported in the seven acute hospitals in Kent and Medway. Currently all of these hospitals provide acute stroke care and, following the immediate acute episode, patients are discharged without further rehabilitation or discharged back to their home with a community rehabilitation package or to a new home, such as a residential care home that is suitable for their needs

41. In 2015/16 only half of all patients were admitted within four hours and this performance is below national average. In addition, all of the hospitals:

    i. only provide five-day stroke consultant face-to-face cover;

    ii. none provide seven-day consultant ward rounds;

    iii. less than 50% of patients receive thrombolysis within 60 minutes; and

    iv. performance against Sentinel Stroke National Audit Programme (SSNAP) is variable and inconsistent.

42. Currently patient volumes are too small to deliver clinical sustainability hyper acute stroke units on all seven acute hospital sites. In particular, there are significant challenges that cannot be met with the current service model of all seven hospitals providing acute stroke care. We need to ensure there is 24/7 consultant availability with a minimum 6 trained thrombolysis consultant physicians on rota and consultant led ward round 7 days a week. This will be supported by a multi-disciplinary team including nurses, physiotherapists and occupational therapists.

43. In order to achieve the above we need to consolidate stroke services on fewer sites to ensure there are sufficient volumes of patients supported on each site to sustain the staffing numbers. For Kent and Medway this means delivering a combined hyper acute stroke unit and acute stroke unit service on a smaller number of sites. In practice for Kent and Medway this means developing hyper acute stroke units that support volumes of over 500 patients and less than 1500 confirmed stroke patients.

44. Alongside the acute stroke provision it is recognised that we need to develop robust early supported discharge and rehabilitation services.

**Elective orthopaedics**

45. There are 7,921 elective orthopaedic inpatient and 13,331 elective orthopaedic day case procedures undertaken in hospitals in Kent and Medway (plus 2,110 inpatient and 425 day case procedures in private hospitals under “choose and book arrangements”, which give patient a choice about where they receive treatment). The majority of the people having these procedures are older (with most procedures in the 64-69 age band).

46. In addition, Kent and Medway acute providers outsource approximately a further 2000 elective orthopaedic procedures each year to private hospitals and there are an additional 6,000 patients waiting for elective orthopaedic procedures across the area, with referral levels for elective procedures varying between CCGs and between practices. Some hospital waiting lists for planned care are long and growing. The number of cancellations on the day of the operation are increasing.

47. Right Care[9] analysis shows a potential significant opportunity in musculoskeletal elective bed days across the patient pathway, circa £8m compared to peers, and an additional £1.8m related to areas such as falls and primary care prescribing.

48. All acute hospital sites in Kent and Medway deliver a mixture of elective (planned) and non-elective (unplanned / emergency) orthopaedic services, with the exception of Kent & Canterbury Hospital which does not undertake any non-elective activity and Maidstone General Hospital which does not undertake any non-elective orthopaedic surgery.

49. Our proposed service model is based on:

- a focus on prevention and self-care and the benefit of a community-led integrated musculoskeletal (MSK) pathway;
- a set of principles including standardised approach, use of multi-disciplinary teams, one-stop services, senior support and better use of digital technology;
- a greater use of multi-disciplinary teams, consultant feedback, earlier discharge planning and ring-fenced elective beds; and
- consolidation of elective orthopaedic surgery onto fewer sites will lead to an improvement in outcomes.

50. The following diagram outlines our proposed service model:

| | |
|---|---|
| 1 MDT clinic | • Identify frail patients to follow proactive care for older people undergoing surgery (POPS) pathway<br>• Combined clinic with consultant, extended scope physio, GPwSI allows in clinic triage to most appropriate clinician<br>• Greater co-working between community staff, primary care and consultants – orthopaedic qualified nurses play a key role<br>• Lower average staff cost per appointment<br>• Spinal injections<br>• Focus on MSK pathway |
| 2 Preoperative assessment | • Conducted at first outpatient appointment; if patient found not fit then plan reviewed same day<br>• Greater use of self-assessment to support, which patients can complete from home<br>• Ensure social circumstances support the treatment plan, pre-booking of rehab/post-op package of care prior to admission |
| 3 Re-check prior to surgery | • Contact at 48-72 hours before day of surgery to reduce late cancellation<br>• Ensure patient is well and still wants surgery |
| 4 Short-notice reserve list | • Ensures effective use of theatre capacity by filling gaps caused by late cancellation |
| 5 Consultant-level feedback | • Transparency of list utilisation, case volumes per list<br>• Peer challenge<br>• Team working to increase available capacity by reducing cancelled sessions due to leave |
| 6 Effective planning for discharge | • Discharge planning at preoperative assessment<br>• Referral to discharge services earlier in the process (i.e. before admission)<br>• Access to community support services |
| 7 Enhanced recovery | • Consistent application of Enhanced Recovery Pathway (ERP) pathways<br>• Clear expectations of predicted length of stay for patient |
| 8 Ring-fenced elective beds | • Reduction in wasted theatre time<br>• Reduction in infection risk for elective cases |
| 9 Theatre utilisation | • Scheduling of theatre cases to optimise utilisation<br>• Ensure critical equipment is scheduled to maintain the order and running of the list |

[9] RightCare is an NHS England programme aimed at improving people's health and outcomes by promoting that the right person has the right care, in the right place, at the right time, making the best use of available resources. It uses data and evidence to highlight unwarranted variation to support quality improvement.

**Hurdle criteria**

51. As with the clinical models, the hurdle criteria have been developed through the hospital care workstream, with clnical and patient engagement, and then reviewed and signed-off by the STP Clinical Board, ahead of being approved at the STP Programme Board.

52. Through consideration of the service models we will identify a long list of options around potential service changes. As outlined in the process diagram at Point 11, these will be evaluated using the hurdle criteria. An option must meet the requirements of each of the hurdle critieria or it will be rejected. This means that through assessing the long list of options by applying the hurdle criteira to them, a short list of options will be generated. This shortlist of options will go forward to more detailed evaluation:

| Criteria | Description in relation to application against long list of options for emergency care, acute medicine and elective orthopaedics | Description in relation to application against long list of options for stroke services |
|---|---|---|
| **Is the potential configuration option clinically sustainable?** | • Does it deliver key quality standards?<br>• Does it address any co-dependencies?<br>• Will the workforce be available to deliver it?<br>• Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effective? | • Does it deliver key quality standards?<br>• Does it address any co-dependencies?<br>• Will the workforce be available to deliver it?<br>• Will there be sufficient throughput or catchment population to maintain skills and deliver services cost effectively? |
| **Is the potential configuration option implementable?** | • Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view, this may mean that some organisations have a net negative financial impact as well as some have a net positive impact. | • Will the option deliver financial and clinical sustainability within a medium-term timeframe by 20/21? This statement is based upon a system wide view |
| **Is the potential configuration option accessible?** | • Is the maximum travel time (by car) an average of one hour or less? | • Can the population access services within a window of 120 minutes from call to needle?[10] |
| **Is the potential configuration option a strategic fit?** | • Does it implement the outcome of other recent consultations or designation processes? | • Does it implement the outcome of other recent consultations or designation processes? |

[10] Using 95% accessing services within 60 mins (off-peak) as a proxy

| | | |
|---|---|---|
| **Is the potential configuration option financially sustainable?** | • Must not increase the 'do nothing' financial baseline | • Must not increase the 'do nothing' financial baseline *(given the need for capital investment at any resulting sites which is of similar quantum, noting more at PFI sites, this will be considered in detail at evaluation stage)* |

**Summary**

53. As indicated at the start of this paper it is envisaged that consultation will take place in two waves, with the first services that are intended to be consulted on being:

    i. Acute stroke services across Kent and Medway

    ii. Emergency services in East Kent (i.e. emergency departments and acute care)

    iii. Elective orthopaedics in East Kent

54. The next step will be to now:

    - agree a long list of options against each of the above services areas;
    - apply the hurdle criteria outlined in this document to the longlist of options to develop a shortlist of options;
    - agree full evaluation criteria; and
    - evaluate the shortlist of option using the full evaluation criteira.

55. The STP partner organisations are asked to consider the contents of this paper and indicate their support for:

    - the service models it outlines; and
    - the hurdle criteria that will be used to assess the long list of options.

56. The Governing Bodies of Clinical Commission Groups are asked to consider and formerly agree the service models and hurdle criteria.

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.2 |
| **Subject:** | Quality Committee Chairman's Assurance Report |
| **Presenting Officer:** | Steve Howe, Chair of the Quality Committee |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | X |

| **Report Summary (including purpose and context):** |
|---|
| The paper summarises the Quality Committee meetings held on 13 June and 4 July 2017. |

| **Proposals and /or Recommendations:** |
|---|
| The Board is asked to receive the Quality Committee Chairman's Assurance Report. |

| **Relevant Legislation and Source Documents:** |
|---|
| |
| **Has an Equality Analysis been completed?** |
| No. High level position described and no decisions required. |

| | |
|---|---|
| Steve Howe, Non-Executive Director | Tel: 01622 211900 |
| | Email: |

Kent Community Health NHS
NHS Foundation Trust

# QUALITY COMMITTEE CHAIRMAN'S ASSURANCE REPORT FOLLOWING JUNE AND JULY 2017 MEETINGS

## Introduction

The Quality Committee met on 13 June and 4 July 2017.

**Annual Safeguarding Report.** The committee reviewed the Annual Safeguarding Report in some depth. It was noted that there had been an overall reduction in safeguarding serious incidents last year.

**Annual Infection Control Report.** The committee reviewed the Annual Infection Prevention and Control Report and was pleased to note that targets were met with the exception of numbers of attributable Clostridium difficile infections (seven with a target of no more than five) and MRSA screening (99 per cent against a target of 100 per cent), although no MRSA bacteraemia infections were found to be attributable to the Trust within the reporting period. The Report was commended to the Board.

**Quarterly Quality and Safety Walkabouts Assurance Report.** It was noted that the visits revealed a significant number of areas of good practice, but where improvements were required, action plans were put into place. For example, teams found a mix of awareness regarding the linkage of Quality Impact Assessments to Cost Improvement Schemes and this was being addressed.

**Directorate and Quality Surveillance Exception Reports.** It was noted that community hospitals in east Kent were experiencing additional pressure through the temporary changes at the Kent and Canterbury Hospital. At the Queen Victoria Memorial Hospital, Herne Bay, patient experience scores had been lower than expected and the unit was experiencing high throughput, with higher readmission rates and delayed transfer of care than was optimal. The committee was reassured that the unit was receiving appropriate executive and quality and nursing support to bring about urgent change.

**End of Life Care Training (EOL).** Levels of EOL care training were currently monitored by the Quality Committee on a monthly basis. If the current trajectory of improvement wass maintained, it assessed that the Trust would be fully compliant by September 2017.

**Lessons from Serious Incidents.** The committee received assurance reports regarding the 'learning' from recent Serious Incidents. The Dental Never Event had resulted in pre-surgery check lists being adopted across all areas of the Trust including podiatry. The recent cross infection at Queen Victoria Memorial Hospital, Herne Bay, had seen improvement in training across the Trust for 'hotel staff' engaged in ward cleaning.

**Review of Risk Registers.** Operational services risk registers were reviewed for quality and safety risks on a quarterly rolling basis. The committee was content that appropriate mitigation action was in place for identified risks. The Dental Service was requested to obtain benchmarking comparisons with other providers regarding waiting times in prisons (identified from risk register) and found the Trust's performance to be similar to like services across the country.

**Board Assurance Framework (BAF).** Quality and clinical risk held on the BAF were reviewed at each meeting as a standing agenda item.

**NED Review of Quality Impact Assessments (QIA) for Cost Improvement Plans (CIP).** A team of four Non-Executive Directors including the Chairs of the Finance, Business and Investment Committee and the Quality Committee visited Tonbridge Cottage Hospital on 7 July 2017 to view the therapy-led unit and talk to staff. This was the second QIA/CIP review visit in the current financial year. The visit was both informative and successful and highlighted an area where there had been quite a stiff savings target, which was later withdrawn following the review of the QIA.

**SC Howe CBE**
**Chairman Quality Committee**
**10 July 2017**

Kent Community Health NHS
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.3 |
| **Subject:** | Integrated Performance Report (Part 1) |
| **Presenting Officer:** | Gordon Flack, Director of Finance |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | X |

**Report Summary (including purpose and context)**

The Integrated Performance Report has been produced to provide the Board with a detailed overview of KCHFTs quality, safety and performance. The report has been produced in collaboration with the Executive Team and their support teams.

The report has been split into to two parts because of the commercial sensitivity of some of the data included.

Part One of the report contains the following sections:

- Key & Glossary
- Corporate Scorecard
- Executive Summary: Narrative

Historic data has been provided to show trends, however, the availability of trend data varies between indicators as can be seen from the trend graphs. The trend graphs are designed to show a 12 rolling month view of performance for each indicator, but as stated this does depend on data availability.

This report shows the year-end forecast position for all indicators.

**Proposals and /or Recommendations**

The Board is asked to note this report.

**Relevant Legislation and Source Documents**

Not Applicable

**Has an Equality Analysis (EA) been completed?**

No
Papers have no impact on people with any of the nine protected characteristics*.

*** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.


| | |
|---|---|
| Nick Plummer, Head of Performance | Tel: 01233 667722 |
| | Email: nick.plummer@kentcht.nhs.uk |

Kent Community Health
NHS Foundation Trust



**Integrated Performance Report - 2017/18**
**Part 1**

**July 2017**
*April 2016 - June 2017 data*

*Excellent care, healthy communities*

Integrated Performance Report

# Contents



## Key and Glossary of Terms

**+ve** = Positive - improvement on last month

**-ve** = Negative - A decline on last month

**stat** = Static - No Change

| | | | |
|---|---|---|---|
| | Off Target | | As per KPI Target |
| | On Target | | Stretch target achieved |

**FOT** Forecast Outturns are based on extrapolation of YTD position unless specified

# KCHFT Corporate Scorecard 2017/18

## Strategic Goals

### 1. Prevent people from becoming unwell and dying prematurely by improving the health of the population through universal targeted services

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 1.1 | Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%) | 80.2% | 104.1% | 23.8% | 100.0% | 4.1% | 100.0% | N/A | +ve |
| 1.2 | Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%) | 100.3% | 100.6% | 0.3% | 100.0% | 0.6% | 100.0% | N/A | -ve |
| 1.3 | Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks | 85.2% | 89.0% | 3.8% | 90.0% | -1.0% | 95.0% | N/A | +ve |
| 1.4 | Health Visiting - Increase the uptake of New Birth Visits by 14 days | 85.8% | 90.9% | 5.1% | 90.0% | 0.9% | 95.0% | N/A | +ve |
| 1.5 | School Health - Reception Children Screened for Height and Weight | 94.1% | 94.8% | N/A | 90.0% | N/A | 95.0% | N/A | +ve |
| 1.6 | School Health - Year 6 Children Screened for Height and Weight | 95.4% | 95.9% | N/A | 90.0% | N/A | 95.0% | N/A | +ve |

### 2. Enhance the quality of life for people with long term conditions by providing integrated services to enable them to manage their condition and maintain their health

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 2.1 | LTCs (including Health Trainers) Teams Contacts: YTD as % of YTD Target | 93.7% | 98.3% | 4.6% | 100.0% | -1.7% | 100.0% | N/A | +ve |
| 2.2 | LTCs Teams - Did Not Attend Rate: DNAs as a % of total activity. | 1.6% | 1.5% | -0.1% | 4.0% | -2.5% | 3.0% | 4.0% | +ve |

### 3. Help people recover from periods of ill health or following injury through the provision of responsive community services

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 3.2 | Total Time in MIU & WiC Service: Less than 4 hours | 99.94% | 99.89% | 0.0% | 95.0% | 4.9% | 99.5% | 99.5% | -ve |
| 3.3 | Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways | 99.6% | 99.6% | 0.0% | 95.0% | 4.6% | 98.0% | 96.8% | -ve |
| 3.4 | Allied Health Professionals Referral to Treatment Times (RTT) | 92.8% | 96.3% | 3.5% | 95.0% | 1.3% | 98.0% | 97.6% | +ve |
| 3.5 | Access to GUM: within 48 hours (Monthly Target 100%) | 100.0% | 100.0% | 0.0% | 100.0% | 0.0% | 100.0% | N/A | stat |
| 3.7 | Bed Occupancy: OBDs as a % of available bed days | 88.6% | 91.1% | 2.6% | 87.0% | 4.1% | 91.7% | 87.9% | +ve |
| 3.8 | Length of Stay (Median Average) | 21.6 | 19.5 | -2.1 | 21.0 | -1.5 | 21.0 | 25.6 | +ve |
| 3.9 | Delayed Transfers of Care as a % of Occupied Bed Days | 12.1% | 12.2% | 0.2% | 3.5% | 8.7% | 3.5% | 11.8% | -ve |

### 4. Ensure that people have a positive experience of care and improved health outcomes by delivering excellent healthcare

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 4.1 | Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate | 23.7% | 23.0% | -0.7% | 15.0% | 8.0% | 25.0% | 30.7% | -ve |
| 4.4 | End of Life Care: Percentage of patients dying in their preferred place. | 86.3% | 89.3% | 3.0% | 95.0% | -5.7% | 95.0% | 83.2% | -ve |
| 4.5 | ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services. | 85.0% | 89.1% | 4.1% | 80.0% | 9.1% | 90.0% | N/A | +ve |

# KCHFT Corporate Scorecard 2017/18

## Strategic Goals

### 5. Ensure people receive safe care through best practice

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 5.2 | Infection Control: C.Diff (Target <6 cases in year) (Target YTD) | 7 | 1 | -6 | 1 | 0 | 1 | N/A | +ve |
| 5.6 | Safety Thermometer: % harm free care New Harms | 97.7% | 97.1% | -0.6% | 95.0% | 2% | 97.5% | 96.3% | +ve |
| 5.7 | Never Events: FOT as % of Annual Target | 1 | 0 | -1 | 0 | 0 | 0 | N/A | stat |
| 5.8 | NICE guidance: New NICE Guidance reviewed within required timescales following review of publication. | 100.0% | 100.0% | 0.0% | 100.0% | 0% | 100.0% | N/A | stat |

## Enabling Strategies

### Finance and Commercial

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 6.1 | Income & Expenditure - Surplus (%) | 1.7% | 1.3% | -0.4% | 1.0% | 0.3% | 1.0% | 1.0% | -ve |

### Workforce

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 7.1 | Sickness Rate | 4.30% | 4.08% | -0.22% | 3.90% | 0.18% | 3.75% | 4.58% | +ve |
| 7.4 | Mandatory Training: Combined Compliance Rate | 94.7% | 94.1% | -0.6% | 85.0% | 9.1% | 92.5% | 88.4% | +ve |

### IM&T

| KPI Ref | KPI Description | 16/17 | 17/18 | YoY Change | Target | RAG/ Variance | Aspiration | Bench Mark | Trend |
|---|---|---|---|---|---|---|---|---|---|
| 8.2 | Data Quality: NHS Number Completeness across clinical systems | 100.0% | 100.0% | -0.01% | 95.0% | 5.0% | 99.9% | 98.5% | -ve |

# Executive Summary: Supporting Narrative - July Report 2017/2018

## Quality

**Infection Control: MRSA & C-Difficile:** There have been no Clostridium difficile Toxin positive infections in KCHFT sites in June.

## Workforce

**Sickness:** The cumulative sickness absence rate for the financial year to June 2017 is 4.08% which up from 3.74% at M2. The sickness rate in June was 4.30%, an increase of 0.19% from last month. The total FTE days lost for the rolling year to June equates to an average of 9.66 days sickness lost per employee, up from last month. The proportion of FTE lost to short-term sickness has increased to 46.5%, compared to 44% in May.

**Mandatory Training:** There is now 1 area which is non-compliant. This is 1. Moving and Handling: Client which has increased to 84.5%.

## Finance

**Income & Expenditure and Financial Risk Rating:** The Trust achieved a surplus of £708k (1.3%) to the end of June. Cumulatively pay and non-pay have underspent by £1,821k and £5k respectively. Income has under-recovered by £1,662k and depreciation/interest has overspent by £74k.

## Access

**Sexual Health Services, MIU 4-Hour wait and 18 week referral to treatment pathways:** currently these targets are all being met at a Trust level, with 98.9% completed RTT pathways within 18 weeks and 99.7% incomplete RTT pathways within 18 weeks for M2. Paediatrics has improved in M2 to 92.6%, compared to 75.2% of children seen within 18 weeks in M1

**Referral to Treatment Times for all Allied Health Professionals** when measured against the 18 week threshold shows 97.1% of patients being seen within this timescale for May 2017, 1.5% up on the April position. Only Podiatric Surgery was below 90% compliance with 18 weeks RTT for May

## National Targets

**Stop Smoking:** The stretch target set by KCC is 3750 quits. KCC have set a minimum target of 3400 quits. Month 1 and 2 data is showing thar we are on track to meet our target oif 3400 quits.

**Health Checks:** The service is was slighly under its target for month 1 but over-achieved in months 2 and 3 target. There is still a slight shortfall but the service is confident it will make this up over the coming months. The service does have some hurdles to overcome with the Health Improvement restructure. It is putting various plans in place to help reduce any shortfall. For example, we are working hard to improve work place checks, we are organising a mini HC week and have arranged pop up events in supermarkets and shopping centres. Most areas of checks are performing well; especially GP delivered checks. KCHFT core checks are slightly below target, but work is happening to help increase the uptake. This includes identifying two year trends of under-performing GP practices and having discussions with them about changing contract types and working with the Wellbeing People to deliver checks in town centres over the summer months.

## Community Hospitals

There were 194 admissions to the Community Hospitals in May and 4,493 occupied beds days from a possible 4,877 bed days, therefore, bed occupancy stood at 92.1%. There were a total of 515 bed days lost due to delayed transfers of care (11.5% of total occupied bed days). The average length of stay (median) was 20.3 days across all hospitals in Month 2.

**Bed Occupancy (Target range 87-92%):** Bed occupancy increased to 92.1% in Month 2, with no sites falling below the 87% target occupancy. Bed occupancy has generally increased due to pressures in the whole system and the need to facilitate patient discharges from acute hospital beds.

**Length of Stay (LOS) - Median (Target 21 days):** Performance against the median average length of stay target continues to be under target at 20.3 days, up slightly from M1 (19 days)

**Delayed Transfer of Care (DTOC) days as percentage of total bed days (Target 3.5%):** Delayed Transfers of Care has decreased in M2 and remains above the target at 11.5%. This relates mainly to high levels at all hospitals, with all sites being above the 3.5% target with the exception of Edenbridge. This is split between 7.9% KCHFT responsibility and 3.5% Social Services/Other

## Activity

KCHFT's clinical services carried out 184,733 contacts (This figure includes various currencies e.g. face to face contacts, telephone contacts, group sessions, Units of Dental Activity), of which 11,480 were MIU attendances, during May 2017. KCHFT is below target at Month 2 (-2.7%), mainly due to low activity in Dental and LD. Performance against 2017/18 contract targets has been summarised at Service Specification level below:

| Service & Currency | M1 Actual | YTD Actual | YTD Target | YTD Variance | Contract BRG | Trend |
|---|---|---|---|---|---|---|
| Long Term Conditions | 55,253 | 106,575 | 108,371 | -1.7% | | |
| Intermediate Care | 22,197 | 42,072 | 42,709 | -1.5% | | |
| MIU Attendances | 11,480 | 21,755 | 19,119 | 13.8% | | |
| Community Hospital Admissions | 194 | 368 | 303 | 21.3% | | |
| Community Hospital Occupied Bed Days (WK) | 2,057 | 3,928 | 4,246 | -7.5% | | |
| Community Hospital Occupied Bed Days (EK) | 2,436 | 4,803 | | | | |
| Specialist and Elective Services | 29,902 | 55,486 | 57,409 | -3.3% | | |
| Learning Disabilities - Face to Face | 3,231 | 5,915 | 7,199 | -17.8% | | |
| *Children's Universal Services | 32,228 | 56,708 | | | | |
| Children's Specialist Services | 15,006 | 25,639 | 23,163 | 10.7% | | |
| Dental Service - All currencies | 10,438 | 20,706 | 27,963 | -26.0% | | |
| Health Trainers | 311 | 536 | 484 | 10.7% | | |
| **All Services and Currencies (Contracted)** | **150,069** | **282,980** | **290,967** | **-2.7%** | | |

Contract
>+10%
>-10%
n/a
<+/- 10%
No Target

*these figures are not included in the table totals as they don't have a contractual target

**Adults:** Long Term Conditions (LTC) contacts are 1.7% (1,796 contacts) below at M2. Intermediate Care and Rehab Services (ICT) are 1.5% below target (630 contacts) with the targets adjusted for 17/18. Activity for the planned care services is 3.3% under target for the year (all currencies).

**Children and Young People:** It should be highlighted that the contract for Health Visiting does not have an activity target (hence the target and variance being greyed out). Health Visiting are measured against specific KPIs, although these still require a certain level of activity to ensure compliance with KPIs such as New Birth Visits, 1 year and 2 1/2 year development checks. Therefore is useful to see overall activity levels to highlight any major changes. Collectively the Childrens Specialist Clinical Services are 5.9% below target at M2, mostly attributed to West Kent Special Schools and ITAC in East Kent.

Integrated Performance Report

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.4 |
| **Subject:** | Monthly Quality Report |
| **Presenting Officer:** | Ali Strowman, Chief Nurse |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | X |

**Report Summary (including purpose and context)**

This report provides assurance to the Board on Patient Safety, Patient Experience and Patient Outcomes.

- Sevenoaks, Tonbridge (Goldsmid) and QVMH had staffing levels below 95%.
- In Quarter 1 there have been 5 category two pressure harms and 3 category 3 harms compared to a total 17 in Quarter 1 2016/17
- There was one fall with fracture which is under investigation.
- There is a steady decline in medication incidents
- Patient experience remains extremely positive.

**Proposals and /or Recommendations**

The Board is asked to receive the report.

**Relevant Legislation and Source Documents**

**Has an Equality Analysis (EA) been completed?** No

No. High level position described and no decisions required/no significant change. Paper has no impact on people with any of the nine protected characteristics.

*** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.


| | |
|---|---|
| Ali Strowman, Chief Nurse | Tel: 01622 211900 |
| | Email: Ali.Strowman@kentcht.nhs.uk |

# QUALITY REPORT

## 1. Patient Safety

1.1. The information below relates to June fill rates per community hospital ward broken down by day and night for registered and unregistered staff. The fill rate for registered nurses has increased from June, producing a total fill rate of 102% for RN's day shifts (95% last month). Night shift fill rates for RN's have also increased at 106%. From June 12th additional beds were opened on wards at Deal (4), Faversham (2), Whitstable and Tankerton (1) and staffing was adjusted accordingly, this is the cause of the RN overstaffing in figure 1. There is no agreed national rating system yet, so the Chief Nurse will provide commentary on any areas less than 95%.

1.2. Sevenoaks, Tonbridge (Goldsmid) and QVMH wards all had RN day shifts below 95% and no hospitals had below 95% for night shifts. Where RN shifts were unable to be filled by bank or agency the wards have increased the use of HCA staff to increase general capacity. Additional HCAs were also used to increase capacity for additional beds, provide enhanced observation (1:1 care) for patients at risk of falling or with dementia. Where the staff bank are unable to fill requested shifts, a clear process for requesting the use of agency nurses is in place with scrutiny and sign off by executive team members following discussion with senior clinical staff.

