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 25 May 2017

In

Room 6 and 7
Trinity House
110-120 Upper Pemberton
Eureka Business Park
Kennington
Ashford
Kent
TN25 4AZ

Kent Community Health
NHS Foundation Trust

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

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 30 March 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 30 March 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report	Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Quality Committee Chairman's Assurance Report	Chairman, Quality Committee	

2.2	To receive the Audit and Risk Committee Annual Report	Chairman, Audit and Risk Committee	
2.3	To receive the Charitable Funds Committee Chairman's Assurance Report • Committee Chairman's Annual Report	Chairman, Charitable Funds Committee	
2.4	To approve the 2016/17 Annual Report and Accounts • 2016/17 Annual Quality Report • Self-Certification with NHS Providers Licence	Director of Finance Chief Nurse	
2.5	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse	
2.6	To receive the Monthly Quality Report	Chief Nurse	
2.7	To receive the Finance Report – Month 1	Director of Finance	
2.8	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications	
2.9	To receive the Kent and Medway Sustainability and Transformation Plan Update Report	Chief Executive	Verbal
2.10	To ratify the Terms of References of Committees • Audit and Risk Committee • Charitable Funds Committee • Finance, Business and Investment Committee • Quality Committee • Remuneration and Terms of Service Committee	Corporate Services Director	

3. REPORTS TO THE BOARD

3.1	To receive the Seasonal Infection Prevention and Control Report – Spring	Chief Nurse
3.2	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.3	To receive the Mortality Annual Report	Medical Director
3.4	To receive the Clinical Audit Annual Report	Medical Director
3.5	To receive the Six Monthly Public Engagement and Equality Report	Director of Workforce, Organisational Development and Communications
3.6	To receive the Annual Information Governance Report	Corporate Services Director
3.7	To receive the Emergency Planning and Business Continuity Annual Report	Corporate Services Director
3.8	To receive the Standards of Business Conduct Report	Corporate Services 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 27 July 2017
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

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10.00 am on Thursday 30 March 2017
in The Committee Room, Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

Meeting held in Public

Present:	David Griffiths, Chairman Arokia Antonysamy, Acting Medical Director Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Peter Conway, Non-Executive Director Richard Field, Non-Executive Director Ruth Herron, Deputy Chief Nurse Steve Howe, Non-Executive Director Gill Jacobs, Deputy Director of Finance Louise Norris, Director of Workforce, Organisational Development and Communications David Robinson, Non-Executive Director Lesley Strong, Deputy Chief Executive/Chief Operating Officer
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Corporate Services Director

30/03/1 **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.

30/03/2 **Apologies for Absence**

Apologies were received from Gordon Flack, Director of Finance; Bridget Skelton, Non-Executive Director; Ali Strowman, Chief Nurse; and Jennifer Tippin, Non-Executive Director.

The meeting was quorate.

30/03/3 **Declarations of Interest**

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

30/03/4 **Minutes of the Meeting of 26 January 2017**

The Board **AGREED** the minutes.

30/03/5 **Matters Arising from the Meeting of 26 Janury 2017**

Audit and Risk Committee Chairman's Assurance Report – the Non-Executive Directors confirmed that they were assured.

Six Monthly Staffing Establishment Report – further clarification was requested by Ms Barber and it was agreed that this action would remain open. Ms Herron would liaise with Ms Strowman.
Action – Ms Herron

The Board **RECEIVED** the Matters Arising.

30/03/6 **Chairman's Report**

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

30/03/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board.

The Trust expected to return a planned surplus for the year 2016/17. This had been in part due to significant control over agency nursing spend. Encouraging results from the 2016 NHS Staff Survey had been received and there had been significant improvement in seven key areas. The Senior Manager's Conference had been well-attended in the month with partner organisations joining the Trust's senior managers to discuss the future co-design of services. A new One Stop Shop in Ashford had been opened to promote healthy living in the community. It was opened by the Trust in conjunction with Kent County Council (KCC) and Ashford Borough Council. A new Specialist Wound Medicine Centre had opened at the Victoria Hospital, Deal. It had been generously supported by the community hospital's League of Friends. A summit had taken place the previous day to explore the issues around the temporary withdrawal of training for junior doctors at the Kent and Canterbury Hospital. Discussions centred on managing the situation in a proactive way and the Trust would be supporting its partners in ensuring that care remained safe.

In response to a question from Mr Field regarding voluntary organisation involvement in the One Stop Shop in Ashford, Mr Bentley confirmed that the Council of Voluntary Organisations had been involved but he would welcome a wider array of voluntary organisations taking part in the future running of the centre.

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

30/03/8 **Quality Committee Chairman's Assurance Report**

Mr Howe presented the report to the Board for assurance.

The Committee had not met formally in February 2017 due to the lack of quoracy but it had met in March 2017. However, the papers for the former meeting had been reviewed. Two Extraordinary Meetings had taken place in January and February 2017 to review the Quality Impact Assessments (QIA) of the 2017/18 Cost Improvement Programme (CIP) on behalf of the Board. All the QIAs had been approved apart from two schemes which were still being developed – east Kent Community Hospitals and some Estates schemes – and it was recommended to the Board that the approved schemes should be accepted.
Other items of note that were discussed by the Committee included a review of the use of DATIX, the risk management software used by the Trust; feedback from the Quality Surveillance Meeting (QSM); and End of Life Care training. There were concerns about infection control management at Queen Victoria Memorial Hospital, Herne Bay and the level of compliance for End of Life Care training across the organisation. A number of policies had been ratified.

In response to a question from Mr Griffiths regarding whether the explanation provided for the Trust's low reporting rate had been tested, Ms Davies confirmed that this had been undertaken and the results had concluded that the Trust did sit within the cohort.

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

30/03/9 **Audit and Risk Committee Chairman's Assurance Report**

Mr Conway presented the report to the Board for assurance.

The Committee had met in February 2017. It had made two recommendations to the Board. The Board had received the Sustainability and Transformation Plan (STP) Risk Register. With regards to cyber security, work was underway by the IT Team and the Internal Auditors to review the recommended best practice in the NHS and discern what was applicable to the organisation. The Committee recommended that the Board should consider its risk appetite in this arena and it was agreed that Ms Jacobs would liaise with Mr Flack to arrange that it was discussed at the Board meeting in May 2017.
Action – Ms Jacobs

In response to a question from Mr Bentley regarding the Committee's conclusion of the risk to the Trust of the new IR35 contractors' tax arrangements, Mr Conway explained that the Trust was not reliant on a large number of these workers. Ms Norris confirmed that the relevant agencies had been contacted and reminded that locums employed by the

Trust must comply with IR35. Confirmation had been received back from the agencies.

In response to a question from Mr Robinson regarding putting in place contingencies to protect the Trust from cyber attacks, it was suggested that this would be done once the Board had received a report on the current work that was taking place.

30/03/10 Charitable Funds Committee Chairman's Assurance Report

Mr Field presented the verbal report to the Board for assurance.

The Committee had met in January 2017. It had approved the Charitable Funds Annual Accounts for 2015/16. Confirmation had been received that more money was being spent by the funds. A presentation had been received on the latest marketing initiatives of the Trust's charity, i care. A presentation had been received from the fund manager responsible for the May Sosbe legacy at Sheppey Community Hospital.

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

30/03/11 Integrated Performance Report

Ms Strong presented the report to the Board for assurance.

It was noted that there had been an error in the report. Key Performance Indicator (KPI) 3.2 was incorrect. The correct figure was 99.9 per cent for Minor Injuries Units and the Trust had always been compliant throughout the year. It was agreed that Ms Strong would liaise with Mr Flack and an updated version of the report would be published on the public website.
Action – Ms Strong

Contract activity was steadily improving. The Kent-wide Stop Smoking target continued to be challenging although at a national level, the Trust was the second highest performer in the country. There was an improving trend with the Health Visiting targets relating to the uptake of the six to eight week assessments and the new birth visits by fourteen days. Both the performance in Length of Stay and Delayed Transfers of Care (DToC) was improving, although further significant work was required.

In response to a question from Mr Field regarding the accuracy of the Units of Dental Activity (UDA), Ms Strong agreed to liaise with Mr Flack and the correct data issued.
Action – Ms Strong

In response to a question from Ms Barber regarding Health Visiting performance, Ms Strong explained that the new birth visits and the six to eight week assessments were taking place but not necessarily within the required mandated timescales. The reasons for this were understood and related to a few identified teams. KCC was aware of the situation and was

tracking the service's progress. An action plan was in place.

In response to a question from Ms Barber regarding tracking the delays in rapid response discharges, Ms Strong confirmed that this tracking was carried out.

In response to a question from Ms Barber regarding DToC, Ms Strong agreed that a high percentage of delays was due to health reasons. This had a wide definition and did not generally relate to waiting for Trust services. The patient choice protocol was in place.

In response to a question from Mr Griffiths regarding providing further information as to whether the Trust would meet the KCC Stop Smoking target, Ms Strong agreed to liaise with Mr Flack and request that supplementary information be provided in future.
Action – Ms Strong

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

30/03/12 Finance Report (Month 11)

Ms Jacobs presented the report to the Board for assurance.

The Trust had achieved a surplus of £3million year to date which was ahead of plan. It was forecast to achieve £3.7million at year end which would be ahead of its control total. This, better than expected, performance was partly due to an improvement in the Trust's forecast position and partly due to Strategic and Transformation Fund (STF) incentive funding. The Trust's final position had been endorsed at the February 2017 Board meeting and formal ratification was sought at that day's meeting.

The Trust's Use of Resource Rating continued to be maintained at the highest level of One. Delivery of the CIP continued to improve in the month and the full target was expected to be achieved at year end. The Trust's cash position was strong. With regard to capital expenditure, spend had increased and was expected to end the year close to the target. With regard to agency spend, there had been a slight overspend in February 2017 but the Trust was forecast to be within the trajectory at year end. This improved position was linked to the overall improved financial position of the Trust.

In response to a question from Mr Griffiths regarding the implementation of a specific project to achieve the forecast capital spend, Ms Jacobs confirmed that the project was underway. However, there was some slippage which had been offset by bringing forward some other schemes. She confirmed that the commitment that the Trust had made to NHS Improvement (NHSI) would be honoured.

The Board **APPROVED** the forecast total for 2016/17.

The Board **RECEIVED** the Finance Report.

30/03/13 **Workforce Report**

Ms Norris presented the report to the Board for assurance.

A summary of the current position was provided. There had been variable performance across the suite of metrics in the month and an explanation was provided against specific measures. The following month the Board would receive a deep dive report into workforce turnover.

In response to a question from Ms Barber regarding compliance with moving and handling client training, Ms Norris confirmed that it was improving.

In response to a question from Mr Field regarding the fill rate performance of the Internal Bank which had showed a dip in the month, Ms Norris explained that when there was a significant short term increased demand for shifts, this impacted on the ability of the Bank to provide sufficient staff. There was a continuous cycle of recruitment to the Bank. All new staff were invited to join the Bank and some leavers also decided to remain on the Bank.

In response to a question from Mr Field regarding the accuracy of the Staff In Post data in Figure 12, Ms Norris agreed that this was incorrect and would investigate and issue the correct information.
Action – Ms Norris

Mr Griffiths suggested that the Executive Team reflect on the way that information was reported to the Board to ensure that the exceptional areas that needed to be focussed on were easily identifiable. It was agreed that this would be discussed at a Board Strategy and Development Day and Ms Jacobs would liaise with Mr Flack.
Action – Ms Jacobs

The Board **RECEIVED** the Workforce Report.

30/03/14 **Quality Report**

Ms Herron presented the report to the Board for assurance.

A summary of the current position was provided with an explanation for specific quality metrics. These included staffing levels on various community hospital units, clinical incidents, pressure ulcers, falls, infection prevention and control outbreaks, medication incidents, the Trust's patient experience scores, the clinical audit programme and the Trust's performance in relation to the latest publications of the National Institute for Clinical Excellence (NICE) guidance. The Quality Surveillance Meeting continued to meet monthly to review all the quality metrics.
The Mortality Surveillance Group continued to meet regularly to review the mortality data. There had been five deaths within the community hospitals in February 2017. All had been expected.

In response to a question from Mr Howe regarding the robustness of the Safer Staffing Standard Operating Procedure in the light of the change in patient acuity that was emerging, Ms Herron confirmed that this would be addressed as part of the Safe Staffing Audit which was due to take place. Ms Strong provided further context and suggested that a plan for safer staffing escalation was needed.

Mr Field highlighted that there was an apparent discrepancy in the assurance provided with regards to the Tonbridge Cottage Hospital night time cover. It was unclear if there was understaffing at the community hospital compared to other hospitals. Ms Herron agreed to liaise with Ms Strowman that this be investigated and an update provided at the Quality Committee meeting in April 2017.
Action – Ms Herron

In response to a question from Ms Barber regarding the Trust's response to the number of low or no harm incidents that had occurred in its community hospital units on shifts with less than the planned Registered Nurse numbers, Ms Herron confirmed that all the incidents were investigated and with regards to Queen Victoria Memorial Hospital, Herne Bay leadership had been reviewed. An improvement in performance was expected over the following two months.

In response to a question from Mr Griffiths regarding clarification of Figure 5: Category Two Pressure Ulcers, Ms Herron agreed to liaise with Ms Strowman that the chart be reconfigured for greater clarity and that a summary of the reading of the current chart be circulated.
Action – Ms Herron

The Board **RECEIVED** the Quality Report.

30/03/15 2017/18 Finance Plan

Ms Jacobs presented the report to the Board for approval.

Final Revenue and Capital Budgets 2017/18

The budget setting framework and principles had been agreed by the Finance, Business and Investment (FBI) Committee in November 2016. The budget would deliver a surplus of £3, 062k which included an element of STF. This had previously been agreed by the Board. Confirmation was provided that the budget was affordable and was not reliant on external borrowing nor was it reliant on non-recurring CIP. The budget would be sufficient to deliver safe and effective services. There was some movement in Income and Expenditure budgets for 2016/17 and 2017/18 which took into account the full year effect of the loss of the North Kent services and Wheelchair Services contract and the award of the new Dental Services contracts. The budget had been reviewed by the FBI Committee the previous day which recommended that the Board approve the budget.

Mr Field commented that the budget would be challenging and contained some risk, but that the Committee was satisfied that the risks had been mitigated. Overall it was a fair budget.

The Board **APPROVED** the Final Revenue and Capital Budgets 2017/18.

Operating Plan

A summary of the plan had been submitted to NHSI at the end of 2016. It had been reviewed by the FBI Committee and the Council of Governors. A copy of the plan would be published on the Trust's website, subject to Board approval.

The Board **APPROVED** the Operating Plan.

2017/18 Cost Improvement Programme

Lesley Strong presented the report to the Board for approval.

The full suite of CIP schemes would meet the Trust's target if the outstanding schemes were approved.

Mr Griffiths confirmed that it was usual practice to approve the CIP total in Part One of the meeting. The details of the schemes would be scrutinised in Part Two of the meeting.

The Board **APPROVED** the 2017/18 Cost Improvement Programme.

30/03/16 2016 Staff Survey Report

Ms Norris presented the report to the Board for assurance.

The response rate for the Trust had been 55 per cent. A summary of the key findings was provided which set out the Trust's performance against the national averages for other community trusts in England. The Trust had shown an improvement in staff engagement compared to last year, as well as in the delivery of mandatory training, appraisals, staff confidence regarding security and reporting on unsafe practice. Overall the scores in the survey were pleasing but it was recognised that there were areas for improvement. These had been identified and an action plan developed to address the issues which had attracted the lowest scores as well as further work to improve staff engagement. The projects that would be undertaken were set out and it was highlighted that there would be a continued focus on devolving decision-making to the front line.

In response to a question from Mr Conway regarding the impact on the overall data of the survey answers from staff in North Kent, who had subsequently moved to a new provider, Ms Norris suggested that she was confident that their answers had not compromised the data and that the survey was a fair reflection of staff sentiment.

Mr Bentley drew attention to the percentage of staff who had reported that they had experienced physical violence from patients, relatives or members of the public in the last twelve months. He highlighted that it was unacceptable for staff to experience such behaviour and he wished to see such levels of violence, harassment and bullying against Trust staff decrease in the future.

In response to a question from Mr Robinson regarding bullying and harassment between staff, Mr Bentley agreed that he wished to see the number of incidents of this decrease as well, and drew attention to the appointment of the Freedom To Speak Up Guardian which was a vehicle for staff to report such instances by colleagues.

The Board strongly supported the sentiments expressed by Mr Bentley and the Trust's commitment towards improving the leadership of teams to improve feedback from staff.

The Board **RECEIVED** the 2016 Staff Survey Report.

30/03/17 **Kent and Medway Sustainability and Transformation Plan (STP) Update Report**

Mr Bentley presented the report to the Board for approval.

The reasons for publishing a Case For Change document were explained. The document was available on the public website and a longer, more technical document was also available. The Board was asked to endorse the Case For Change.

With regards to Local Care Development, a significant amount of work had been undertaken which aimed to unlock the changes that were required to improve patient care. The aim was to develop resilient services that would deliver correct, consistent care to patients. Ms Strong was the Lead for the Trust and would be supported by Dr Sarah Phillips when she commenced in post as Medical Director with the Trust in April 2017.

The STP for Kent and Medway was addressing many of the same issues as other areas of the country. The Trust was heavily involved in developing and shaping it and its direction of travel was consistent with the Trust's strategy.

In response to a question from Ms Barber regarding how the Trust was engaging with the general community and the role of the Council of Governors in promoting the STP, Mr Bentley confirmed that the Council had been briefed twice, informally and formally. However, he recognised that there had been a number of changes in the membership of the Council which suggested it would be helpful if they received a further update. It was agreed that this would be arranged. Additionally, a series of listening events had been organised to which the public were encouraged to attend.
Action – Mr Bentley

Mr Conway suggested that the Executive Team reflect on the time that was allocated for discussion of the STP at Board meetings because of its strategic importance to the Trust.

The Board **ENDORSED** the Case For Change.

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

30/03/18 **People Strategy**

Ms Norris presented the report to the Board for approval.

Consultation with staff had been carried out. The Executive Team had agreed that the strategy set out the key strategic challenges for the organisation. The document set out the broad strategic intent rather than a detailed plan. The contents of the strategy were summarised.

In response to question from Mr Field regarding succession planning, Ms Norris confirmed that the Executive Team was addressing this and would come to the Board with a proposal in the future. It was agreed that the subject would be discussed at a future Board Strategy and Development Day.
Action – Ms Norris

The Board **APPROVED** the People Strategy.

30/03/19 **Risk Management Strategy**

Ms Davies presented the report to the Board for approval.

The strategy had had its annual review at the February 2017 Audit and Risk Committee meeting.

In response to a comment from Mr Bentley regarding the inclusion of the strategic goals that the Board had approved in September 2016, it was agreed that these would be included.
Action – Ms Davies

The Board **APPROVED** the Risk Management Strategy, subject to the amendment.

30/03/20 **Ratification of Policies**

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

- Professional Registration Policy
- Annual Leave Policy
- Annualised Hours Guidance
- Probationary Period Policy
- Ordinary Parental Leave Policy

- Shared Parental Leave Policy
- Maternity and Maternity Support Parental Leave Policy
- Adoption/Surrogacy Leave Policy
- Disciplinary Procedure Review Policy

The Board **RATIFIED** the Policies.

30/03/21 **Quarterly Patient Experience Exception Report**

Ms Herron presented the report to the Board for assurance.

The Trust had seen a downward trend in complaints compared to the previous year and to similar organisations. This was being triangulated as to whether this was an accurate picture of patient experience. Feedback from Healthwatch indicated that it had received fewer complaints about the Trust compared to other NHS organisations in Kent.

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

30/03/22 **Seasonal Infection Prevention and Control Report – Winter**

Ms Herron presented the report to the Board for assurance.

A summary of the current position was provided with an explanation of specific performance relating to incidents of Clostridium difficile in the community hospitals, MRSA incidents, Urinary Tract Infections and Catheter Acquired Urinary Tract Infections, decontamination management, Sepsis, and the influenza vaccination programme.

In response to a question from Mr Robinson regarding whether Sepsis performance would become a reportable item, Ms Herron agreed to discuss this with Ms Strowman.
Action – Ms Herron

In response to a question from Ms Barber regarding the plan for the staff influenza vaccination programme for 2017/18, Ms Strong confirmed that this was being discussed by the Executive Team. Last year's process had been reviewed and the obstacles to increasing take up had been identified. These would be addressed. Discussions were underway with StaffSide and the Communications Team. The development and roll out of the programme would be monitored by the Commissioning for Quality and Innovation (CQUIN) Board.

The Board **RECEIVED** the Infection Prevention and Control Declaration December 2016.

The Board **RECEIVED** the Seasonal Infection Prevention and Control Report –Winter.

30/03/23 Six Monthly Freedom To Speak Up Guardian's Report

Ms Norris presented the report to the Board for assurance.

The Trust had appointed its Guardian in September 2016. There had been seven cases dealt with to date. The main themes of concerns raised to date related to a bullying culture and a failure of middle managers to resolve concerns that were raised locally.

In response to a question from Ms Barber regarding how cases would be tracked, Ms Norris confirmed that the intention was to keep in touch with staff and to devise a way in which reported themes were reported back through the organisation. With regard to capturing feedback from students who spent time in the Trust, their comments were fed back to the Clinical Education and Standards Team in the first instance. Ms Norris suggested that the Strategic Workforce Group had a role to play in tracking and responding to the themes.

The Board **RECEIVED** the Six Monthly Freedom To Speak Up Guardian's Report.

30/03/24 Annual Use of the Trust Seal Report

Ms Davies presented the report to the Board for assurance.

The Board **RECEIVED** the Annual Use of the Trust Seal Report.

30/03/25 Any Other Business

There was no further business to discuss.

30/03/26 Questions from Members of the Public Relating to the Agenda

There were no questions from the public.

The meeting closed at 12noon.

30/03/27 Date and Venue of the Next Meeting

Thursday 25 May 2017 at 10am at Kent Community Health NHS Foundation Trust offices, Room 6 and 7, Trinity House, 110 – 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford, Kent TN25 4AZ

Kent Community Health NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 30 MARCH 2017 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Six Monthly Staffing Establishment Report	To investigate the reasons for the differentials in acuity between east and west Kent community hospitals.	Ms Herron	Further information requested by the Board. Ms Herron to liaise with Ms Strowman. Action open. There is no single identifiable reason why patient dependency and acuity should be higher in the inpatient units in the east of the county. Contributory factors may be that one hospital (Sevenoaks) does not take patients with dementia (due to health and safety reasons) and the east of the county has higher levels of deprivation which may lead to increased dependency on health services.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Audit and Risk Committee Chairman's Assurance Report	To liaise with Mr Flack to arrange that the Trust's risk appetite on cyber security was discussed at the May 2017 Board meeting.	Ms Jacobs	To be discussed at the May 2017 Board Strategy and Development Day.
Integrated Performance Report	To liaise with Mr Flack to publish an updated version of the report on the public website.	Ms Strong	Completed.
Integrated Performance Report	To liaise with Mr Flack to investigate the accuracy of the Units of Dental Activity and issue the correct data.	Ms Strong	Completed.
Integrated Performance Report	To liaise with Mr Flack to provide supplementary information regarding the Trust's performance against the Kent County Council Stop Smoking Key Performance Indicator.	Ms Strong	More detailed indicators in Part Two Integrated Performance Report.
Workforce Report	To investigate the Staff In Post data in Figures 12 and issue the correct information.	Ms Norris	Action complete.
Workforce Report	To liaise with Mr Flack on the way that information was reported to the Board and to bring an agenda item to a future Board Strategy and Development Day.	Ms Jacobs	Ms Norris confirmed that the Board's comments had been taken into account in the latest Workforce Report to the Board.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Quality Report	To liaise with Ms Strowman to investigate the discrepancy in assurance regarding the Tonbridge Cottage Hospital night time cover i.e. if there was understaffing at the hospital compared to other hospitals; and report to the April 2017 Quality Committee meeting.	Ms Herron	Tonbridge are using the staff from the therapy unit to support patients who require 1-1 help, the therapy ward has 6-8 patients most of the time with 3 staff. As the patients' with us for rehabilitation require very little care at night the staff are able to help on the ward next door.
Quality Report	To liaise with Ms Strowman to reconfigure Figure 5: Category Two Pressure Ulcers and circulate a summary of the current chart.	Ms Herron	Action complete.
Kent and Medway Sustainability and Transformation Plan (STP) Update Report	To arrange a further briefing of the Council of Governors regarding the STP.	Mr Bentley	Action complete.
People Strategy	To discuss the talent management strategy of the Trust at a future Board Strategy Development Day.	Ms Norris	Action complete.
Risk Management Strategy	To include the strategic goals of the Trust in the final document.	Ms Davies	Action complete.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Seasonal Infection Prevention and Control Report –Winter	To discuss with Ms Strowman whether Sepsis performance would become a reportable item.	Ms Herron	The algorithm will provide a standardised process for staff to follow to identify sepsis. As yet there is not an appropriate metric to report but this will be reviewed as work on sepsis progresses.