**Figure 1:**

| | Day Fill Rate % | | Night Fill Rate % | | Day | | | | Night | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RN's | HCA's | RN's | HCA's | RN's | | HCA's | | RN's | | HCA's | |
| | | | | | P hours | A hours | P hours | A hours | P hours | A hours | P hours | A hours |
| Faversham | 114.2% | 148.3% | 98.3% | 128.3% | 900 | 1027.5 | 1350 | 2002.5 | 660 | 649 | 660 | 847 |
| Deal | 125.0% | 150.0% | 141.7% | 101.7% | 900 | 1125 | 1350 | 2025 | 660 | 935 | 660 | 671 |
| QVMH | 90.8% | 128.9% | 98.3% | 101.7% | 900 | 817.5 | 1350 | 1740 | 660 | 649 | 660 | 671 |
| Whit &Tank | 99.2% | 145.3% | 98.3% | 105.0% | 900 | 892.5 | 1125 | 1635 | 660 | 649 | 660 | 693 |
| Sevenoaks | 92.5% | 115.6% | 100.0% | 105.0% | 900 | 832.5 | 1350 | 1560 | 660 | 660 | 660 | 693 |
| Tonbridge - Goldsmid | 86.7% | 108.7% | 100.0% | 126.7% | 900 | 780 | 1125 | 1222.5 | 660 | 660 | 330 | 418 |
| Tonbridge - Primrose | 95.0% | 95.0% | N/A | 87.8% | 450 | 427.5 | 1350 | 1282.5 | 0 | 88 | 990 | 869 |
| Hawkhurst | 98.3% | 112.0% | 98.3% | 103.3% | 900 | 885 | 1312.5 | 1470 | 660 | 649 | 660 | 682 |
| Edenbridge | 114.2% | 103.3% | 100.0% | 100.0% | 900 | 1027.5 | 900 | 930 | 660 | 660 | 330 | 330 |
| **Total** | **102%** | **124%** | **106%** | **105%** | **7650** | **7815** | **11213** | **13868** | **5280** | **5599** | **5610** | **5874** |
| | Over 90% Fill Rate | | | 65%to90% Fill rate | | | | Less than 65% | | | | |

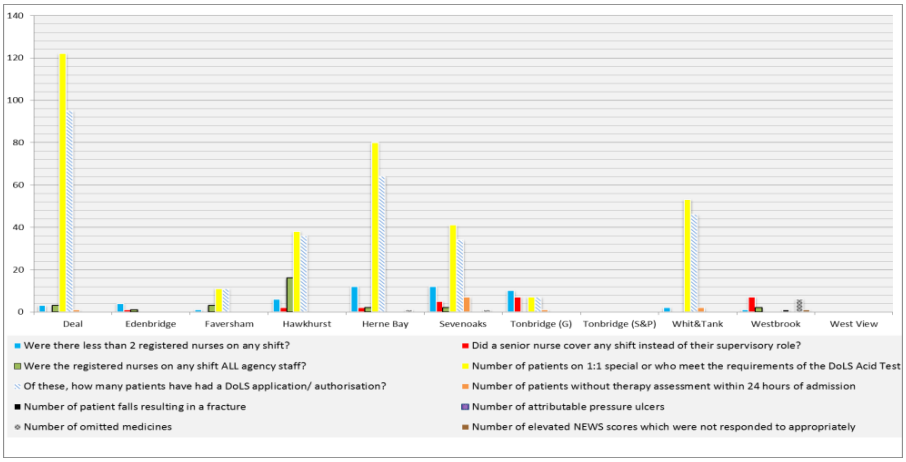
1.3. All wards are required to submit the Red Flag assessment each day, identifying any key quality indicators for safe patient care, this is summarised in Figure 2. Where there are difficulties in filling shifts with the potential of impacting on patient safety, these are

escalated to the operational lead that day and a number of measures are taken to ensure safety. These include:

- move staff from other wards to provide cover
- offer staff opportunity to work when they are not on duty
- convert supervisory time to clinical time
- move rapid response or the night teams to be based at the same site
- ensure the minor injuries units, when located in the same building, are aware the ward has one nurse on duty so they are prepared to respond if required

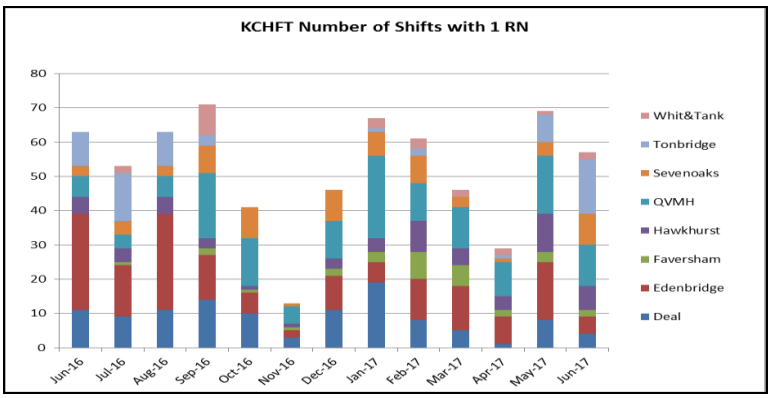
1.4. There continues to be a high number of patients requiring 1-1 support, some related to an increase in the number of inpatients with mental health needs and work continues to explore how we support patients with dementia differently.

**Figure 2**:




1.5. In June the E-roster data reports that 57 shifts had 1 RN on duty (excluding Primrose which has I RN planned), this is a decrease from May where 69 shifts had 1 RN on duty. Tonbridge, QVMH and Goldsmid, were the wards that were challenged in filling RN shifts and this is reflected in their lower fill rates. The table below shows the trend in respect of shifts where 1 RN is present across the Trust.

**Figure 3:**




1.6. Within these shifts, safety was maintained by operational managers by implementing the measures stated in figure 1.3 above. Of the 57 shifts with 1 RN, there were clinical incidents on 15 of these shifts (Figure 4), all of which have been investigated

and were low or no harm incidents. Whilst there cannot be a definitive correlation drawn between reduced numbers of RNs and incidents (as incidents happen on shifts where the full complement of staff are present), we continue to monitor this closely.

**Figure 4:**

| Hospital | Incident date | Type of Incident | Additional detail | Impact on Patient |
|---|---|---|---|---|
| Hawkhurst Hospital | 07.06.17 | Deteriorating patient | GP on ward at the time of deterioration and patient transferred to the acute | Low harm |
| Hawkhurst Hospital | 12.06.17 | Fall | Patient decided to move independently from wheelchair to bed | No harm |
| Whit and Tank Hospital | 23.06.17 | Fall | Non ambulant patient tried to stand independently | No Harm |
| Whit and Tank Hospital | 23.06.17 | Fall | Patient attempted to stand independently | No Harm |
| QVMH Hospital | 19.06.17 | Medication Error | Irregularities in medication stock/no patient involvement | No harm |
| Sevenoaks | 18.06.17 | Fall | Patient chose to walk independently although had been advised to request support | No Harm |
| Tonbridge | 02.06.17 | Medication Error | Lower dose of medication administered to patient in error, no perceived effect by patient | No Harm |
| Tonbridge | 07.06.17 | Fall | Patient transferring with one staff member when legs gave way and guided to floor | No Harm |
| Westbrook | 05.06.17 | Medication Error | Late dose of antibiotic omitted | No Harm |
| Westbrook | 05.06.17 | Medication Error | Issue with transcribing and drug being initialled | No Harm |
| Westbrook | 05.06.17 | Medication Error | Self-medicating patient has been taking a lower dose of medication due to error in writing patient self-medication chart | No Harm |
| Westbrook | 05.06.17 | Medication Error | Issue relating to transfer between organisations and transcribing | No Harm |
| Westbrook | 07.06.17 | Fall | Patient attempted to reach drink from bed and fell to floor, happened 5 minutes after nurse had checked patient | Low Harm |
| Westbrook | 07.06.17 | Medication Error | Omission of a 7am medication | No Harm |

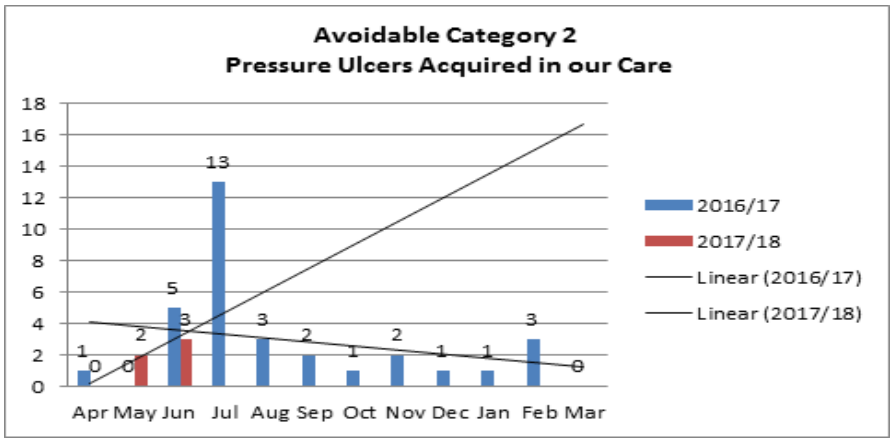
1.7. **Pressure Ulcers**

The Pressure Ulcer Taskforce Group continues to meet monthly to progress prevention strategies in pressure ulcer management and gain assurance that all interventions are being implemented.

**Category 2 Pressure Ulcers**

There have been 3 confirmed avoidable category 2 incidents acquired in our care this month with an additional category 2 harm confirmed in May bring the total to 5 in Quarter1. There are 66 (42) outstanding category 2 investigations to be completed. The tables below compare our current position with 2016/17.

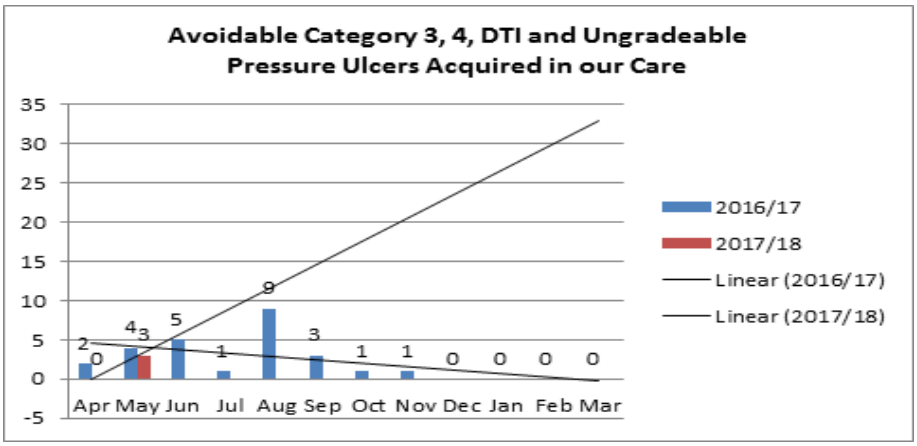
**Figure 5:**




**Category 3, 4 and ungradeable pressure ulcers**

There have been no confirmed avoidable serious harms acquired in our care this month, but 3 category 3 harms were confirmed in May in the Canterbury locality. There are 49 outstanding incidents (category 3; 4; ungradeable; deep tissue injury) to be investigated.

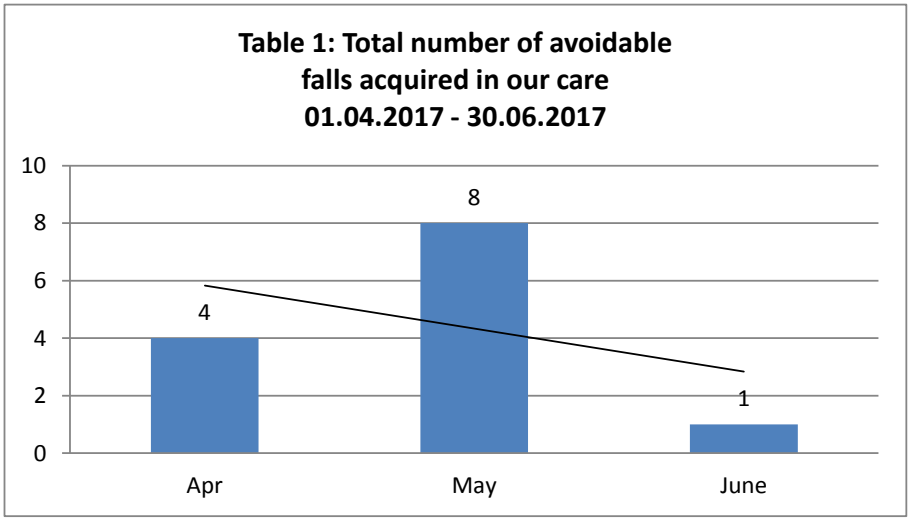
**Figure 6:**




1.8. **Falls**

There were 44 falls reported across KCHFT in June (45 last month) of which 1 fall acquired in our care was found to be avoidable - this is a decrease from the previous month where 8 falls acquired in our care were found to be avoidable (Fig 7).

**Figure 7:**




One serious incident was declared in June as a result of a fracture. This occurred at Faversham Community Hospital during night time hours. The ward was fully staffed at the time and the RCA process is underway.

Work in relation to falls prevention across the community hospitals is progressing well, the first East and West Kent Falls Prevention Quality Improvement Groups have now taken place, the groups are focused on the 6 key falls prevention actions for the wards following the NHSI falls collaborative and internal falls audit. Progress against these actions will be reviewed at the next meetings in September. The role and responsibilities for the falls prevention champions have been written and agreed, falls prevention champion lanyards have been designed and ordered and the matrons have agreed to allow the champions to have 3 hours per month to focus on this work for their unit. The updated falls prevention policy has now been finalised and has been disseminated via the June policy update.

KCHFT will receive the results of the recent Royal College of Physicians National Audit of Inpatient Falls in September.

1.9. **Medication Incidents**

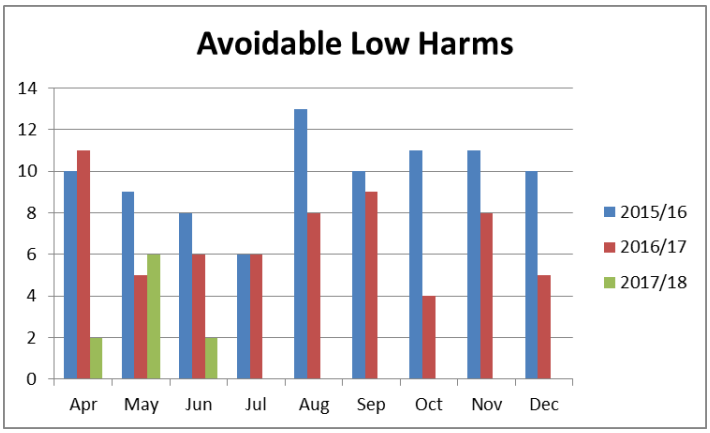
The table below shows the number of actual medication incidents received and investigated in June so far. The final number of incidents will change and the numbers are updated for each report.

| | Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17 | Oct-17 | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Actual** | 38 | 59 | 59 | | | | | | | | | |
| **Near Miss** | 4 | 8 | 4 | | | | | | | | | |

A total of 59 avoidable medication incidents, acquired in our care, have been reported and investigated so far for June 2017. The highest reported category of avoidable incidents is omitted medication making up 34% each of the total number logged since the last report.
Of the 59 incidents that occurred during June 2017:

- 97% resulted in 'no harm' to the patient with the majority of these being omitted medication and wrong method of preparation or supply.
- 3% resulted in 'low harm' with these 2 incidents being omitted medication and wrong or unclear dose or strength.
- There were no incidents that resulted in 'moderate harm', 'severe harm' or 'death' of a patient.

The table below shows the number of avoidable low harms reported and investigated to date for June. The table shows a considerable decline in incidents this year.




1.10. **Infection, prevention and control**

Cleaning standards in two inpatient areas are below the expected standard of 95%, these are Sevenoaks and Faversham. The interim Head of Hotel Services has plans in place to improve the standards in these areas, including increased training, competency assessments and independent audits. Cleaning is improving in QVMH, with weekly audits showing an improvement, however progress is inconsistent and actions are being implemented by the Head of Hotel Services.

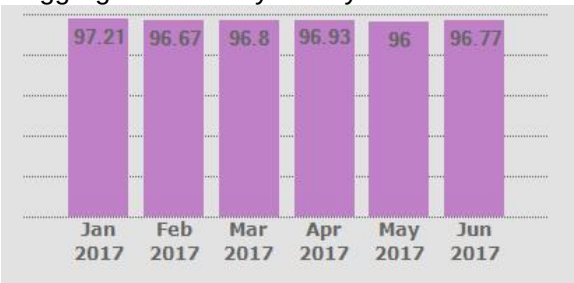
## 2. Patient Experience

2.1. **Meridian Patient Experience Survey results for June 2017**

6,037 surveys were completed by patients using KCHFT services throughout June with an excellent combined satisfaction score of 96.77%. This includes 2,578 short NHS FFT surveys used by the MIUs that achieved an very positive overall satisfaction score of 97.25%.

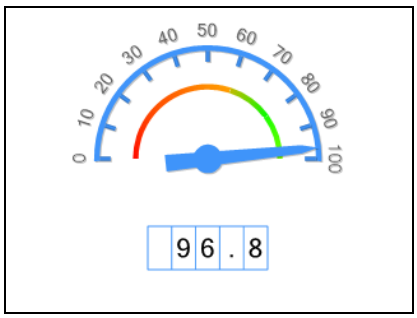
Volumes


Aggregated monthly survey scores




The NHS Friends and Family Test score response comparison is shown below and satisfaction levels remain consistently high.


| Combined result from all questionnaires submitted between 1-Jun-2017 and 30-Jun-2017 | Number of questionnaires submitted between 1-Jun-2017 and 30-Jun-2017 |
|---|---|
| **96.77%** | **6037** |




**Word clouds (selection of key words used within Meridian survey responses) for June 2017:**


**Key**
Whether a word is green or red is based on whether the score for completions containing a comment with that word is above or below the average score. They are also sized to show how often they appear (the larger the more frequent).

NHS Friends and Family Test (FFT) trust wide results for June demonstrate that less than 1% of patients were unhappy with our services.

| | Recommend | Not Recommend | Total Responses | Extremely Likely | Likely | Neither Likely or Unlikely | Unlikely | Extremely Unlikely | Don't Know |
|---|---|---|---|---|---|---|---|---|---|
| Trust | 97.44% | 0.62% | 5786 | 4754 | 884 | 71 | 14 | 22 | 41 |

2.2. **Selection of positive feedback**

| | |
|---|---|
| WKUC Home Treatment Service - Sevenoaks | Staff were very supportive and clear and very good at explaining what they were doing. I do not know what we would have done without them - hospital would have been the only option. |
| Respiratory Nursing - Thanet | Quite simply my life probably wouldn't be worth living without the advice and care from the whole team. |
| Community Nutrition Service - Tonbridge | I really can't express how much you have helped me over the past year. I always feel a million times better and more motivated after our chats. |
| Epilepsy Nursing - Margate | It is useful to have someone to listen to me and understand how I feel. Not just giving me medical advice but being caring and asking me about my feelings is so lovely. |
| Health Trainers - Maidstone | Having someone actually to talk to on a good or bad day. Someone to just listen. Having an outside perspective and care about all the other bits that people miss. |
| Children's Audiology (Hearing Service) - Maidstone | The staff are amazing and very informative, sensitive and helpful. Great at explaining everything. |
| Dental (Adult and Children) - St Leonards Hospital | Excellent service polite and friendly staff. Very caring of my daughters experience and phobia of dentist and pain. Professional and skilled staff |

| | |
|---|---|
| Sexual Health Service - Gravesend | As during my experience within this clinic I have found them pleasant, comfortable and informative, from all staff members, whom have treated me with fairness, friendliness, whilst all being very professional at all times. |
| Children's Specialist Respiratory Nurse - Canterbury | Very friendly staff, listens to concerns, explains everything so I can understand. |
| Children's Bladder and Bowel Nursing - Thanet | Great explanations to children and parents. Lots of reassurance and encouragement given. |

2.3. **Selection of negative feedback from the NHS Friends and Family Test question–** all flagged to services for investigation and action where possible.

| **Service** | **FFT response** | **Notes and reason given for response** |
|---|---|---|
| Minor Injury Unit (Royal Victoria Hospital, Folkestone) | Unlikely | **Comment:**<br>Children should be prioritised, reception should triage and be more efficient when checking people in. |
| Service response: Patient waited 30 minutes from booking in. The Nurse Practitioner felt they were fine when they got in the room and the child was fine. Reception staff are aware of when to call a nurse to see a patient who is urgent and an icon comes up on the screen to say they are concerned and could a nurse assess the patient. Any child we are concerned about will be brought in early but as our numbers are high generally, if all children were taken first all the time, adults could have to wait a long time to be seen and they may be unwell or in pain. | | |
| Continence Project Team - West Kent | Unlikely | Because pads are not as good as Hartmans. Night pad I'm having wet underwear, day one ok. Not happy having to pay 10p per minute for phone call to Tena |
| Service response: I understand the patient has been unhappy with the new providers' products and I understand is now being offered a continuation of previous product. Deputy Head of Service for Kent Continence has confirmed that SCA (product providers) are in the process of changing their telephone number to a local rate number which should be in place in September. | | |
| Dental (Adult and Children) - Five Elms Medical Centre | Unlikely | **Comment:**<br>The booking system now, centralised is not up to standard. Long wait, Incorrect appointment booked. Difficult to get hold of. |
| Service response: The Central Administration Team are working with interim facilities which have been recognised as needing improvement. I anticipate that this problem should be resolved over the coming weeks pending the outcome of the dental services consultation in which the proposal is to have designated reception staff at each site which will enable patients to book appointments immediately following their consultation appointment. We are also having a new telephone system being installed which will enable telephone access much easier. Details of action being taken, re new telephone system, added to the service's Patient Experience Improvement Plan. | | |
| Sexual Health Service - Canterbury | Unlikely | **Comment:**<br>The waiting time is beyond ridiculous, and you can't book appointments within multiple weeks of notice. |
| I emailed this client today and asked her to contact me for further discussion at her earliest convenience. I apologised for the fact she felt she has an unacceptable wait time when she visited. Details of action being taken, re sourcing of air con units, added to the service's Patient Experience Improvement Plan. | | |

2.4. **Patient Outcomes**

**Selection of actions completed in June 2017:**

**Sexual Health service, The Gate, Canterbury** – Some patients said that refreshments, other than water, should be available as waiting times can sometimes be long. **Action:** As there is no space in the waiting area for a vending machine, a poster is now displayed advising patients that they are welcome to leave the area to get refreshments as long as they let reception staff know before doing so. Details of where refreshments can be purchased in the main hospital are also provided.

**Community Paediatric service, Sevenoaks Hospital** – Parent/carers highlighted that no directions are visible to the clinic rooms from the main reception area and clinic room doors aren't named. Somewhere to leave feedback would be useful. Action: Blue arrows on the walls now mark the way from the reception area to the 2nd floor waiting area. Clinic room doors are named and a patient feedback box is in the waiting area by the leaflet rack.

**Specialist Weight Management service:** Some client said they had not received an explanation of the programme prior to attending assessments. **Actions:**

- A typical script describing what should be said to potential new clients has been sent to Central Admin Team staff
- An additional supply of SWMS leaflets have been provided to the two admin centres to be sent with future initial contact letters

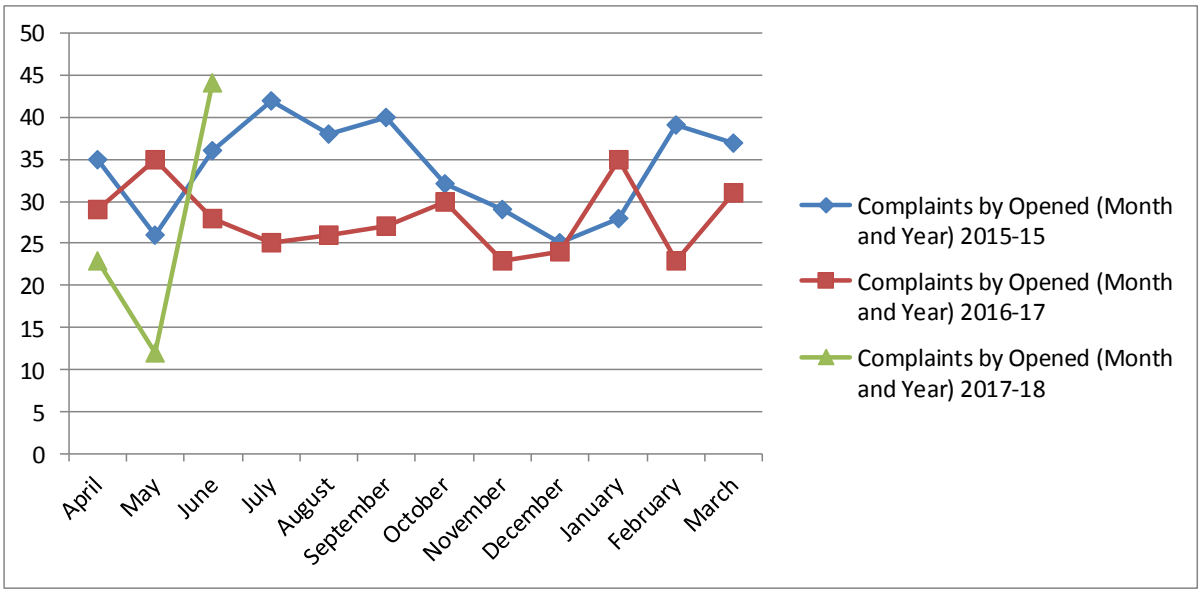
Other actions are ongoing and are due for completion in several months' time.