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 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

Chief Executives Report

Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
MAY 2017

As previously I wanted to highlight to the Board the following significant developments since my last formal report to the Board, for ease of the Board I have categorized the report into 3 groups, patients and partnerships but I have added a new category of people to reflect the importance of the people who work with us. Material to all of these areas I welcome Dr Sarah Phillips who joined Kent Community Health NHS Foundation Trust as Medical Director; Sarah has a wealth of experience as a GP in East Kent, Chair of a Clinical Commissioning Group and Chair of the East Kent Strategy Board. Sarah will continue to practice as a family doctor in a practice in East Kent.

Patients

1. Cyber Attack

The weekend of 12 - 14 May saw the most sustained and widespread cyber-attack on the information technology systems which the NHS has experienced. KCHFT systems were not directly impacted by the attack, however we took a number of precautionary measures to ensure our systems were not vulnerable. Our teams responded very well to the temporary changes and by Sunday night all systems were back up. The weekend saw the IT team led by Mark Ashby make a number of changes which improved our cyber security.

2. New Services for Patients

On 3 April we commenced providing services to patients for special care and paediatric dental services across eight North East London boroughs – with a step change in delivery of care and working to new national care pathways.

Staff transferred to the Trust and we have worked to incorporate the teams into the successful and high performing team which is our Dental Services.

3. Gift of Play Charity Appeal

Our charity, *i care*, has achieved its first appeal target raising £28,000 to fund a sensory room for children with disabilities in Coxheath, Maidstone.

I would like to thank Maidstone Lions Club for their generous donation. They have agreed to purchase all of the equipment for the sensory room at the Heathside Centre up to a total of £20,000. This, combined with the money we

have already raised, means we have raised enough money to open the sensory room.

The donation came following a presentation we gave to the club back in February. We are hugely grateful for their support and delighted at the difference this will make to children.

4. Control of Infection Campaign

KCHFT's Chief Nurse, Ali Strowman and Assistant Director for Infection Prevention and Control, Lisa White are heading up a campaign to make sure colleagues, patients and visitors are keeping their hands clean thereby reducing the risk of infection

A greater visual reminder is present in our community hospitals and clinics, to raise awareness of the importance of good hand hygiene. The aim is to prevent infections, such as C-Difficile, flu and norovirus. We cannot underestimate the need to remain hyper-vigilant to the risks of infection and visual reminders are one area of the tools in our toolkit to address the possible risk.

5. Governors

I join the Chairman in welcoming a number of new Governors to the Trust as members of the Council of Governors. The recent Council meeting was both productive and helpful with a focus on the work of our Governors in the local communities where Governors were able to represent the views of the communities which they represent. All Governors are a very important and valuable resource for the Trust and I look forward to working with our Governors as they fulfil their important role.

People

1. Overseas Recruitment

Whilst significant progress has been made to reduce turnover within the Trust a significant number of vacancies still remain. To this end, two key exciting joint initiatives have been taken: international recruitment and rotation posts.

In collaboration with the other Trusts in Kent and Medway we are tendering for an agency to assist with us with international recruitment to recruit nurses from overseas in order to fill vacant posts and further reduce the levels of temporary nursing usage and associated costs. This campaign is essential with UK trained available staff being less than normal, annual turnover and significant numbers of the workforce reaching retirement age. Recruitment in the UK alone will not be able to meet the requirements for the Trust.

2. Rotational Posts

We have embarked on an initiative with Kent and Medway NHS and Social Care Partnership Trust to introduce inter-Trust rotational posts for Band 5 nurses with an interest to develop skills across care of the elderly and mental health. Developing nursing skills and experience across these areas of care will benefit patients, staff and both Trusts and help move care forward for the health economy of the future.

The Rotational Programme lasts for 18 months, with nine months in a community hospital, and the other nine months in a mental health setting. Both Trusts will have an equal number of staff on the programme; participants will be employed by each Trust, and seconded to the other for half of the programme. Structured training will be provided for both specialties, and 'buddies' will be assigned for each recruit at both workplaces.

The programme has been advertised on Facebook for a period of three weeks and interviews are to be held jointly at the beginning of June.

We have also started similar conversations with Maidstone and Tunbridge Wells NHS Trust and expect to be advertising these roles in the next three months. The programme will be for two years and will be across Medicine, Surgery in the acute and Rapid Response and Intermediate Care teams within KCHFT.

3. Planned Productivity Reviews to Maximise Patient Facing Time

The Trust is continuing its work on productivity and has a specific aim to increase the amount of time our clinicians spend face to face with patients and clients. We will be working with a partner in the coming months linked to the Lord Carter Review team work.

Partnerships

1. Contracts

The Trust is pursuing a number of partnerships, further integrating care around the needs of our patients. Partnerships are being pursued with a number of GP groups across the county, particularly in the east of the county. In each of these areas, a focus on prevention and avoiding hospital admissions is key. Our close working relationships with the East Kent Hospitals University NHS Foundation Trust and Maidstone and Tunbridge Wells NHS Trust are both bearing fruit in different fields including urgent care and older people's services. We also continue to work very strongly with Kent County Council, and most recently with Ashford District Council which has led to the opening of the 'One You' shop in Ashford, promoting good health.

2. End of Life/NHSI Collaborative

Last week, we commenced a collaboration with NHS Improvement to look at what more we can do to improve our end of life care. The Trust will be take part in four workshops to help focus on key aspects, in particular to ensure we record people's wishes to enable patients die in their preferred place. We have promoted a variety of opportunities for people to talk about death in a more open manner than has previously been the case. This work is undertaken in collaboration with hospice care providers in the county and I particularly want to thank the Heart of Kent who with the Trust co-led a conference earlier this month.

3. Lord Carter's Team Visit

Lord Carter's team will be visiting the Trust on 18 May as part of his work with a selection of pilot community and mental health trusts to review operational productivity and performance. This is follow up work to similar reviews done in acute trusts. The Trust is looking forward to working with his team to disseminate our good practice and learn from elsewhere.

4. Complimentary Audit Report

The Trust has completed its financial year end 2016/17 and has delivered a surplus of £4.6m of which £3.2m is national funding for Sustainability and Transformation to ensure the whole of the NHS provider sector in total eventually achieves a breakeven position. The Trust has had its external audit and the auditors again complimented the Trust on the high standard of the working papers and no changes were required to the accounts statements. This is testament to the good work of the Finance Team and in particular Carl Williams the Trust's Head of Financial Accounting.

Paul Bentley
Chief Executive
May 2017

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.1
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 4 April and 2 May 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 Foundation Trust

QUALITY COMMITTEE CHAIRMAN'S ASSURANCE REPORT FOLLOWING APRIL AND MAY 2017 MEETINGS

Introduction

The Quality Committee met on 4 April and 2 May 2017

4 April 2017

The Committee was informed of the new Care Quality Commission (CQC) requirement regarding reviews of patient deaths: learning, candour and accountability. It was noted that Dr Arokia Antonysamy, Deputy Medical Director, would lead on behalf of the Trust. Pippa Barber, Non-Executive Director (NED), attended the London CQC briefing with Dr Antonysamy and has agreed to fill the mandated role of NED Lead for the oversight of these mortality reviews.

The Committee was updated on the Dental Services Never Event Action plan and noted that the Quality Surveillance Meeting (QSM) had operational oversight of progress.

The results of the annual review of committee effectiveness revealed concerns about the number and length of papers received, the focus becoming too operational, and the level of quality assurance provided to the Board.

Following correspondence with the Chairman and discussion with the Chief Executive, it was agreed that while the current format had contributed to the Trust being granted Foundation Trust status, it was time to follow the design adopted by some trusts graded as Outstanding and make the committee function more strategic, reduce membership to senior executive and NEDs, and where possible reduce the paper load. It is recognised that prior to any change occurring, there will need to be a review and a degree of re-engineering of sub-committees, to ensure quality assurance; and the sub-committee new accountabilities are clearly defined and evidence of challenge recorded.

2 May 2017

The Dental Services Never Event Action plan was reviewed and it was noted that the Trust had now adopted a requirement to complete a WHO pre-treatment check list and dental software had been adapted to facilitate this. In recent months, the Committee has become concerned about dental treatment waiting times in prisons and the difficulties in managing patient lists with high Did Not Attend (DNA) rates. This is compounded by current prison service staffing levels. The CQC who had previously expressed concerns about the length of waiting lists have been informed of the current challenges. The Committee has requested that benchmarking

information from other community dental providers supporting prison populations is provided.

The Committee received the Spring Infection and Control Report and noted that there had been thirteen significant outbreaks this year caused, in the main, by Norovirus and Influenza A with a significant impact on staffing levels. An update was received on the progress of the Serious Incident (SI) into the cross infection of Clostridium difficile (CDI) on Heron Ward, Queen Victoria Memorial Hospital, Herne Bay involving two patients. It is noted that reinforcement of ward leadership has occurred and support is being given to staff to improve both environmental conditions and infection prevention and control practice. MRSA screening compliance is 98 per cent against a Trust target of 100 per cent.

It was pleasing to note that there have been no avoidable pressure ulcers recorded, thus far, in this calendar year.

The Mortality Surveillance Group reported five recorded deaths within community hospitals in February 2017 and three deaths in March 2017. All of these were classified as expected. When benchmarked against ten peer trusts the Trust is statistically below expected mortality levels.

SC Howe CBE
Chairman Quality Committee
10 March 2017

Kent Community Health NHS Foundation Trust

2.2 – Audit and Risk Committee Annual Report

This Paper is To Follow

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.3
Subject:	Charitable Funds Committee Chairman's Assurance Report
Presenting Officer:	Jennifer Tippin, Chair of the Charitable Funds Committee

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context):
The report summarises the Charitable Funds Committee meeting held on 26 April 2017.

Proposals and /or Recommendations:
The Board is asked to receive the Charitable Funds 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. This paper has no impact on people with any of the nine protected characteristics.

Jennifer Tippin, Non-Executive Director	Tel: 01622 211900
	Email:

Charitable Funds Committee Chairmans Assurance Report

Kent Community Health
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE CHAIRMAN'S ASSURANCE REPORT FOLLOWING APRIL 2017 MEETING

Introduction

The Charitable Funds Committee met on the 26 April 2017.

The Committee reviewed the latest performance of the Charity's balance sheet including most recent spend and income profiles. A report was received on a recent review that had been undertaken of the use of restricted funds which provided assurance that restricted funds were being used appropriately. The Committee discussed the importance of ensuring that the restricted funds were spent within a reasonable timeframe for the correct purpose and asked that a plan be brought back by the Fund Managers to show how the funds are intended to be spent at the next meeting of the committee in July.

The Committee was delighted to hear that the Charity's first appeal target – 'The Gift of Play' – for a children's sensory room – has been met, raising over £20,000. Plans will now start to turn to execution and also planning for the adults' appeal to support cardiac rehabilitation.

The Committee discussed a 'Pennies from Heaven' style staff charitable contribution system. Whilst the committee was directionally supportive of this suggestion, the Committee requested that this be specifically considered by the Trust's Executive Team.

The Committee discussed a proposal for coloured crockery to support patients suffering from dementia. The Committee was supportive but asked the Executive Team to consider the overall Trust strategy for dementia so that this proposal could be seen in appropriate context.

The Committee reviewed the Annual Report for the Charitable Funds Committee which will be presented to the Board for approval.

Finally, the Committee discussed the questionnaire which will be sent to members to assess overall committee effectiveness and approved the forward plan of agenda items.

Jennifer Tippin
Chairman, Charitable Funds Committee
May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.3
Subject:	Charitable Funds Committee Chairman's Annual Report
Presenting Officer:	Jennifer Tippin, Chair of the Charitable Funds Committee

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)
This report provides a summary of the work of the Charitable Funds Committee in 2016/17 financial year including assurance that the terms of referee have been fulfilled and compliance with latest best practice.

Proposals and /or Recommendations
The Board is asked to note the report.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required/no significant change. 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.

Jennifer Tippin, Non-Executive Director	Tel: 01622 211900
	Email:

Kent Community Health
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE CHAIR'S 2016/17 ANNUAL REPORT

During the year, the Committee met twice and was quorate each time. The Committee is made up of Non-Executive Directors, the Director of Finance and the Chief Operating Officer. Other representatives include Fund Managers, StaffSide representation and a Governor.

The Committee has scrutinised the Charitable Funds' financial performance at each meeting and has been satisfied with the financial management shown by the Finance Team. The net assets of the Charitable Fund as at 31 March 2016 were £573k. Income during the year totalled £84k and included income from donations, legacies and interest earned from bank accounts. Donations in the period totalled £7k and income from legacies amounted to £75k. Expenditure during the period totalled £143k of which £71k was expended on patients' welfare and amenities and £48k on staff welfare and amenities. The expenditure on fundraising activities included approved financing of marketing activities carried out by the Trust's Communications department to support the Trust's charity i care.

With regards to the Charitable Funds investment strategy, all funds are held as cash in Government Banking Service accounts. No grants were made to non-NHS organisations during the 2015/16 financial period and the Committee's policy on reserves management was adhered to.

The Committee has monitored and supported the rationalisation of Funds. The number of funds has reduced from twenty four to nine with one fund being re-classified from unrestricted to restricted. This exercise was for administrative purposes only and has not impacted on the functioning of the funds themselves.

The Charitable Funds Report and Accounts 2015/16 were presented to the Committee in January 2017 and were approved. The accounts had been compiled in accordance with the applicable Accounting Standards in the UK and the Statement of Recommended Practice and charity regulations. An independent audit was carried out in November 2016 and no significant issues were identified.

During the year, the Committee received a presentation from the Fund Manager responsible for the May Sosbe Legacy for the Sheppey Community Hospital. This gave the Committee the opportunity to be updated on how the fund was being spent for the benefit of the patients and the ward. The Fund Manager has emphasised her responsibility to discharge the funds to ensure that they are not retained by the Trust.

Other Fund Managers will be invited to present to the Committee at its meetings in the future.

The Communications and Marketing Team has been busy with increasing awareness amongst staff and the wider community of the Trust's charity i-care. It has been focusing this year on completely re-launching the Trust's charity, under the new brand i care, to help market and promote it more easily. The charity's official name remains Kent Community Health Charitable Fund and is still registered with the Charity Commission under that name. As part of the charity's re-launch, a mission statement was introduced and a set of challenging objectives agreed for 2016/17. These objectives were to:

1. increase donations/fundraising for the general fund/specified funds in year by one third from 2015/16
2. run two specified appeals for the year - one for adults and the other for children, with a specified total for each
3. seek to acquire 100 new donors in the year and to retain 75 per cent of those new donors and existing donors in the following year .

The first objective has been completely achieved as can be seen in i care's accounts for 2016/17 and 2015/16. The second objective has been partially achieved in that a children's appeal (as outlined below) has been identified and has a high chance of being successfully supported. An appeal for adults has been identified; fund-raising for this will start in 2017/18. In terms of objective three, there were 149 donations during the period and the work to retain these begins in earnest in 2017/18.

New donation methods were introduced to help people to donate to the charity. A JustGiving page was set up and the ability for people to donate by text message as well was launched. The Trust has now put arrangements in place to receive Gift Aid.

New branding has been developed for the Charity and has been introduced across all new marketing materials to help promote its work and raise its profile. The Charity now has a dedicated section on the Trust's public website.

This year's fund raising activities have centred around the appeal for a children's sensory room for the Integrated Therapy Team in Coxheath. The appeal has been titled 'The Gift of Play', and marketing materials, photos and a short film have been produced to promote the appeal, which aims to raise around £28,000 to build the sensory room. The appeal launched at Christmas and was featured in the Trust's Christmas Card. The Communications and Marketing Team has successfully approached a number of local businesses for donations and has also held a successful Big Quiz which raised over £1000. The Coxheath Team is also involved in the fundraising and has a range of events that it is taking part in to raise sponsorship money. The Communications and Marketing Team has also approached local businesses and local Rotary and Lions clubs in Maidstone who are

supporting the appeal. At the end of 2017/18, it was looking very likely that the full £28,000 needed would be in place by the beginning of summer 2017.

There is a project plan in place for more fundraising activity in 2017.

Members of the Committee were asked to complete a Committee Effectiveness Self-Assessment Questionnaire mid-year. It was agreed in principle to increase the frequency of the meetings to quarterly. Fund managers would be invited to present on their funds and it was decided that the Communications and Marketing Team would provide a monthly update on its activities. The Committee also welcomed interest from the Governors in its work.

Finally, the Committee would like to thank all the patients, their relatives and the staff of the Trust who have made charitable donations and supported the Fund.

Jennifer Tippin, Non-Executive Director
Chair, Charitable Funds Committee
March 2017

Kent Community Health
NHS Foundation Trust

2.4 - 2016/17 Annual Report and Accounts and 2016/17 Annual Quality Report

These Papers are To Follow

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.4
Subject:	Self-Certification with NHS Providers Licence Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary (including purpose and context)
As required by its Foundation Trust licence, the Trust is required to self-certify whether or not it has complied with the conditions of the NHS provider licence, have the required resources available if providing commissioner requested services, and have complied with governance requirements.

Proposals and /or Recommendations
This report describes the two conditions required by the NHS Provider Licence of which the Board is asked to sign off that they are satisfied with compliance.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described. The 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.

Alicia Irvine, Assistant Director of Compliance	Tel: 01622 211900
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SELF-CERTIFICATION FOR NHS TRUSTS

1. **Introduction**

1.1. As required by its Foundation Trust licence, the Trust is required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

1.2. This report describes the two conditions required by the NHS Provider Licence of which the Board is asked to sign off that they are satisfied with compliance against

1 Condition G6(3) – Providers must certify that their Board has taken all precautions necessary to comply with the licence, NHS Act and NHS Constitution (31 May 2017)

2 Condition FT4(8) – Providers must certify compliance with required governance standards and objectives (30 June 2017)

1.3. As part of the Trust's ongoing framework for maintaining oversight of compliance with the licence conditions, the Audit and Risk Committee (ARC) continue to receive a deep dive report into a specified condition and the review date for conditions G6 and FT4 are planned.

1.4. Each condition has been risk assessed for Trust compliance, and in February 2017 the ARC received a paper that confirmed the risk score for each condition and both G6 and FT4 received a low score of 1. This affirms the confidence of the committee that the Trust is compliant with its requirements and responsibilities to G6 and FT4.

2 **Condition G6 Systems for compliance with licence conditions and related obligations**

2.1 Criteria

The Licensee shall take all reasonable precautions against the risk of failure to comply with:

a) The conditions of this Licence

b) Any requirements imposed on it under the NHS Acts, and

c) The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS

2.2 Without prejudice to the generality of paragrah1, the steps that the Licensee must take pursuant to that paragraph shall include:

a) The establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

b) Regular review of whether those processes and systems have been implemented and of their effectiveness

2.3 No later than two months from the end of each Financial Year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this condition.

2.4 Evidence includes: The Board and supporting committees who receive regular reports and supporting data analysis covering patient safety, clinical quality, patient experience, workforce, performance and finance. The Board Assurance Reports, Internal Audit and External Audit Reports, Clinical Audit Reports, Patient Surveys, Staff Surveys, Board Assurance Framework (BAF), Internal Quality Reports, Executive Patient Safety Walkabouts and internal audit reports.

2.5 Of the internal audit reports, the board assurance framework, serious incident reporting process and the Data quality Key performance indicators, all received a score of reasonable assurance

3 **Condition FT4 NHS Foundation Trust Governance Arrangements**

3.1 Criteria

The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. The Licensee shall establish and implement effective board and committee structures; clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and clear reporting lines and accountabilities throughout its organisation.

The Licensee shall submit to NHS Improvement within three months of the end of each financial year:

a corporate governance statement by and on behalf of its Board confirming compliance with this condition as at the date of the statement and anticipated compliance with this condition for the next financial year, specifying any risks to compliance with this condition in the next financial year and any actions it proposes to take to manage such risks.

3.2 Evidence includes:

- The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement.
- The Board implements effective Board and committee structures, clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees and clear reporting lines and accountabilities throughout its organisation.
- Annual Governance Statement part of the Annual Report.

4 **Training of Governors**

During the financial year the Trust has provided the necessary training to its Governors to ensure they are equipped with the skills and knowledge that they need to undertake their role. Every Governor receives a full day Induction Training following election and follow up informational visits to areas of the Trust as appropriate. Dedicated development days are built into Governors' annual calender.

5 **Recommendation**

It is recommended that the Board endorse the Trust response 'confirmed' to both of the conditions and that electronic signatures for the Chairman and Chief Executive are applied to the statement.

Alicia Irvine
Assistant Director of Compliance
May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.5
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.

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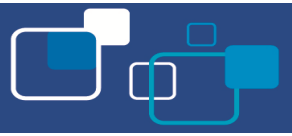
	Email: nick.plummer@kentcht.nhs.uk

Kent Community Health NHS
NHS Foundation Trust

Integrated Performance Report - 2016/17
Part 1

May 2017
April 2015 - April 2017 data

Excellent care, healthy communities



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 2016/17

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	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
1.1	Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)	77.3%	75.5%	-1.8%	100.0%	-24.5%	100.0%	N/A	-ve
1.2	Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)	75.0%	100.3%	25.3%	100.0%	0.3%	100.0%	N/A	-ve
1.3	Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks	57.9%	82.3%	24.4%	95.0%	-12.7%	95.0%	N/A	+ve
1.4	Health Visiting - Increase the uptake of New Birth Visits by 14 days	70.7%	85.8%	15.1%	85.0%	0.8%	95.0%	N/A	+ve
1.5	School Health - Reception Children Screened for Height and Weight	96.6%	94.2%	N/A	90.0%	N/A	95.0%	N/A	+ve
1.6	School Health - Year 6 Children Screened for Height and Weight	96.0%	95.4%	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	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
2.1	LTCs (including Health Trainers) Teams Contacts: YTD as % of YTD Target	75.7%	93.7%	18.0%	100.0%	-6.3%	100.0%	N/A	+ve
2.2	LTCs Teams - Did Not Attend Rate: DNAs as a % of total activity.	0.8%	1.6%	0.9%	4.0%	-2.4%	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	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
3.2	Total Time in MIU & WiC Service: Less than 4 hours	99.96%	99.94%	0.0%	95.0%	4.9%	99.5%	99.5%	-ve
3.3	Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways	100.0%	99.6%	-0.3%	95.0%	4.6%	98.0%	96.8%	-ve
3.4	Allied Health Professionals Referral to Treatment Times (RTT)	92.1%	92.8%	0.7%	95.0%	-2.2%	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	88.8%	89.1%	0.3%	87.0%	2.1%	91.7%	87.9%	+ve
3.8	Length of Stay (Median Average)	24.2	21.6	-2.6	21.0	0.6	21.0	25.6	+ve
3.9	Delayed Transfers of Care as a % of Occupied Bed Days	13.8%	12.0%	-1.8%	3.5%	8.5%	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	15/16	16/17	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	25.3%	23.7%	-1.5%	15.0%	8.7%	25.0%	30.7%	+ve
4.4	End of Life Care: Percentage of patients dying in their preferred place.	100.0%	86.3%	-13.7%	90.0%	-3.7%	95.0%	83.2%	+ve
4.5	ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.	93.1%	85.0%	-8.0%	80.0%	5.0%	90.0%	N/A	-ve

KCHFT Corporate Scorecard 2016/17

Strategic Goals

5. Ensure people receive safe care through best practice

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
5.2	Infection Control: C.Diff (Target <6 cases in year) (Target YTD)	1	7	6	5	2	5	N/A	-ve
5.6	Safety Thermometer: % harm free care New Harms	99.0%	97.7%	-1.2%	95.0%	3%	97.5%	96.3%	-ve
5.7	Never Events: FOT as % of Annual Target	0	1	1	0	1	0	N/A	+ve
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	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
6.1	Income & Expenditure - Surplus (%)	1.5%	1.7%	0.2%	1.0%	0.7%	1.0%	1.0%	+ve

Workforce

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
7.1	Sickness Rate	3.97%	4.30%	0.33%	3.90%	0.40%	3.75%	4.58%	+ve
7.4	Mandatory Training: Combined Compliance Rate	94.1%	94.7%	0.5%	85.0%	9.7%	92.5%	88.4%	+ve

IM&T

KPI Ref	KPI Description	15/16	16/17	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 - May Report 2016/2017

Quality

Infection Control: MRSA & C-Difficile: There has been one case of Clostridium difficile infection on the rehab unit at Tonbridge Cottage Hospital, an investigation is underway, but early investigation suggest this is an unavoidable case due to appropriate antimicrobial prescribing.