2.5. **Complaints data for June 2017**

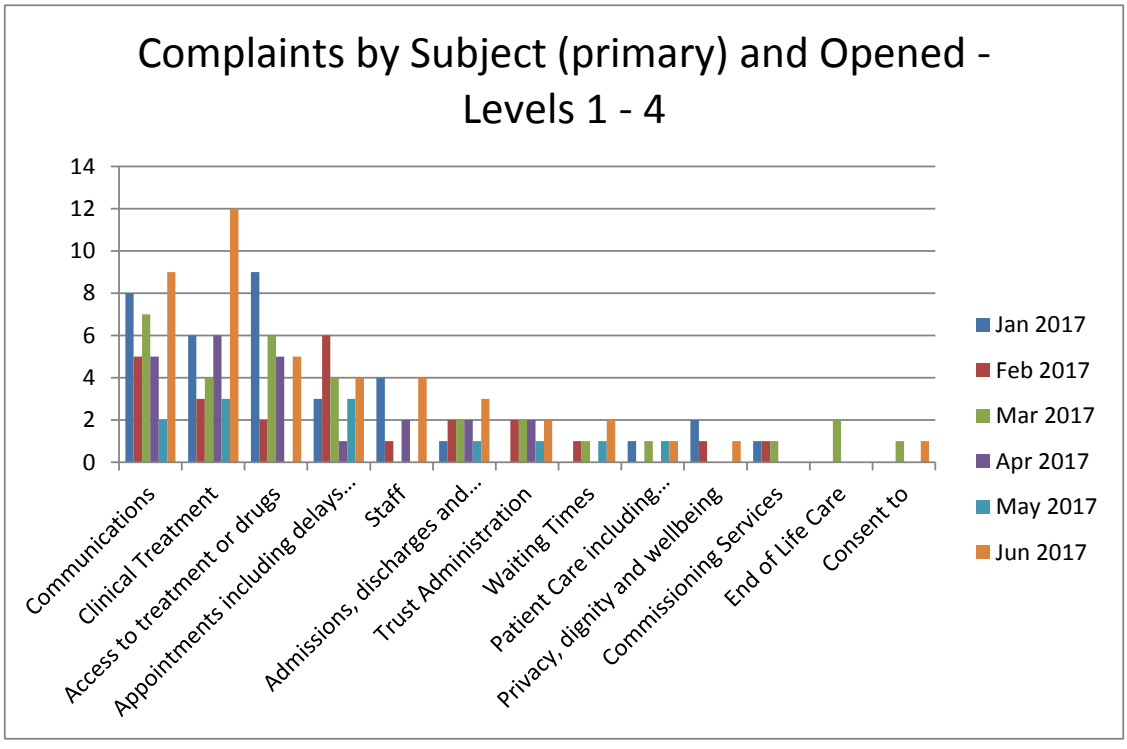
In June 2017 there were 44 complaints for services, compared to 12 in May 2017 and of these were 7 multi-agency complaints. Possible reasons behind the increase in complaints are that 5 multi-agency complaints were received from EKHUFT (1 last month), and 4 comments received into PALS in May could not be resolved locally and have been logged as complaints in June. In view of the increase from last month a break down has been provided below and demonstrates coverage across services:

Adults Directorate: 26 complaints (8 in May), 21 graded as low risk, 2 as medium risk and 3 ungraded at this time. There were 7 multi-agency complaints. The complaints are broken at service level as follows: 1 SALT, 1 cardiac, 1 dietetics, 5 chronic pain, 3 inpatients, 5 community nursing, 2 intermediate care, 2 lymphedema, 1 MIU, 1 MSK and 4 podiatry.
CYP Directorate: 18 Children and Young People's Directorate complaints (3 last month), 16 graded as low risk, 1 as high risk and 1 ungraded at this time.
11 in children's services (1 audiology, 1 therapy, 3 community paediatrics, 2 east Sussex CITs, 1 HV, 1 specialist nursing and short breaks, 2 school nursing), 2 in sexual health and 5 in dental services (1 in dental last month). The 5 in dental services are related to access in mainly the newly commissioned London services.

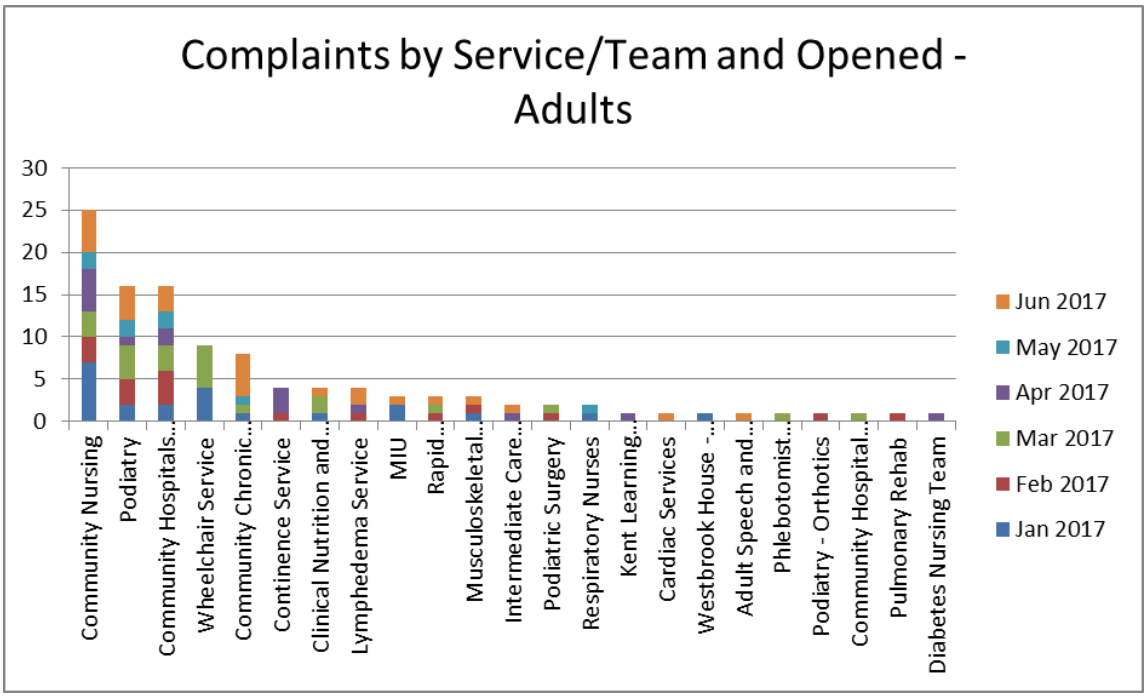
The following graph shows complaints received by month for the last 3 years, taken over the last three months this is less than the average of previous years.



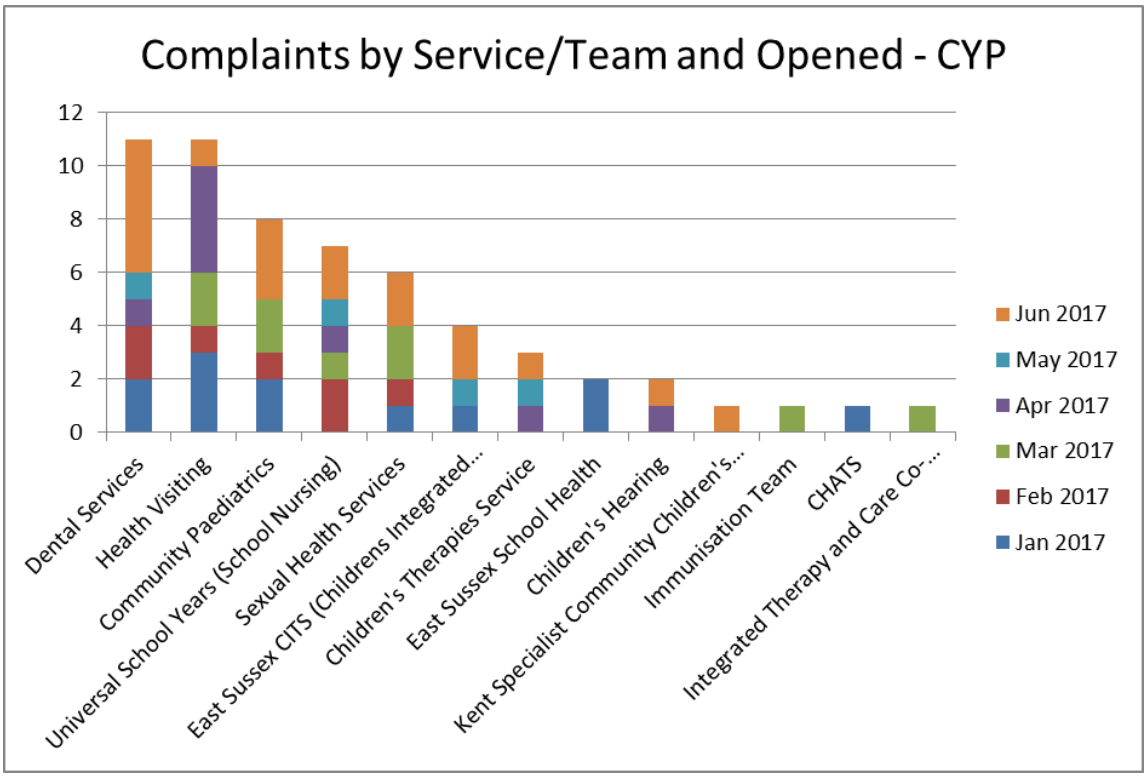

The following table shows complaints received by subject January 2017 to June 2017




The following table shows numbers of complaints for adult services January 2017 to June 2017




The following table shows numbers of complaints for children and young people's services from January 2017 to June 2017



| Directorate | Complaints in June 2017 | High Risk | Medium Risk | Low Risk | Ungraded |
|---|---|---|---|---|---|
| Adults | 26 | 0 | 2 | 18 | 6 |
| Children & Young People | 11 | 0 | 0 | 10 | 1 |
| Dental | 5 | 1 | 0 | 4 | 0 |
| Sexual Health | 2 | 0 | 0 | 2 | 0 |
| **Total** | **44** | **1** | **2** | **34** | **7** |

| Level of complaint | Number |
|---|---|
| Level 1: minor complaints resolved within 24 hours. (These are not required to be reported to the Department of Health) | 27 |
| Level 2: significant, complaints which require some investigation and correspondence | 9 |
| Level 3: serious complaints which require in depth investigation and June involve an SI investigation or independent clinical opinion | 1 |
| Level 4: multi agency complaint involving more than one organisation | 7 |

**The 7 multi- agency complaints are:**

| | | | |
|---|---|---|---|
| Sexual Health Services | Medway | Clinical Treatment | Sexual Health: Multi-Agency KCHFT leading Unhappy with treatment |
| Community Hospitals inpatients | Canterbury | Clinical Treatment | EKHUFT LEADING: Inpatients: Unhappy with lack of physiotherapy and care package |
| Clinical Nutrition and Dietetics | Canterbury | Clinical Treatment | EKHUFT LEADING: Dietetics: unhappy with investigation and treatment |
| Community Nursing | Dover and Deal | Patient Care including Nutrition/Hydration | EKHUFT LEADING: Community nursing: unhappy with wound care provided. |
| Community Hospitals inpatients | Maidstone and Malling | Clinical Treatment | MTW LEADING- Inpatients: unhappy with care provided in hospital and transfer of care |

| | | | |
|---|---|---|---|
| Health Visiting | Sevenoaks Tonbridge and Tunbridge Wells | Clinical Treatment | MTW leading: unhappy with health visitor advice. |
| Cardiac Services | Dover and Deal | Clinical Treatment | EKHUFT LEADING: Community nursing. Complaint not relating to actions of KCHFT but providing confirmation of input. |

2.6. **Themes and trends of complaints**

**Adult services**

Clinical treatment

During the month there were 10 complaints in this category.

The complaints received were in relation to:
- Unhappy with treatment received at MIU
- Unhappy with change to pain relief
- Unhappy with nursing care as had sepsis 2 days after discharge from community nursing
- Unhappy with delay in change of catheter
- Unhappy with podiatry treatment received
- Unhappy with lack of physiotherapy in hospital
- 3 x comments only to other trust on information provided by dietitian and on cardiac care received and care provided in hospital.

Referrals, appointments, admissions, discharges and transfers

During the month there were 6 complaints that fell into this category.
- 3 x unhappy that discharged from services (community nursing and chronic pain)
- Unhappy with lack of Adult SLT appointments and when held that not long.
- Unhappy that no visit to administer insulin
- Unhappy with podiatry booking system

Access to treatment and medication

During the month there were 3 complaints that fell into this category.
- Unhappy that appointments cancelled and then waiting time for another appointment
- Unhappy with delay in getting catheter changed
- Unhappy with the lack of support from the lymphoedema team.

Values and behaviours

During the month there were 5 complaints that fell into this category:
Unhappy that asked to leave physiotherapy group as holding others back as in wheelchair
- 2 x unhappy with podiatry staff attitude
- Unhappy with staff attitude in hospital
- Unhappy that staff did not act proactively to refer patient

Communication

During the month there were 3 complaints that fell into this category. This concern was in relation to being:

- 2 letters being sent incorrectly for appointments in the chronic pain service.
- Lack of communication and no actions updated and no contact made by service

**CYP Services**

Clinical treatment

During the month there were 4 complaints in this category.

- Unhappy that child not put on joint ASD pathway
- Unhappy with no formal Autism diagnosis
- Unhappy that coil fitted incorrectly
- Unhappy that staff did not listen to concerns raised by family and feels that contributed to child's death.

Referrals, appointments, admissions, discharges and transfers. This includes waiting times.

During the month there were 0 complaints that fell into this category.

Access to treatment and medication

During the month there were 3 complaints that fell into this category.

- Unhappy with delay in being seen and that passed to other staff to avoid treating patient.
- Unhappy with delay in dental referral when patient in pain
- Unhappy with wait for equipment and adaptations.

Values and behaviours

During the month there were 3 complaints that fell into this category. Unhappy that not listening to family, attitude of staff and using jargon

- Confidentiality broken as copy of letter sent to parents incorrectly
- Unhappy that hearing and vision screening done with parent consent

Communication

During the month there were 4 complaints that fell into this category.

- Unhappy with lack of communication and response and sharing incorrect info to other organisations
- Unhappy that unable to contact dental surgery as telephone never answered
- Unhappy that when trying to contact service goes straight to voicemail and then that mail box full
- Unhappy that attended emergency dental appointment and not booked

## 3. Patient Outcomes

### 3.1. Clinical audit programme April 2017- March 2018

The annual audit programme was ratified at the Trust Clinical Audit Group in March and went live in April. At the end of June 2017, there were 159 clinical audits on the audit programme. Of the 159 audits, an action plan is in place or currently being developed for 37% (59/159) projects. 18 projects have been completed with all actions implemented.

**Key Performance Indicators (KPIs)**

We monitor all the actions identified from clinical audits and quality check implementation evidence to close the action.

Three Key Performance Indicators (KPIs) were introduced in 2014 based on the status of actions identified from clinical audits. The annual target is for 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year.

KPIs at the end of May 2017 showed compliance target met in all 3 KPI areas.

| Key Performance Indicators – Actions<br><br>Stepped Target | April Target >35% | May Target >35% | June Target >55% | Achieved |
|---|---|---|---|---|
| 1. Due audit recommendations implemented - KPI 4.6<br>Target April >35% | 43% | 61% | 51% | No |
| 2. Actions overdue by more than 3 months - PI 36<br>Target <=10% | 3% | 0% | 6% | Yes |
| 3. Actions overdue by more than 6 months - PI 37<br>Target <=5% | 3% | 0% | 0% | Yes |

The position for 2017-18 is slightly behind the same period last year when we had achieved 63% completion of all due recommendations at the end of June. However, in terms of actions overdue for 3 and 6 months this is an improvement in comparison with last year's figures where there were 14% of actions overdue by more than 3 months and 3% by over 6 months

**Clinical Audit Reporting**

Dashboard and SBAR reporting was recently introduced for clinical audit. These relate to receiving the full report within a specified timeframe after receipt of dashboard reporting

- Within 60 days of receipt of dashboard for audits with full or significant assurance.
- Within 30 days of receipt of dashboard for audits with limited assurance.
- Within 15 days of receipt of dashboard for audits with no assurance.

| Key Performance Indicators – Reporting Target 50% | April | May | June | Achieved |
|---|---|---|---|---|
| Receipt of full report within specified timeframe following receipt of dashboard | 15% | 40% | 44% | No |

Whilst the KPI for reporting has not been achieved there has been a significant improvement from April and there has been an improvement from the same period last year in terms of reporting. There is a general upwards trajectory.

**Shared Learning**

The latest narrated presentation on Reasonable Adjustments in Learning Disabilities has just gone live and is available on Flo. The aim of this is promote and embed learning in an accessible format.

3.2. **National Institute for Clinical Excellence (NICE)**

The number of NICE guidance/ standards that were issued in June 2017 was twenty-two. Guidance has a due date of 3 months from release and responses are not due until September 2017.

The number of guidance/standards issued in March 2017 that were due for assessment in June 2017 was twenty-four in total. Seven of the guidance/ standards issued were deemed applicable to at least one service throughout the trust and seventeen were assessed as not applicable.

There were eighteen services that identified guidance/ standards as applicable and the following assessments have been completed

- Fourteen still remain under initial review and have not yet been fully assessed.
- Four have been identified as fully compliant, where a proforma has been completed and identified no gaps in service in relation to standard/guidance.

**Ali Strowman Chief Nurse**
**July 2017**

**Contributions from the Nursing and Quality Team**
**Audit and Performance teams**

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.5 |
| **Subject:** | Month 3 Finance Report |
| **Presenting Officer:** | Gordon Flack, Director of Finance |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | x |

**Report Summary (including purpose and context)**

This report provides a summary of the financial position for Kent Community Health NHS Foundation Trust (KCHFT) to the month of June 2017.

The Trust achieved a surplus of £708k year-to-date (YTD) which was £90k better than plan. The Trust is forecasting to reach a surplus of £3,026k in line with plan.

| **Key Messages** | |
|---|---|
| **Surplus:** The Trust achieved a surplus of £708k (1.3%) to the end of June. Cumulatively pay and non-pay have underspent by £1,821k and £5k respectively. Income has under-recovered by £1,662k and depreciation/interest has overspent by £74k. | ● |
| **Continuity of Services Risk Rating:** EBITDA Margin achieved is 2.7%. The Trust scored 1 against the Use of Resources Rating, the best possible score. | ● |
| **CIP:** £710k of savings has been achieved to June against a risk rated plan of £1,019k which is 30% behind target. The full year savings target of £4,271k is forecast to be achieved in full. | ● |
| **Cash and Cash** Equivalents: The cash and cash equivalents balance was £18,368k, equivalent to 31 days expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 96% for value. | ● |
| **Capital:** Spend to June was £921k, representing 82% of the YTD plan. | ● |
| **Agency:** Agency spend was below trajectory for June. | ● |

**Proposals and /or Recommendations**

The Board is asked to note the contents of the report.

| Relevant Legislation and Source Documents |
|---|
| Monitor NHS Foundation Trusts Annual Reporting Manual<br>NHS Manual for Accounts 2014/15 |
| **Has an Equality Analysis (EA) been completed?** |
| No. High level financial position described and no decisions required. Paper has no impact on people with any of the nine protected characteristics*. |
| *** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation. |


| | |
|---|---|
| Gordon Flack, Director of Finance | Tel: 01622 211934 |
| | Email: Gordon.flack@kentcht.nhs.uk |

Kent Community Health
NHS Foundation Trust

# FINANCE REPORT – JUNE 2017 (MONTH 3 of 2017-18)

The Trust achieved a surplus of £708k year-to-date (YTD) which was £90k better than plan. The Trust is forecasting to reach a surplus of £3,026k in line with plan which is supported by £1,759k of sustainability and transformation funding.

# Dashboard

**Surplus** — Rag rating: Green

| | Actual | Plan | Variance |
|---|---|---|---|
| **Year to Date £k** | 708 | 618 | 90 |
| **Year End Forecast £k** | 3,026 | 3,026 | 0 |

The Trust achieved a surplus of £708k to the end of June.

Pay and non-pay have underspent by £1,821k and £5k respectively. Depreciation/interest has overspent by £74k and income is £1,662k under-recovered.

**Use of Resource Rating** — Rag rating: Green

| | Year to Date Rating | Year End Forecast Rating |
|---|---|---|
| **Capital Service Capacity** | 1 | 1 |
| **Liquidity** | 1 | 1 |
| **I&E margin (%)** | 1 | 1 |
| **Distance from Financial Plan** | 1 | 1 |
| **Agency Spend** | 1 | 1 |
| **Overall Rating** | 1 | 1 |

The Trust has scored the maximum '1' rating against the Use of Resource rating metrics for M3 2017-18.

**CIP** — Rag rating: Amber

| | Actual | Plan | Variance |
|---|---|---|---|
| **Year to Date £k** | 710 | 1,019 | -309 |
| **Year End Forecast £k** | 4,271 | 4,271 | 0 |

The Trust achieved CIPs of £710k to the end of June against a plan of £1,019k, which is 30% behind target.

67% of the total annual CIP target has been removed from budgets to month three.

Despite the shortfall year to date, the Trust is forecasting to achieve the full plan of £4,271k by the end of the year.

**Cash and Cash Equivalents** — Rag rating: Green

| | Actual | Forecast | Variance |
|---|---|---|---|
| **Year to Date £k** | 18,368 | 20,128 | -1,760 |
| **Year End Forecast £k** | 21,559 | | |

Cash and Cash Equivalents as at 30 June 2017 stands at £18,368k, equivalent to 31 days operating expenditure.

**Capital Expenditure** — Rag rating: Amber

| | Actual/Forecast | Plan | Variance |
|---|---|---|---|
| **YTD Expenditure £k** | 921 | 1,122 | 201 |
| **Year End Forecast £k** | 4,179 | 4,179 | 0 |

Capital Expenditure year to date is £921k, representing 82% of the YTD plan.

**Agency Trajectories** — Rag rating: Green

| | M3 | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | Actual £ | Trajectory £ | Variance £ | Actual £ | Trajectory £ | Variance £ |
| **External Agency Expenditure (inc. Locums)** | 345,029 | 723,333 | 378,304 | 1,047,736 | 2,170,000 | 1,122,264 |
| **Locum Expenditure** | 87,444 | 106,250 | 18,806 | 225,665 | 318,750 | 93,085 |

## 1. Income and Expenditure Position

The position for June was £34k favourable compared to plan. The in-month performance comprised an underspend on pay of £845k, partly offset by overspends on non-pay and depreciation/interest of £315k and £23k respectively, and an under-recovery on income of £473k. The summary income and expenditure statement is shown below:

| | JUNE ACTUAL £'000 | JUNE BUDGET £'000 | JUNE VARIANCE £'000 | % VARIANCE | YTD ACTUAL £'000 | YTD BUDGET £'000 | YTD VARIANCE £'000 | % VARIANCE |
|---|---|---|---|---|---|---|---|---|
| CCGs - Non Tariff | 10,321 | 10,916 | -596 | -5.5% | 31,110 | 32,697 | -1,587 | -4.9% |
| CCGs - Tariff | 252 | 338 | -86 | -25.5% | 859 | 1,084 | -225 | -20.8% |
| Charitable and Other Contributions to Expenditure | 11 | 6 | 6 | 104.8% | 4 | 17 | -12 | -73.3% |
| Department of Health | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Education, Training and Research | 215 | 219 | -4 | -2.0% | 654 | 605 | 50 | 8.3% |
| Foundation Trusts | 266 | 279 | -13 | -4.6% | 808 | 838 | -30 | -3.6% |
| Income Generation | 23 | 13 | 10 | 74.5% | 102 | 39 | 62 | 158.2% |
| Injury Cost Recovery | 34 | 27 | 7 | 27.6% | 101 | 80 | 21 | 26.4% |
| Local Authorities | 4,183 | 4,063 | 120 | 3.0% | 12,129 | 12,154 | -25 | -0.2% |
| NHS England | 1,921 | 1,867 | 54 | 2.9% | 5,701 | 5,502 | 198 | 3.6% |
| NHS Trusts | 485 | 549 | -64 | -11.7% | 1,371 | 1,647 | -276 | -16.8% |
| Non NHS: Other | 112 | 102 | 9 | 9.2% | 363 | 307 | 56 | 18.3% |
| Non-Patient Care Services to Other Bodies | 64 | 44 | 20 | 44.9% | 157 | 133 | 24 | 17.7% |
| Other Revenue | 212 | 174 | 38 | 21.9% | 519 | 521 | -2 | -0.4% |
| Private Patient Income | 49 | 23 | 26 | 111.6% | 152 | 69 | 83 | 120.8% |
| Sustainability and Transformation Fund | -29 | -29 | 0 | 0.0% | 264 | 264 | 0 | 0.0% |
| **INCOME Total** | **18,119** | **18,592** | **-473** | **-2.5%** | **54,294** | **55,957** | **-1,662** | **-3.0%** |
| Administration and Estates | 2,528 | 2,736 | 209 | 7.6% | 7,680 | 8,054 | 374 | 4.6% |
| Healthcare Assistants and other support staff | 1,818 | 1,892 | 74 | 3.9% | 5,465 | 5,701 | 236 | 4.1% |
| Managers and Senior Managers | 767 | 822 | 55 | 6.7% | 2,267 | 2,439 | 172 | 7.1% |
| Medical and Dental | 814 | 813 | -2 | -0.2% | 2,394 | 2,436 | 43 | 1.8% |
| Qualified Nursing, Midwifery and Health Visiting | 4,203 | 4,692 | 489 | 10.4% | 13,285 | 14,141 | 856 | 6.1% |
| Scientific, Therapeutic and Technical | 2,503 | 2,710 | 206 | 7.6% | 7,513 | 8,082 | 568 | 7.0% |
| Employee Benefits | 49 | 0 | -49 | -100.0% | -42 | 0 | 42 | 100.0% |
| CIP Target Pay | 0 | -34 | -34 | -100.0% | 0 | -159 | -159 | -100.0% |
| East Kent Savings | 0 | -72 | -72 | -100.0% | 0 | -218 | -218 | -100.0% |
| North Kent Savings | 0 | -31 | -31 | -100.0% | 0 | -94 | -94 | -100.0% |
| **PAY Total** | **12,683** | **13,528** | **845** | **6.2%** | **38,563** | **40,384** | **1,821** | **4.5%** |
| Audit fees | 5 | 5 | 0 | 3.8% | 14 | 15 | 1 | 3.8% |
| Clinical Negligence | 41 | 41 | 0 | 0.6% | 124 | 124 | 1 | 0.8% |
| Consultancy Services | 28 | 16 | -12 | -72.0% | 62 | 39 | -23 | -59.2% |
| Education and Training | 41 | 69 | 28 | 40.7% | 126 | 206 | 81 | 39.1% |
| Establishment | 603 | 684 | 81 | 11.9% | 1,698 | 2,328 | 630 | 27.0% |
| Hospitality | 3 | 1 | -2 | -213.3% | 4 | 2 | -1 | -53.8% |
| Impairments of Receivables | 0 | 0 | 0 | 0.0% | -86 | 0 | 86 | 0.0% |
| Insurance | 3 | 1 | -2 | -154.3% | 10 | 3 | -6 | -177.8% |
| Legal | 35 | 26 | -9 | -33.9% | 102 | 78 | -24 | -30.9% |
| Other Auditors Remuneration | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Other Expenditure | 9 | 10 | 1 | 10.6% | 26 | 30 | 4 | 13.4% |
| Premises | 1,250 | 1,331 | 81 | 6.1% | 4,012 | 3,996 | -17 | -0.4% |
| Research and Development (excluding staff costs) | 0 | 0 | 0 | 100.0% | 0 | 1 | 1 | 100.0% |
| Services from CCGs | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Services from Foundation Trusts | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Services from Other NHS Trusts | 151 | 129 | -22 | -16.9% | 227 | 180 | -48 | -26.5% |
| Supplies and Services - Clinical | 2,211 | 1,840 | -370 | -20.1% | 6,345 | 5,816 | -529 | -9.1% |
| Supplies and Services - General | 100 | 103 | 3 | 2.6% | 268 | 324 | 56 | 17.3% |
| Transport | 465 | 421 | -43 | -10.3% | 1,317 | 1,261 | -56 | -4.5% |
| CIP Target Non Pay | 0 | -50 | -50 | -100.0% | 0 | -150 | -150 | -100.0% |
| **NONPAY Total** | **4,943** | **4,628** | **-315** | **-6.8%** | **14,248** | **14,253** | **5** | **0.0%** |
| EBITDA | 493 | 436 | 57 | 13.1% | 1,483 | 1,320 | 163 | 12.4% |
| EBITDA % | 2.7% | 2.3% | -0.4% | | 2.7% | 2.4% | -9.8% | |
| DEPRECIATION/AMORTISATION | 262 | 240 | -22 | -9.1% | 785 | 720 | -65 | -9.0% |
| INTEREST PAYABLE | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| INTEREST RECEIVED | 4 | 6 | -2 | -28.5% | 9 | 18 | -9 | -47.7% |
| **SURPLUS/(DEFICIT)** | **236** | **202** | **34** | **16.8%** | **708** | **618** | **90** | **14.5%** |
| SURPLUS % | -1.3% | -1.1% | -0.2% | | -1.3% | -1.1% | -0.2% | |

*Table 1.1: Trust Wide variance against budget in month*

## 2. Risk Ratings

The Trust has scored a 1 against this rating.