Workforce

Sickness: The cumulative sickness absence rate for the financial year to April 2017 was 3.65% which is down from 4.3% for 16/17. The sick rate in April was 3.65%, a decrease of 0.43% from last month. The total FTE days lost for the rolling year to April equates to an average of 9.62 days sickness lost per employee, down from last month. The proportion of FTE lost to short-term sickness has increased to 45.9%, compared to 40.5% in March

Mandatory Training: There remains 1 area which is non-compliant. This is: 1. Moving and Handling: Client which has decreased to 81.9%

Finance

Income & Expenditure and Financial Risk Rating: The Trust achieved a surplus of £237k (1.3%) to the end of April. Pay and non-pay have underspent by £360k and £210k respectively and depreciation/interest has overspent by £26k. Income has under-recovered by £517k

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 96.2% completed RTT pathways within 18 weeks and 99.4% incomplete RTT pathways within 18 weeks. However, this has dipped in recent months within Paediatrics, with M12 only 83.7% of children seen within 18 weeks. A small issue was highlighted in data collection spreadsheets used by the local team which has resulted in some children categorised as breaching when in fact they hadnt. The February and March figures have been corrected and the issue is rectified for future reporting.

Referral to Treatment Times for all Allied Health Professionals when measured against the 18 week threshold shows 93.6% of patients being seen within this timescale for March 2017, up slightly on the February position. Continence, MSK West Block, Podiatry and Podiatric Surgery were all below 90% compliance with 18 weeks RTT for March

National Targets

Stop Smoking: The stretch target set by KCC is 4500 quits. Based on the national trend the service predicts a more realistic target of 2526 quits but is striving towards the 4500 or to maintain the 2015/16 achievement of 3417 quits. KCC have set a minimum target of 3100 quits.

Health Checks: The Health Checks team have met the checks performance target from KCC for this year. The service is on 104% of the 46% uptake target. All areas of checks have performed well; GP delivered checks and KCHFT core checks have both improved on this time last year and there has been an increase in overall checks compared to the same period last year.

Community Hospitals

There were 194 admissions to the Community Hospitals in March and 4,472 occupied beds days from a possible 4,985 bed days, therefore, bed occupancy stood at 89.7%. There were a total of 530 bed days lost due to delayed transfers of care (11.9% of total occupied bed days). The average length of stay (median) was 18.2 days across all hospitals in Month 12.

Bed Occupancy (Target range 87-92%): Bed occupancy decreased to 89.7% in Month 12, with Deal (81%), the only site 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 by year end): Performance against the median average length of stay target remains slightly above target for the year at 21.6 days, however for M12 this decreased to 18.2 days.

Delayed Transfer of Care (DTOC) days as percentage of total bed days (Target 3.5%): Delayed Transfers of Care has increased in M12 and remains above the target at 11.9% (12% YTD). This relates mainly to high levels at all hospitals, with all sites being above the 3.5% target with the exception of Sevenoaks and Edenbridge. This is split between 7.4% NHS responsibility and 4.5% Social Services/Other

Activity

KCHFT's clinical services carried out 150,337 contacts (This figure includes various currencies e.g. face to face contacts, telephone contacts, group sessions, Units of Dental Activity), of which 10,319 were MIU/WiC attendances, during March 2017. KCHFT is above target at Month 12 (+1.9%), mainly due to improved performance in a number of services. Performance against 2016/17 contract targets has been summarised at Service Specification level below:

Service & Currency	M12 Actual	YTD Actual	YTD Target	YTD Variance	Contract BRG	Trend
Long Term Conditions - Face to Face	59,673	724,298	773,020	-6.3%		
Intermediate Care - Face to Face	23,666	307,367	300,518	2.3%		
Intermediate Care - Attendances	10,319	118,523	108,727	9.0%		
Intermediate Care - Occupied Bed Days	107	1,552	1,548	0.3%		
Planned Care - Face to Face	21,106	239,864	249,339	-3.8%		
Planned Care - AQP/Tariff (no target)	8,086	82,694				
Learning Disabilities - Face to Face	3,235	38,126	43,008	-11.4%		
*Children's Universal Services - Face to Face	34,798	367,742				
Children's Specialist Services - Face to Face	15,347	161,926	156,491	3.5%		
Dental Service - UDAs	6,581	88,086	97,100	-9.3%		
Health Improvement Services - Face to Face	392	4,555	3,000	51.8%		
All Services and Currencies (Contracted)	**150,337**	**1,788,563**	**1,755,088**	**1.9%**		

Contract
>-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 6.2% (53,444 contacts) below at year end. This is due to under-reporting in some areas in the first half of the year.. Intermediate Care and Rehab Services (ICT) are 2.3% above target (6,849 contacts) with the targets adjusted for 16/17. Activity for the planned care services is 3.8% 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 3.5% above target at year end. This includes activity where there is no target. Against target only the services are 9.9% below target for the year, mostly attributed to West Kent Special Schools and ITAC in East Kent. The West Kent Special Schools target has been adjusted for 17/18

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.6
Subject:	Monthly Quality Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary

This report provides assurance to the Board on Patient Safety, Patient Experience and Patient Outcomes.
There was an improved fill rate in April for RN's. However, Herne Bay and Tonbridge did not meet the 95% fill rate standard. A high number of number of patients required 1:1 care in the community hospitals.
There continues to be an improving position in respect of pressure ulcers and there have been no serious incidents in relation to falls
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. 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.

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NHS
Kent Community Health
NHS Foundation Trust

MONTHLY QUALITY REPORT

1. Patient Safety

Workforce Data and Quality Metrics

1.1. The information in Figure 1 relates to April fill rates per community hospital ward broken down by day and night for registered and unregistered staff.

1.2. The fill rate for registered nurses has improved from the March position, producing a total fill rate of 102% for RN's day shifts (97% last month). The reason for overfill is staff undergoing induction or being rostered on duty although attending training. Night shift fill rates for RN's has increased from 97% to 98%. There is no agreed national rating system yet, so the Chief Nurse will provide commentary on any areas less than 95%.

1.3. Tonbridge was the only Hospital that had RN day shifts below 95% and QVMH was the only hospital with 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 provide enhanced observation (1:1 care) for patients with dementia. The Operational and Nursing and Quality teams are jointly exploring the requests for additional staff and reviewing whether other measures can be put in place for patients who need observation. 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:

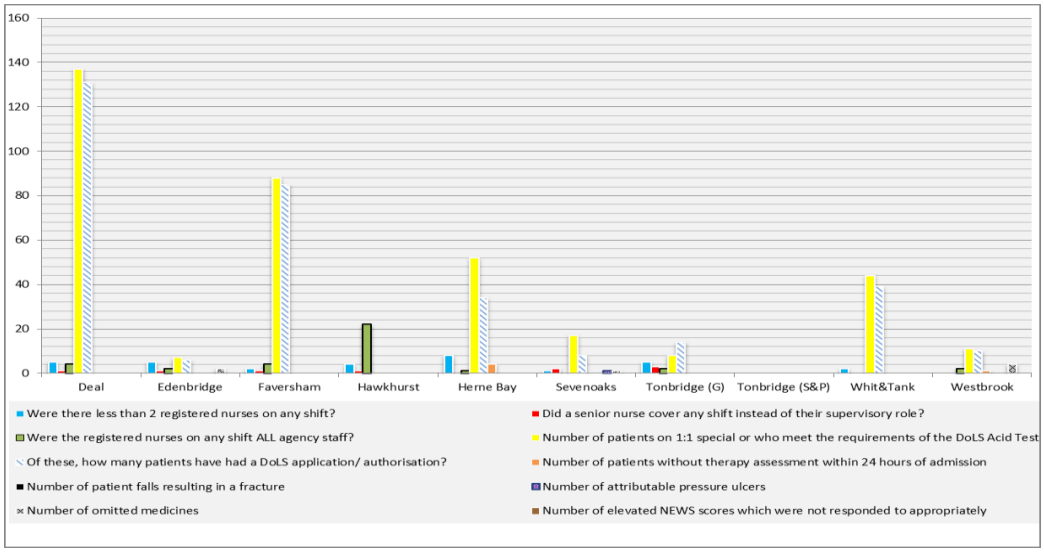
	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Faversham	122.5%	174.4%	101.7%	108.3%	900	1102.5	1350	2355	660	671	660	715
Deal	100.8%	144.4%	100.0%	111.7%	900	907.5	1350	1950	660	660	660	737
QVMH	95.0%	155.6%	93.3%	150.0%	900	855	1350	2100	660	616	660	990
Whit &Tank	100.8%	139.3%	96.7%	103.3%	900	907.5	1125	1567.5	660	638	660	682
Sevenoaks	106.7%	113.9%	100.0%	108.3%	900	960	1350	1537.5	660	660	660	715
Tonbridge	93.3%	136.7%	100.0%	133.3%	1350	1260	1800	2460	660	660	990	1320
Hawkhurst	104.2%	112.0%	98.3%	100.0%	900	937.5	1312.5	1470	660	649	660	660
Edenbridge	95.0%	125.0%	96.7%	103.3%	900	855	900	1125	660	638	330	341
Total	**102%**	**138%**	**98%**	**117%**	**7650**	**7785**	**10538**	**14565**	**5280**	**5192**	**5280**	**6160**
	Over 90% Fill Rate			65%to90% Fill rate				Less than 65%				

1.4. 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/alert staff from other wards to provide cover or offer support
- 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
- request to operationalize staff within the Clinical Education Team

1.5. Wards are required to submit a daily red flag report (Figure 2) detailing incidents related to quality.

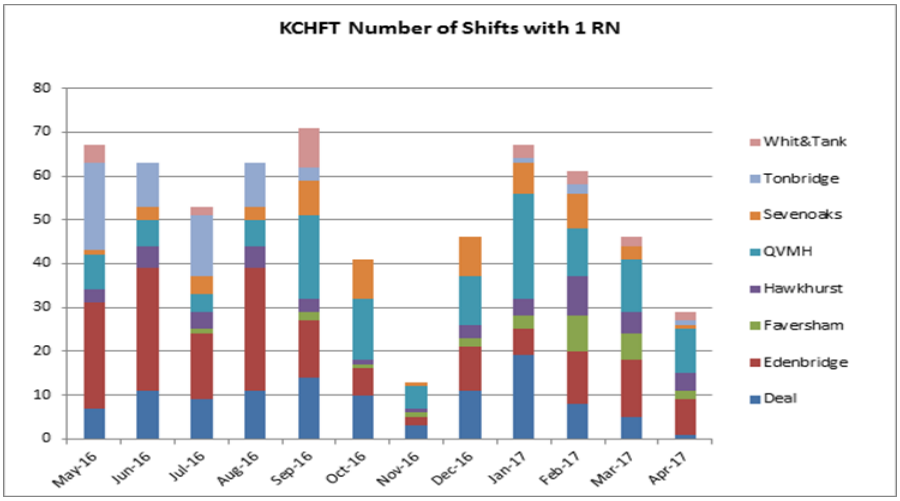
Figure 2:



1.6. There has been an increase in the number of patients requiring 1-1 support; the majority of these are related to the number of inpatients with mental health needs. Deal hospital had over 130 occasions where a patient required a 1-1 special on a shift. Whilst work is underway to explore different ways of supporting these patients there has been the need to request additional staff to maintain safety.

1.7. There were 29 shifts when there was 1 RN on duty (Figure 3), this is an improved position from March where 46 shifts had 1 RN on duty. Edenbridge, QVMH and Hawkhurst, were the wards most challenged in filling RN shifts and this is reflected in their lower fill rates. There is still some work to do to ensure ward leaders are recording this accurately and not when they are using non rostered staff or temporary staff to cover shifts.

Figure 3:



1.8. Of the 29 shifts with 1 RN, there were clinical incidents on 4 of these shifts (Figure 4), all of which 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	Impact on Patient
Hawkhurst	11.04.17	Fall	No Harm
Hawkhurst	20.05.17	Fall	No Harm
QVMH Hospital	09.05.17	Fall	No Harm
Tonbridge	11.05.17	Pressure Ulcer	Low Harm

Within these shifts, safety was maintained by operational managers by implementing the measures stated in figure 1.4.above. After investigation all falls were found to be unavoidable i.e. all elements of the falls bundle were in place.

2. Pressure Ulcers

2.1 The Pressure Ulcer Taskforce Group continues to meet monthly to progress prevention strategies in pressure ulcer management. Monthly highlight reports

are submitted by each locality to evidence progress, actions and audit outcomes. New trajectory targets have been agreed for 2017/18 as a 10% reduction in all categories of avoidable pressure ulcer harms. Root cause analysis is carried out for all category 3, 4 and ungradeable pressure ulcers and are signed off by the Chief Nurse. Action plans are in place for all localities which are monitored at the Pressure Ulcer Taskforce meetings.

2.2 **Category 2 pressure ulcers**

There have been no confirmed avoidable category 2 incidents acquired in our care this month. There are 48 outstanding category 2 investigations (15 last month) to be completed of which 8 are overdue.
There have been no reported category 2 pressure ulcers in April.

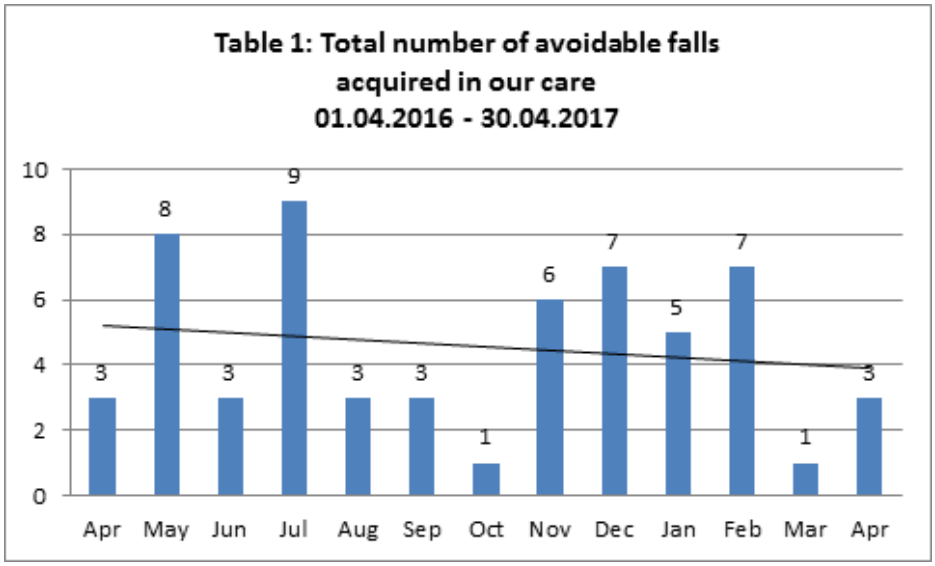
2.3 **Category 3, 4 and ungradeable pressure ulcers**

There have been no confirmed avoidable category 3 or above harms acquired in our care this month, although there are 2 potential harms currently under investigation. There are 49 outstanding incidents (26 last month) to be investigated of which 5 are overdue.
There have been no reported category 3, 4, or ungradable pressure ulcers in April.

3.0 Falls

3.1 There were 56 falls reported across KCHFT (55 last month) of which 3 were found to be avoidable - this is an increase from 1 in March. The 3 falls occurred within Westbrook House, were all unwitnessed and resulted in low harm to the patient. No falls resulted in a fracture in April which is an improved position from March where 1 was declared.

Figure 5



3.2 It is now possible to collect data by Occupied Bed Days (OBDs) which enables easier benchmarking and does not depend on categorisation by an individual into avoidable/not avoidable. It has been agreed that in 17/18 KCHFT will measure falls data in this format and the annual falls target will be set as follows:

- 10% reduction in all falls per 1000 Occupied bed days (OBDs)
- 10% reduction in falls that result in moderate and severe harm per 1000 occupied bed days (OBDs)

The Falls operational group will be split into East and West Kent Quality Improvement Groups and will focus on and analyse the OBD data / actions and ward specific issues. April data is not yet available but it is anticipated that monthly data will be in this report going forward.

3.4 The Trust is taking part in the Royal College of Physicians audit of in-patient falls. This is the first time community trusts have been invited to take part in this national audit. Data collection will take place on 16th & 17th May 2017.

4. Medication Incidents

4.1. There have been 27 avoidable medication incidents reported and investigated to date, 5 of these were near misses and all were low or no harm. The highest reported category of avoidable incidents is omitted medication making up just over a third of the total number logged since the last report.

4.2. April incident reporting rate is low to date but there are a number of incidents waiting to be investigated. There have been no reported moderate or severe harms in April 2017.

Figure 6

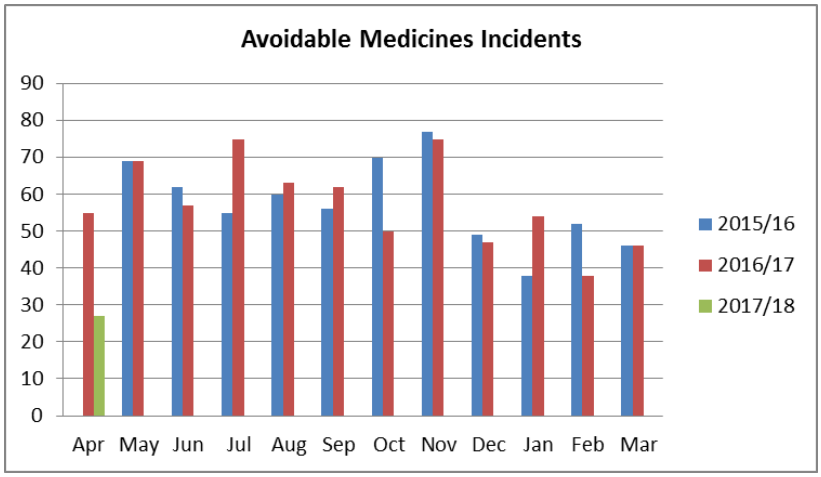


Figure 7

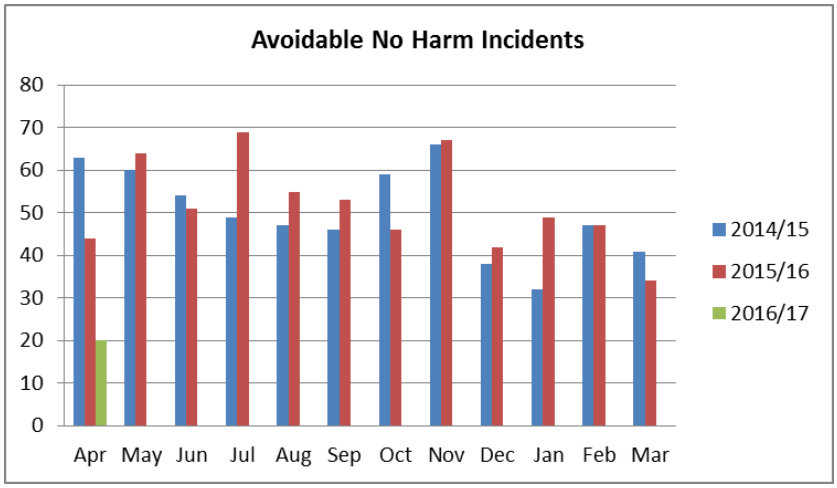
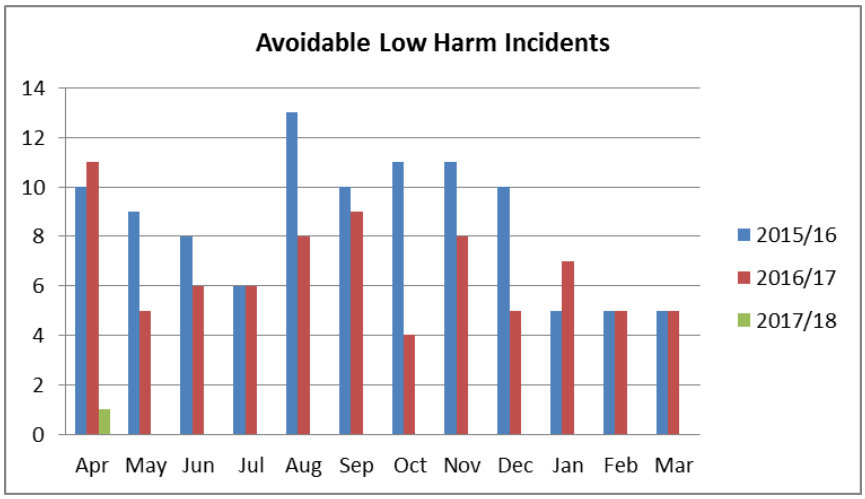


Figure 8



5. Infection, prevention and control

5.1. This month the focus has predominantly been on the development and implementation of a Clostridium Difficile action plan in response to last year's breach of target. The focus is on communication and antimicrobial stewardship. The team are also now working to help achieve the national target of reducing gram negative bacteraemias by 50% by 2021, with a target nationally of a 10% reduction in healthcare associated E-coli bacteraemias in 2017/18. The team are undertaking local surveillance alongside the CCG's and Acute Trusts to allow a focussed campaign, and will be reviewing the current processes in relation to UTI treatment protocols. The SEPSIS recognition and action algorithms have now been finalised, and the information will be disseminated during May 2017.

5.2. There has been 1 outbreak of vomiting and diarrhoea within a bay in Whitstable and Tankerton Hospital, however no pathogens were grown.

Figure 9

Outbreak summary data 2017/2018

Hospital	Period	Outbreak	Outcome
Whitstable and Tankerton	One Bay closed 24/4/17 – 27/4/17	Diarrhoea and vomiting – nil pathogens isolated	3 patients and 1 staff affected

6. Quality Surveillance

Verbal Update- need to ensure we have this for board or just take it out

7. Patient Experience

7.1. Meridian Patient Experience Survey results for April 2017

5,644 surveys were completed by patients using KCHFT services throughout April with a combined satisfaction score of 97%. This includes 2,354 short NHS FFT surveys used by the MIUs that achieved an overall satisfaction score of 97.51%.

Satisfaction levels remain consistently high.

Combined result from all questionnaires submitted between 1-Apr-2017 and 30-Apr-2017	Number of questionnaires submitted between 1-Apr-2017 and 30-Apr-2017
96.95%	**5,644**

Selection of key words used within Meridian survey responses) for April 2017:

Key: Green positive feedback words / Red negative feedback words. This is a computer generated image and in this case the word *good* appears in red because patients have used it several times in a survey that didn't have a very high overall satisfaction percentage.

6.2 The below table demonstrates the NHS Friends and Family Test (FFT) trust wide results for April

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.62%	0.56%	5326	4411	788	71	17	13	26

The majority of responses are extremely positive about KCHFT services.

A selection of positive feedback is detailed in figure 12.

Figure 10

Intermediate Care (including Rapid Response) - Tonbridge and Malling	Ann has been extremely helpful and has motivated and made a big improvement to his mobility which in turn helps to raise his spirit and hopes for the future.
Lymphoedema Service - Tunbridge Wells	A brilliant service, condition fully explained and also ways to improve situation. A very pleasant and knowledgeable practitioner with excellent communication skills.
Community Nursing - Dover	The service I receive is marvellous. We are so lucky to have the NHS and I am so lucky to have the nurses visit me at home. I am so grateful. What we would we do without you?
Acute Nutrition and Dietetics - Margate	Very helpful and informative. Helped with all our concerns and given leaflets and help line info. So much better after this.
Heart Failure Specialist Nurses - Thanet	Treated promptly, professionally but friendly. Listened to, explanation and discussion so I fully understand my condition.
Dental (Adults and Children) - Canterbury	My son has had a complete fear of the dentist hence our referral with this service. this is not our first appointment here but I can't praise the dentist enough in her treatment of my son - her kindness and patience has been amazing and she has really helped him overcome his fear
Children's Audiology (Hearing Service) - Sittingbourne	Your staff are quite friendly and warm. We absolutely love this service.
Community Paediatrics - Maidstone	The paediatrician was excellent, caring professional, attentive and made us feel at home. The receptionist was welcoming too.
School Nursing - Shepway	School nursing service has been a very positive experience and helped us to make positive lifestyle changes.
Children's Speech and Language Therapy - Dartford	Lots of helpful (and much needed) strategies given which have led to real progress. I felt listened to and time was taken to really understand my child and his needs.

All negative comments are flagged to services for investigation and action if possible and a selection of negative feedback from the NHS Friends and Family Test question is below.