## 3. Cost Improvement Programme

| Year to date CIP target (£k) | Year to date CIP Achieved(£k) | Year to date variance – negative denotes an adverse variance (£K) | Full year CIP target (£k) | CIP Achieved (£k) | Full year CIP forecast (£k) | Full Year Total CIP | Full year variance (£k) – negative denotes an adverse variance |
|---|---|---|---|---|---|---|---|
| 1,019 | 710 | -309 | 4,271 | 2,882 | 1,389 | 4,271 | 0 |

*Table 3.1: Cost Improvement Programme Performance*

The cost improvements required this year amount to £4,271k.

YTD achievement is 30% behind plan with £710k removed from budgets at month three against a risk rated year to date plan of £1,019k. This position is improved from a shortfall of 33% to month two. Of the total CIP removed from budgets for the year, all savings have been achieved recurrently.

The forecast is to deliver the full £4,271k CIP target.

## 4. Statement of Financial Position and Capital

| | At 31 Mar 17 £000's | At 31 May 17 £000's | At 30 June 17 £000's | Variance Analysis Commentary |
|---|---|---|---|---|
| **NON CURRENT ASSETS:** | | | | |
| Intangible assets | 238 | 304 | 298 | |
| Property, Plant & Equipment | 16,717 | 16,766 | 16,795 | |
| Other debtors | 68 | 64 | 63 | |
| **TOTAL NON CURRENT ASSETS** | **17,023** | **17,134** | **17,156** | |
| **CURRENT ASSETS:** | | | | NHS & Non NHS - Invoiced Debtors (net of bad debt provision) |
| NHS & Non NHS - Invoiced Debtors (net of bad debt provision) | 13,715 | 16,587 | 13,073 | The in-month decrease is primarily due to the receipt in June of the |
| NHS Accrued Debtors | 2,026 | 3,432 | 3,853 | previously reported late payment of the M1 SLA with KCC |
| Other debtors | 2,604 | 2,751 | 3,511 | (HV, FNP and CYP Services) and the M1 and M2 SLA invoices with |
| **Total Debtors** | **18,345** | **22,771** | **20,438** | NHSE for the new Dental contracts in London. |
| Cash at bank in GBS accounts | 2,118 | 203 | 18,341 | |
| Other cash at bank and in hand | 49 | 30 | 27 | **Deposit with the National Loan Fund (Liquid Investment)** |
| Deposit with the National Loan Fund (Liquid Investment) | 17,000 | 14,500 | 0 | Deposit of £15m was returned on 30 June. Interest rate for re-investment |
| **Total Cash and Cash Equivalents** | **19,166** | **14,734** | **18,368** | on 30 June was 0.14%, the same rate offered by the main GBS account |
| **TOTAL CURRENT ASSETS** | **37,511** | **37,504** | **38,806** | and therefore no investment was placed on 30 June. |
| **CREDITORS:** | | | | |
| NHS & Non NHS - Invoiced Creditors falling due within 1 year | -5,322 | -2,805 | -3,392 | |
| NHS - accrued creditors falling due within 1 year | -3,234 | -2,468 | -2,499 | |
| Non NHS - accrued creditors falling due within 1 year | -8,283 | -12,171 | -12,910 | |
| Other creditors | -6,993 | -6,241 | -6,015 | |
| **Total amounts falling due within one year** | **-23,832** | **-23,685** | **-24,816** | |
| **NET CURRENT ASSETS** | **13,679** | **13,820** | **13,990** | |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **30,702** | **30,954** | **31,146** | |
| Total amounts falling due after more than one year | 0 | 0 | 0 | |
| **PROVISION FOR LIABILITIES AND CHARGES** | -3,584 | -3,364 | -3,320 | |
| TOTAL ASSETS EMPLOYED | 27,118 | 27,590 | 27,826 | |
| **FINANCED BY TAXPAYERS EQUITY:** | | | | |
| Public dividend capital | -2,612 | -2,612 | -2,612 | |
| Income and expenditure reserve | -23,740 | -24,212 | -24,448 | |
| Revaluation Reserve | -766 | -766 | -766 | |
| TOTAL TAXPAYERS EQUITY | - 27,118 | - 27,590 | - 27,826 | |

*Table 4.1: Statement of Financial Position, June 2017*

| | Total Assets | Total Liabilities | Assets/ Liabilities |
|---|---|---|---|
| Jun-16 | 54,514 | 31,237 | 1.75 |
| Jul-16 | 56,839 | 33,298 | 1.71 |
| Aug-16 | 57,325 | 33,498 | 1.71 |
| Sep-16 | 59,160 | 35,016 | 1.69 |
| Oct-16 | 60,044 | 35,658 | 1.68 |
| Nov-16 | 55,963 | 31,331 | 1.79 |
| Dec-16 | 56,752 | 31,871 | 1.78 |
| Jan-17 | 59,366 | 34,202 | 1.74 |
| Feb-17 | 53,766 | 28,267 | 1.90 |
| Mar-17 | 53,651 | 27,417 | 1.96 |
| Apr-17 | 54,618 | 27,263 | 2.00 |
| May-17 | 54,639 | 27,048 | 2.02 |
| Jun-17 | 55,962 | 28,135 | 1.99 |

*Table 4.2: Assets and Liabilities*

| | Financial Period | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Financial Ratio/Metric | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Dec-16 | Jan-17 | Feb-17 | Mar-17 | Apr-17 | May-17 | Jun-17 |
| Liquidity ratio days | 12 | 13 | 14 | 14 | 15 | 15 | 16 | 16 | 17 | 16.48 | 17.80 | 18.08 | 18.39 |
| Trade Receivables days | 20 | 18 | 19 | 21 | 18 | 16 | 20 | 19 | 22 | 25 | 26 | 29 | 23 |
| Trade Payables days | 99 | 109 | 103 | 103 | 106 | 73 | 93 | 115 | 71 | 86 | 65 | 61 | 62 |
| CAPEX (% of plan) | 31.7% | 25.1% | 38.5% | 46.8% | 45.9% | 59.3% | 55.3% | 64.2% | 70.1% | 100.0% | 57.1% | 111.6% | 82.1% |

*Table 4.3: Balance Sheet Metrics*

## 5. Capital

The table below shows the Trust's total expenditure on capital projects for the year to date 2017-18. The Trust's total Capital Plan for 2017-18 is set at £4.2m.

| Capital Projects | M3 Actual YTD £000's | M3 Plan YTD £000's | M3 Variance to plan | Full Yr Forecast | Full Yr Plan £000's | Full Yr Variance | Variance Analysis Commentary |
|---|---|---|---|---|---|---|---|
| Estates Developments | 603 | 666 | 63 | 1,676 | 1,676 | 0 | Actual expenditure YTD relates to continued works on the Orthotics Site, the completion of the Sevenoaks Wound Care Centre and works relating to service relocation at Wrotham Rd/Rochester Rd. |
| Backlog Maintenance | 194 | 135 | -59 | 455 | 455 | 0 | Actual expenditure YTD primarily relates to the Hawkhurst Flooring Project which has progressed in advance of plan. |
| IT Rolling Replacement & Upgrades | 76 | 219 | 143 | 1,556 | 1,556 | 0 | Actual expenditure YTD relates to Licensing Upgrade requirements. |
| Dental SBU | -6 | 102 | 108 | 242 | 242 | 0 | Actual expenditure YTD relates to VAT refunds for 16/17 Capital Projects |
| Other Minor Schemes | 54 | 0 | -54 | 250 | 250 | 0 | Actual expenditure YTD relates to an upgrade of the Trust's Qlikview reporting capabilities. |
| **Total** | **921** | **1,122** | **201** | **4,179** | **4,179** | **-** | |

*Table 5.1: Capital Expenditure June 2017*

**Gill Jacobs**
**Deputy Director of Finance**
**July 2017**

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.6 |
| **Subject:** | Workforce Report |
| **Presenting Officer:** | Louise Norris, Director of Workforce, Organisational Development and Communications |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | **X** |

| **Report Summary** |
|---|
| This report provides the Board with an update on the current workforce position as at June 2017. It includes performance on: vacancies, recruitment timescales, absence, turnover, bank and agency fill rates, agency usage (measured as shifts) and cost, training / appraisal compliance, suspensions, headcount, starters and leavers. This report is generally an 'exception' report; it contains narrative relating to those metrics against which KCHFT is performing below target in June. |

| **Proposals and /or Recommendations** |
|---|
| The Board is asked to note the current position on workforce performance. |

| **Relevant Legislation and Source Documents** |
|---|
| |
| **Has an Equality Analysis (EA) been completed?** |
| No. This is an assurance report and no decisions required/no significant change.<br>The workforce update report in itself will have no impact on people with any of the nine protected characteristics* |
| *** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation. |



| | |
|---|---|
| Louise Norris | Tel: 01622 211910 |
| Director of Workforce, Organisational Development and Communications | Email: louise.norris@kentcht.nhs.uk |

NHS
Kent Community Health
NHS Foundation Trust

# WORKFORCE REPORT

## 1. Report Summary

1.1 This report provides the Board with an update on the current workforce position as at June 2017. It includes performance on: vacancies, recruitment timescales, absence, turnover, bank and agency fill rates, agency usage (measured as shifts) and cost, training / appraisal compliance, suspensions, headcount, starters and leavers. This report is generally an 'exception' report; it contains narrative relating to those metrics against which KCHFT is performing below target in June.

## 2. Overview

2.1 An overview of the current position is provided in the table below with further exception detail included in the report. The table shows the direction of travel based on a comparison against the previous month's data. An upward arrow indicates better performance and a trend line has now been included to illustrate current performance against recent performance. Each metric has been rated to illustrate performance against the Trust target.

| Month | Jun-17 | | | |
|---|---|---|---|---|
| Direction (Better/Worse) | Metric | Target | Current Position | 6mth Trendline (Jan to Jun 2017) |
| ↓ | Turnover (12 mths to Jun) | 10.50% | 15.29% | |
| ↓ | Absence (2017/18 cumulative) | 3.90% | 4.04% | |
| ↓ | Vacancies | 5.00% | 6.90% | |
| ↑ | Fill Rate Overall | No target set (rated on 75%) | 96.45% | |
| ↑ | Fill Rate Bank | No target set (rated on 30%) | 65.52% | |
| ↑ | Agency spend as a proportion of the trajectory (Jun, without contingency) | < 100% | 47.7% | |
| ↓ | Agency shifts - Framework agency used - compliant with price cap | 100% | 92.7% | |
| ↓ | Average Recruitment Time in Weeks (in Jun 2017) | < 7 Weeks | 6.27wks | |
| ↑ | Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target) | 85% | 98.2% | |
| N/A | Number of suspended staff | No target set | 3 | |
| ↑ | Appraisals (annual figure) | 85% | 97.9% | |
| N/A | Trust Headcount (at 30 Jun 2017) | No target set | 4,939 | |
| ↑ | Number of Starters (Jun) | No target set | 46 | |
| ↓ | Number of Leavers (Jun) | No target set | 81 | |

## 3. Performance Commentary

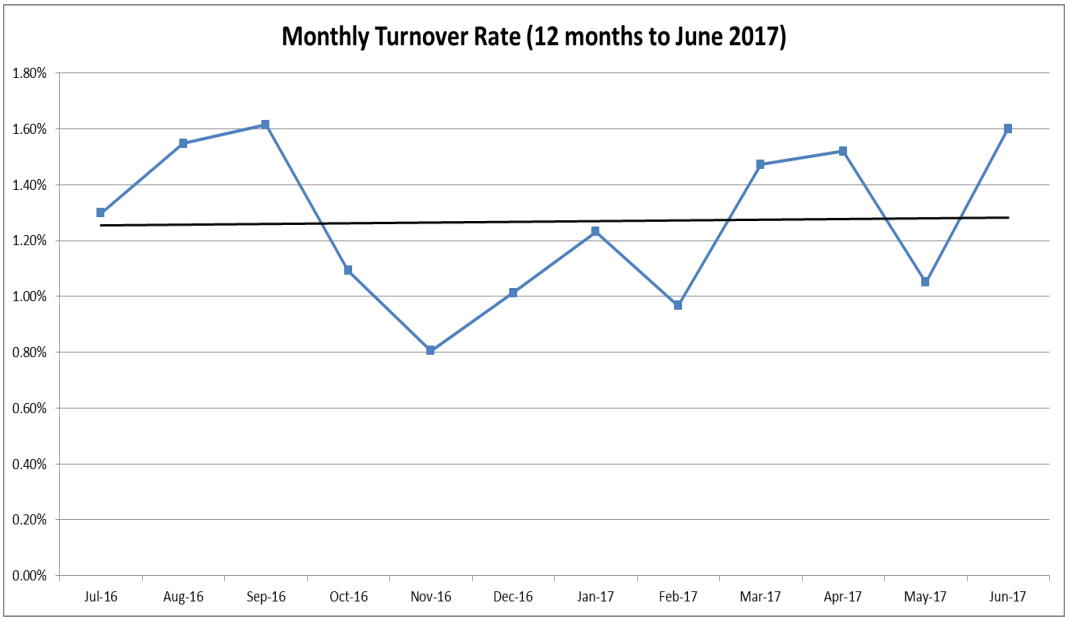
Turnover

3.1 Turnover is rated red this month. The turnover rate for the 12 months to June 2017 is 15.29%, which is an increase against May's figure of 14.91% and above the target of 10.50%. This turnover data excludes TUPE transfers.

3.2 Figure 1 below shows turnover for the month of June, which stands at 1.60% compared to 1.05% the previous month.

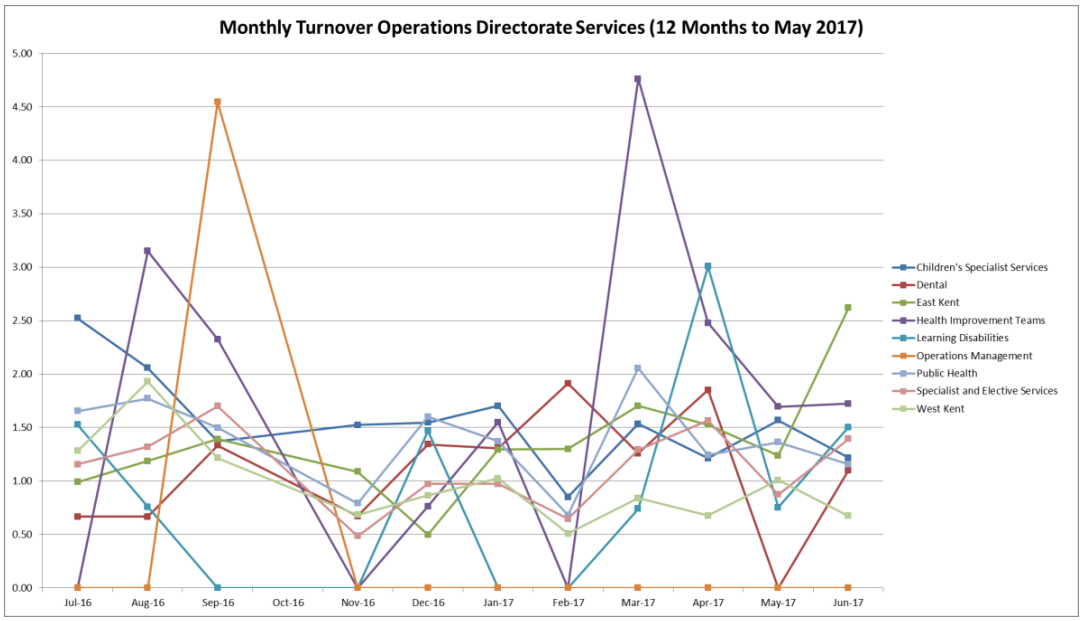
3.3 The trend line for turnover has been fluctuating for the past few months and in June the latest trajectory is showing a slight upwards trend.

**Fig.1: Monthly Turnover Rates for the 12 Months to June 2017**



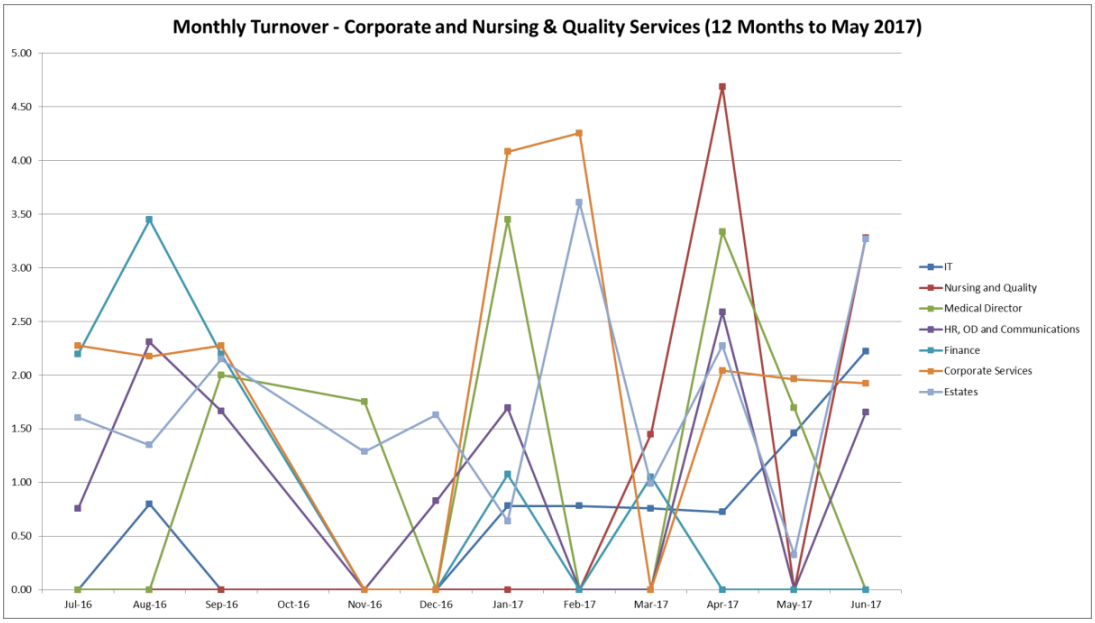

3.4 Fig. 2 below shows turnover for services within the Operations Directorate. In June 2017 East Kent had the highest turnover rate at 2.62% for the first time in the past 12 months, up from 1.24% last month (it should be noted that East Kent has also had high sickness absence levels over the past year as reported last month). The second highest turnover was for Health Improvement Teams at 1.72%, up from 1.69% the previous month. Third highest turnover was in Learning Disabilities at 1.50% compared to 0.75% the previous month. The highest proportional increase in June 2017 was East Kent followed by Learning Disabilities which increased from 0.75% to 1.50%. Within Dental where turnover increased from 0.00% last month to 1.10%

**Fig.2: Monthly Turnover for Operational Directorate Services (12 months to June 2017)**




3.5 Fig. 3. below shows turnover by directorate for other Trust services. These are primarily corporate related services but also Nursing and Quality. The highest turnover rate within this group was in Nursing and Quality which had a rate of 3.28% in June compared to 0.00% in May. Second highest turnover was in Estates with 3.27%, up from 0.32% the previous month. The third highest turnover rate was for IT at 2.22% in June, up from 1.46% the previous month. The highest proportional increase in turnover was for Estates followed by IT. Two services with no turnover last month had increases in turnover; Nursing and Quality mentioned above and HR, OD and Communications which had a turnover rate of 1.65% against no turnover last month.

**Fig.3: Monthly Turnover for Corporate and Nursing & Quality Services (12 months to June 2017)**

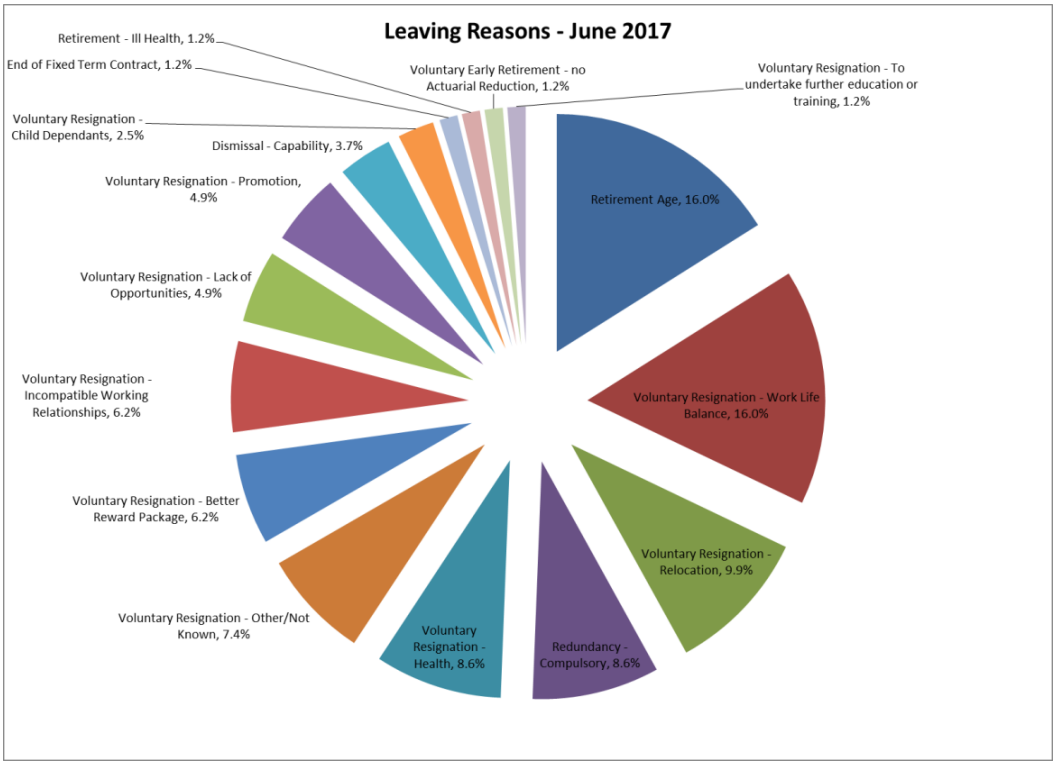


Leaving Reasons

3.6 There were 81 leavers in June 2017 compared to an average number of leavers of 66 during the previous period of 12 months to May. There were 46 starters in June. This means there was a net loss of 35 staff in June compared to a loss of nine staff in May.

3.7 The figures below show leaving reasons for June. The largest number of leavers were for retirement reasons and work life balance reasons, both constituting 16% of leavers each. Work life balance was in first place last month with retirement reasons in second place. In third place is voluntary resignation for relocation reasons at 9.9%, which was also in third place last month. Together with redundancies at 8.6% these four reasons account for 50.6% of leavers. Last month's fourth place was leaving for promotion at 9.43% which this month is in tenth place with 4.9% of leavers.

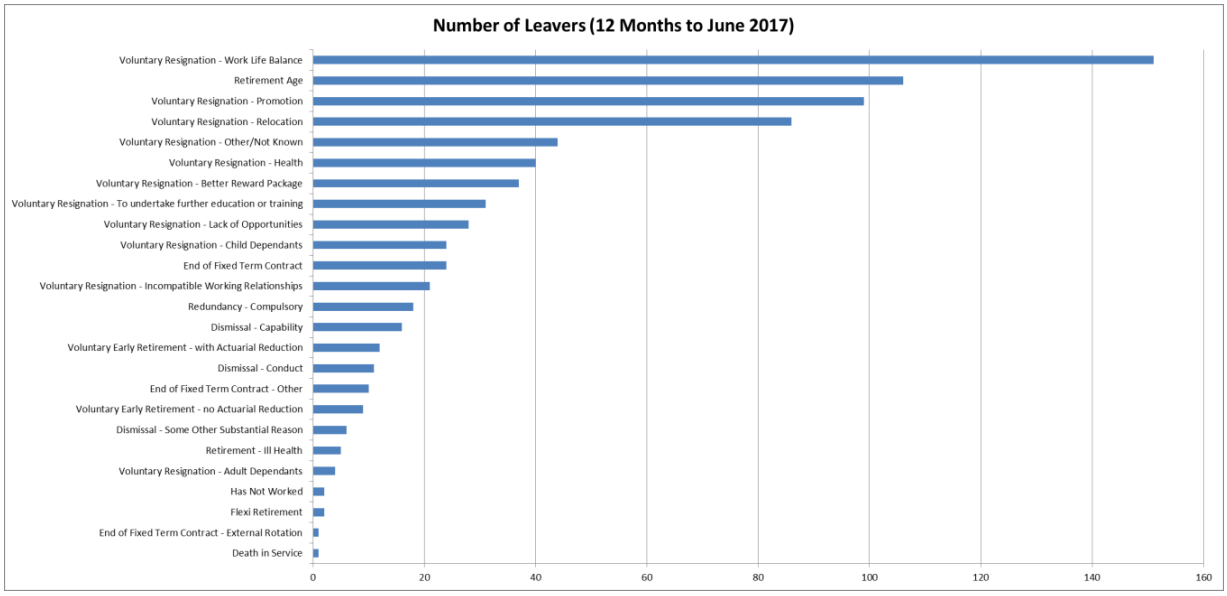
**Fig.4: Leaving reasons – June 2017**




3.8 Looking at the trend over the year as a whole, Fig. 5 below shows the latest picture on leaving reasons over the past 12 months to June 2017. The figures shown represent the actual number of leavers. TUPE leavers are not included.

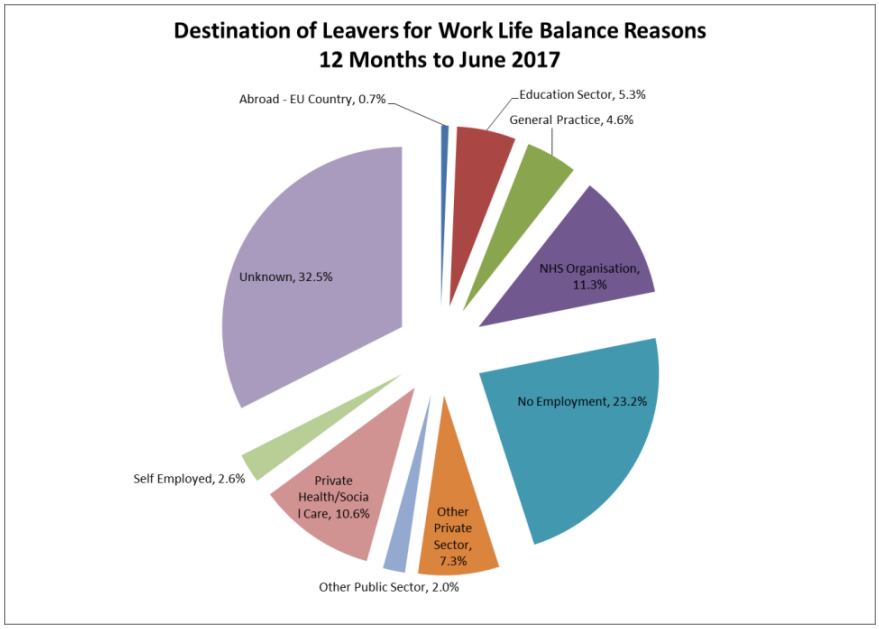
3.9 Resignation for work life balance reasons remains as the top reason with 151 leavers (down from 153 last month). This was followed by retirement age with 106 leavers (up from 102 last month and third place last month). If other forms of retirement are taken into account this increases to 134 leavers for this reason (up from 132 last month). Third highest reason for leaving was voluntary resignation for promotion reasons with 99 leavers (at 109 and second place last month) and in fourth place voluntary resignation for relocation reasons with 86 leavers (97 last month). Together these four reasons constitute 56.1% of leavers for the 12 months to June.