Figure 11

Community Chronic Pain Shepway	Extremely unlikely	Your service is too slow, people in pain can't wait 14 or more weeks between appointments. I was seen in July, not seen again until November then not till February, now waiting on the end of May. You don't actually offer anything a patient can't get elsewhere. More importantly you don't offer, or at least advise on, alternative non pill therapies. You also don't help with the conflicting interaction between multiple services, only GP. You also, and I STILL can't believe this, REFUSE to talk to patients outside of scheduled appointments. The nurses are fab but the overall service is ineffective. Why on earth, and I would complain but you only take them by letter (in an email age!!!) Would you arrange pain education mornings at an out of town venue NOT on a bus route??? I don't have the money for taxis so this service is denied to me. I'm very cross with this lack of thought, even if I had a car, I'm unable to drive due to my pain meds. **Action**: *Survey flagged to service. Service response: we discussed this at our operational management meeting yesterday and we suspect the patient that completed this survey may have actually also been in touch with the customer care team later that day via email.* *The complaints team then received a complaint that was very similar to this feedback. The Head of Service emailed complainant to apologise and say it is not always possible to attend all aspects of the pain management service, however we do have some alternatives e.g. online programmes.* *Patient now has an appointment at Folkestone.*
Community Nursing - Deal	Unlikely	Had a lot of problems. DN's been asked to various things but they don't happen. Really need a good shake up. This was about a year ago but still not very efficient. Would like a phone call prior to visit. ***Action**: this has been sent to the service for comment and action.*
Health Checks - Maidstone	Unlikely	It was a rubbish summary of my health. It only covered basic issues and my questions could not be answered. ***Action**: this is being followed up with the programme manager*
Community Learning Disability Team -Dover	Unlikely	These appointments have been made before asking permissions from parent or even asking if we want this service for my son. ***Action**: Service response from Business Development Manager: I have now made our Head of service aware and SLT consultant/professional lead aware of this feedback. We will discuss at our senior management team meeting and make a decision to improve on any gaps. We do appreciate*

		that we may not get it right for everyone, but we will as a service continue to improve areas that our service users(clients) are not particularly happy with.

6.4 There are no examples of negative feedback received for C&YP services during April. The majority of unlikely and extremely unlikely were received via child/young people surveys where there was no negative feedback on the rest of the surveys. The remaining few were possibly chosen in error as all survey questions were answered positively and no negative comments made.

6.5 **Selection of actions completed in April**

- **Intermediate Care Team, Shepway** - Patient unhappy with provisions of physiotherapy in residential home and provisions following discharge at patient's home.

Action: Service produced a leaflet to be given to patients being discharged to Broadmeadow Rehabilitation Unit. Stroke Specialist nurse and ICT Operational Manager met with Acute trust and will invite Stroke consultant to visit Unit to better understand staffing levels and provision of Neuro-rehabilitation (this action also included in Model of Care action plan)

- **Sevenoaks Minor Injury Unit -** Patient unhappy with attitude of receptionist. **Action:** Discussed at team away day about how staff would expect to be treated if they were in an unfamiliar environment and sometimes how they are perceived.

- **Sheppey Minor Injury Unit -** Family member contacted Customer Care Team. Unhappy that patient was misdiagnosed at MIU. Service to review procedures of patients attending with abdominal pain. Staff across MIUs in Gravesham, Sheppey and Sittingbourne to receive training updates as necessary.

Action: Staff member had a meeting with lead to identify any areas of update required / Staff have quarterly peer audits within MIU during which clinical and clerical and notes are scrutinized. New Clinical Lead at Gravesham is planning to start in house training sessions as Swale already do.

- **Clinical Nutrition & Dietetics** - Community Nutrition Service - Lack of interpreters available.

Action: Feedback related to booking service. Admin team has updated process for booking interpreters to make codes available.

- **Sexual Health Service -** Patient unhappy that they have been unable to book an appointment at sexual health clinic and that telephone number was going straight to voicemail.

Action: New answerphone message has been recorded to ensure that patients are directed to the correct number to call if they cannot get through (0300 790 0245).

- **Community Paediatrics -** Unhappy with lack of paediatric care received for patient over last few years, that procedures need reviewing due to delay in processing information provided.

Action: Letter amended to include information for families wishing to hand deliver documents to clinic in Maidstone to ensure they are received by the service.

- **Community Paediatrics -** Unhappy that patient has been on waiting list for over 1 year to be assessed for ASD pathway.

Action: Triage process reviewed to ensure patients who may be higher risk are prioritized.

7.0 Patient outcomes

7.1 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 April 2017, there were 157 clinical audits on the audit programme. Of the 157 audits, an action plan is in place or currently being developed for 31% (49/157) projects. 1 project is fully completed.

A review of audits on the 2017/18 programme indicates that audits are focussed on:

- National Priorities / National Audit / NICE Guidelines
- Corporate Assurance / Organisational Priority and Safeguarding
- Local priority monitoring and evidencing KPIs
- Risk (including Re-audits of Limited or No Assurance Audits from 2016/17)
- Commissioning Priorities

The order of the top 5 themes matches that in place at the close of the 2016/17 programme.

7.2 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. Achievement against the targets is reported bi-monthly to the Performance Team, who publish the results in the Integrated Performance Report. 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 April 2017 showed compliance target met in all 3 KPI areas.

Figure 12

Key Performance Indicators	April	Achieved
1. Due audit recommendations implemented - KPI 4.6 Target April >35%	43%	Yes
2. Actions overdue by more than 3 months - PI 36 Target <=10%	3%	Yes
3. Actions overdue by more than 6 months - PI 37 Target <=5%	3%	Yes

12. National Institute for Clinical Excellence (NICE)

12.1 The number of NICE guidance/ standards that were issued in April 2017 was nine. The number of guidance/standards issued in January 2017 that were due for assessment in April 2017 was twelve in total. Six of the guidance/ standards issued were deemed applicable to at least one service throughout the trust and six were assessed as not applicable. Of the twelve responses from different services that identified guidance/ standards as applicable, the following assessments have been completed;

- Eight still remain under initial review and have not yet been fully assessed.
- Four have been identified as fully compliant

Ali Strowman
Chief Nurse
May 2017

Contributions from the Nursing and Quality and Audit and Performance teams

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.7
Subject:	Finance Report, Month 1
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary

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

The Trust achieved a surplus of £237k which was £27k 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 £237k (1.3%) to the end of April. Pay and non-pay have underspent by £360k and £210k respectively and depreciation/interest has overspent by £26k. Income has under-recovered by £517k.	●
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: £210k of savings has been achieved for April against a risk rated plan of £340k which is 38% behind target. All savings have been achieved on a recurrent basis.	●
Cash and Cash Equivalents: The cash and cash equivalents balance was £16,844k, equivalent to 29 days expenditure. The Trust recorded the following YTD public sector payment statistics 96% for volume and 93% for value.	●
Capital: Spend to April was £121k, representing 57% of the YTD plan.	●
Agency: Agency spend was below trajectory for April.	●

Proposals and /or Recommendations

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

Finance Report M1

Relevant Legislation and Source Documents
Monitor NHS Foundation Trusts Annual Reporting Manual NHS Manual for Accounts 2014-15
Has an Equality Analysis (EA) been completed
No. High level financial position described and no decisions required. 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.

Gordon Flack, Director of Finance	Tel: 01622 211934
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Kent Community Health
NHS Foundation Trust

FINANCE REPORT – APRIL 2017 (MONTH 1 of 2017-18)

The Trust achieved a surplus of £237k for April which was £27k better than plan. The Trust is forecasting to reach a surplus of £3,026k in line with plan.

Dashboard

Surplus — **Rag rating: Green**

	Actual	Plan	Variance
Year to Date £k	237	209	28
Year End Forecast £k	3,026	3,026	0

The Trust achieved a surplus of £237k to the end of April.

Pay and non-pay have underspent by £360k and £210k respectively. Depreciation/interest have overspent by £26k and income is £517k 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 M1 2017-18.

CIP — **Rag rating: Amber**

	Actual	Plan	Variance
Year to Date £k	210	340	-130
Year End Forecast £k	4,271	4,271	0

The Trust achieved CIPs of £210k to the end of April against a plan of £340k, which is 38% behind target.

59% of the total annual CIP target has been removed from budgets in M1.

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	16,844	18,977	-2,133
Year End Forecast £k	20,735		

Cash and Cash Equivalents as at 30 April 2017 stands at £16,844k, equivalent to 29 days operating expenditure.

Capital Expenditure — **Rag rating: Green**

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	121	212	91
Year End Forecast £k	4,179	4,179	0

Capital Expenditure year to date is £121k and represents 57% of the YTD plan.

Agency Trajectories — **Rag rating: Green**

	External Agency and Locum Expenditure	Trajectory M1 (£)	Spend Less Than Trajectory	Adverse or Favourable Variance to Trajectory
Total Directorate Position compared to an average of previous 7 months costs	321,983	723,333	401,350	**F**

External Agency and Locum Expenditure was £321,983 in M1 2018.
The Total Directorate Trajectory based on last year Trajectory is £723,333.

1. Income and Expenditure Position

The position for April was £27k favourable compared to plan. The in-month performance comprised underspends on pay and non-pay of £360k and £210k respectively, partly offset by an overspend on depreciation/interest of £26k and an under-recovery on income of £517k. The summary income and expenditure statement is shown below:

	APRIL ACTUAL £'000	APRIL BUDGET £'000	APRIL VARIANCE £'000	% VARIANCE
CCGs - Non Tariff	10,591	10,900	-310	-2.8%
CCGs - Tariff	256	373	-117	-31.5%
Charitable and Other Contributions to Expenditure	-14	6	-20	-352.8%
Department of Health	0	0	0	0.0%
Education, Training and Research	247	193	54	28.1%
Foundation Trusts	267	279	-12	-4.4%
Income Generation	62	13	49	369.4%
Injury Cost Recovery	38	27	11	41.6%
Local Authorities	3,958	4,047	-89	-2.2%
NHS England	1,867	1,799	68	3.8%
NHS Trusts	372	549	-177	-32.2%
Non NHS: Other	107	102	5	4.5%
Non-Patient Care Services to Other Bodies	49	44	5	10.6%
Other Revenue	148	159	-11	-7.0%
Private Patient Income	51	23	28	119.8%
Sustainability and Transformation Fund	147	147	0	0.0%
INCOME Total	**18,144**	**18,661**	**-517**	**-2.8%**
Administration and Estates	2,563	2,557	-6	-0.3%
Healthcare Assistants and other support staff	1,802	1,894	92	4.9%
Managers and Senior Managers	732	803	71	8.9%
Medical and Dental	782	797	15	1.9%
Qualified Nursing, Midwifery and Health Visiting	4,463	4,721	258	5.5%
Scientific, Therapeutic and Technical	2,483	2,648	165	6.2%
Employee Benefits	58	0	-58	-100.0%
CIP Target Pay	0	-71	-71	-100.0%
East Kent Savings	0	-73	-73	-100.0%
North Kent Savings	0	-33	-33	-100.0%
PAY Total	**12,883**	**13,243**	**360**	**2.7%**
Audit fees	5	5	0	3.8%
Clinical Negligence	41	41	0	0.9%
Consultancy Services	8	10	3	26.5%
Education and Training	16	69	53	76.6%
Establishment	665	1,014	349	34.4%
Hospitality	0	1	1	74.2%
Impairments of Receivables	-4	0	4	0.0%
Insurance	4	1	-3	-288.3%
Legal	43	26	-17	-66.1%
Other Auditors Remuneration	0	0	0	0.0%
Other Expenditure	11	10	-1	-5.1%
Premises	1,382	1,305	-77	-5.9%
Research and Development (excluding staff costs)	0	0	0	100.0%
Services from CCGs	0	0	0	0.0%
Services from Foundation Trusts	0	0	0	0.0%
Services from Other NHS Trusts	39	25	-14	-55.0%
Supplies and Services - Clinical	2,004	1,997	-7	-0.4%
Supplies and Services - General	77	107	31	28.8%
Transport	474	421	-53	-12.6%
CIP Target Non Pay	0	-58	-58	-100.0%
NONPAY Total	**4,765**	**4,975**	**210**	**4.2%**
EBITDA	496	443	53	11.9%
EBITDA %	2.7%	2.4%	-0.4%	
DEPRECIATION/AMORTISATION	262	240	-22	-9.0%
INTEREST PAYABLE	0	0	0	0.0%
INTEREST RECEIVED	2	6	-4	-61.1%
SURPLUS/(DEFICIT)	**237**	**209**	**27**	**13.1%**
SURPLUS %	-1.3%	-1.1%	-0.2%	

Table 1.1: Trust Wide variance against budget in month

2. Risk Ratings

From October 2016 NHSI has introduced a new rating system as part of the Single Oversight Framework. The Trust is now being measured on agency spend vs trajectory as well as existing measures and the best rating is a score of 1 rather than 4. The Trust has scored a 1 against this new 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
340	210	-130	4,271	2,521	1,750	4,271	0

Table 3.1: Cost Improvement Programme Performance

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

YTD achievement is 38% behind plan with £210k removed from budgets at month one against a risk rated year to date plan of £340k. Of the total CIP 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 30 Apr 17 £000's	Variance Analysis Commentary
NON CURRENT ASSETS:			**NHS Accrued Debtors**
Intangible assets	238	310	The in-month increase is principally due to the M1 accruals for
Property, Plant & Equipment	16,717	16,506	Market Rate income, STF income, MSK activity and Newborn
Other debtors	68	66	Hearing activity yet to be invoiced.
TOTAL NON CURRENT ASSETS	**17,023**	**16,882**	
CURRENT ASSETS:			**Other debtors**
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	13,715	14,050	The in-month increase is in main due to prepayments for rent and
NHS Accrued Debtors	2,026	3,439	rates and M1 accrued income entries for KCC.
Other debtors	2,604	3,403	
Total Debtors	**18,345**	**20,892**	**Cash and Cash Equivalents**
Cash at bank in GBS accounts	2,118	2,307	The in-month decrease is primarily due to the underpaid M1 SLA
Other cash at bank and in hand	49	37	value from West Kent CCG and the settlement of M12 Capital and
Deposit with the National Loan Fund (Liquid Investment)	17,000	14,500	NHS Creditors.
Total Cash and Cash Equivalents	**19,167**	**16,844**	
TOTAL CURRENT ASSETS	**37,512**	**37,736**	**NHS & Non NHS - invoices creditors falling due within 1 year**
CREDITORS:			The in-month decrease is due to the payment of o/s invoices with
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-5,322	-3,092	Dartford & Gravesham NHS Trust (CRC SLA invoices), MTW
NHS - accrued creditors falling due within 1 year	-3,234	-2,793	(Romney Ward invoice) and EKHUFT (Winter Pressure invoice).
Non NHS - accrued creditors falling due within 1 year	-8,283	-11,391	
Other creditors	-6,993	-6,418	**Non NHS - accrued creditors falling due within 1 year**
Total amounts falling due within one year	**-23,832**	**-23,694**	The in-month increase is due to accruals for M1 NHSPS costs
NET CURRENT ASSETS	**13,680**	**14,042**	yet to be invoiced.
TOTAL ASSETS LESS CURRENT LIABILITIES	**30,703**	**30,924**	
Total amounts falling due after more than one year	**0**	**0**	
PROVISION FOR LIABILITIES AND CHARGES	-3,584	-3,569	
TOTAL ASSETS EMPLOYED	27,118	27,355	
FINANCED BY TAXPAYERS EQUITY:			
Public dividend capital	-2,612	-2,612	
Income and expenditure reserve	-23,740	-23,977	
Revaluation Reserve	-766	-766	
TOTAL TAXPAYERS EQUITY	- 27,118	- 27,355	

Table 4.1: Statement of Financial Position, April 2017

	Total Assets	Total Liabilities	Assets/ Liabilities
Apr-16	53,592	31,054	1.73
May-16	55,219	32,630	1.69
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

Table 4.2: Assets and Liabilities

	Financial Period												
Financial Ratio/Metric	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17
Liquidity ratio days	11	11	12	13	14	14	15	15	16	16	17	16.48	17.80
Trade Receivables days	22	25	20	18	19	21	18	16	20	19	22	25	26
Trade Payables days	94	103	99	109	103	103	106	73	93	115	71	86	65
CAPEX (% of plan)	42.1%	20.3%	31.7%	25.1%	38.5%	46.8%	45.9%	59.3%	55.3%	64.2%	70.1%	100.0%	57.1%

Table 4.3: Balance Sheet Metrics

4.1 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	M1 Actual YTD £000's	M1 Plan YTD £000's	M1 Variance to plan	Full Yr Forecast	Full Yr Plan £000's	Full Yr Variance
Estates Developments	44	187	143	1,676	1,676	0
Backlog Maintenance	-	-	0	455	455	0
IT Rolling Replacement & Upgrades	77	20	-57	1,556	1,556	0
Dental SBU	-	5	5	242	242	0
Other Minor Schemes	-	-	0	250	250	0
Total	**121**	**212**	**91**	**4,179**	**4,179**	**-**

Table 4.4: Capital Expenditure April 2017

Gordon Flack
Director of Finance
May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.8
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 April 2017. It includes performance on: vacancies, recruitment timescales, absence, turnover, bank and agency fill rates, agency usage (measured as shifts), training / appraisal compliance, headcount, starters and leavers. This report is an 'exception' report; it contains narrative relating to those metrics against which we are performing below target in April.

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.
The Workforce 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.

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Kent Community Health
NHS Foundation Trust

WORKFORCE UPDATE REPORT

1. Report Summary

1.1 This report provides the Board with an update on the current workforce position as at April 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 an 'exception' report; it contains narrative relating to those metrics against which KCHFT is performing below target in April.

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. Each metric has been rated to illustrate performance against the Trust target.

Month	April 2017		
Direction (Better/Worse)	Metric	Target	Current Position
↓	Turnover (12 mths to April)	10.50%	14.76%
↑	Absence (2017/18 cumulative)	3.90%	3.65%
↑	Vacancies	5.00%	5.3%
↓	Fill Rate Overall	No target set (rated on 75%)	94.29%
↑	Fill Rate Bank	No target set (rated on 30%)	63.62%
↑	Agency spend as a proportion of the trajectory (April, without contingency)	< 100%	70.39%
↑	Agency shifts - Framework agency used - compliant with price cap	100%	95.05%
↓	Average Recruitment Time in Weeks (in April 2017)	< 7 Weeks	6.18wks
↓	Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target)	85%	86.2%
N/A	Number of suspended staff	No target set	3
↑	Appraisals (annual figure)	85%	90.8%
N/A	Trust Headcount (at 30 April 2017)	No target set	5,069
↑	Number of Starters (April)	No target set	196
↓	Number of Leavers (April)	No target set	76

3. Restructure

3.1 A recent organisational restructure means that the structure of this report has been amended for April 2017 onwards. The previous Adult Clinical Services and Children and Young People Directorates have been merged into the new Operations Directorate. This Directorate incorporates all of the services previously under the remit of the old Directorates. It also incorporates Sexual Health and Dental.

3.2 Strategy and Transformation, previously reported as a separate directorate, is now within the Finance Directorate.

3.3 With this restructure the twelve areas previously reported on at directorate level become eight, consisting of two clinical directorates (Operations and Nursing and Quality) and six corporate directorates. The majority of headcount sits within the Operations Directorate.

3.4 In order to ensure meaningful reporting a revised structure is being reported from April 2017 (in exception reporting where a breakdown of trust-level data is required). The Operations Directorate is therefore being reported at the level directly below directorate and includes:

- Children's Specialist Services.
- Public Health.
- East Kent.
- West Kent.
- Dental.
- Health Improvement Teams.
- Specialist and Elective Services.
- Operations Management.
- Learning Disabilities (still subject to discussion).

4. Performance Commentary

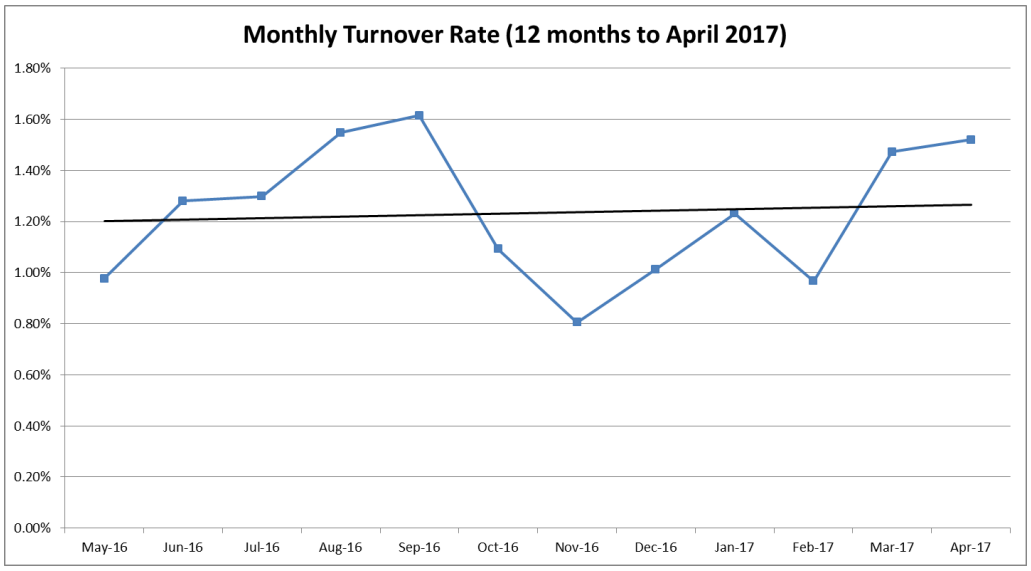
Turnover

4.1 Turnover is rated red this month. The turnover rate for the 12 months to April 2017 is 14.76%, which is an increase against March's figure of 14.37% and above the target of 10.50%. This turnover data excludes TUPE transfers.

4.2 Figure 1 below shows turnover for the month of April, which stands at 1.52% compared to 1.47% the previous month. This is the same pattern as last year where turnover decreased from 1.59% in March 2016 to 1.20% in April 2016.

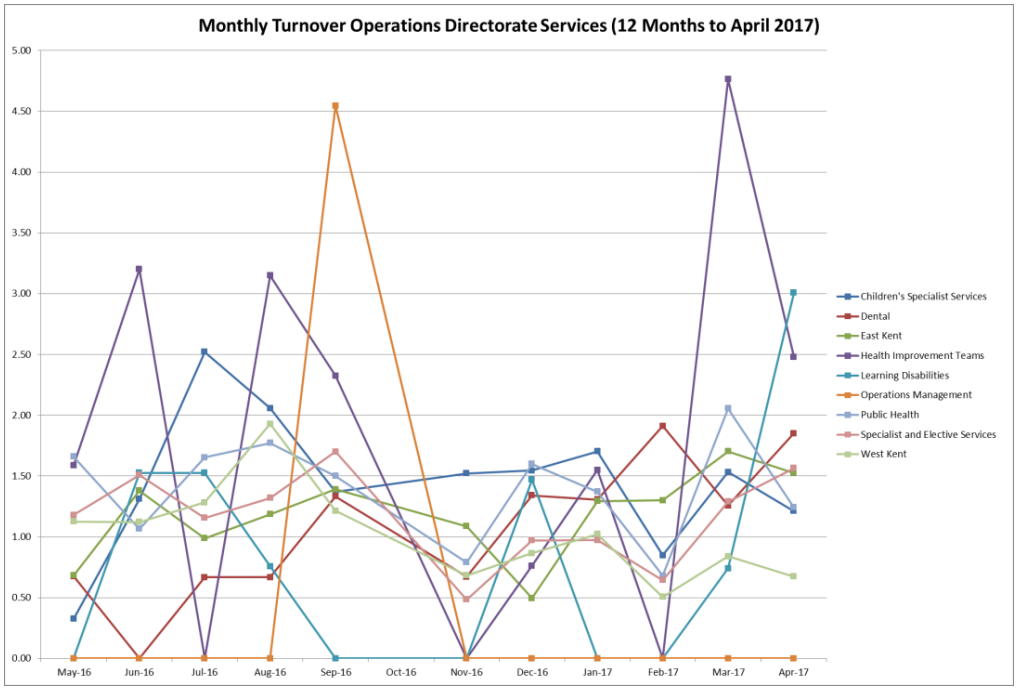
4.3 With two months of increases in the monthly turnover rate the trendline is now showing a slightly upwards trajectory having previous been downwards. This may revert to a downwards trend depending on performance in May 2017.