**Fig.5: Leaving reasons – 12 months to June 2017 (excluding TUPE)**




3.10 Fig. 6 below shows the destination of work life balance leavers during the year to June 2017. The top destination of leavers remains no employment at 23.2% of leavers (down from 24.2% last month). The second most popular destination for leavers was NHS organisations at 11.3% (up from 11.1%) followed by Private Health/Social Care at 10.6% (up from 10.5% from last month) and 7.3% other private sector providers (up from 5.9%). These top four destinations remain the same as last month. The Trust does not know the destination of 32.5% of work life balance leavers (down from 34% last month). Our Payroll provider SBS has been asked to ensure that data for destinations for leavers is recorded wherever possible.

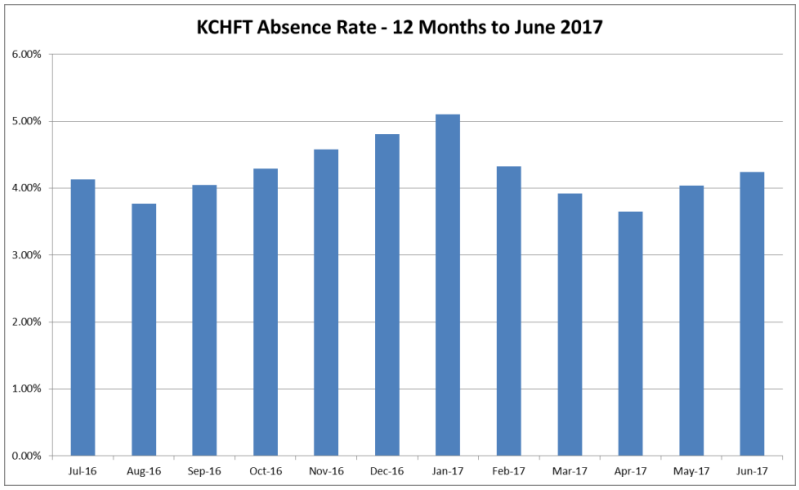
**Fig.6: Destination of Leavers for Work Life Balance Reasons 12 months to June 2017**



Sickness Absence

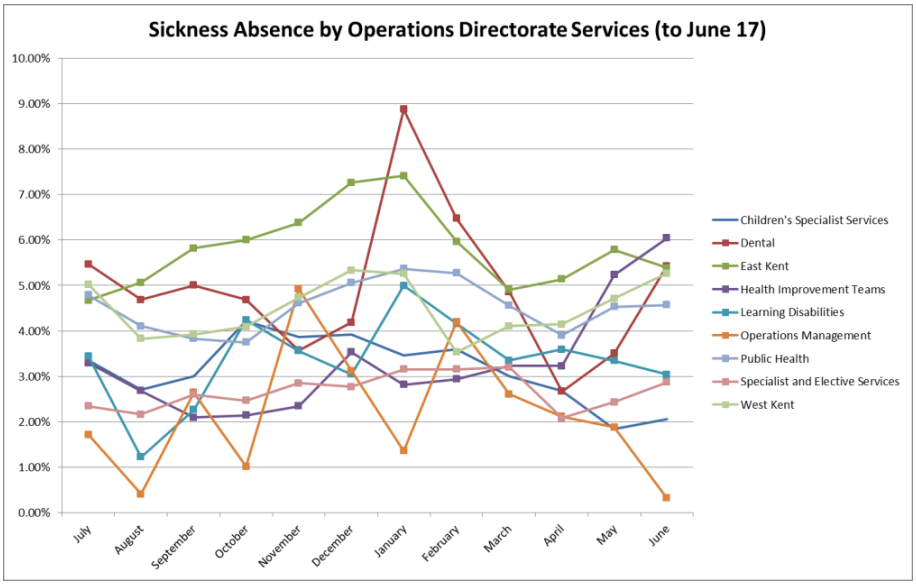
3.11 Sickness absence is rated red for June 2017. Cumulative sickness absence for 2017/18 is 4.04% to date which is above the target of 3.90% (up from 3.84% last month). Sickness absence performance for June 2017 alone was 4.24% (up from 4.04% for May 2017). Fig 7 below shows the absence rate for each individual month during the past 12 months.

**Fig.7: Sickness Absence Rate for the 12 months to June 2017**



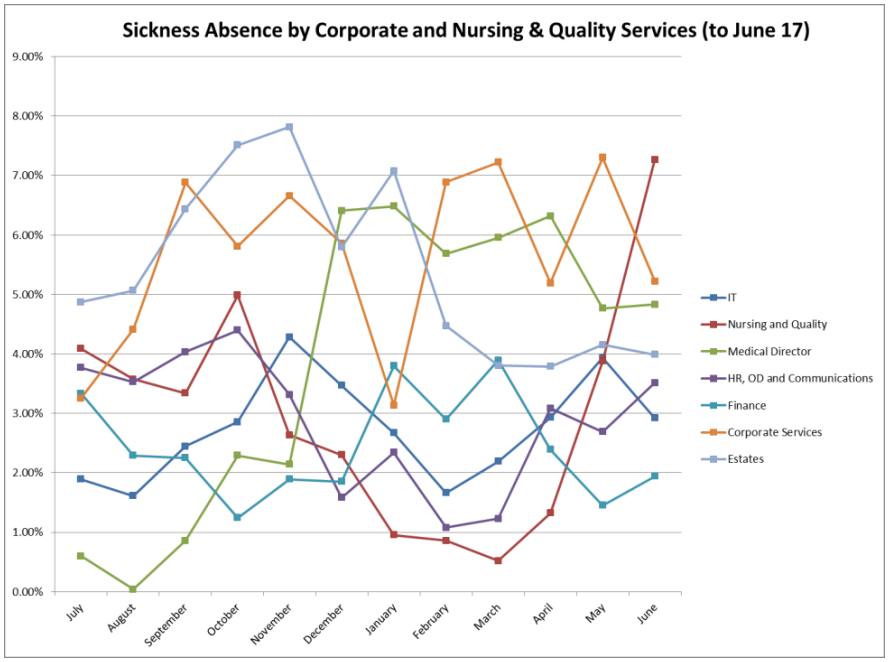

3.12 Fig 8 below shows sickness rates within the Operational Directorate. Health Improvement Teams had the highest sickness rate in June 2017 at 6.04%, an increase from 5.23%. The second highest sickness rate is Dental at 5.43%, up from 3.51% the previous month. East Kent had the third highest rate at 5.39%, down from 5.79%. The highest proportional sickness increase from May to June 2017 was for Dental (with a 1.92 point increase) with the second highest being Specialist and Elective Services with a 0.44 point increase. The largest proportional fall in sickness was in Operations Management which saw a decrease from 1.87% last month to 0.32% this month.

**Fig.8: Sickness Absence for Operations Directorate 12 mths to June 2017**



3.13 Fig.9 below shows sickness absence by corporate directorates and Nursing and Quality for June 2017. The highest absence rate was in Nursing and Quality at 7.27%, up from 3.88% the previous month. This was also the highest proportional increase in sickness for the month with a 3.39 percentage point increase. The second highest absence rate was Corporate Services at 5.22%, although this was a reduction from the previous month's 7.30%. In third place was the Medical Directorate with a sickness rate of 4.83%, up from 4.76% the previous month. The highest proportional decrease in sickness was in Corporate Services with a 2.08 point decrease.

**Fig.9: Sickness Absence by Corporate and Nursing and Quality Services 12mths to June 2017**




Training Compliance

3.14 Training compliance is at 98.2% and is therefore rated green for June 2017 (this is up from 92.1% last month).

3.15 Areas of training rated amber are outlined below:

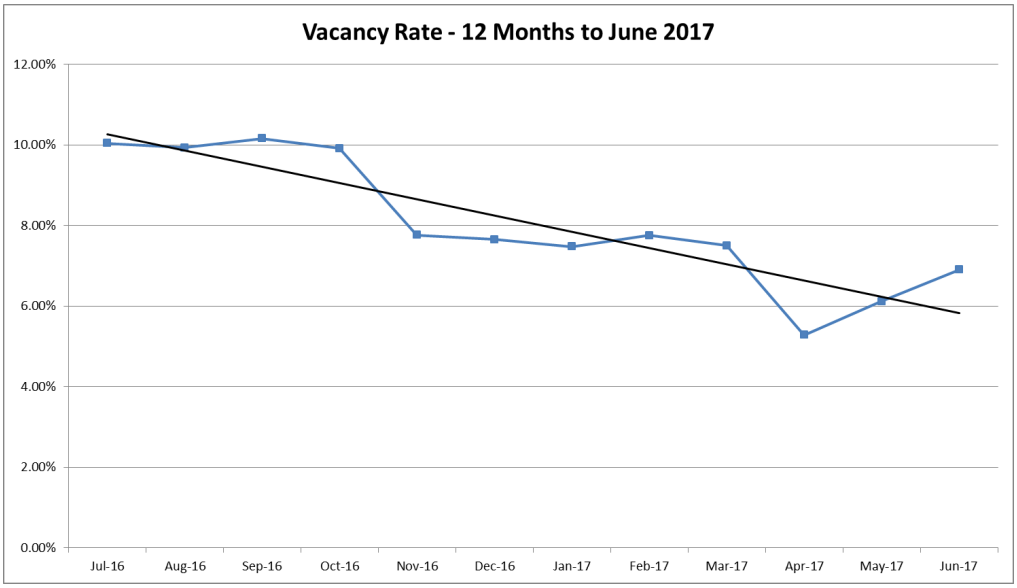
- **Client Moving and Handling** - has increased by 1.8% and sits at 84.5%. The measure is 0.5% away from turning green for the first time in over a year. Although the Trust is currently carrying non-compliance of 330 staff courses are constantly being run at low capacity and there is cancelling due to courses not being viable to run (there have to be at least three people for the practical elements of this subject). Non-compliant staff have been directly emailed with low capacity dates (as well as Heads of Service), but they continue to run at low numbers.

- **Mental Capacity Act Level 3** - has held at the same compliance percentage this month. The target audience is very small and hard to arrange training for. Compliance has been escalated to Safeguarding.

Vacancies

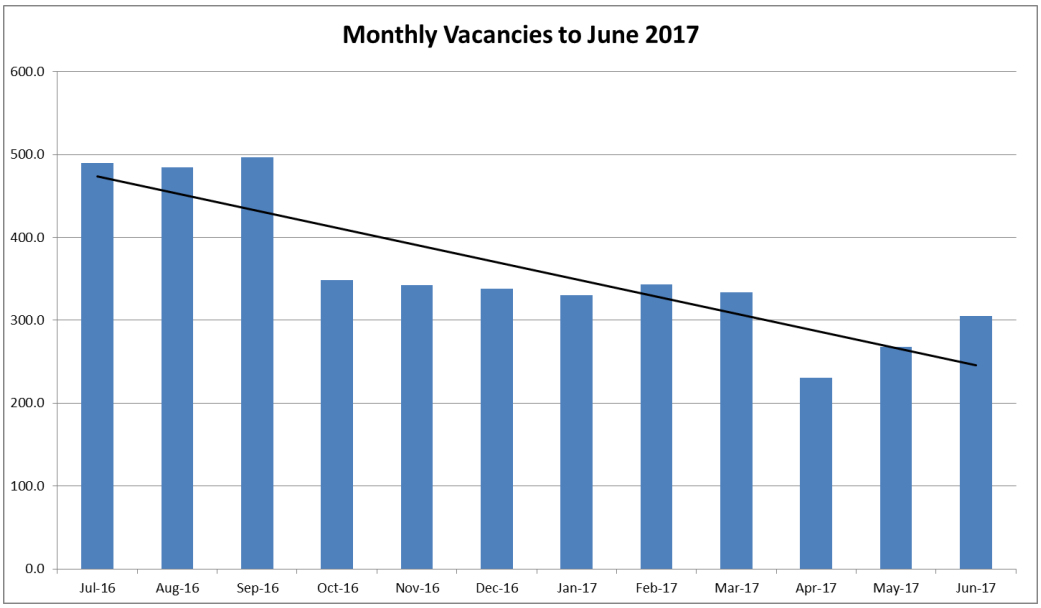
3.16 The vacancy rate for June 2017 is 6.90% compared to a target of 5.0% which means performance has been rated as red this month. The rate has increased to 6.90% from 6.12% in April. This is the second month of increase following two months of decrease and a general overall downward trend in the vacancy rate. April's performance was the lowest vacancy rate for around two years and Fig.10 shows that an overall downward trend is still being maintained.

**Fig.10: Vacancy Rate for the 12 months to June 2017**



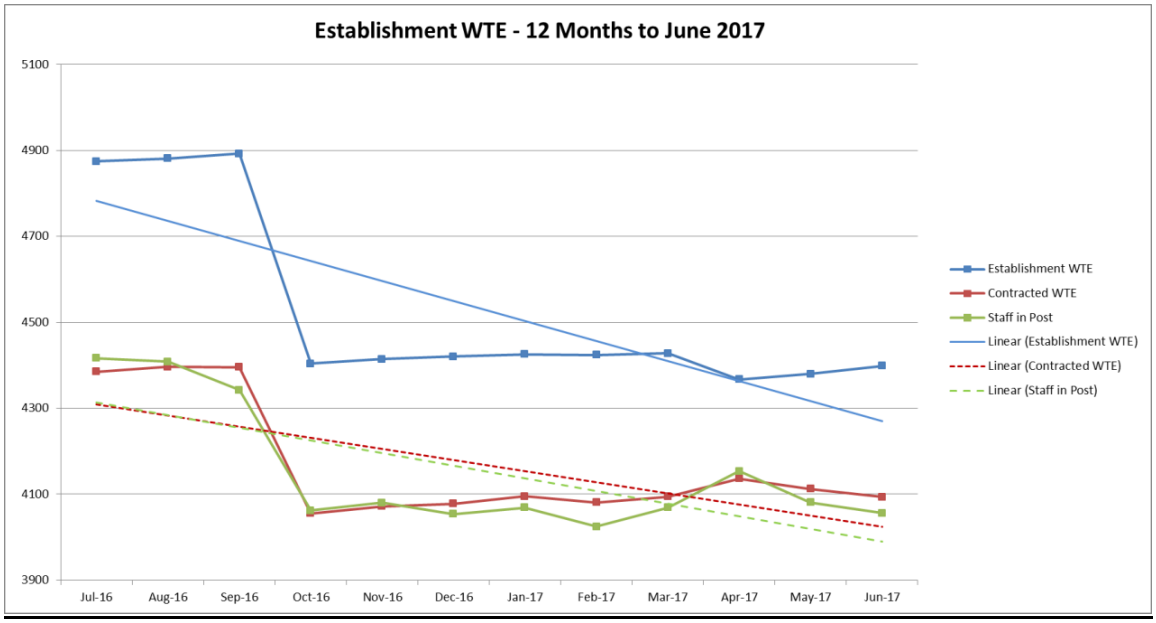

3.17 Fig. 11 shows the number of vacancies has increased to 305.19 WTE in June 2017 compared to 267.90 WTE last month.

**Fig.11: Vacancy Levels for the 12 months to June 2017**



3.18 Fig 12 shows there was a 18.3 WTE increase in the establishment from 4380.29 WTE in May to 4398.57 in June. The 18.3 WTE represents a 0.4% increase in the establishment. The number of contracted staff has fallen from 4112.39 WTE in May to 4093.38 WTE in June (a 19.0 WTE or 0.6% decrease in contracted staff). This has therefore resulted in an overall proportional increase in the vacancy rate of 12.8% (or 0.78 percentage points) to 6.90%.

**Fig. 12: Establishment: July 2016 to June 2017**




Temporary Staff Usage

3.19 The table below shows shifts for June 2017 filled by agencies. The number of shifts filled with framework agencies compliant with the price cap is 92.7%, down from 93.72% last month and rated red. The measure becomes amber at 95%.

| | Framework | | Non Framework | | Total |
|---|---|---|---|---|---|
| | Price cap breach | Price cap compliant | Price cap breach | Price cap compliant | |
| Number of Shifts | 39 | 1145 | 50 | 1 | 1235 |
| Percentage | 3.2% | 92.7% | 4.0% | 0.1% | 100.0% |

3.20 This month's performance is a slight reduction on the previous month but is within the context of significant upward performance achieved on this measure during the past year towards a target of 100%. As performance is now on the approach towards the 100% mark inevitably there will be some fluctuations in performance as we seek to weed out the remaining shifts filled by other means; these will be the harder areas to reduce.

3.21 As well as the 93.72% of shifts compliant with price caps, a further 3.2% of shifts were booked with framework agencies who do not meet the price cap. In June 2017 a total of 95.9% of shifts were therefore filled using framework agencies, a slight decrease from 97.12% last month. This equates to 1,184 of shifts being filled with framework compliant agencies in June (a 1.74% increase in the number of shifts filled this way since May's 1,205 shifts; against a 1.83% overall fall in the number of shifts).

3.22 The remainder of shifts were filled using non framework agencies which do (0.1%) and do not (4.0%) adhere to the price cap. This represents 4.1% of shifts in total, a slight decrease from 4.2% the previous month.

3.23 The NHS Improvement Standards state that only framework agencies (who are adhering to the price caps) should be used unless in exceptional circumstances, where patient safety may be at risk.

3.24 Fig. 13 on the following page shows agency spend for June 2017 compared to data available for last year in advance of a trajectory being established for 2017/18. For Month 3 agency spend is £345,029. Measured against an average of the previous 7 months costs this is 47.7% of the comparative data (including the contingency fund).

**Fig. 13. Agency spend for June 2017**

| Directorate and Locality | External Agency and Locum Expenditure M3 (£) | Trajectory M3 (£) | Adverse or Favourable Variance to Trajectory |
|---|---|---|---|
| **Operations** | 330,005 | 453,147 | F |
| **Childrens Specialist Services** | 70,196 | 70,744 | F |
| Audiology Service | 0 | 173 | F |
| East Sussex Childrens Integrated Therapy Services (CITS) | 0 | 12,304 | F |
| Integrated Therapy and Care Services | 8,488 | 10,776 | F |
| Kent Looked After Children Service | 7,607 | 0 | A |
| Paediatrics Service | 54,102 | 27,691 | A |
| Specialist Community Childrens Nursing Services | 0 | 3,061 | F |
| Universal SLT Services | 0 | 16,738 | F |
| **Dental** | 0 | 1,408 | F |
| **East Kent** | 131,713 | 188,094 | F |
| Ashford Community Hospitals | 873 | 794 | A |
| Canterbury Community Hospitals | 32,410 | 25,923 | A |
| SKC Community Hospitals | 24,587 | 10,964 | A |
| Thanet Community Hospitals | 14,873 | 22,179 | F |
| East Kent Management | 22,140 | 24,362 | F |
| Ashford Intermediate Care | -4 | 10,340 | F |
| Canterbury Intermediate Care | 17,952 | 21,857 | F |
| Thanet Intermediate Care | | 12,322 | F |
| SKC Intermediate Care | 1,773 | 24,628 | F |
| Ashford LTC | -1,271 | 7,148 | F |
| Canterbury LTC | 6,447 | 7,723 | F |
| SKC LTC | 11,933 | 16,957 | F |
| Thanet LTC | 0 | 2,750 | F |
| East Kent ICT & Community Hospitals Management | 0 | 1 | F |
| Management of SKC & Thanet LTC | 0 | 68 | F |
| SKC MIU | 0 | 79 | F |
| **Health Improvement Teams** | 1,217 | 111 | A |
| **Learning Disabilities** | 3,942 | 13 | A |
| **Operations Management** | 0 | 302 | F |
| **Public Health** | -2,733 | 6,180 | F |
| East Kent Sexual Health Service | 0 | 31 | F |
| Health Visiting | -1,993 | 4,023 | F |
| Immunisations – Kent | 0 | 731 | F |
| Management of Public Health Services | 0 | 769 | F |
| Management of Sexual Health | 0 | 194 | F |
| Medway Sexual Health Services | 0 | 63 | F |
| North Kent Sexual Health Services | 0 | 16 | F |
| School Nursing | -740 | 354 | F |
| **Specialist & Elective Services** | 12,006 | 19,639 | F |
| **West Kent** | 113,664 | 166,656 | F |
| Community Hospitals West Kent | 47,890 | 76,114 | F |
| Add Additional Ward - Primrose Ward | 5,600 | 5,600 | F |
| Intermediate Care Services West Kent | 49,624 | 61,993 | F |
| Long Term Service West Kent | 15,725 | 15,343 | A |
| Management of West Kent Locality (ACS) | 0 | 3,004 | F |
| Minor Injury Units West Kent | 425 | 4,601 | F |
| **Corporate Services** | 5,896 | 819 | A |
| **Estates** | 0 | 13,576 | F |
| **Finance** | 0 | 880 | F |
| **HR, OD & Communications** | 0 | 961 | F |
| **IT** | 5,597 | 3,154 | A |
| **Medical Director** | 2,999 | 0 | A |
| **Nursing & Quality** | 532 | 184 | A |
| **Total Directorate Position** | **345,029** | **472,722** | F |
| **Contingency** | | **250,611** | F |
| **Total Directorate Position/Trajectory based on last year Trajectory** | **345,029** | **723,333** | F |

## 4. Conclusions

4.1 This month there is an increase in three key measures of turnover, absence and vacancies and these need to be addressed to avoid performance continuing on an upward trend.

## 5. Recommendations

5.1 The Board is asked to note the current position on workforce performance and the proposed actions.

**Louise Norris**
**Director of Workforce, Organisational Development and Communications**
**July 2017**


NHS
Kent Community Health
NHS Foundation Trust

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.7 |
| **Subject:** | Community Hospitals Safer Staffing Review |
| **Presenting Officer:** | Ali Strowman, Chief Nurse |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | X | Assurance | ☐ |

**Report Summary (including purpose and context)**

This paper provides a full review of safer staffing levels in the inpatient wards of community hospitals. It demonstrates that the acuity and dependency of patients has increased on the majority of wards.
This requires an increase in staffing for two wards.

The paper proposes a new service development to pilot a model of therapeutic workers working closely with the ward teams to increase positive and engaging activities for inpatients.

**Proposals and /or Recommendations**

The Board is asked to note the information in the Safer Staffing review, to approve changes to safer staffing levels and agree a pilot to improve therapeutic activities in inpatient wards in community hospitals.

**Relevant Legislation and Source Documents**

CQC fundamental standards

**Has an Equality Analysis (EA) been completed?**

No. High level position described and no significant service change.

*** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.


| | |
|---|---|
| Ali Strowman, Chief Nurse | Tel: 01622 211920 |
| | Email: Ali.Strowman@kentcht.nhs.uk |

# COMMUNITY HOSPITALS SAFER STAFFING REVIEW



## 1. Introduction

1.1. Safe staffing levels are fundamental to the delivery of high quality, safe care. In order to comply with the statutory requirements (National Quality Board 2013) the Trust is required to review staffing and patient acuity and dependency in all inpatient areas twice per annum.

1.2. Kent Community Health Foundation Trust (KCHFT) has a developed methodology for undertaking the review and this reflects the principles of work undertaken nationally related to calculating safer staffing levels (Safer Nursing Care Tool 2013, NICE SG1, July 2014). This paper outlines the review methodology and process applied in reviewing safe staffing and the recommendations from that review.

## 2. Background

2.1. An accurate calculation of staffing levels to provide safe care is a crucial part of the planning of clinical care. The Trust has a duty to ensure that wards are adequately staffed and that patients are cared for by appropriately qualified and trained staff. This is incorporated in the NHS Constitution for England (2013) and the Health and Social Care Act (2012). KCHFT is commissioned to provide rehabilitation inpatient care and the wards predominantly care for older patients. It is well recognised that older patients often have complex care needs and may have significant levels of dependency. Wards therefore require a skilled workforce with time to deliver appropriate care in a dignified manner. The daily impact of staffing levels is monitored through a range of quality measures including patient experience data, complaints, incidents, audit findings and staff wellbeing.

## 3. Summary of key actions from the previous reviews

3.1. The Trust has demonstrated that it is committed to ensuring that action is taken following safe staffing reviews, and following previous reviews changes have been made to registered nurse to patient ratios, skill mix ratio and funding for staffing. The audit tool is reviewed regularly to ensure clinicians are confident it is reflecting the patient cohort.

## 4. Methodology for the October 2017 review

4.1. Following the previous review in December 16 the acuity/dependency assessment tool has been further improved to include a section on patients requiring 1-1 and frequent observation. The principles remain the same in that a set of metrics are mapped and triangulated with professional judgement and quality data to provide a robust method of reviewing the staffing levels.

4.2. Over a 21 day period in April 2017 the wards measured the acuity/dependency of the patients in the wards. Data was submitted to the performance team and analysed with an allocation of a Red/Amber/Green rating (appendix 1). This identifies the number of patients with high, medium or low levels of acuity/dependency on each ward. Red classifications are for complex, highly dependent patients who require support to meet almost all of their needs and may be end of life or have significant level of cognitive impairment. Amber classifications are patients that need a level of substantial support, and Green classifications are patients who are able to self-manage the majority of their care.

4.3. The findings of the audit are shared with ward leaders for their professional opinion and triangulation of the quality indicators that may be linked to nurse staffing issues, including effective leadership, current establishment levels, skill-mix and training and development of staff. Other elements considered were:

- Data contained in the Early Warning Trigger Tool including quality data
- Red Flag data
- Patient experience
- Comparison with previous audit
- Consideration of changes in ward factors
- Benchmarking

4.4. Additionally KCHFT has an agreed set of rules which have been applied:

- a limit of no less than one registered nurse to 13 (1:13) patients, in addition to this will be support from the Assistant Practitioner
- Each ward will have a minimum of two RNs despite the minimal number of patients
- Each ward will have an Assistant Practitioner on an early shift
- Wards over 20 beds will have an Assistant Practitioner on a late shift
- Each ward will have, in addition 1 WTE supervisory manager, this is the Matron/Ward Manager at Band 7.

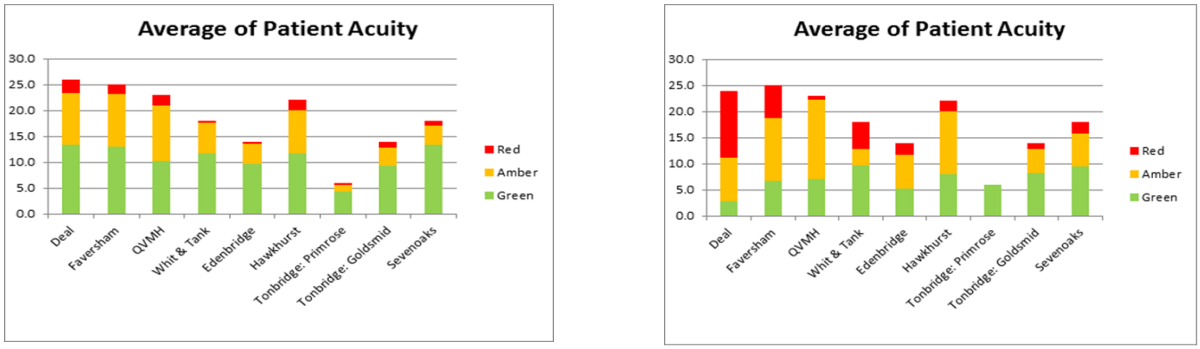
## 5. Summary of findings

5.1. The triangulated assessment of audit findings, professional judgement and quality metrics provides evidence that acuity/dependency of patients has increased, slightly in some wards and more markedly in others. The number of complex patients has increased by 11 to 31 (+181%), the moderately complex increased by 57 to 68 (+19%) and the more independent patients has decreased from 92 to 66 (-28%), the therapy ward Primrose and Sommerhill has not been included as it was not audited 6 months ago. Deal hospital has experienced the largest change, however the Matron has reported that the over the 3 week audit period the patient cohort was unusually dependant, and this is not the norm for the ward.