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



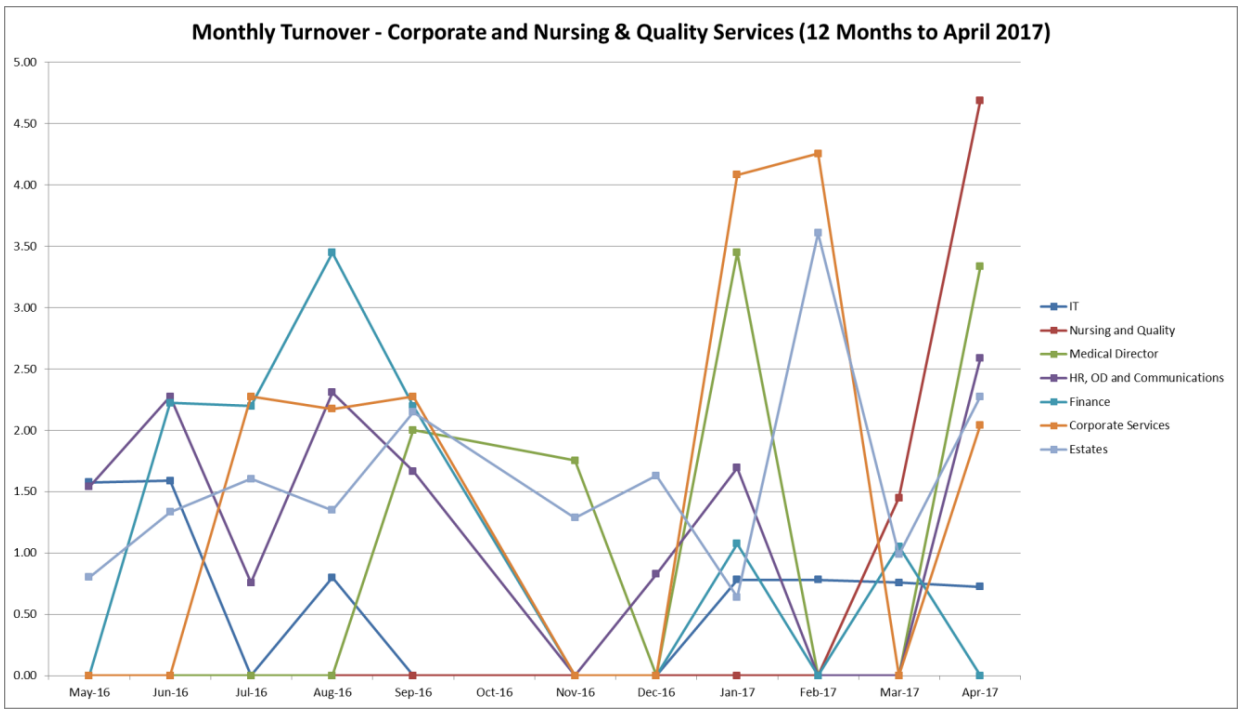
4.4 Fig. 2 below shows turnover for services within the Operations Directorate. Learning Disabilities has the highest rate for the month of April 2017 at 3.01%, up from 0.74% in March. The Health Improvement Teams have the second highest rate at 2.48%, although this is a reduction of the previous month's performance of 4.76% due to service reconfiguration. The third highest turnover rate is within Dental which stands at 1.85%, an increase from last month's 1.26%. The highest proportional increases in turnover against the previous month are for Learning Disabilities and Dental. The change in the Health Improvement Team rate is the highest proportional decrease in turnover since last month, with Public Health also seeing a high proportional decrease from 2.05% last month to 1.24% this month.

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



4.5 Fig. 3. below shows turnover by directorate for other Trust services. These are primarily corporate services but also Nursing and Quality. The highest turnover rate for April 2017 was Nursing and Quality at 4.69%, an increase from 1.45% last month. The second highest turnover rate was 3.33% in the Medical Directorate, up from 0% in the previous two months. Third highest was HR, OD and Communications with a turnover rate of 2.59%, also up from the 0% achieved in the last couple of months. Not taking into account services achieving 0% turnover last month, the highest proportional increase in turnover was for Nursing and Quality, with Estates having the second highest proportional increase in turnover with an increase from 0.99% last month to 2.27% this month. Finance have reduced their turnover rate from 1.05% last month to 0% this month.

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



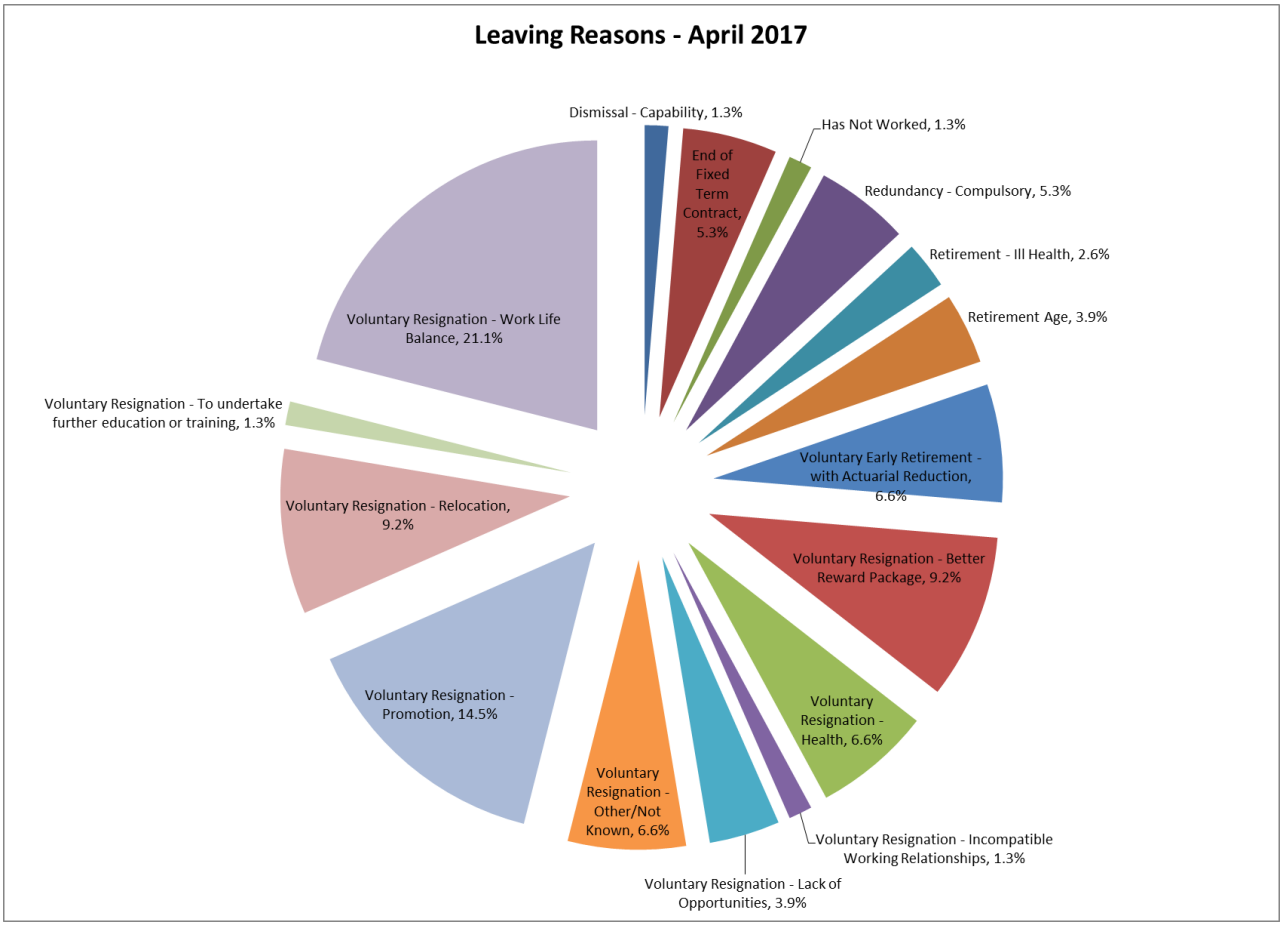
Leaving Reasons

4.6 There were 76 leavers in April 2017 compared to an average number of leavers of 63 during the 12 months to April. There were 197 starters in April 2017, higher than normal because of the North East London Dental and KMF TUPE transfers into the Trust. There was also a TUPE out of Wheelchair Services (not included in these figures) in April.

4.7 The figures below show leaving reasons for April, leaving reasons for the rolling 12 month period to April and the destination of those leaving for 'work-life balance', the most prevalent reason given for leaving.

4.8 Fig. 4 shows that 21.1% of April leavers left for work life balance reasons, slightly down from 21.4% last month. The second highest reason was retirements at 13.1%. This is shown broken down in the chart into the separate categories of ill health retirement, retirement age and voluntary early retirement. The third highest reason was voluntary resignation for promotion at 14.5%, up from 11.43% last month.

Fig.4: Leaving reasons – April 2017



4.9 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 April 2017. The figures shown represent the actual number of leavers.

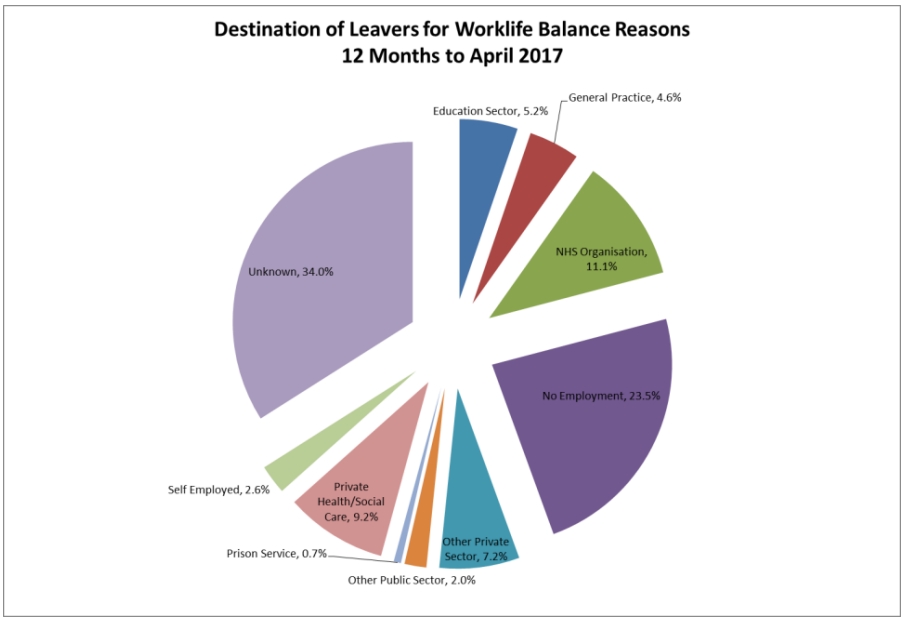
4.10 Resignation for work life balance reasons remains firmly as the top reason with 152 leavers (an increase of 2 leavers from the previous month). This was followed by promotion at 106 (up from 103) and retirement age at 98 (down from 103). For retirements, the figure of 98 leavers increases to 129 if other forms of retirement are taken into account. The fourth highest reason for leaving was relocation with 81 leavers (down from 86). These four reasons account for 437 leavers (468 if other forms of retirement than retirement age are included) which is 59% of all leavers. These figures exclude TUPE transfers.

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

4.11 Fig. 6 below shows the destination of work life balance leavers during the year to April 2017.

4.12 The top destination of work life balance reason is no employment at 23.5% (up from 22.37% last month), with 11.1% leaving for other NHS organisations (down from 19.74%). This is followed by 9.2% going to private health/social care providers (remaining the same as last month) and 7.2% to other private sector providers (down from 7.89%). The Trust does not know the destination of 34% of work life balance leavers.

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

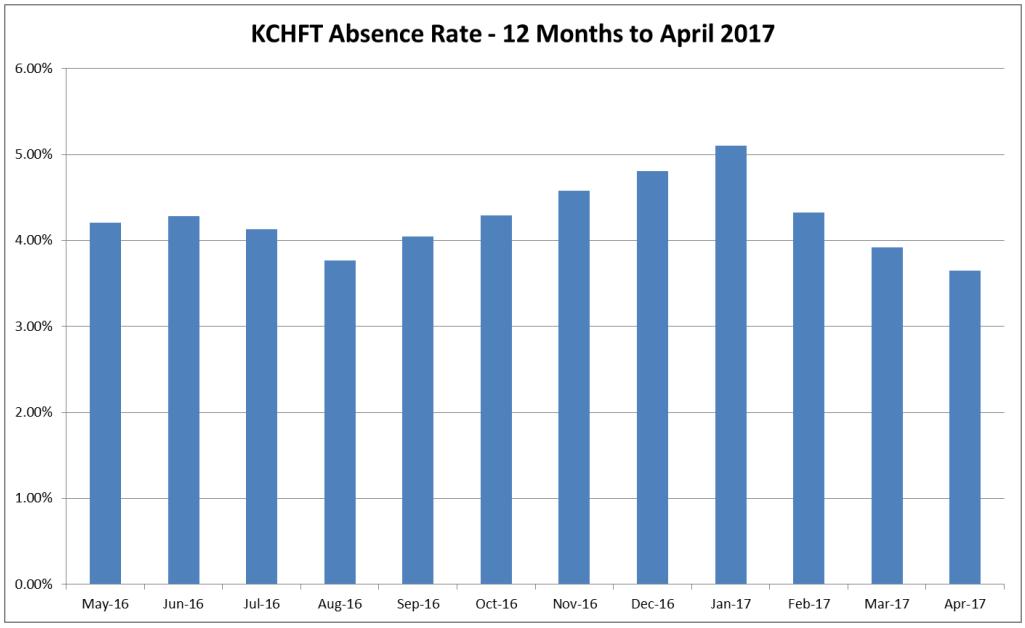


Sickness Absence

4.13 Sickness absence performance for April 2017 was 3.65% (down from 4.30% in 2016/17) and is therefore within the target of 3.90%. This is the second time in the past year below target and the lowest figure in the past year and beyond.

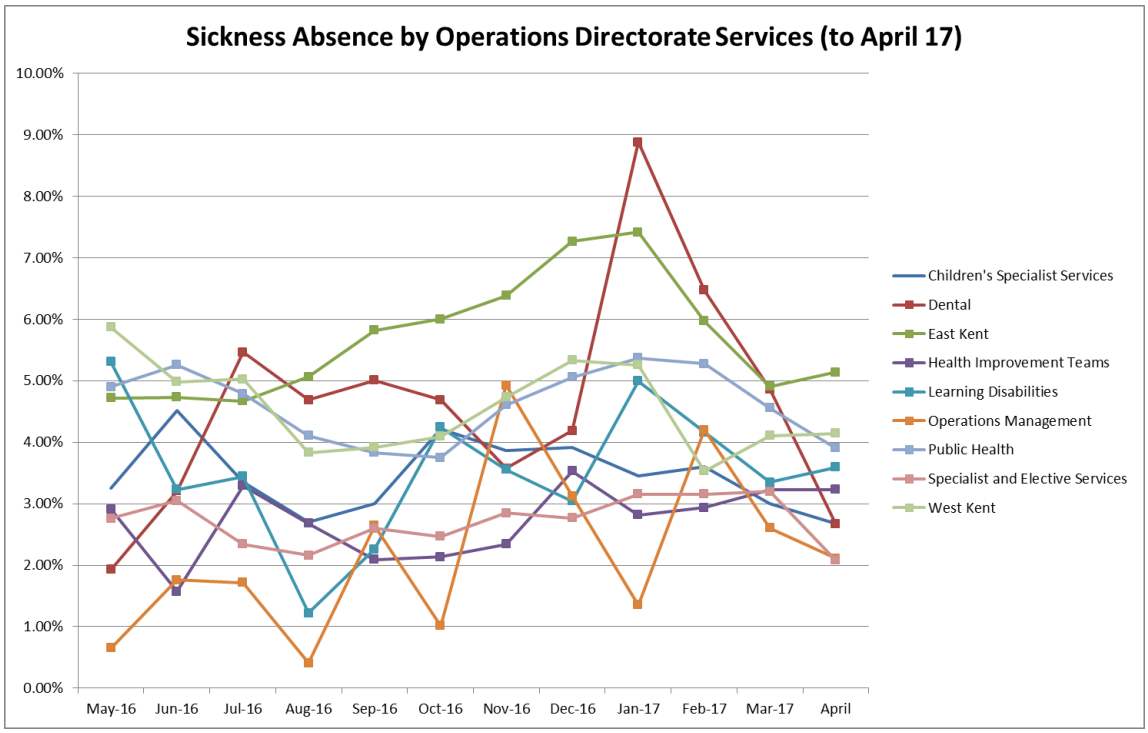
4.14 Fig. 7 shows the absence rate during the past 12 months and shows the lowest performance during the rolling period, with only August 2016 having a sickness figure near this at 3.77%. August often has a low sickness rate because fewer employees are at work because of annual leave, therefore fewer staff available to be absent.

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



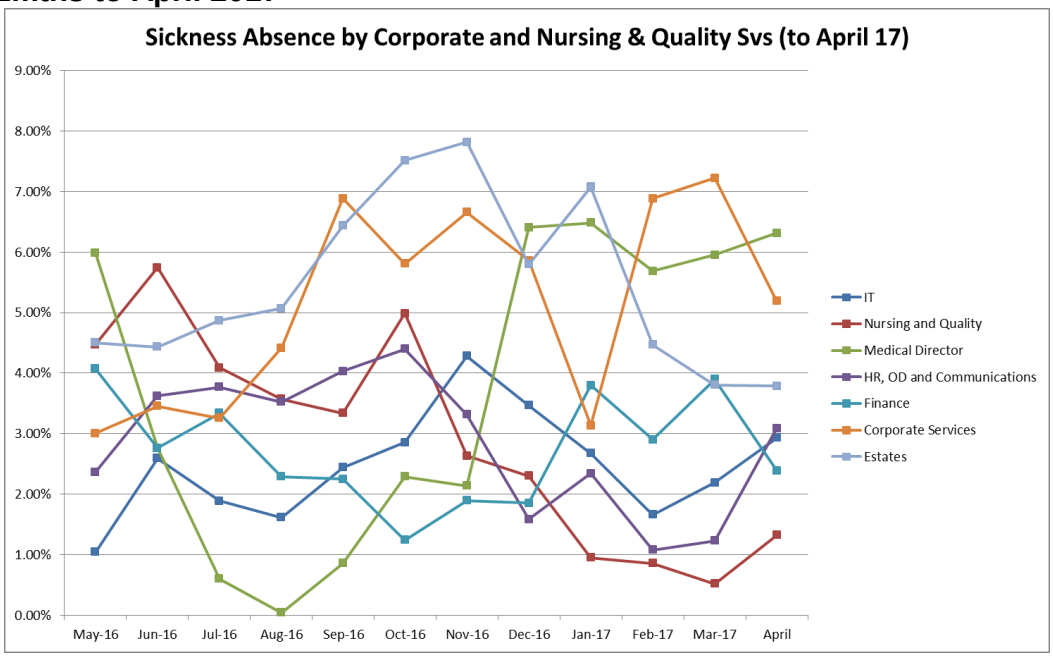
4.15 Fig 8 below shows sickness rates within the Operational Directorate. In April 2017 East Kent had the highest sickness rate at 5.13%, an increase on the previous month's figure of 4.91%. The second highest sickness rate was in West Kent at 4.14%, up slightly from 4.10% the previous month. The third highest rate is Public Health at 3.90%, a decrease on March's 4.56%. Learning Disabilities had the highest proportional increase in sickness absence, up from 3.35% in March to 3.59% in April. The largest proportional fall in sickness absence was in Dental, from 4.86% in March to 2.67% in April.

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



4.16 Fig.9 below shows sickness absence by corporate directorates and Nursing and Quality for April 2017. The Medical Directorate had the highest sickness rate for April 2017 at 6.32% compared to a rate of 5.95% in in March. The second highest rate was 5.19% in Corporate Services, down from 7.22% the previous month. The third highest rate was Estates with a sickness absence rate of 3.79%, a very slight decrease from 3.80% the previous month. Nursing and Quality had the highest proportional increase in sickness, increasing from 0.52% in March to 1.32% in April. The largest proportional fall in sickness absence was within Finance which saw a decrease from 3.89% to 2.39%.

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

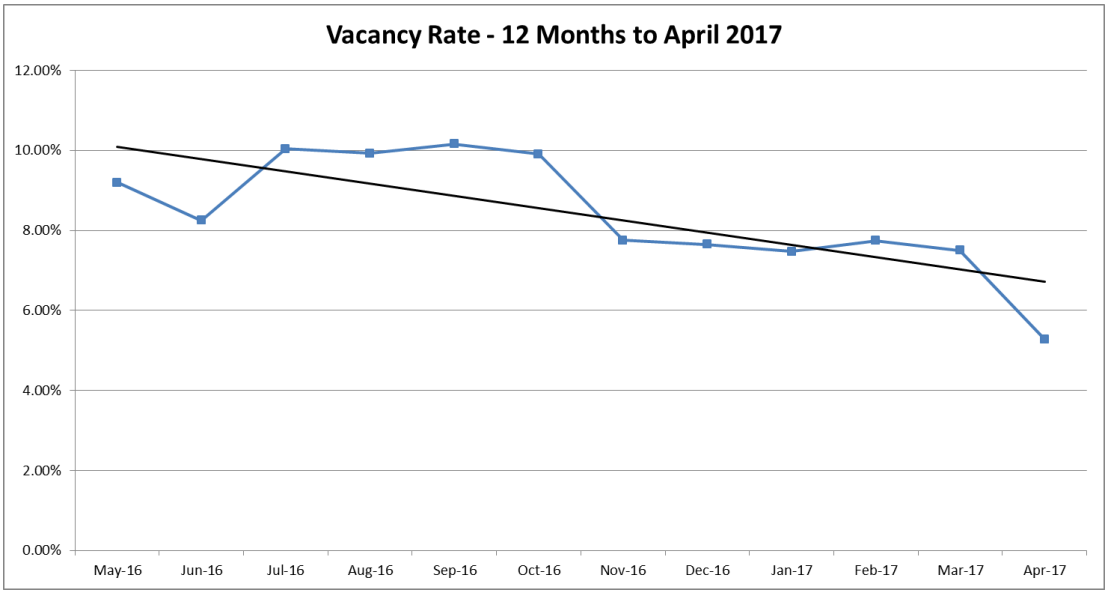


Vacancies

4.17 The vacancies figure for April 2017 is 5.3%, above the target of 5.0%. This has been rated Amber.

4.18 Fig.10 shows that at 5.3%, the figure for April 2017 is considerably lower than the 7.50% recorded for March 2017.

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



4.19 Fig. 11 shows the number of vacancies has decreased from 333.76 WTE in March to 230.73 WTE in April 2017, a reduction of 103.03 WTE vacancies.

4.20 Fig. 12 shows that there was a decrease in the budgeted figure from 4,427.80 WTE in March to 4,367.39 WTE in April, a reduction of 60.41 WTE. There was an increase in the number of contracted staff from 4,094.04 WTE in March 2017 to 4,136.66 WTE in April. This is an reduction of 1.4% in the budget and an increase of 1% in the number of contracted staff. The TUPE in of staff will have increased the number of contracted staff but this should have a negligible effect with a commensurate increase having been made in the establishment.