5.2. Figure 1 below details the RAG rating for the patient cohort audited.

**Figure 1 Acuity dependency scores by Hospital**

**November 2016** **April 2017**




5.3. Ward managers and nursing and quality staff triangulated the audit results with the other data sources and concluded that their staffing numbers continue to be acceptable, with the following requests:

5.3.1. Sevenoaks requested night time staffing is increased by 1 HCA. This is due to the environment as the ward is separated into two different areas. During a break there is just one staff member with the patients in one area, and staff in the other area cannot hear them if help is required. A review of relevant data has shown that there is no higher rate of incidents, but when an incident does occur help needs to be available. Edenbridge has a similar ward layout and the same challenges, and to maintain safety this ward will also require an additional HCA. A comparison with other wards has demonstrated they do not have similar risk.

5.3.2. All wards requested additional supervisory time for Band 6 staff. When benchmarked with other hospitals the 1 WTE allowance for KCHFT wards is generous and therefore instead of increasing hours it is suggested that operational managers work with the Matrons/Ward managers to support them in exchanging some of their office work for clinical shifts with the Matrons.

5.3.3. The number of patients with cognitive impairment on our wards has increased. Matrons/Ward managers are aware of the importance of ensuring staff have the skills to manage the care of these patients and the importance of creating dementia friendly environments.

5.4. Benchmarking with another Trust of similar patient mix demonstrates KCHFT is in line with their staffing. Consideration has been given to the RCN Older People safe staffing guidance on the nurse to patient ratios. Ideally wards should have 3.3 - 3.7 patients to each staff member (will include RN and HCA). Figure 2 sets out the data by ward and the table includes the previous data related to the last audit of December 2016 (audit, staffing). It also includes the vacancies for reference.

5.5. In recognition that rehabilitation patients require a higher level of the key fundamentals of care it has been considered appropriate to have a skill mix 40% RN: 60%HCA split where staffing numbers allow.

**Figure 2 Audit findings and staffing levels**

| Ward | Beds | Audit results Oct 16 | Agreed staffing | Patient to staff ratio adjusted to within benchmark limits early shift | Audit results April 17 | Supervisory time B7 | Proposed staffing | Proposed changes | Band 6 vacancies | Band 5 vacancies | Assistant Practitioner (b4) vacancies | Band 3 vacancies | Band 2 vacancies |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Deal | 26 | 13 | 2+2+3 | 3.7 :1 | 3 | | 2+2+3 | | | | | | |
| | | 10 | 2+1+2 | | 9 | | 2+1+2 | 0.6 Band 3 | | | | | |
| | | 3 | 2+0+2 | | 12 | 1 | 2+0+2 | | 0 | 4.19 | 5.17 | 1.01 | 1.64 |
| Faversham | 25 | 13 | 2+2+3 | 3.5 :1 | 7 | | 2+2+3 | | | | | | |
| | | 10 | 2+1+2 | | 12 | | 2+1+2 | 0.6 Band 3 | | | | | |
| | | 2 | 2+0+2 | | 6 | 1 | 2+0+2 | | 0 | 1.9 | 4.17 | 2.68 | 2.77 |
| QVMH | 23 | 10 | 2+1+3 | 3.8 :1 | 7 | | 2+1+3 | | | | | | |
| | | 11 | 2+1+2 | | 15 | | 2+1+2 | 0.6 Band 3 | | | | | |
| | | 2 | 2+0+2 | | 1 | 1 | 2+0+2 | | 1 | 2.17 | 2.45 | 1.0 | 1.57 |
| Whit & Tank | 18 | 12 | 2+1+2 | 3.6 :1 | 10 | | 2+1+2 | | | | | | |
| | | 6 | 2+1+2 | | 3 | | 2+1+2 | 0.6 Band 3 | | | | | |
| | | 0 | 2+0+2 | | 5 | 1 | 2+0+2 | | 1 | 2.69 | 3.45 | 3 | 1.18 |
| Hawkhurst | 22 | 12 | 2+1+3 | 3.6 :1 | 8 | | 2+1+3 | | | | | | |
| | | 8 | 2+1+2 | | 12 | | 2+1+2 | | | | | | |
| | | 2 | 2+0+2 | | 2 | 1 | 2+0+2 | | 0 | 4.09 | 3.45 | 1 | 1.63 |
| Sevenoaks | 18 | 13 | 2+1+3 | 3 :1 | 10 | | 2+1+3 | | | | | | |
| | | 4 | 2+0+3 | | 6 | | 2+0+3 | | | | | | |
| | | 1 | 2+0+2 | | 2 | 1 | 2+0+3 | | 0.2 | 3.29 | 0.72 | 1.6 | 2.41 |
| Edenbridge | 14 | 10 | 2+1+2 | 2.8 :1 | 5 | | 2+1+2 | | | | | | |
| | | 4 | 2+0+2 | | 6 | | 2+0+2 | | | | | | |
| | | 0 | 2+0+1 | | 2 | 1 | 2+0+1 | | 0.2 | 5.34 | 1.72 | 2 | 3.43 |
| Tonbridge: Goldsmid | 14 | 9 | 2+1+2 | 2.8 :1 | 8 | | 2+1+2 | | | | | | |
| | | 4 | 2+0+2 | | 5 | | 2+0+2 | | | | | | |
| | | 1 | 2+0+1 | | 1 | 1 | 2+0+1 | | 0.08 | 0.08 | 3.29 | 1.72 | 0.5 |
| Primrose and Sommerhill | 8 | No previous data | | | 8 | 0.5 | 0+1+2 | Staffed by agency staff at present | | | | | |
| | | | | | | | 0+1+2 | | | | | | |
| | | | | | | | 0+0+2 | | | | | | |



## 6. Outcome

6.1. The audit has demonstrated that acuity and dependency is higher on the wards. This can be accommodated by current staffing levels with the exception of two wards where increased staffing is proposed to ensure the continued safe care to patients during night time hours:

- Sevenoaks – 8 hours each night Band 2
- Edenbridge – 8 hours each night Band 2

<u>The cost of this will be £74,976 (August to March).</u>

6.2. Matrons are able to request additional staff on a daily basis should acuity/dependency rise through the established escalation process and the audit with be repeated in 6 months' time.

## 7. Service development

7.1. It is clear that the number of patients with cognitive impairment is increasing, particularly in east Kent. All wards are being encouraged to increase activities for patients, and the importance of this is championed by the Dementia nurse specialists. On our wards all patients are encouraged to dress and spend time in the day room to increase social interaction and to increase their sense of independence. This includes patients with dementia for whom the importance of social stimulation is well evidenced to have a positive effect on behaviours. Matrons have suggested

additional funding would allow them to recruit a therapeutic worker to work with patients providing a timetable of daytime activities. Therefore it is proposed that Faversham and Deal hospital wards where acuity and dependency is highest have additional funding for a 0.6 WTE Band 3 for the remainder of the year, and the impact monitored and measured by the Ward Matrons.

The cost of this for 2 wards is £25,940 (August to March)

## 8. Conclusion

8.1. The safer staffing review has applied a tested robust methodology to identify the right numbers of staff required for the delivery of safe, quality care in the community hospital in patient wards. The levels of staffing take into account a wide range of factors including the type of ward, professional judgement from the senior nursing leaders, and quality and safety metrics.

8.2. The acuity and dependency of patients in community hospitals has increased, however the majority of ward managers have said the staff numbers remain satisfactory. The exception to this is Sevenoaks and Edenbridge wards where additional HCA hours are required to maintain a safely staffed environment.

8.3. A pilot in east Kent will trial the use of a therapeutic worker to provide stimulating activities to patients and improve patient experience.

8.4. Daily assessment of staffing levels is made in the community hospitals to ensure safety. If acuity and dependency of patients changes significantly there will be a further acuity study undertaken before the required 6 monthly review.

## 9. Recommendations

9.1. The Board is asked to note the information in the Safer Staffing review, to agree the methodology as robust and approve the agreed safer staffing levels in inpatient wards in community hospitals.

**Ruth Herron**
**Deputy Director of Nursing and Quality**
**9 June 2017**

**References**

Health and Social Care Act (2012) UK Parliament

Making the Case for ward sisters/team managers to be supervisory (2011) Royal College of Nursing

NHS Constitution for England (2013) Department of Health

Safer Nursing Care Tool (2013) Shelford Group. The Association of UK University Hospitals

Safe staffing for nursing in adult inpatient wards in acute hospitals (2014) NICE

Safer staffing for older peoples wards, an RCN toolkit (2012) Royal College of Nursing

**Appendix 1**

**Green**

This type of patient may need help with a limited number of areas of daily living and will be progressing well along the rehabilitation pathway. They will be stable in terms of their health, and able to manage a degree of self-care. They may need minimal or no help with walking, washing and dressing, eating and drinking and repositioning. They are likely to be able to communicate well, or with minimal help and have an awareness of safety. If they have pain this is likely to be controllable and they are likely to be able to take medication independently. They will be able to self-manage any personal condition or be in the process of learning to do this.

**Amber**

This patient is likely to need support with several areas of daily living including washing, dressing, eating and drinking. They will probably need help when walking, and support to reposition to prevent pressure damage. They may have fluctuating pain and need help to manage this. These patients may need assistance with bed/chair transfers. Safety awareness may be limited and they may be confused and/or have a degree of socially inappropriate behaviour and/or aggression. These patients need a degree of nursing care and may have one or more long term condition that is unstable, needs treatment and requires monitoring.

**Red**

This patient requires a high degree of nursing care. They will include heavily dependent patients, and medically unstable patients who require frequent monitoring. Patients may be receiving care at the end of their life. Alternatively patients may be aggressive and disruptive. Patients are likely to require 1-1 care.

Kent Community Health NHS
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 2.8 |
| **Subject:** | Policy for Ratification |
| **Presenting Officer:** | Louise Norris, Director of Workforce, Organisational Development and Communications |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | X | Assurance | |

| **Report Summary (including purpose and context):** |
|---|
| This report presented for ratification is:<br><br>• Maintaining High Professional Standards Policy |

| **Proposals and /or Recommendations:** |
|---|
| The Board is asked to ratify this policy. |

| **Relevant Legislation and Source Documents:** |
|---|
| |
| **Has an Equality Analysis been completed?** |
| Yes and available electronically. |



| | |
|---|---|
| Louise Norris, Director of Workforce, Organisational Development and Communications | Tel: 01622 211905 |
| | Email: Louise.norris@kentcht.nhs.uk |



Policy for Ratification

Kent Community Health NHS
NHS Foundation Trust

# RATIFICATION OF POLICIES

## 1. Introduction

1.1 A KCHFT policy has been revised and the Board is asked to ratify this policy.

## 2. Policy for ratification

2.1 The policy presented for ratification is –

- Maintaining High Professional Standards Policy

2.2 The above policy is available electronically if required prior to the meeting of the Board.

2.3 The main changes to this policy are:

- Addition of paragraph to confirm policy supersedes previous iterations
- Removal of requirement to complete initial assessment report and instead inclusion of requirement to document the rationale for decisions made at the preliminary stages
- Reference to Trust Suspension policy removed. Information regarding exclusion now included in disciplinary procedure
- Amendment to paragraph 5.4.2 changing “informal improvement notice” to “informal recorded warning” in line with the disciplinary procedure
- Addition of paragraph 8.1.6 relating to remediation
- Revision to the role of NCAS in relation to the convening of a capability hearing
- References to SHA amended to appropriate regulatory body
- References to policies/procedures, documents, websites and contact details included and document titles updated
- Inclusion of “nominated representative” where actions associate with the Chief executive are mentioned
- Inclusion of necessity to report allegations of Fraud, Bribery or Corruption to TIAA (Counter Fraud Specialist)
- Equality, Diversity and Inclusion wording updated as per policy template.
- Equality Inclusion wording updated as per policy template.
- New Trust logo added.

- Formatting tidied.

## 3. Process of developing and consulting on policies

3.1 The process for developing and consulting on new/revised policies is as follows:

a. The policy is written by the Policy Owner
b. Consultation within the appropriate Directorate to seek further professional input
c. Policies are placed on to Flo for two weeks for general consultation and the feedback collated by Staffside and fed back to policy authors
d. Approval from the appropriate committee or group. See consultation and sign off sheet attached below
e. Board ratification

## 4. Recommendation

4.1 The Board is asked to ratify the above policy.

**Louise Norris**
**Director of Workforce, Organisational Development and Communications**
**July 2017**

## POLICIES – CONSULTATION AND SIGN OFF

| Policy Title | Consultation With | Signature of the Chair(s) | Signature of Director with Responsibility |
|---|---|---|---|
| Maintaining High Professional Standards Policy | HR Team<br>All staff through Flo<br>SPF | Louise Norris<br>Director of Workforce, OD and Communications<br><br>Neil Sherwood<br>Staffside Convenor | Louise Norris<br>Director of Workforce, OD and Communications |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 3.1 |
| **Subject:** | Annual Infection Prevention and Control Report |
| **Presenting Officer:** | Ali Strowman, Chief Nurse/ Director of Infection Prevention and Control (DIPC) |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | ☒ |

**Report Summary (including purpose and context):**

This paper is the Annual DIPC Report 1 April 2016 – 31 March 2017.

- The Trust achieved the target of Zero attributable MRSA bacteraemias
- The Trust breached the target of no more than 5 attributable *Clostridium difficile* infections, with a total of 7 reported cases
- MRSA screening targets were not fully met, achieving 99% compliance pertaining to 2 patients throughout the year not being screened as per policy
- Catheter associated urinary tract infections and Urinary tract infection reduction targets were over achieved
- Compliance to Infection prevention and Control training was achieved
- National guidance was analysed and incorporated into annual work plans
- Policies were reviewed to reflect national and best practice guidance.
- KCHFT continue to work collaboratively with the Kentwide HCAI reduction group
- There were 13 outbreaks of infection throughout the year, closing inpatient beds
- The Trust remains strategically compliant with all aspects of the Hygiene code.

**Proposals and /or Recommendations:**

Report for assurance

**Relative Legislation and Source Documents:**

Health and Social Care Act – 2008, revised 2010 and 2015

| Has an Equality Analysis been completed? |
| --- |
| No. High level position described and no decision required. |

| | |
| --- | --- |
| Ali Strowman | Tel: 01622211923 |
| Chief Nurse / Director Infection Prevention and Control (DIPC) | Email: Ali.strowman@kentcht.nhs.uk |

Kent Community Health
NHS Foundation Trust

# Infection Prevention and Control Annual Report 2016-17


Infection Prevention and Control Conference 2016

Ali Strowman Chief Nurse / Director of Infection Prevention and Control
Lisa White Assistant Director of Infection Prevention and Control

**Executive Summary**

**O**ver the last year the Infection and Prevention team have supported the operational teams to deliver further improvements in infection prevention and control. This annual report provides a full account of this activity. In addition, new guidance and evidence has been reviewed and incorporated into policies, practice, education and guidance.

### 1.1 Director of Infection Prevention and Control assurance

The DIPC gives the following assurances:

- Kent Community Health NHS Foundation Trust is strategically compliant with the Hygiene Code.
- 100% of patients presenting for elective surgery are MRSA screened at pre-assessment.
- Every case of *Clostridium difficile* infection is investigated and a Root Cause Analysis completed, with the clinical teams, to ensure lessons are learned and actions taken for non-compliance
- Kent Community Health NHS Foundation Trust take part in the Post Infection Review process for all MRSA bacteraemia as part of the whole systems approach to healthcare
- The Infection Prevention and Control Team carry out an annual programme of audit as required by the Hygiene Code
- Kent Community Health NHS Foundation Trust use National cleaning specifications to determine cleaning frequencies and methodology within the healthcare environment
- Kent Community Health NHS Foundation Trust undertake decontamination audits and report to the Medical Devices Decontamination Committee which reports to the Board.
- Kent Community Health NHS Foundation Trust has Occupational Health provision from an external provider. Screening is carried out on all staff at pre-employment checks and further surveillance and screening is carried out at agreed intervals and as necessary
- Kent Community Health NHS Foundation Trust has the required infection prevention and control arrangements in place. (See Appendix 1 for Infection Prevention and Control Team Reporting Structure and Appendix 2 for Terms of Reference of Infection Prevention and Control Committee).

### 2.0 Healthcare Associated Infection Surveillance

| Indicator Description | Target | Year Total |
|---|---|---|
| MRSA bacteraemia | 0 | 0 |
| MRSA screens for podiatric surgery % compliance | 100 | 100 |
| MRSA screens in Community Hospitals % compliance | 100 | 98 |
| *Clostridium difficile* infections | ≤ 5 cases, 0 Level 3 lapses in Care | 7 cases, 1 level 3 lapse in care |
| *Hospital acquired UTI's (5% less than 2015/16)* | 130 | 114 |
| *Hospital acquired CAUTI's ( 5% less than 2015/16)* | 25 | 14 |

### 2.2 *Clostridium difficile* 2016/17

The Trust breached its target of no more than 5 cases of *Clostridium difficile* and no level 3 lapses in care, by reporting 7 attributable cases, with one level 3 lapse in care. A full Root Cause analysis was

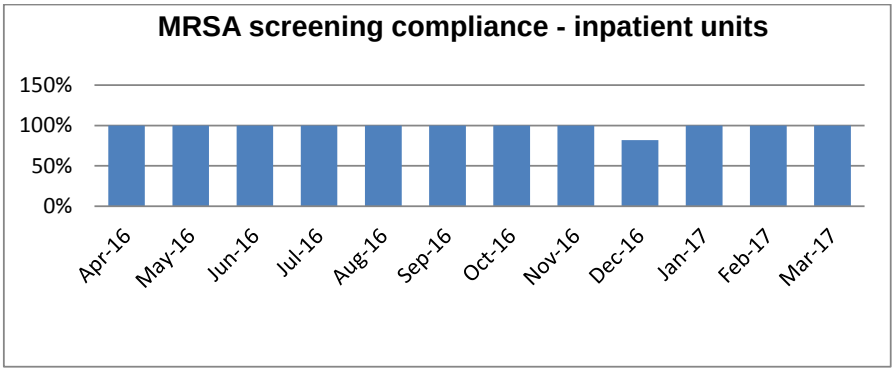
undertaken on all cases, 5 were deemed to be unavoidable, and due to appropriate antimicrobial prescribing, 1 was proven cross infection - but not in KCHFT, and one case was proven to be cross infection within KCHFT. An SI was declared, and this incident was fully investigated, with actions to be implemented. A Trust wide *Clostridium difficile* reduction action plan has also been produced and is being implemented and monitored through the IPC and Quality Committee.

### 2.3 Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemias

For the third year running, there were no MRSA blood stream infections attributed to the Trust in 2015/16, although 10 cases where KCHFT staff were providing care were investigated – one more than last year, all were reviewed by NHS England and deemed as either unavoidable and attributed as a 'third party assignment', or avoidable, but attributed to another NHS organisation.

### 2.4 MRSA Screening

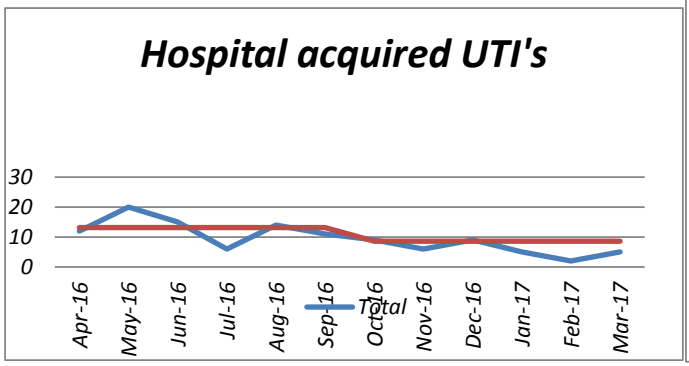
KCHFT continue to screen high risk patients admitted to our inpatient units, and all patients undergoing podiatric surgery. 98 patients were admitted to the inpatient units who fitted the 'high risk' category, and 96 were screened. Actions were implemented in the hospital where the omissions occurred, and these were related to use of agency staff.

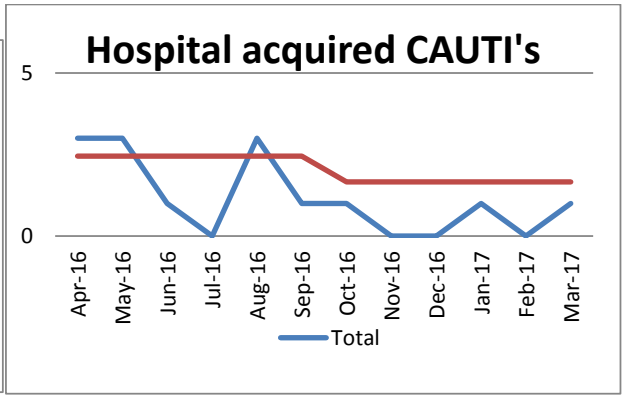



### 3.0 Hospital Acquired Catheter Associated Urinary Tract infections (CAUTIs) and Urinary Tract Infections (UTIs)

The target for 2016/2017 was to reduce CAUTI's and UTI's by 5% with no more than 25 cases of Hospital acquired UTI's and no more than 131 UTI's. This was over achieved, with 14 CAUTI's and 114 UTI's. Focus on reduction of these infections has continued in preparation for the E-coli bacteraemia reduction target for 2017, the catheter passport continues to be used, and catheter bundles have been revised and implemented, with all infections investigated by the IPC team –this has led to the significant and ongoing reductions seen. Lisa White was invited to speak at a national conference about the Trusts success in reducing these infections, and presented at the Knowlex Infection prevention and control conference in March 2017.

**Figure 3: Community Hospital acquired UTIs and CAUTI's**




**4.0 Outbreaks**

In total in 2016 / 2017 there were 13 outbreaks of infection that led to ward closures, 6 confirmed Norovirus, 2 Diarrhoea (no confirmation of pathogens) and 3 respiratory viral outbreaks with no Influenza A this year. This is a significant reduction in the number of outbreaks occurring last year (17). The IPC team continue to update and provide training on outbreaks management to staff and provide all resources required for this.

**5.0 Seasonal Flu Campaign**

During 2016/17 flu season staff were given the opportunity to be vaccinated against influenza in line with the Department of Health Staff flu programme. An in house vaccination programme was run, and 53% of patient facing staff were vaccinated, which is a 6% increase from the previous year.

**6.0 Decontamination of medical devices.**

Kent Community Health NHS Foundation Trust recognises the risks to patients, staff and others created by the use of medical devices. There is an operational system in place which manages the procurement, usage, maintenance and disposal of medical equipment, to meet the requirements of national legislation and NHS guidance and to make sure that equipment is used safely, competently and effectively for the care of our patients.

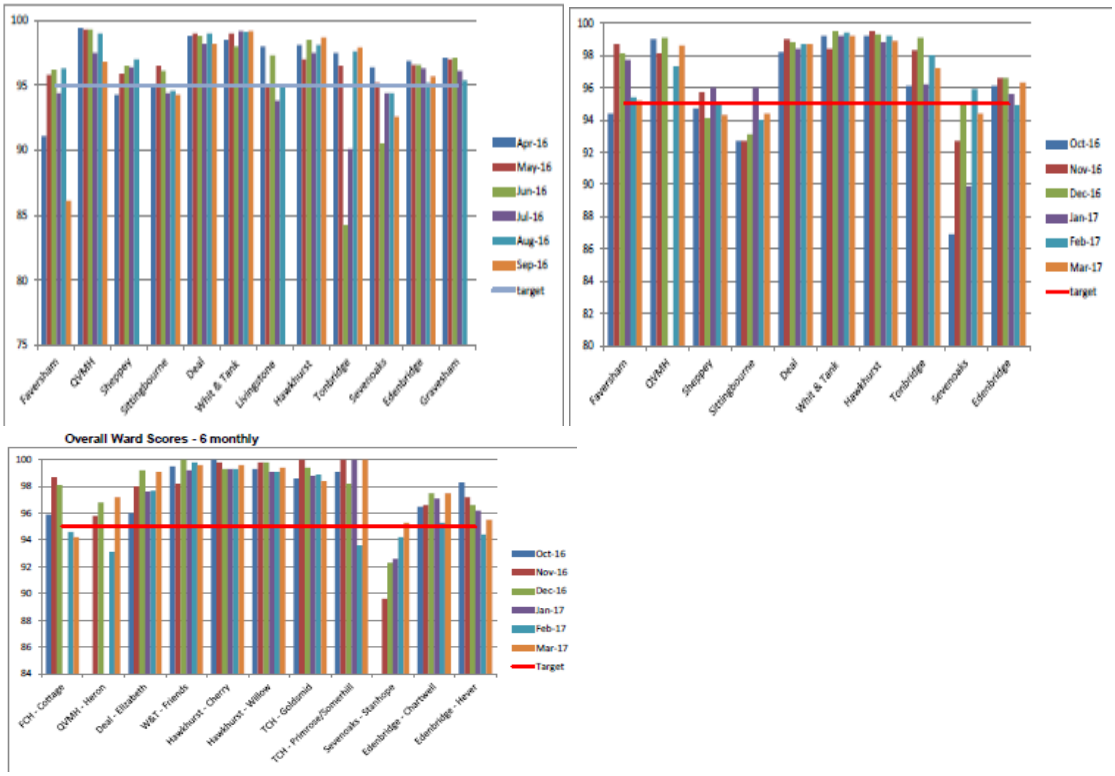
Decontamination processes are jointly managed and reported through KCHFT. The Medical Devices and Decontamination Group receive exception reports, and provide assurance for the Trust on all aspects of decontamination. The Infection prevention and control team undertake audits in areas that utilise re-usable instruments, and in all outpatient departments and Dental services found full compliance with decontamination processes. The Trust Independent Authorised Engineer for Decontamination also verified the compliance of the Central Sterilisation Services that KCHFT utilise, and has supported the Dental Service in their return to local reprocessing in 2 sites.

**7.0 Cleaning Services**

Each site is monitored for cleanliness against the National Standards and reports are received by the IPCT monthly and included in the report to the Board. The charts below show monitoring results for environmental cleanliness within Community Hospitals.

**Figure 5 :** Environmental Cleaning

Hospital results:




Cleaning scores are presented 6 times a year to the IPC committee, during 2016/17 the committee requested a further breakdown within the cleaning reports, to ensure local scrutiny of the ward cleaning results, hence 6 months data for the inpatient areas.Moving into 2017 further changes will be made to this report to enhance readability and give greater clarity with regard to the all-round performance of the Hotel Services team.

**Site Review**

Throughout 2016/17 most of the sites have achieved and excellent standard of cleaning performance in particular Whitstable, Hawkhurst and Tonbridge, however a few of sites have given IPC cause for concern.

- Sevenoaks (Ward) – although the ward scores are not low and have seen month on month improvement, they have consistently been below the target figure of 95%. The site has lacked leadership at ground level due to maternity leave and a suitable structure not put in place. However, a new charge hand role is being created and new cleaning schedules are being produced to provide greater clarity for the cleaning and clinical staff as well as patients and visitors.
- QVMH (Heron Ward) – a good overall (annual) performance from the staff at Heron Ward with the exception of a number of months over the winter period. This is largely due to a number of outbreaks on the ward. This meant more intensive cleaning, but with only a small pool of staff to obtain additional help from. New ways of working and cleaning schedules will be introduced in 2017.
- Faversham (ward) – audit scores on the ward fell in the last part of 2016/17. There have been gaps in supervision due to sickness, but as with Sevenoaks and QVMH the site structure and strategy need to be improved. New cleaning schedules are being introduced in 2017 and structure reviewed.

- Sittingbourne and Sheppey – both the sites now receive cleaning in outpatient areas only since the loss of ward cleaning at the end of September 2016. The scores have fluctuated above and below the national standard, but have never fallen below 93% as a site. There is no set cause for the changes in score, and these sites will just as the other above receive a structure review along with new cleaning schedules.

A number of specific tasks will take place within the cleaning service during 2017 to ensure a cost effective agile service is provided to not only wards but all KCHFT properties.

- A review of cleaning time and supervision will take place to ensure a robust effective service.
- New cleaning schedules are to be produced for every site in line with The NHS Healthcare Cleaning Manual. On wards these will be displayed along with the most recent audit for all staff, patients and visitors to see.
- Independent quarterly audits will take place and used as part of the scores provided in the IPC report.
- New more effective equipment will be purchased and greater emphasis on the daily use of floor machines as well as existing steam machines.
- H&S records are to be improved at each site to ensure up to date information is at hand on ward level
- All staff are to receive SOP refresher training which will be documented.
- All staff are to receive equipment refresher training which will be documented.
- All staff are to receive refresher training on cleaning materials which will be documented.
- New staff will be issued with a local induction hand book and more receive more intensive training from the site supervisor. This will be documented.
- New training for “Deep Clean” has been devised in conjunction with IPC and has been implemented immediately.

KCHFT have a loyal and hardworking Hotel Services team and the new initiatives above will serve to enhance their current work ethic and provide the team with a strategy and common purpose.

## 8.0 Estates

The IPC team continue to work closely with the trust Estates team in order to ensure the environment is conducive to the prevention and control of infections with far more interaction between teams this year. IPCT continue to be involved at an early planning stage in refurbishments, new builds and projects which involve patient areas. Estates project managers are required to seek professional advice from infection prevention and control colleagues. Typical examples of this would be the interaction on the refurbishment of Hawkhurst Cottage Hospital and new wound care facilities at Sevenoaks Hospital where interaction and advice has been sought between teams to achieve positive IPC outcomes.

The IPCT continue to risk assess any maintenance or construction activity to ensure the presence of construction workers does not pose a risk to the patients within the adjoining areas – including the removal of waste, reduction of dust within the environment and avoidance of contamination of the air supply and extract systems. KCHFT estates operations managers have the benefit of more training and improved line management structures that address IPC issues.

KCHFT also have maintenance agreements in place with NHS Property Services and Kent and Medway Partnership Trust to provide assurance of compliance with requirements for water quality in all buildings where we are owners, tenants or occupiers. The Trust Water Quality and Safety Committee (WQSC) has been working with these partners to ensure the assurance is received by the Trust, in a timely manner, to enable any issues to be identified and rectified. Work continues on the water safety policy which is also in production through the WQSC co-chaired by the Assistant

Director IPC. This group has made good progress this year, with regular reporting to CCG's and the IPCC on water safety issues. The trust has also improved formal training in water safety matters for key staff.IPCT have also been consulted on new estates procedures and policy. In particular, the production of a management and control of contractors policy, Control of Asbestos and Contractors Health and Safety Handbook which have been updated and produced this year. These also consider IPC implications. Bi-annual property inspections have also commenced, with IPC involvement ensuring any Estates issues identified that may affect IPC in the unit are highlighted for action.

The mobilisation of new estate in the KCHFT portfolio is also undertaken with IPCT. This year has seen the adoption of new dental sites within North London. Joint visits have taken place with IPCT and estates colleagues to determine the risks and associated action pertaining to the patient environment. This joint work has resulted in formal requests for improvements from landlords.

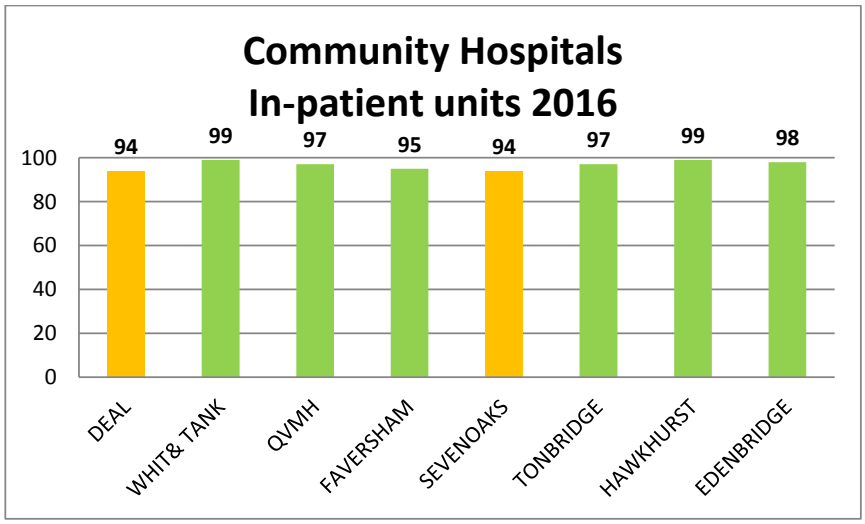
Improvements have been made to the estates on call and incident processes this year to further improve interaction between the estates team to respond to issues where IPCT require estates involvement and action. In joint consultation with the IPCT team, a full 24 hr on call estates incident process now exists in order to respond to IPCT and Trust wide issues, to ensure a robust system is in place to respond 365 days of the year.

Key improvements are planned to see more interaction between Estates and the Soft FM team in 17/18 through full consultation with the IPCT further enhancing and improving the service provision within the trust.

**9.0 Audit and Monitoring**

The Essential Steps programme of self-assessment is in use in all Community Hospitals and appropriate clinical teams. This monitoring tool incorporates hand hygiene, urinary catheter care, IV devices care and enteral feeding. Results of this monitoring are stored locally as CQC evidence, and the results are reported to the Infection prevention and control committee – each service is required to present results twice annually.

During 2016 the Infection Prevention and Control team audited 8 Community Hospitals against standards of infection prevention and control, laid out in the hygiene code (4 hospitals previously audited changed provider within the year, therefore were not audited by KCHFT).




6 hospitals received a GREEN rating: 95 - 100% compliance.

2 hospitals received an AMBER rating: 94% compliance.

Six hospitals achieved the same or improved scores from the previous year (Whitstable and Tankerton; QVMH; Sevenoaks; Tonbridge; Hawkhurst and Edenbridge). Two hospitals scored lower than in 2015 (Deal 94% previously 97% and Faversham 95% previously 98%). The 3 main areas for improvement this year were identified as improvements in catheter care documentation, use of temporary closure mechanisms on sharps bins, and decluttering of clinical environments.

All areas of non-compliance produce an individual action plan which is produced by the Matron and manager, who have the responsibility to ensure actions are completed. All actions identified in these audits within the Matrons direct control have been completed.

**10.0 Antimicrobial Stewardship**

KCHFT has in place an Antimicrobial Strategy with an associated action plan that is monitored by KCHFT Antimicrobial Stewardship Group. KCHFT actively participates in the Kent Clinical Commission Groups Antimicrobial Steward Groups. The annual audit of antimicrobial use was under taken in the community hospitals; it indicated that actions previously put in place have sustained prudent use of antibiotics. Effective antimicrobial stewardship is supported by the launch of a revised antimicrobial e learning package and by an increasing numbers of staff signing up to national Antibiotic Guardian campaign.

**11.0 Waste.**

The waste and environmental management service is provided to KCHFT by Kent & Medway NHS Facilities (KMF). As part of the service, KMF provide contract management, audits, training, technical advice and policy writing to KCHFT and its staff. The Waste policy was under review at the end of 2016/17, and the new Waste management consortium continues to provide KCHFT a Waste collection service.

## Waste Audits

Between April 1st 2016 and 31st March 2017, the KMF Waste and Environment Team audited 32 sites out of a total of 39. There were 7 sites that were not audited during this period, due to the KMF disbandment, which will be completed early in 2017-18 audit programme.

The reduction in the number of sites, 10 in total, between the 2016-17 and the 2017-18 audit programme was due to some sites being moved back to NHS PS and other sites being closed.

Of the sites where the audits were completed there were 3 red, 23 amber and 6 green risk ratings awarded. All immediate actions were taken on the sites rated, red, and all were related to either broken locks or unlocked waste containers / compounds.

**12.0 Patient Experience of infection prevention and control**

Every month all in-patients in community hospitals are asked to participate in a 34 patient satisfaction questionnaire relating to their hospital stay. Four questions pertain to infection prevention and control, and in 2016/17 the following results were received:

99% of respondents stated the ward was clean and tidy.

97% of patients said they did see staff wash / gel their hands prior to treating them.

92% respondents said staff encouraged them / offered them the opportunity to wash their hands after going to the toilet

89% of respondents were not offered the opportunity to clean their hands before meals.

Following these results actions have been put in place to remind staff to provide hand hygiene information to patients after toileting, and 2 patient wipes are now being provided at meal times, so patients can clean their hands both before and after meals. However, the question relating to toileting was deemed to be ambiguous, and the question has slightly changed for 2017/18.

**13.0 Infection Prevention and Control Training and Education**

Infection Prevention and Control training is mandatory for all staff and compliance is monitored centrally and reported to the Board. By March 2017 Trust Compliance with hand hygiene training was 90.5%, and mandatory training 96%. Compliance amongst clinical staff was 88.6% for hand hygiene and 95.5% for mandatory training. Bespoke training is provided for services at their request, and external organisations have also contracted KCHFT to undertake training in different settings, such as nursing and residential homes.

**14.0 Link Workers Education**

Kent Community Health NHS Foundation Trust continues to support and facilitate an education programme for Infection Prevention and Control Link Workers.

These staff are given time within their service to complete the aspects of their role that improve patient services, and are released to attend educational updates and meetings with the Infection Prevention and Control Team twice a year. This is an extension to their existing role and provides their colleagues with a point of contact for additional advice on infection prevention. Over 200 Link Workers are in post across the Trust and in 2016/17 the team put on 62 Link worker meetings, which provide continued professional education, audit assurance and sharing of innovations and ideas.

**15.0 Conference**

In November 2016, the IPC team hosted an Infection Prevention and Control conference focussed on antimicrobial resistance, and antimicrobial stewardship, with an internal, external staff split of approx. 50:50. There were over 200 attendees, who received talks and presentations from an array of experts, including a consultant from Public Health England, A Consultant Microbiologist, and a SEPSIS expert from the Patient Safety Collaborative. The conference was very well received and evaluated, and the team are already planning for a 2018 conference.

**16.0 Review and update of policies, procedures and guidance**

The review and update of the IPCT policies has continued throughout 2016/17. All policies and protocols are based on National guidance and are updated as new evidence is available and all Infection Prevention and Control policies are up to date.
The Trust Waste Policy and Water Quality and Safety Policy are currently under review, owing to both legislative and national guidance changes.

## 17.0 Staff Health

Kent Community Health NHS Foundation Trust provides an occupational health (OH) service for Staff via a contract with PAM Occupational Health department. This contract has been in place since June 2016, and is working well. A programme of identification of staff vaccination status continues, and the systems are now in place for managing staff who receive sharps injuries both high and low risk. An internal system has been put in place for any staff requiring Post Exposure Prophylaxis for HIV.

## 18.0 Collaborative Working

Throughout 2017/18 the Infection Prevention and Control team have continued to work closely and collaboratively with partner organisations, including the Kent wide HCAI reduction group who's overall aim is to adopt a healthcare economy wide approach to reduction of HCAI's through partnership working and effective communication and pathways. The group have begun to focus on projects to reduce Gram negative Bacteraemias in line with the national target of 50% reduction by 2021.

## 19.0 Conclusion

The actions put in place to reduce the incidence of Health care associated infection on the whole have been effective in 2016/17. However, the cross infection of clostridium difficile has led to a review of systems and processes, both internally, but also improved communication with our partners.

Going forward the focus on collaborative working will be essential, as the reduction in UTI and CAUTI's continues to be a focus, and as many of our partners jointly care for patients with invasive devices, the best way to make an impact is to dovetail our approach to care.

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 3.2 |
| **Subject:** | Seasonal Infection Prevention and Control Report – Summer |
| **Presenting Officer:** | Ali Strowman, Chief Nurse /Director of Infection Prevention and Control |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☐ | Assurance | **x** |

**Report Summary (including purpose and context):**

This paper provides a summary of infection prevention and control activity between April 1 and May 31 2017

- The 2017/18 Clostridium difficile target is no more than 5 cases, with no level 3 lapses in care. There were 1 attributable *Clostridium difficile* infections in April in Tonbridge rehabilitation unit, deemed unavoidable and no level 3 lapse in care. Actions following the Cross infection of Clostridium difficile infection have been implemented across the organisation

- There was an MRSA bacteraemia case in April where KCHFT staff provided care, but the case was assigned to EKHUFT

- KCHFT have commenced E-coli bacteraemia surveillance in order to gain baseline information to focus IPC programmes and actions in order to participate in the nationwide target to reduce these infections by 10% by the end of the year

- Trust Compliance with hand hygiene training was reported as 89%, and mandatory training 94% in May. Compliance amongst clinical staff was 86.6% for hand hygiene, and 93.5% for mandatory training

- The Trust have set a target to reduce CAUTI's by 15% and UTI's by 10% in this year – currently we are on trajectory to achieve this

- There have been 3 outbreaks in this time, 2 Diarrhoea and vomiting, and one confirmed Influenza B, all well contained and controlled. The Sevenoaks Hydrotherapy pool closed for a week due to erroneous microbiological results

- The Water Safety Committee continues to meet to ensure there are planned actions to evidence compliance with Water safety legislation

- The Antimicrobial Stewardship committee continues to meet, and will be implementing some of the Clostridium difficile reduction actions through the committee. Currently focus remains upon collaborative working across Kent through CCG lead Antimicrobial stewardship groups

- The SEPSIS algorithms and prompt cards have been launched and implemented, and have been well evaluated.

| **Proposals and /or Recommendations:** |
|---|
| For assurance only. |

| **Relevant Legislation and Source Documents:** |
|---|
| **Has an Equality Analysis been completed?** |
| No. High level position described and no decisions required. |

| | |
|---|---|
| Lisa White | Tel: 01233667914 |
| Assistant Director of Infection Prevention and Control | Email: lisa.white1@nhs.net |

# SEASONAL INFECTION PREVENTION AND CONTROL REPORT – SUMMER



## 1. Introduction

The content of this report was presented and discussed at the Quality Committee on 4 July 2017.

## 2. *Clostridium difficile*

Target: The national objective has remained unchanged in 2017/18; therefore the Trust must be attributed no more than 5 cases of *Clostridium difficile* infections with no level 3 lapses in care. One case in Tonbridge rehabilitation unit in April was deemed unavoidable, but lessons were learned in relation to prescribing of loperamide.

***Clostridium difficile* cross infection – Update on lessons and actions.**

Following the cross infection of *Clostridium difficile* in Feb 2017, many actions have been implemented including revision of policies and protocols, and review of both domestic and clinical staff cleaning processes and training.

## 3. MRSA

There was an MRSA bacteraemia case in April where KCHFT staff provided care, but the case was assigned to EKHUFT. Compliance to MRSA screening in inpatient units and Podiatric surgery was 100% in this timeframe.

## 4. E-coli bacteraemias

KCHFT have commenced E-coli bacteraemia surveillance in order to gain baseline information to focus IPC programmes and actions in order to participate in the nationwide target to reduce these infections by 10% by the end of the year. In April there were 116 E-Coli bacteraemias in Kent, 25 of which had input from KCHFT staff, and in May there were 127 E-coli bacteraemias in Kent, 29 of which had care from KCHFT. A Kentwide review of all cases will be undertaken at the end of quarter 1 to guide the actions going forward.

## 5. Training

In April 2017 Trust Compliance with hand hygiene training was 89%, and mandatory training 93.5%. Compliance amongst clinical staff has remained on target at 87.2% for hand hygiene, and 92.7% for mandatory training.

## 6. UTI's and CAUTI's

The target for 2017/2018 is to reduce CAUTI's by 15% and UTI's by 10%, in hospitals – translating to no more than 102 UTI's and 12 CAUTI's. Currently the Trust are on trajectory to achieve this.

## 7. Incidents and Outbreaks

There have been 3 outbreaks in this time, 2 Diarrhoea and vomiting, and one confirmed Influenza B, all well contained and controlled. The Sevenoaks Hydrotherapy pool closed for a week due to erroneous microbiological results, full investigation was completed, and 2 clear results received prior to re-opening

## 8. Water safety

The Water Safety Committee continues to meet to discuss the assurances required, revise polices and protocols and identify gaps and actions where necessary. Minutes and actions are reported through the Infection prevention and control committee, and the water quality and safety action plan is encompassed in the organisational Estates plan.

## 9. Antimicrobial Stewardship

The Antimicrobial Stewardship committee continues to meet, and will be implementing some of the Clostridium difficile reduction actions through the committee. Currently focus remains upon collaborative working across Kent through CCG lead Antimicrobial stewardship groups, and achievement of the antibiotic prescribing CQUIN.

## 10. SEPSIS

The SEPSIS algorithms and prompt cards have disseminated and are being implemented. Feedback so far has been excellent, and evidence already that patients have been correctly identified as having sepsis, have been recognised quickly, and transferred for immediate treatment, with positive outcomes.

**Lisa White**
**Assistant Director of Infection Prevention and Control**
**14 July 2017**

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 3.3 |
| **Subject:** | Equality and Diversity Annual Report 2016/17 |
| **Presenting Officer:** | Louise Norris, Director of Workforce, Organisational Development and Communications |

| | | | | |
|---|---|---|---|---|
| **Action - this paper is for:** | Decision | ☒ | Assurance | ☐ |

**Report Summary (including purpose and context)**

The Equality and Diversity Annual Report sets out how the Trust is meeting its public sector duties in relation to the Equality Act 2010, and our specific duties in relation to setting equality objectives and achieving these objectives. The Trust's equality objectives are set in line with the EDS2 Framework which is a mandatory framework for NHS organisations to assess how they are promoting equality through improving patient experience and public engagement, reducing health inequalities, developing a diverse workforce and providing strategic direction to reduce discrimination for patients, their families and staff.

The report also sets out the Trust's proposed equality objectives for 2017/18. These have been developed in consultation with the Trust's Patient Experience, Engagement and Equality Committee.

**Proposals and /or Recommendations**

The Board is asked to note the report and approve the equality objectives for 2017/18.

**Relevant Legislation and Source Documents**

Equality Delivery System (EDS) 2
Equality Act 2010
Workforce Race Equality Standard (WRES)
KCHFT Equality and Diversity Statement

**Has an Equality Analysis (EA) been completed?**

No. This is an annual report on activity and outcomes related to equality and diversity. All actions undertaken and proposed actions are in line with the NHS Equality Delivery System (EDS) 2 and are undertaken in order for the Trust to meet its public sector duties and specific duties under the Equality Act 2010.


| | |
|---|---|
| Karen Edmunds | **Tel**: 01233 667816 |
| Head of Engagement | **Email**: karenedmunds@nhs.net |

Kent Community Health
NHS Foundation Trust

# Equality and Diversity Annual Report 2016/17


MINDFUL EMPLOYER
10th Anniversary
2004 - 2014

## Introduction

At Kent Community Health NHS Foundation Trust (KCHFT) we believe that equality and diversity are essential to good quality patient care. Our patients have different needs, beliefs and characteristics and we must understand this. And we do. We put our beliefs into action, which is why the Board and I value the diversity of our workforce and our commitment to that diversity.

We all have our part to play in making sure there is fair access to healthcare for all, but it is not something we do alone – listening to people about their needs and how we can deliver what they need often means working in partnership with others. It also means listening to our colleagues who find themselves at the sharp end at work and sometimes, also at home – as a carer for example.

So much hard works goes on every day promoting equality and diversity, it is impossible to mention everything that is happening, but I just wanted to talk about two highlights of the past year.

From May to July 2016 we worked with colleagues from West Kent CCG and Edenbridge Medical Practice to listen to the people of Edenbridge about what health services they want in the town. We made particular efforts to get the views of young people, parents of young children and older people, all of whom may find it harder to get their voices heard. This listening exercise was well received by the community and laid the foundations for a very successful formal public consultation this spring on options for a new combined GP and community health centre.

In October 2016, I attended the Staff Networks' conference on the theme of 'Recruiting and Retaining a Diverse Workforce'. I was inspired by the stories of our staff from a range of backgrounds and proud to hear that they feel KCHFT is a great place to work. Their ideas for recruiting and retaining a diverse workforce are now being implemented through an action plan. One particular theme from the conference was the value of mentoring, which Rabi Atiti, Business Development Manager, for our Learning Disability Service spoke about passionately and whom I now mentor. We are working hard to help make KCHFT a place where mentoring is encouraged and supported.

Our patient satisfaction surveys show that more than 99 per cent of people feel they have been treated fairly by the trust when using our services. That is fantastic and all credit to our great teams.

I hope you enjoy reading the annual report.

Best wishes

Paul Bentley
**Chief Executive**

## 2.0 KCHFT Equality and Diversity Statement

### 2.1 Introduction

The trust believes that promoting equality and valuing diversity is essential to achieving its mission to provide excellent healthcare and to promote a healthy community. We recognise that we provide services to an increasingly multi-cultural and diverse community and we are committed to ensure that:

- we treat all individuals fairly
- we treat people dignity and respect
- the healthcare we provide is open to all
- we provide a safe, supportive and welcoming environment for patients, patients' families and staff.

### 2.2 Our commitment

In particular we will:

- make sure our services and the information we provide is accessible to disabled people, so they can get the services they need and be involved in decisions
- make sure our services are culturally sensitive and responsive to meet the diverse needs of our patients, families and staff, so they feel welcomed and supported
- assess the needs and impact on lesbian, gay, bisexual and transgender people when producing policies and strategies and developing our health services, so we don't disadvantage people using our services or working for us
- respect and be sensitive to our patients' and families' religious and spiritual beliefs in delivering healthcare, so their spiritual needs are met
- be aware of the differing needs of our male and female patients and develop responsive services that meet those needs appropriately
- promote age equality so our policies, practices and attitudes of our staff are not discriminating against patients based upon their age
- make sure our staff are aware that health inequalities disproportionately affect people living in more deprived communities and that other factors such as poverty, mental health, homelessness and language barriers will affect people's access to services. This will help reduce the barriers to people using our services.
- Challenge discriminatory behaviour towards our patients, their families and our staff.

### 2.3 Our Public Sector Equality Duty

As an NHS trust, we are subject to both the general public sector duty set out in the Equality Act 2010 and the specific duties which came into law on the 10 September 2011 in England. In summary, this means that when delivering our services we must:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not.

Advancing equality involves:

- removing or minimising disadvantages experienced by people due to their protected characteristics
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low
- taking steps to take account of disabled people's impairments and access requirements to meet different needs

Fostering good relations includes:

- tackling prejudice and promoting understanding between people from different groups

**2.4 Protected characteristics**
Compliance with our public sector duty may involve treating some people more favourably than others. The duty covers people with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex (gender)
- Sexual orientation.

As an NHS employer we also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status.

**2.5 The Equality Delivery System 2 (EDS2) and Equality Analysis (EA)**
To help the Trust to meet its public sector duty we use the Equality Delivery System 2 and Equality Analysis to ensure that equality considerations are reflected in the design of policies and the delivery of services and for these issues to be kept under review. The Trust's Patient Experience and Equality Committee monitors the Trust's implementation of EDS2 and the process for carrying out EAs.

The Board is responsible for agreeing the Trust's Equality and Diversity Statement and annual equality objectives. The full version of our Equality and Diversity statement can be found on our website www.kentcht.nhs.uk/about-us/equality-diversity/ or on request from the Engagement Team: kchft.equality@nhs.net or 01233 667812.

### 3.0 Equality Delivery System 2 2016/17 and KCHFT's Equality Objectives

The Trust had four equality objectives in 2016/17 that had been developed by assessing our performance against the Equality Delivery System (EDS) 2 Goals.

- **Goal 1: Better health outcomes:** Objective: to work with other NHS organisations, the voluntary sector and local authority to engage with young people to promote health improvement and reduce health inequalities. This includes working with young people who are from black and minority ethnic communities, disabled, LGBTQ and young carers.
- **Goal 2: Improved patient access and experience:** Objective: using co-design principles to work with our patients and their families, our staff, other NHS organisations and the voluntary sector to improve access to services and patient and family experience of health care.
- **Goal 3: A representative and supported workforce:** Objective: to support our staff to recruit and manage a diverse workforce and to create a workplace where our staff feel they are able to be themselves (continued from 2015/16)
- **Goal 4: Leadership:** Objective: to ensure that equality and diversity is embedded in the business of KCHFT (continued from 2015/16).

We made progress on all these objectives and some examples of this are included in sections 4 and 5 of this report. The objectives related to workforce and leadership are longer term and therefore these will be continued in the coming year.

### 4.0 Summary of key achievements

This year has been a busy one for the Trust in terms of Equality and Diversity matters. It simply isn't possible to highlight all of the equality and diversity work that the Trust has been involved in this year, so we take this opportunity to present the following examples.

### 4.1 Accessible Information Standard (AIS)

The Trust has carried out a large amount of work to meet the requirements of the Accessible Information Standard (AIS), which came into force in July 2016. The AIS aims to make sure patients, and where applicable their carers and parents who have a disability, impairment or sensory loss, get information in accessible formats they can understand and receive the communication support they need. All health and social providers are expected to identify, record, flag, share and meet the needs on request. We have developed material and information to support staff including an AIS staff handbook, a pack for managers, new leaflet/letter templates and have held staff drop-in sessions. Our Community Information System (CIS) has been updated to enable electronic patient records to record the communication need and stickers to use on paper patient records such as referral forms. A new policy and e-learning course is available for staff and in-house training, where appropriate, and induction provides an overview of the AIS. Our public website provides a Browsealoud tool to offer reading and translation support and a glossary to explain difficult or long words including a patient survey. We are also in the process of installing hearing loops across many of our sites.

### 4.2 Young people

The Trust has led on setting up a Kent and Medway NHS Youth Forum. This includes co-ordinating a steering group of partners, surveying young people about what type of involvement they want and attending both district and county youth councils to get young people's views. A total of 187 young people completed a survey and most would like a virtual forum / discussion space and face-to-face meetings. They want to feel their involvement makes a difference and get recognised for their contribution. Their views will shape how we take this work forward during the next year.

### 4.3 Migrant communities

The Trust co-ordinates the Kent Migrant Communities Network. The virtual network enables professionals to share good practice and post queries. It has 260 members and is overseen by a multi-disciplinary steering group, chaired by KCHFT. This work has strengthened partnership working and has led to a joint project on migrant health being developed with Public Health for which funding is currently being sought.

### 4.4 Carers

The Trust has engaged with carers and families of our patients to develop a 'Relatives and Carers Promise' for our community hospitals. This is a commitment to working with relatives, carers and friends to make sure we deliver personal, effective care that always put the individual at the heart of their care plan. Some of the ways we will do this will be by keeping relatives and carers involved, making visiting times as convenient as possible and showing them exercises we are doing with their relative or friend so they can help with them if they want to.