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

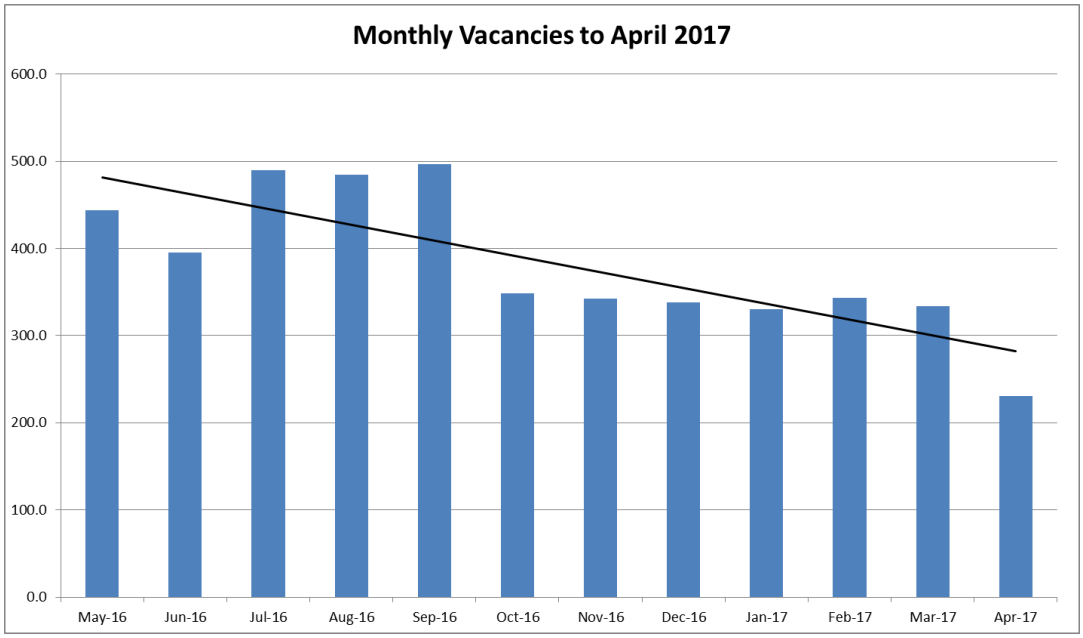
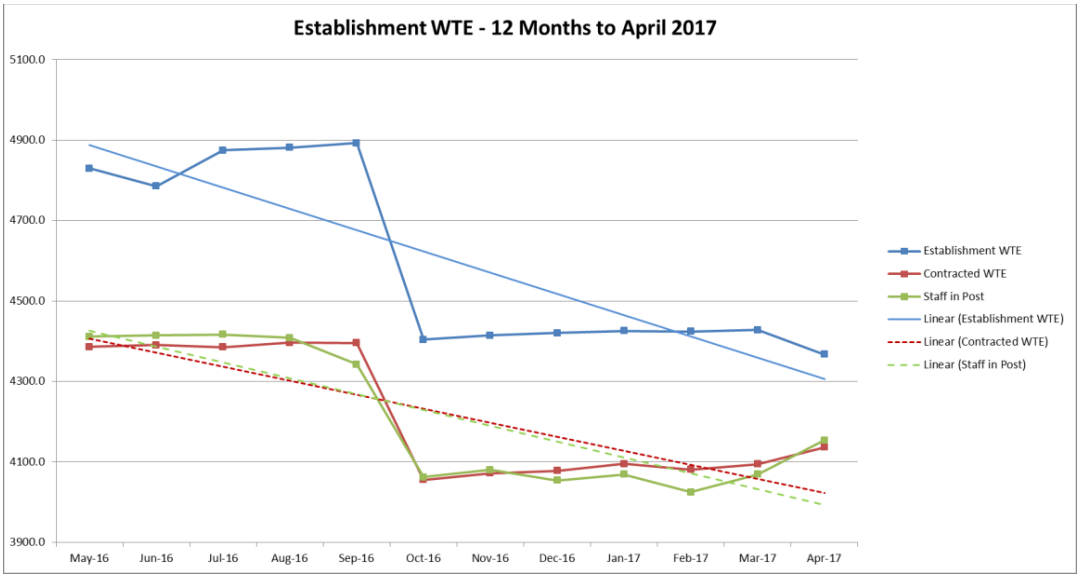


Fig. 12: Establishment in May 2016 to April 2017



Temporary Staff Usage

4.21 The table below shows shifts for April 2017 filled by agencies. The number of shifts filled with framework agencies compliant with the price cap is 95.05% against a target of 100%; this performance has been rated amber.

	Framework		Non Framework		Total
	Price cap breach	Price cap complaint	Price cap breach	Price cap complaint	
Number of shifts	25	980	21	5	1031
Percentage	2.42%	95.05%	2.04%	0.48%	100.00%

4.22 In April 2017, 95.05% of shifts were filled using framework agencies which are compliant with the price cap, up from 94.38% the previous month. There continues to be upward performance on this measure with a target of 100%; in

April 2017 the Trust has moved from red to amber because performance has reached 95%.

4.23 As well as the 95.05% of shifts compliant with price caps, a further 2.42% of shifts were booked with framework agencies who do not meet the price cap. In April 2017 a total of 97.47% of shifts were therefore filled using framework agencies, a decrease from 98.69%. This equates to 1,005 shifts being filled with framework compliant agencies in April.

4.24 The remainder of shifts were filled using non framework agencies which do (0.48%) and do not (2.04%) adhere to the price cap. This represents 2.52% of shifts in total, an increase from 1.31% the previous month.

4.25 The remainder of shifts were filled using non framework agencies which do (0.29%) and do not (1.02%) adhere to the price cap. This represents 1.31% of shifts in total (equating to 18 actual shifts), a positive reduction from the 1.78% of shifts in February.

4.26 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.

4.27 Fig. 13 shows agency spend for April 2017 compared to data available for last year in advance of a trajectory being established for 2017/18. At Month 1 agency spend is £321,983. Measured against an average of the previous 7 months costs this is 70.39% of the comparative data (minus the contingency).

Fig. 13. Agency spend for April 2017

Directorate and Locality	External Agency and Locum Expenditure M1 (£)	Trajectory M1 (£)	Adverse or Favourable Variance to Trajectory
Operations	308,298	451,917	F
Childrens Specialist Services	42,116	64,769	F
East Sussex Childrens Integrated Therapy Services (CITS)	1,290	3,421	F
Integrated Therapy and Care Services	9,638	8,193	A
Paediatrics Service	31,188	38,367	F
East Sussex Looked After Children Service	0	11,961	F
Kent Looked After Children Service	0	180	F
Specialist Community Childrens Nursing Services	0	0	F
Unaccompanied Asylum Seeker Children (UASC)	0	0	F
Universal SLT Services	0	2,648	F
East Kent	119,696	176,217	F
Ashford	839	8,435	F
Canterbury	19,094	27,030	F
Community Hospitals East Kent	57,619	74,208	F
East Kent Management	32,500	38,457	F
SKC	9,561	21,583	F
Thanet	83	6,504	F
North Kent	-1,203	-4,031	A
Swale	-1,203	-4,031	A
Learning Disabilities	4,295	2,924	A
Public Health	1,336	2,619	F
Specialist & Elective Services	6,406	15,916	F
West Kent	126,020	173,282	F
Add additional Tonbridge ward for 12 months	9,632	9,632	F
Corporate Services	6,952	1,581	A
HR	0	-720	A
Estates	804	3,620	F
Medical Director		382	F
IT	4,061	5,253	F
Reserves		-5,187	A
Nursing & Quality	1,867	571	A
Total Directorate Position compared to an average of previous 7 months costs	**321,983**	**457,417**	F
Contingency		**265,916**	F
Total Directorate Position/Trajectory based on last year Trajectory	**321,983**	**723,333**	F

4. Conclusions

4.1 Whilst turnover has increased this was expected due to the number of current restructurings taking place. However, during periods of restructuring our experience is that sickness increases. Therefore our focus will be on trying to minimise sickness absence during restructuring.

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
May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	2.10
Subject:	Committees Terms of Reference
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	x	Assurance	

Report Summary (including purpose and context)
The Terms of Reference for each of the following committees have been reviewed and approved. • Audit and Risk Committee • Charitable Funds Committee • Finance, Business and Investment Committee • Quality Committee • Remuneration and Terms of Service Committee

Proposals and /or Recommendations
The Board is asked to ratify the Terms of Reference.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no significant change proposed. 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.

Natalie Davies, Corporate Services Director	Tel: 01622 211900
	Email: Natalie.davies@kentcht.nhs.uk

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	21.03.11	Craig Sharples	New Document
1.1	Draft	26.01.12	Craig Sharples	Minor amends to reflect organisational change
2.0	Final	26.09.12	Craig Sharples	Update administrative section of TOR. Update references to CFSMS to NHS Protect in TOR. Explicitly reference relationship with the Finance, Business and Investment Committee in TOR.
2.1	Draft	05.02.13	Anthony May	Added section 7, expanded section 5 to state frequency of attendance required and amended requirement for a quorum
2.2	Draft	Aug 2014	Natalie Davies	Clinical Audit and Counter Fraud
2.3	Draft	March 2015	Rob Field	Updated to reflect Foundation Trust Status
2.4	Draft	March 2015	Rob Field	Amendment to Section 1.2 Objectives Trust Governance. Reallocation of

				delegated decision-making from ARC to FBI Committee. Amendment to Section 5.3 Membership, Removal of reference to attendance.
2.5	Draft	February 2017	Gina Baines	Minor amendments: Trust logo updated. Job titles updated.

Review

Version	Approved date	Approved by	Next review due
1.0	4 April	KCHT Board	April 2012
1.1	26.01.2012	KCHT Board	April 2012
2.0	Sept 2012	Audit and Risk Committee	Sept 2013
2.0	Sept 2012	KCHT Board	Sept 2013
2.1	Feb 2013	Audit and Risk Committee	Sept 2013
2.2	Sept 2014	Audit and Risk Committee	Sept 2015
2.3	March 2015	KCHFT Board	April 2016
2.4	March 2015	KCHFT Board	April 2016
2.4	February 2016	Audit and Risk Committee	February 2017
2.5	February 2017	Audit and Risk Committee	February 2018

1. Role

The Audit and Risk Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

The purpose of the Audit and Risk Committee is to:

- Seek assurance that the financial reporting, risk management and internal control principles are applied;
- Maintain an appropriate relationship with the Trusts auditors, both internal and external; and
- Offer advice and assurance to the Trust Board about the reliability and robustness of the process of internal control.

The Board may request the Audit and Risk Committee to review specific issues where it requires additional assurance about the effectiveness of systems of internal control or areas where risk management reports highlight concerns.

It is incumbent upon the Audit and Risk Committee to work closely with other committees of the Trust Board to ensure that all issues relating to finance, risk management and internal control are considered in a holistic and integrated way.

1.2 Objectives:

<u>Governance, Risk Management and Internal Control</u>

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commissions Essential Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurance, prior to endorsement by the Board

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements

- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

In undertaking such review the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

In carrying out this work the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

- Considering the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

- Annual review of the effectiveness of Internal Audit

Clinical Audit

The committee shall ensure there is an effective clinical audit function established by management. This will be achieved by:

- Consideration of the Clinical Audit Strategy and Annual Plan to determine the scope, scale and focus of the plan meets Trust identified risk priorities

- Assessment of the timeliness and effectiveness of management responses to clinical audit reports, drawing any deficiencies to the attention of the Quality Committee

- Ensuring the Clinical Audit function is sufficiently resourced and these resources are targeted to emerging priorities as they are identified.

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the independence, appointment and performance of the External Auditor, as far as the Audit Commission's rules permit

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors of their local evaluation of

audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all External Audit reports, including the report to those charged with governance, the annual audit letter before submission to the Trust Board and any work in the nature of audit work carried out outside the annual audit plan, together with the appropriateness of management responses

The committee shall provide an opinion to the Council of Governors on the appointment of the external auditor at the end of the contracted period for its consideration.

Counter Fraud

The committee shall review the effectiveness and impact of Counter Fraud operations within the Trust. This will be achieved by:

- Review of independent assessments of the Counter Fraud service
- Consideration, agreement and monitoring for assurance purposes of an annual programme of work balancing the need for proactive and reactive work
- Review of Counter Fraud Service reports and recommendations determining whether appropriate management responses have been received

Trust Governance

- Oversee the maintenance of an effective system of internal controls, assurance framework and management reporting and ensure that the Board is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored
- Monitor the implementation of Board policies on standards of business conduct
- Consider the content of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and review the management responses before presentation to the Board

Financial Reporting

The committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Major judgmental areas
- Significant adjustments resulting from the audit

Review of the completeness and accuracy of financial information provided to the Trust Board

2. Accountability

The Audit and Risk Committee is accountable to:

KCHFT Board.

And accountable for:
The Audit and Risk Committee has no sub committees.

3. Decision Making

The Audit and Risk Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control.

4. Reporting Arrangements:

The Audit and Risk Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. Governance

5.1 Chair:
One Non-Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

5.2 Secretariat:
The Corporate Services Director will act as Secretariat to the Audit and Risk Committee.

5.3 Membership:
The committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than 3 members. One of the members will be appointed chair of the committee by the Trust Board. The Chairman of the Trust should not be a member of the Audit and Risk Committee.

The Head of Internal Audit, Head of External Audit and the Local Counter Fraud Specialist, or their deputies, shall normally attend meetings. Other individuals with specialist knowledge may attend for specific items with the prior consent of the Audit and Risk Committee Chairman.

At least once a year the committee should meet privately with the External and Internal Auditors and the Local Counter Fraud Specialist.

The Chief Executive and other executive directors should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

5.4 Key Relationships:
Quality Committee
Finance, Business and Investment Committee
The Executive Committees

5.5 Quorum:
The meeting will be quorate if two Non-Executive Directors are in attendance.

5.6 Frequency of Meetings:
Meetings will be held not less than three times a year.
The Chair of the Committee can call extra-ordinary meetings as necessary

5.7 Notice of Meetings:
Meetings of the Audit and Risk Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

5.8 Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

5.9 Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

5.10 Minutes of Meetings:

The secretariat will record the minutes of the Audit and Risk Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Audit and Risk Committee shall be circulated promptly to all members by the secretariat.

5.11 Confidentiality:

The minutes (or sub-sections) of the Audit and Risk Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

6. Approval and Review of Terms of Reference

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

7. Monitoring Compliance

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Following each meeting.
Frequency of attendance	Attendance register of each meeting	Corporate Services Director will report to the Committee Chair	Annually

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
0.1	Draft	11.01.12	Craig Sharples	New Document
0.2	Draft	12.01.12	Craig Sharples	Revised following Charitable Funds Committee meeting – Submitted to Board for ratification
0.3	Draft	16.03.15	Rob Field	Amended to reflect Foundation Trust status
0.4	Draft	March 2016	Gina Baines	Amended point 5 attendance to include Governor as a member.
0.5	Draft	April 2017	Gina Baines	Amended point 5 attendance to include Fund Managers and Assistant Director of Communications and Marketing. Trust logo. Updated job titles

Review

Version	Approved date	Approved by	Next review due
1.0	26.01.2012	KCHT Board	April 2012
1.1	26.03.2015	KCHFT Board	April 2016
1.2	March 2016	Charitable Funds	April 2017
1.3	April 2017	Charitable Funds	April 2018

1. ROLE

The Charitable Funds Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference to

Purpose:

The Charitable Funds Committee will act on behalf of the Corporate Trustee, in accordance with the Kent Community Health NHS Foundation Trust Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from its exchequer funds.

The committee is authorised by the Board to obtain reasonable external, legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

Objectives:

The committee is delegated by the Board to undertake the following duties and any others appropriate to fulfilling the purpose of the committee (other than duties which are reserved to the Board alone):

- To ensure the Kent Community Health NHS Foundation Trust Charitable Fund is being managed and accounted for within the terms of its declaration of trust and Department of Health policy, including all legal and statutory duties, and in compliance with Charity Commission regulations. As a committee of the Board, in so far as it is possible to do so, most of the sections of the Standing Financial Instructions will apply to the management of charitable funds.
- To approve any new funds, the name and terms of reference of a Fund, and identify the nominated Fund Holder.
- To set and annually review the charity's reserves policy.
- To manage the investment of funds in accordance with the Trustee Act 2000.
- To determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider.
- To monitor the performance of Investment Managers if appointed.
- To ensure funding decisions are appropriate and are consistent with Kent Community Health NHS Foundation Trust's objectives, to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds.
- To receive regular monitoring reports on the utilisation of charitable funds by nominated fund budget-holders and take action to ensure Trust policy is implemented.
- To review and monitor Charity appeals and receive regular reports on the performance of all charitable fundraising activities.
- To implement as appropriate, procedures to ensure that accounting systems are robust, donations received are coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.
- To examine financial statements of the Charity and approve the annual accounts and report and ensure that relevant information is disclosed.
- To ensure that the Charitable Funds Committee membership is such that undue reliance is not placed on particular individuals when undertaking the duties of the Charitable Funds Committee Terms of Reference.

- To assure the Board that charitable funds are being managed and accounted for in terms with Trust and wider Charity Commission and Department of health policy.

2. ACCOUNTABILITY

Accountable to:
KCHFT Board.

Accountable for:
The Charitable Funds Committee has no sub committees.

3. DECISION MAKING

The Charitable Funds Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control on the management of charitable funds.

4. MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The Charitable Funds Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. GOVERNANCE

Chair:
One Non Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Secretariat:
The Corporate Services Director will provide the Secretariat to the Charitable Funds Committee.

Membership:
The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors.

Members will include:

Chair	Non Executive Director
Other Members	Non Executive Director Director of Finance Deputy Chief Executive/Chief Operating Officer Governor
In Attendance	Staff Side Representative Fund Managers Assistant Director of Communications and Marketing

In the absence of the Chair, another Non-Executive Committee member will perform this role.

Key Relationships:
Audit and Risk Committee
The Executive Committees
The Charity Commission

Quorum:
The quorum necessary for the transaction of business shall be two members, one of which must be a Non-Executive Director.

Frequency of Meetings:
Meetings will be held not less than twice a year.
The Chair of the Committee can call extra-ordinary meetings as necessary

Notice of Meetings:
Meetings of the Charitable Funds Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:
The secretariat will record the minutes of the Charitable Funds Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Charitable Funds Committee shall be circulated promptly to all members by the secretariat.

Confidentiality:
The minutes (or sub-sections) of the Charitable Funds Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

7. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

Kent Community Health
NHS Foundation Trust

Terms of Reference V.6

Finance, Business and Investment Committee

Document Control

Version No.	Draft / Final	Date	Author	Summary of Changes
V.1	Draft	1st Oct 2012	Gordon Flack	First draft of ToR for discussion at inaugural meeting of the FBI Committee on 12/10/12.
V.2	Draft	12th Oct 2012	Gordon Flack	ToR amended with minor changes agreed at FBI Committee on 12.10.12.
V.3	Draft	25th Oct 2012	Gordon Flack	ToR amended with change to clause on frequency of meetings agreed at Informal Board meeting on 25th October 2012.
V.4	Final	29th Nov 2012	Gordon Flack	ToR ratified at formal Board meeting on 29th November but quoracy changed from four members to three, including at least one NED.
V.5	Draft	15th Mar 2013	Gordon Flack	Proposed decision rights delegated by Board
V5.1	Final	15th May 2013	Gordon Flack	Amends following FBI to recognise capital projects within overall approved budget and E&D
V6	Final	15th February 2014	Gordon Flack	Amended to allow FBI to sign off Reference Costs return.
V6.1	Draft	16th March 2015	Rob Field	Amended to reflect Foundation Trust status
V6.2	Final	25th March 2015	Rob Field	Amendment to point 6.1 Finance, point 7. Additional point added to 6.1 Finance regarding procurement
V6.3	Draft	April 2016	Gina Baines	Amendment to point 4.2. any Board member could request a meeting.
V6.4	Draft	29 March 2017	Gina Baines	Updated Trust logo, job titles and reference to Monitor changed to NHS Improvement.

Review

Version No.	Approved Date	Approved By	Next Review Date
6.1	26 March 2015	Board	April 2016
6.2	26 March 2015	Board	April 2016

6.3	April 2016	Finance, Business and Investment Committee	March 2017
6.4	March 2017	Finance, Business and Investment Committee	March 2018

FINANCE, BUSINESS AND INVESTMENT COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Business and Investment Committee (The Committee), which is to be directly accountable to the Board.

1.2. The overall objectives of the Committee are to:

- Scrutinise current financial performance and future financial plans (Annual Plan and Budget and Long Term Financial Model);
- Monitor performance against Cost Improvement Plans;
- Scrutinise the development and implementation of Service Line reporting and Service Line Management;
- Monitor decisions to bid for business opportunities and approve those up to £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval;
- Review and approve capital investment decisions between £1m to £3m within capital budget and the overall capital programme development, refer with recommendation, larger cases to the Board for approval;
- Review and approve revenue business cases between £1m to £3m annual value and refer with recommendation, larger cases to the Board for approval;
- Approve treasury management policy and scrutinise implementation;
- Promote good financial practice throughout the Trust.

1.3. All procedural matters in respect of conduct of meetings shall follow the Trust's Standing Orders.

2. MEMBERSHIP

2.1. The members of the Committee shall be as follows:

- Two Non-Executive Directors
- Chief Executive
- Director of Finance
- Deputy Chief Executive/Chief Operating Officer

2.2. A quorum shall be three members, including at least one non-executive director.

2.3. The Chair of the Committee shall be one of the non-executive directors and shall be appointed by the Board. The second non-executive director shall deputise in the absence of the Chair.

3. ATTENDANCE AT MEETINGS

3.1. Executive directors and senior service leads will be invited to attend when the Committee is discussing issues relating to their area of responsibility.

3.2. All non-executives in addition to the members will be invited to every meeting of the committee and the full board will receive all papers.

4. FREQUENCY OF MEETINGS

4.1. The Committee will initially meet on a monthly basis and subsequently at least four times a year, when the Committee feels it is appropriate to reduce the frequency of meetings.

4.2. Any Board member may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

5.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

6.1. Finance:

- To scrutinise current financial performance and assess adequacy of proposed recovery plans to bring performance in line with plan (where necessary);
- To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity;
- To scrutinise annual financial performance and current projections;
- To review budget control framework, including budget setting and guidelines;
- To scrutinise proposed budgets (revenue and capital) and recommend adoption of final budgets by the Trust Board;
- To review proposed financial returns to NHS Improvement;
- To review strategic assumptions underpinning the Long Term Financial Plan and review the development of this plan;
- To review contract documentation with main commissioners, and development of Model Contracts with such commissioners;
- To assess, periodically, impact of different financial assumptions on the future financial position of the Trust, and to assess adequacy of mitigating actions to protect the future financial position of the Trust;
- To assess, periodically, the skills base within the Finance Department and the adequacy of Treasury and Management Accounting reporting;
- To advise on the development of financial policies including service line reporting and associated costing and development of tariff;
- To review implications of national financial policies, and changes therein, on the Trust;
- To review the Trust Cost Improvement Programme and assess whether the Trust has established robust PMO arrangements to ensure delivery and with regular reporting from the Trust CIP group meeting;

- To review and approve business cases between £1m and £3m within capital budget or annual revenue investment and recommend approval by the Trust Board for larger cases.
- To scrutinise decisions with reference to their impact on equality using resources such as the "Equality Analysis Toolkit"
- To approve the annual Reference Costs return on behalf of the Board.
- To scrutinise and review procurement activity.

6.2. Business

- To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions;
- To scrutinise capital investment proposals for financial implications and consistency with strategic service plans;
- To review the Trust's Annual and Strategic Business Plans;
- To receive, scrutinise and approve (£1m to £3m per annum) proposed service developments, including enhancements to existing contracts, to ensure proper financial evaluation including impact on the future risk ratings, making recommendations to the Board where larger than £3m per annum;
- To review the commercial strategy and individual bids and acquisitions, to ensure proper financial evaluation and approve those with a contract turnover up to £15m and in line with Trust Strategy and otherwise make recommendations to the Board;
- To review, periodically, market analysis undertaken on behalf of, or by, the Trust.

6.3. Investments

- To monitor adequate safeguards on investment of funds by approving:
    - List of institutions with whom funds can be placed;
    - Appointment of bankers and brokers;
    - Investment limits for each institution;
    - Investment types.
- To confirm that bank mandates are in place for all accounts and that such mandates are updated for changes in signatories and authority levels;
- To approve cash management and investment policies and test compliance with such policies;
- To approve any draw down of Working Capital Facility or Prudential Borrowing Limits;
- To review investment performance and risk.

7. REPORTING

7.1. The minutes of the Committee meetings shall be formally recorded and submitted to the following private or informal Board meetings.

7.2. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.3. The Committee will report to the Board annually on its work, in advance of the Board meeting to agree the Annual Budget.

8. ADMINISTRATION

8.1. The Committee will be supported administratively by the office of the Corporate Services Director, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent areas;

8.2. The agenda for each meeting will be circulated seven days in advance, together with any supporting papers and will be distributed by the Secretariat.

8.3. The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

9. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference and assess performance against these at least once each year to reflect changes in NHS requirements or best governance practice.

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

QUALITY COMMITTEE

Document Control

Version	Draft/ Final	Date	Author	Summary of changes
0.1	Draft	13 10 2011	Karen Proctor Director of Nursing and Quality	
0.2	Draft	17 01 2012	Stephen Robinson Director of Corporate Services	Format into KCHT Template. Amend to clarify role as Assurance Committee role.
0.3	Draft	12.7.2012	Karen Proctor Director of Nursing /Quality	Addition of groups reporting to committee and membership
0.4		27.09.2012	Director of Nursing/Quality	Changed membership and committee groups
0.5		27.09.2012	Director of Nursing/Quality	Changed reasonability for accountability to assurance
0.6		29.01.2013	Head of Risk Management	Amended to reflect NHSLA requirements
0.7		14.02.2013	Corporate Secretary	Amended Head of Health and Wellbeing to Health and Wellbeing Director
0.8	Draft	10.12.13	Corporate Secretary	Amended secretarial references Addition of reference to Finance, Business and Investment Committee Updating of HR Director title

0.9	Draft	5.5.14	Director of Nursing/Quality	Amended to reflect changes and assurance
1.0	Draft	16.3.15	Assistant Director of Assurance	Amended to reflect Foundation Trust status
1.1	Draft	07.03.2017	Assistant Trust Secretary	Amended Trust logo, job titles.

Review

Version	Approved date	Approved by	Next review due
0.2	26.01.2012	KCHT Board	April 2012
0.5	27.09. 2012	Quality Committee	September 2013
0.9	03.06.2014	Quality Committee	June 2015
1.0	26.03.2015	Board	April 2016
1.0	08.03.2016	Quality Committee	March 2017
1.1	07.03.2017	Quality Committee	March 2018

1.0 ROLE

The Quality Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference.

Purpose:
To support the Board in ensuring that quality is integral to the function of the organisation by providing an overview of the quality assurance and clinical governance issues identified that may influence the overall success of the organisation. The quality committee should review all elements of the quality strategy, ensuring that the measures for success are implemented in the agreed timescales.

The role of the Quality Committee is to focus on quality and risk issues and to ensure that the appropriate governance structures, systems and processes are in place across the Trust to assure performance and quality on behalf of the Trust Board. The committee will ensure that there is clear strategic direction, strong leadership and transparent lines of accountability and that the organization has the right systems from a patient perspective to deliver safe and effective services.

The Board may request the Quality Committee to review specific issues where it requires additional assurance about the effectiveness of systems of internal control or areas where quality indicators highlight concerns.

Objectives:

1. Safety

To receive, review and provide assurance from the following compliance reports on a rolling basis and to ensure that risks are actively identified and managed at all levels of the organisation. To ensure that any service developments or service changes that are developed either as part of service redesign or as part of the cost improvement programme are putting patients and patient safety, quality and safeguarding above all other considerations

- Care Quality Commission's Regulations on Essential Standards of Quality and Safety.
- Care Quality Commission Reports and inspections
- NHS Improvement Quality Governance Framework
- Healthcare Associated Infections
- Safeguarding adults and children
- Patient safety incident and serious incidents reports
- Exception reports of clinical risks including serious incidents, investigations of poor quality care/patient safety and mortality and morbidity reviews
- Medicines management
- Medical devices
- Agree and monitor Quality Impact Assessments from service redesign or cost improvement programme
- Decontamination
- Quality Gurveillance Group monitoring to ensure the full range of interventions are implemented and gain assurance on quality performance.
- To monitor production of the Quality Account and implementation throughout the year ensuring that it is produced annually in line with national guidance.

- Any areas of exception
- Morbity and Mortality for community hospital (when available)
- Patient safety Walkabouts.

To performance manage and hold the Executive Team to account for delivery against safety requirements and developments.

To advise the Board on the escalation of quality and safety risks onto the Corporate Risk Register/Board Assurance framework.

To review high level risks on the Trust clinical risk register that relate to patient safety and recommend appropriate actions.

To oversee the ratification and monitoring of clinical policy development and implementation.

To assure the Board that:

- information and performance reports are accurate and of high quality and provide the assurance required or identify gaps in assurance.
- the Executive learns from national and local reviews / inspections and implements all necessary recommendations to improve the safety and quality of care.
- the governance arrangements for safeguarding children and vulnerable adults are robust and action plans are implemented following Serious Case Reviews and Adult and Children Protection Investigations
- the monitoring, safe use and management of medical devices is undertaken
- the monitoring, safe use and management of medicines is undertaken
- staff maintain professional competence and undertake continuous professional development.
- That learning is embedded within the organization.

2. Effectiveness

To advise the Trust Board on the appropriate quality and safety indicators and benchmarks for inclusion on the Trust performance dashboard and keep these under regular review to develop locally sensitive quality indicators and metrics in order to continually improve the quality of services and ensure that there is continuous improvement in the standard of quality and safety across the whole organization.

To approve and regularly review the annual Clinical Audit programme. To ensure that recommendations made by internal and external reviewers are considered and acted upon on a timely basis, that action plans are reviewed and monitored and organizational learning can be demonstrated as a result.

Receive assurance from the Executive that appropriate governance frameworks, management structures and policies are in place for:

- Clinical Governance/Quality
- Safeguarding
- Incidents, Complaints, Claims and Compliments
- Infection Control

- National Enquiries
- Monitor compliance CQC Registration standards
- National reports eg Francis, Berwick
- NICE
- NHSLA
- Any other national initiatives or reporting, such as Francis, Berwick etc.
- Service delivery changes
- Caldicott Reports
- Monitor compliance with CQUIN performance
- Monitor compliance Quality Standards set by Commissioners
- Ensure that lessons are learned from patient safety incidents, serious incidents, complaints and claims.

To provide the Trust Board with assurance on the effectiveness, safety and user view of services by:

- receiving assurances from the Executive that areas relating to clinical governance and quality assurance are implemented.
- receiving assurances from the Executive the quality agenda is leading to improvements in patient experience, productivity and prevention through innovation and to develop a robust process for ensuring patient safety is paramount in all decisions.
- receiving annual assurance reports in relation to both research and education governance issues.
- monitoring and reviewing reports from services on progress against existing Quality work plans, and to review new work plans.
- monitoring and reviewing reports from each clinical division on progress in delivering Quality and patient safety and actions taken to enhance clinical quality and safety, including in response to the findings of internal and external reviews, audits and inspections and trends in adverse events, complaints, claims and litigation.
- monitoring and reviewing the Trust's statutory compliance with NHS Constitution, Health Act, NHS Litigation Authority and The Hygiene code and other regulatory frameworks.
- monitoring and reviewing the effectiveness of actions to support a safer environment for patients, staff and visitors, including the work of the Safer Patients Initiative programme and Patient Environment Action Team (PEAT) assessments.
- reviewing remedial action taken by services in relation to breaches in quality standards.
- receiving reports and minutes from the NICE Compliance Group on progress and action to address any potential lapses in implementation of NICE Guidance.
- receiving reports and minutes from the Clinical Audit Research and Effectiveness Group and approve the annual Clinical Audit Plan and Annual Clinical Audit Report.
- send revalidation report to the Part 1 Board annually with the annual audit as an appendix.

3. Patient Experience

To advise the Board as to whether proposed new models of care for service developments and redesign of patient pathways will deliver the Board's strategy and agreed criteria in relation to quality and safety.

To approve a year plan setting out the priorities for audits of patient experience.

To assure the Board that risk assessments are conducted and action plans followed up.

To receive assurance from the Executive that the views and experiences of patients and carers have been built into the design and delivery of services;

To receive patient experience reports (both qualitative and quantitative) on a monthly basis, including Patient Advice and Liaison (PALS) reports and complaints reports, that identify themes and trends and hold the Executive to account for any consequent change in practice.

To review trends in complaints received in relation to services and hold the Executive to account for implementing any remedial requirements.

To monitor and hold the Executive to account for performance against agreed CQUINs.

To have a specific focus on the patient experience, reviewing initiatives to learn more about and improve patient experience and spread best practice.

2.0 ASSURANCE

Assurance to:
KCHFT Board.

Groups:
Clinical Audit Group
CQC Assurance Group
Clinical Directorate Quality Committees
Education and Workforce Development Group
Infection Prevention and Control Group
Medicines Management Governance Group
Medical Devices Group
Decontamination group
Morbidity and Mortality Review Group
Research and Development Group
Safeguarding Assurance Groups
Trust Nursing Standards and Leadership Group

3.0 DECISION MAKING

The Quality Committee is an Assurance and Performance Management Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the quality and safety of all clinical services.

4.0 MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The Quality Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community

Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively practicable.

5.0 GOVERNANCE

Chair:
One Non Executive Director will be appointed as Chair of the committee by the Trust Board Chair.

Secretariat:
The secretariat function will be provided by the Corporate Services Director.

Membership:
The committee shall be appointed by the Board from amongst the Non Executive Directors of the Trust and shall consist of not less than 3 members. One of the members will be appointed chair of the Committee by the Trust Board. The Chairman of the Trust should not be a member of the Quality Committee.

All members must attend at least 75% of meetings.

The Chief Nurse and the Medical Director, or their deputies, shall normally attend meetings. The Chief Operating Officer/Deputy Chief Executive, the Director of Children and Young People/Caldicott Guardian, and the Director of Workforce, Organisational Development and Communications, will also attend meetings.

Other individuals with specialist knowledge may attend for specific items with the prior consent of the Quality Committee Chairman. In particular and where appropriate, the Committee will invite clinical teams to attend its meetings to provide assurance on key governance and risk issues.

Key Relationships:
Audit and Risk Committee
Finance, Business and Investment Committee
The Executive Committee

Quorum:
The meeting will be quorate if two Non Executive Directors, one Operational Director and either the Chief Nurse or Medical Director is present.

Frequency of Meetings:
Meetings will be held a minimum of six times per year and diarised on an annual basis. The Chair of the Committee can call extra-ordinary meetings as necessary

Notice of Meetings:
Meetings of the Quality Committee, other than those regularly scheduled as above, shall be summoned by the Corporate Services Director at the request of the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Corporate Services Director.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:
The Assistant Trust Secretary will record the minutes of the Quality Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Quality Committee shall be circulated promptly to all members by the Assistant Trust Secretary.

Confidentiality:
The minutes (or sub-sections) of the Quality Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the formal Board meeting papers.

6.0 APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

7.0 MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Bi-monthly to public Board
Frequency of attendance	Attendance register of each meeting	Assistant Trust Secretary will report to the Committee Chair	Annually

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

REMUNERATION AND TERMS OF SERVICE COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	21.03.11	Craig Sharples	New Document
1.1	Final	17.01.12	Craig Sharples	Minor amends to reflect organisational change.
1.3	Draft	16.03.15	Rob Field	Amended to reflect Foundation Trust status
1.4	Draft	18.05.2017	Gina Baines	Amended Trust logo

Review

Version	Approved date	Approved by	Next review due
1.0	4 April 2011	KCHT Board	April 2012
1.1	26.01.12	KCHT Board	April 2012
1.2	6 April 2013	Committee	April 2014
1.3	26 March 2015	Board	April 2016
1.3	26 May 2016	Board	April 2017

1. ROLE

The Remuneration and Terms of Service Committee is an executive committee of the Board with delegated decision-making powers specified in these Terms of Reference to

Purpose:

The Remuneration and Terms of Service Committee is a committee of the Trust Board. The committee will determine the remuneration and conditions of service of the Chief Executive and other Directors and (other senior managers with Board responsibility who report directly to the Chief Executive), ensuring that these properly support the objectives of the Trust, represent value for money and comply with statutory requirements. The committee does not determine the remuneration of the Non-Executive Chairman and the Non Executive Directors, which is set by the Council of Governors.

In setting the remuneration and conditions of service for the Chief Executive and other Directors, the committee shall take into account all factors which it deems necessary including relevant legal and regulatory requirements, the provisions and recommendations the Foundation Trust Licence and associated guidance from Monitor.

When required the committee will oversee the appointment of Executive Directors in accordance with Standing Orders. During these sittings the committee will be known as the Executive Appointments Committee and the minutes should reflect this position.

Objectives:

The objectives of the committee are to recommend to the Kent Community Health NHS Foundation Trust Board remuneration and terms of service for the Chief Executive, Executive Directors and other Directors, subject to any applicable NHS policies for Trusts and the Foundation Trust Licence including:

- All aspects of salary
- Provisions for other benefits including pensions and cars.
- Arrangements for termination of employment and other contractual terms and scrutiny of termination payments, taking account of legislation and such national guidance as is appropriate.

Remuneration and terms of service for the Chief Executive and Executive Directors shall be set so as to attract, retain and motivate executive management of the quality required to run the Trust successfully without paying more than is necessary, having regard to views of the Council of Governors and the public. The terms set should have regard to the risk appetite of the Trust and alignment to the Trust's long term strategic goals. A significant proportion of remuneration should be structured so as to link rewards to Trust and individual performance and designed to promote the long term success of the Trust.

Where necessary independent advice and support may be required.

To develop recommendations for remuneration of Medical/Clinical Directors and discretionary points where these fall outside national agreements.

To receive any business case for non-contractual, novel or unusual termination payments relating to any staff employed by the Trust and make recommendations to the Trust Board.

To report to the Trust Board in writing the basis of its recommendation(s).

The committee shall report in writing to the Trust Board the basis for its recommendation(s); minutes will be submitted where required. The Trust Board shall use the report as the basis of its decisions, and remain accountable for taking decisions for the remuneration and terms of service

of the Chief Executive, Executive Directors and other Directors. The minutes of the Board's meetings shall record such decisions.

The committee must refer the following types of issue to the full Trust Board:

- Change the strategic direction of the Trust;
- Conflict with statutory obligations;
- Contravene national policy decisions or governmental directives;
- Have significant revenue implications;
- Have significant governance implications;
- Be likely to arouse significant public or media interest.

When sitting as the Executive Appointments Committee the sole duty is to assess and appoint the Chief Executive and /or Executive Directors in accordance with the 1990 Regulations.

Where necessary independent advice and support may be required.

Role of the Council of Governors
The Council of Governors is required to approve the appointment and proposed remuneration of the Chief Executive.

2. ACCOUNTABILITY

Accountable to:
KCHFT Board.

Accountable for:
The Remuneration and Terms of Service Committee has no sub committees.

3. DECISION MAKING
The Remuneration and Terms of Service Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control.

4. MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The Remuneration and Terms of Service Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports.

5. GOVERNANCE

Chair:
The Chair of the Trust Board will act as Chair of the Remuneration and Terms of Service Committee.

Secretariat:
The Chief Executive or the Director of Human Resources, Organisational Development and Communications will act as Secretariat to the Remuneration and Terms of Service Committee.

Membership:
The committee membership shall be appointed by the Board and include all non executive directors of the Trust.

The Chief Executive and Director of Human Resources, Organisational Development and Communications will normally attend meetings (except where matters relating to them are under discussion). All Non-Executive Directors are invited to attend meetings and are designated as members for the meetings that they attend.

When sitting as the Executive Appointments Committee all Non-Executive Directors will be counted as members and shall be counted as such when assessing quorum and declaring votes. The Chief Executive shall only be counted as a member if the position of Chief Executive is not being discussed and no other Executive Directors will be counted as members.

Key Relationships:
Audit and Risk Committee
The Executive Committees
Council of Governors

Quorum:
The quorum necessary for the transaction of business shall be 3 members including the Trust Chairman. A duly convened meeting of the committee at which quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the committee.

Frequency of Meetings:
Meetings will be held not less than once a year.
The Chair of the Committee can call extra-ordinary meetings as necessary

Notice of Meetings:
Meetings of the Remuneration and Terms of Service Committee, other than those regularly scheduled as above, shall be summoned by the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:
The secretariat will record the minutes of the Remuneration and Terms of Service Committee meetings, including the recording of names of those present and in attendance.

Draft minutes of the Remuneration and Terms of Service Committee shall be circulated promptly to all members by the secretariat. Once approved, minutes should be circulated to all other members of the Board unless in the opinion of the committee chairman it would be inappropriate to do so.

Confidentiality:
The minutes (or sub-sections) of the Remuneration and Terms of Service Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

7. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.1
Subject:	Seasonal Infection Prevention and Control Report - Spring
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 March 1st 2017 and April 30th 2017, with a brief annual summary for 2016/17

- There were 7 attributable *Clostridium difficile* infections in 2016/17, with one case being proven cross infection in KCHFT, a full *Clostridium difficile* reduction action plan is being implemented.
- There has been 1 case of *Clostridium difficile* in April 2017; early indications show this case to have been unavoidable.
- In 2016/17 there were 10 MRSA bacteraemias investigated where KCHFT staff provided care, all were assigned to either other organisations or a 3rd party. However one case remains with NHS England for final assignment, but the suggested assignment is 3rd party.
- There is currently one MRSA bacteraemia case from April under investigation at EKHUFT where KCHFT staff provided care prior to admission, the decision for assignment of the case is awaited.
- Trust Compliance with hand hygiene training was reported as 90.5%, and mandatory training 96% in March 2017. Compliance amongst clinical staff had risen again and is now at 88.6% for hand hygiene, and 95.5% for mandatory training
- The Trust exceeded our 5% reduction target for CAUTI's and UTI's, reporting 114 hospital acquired UTI's against a target of no more than 130, and 14 CAUTI's against a target of no more than 25. 2017/18 reduction target has been set, and in April we are on target to achieve.
- There were 13 outbreaks of infection during 2016/17, and one in April 2017, closing 1 bay for 3 days.

- The Trust Occupational Health provider continues to evidence to the Infection prevention and control committee their compliance with guidelines on staff checks and vaccinations are undertaken.

- The 2 Dental Services in Ramsgate and Sandwich have returned to local instrument reprocessing.

- The Water Safety Committee continues to meet to ensure there are planned actions to evidence compliance with Water safety legislation. Currently the policy and water safety schemes are being updated, and ongoing work is being undertaken by the Corporate Estates team to obtain ongoing assurance from NHS Property Services, and identify gaps.

- The Antimicrobial Stewardship committee continues to meet and discuss the actions required to meet the 5 year plan. Currently focus is upon collaborative working across Kent through CCG lead Antimicrobial stewardship groups.

- The SEPSIS algorithms and prompt cards have been agreed, there is a planned awareness launch in June, with champions being requested from clinical services to roll out internally.

Proposals and /or Recommendations:
For assurance only. The Board is asked to note the report.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. Not required. High level position described and no decision required. The paper has no impact on people with any of the nine protected characteristics.

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

Kent Community Health
NHS Foundation Trust

SEASONAL INFECTION PREVENTION AND CONTROL REPORT - SPRING

1. Introduction

The content of this report was presented and discussed at the Quality Committee on 2 May 2017.

2. Clostridium difficile

The Trust had a target of no more than 5 cases of *Clostridium difficile* infection in 2016/17 and no level 3 lapses in care which was breached by 2 cases, with one internal proven cross infection. A full action plan has been approved by the Trust Infection Prevention and Control committee, and actions will be monitored through both the IPC and Quality Committee. In April 2017 the target remains unchanged (as per national objectives) and 1 case have been reported in April 2017, the Root Cause Analysis has yet to be held, but early indications suggest this is an unavoidable case.

3. MRSA

There were no MRSA bacteraemias attributed to the organisation in 2016/17, however there were 10 investigated where KCHFT provided care. Clinical teams were involved in every investigation, and the predominant lesson from these cases was failure to effectively communicate between different care providers, e.g. Acute Trust, Community Trust, GP, etc. These issues are being reported through transfer of care groups and CIS is now helping to reduce these. One case is currently under investigation from April 2017, and a decision on attribution is awaited.

4. Training

In March 2017 Trust Compliance with hand hygiene training was 90.5%, and mandatory training 96%. Compliance amongst clinical staff had risen again and is now at 88.6% for hand hygiene, and 95.5% for mandatory training.

5. UTI's and CAUTI's

In 2016/17 the Trust exceeded the 5% reduction target for UTI's and CAUTI's. The and the Trust recorded 114 Cases. Of UTI's against a target of no more than 131, and 14 CAUTI's against a target of no more than 25. The plan for 2017/18 is no more than 12 CAUTI's and no more than 102 UTI's.

6. Incidents and Outbreaks

There were a significant number of outbreaks in 2016/17 (13 in total, plus one in Westbrook House). The outbreaks were a mix of respiratory viral outbreaks and Diarrhoea and Vomiting. In each outbreak, the teams have had lessons to learn, and the impact on staffing has been significant due to sickness, and the IPC team are already preparing for 2017/18 season.

7. Occupational Health

The Trust Occupational Health provider continues to evidence to the Infection control committee their compliance with guidelines on staff checks and vaccinations are undertaken.

8. Decontamination

The two Dental Services have returned to local reprocessing, and audits have shown full compliance.

9. Water Safety Committee

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.

10. Antimicrobial Stewardship

The Antimicrobial Stewardship committee continues to meet and discuss the impact of increasing antimicrobial resistance, and how to implement the 5 year antimicrobial stewardship strategy, and meet the Antimicrobial CQUIN.

11. SEPSIS

The SEPSIS algorithms and prompt cards have been agreed, there is a planned awareness launch in June, with champions being requested from clinical services to roll out internally.

Lisa White
Assistant Director of Infection Prevention and Control
11 May 2017

Kent Community Health NHS
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.2
Subject:	Quarterly Patient Experience Report
Presenting Officer:	Ali Strowman, Chief Nurse

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

Report Summary (including purpose and context):

The Trust's overall patient experience score for Quarter 4 is 96.90% based on 18,034 surveys. This has remained consistently high throughout the year. Complaints per 10,000 shows a decrease in the number of complaints per month overall for the year but with a slight increase in Q4 of 2016/17.There is one complaint with the Health Service Ombudsman. A report published by Healthwatch was presented to KCHFT in January 2017.The report summarises feedback they have received from the public in 2016. Feedback KCHFT received from the report was very positive as it was identified that the patient experience team and clinical services respond effectively to queries and complaints received within the Trust.

Proposals and /or Recommendations:

The Board is asked to:

- Note the report.
- Consider if further work should be undertaken to display live patient experience data on the Trust intranet.

Has an Equality Analysis been completed?

No. An EA was carried out on the Customer Care Policy and on the Meridian patient experience programme. The report sets out complaints received by subject, risk grade and service. Complainants are asked to complete a short survey giving feedback on how their complaint was handled by the Trust, any issues related to equality and diversity will be reported. Meridian surveys ask patients if they feel they have been treated unfairly due to any of the 'protected characteristics'. Patients very rarely say they have.

Mary Kirk, Head of Practice Excellence and Quality	Email: mary.kirk1@nhs.net

QUARTERLY PATIENT EXPERIENCE REPORT

1. Situation

1.1 This report provides the Board with assurance that the Trust is gathering patient feedback, responding to complaints and acting on this feedback to improve services.

1.2 Kent Community Health NHS Foundation Trust is committed to improving patient experience. Our key values are to ensure good care that meets our organisational values: compassion, aspirational, responsive and excellence. All our staff hold responsibility to deliver care that is safe, effective and provide patients and their families with a positive experience. This report details the feedback for Quarter 4, 1 January to 31 March 2017.

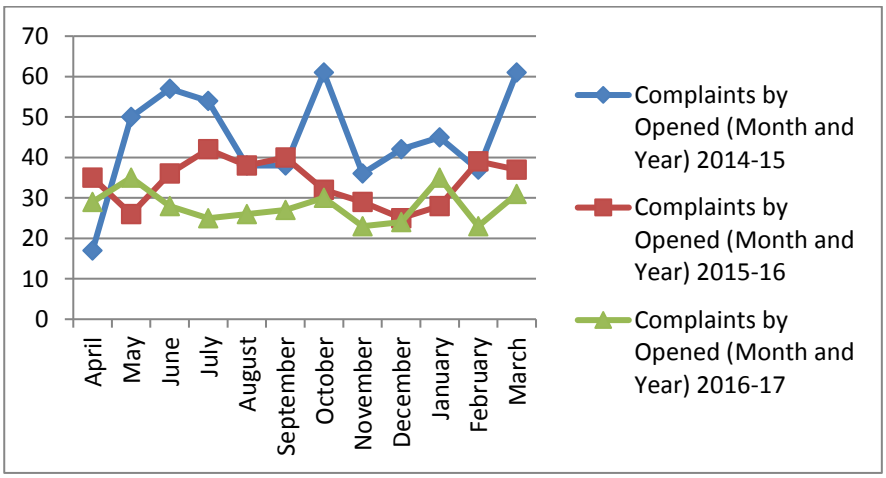
2. Background

2.1 The Care Quality Commission, as the independent regulator in England, registers and inspects services to ensure they meet fundamental standards of care, including how caring and responsive organisations are to those in their care. Having a good experience of care, treatment and support has increasingly been seen as an essential part of an excellent health and social care service, alongside clinical effectiveness and safety. There are poorer outcomes, and health resources are wasted when people do not feel involved or do not understand the treatment they are offered (Doyle et al 2013). Data is taken from the Meridian surveys and is reported by team/locality. Complaints are recorded following the Trust's complaints process.

3. Assessment

3.1 Complaints

The graph below shows complaints per 10,000 contacts, based on average monthly contacts, showing a decrease in the number of complaints per month overall for the year but with a slight increase in Q4 for 2016/17.Further information can be noted at point 3.3 of the report.