## 5.0 Workforce Race Equality Standard (WRES)

In addition to our four equality objectives, the Trust has reviewed how we are doing against the requirements of the Workforce Race Equality Standard (WRES) and identified a series of actions related to recruitment, retention and support of Black and Minority Ethnic (BME) staff. This action plan was developed with the involvement of our BME Staff Network, whose lived experience and ideas have been invaluable. A copy of the updated 2016/17 WRES report and 2017/18 WRES Action Plan is available on our public website: www.kentcht.nhs.uk/about-us/equality-diversity/workforce-equality-monitoring/ or available by contacting the Engagement Team. Please see section 9 of the report for full contact details.

## 6.0 Staff networks

The Trust is proud to support three staff networks. They provide safe spaces for people that share protected characteristics to discuss experiences. They also serve to provide information sharing opportunities and the ability to influence policy and strategy. This ensures that people with those protected characteristics are achieving equality and not being disadvantaged in the Trust. While the networks exist to support the workforce, they also provide benefits to the Trust, as we are able to consult and involve staff and gain insight into the experiences of people with these characteristics.

The three staff networks work together to improve the working environment for all staff. In October 2016, they held their first joint event for some years. The theme was 'Cultivation: Recruiting and Retaining a Diverse Workforce'. Fifty colleagues attended from all levels of the organisation and heard inspirational stories of how people's lived experience brings richness to the work of the NHS and our partners. A diverse workforce has a direct impact on improving patient experience.

### 6.1 Black and Minority Ethnic (BME) Staff Network

During the past year, the BME Staff Network was chaired by Pramod Selkar, with support from Vice-Chair Habiba Rawoof and Secretary Shola Oso. Membership has grown and all the quarterly meetings have gone ahead as planned. The network held a successful event in October 2016 attended by more than 100 staff to celebrate Black History Month. There was food from different cultures, information and networking. The network feeds in to the Trust's Workforce Equality Group. This has supported the Trust to develop a clear action plan in relation to the Workforce Race Equality Standard (WRES). In particular, the need to look at how the Trust recruits and retains BME staff. The BME network will continue to work with the Trust to improve cultural awareness and promote the value of diversity in the workplace.

Pramod Selkar (Chair)

### 6.2 Disability Staff Network

During the past year, along with offering support for disabled colleagues as required, the Disability Staff Network has been working closely with the other two Trust networks, BME and LGBTQ, collaborating to deliver a successful conference and workshop on the theme of Cultivation: Recruiting and Retaining a Diverse Workforce. An action plan of deliverable measures was developed from the conference, and the networks have been working alongside stakeholders within the Trust to deliver on those actions. As part of this work, a specific action for the Disability Network was to draft a guidance document, working with Employee Relations, about reasonable adjustments in the workplace. This guidance is in the final stages of development and will be available to managers and staff in the coming months.

Catey Bowles (Chair)

### 6.3 Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Staff Network

The LGBTQ staff network has felt the benefits of collaborating with the other two staff networks, BME and Disability some of which includes finding common ground and a common voice on issues such as identifying and addressing unconscious bias. We are extremely proud of our contribution to the joint staff network conference in October *2016 Cultivation: Recruiting and retaining a diverse and fair-minded workforce* and delighted to have received positive feedback from across the organisation as well as from external partners about how stimulating and dynamic the event was. We decided to make this an annual event and we have secured a budget from the organisation to develop this.

The LGBTQ staff network have successfully built our network from three members last year to 10 currently and are all the richer for it as demonstrated by our diversity of blogs throughout LGBT History month in February 2017 and our very well attended soiree / quiz night fundraiser for i care, our Trust's charity.

We look forward to the next year where we continue to strive to align our work to trust business, continue to promote the many aspect of the network and develop mentoring and CPD opportunities in to the work of the network.

Fiona Thomson (Chair)

## 7.0 Patient Experience

The Trust collects patient experience data in 'real time'. In 2016/17 we collected 70,035 surveys (including the short NHS Friends and Family Test survey) with an overall satisfaction score of 96.8 per cent. The equality and diversity scores throughout the surveys are among the highest, in what is generally a high scoring Trust for patient satisfaction and experience.

### 7.1 Overall patient satisfaction


### Survey questions and competencies

The software we use enables the Trust to track satisfaction scores on questions linked to 'competencies' or indicators and then run reports on these competencies.

The equality and diversity competency is based on the question:

Do you feel that you have been treated fairly when using our services?
Yes / No / Prefer not to say
If No, is this because of your: Age, sex, disability status, race/ethnicity, religion/belief, sexual orientation (being straight, lesbian, gay or bisexual (in surveys for over 13-year-olds), gender reassignment, other (please state), no, prefer not to say.
Users are asked to tick as many as apply and explain why.

The equality and diversity score was consistently high across all localities. The following table shows overall results for the Trust in 2016/17:

| Locality | No. of surveys | Equality and Diversity score |
|---|---|---|
| Ashford | 2,602 | 99.51% |
| Canterbury and Coastal | 7,021 | 99.53% |
| Dartford, Gravesham and Swanley | 5,081 | 99.90% |
| Dover, Deal and Shepway | 4,384 | 99.42% |
| East Sussex | 2,210 | 99.66% |
| West Kent | 7,778 | 99.43% |
| Medway | 1,324 | 99.22% |

| Locality | No. of surveys | Equality and Diversity score |
|---|---|---|
| Other (London, Prisons and Looked After Children) | 2,167 | 96.12% |
| Swale | 1,901 | 99.78% |
| Thanet | 4,014 | 99.36% |
| Transferred to Virgin Care | 627 | 98.35% |
| **Trust Total** | **39,109** | **99.32%** |

There were a few comments related to people who said they felt they were not treated fairly:

- **Children's Continuing Care – Thanet:** 'Sometimes. I don't feel children with long term profound conditions are seen as public priority or as 'sexy' as say children with cancer.'
- **Lymphoedema Service – West Kent:** 'More centres for Lymphoedema management are needed across the West Kent area, Central Kent as opposed to the border with Sussex.'

Any negative comments made in the surveys are flagged up to the services concerned in case staff can take action to make an improvement, whenever possible, as a result of their patient feedback.

### 7.2 NHS Friends and Family Test (FFT) information

**How likely are you to recommend this service to friends and family if they needed similar care or treatment?**

66,083 patient surveys have been completed from 1.4.16 to 31.3.17 with the following responses to this question.

| | Recommend | Not Recommend | Total Responses | Extremely Likely | Likely | Neither Likely or Unlikely | Unlikely | Extremely Unlikely | Don't Know |
|---|---|---|---|---|---|---|---|---|---|
| Trust | 97.52% | 0.53% | 66,083 | 53,663 | 10,779 | 818 | 185 | 165 | 473 |

The recommend score has increased from 97.11% in 2015/16.

**8.0 Equality Objectives 2017/18**
The Trust has four main objectives for the current year. The actions under each of these were developed with the involvement of our Patient Experience, Engagement and Equality Committee.

**Goal 1 Better health outcomes:**
Objective 1: To work with other NHS organisations, the voluntary sector and local authority to engage with young people and migrant communities to promote health improvement and reduce health inequalities. This includes working with young people who are from black and minority ethnic communities, disabled, LGBTQ and young carers.

Actions:

- Hold the first meeting of the Kent and Medway NHS Youth Forum, which KCHFT leads on
- Work with KCC Public Health to bid for funding for targeted health interventions with migrant communities and cultural awareness training for staff working with those communities.

**Goal 2 Improved patient access and experience:**
Objective 2: Using co-design principles to work with our patients and their families, our staff, other NHS organisations and the voluntary sector to improve access to services and patient and family experience of health care.

Actions:

- Engage with disabled people and disability organisations to get feedback on their experience of having their communication needs met by the NHS.
- Set up a network of engagement champions in Children and Young People's services and provide them with access to training and on-going support.

**Goal 3 A representative and supported workforce:**
Objective 3: To recruit and manage a diverse workforce and to create a workplace where our staff feel they are able to be themselves

Actions:

- Review KCHFT policy and procedure against the requirements of the Workforce Disability Equality Standard, which is due to come into force in April 2018.
- Develop an action plan related to the NHS Pledge supporting the employment of more people with learning disabilities in the NHS.
- Agree a Transitioning at Work Policy to support transgender staff.

**Goal 4 Leadership:**
Objective 4: To ensure that equality and diversity is embedded in the business of KCHFT.

Actions:

- Equality and Diversity Theme / Speaker at Senior Manager's conference in 2017/18
- Chief Executive to sign the NHS Employers / NHS England Pledge supporting the employment of more people with learning disabilities in the NHS www.nhsemployers.org/your-workforce/plan/building-a-diverse-workforce/need-to-know/creating-a-diverse-workforce-learning-disability/pledge-functionality

## 9.0 Talk to us

If you have any comments or feedback on this report or would like to get involved by becoming a Foundation Trust member or join our Patient Engagement Network please contact KCHFT's Engagement Team using the contact details below:

**Membership:** kcht.membership@nhs.net

**Patient Engagement Network:** kchft.involveme@nhs.net

**Equality – feedback on this report or if you would like this report in large print, audio, Braille or Easy Read:** kchft.equality@nhs.net

**Engagement Team**
Kent Community Health NHS Foundation Trust
Trinity House
110-120 Upper Pemberton
Ashford
Kent TN25 4AZ

Tel: 01233 667810

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting – Part 1 (Public) |
| **Date of Meeting:** | 27 July 2017 |
| **Agenda Item:** | 3.4 |
| **Subject:** | Medical Appraisal and Revalidation Annual Report |
| **Presenting Officer:** | Dr Sarah Phillips, Medical Director |

| **Board Action - this paper is for:** | Decision | | Assurance | **X** |
|---|---|---|---|---|

| **Report Summary (including purpose and context):** |
|---|
| The purpose of this paper is to provide assurance to the Board regarding the policies and systems in place within Kent Community Health NHS Foundation Trust (KCHFT) to meet the requirements of medical appraisal, revalidation and licensing. NHS England requires a report on Medical Appraisal and Revalidation to be presented to the Board annually. |

| **Proposals and / or Recommendations to the Board:** |
|---|
| To note the report as required by NHS England. Following this, the Chief Executive is asked to sign the accompanying 'Statement of Compliance', which should be returned to the Responsible Officer Dr Sarah Phillips for submission to NHS England before the end of September 2017. |

| **Relative Legislation and Source Documents:** |
|---|
| The Medical Profession (Responsible Officers) Regulations 2010<br>The Medical Profession (Responsible Officers) (Amendment) Regulations 2013<br>General Medical Council (GMC) documents – 'The Good Medical Practice framework for appraisal and revalidation 2012' and 'Supporting Information for appraisal and revalidation'<br>KCHFT Policies are based on recommendations from the NHS Revalidation Support Team and NHS England's Medical Appraisal Guide. |

| **Has an Equality Analysis been completed?** |
|---|
| Yes. Although this report is just for noting, an Equality Analysis has been completed on the five Trust policies relating to this report. |

| **For further information or enquiries relating to this report please contact:** | |
|---|---|
| Dr Emma Fox, Lead Appraiser, Clinical Lead for Sexual Health, Consultant in Genitourinary/HIV Medicine | Tel: 075544 37340<br>email:emma.fox2@nhs.net |

Kent Community Health
NHS Foundation Trust

# MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT FOR APPRAISAL YEAR 2016/2017

## SITUATION

Doctors must be registered with a licence to practise with the General Medical Council (GMC) to practise medicine in the UK. Medical revalidation was introduced in December 2012 and is the process by which the GMC confirms the continuation of a doctor's licence to practise in the UK. Its purpose is to give assurance that licensed doctors are up to date and fit to practice and it aims to improve the quality of care provided to patients, improve patient safety and increase public trust and confidence in the medical system.

The purpose of this paper is to provide assurance to the board regarding the policies and systems in place within Kent Community Health NHS Foundation Trust (KCHFT) to meet these requirements. An annual board report is mandated by NHS England. Following presentation of this board report we request that the Chief Executive signs the attached 'Statement of Compliance' for the responsible officer to forward to NHS England.

## BACKGROUND

Provider organisations have a statutory duty to support their responsible officers in discharging their duties under the Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

The key roles are the responsible officer (RO) and the lead appraiser. Both roles are set out in detail in KCHFT's policies. The medical director is the responsible officer and is accountable for the quality assurance of the revalidation appraisal and governance processes, making recommendations to the GMC regarding a doctor's revalidation. The board should note that following the departure of the previous medical director and appointment of a new medical director, KCHFT's RO changed in June 2017. The lead appraiser is responsible for the appraisal processes across the trust, ensuring that it reflects best current practice and meets all legislative requirements, working with KCHFT medical appraisers to ensure the appraisals are of a high quality. The current lead appraiser commenced the role on 1 April 2013 and comes to the end of her tenure in July 2017. We are in the process of recruiting a new lead appraiser and a band 4 appraisal administrator.

The Trust has the following policies in support of the revalidation system.

- Medical Appraisal Policy KCHFT HR043 – ratified February 2014 and amended with the addition of KCHFT's Procedure for Managing non-participation in Appraisal.
- Medical Revalidation Policy KCHFT HR042 – ratified February 2014
- Medical Revalidation – Supporting Doctors in Difficulty Policy KCHFT HR044 –ratified February 2014.
- Job Planning for Consultants policy KCHFT HR046 – ratified July 2014
- Job Planning for SAS Doctors KCHFT HR048 – ratified October 2015

All five policies have had an equality impact assessment which has provided assurance that inequality/equality issues have been considered and addressed. Both the Medical Appraisal and Medical Revalidation Policies have expired. An extension has been requested pending review by the end of 2017, once administrative support has been given for the lead appraiser and the new RO has undergone recognised responsible officer training.

**ASSESSMENT**

**1. Appraisers**

At the start of 2016/17, KCHFT had nine active trained appraisers. One left during the year but three new experienced appraisers joined KCHFT, so it is the lead appraiser's opinion that there are sufficient trained medical appraisers within the organisation.

The lead appraiser attends NHS England's regional responsible officer and appraisal leads network meetings to keep up to date. She is responsible for ensuring that the appraisers have appropriate training, support and supervision. She has run two appraiser updates during the last appraisal year, including an appraiser's refresher course delivered by MIAD.

**2. Appraisal and Revalidation Performance Data**

There were 42 doctors with a prescribed connection to KCHFT at the end of the appraisal year 2016/17. Forty of these doctors had a completed appraisal during the appraisal year (95%). This compares with 89% in 2012/13, 74% in 2013/14 and 97% in 2014/15 and 98% in 2015/16. One doctor did not have an appraisal meeting and this is currently being addressed through trust disciplinary processes. The other doctor complied with the appraisal but his appraiser did not complete his appraisal paperwork until after the end of the appraisal year.

There were 42 general practitioners (GPs) working for KCHFT who do not have a prescribed connection to KCHFT. Although in the past assurance has been obtained from these doctors' designate body that there are no concerns over their performance, following publication of NHS England's document *'Information flows to support medical governance and responsible officer statutory function',* it has become clear that it is not the role of the designate body to provide this assurance routinely, and communication should only take place if there is a significant concern about a doctor. We do not specifically have confirmation that these doctors are participating in appraisal within their designate body.

The lead appraiser carries out an audit of all incomplete of missed appraisals within KCHFT ( Appendix A; Audit of all missed or incomplete appraisals).

**3. Quality Assurance**

The quality assurance processes are as follows:

For the appraisal portfolio:

- The RO reviews appraisal outputs as they are received to provide assurance that the PDP, summary and sign offs are complete and to an appropriate standard

- The RO reviews appraisal outputs to provide assurance that complaints or other key items identified pre-appraisal as needing discussion during the appraisal are included in the appraisal outputs
- The lead appraiser assess the quality of a proportion of the appraisal outputs (two per appraiser) using the PROGRESS tool (Appendix B). For the first time this year, a proportion of appraisal outputs were also reviewed externally (Appendix C).

For the individual appraiser:
- Each appraiser is asked to complete a form recording their reflection on appropriate continuing professional development. The response to this is generally poor.
- An annual record of the appraiser's attendance at appraisal workshops is kept. We expect attendance at a minimum of at least one workshop annually.
- Feedback from doctors on their appraisal – each doctor is asked to complete feedback after their appraisal has taken place. The lead appraiser views each response immediately to pick any serious concerns needing immediate action (there have been none). They are assessed in detail annually and fed back to the RO and each appraiser (Appendix D).

For the organisation:
- There is an annual audit of timelines of the process of appraisals
- There is an annual review of lessons learned from any significant events. This year there have not been any 'never events' or SUI involving doctors.

**4. Access, security and confidentiality**

The lead appraiser and RO keep information from appraisals electronically in a secure site that can only be accessed by the RO, the RO's personal assistant and the lead appraiser. The Lead Appraiser has written *'KCHFT's Medical Appraisal Documentation Access Statement'* which details what should happen with appraisal information within KCHFT, adapted from NHS England's 2016 document *'Information flows to support medical governance and responsible officer statutory function'*.

**5. Revalidation Recommendations to the GMC 2016/2017**

During the year the RO made one revalidation recommendation. This recommendation was on time and was a request for deferral. There were no non engagement notifications. The deferral was for a doctor who had returned to the UK after several years working abroad and hence could not fulfil the requirements for revalidation. It should be noted that a deferral is considered a neutral act (Appendix E).

Doctors due to revalidate are now discussed in a multidisciplinary monthly revalidation meeting chaired by the responsible officer, with an employee liaison /human resources representative, a lay member and the lead appraiser. The lay member has been in the role for over a year to improve public and patient involvement in appraisal and revalidation processes.

**6. NHS England Appraisal Reporting**

KCHFT is required to submit quarterly data on medical appraisals to NHS England and to take part in NHS England's Annual Organisational Audit. This is based on current RO Regulations and associated guidance and criteria suggested by the GMC. The KCHFT's AOA report for 2016/17 is attached in Appendix F. In this audit we were able to respond positively to all questions except;

1. Question 1.6 - *In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.* This will be resolved by the appointment of an appraisal administrator and introduction of an appraisal and revalidation software package.
2. Question 3.2 - *The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's*

*board (or an equivalent governance or executive group).* KCHFT does not have a responding to concerns policy but on further review we feel that our current policies 'Supporting Doctors in Difficulty' and 'Maintaining High Professional Standards' cover all these areas.

In May 2015 KCHFT's appraisal and revalidation processes were subject to an Independent Verification visit from NHS England. We received a rating of 'good' or 4/6 on the 'ICE Maturity Continuum', which confirms that we meet most core standards and are quality assured in all areas. This was presented in last year's report.

**7. Recruitment and engagement background checks**

The references of all substantive medical staff are checked by the RO prior to an offer of a substantive post. Where there are concerns, or the reference is anodyne, the RO communicates directly with the doctor's previous RO using NHSE's Medical Practice Information Transfer (MPIT) form. All new doctors undergo checks on their identity, qualifications, DBS, GMC licence and any undertakings.

In April 2013, new regulations came into force requiring ROs to assure themselves that the doctors they are responsible for have the appropriate level of language competency to enable them to practise safely. The Lead Appraiser produced a document entitled 'Procedure for testing English language competency for medical staff in KCHFT' in May 2014 to ensure that the RO fulfils their statutory duties around this. This procedure is designed to meet these regulations.
Previously employment of locum doctors was devolved to individual services within KCHFT. From the start of this appraisal year the staff bank took over this function. However we still have limited data so that the annual audit of recruitment and engagement background checks for locums is incomplete (Appendix F).

**Monitoring Performance**

The RO is sent information on all complaints, DATIX reports, SUI and 'never events' naming doctors. Serious concerns over a doctor's performance are escalated by the lead consultant or head of service to the RO. There are now two ratified job planning policies which set out the process for monitoring consultants' and SAS doctors' performance. Any relevant Royal College or governance reviews, Care Quality Commission reports are fed back to individual doctors. The responsible officer identifies any issues arising from this information and ensures that the designated body takes steps to address such issues. Advice is taken from GMC employer liaison advisers, the National Clinical Assessment Service (NCAS), local expert resources, specialty and Royal College advisers where appropriate.

**8. Responding to Concerns and Remediation**

KCHFT has two polices relevant to this and both are currently under review:

- Medical Revalidation – Supporting Doctors in Difficulty Policy KCHFT HR044 – ratified February 2014
- People Management - Maintaining High Professional Standards(MHPS) KCHFT HR027 – ratified May 2014

In the past year, advice has been sought from NCAS about one doctor. This was regarding failure to have an appraisal and this is currently being investigated as part of a disciplinary process. There have been no NCAS assessments.

**9. Risk and Issues**

These are:

1. Although doctors understand the need to complete a personal development plan (PDP) set at their medical appraisal, and appraisers report on this in the appraisal output, we do not

have assurance that this is done consistently. MIAD have now delivered appraiser refresher training which included work to ensure PDPs set at appraisal are 'SMART'. We planned to audit progress against PDPs by doctors from appraisal year 2016/17.

2. The appraisal and revalidation policies are now out of date. Due to lack of any administrative support for medical appraisal and revalidation, the lead appraiser has not had time to update these policies.
3. NHSE published *'Information flows to support medical governance and responsible officer statutory function'* in August 2016. This has highlighted that over the past year we do not have sufficient assurance that our non-designate doctors (mainly GPs) are compliant with appraisal and revalidation requirements or that there are good communication channels between responsible officers of other designate bodies.
4. GPs are required to have a 'mini appraisal' or some structured reference from all their employers/areas of professional practice. Despite structured documents to support this being available since the start of revalidation in 2012, only a few GPs have requested any information from us about the work they do for KCHFT.
5. We do not have assurance around employment and performance of locum doctors within KCHFT, as evidenced by incomplete information in Appendix G.

## 10. Corrective Actions, Improvement Plan and Next Steps

1. Support for appraisal and revalidation has been recently considered by the executive team. It has been agreed that additional support is needed in the form of a new Band 4 administrative assistant and a software package to manage appraisal and revalidation process for doctors, their appraisers and the responsible officer. This will give the lead appraiser time to update trust policies and to concentrate on the core role of a lead appraiser.
2. The new RO now in post is reviewing processes around appraisal, revalidation, the RO role in Maintaining High Professional Standards (MHPS) and how departments work together. This is ongoing and will report to the executive team in the first instance
3. Now that appraisal year 2016/17 is complete, we will audit progress against PDPs by KCHFTs doctors from this year.
4. The lead appraiser has written *'KCHFT's Medical Appraisal Documentation Access Statement'* which details what happens with appraisal information within KCHFT. The lead appraiser has also produced a series of standard letters for communication between ROs. Once the appraisal administrator is in post, these letters can be used and this will provide the RO with assurance that there are no concerns about the work of KCHFTs non-designate doctors outside KCHFT. The service level agreements / contracts of non-designate doctors will be amended to ensure that these doctors present their appraisal outputs to KCHFTs RO in future as part of this assurance.
5. Further work needs to be done to find out why so few GPs have requested a 'mini-appraisal' or structured reference from KCHFT to take to their main appraisal. It should be noted that it is the GPs responsibility to seek this information. A review of the current forms and process will be undertaken.
6. The staff bank has now taken over recruitment of locums. Locums are only employed through framework agencies, where there is greater assurance that the correct checks have been carried out. A review of how we work with HR is underway, and work will be done with the bank to ensure that the RO has greater assurance and information on locums working within KCHFT.

## RECOMMENDATIONS

The Board is asked to accept this annual report, noting that it will be shared, along with the annual audit, with the higher level responsible officer and to consider any needs/resources required.

We ask the Board to approve the ‘Statement of Compliance’ confirming that the organisation, as a designated body, is in compliance with the relevant regulations. Following this we ask the Chairman to sign the attached ‘KCHFT’s Statement of Compliance Medical Appraisal Revalidation’ and return this to Dr Sarah Phillips to forward to NHS England.

**Dr Emma Fox**
**Lead Appraiser KCHFT / Lead Consultant Sexual Health**
**July 2017**

**APPENDICES**

| | | |
|---|---|---|
| **Appendix A** | Audit of all missed or incomplete appraisals | Appendix A - Audit of missed appraisals.( |
| **Appendix B** | Audit of quality of appraisal outputs | Appendix B - ANONYMOUS QA of A |
| **Appendix C** | External audit of quality of appraisal outputs | Appendix C - ANONYMOUS QA of |
| **Appendix D** | Audit of appraisal feedback questionnaires | Appendix D - Appraisee feedback q |
| **Appendix E** | Audit of revalidation recommendations | Appendix E - Audit of revalidation recomme |
| **Appendix F** | KCHFT's Annual Organisations Audit report | Appendix F - KCHFT AOA 2016 2017.pdf |
| **Appendix G** | Audit of recruitment and engagement background checks | Appendix G - Audit of recruitement check |

Kent Community Health
NHS Foundation Trust

**Meeting of the Kent Community Health NHS Foundation Trust Board**
**to be held at 10am on Thursday 27 July 2017**
**in The Committee Room,**
**Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill,**
**West Malling Kent ME19 4LZ**

**This meeting will be held in Public**

## AGENDA

| | | | |
|---|---|---|---|
| **1.** | **STANDARD ITEMS** | | |
| 1.1 | Introduction by Chair | Chairman | |
| 1.2 | To receive any Apologies for Absence | Chairman | |
| 1.3 | To receive any Declarations of Interest | Chairman | |
| 1.4 | To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on<br>• 25 May 2017<br>• 29 June 2017 | Chairman | |
| 1.5 | To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on<br>• 25 May 2017<br>• 29 June 2017 | Chairman | |
| 1.6 | To receive the Chairman's Report | Chairman | Verbal |
| 1.7 | To receive the Chief Executive's Report<br>• Sustainability and Transformation Plan Update | Chief Executive | |

| | | |
|---|---|---|
| **2.** | **BOARD ASSURANCE/APPROVAL** | |
| 2.1 | To approve the Sustainability and Transformation Plan Hurdle Criteria | Medical Director |
| 2.2 | To receive the Quality Committee Chairman's Assurance Report | Chairman, Quality Committee |
| 2.3 | To receive the Integrated Performance Report | Chief Operating Officer/Deputy Chief Executive<br>Chief Nurse |
| 2.4 | To receive the Monthly Quality Report | Chief Nurse |
| 2.5 | To receive the Finance Report – Month Three | Deputy Director of Finance |
| 2.6 | To receive the Workforce Report | Director of Workforce, Organisational Development and Communications |
| 2.7 | To approve the Community Hospitals Safer Staffing Review Report | Chief Nurse |
| 2.8 | Policy for Ratification<br>• Maintaining High Professional Standards | Director of Workforce, Organisational Development and Communications |
| **3.** | **REPORTS TO THE BOARD** | |
| 3.1 | To receive the Infection Prevention and Control Annual Report 2016/17 | Chief Nurse |
| 3.2 | To receive the Seasonal Infection Prevention and Control Report – Summer | Chief Nurse |
| 3.3 | To receive the Equality and Diversity Annual Report<br>• To approve the Equality Objectives for 2017/18 | Director of Workforce, Organisational Development and Communications |

Kent Community Health
NHS Foundation Trust

| | | |
|---|---|---|
| 3.4 | To receive the Medical Appraisal and Revalidation Annual Report 2016/17<br>• To approve the Statement of Compliance | Medical Director |

**4. ANY OTHER BUSINESS**

| | |
|---|---|
| To consider any other items of business previously notified to the Chairman. | Chairman |

**5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**

**6. DATE AND VENUE OF NEXT MEETING**

**Thursday 28 September 2017**
**Council Chamber, Sevenoaks Town Council Offices, Sevenoaks, Kent**