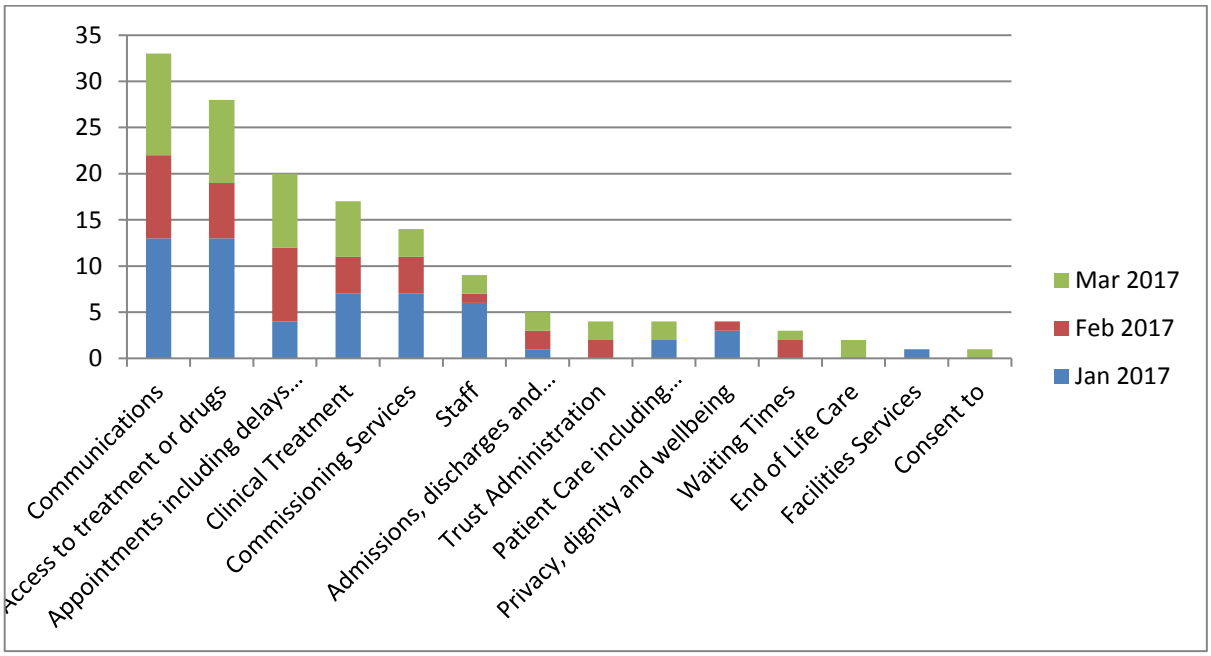


3.2 Benchmarking against other providers

The benchmarking club of community trusts shows the following (KCHFT orange bar). This is complaints per 1000 WTE budgeted staff. The community Trusts within the peer group are not identified as this is part of the agreement for data sharing. This shows that KCHFT has a consistently low number of complaints when benchmarked against similar NHS Trusts.

3.3 Complaints received

There were 90 complaints for Q4.This number is an increase on Q3 (77 complaints). The graph below shows complaints by subject opened for Q4. (Note: some complaints may cover more than 1 area). The KO41 data has been submitted as required to NHS England.



3.4 Key themes

Clinical Treatment

Complaints that fall into this category may involve aspects of clinical care provided by health professionals, medical nursing or allied health professionals. They involve complaints about the patient's diagnosis and treatment, complications that may arise either during or after treatment, patient falls, nutrition and hydration, infection control measures, hygiene, and pressure area care.

During the quarter there were 13 complaints that fell into this category, a reduction on Q3 which had 26. These complaints were all in adult services and included:

- being unhappy with the level of care provided (x5)
- being unhappy with the level of care provided both as inpatient and for end of life nursing care. This complaint is still open as care at Sheppey Hospital is now being provided by Virgin Care. The nursing team was concerned about patient's condition and responsive to her family's concerns. This resulted in referrals being made to the dietician and speech and language therapies and regular medical reviews which led to the gastroscopy referral. Patient had been admitted for rehabilitation and when she was discharged investigations were still on-going, including the gastroscopy.
- unhappy with care from doctor in community hospital and feels that the transfer to the acute hospital was unnecessary
- unhappy that staff did not notice and act on deterioration of ulcerated legs

Admissions, discharges and transfers

During the quarter there were 18 complaints (10 in adult services and 8 in children's services) for Q4, a significant increase on 4 in the previous quarter. Complaints that fell into this category include:

- issues relating to patient appointments / unhappy with podiatry booking system
- unhappy with discharge from community hospital (x3)
- unhappy with cancellation of podiatry surgery and cost to family and loss of holiday
- unhappy with delay in physiotherapy as referral misfiled / lack of referral for a wisdom tooth
- delays in ASD assessment /unhappy with discharge from paediatric service

Access to treatment and medication

During the quarter there were 19 complaints that fell into this category (17 for adult services and 2 for children's services), a reduction on 24 in Q3. The majority of these concerns were in relation to:

- unhappy with the continence team and access to them / new products not fit for purpose. Two complaints received:
  a) West Kent Community Nursing had a complaint where family was unhappy with samples of new continence products and reaction to these by patient. Contact made with family and new samples provided and revised order now being delivered. Service in contact to make sure new products will be suitable once patient discharged home.
  b) Continence Service - letter sent to MP advising that service contacted patient and products amended and patient happy with outcome. Apologies from nursing staff for delay in responding and notes updated to allow email contact.
- unhappy with lack of parking especially accessible parking
- unhappy with the delays in receiving a wheelchair (x4) / unhappy with change to wheelchair provision due to illness and criteria

- unhappy that no Rapid Response visit to end of life patient. Letter sent apologising that staff member mistakenly acted on an old referral when advised that new referral had been received. Referral was not highlighted as urgent or that patient was near end of life. Staff member has been reminded to always check the information and dates on referrals to ensure this does not happen again. Meeting has been arranged with complainant.
- unhappy with access to specialist nurse for blood tests

Values and behaviours

This category may include complaints about staff attitude, professional behaviour, failure of staff to introduce themselves and breaches of confidentiality. During the quarter there were 14 complaints that fell into this category (6 in adult services and 8 in children's services), an increase on 8 in Q3. These concerns included:

- staff attitude
- unhappy with reaction following blood test in sexual health service and that not advised of possible side effect
- breach of confidentiality
- family unhappy that treatment given without parental consent
- breach of confidentiality

Communication

During the quarter there were 22 complaints that fell into this category (12 in adult services and 10 in children's services), consistent with 25 in Q3. The concerns were in relation to:

- unhappy with a warning letter (x2)
- unhappy with antenatal letter
- unhappy with wording of National Child Measurement Programme (NCMP) letter (x2)
- difficulty in getting hold of podiatry service
- lack of communication about changes to phlebotomy service (x2)

There has been an ongoing problem with the ante-natal letters and this has been addressed by service managers and the chief nurse. It is hoped going forward that new ways of working will prevent women receiving letters inappropriately.

There were no further noticeable themes and trends from this and previous quarters that require on going action.

4. Ombudsman Cases

4.1 There is currently 1 complaint case with the Ombudsman, this is from care received in May 2015 within East Kent and the initial investigation was led by East Kent Hospitals. This is in relation to:

4.2 During the quarter we have received 2 Ombudsman rulings and the 2 cases were not upheld. These cases related to booking an appointment (not upheld) and inpatient care in Swale (partially upheld).

5. Response Times

5.1 The timescale for responding to each complaint is dependent upon the nature of the issues raised and the level of investigation required. For the majority of complaints the Trust aims to respond within 25 working days. For more complex complaints, for example those involving a number of different specialties, organisations or a serious incident that require a root cause analysis, a longer timescale for the response is agreed with the complainant allowing time to undertake a thorough and fair investigation – this may take up to 60 working days to complete. The Trust now works to a response of 60 working days for multi-agency complaints that it is leading

on. During Q4 the Trust responded to 89% of all complaints within the timescale initially agreed. Where delays occurred regular contact was made with the patient/family to keep them updated.

In the last 3 months there were 10 complaint responses not meeting the set 25 day (internal) timeline. This is largely due to a revision in the process to improve upon the quality of the response letters.

6. Complaint Feedback

6.1 The Trust surveys complainants after the complaint is closed in order to get feedback on the way the complaint was handled. There were 12 x level 1 to 4 complaints re-opened in quarter 4. 3 for community nursing, 3 for podiatry. In Quarter 4 there were no responses to the Trust's survey sent to complainants. Although surveys are sent out to all complaints we are unable to enforce a response. Other local providers have highlighted similar challenges.

7. The Customer Care Team (PALS)

7.1 Customer Care enquiries are contacts from patients or family members that can be easily remedied by the service concerned. The Customer Care Team contacts the service to ask them to resolve the issue and make contact with the caller. This enables services to resolve issues as they arise, and reduce the number that go on to become complaints.

Key themes from PALS feedback:

- Many calls from people who have received letters from services and, as the Customer Care Team telephone number is prominent on the letter, they contact the team believing they are calling the service. When advised to look in the top right hand corner of their letter the enquirer is usually able to find the correct number they require.
- Verbal Compliments

8. Compliments

Services are encouraged to log compliments. The table below shows the compliments logged in quarter 3. It is estimated that there is substantially more feedback that is not shared centrally and therefore this is a snapshot of the compliments across KCHFT.

Directorate	Written Compliments	Verbal Compliments	Total
Adults	120	43	163
Adults – Health Improvement & Self-Management	36	33	69
Children and Young People	65	19	84
CYP- Dental	2	1	3
CYP – Sexual Health	4	12	16

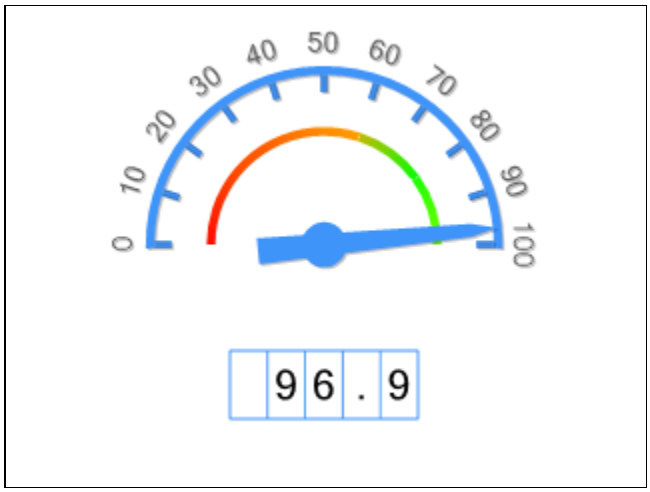
Other Directorate	1	-	1

Feedback includes:

- Many thanks for the very professional and caring way you attended to John during his recovery
- thank you to the nurses for their kindness and sensitivity shown to my wife during the last few weeks of her life
- big thank you to and your colleagues for all the care you gave mum, we know mum had her moments when she was hard work more so towards the end …but she often said how nice her nurses and carers were, you was very comforting to me when I became upset seeing mum like she was towards the end.
- Angela was so approachable friendly, really helpful. Would make me so confident to come back to clinic"
- To all the lovely nurses… you have been coming to me for a long time and I shall miss you and your smiling faces

8.1 **Meridian data**

8.2 The Trust's overall patient experience score for quarter 4 is 96.90 % based on 18,034 completed surveys. This is a consistent score (96.76) and an increase in survey returns when compared with quarter 3(15,522).



8.3 The Trust's NHS Friends and Family Test (FFT) score for quarter 4 is 97.28% to recommend, which is consistent with the last quarter of 97.71%. 16,401 people answered the FFT question, with only 106 patients being unlikely or extremely unlikely to recommend. This increase in numbers of responses is due to the children's immunisation surveys which are only completed at certain times of the year. Young people tend to choose a negative response to the friends and family test question as they feel that having an injection is not a pleasant experience.

Quarter 4	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.28%	0.65%	16401	13389	2566	214	51	55	126

Quarter 3	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.71%	0.46%	14891	12183	2367	154	36	32	119

8.4 Tables showing further breakdown of the FFT score can be seen in the appendix. This includes for all services per CCG, Minor Injury Units (MIUs), and community hospital in-patients in the last quarter. These findings demonstrate high levels of satisfaction within the services.

8.5 All surveys which receive an unlikely or extremely unlikely response to the FFT question are recorded and also included in Quality Group reports and teams are asked to note and take action where there is negative feedback, if possible

Examples of negative feedback and actions include:

- Unlikely - reason given: 'I think that this place is very miserable. Staff are lovely and very caring.' (Community Hospital, Sevenoaks – Inpatient)

- Extremely unlikely – reason given: 'Cost - I have switched to D W Sports and pay much less. Locking people into Herons' yearly membership and high cost per session is wrong).(Exercise Referral Scheme)

- Extremely unlikely – reason given: 'Patients are called by name! It should be anonymous as it was in Gillingham GUM where numbers were called for peoples' appointments'. Action taken: The service has produced laminated numbers which are offered to patients that would prefer to be called in this way. (Sexual Health Service, Gillingham)

- Unlikely – reason given: '6 beds in a 4 bed room. Far too packed, cramped, and NO privacy or personal space. Untidy, cluttered and too small'. The service is in discussions with Estates about how this can be addressed. (Community Hospital, Herne Bay – Inpatients)

- Extremely unlikely – reason given: 'A new reception has been placed today when we arrived, we can't access new area as chairs are in the way. My son is a wheelchair user so he can't get to the desk with chairs in the way. He can't hear what the lady in reception is saying and we can't reach the reception as it is too far. Action taken: The service moved the chairs to allow access for wheelchair users and connected a speaker phone that all patients can hear when they are called by reception for their appointments.

8.0 The Trust measures patient experience against seven key areas. The table below shows the overall scores per locality based on a combined score across children's and adult services.

Locality	Returns	Communi-cation	Co-ordinated Care	Equality and Diversity	Given necessary info	Involved in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
Ashford (Locality)	595	98.10%	94.03%	99.14%	98.71%	99.15%	99.07%	99.13%
Canterbury and Whitstable (Locality)	1914	97.88%	92.81%	99.52%	96.16%	98.56%	99.08%	99.33%
Dartford, Gravesham and Swanley	1189	97.63%	-	99.91%	99.43%	99.27%	99.40%	99.72%
Dover, Deal and Shepway	1014	98.53%	96.30%	99.04%	97.84%	98.23%	98.61%	99.20%
East Sussex (Locality)	1102	99.17%	88.10%	99.08%	90.04%	96.94%	99.08%	99.64%
Maidstone, Malling, West Kent and Weald	1891	97.62%	93.36%	99.71%	96.66%	98.30%	98.92%	99.37%
Medway (Locality)	611	98.39%	95.00%	98.81%	98.96%	99.32%	99.66%	99.23%
Other	254	98.81%	-	96.02%	100.00%	97.96%	99.60%	100.00%
Swale (Locality)	719	99.02%	100.00%	99.86%	99.26%	99.45%	99.47%	99.88%
Thanet (Locality)	1081	97.84%	95.34%	99.02%	97.07%	98.99%	99.41%	99.81%
Trust Total	**10294**	**98.12%**	**93.85%**	**99.36%**	**96.95%**	**98.69%**	**99.13%**	**99.47%**

8.1 Key Words (from Meridian data)

Words are coloured green/red depending on the score (above/below average) of the surveys they appear in. They are also sized to show how often they appear (the larger the more frequent).

9. Selection of actions from closed complaints and meridian feedback:

- Hawkhurst Community Hospital: Patient feedback regarding needs for grab rails. All wash areas fitted with adequate support to aid patient safety and ability to enhance independence as far as possible.
- Podiatry Service: a new process was implemented to ensure that when clients attend clinic for their insoles that they are available for collection. This was following feedback from a patient who had been informed that insoles were ready for collection, only to arrive at the clinic to find they were not.
- Community Learning Disability Team: 69 members of staff received End of Life training to enable them to give more suitable support to their clients, if relevant. This was following feedback from carers at a residential home regarding needing more support with clients at their end of life.
- Dental Services: The design of the reception area was causing issues for patients booking in and it was difficult to hear when being called for appointments. Action taken: The reception area has been redesigned and a loud speaker installed. Patients can now book in more easily and hear when they are called.
- Sexual Health Service: Clients were unhappy about the lack of contact from the service, as they felt that the service did not always respond to answerphone messages. Action taken: The telephone system has been changed so that all telephone messages left by patients are automatically converted to text and emailed to the service. This will ensure messages do not get missed. Service has also created a database to facilitate direct contact with reception areas in shared buildings, which is available on the shared drive.
- Food Champion Programme: Clients said they would like the training to have more of a focus on weaning, so the service added more specific information onto their training slides.

10. NHS Choices / Patient Opinion comments

10.1 There were 23 comments on NHS Choices and Patient Opinion during the quarter. A selection of these is listed below:

- I have just come back from a visit to your hygienist, what a friendly and knowledgeable team the hygienist advised me how to look after my lower front teeth & keep plaque at bay which I have a problem with, the nurse was very helpful & all in all a very professional team which made my visit a pleasure. As well as my teeth feeling great after the clean. Thank you. (Dental Service, Ramsgate)

- Always been a great service here but no more. Has switched to appointment system. Made 18 calls to constantly engaged number and when I did get a ring tone the call was not answered. Naturally the next call was engaged. A retrograde step from the walk in tests we had before. (Phlebotomy, QVMH, Herne Bay)
- The staff are heroes
  I had my bunion operation today. Firstly I wanted to say it was reading positive reviews on this site which helped me to be brave and go through with the operation! And now it's my turn. The hospital is definitely very clean, very friendly, bright and pleasant. I was nervous and the nurses were so lovely to me and my husband and three year old were allowed to be with me on the ward, they were sweet to her too. I watched TV with head phones on throughout the procedure which was a very good distraction. It wasn't a long operation, the only thing was the tourniquet got a bit uncomfortable but that wasn't for long. Just a very good experience in a lovely hospital so thank you. (Podiatry Surgery, QVMH, Herne Bay)
- Opening times are misleading. On being given the advice (by my surgery) to go to the Minor Injuries Unit as it sounded like I needed an x-ray, I looked up your website to find out directions. The opening hours are listed as 8 - 8, 7 d.p.w. However, the x-ray dept. closes at 5, and is not open on Bank Holidays. We had got there by 2pm, shortly afterwards the waiting time was amended to 2 - 3 hours, and I was seen by the Nurse Practitioner at about 4:45 and they sent me straight to x-ray, with just minutes to spare and they were still doing the paperwork (fortunately, as it turned out). I really do think the X-ray information should be shown on the website - we had driven there from Hextable. (X-ray department, Sevenoaks Hospital)

- Couldn't have been more helpful
  After a painful fall down the stairs I eventually admitted defeat and went to the hospital, having only moved to the area last week I wasn't really aware of what they covered or whether I'd need to go elsewhere. They were very quick to assess me and advise a course of action. Hardly any wait and a very quick yet thorough review. Thank you. (Minor Injury Unit, Edenbridge)

11. Innovations/Updates

11.1 The Meridian system provided by Optimum healthcare has been re-commissioned for a further 2 years. The system is able to provide live data this could include friends and family data and patient feedback and could be presented on the Trust website for the public to view. 2 similar community trusts utilise this model of feedback on their public websites. This is seen as best practice and would display that the Trust has an open and transparent culture. The team are working closely with the standards assurance team to develop a system where patient experience feedback can be linked into the CQC 5 key domains. This will create more measurable outcomes and richer data in line with the domains of safe, effective, caring, responsive and well led.

The complaints team have modified their telephone system to be able to record calls received by the service. This will help improve the quality of service provision and enable the team to listen back to callers queries/complaints to ensure key concerns are fully addressed.

11.2 A report published by Healthwatch was presented to KCHFT in January 2017.The report summarises all the feedback they have from the public from April 2015 – March 2016. There were 17 individual experiences reported to them in 2015/16. Healthwatch identified that the volume of feedback they received was very low and

this was seen by them as very positive as they identified that this suggests that the patient experience team and clinical services respond effectively to queries and complaints received within the Trust.

The patient experience team have been attending team meetings to raise the awareness of the importance of listening to and learning from patient feedback. As part of this work the team have supported teams to review their local data on the electronic meridian system this has led to an increase in staff accessing data on meridian by 34%. (Q3 97 vs.Q4 130)

12. Recommendations

The Board is asked to:

- Note this report
- Consider if there is a benefit of displaying live friends and family test data on the Trust internet site

Mary Kirk
Head of Practice Excellence and Quality
April 2017

Appendix 1
The Following tables show further breakdown of FFT data:

This table below shows the FFT score across all services per CCG:

Clinical Commissioning Group	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Ashford (Locality)	96.63%	0.64%	623	461	141	13	2	2	4
Canterbury and Whitstable (Locality)	97.07%	0.70%	2012	1629	324	27	6	8	18
Dartford, Gravesham and Swanley	96.57%	0.48%	1457	1141	266	29	3	4	14
Dover, Deal and Shepway	98.52%	0.41%	2699	2263	396	17	5	6	12
East Sussex (Locality)	85.63%	3.85%	494	291	132	27	10	9	25
Maidstone, Malling, West Kent and Weald	97.63%	0.51%	3336	2720	537	41	9	8	21
Medway (Locality)	95.32%	2.01%	598	469	101	8	6	6	8
Other	95.31%	1.56%	256	159	85	6	2	2	2
Swale (Locality)	99.26%	0.11%	3763	3378	357	19	1	3	5
Thanet (Locality)	95.01%	1.20%	1163	878	227	27	7	7	17
Summary	97.28%	0.65%	16401	13389	2566	214	51	55	126

This chart shows data for other commissioned services:

Services that fall into 'Other' category above	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
CHATS (Child and Adult Therapy Service) - London	100.00%	0.00%	3	2	1	0	0	0	0
Community Chronic Pain - Hillingdon	80.00%	0.00%	10	4	4	1	0	0	1
Dental (Adult): Colnbrook Immigration Removal Centre	100.00%	0.00%	10	6	4	0	0	0	0
Dental (Adult): Harmondsworth Immigration	100.00%	0.00%	20	12	8	0	0	0	0

Services that fall into 'Other' category above	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Removal Centre									
Dental (Adult): HMP Maidstone - Maidstone	92.31%	0.00%	13	5	7	1	0	0	0
Dental (Adult): HMP Standford Hill - Swale (Isle of Sheppey)	85.71%	7.14%	14	5	7	1	1	0	0
Dental (Adult): HMP Swaleside - Swale (Isle of Sheppey)	92.00%	8.00%	25	12	11	0	1	1	0
Dental (Adults and Children) - Appleby Centre	96.77%	1.08%	93	62	28	2	0	1	0
Dental (Adults and Children) - Shrewsbury Centre	97.06%	0.00%	68	52	14	1	0	0	1
Summary	95.31%	1.56%	256	160	84	6	2	2	2

The table below shows the FFT scores for Minor Injury Units (MIUs) in the last quarter. Responses for unlikely and extremely unlikely for this quarter are at the lowest for the year. The recommend score continues to improve in comparison to previous quarters.

MIUs	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Minor Injury Unit (Community Hospital at Deal)	99.29%	0.28%	708	641	62	3	1	1	0
Minor Injury Unit (Community Hospital in Edenbridge)	99.21%	0.16%	630	545	80	3	0	1	1
Minor Injury Unit (Community Hospital in Sevenoaks)	99.30%	0.28%	715	644	66	3	0	2	0
Minor Injury Unit (Gravesham Community Hospital)	99.68%	0.32%	310	275	34	0	1	0	0
Minor Injury Unit (Royal Victoria Hospital,	99.08%	0.10%	975	799	167	7	0	1	1

MIUs	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Folkestone)									
Minor Injury Unit (Sheppey)	99.73%	0.09%	1111	1023	85	2	0	1	0
Minor Injury Unit (Sittingbourne)	99.69%	0.00%	1918	1812	100	4	0	0	2
Summary	99.47%	0.13%	6367	5739	594	22	2	6	4

The following shows FFT scores for community hospital in-patients in the last quarter. These are showing high levels of satisfaction within the services.

Community Hospitals	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Community Hospital (Deal) - Elizabeth Ward	97.78%	0.00%	45	31	13	0	0	0	1
Community Hospital (Edenbridge)	95.24%	4.76%	21	18	2	0	1	0	0
Community Hospital (Faversham)	100.00%	0.00%	38	29	9	0	0	0	0
Community Hospital (Hawkhurst)	100.00%	0.00%	16	12	4	0	0	0	0
Community Hospital (Herne Bay) - Heron Ward	89.29%	7.14%	28	18	7	1	2	0	0
Community Hospital (Sevenoaks)	94.59%	2.70%	37	23	12	1	1	0	0
Community Hospital (Tonbridge) - Goldsmid Ward	93.33%	6.67%	15	13	1	0	1	0	0
Community Hospital (Whitstable and Tankerton) - Friends Ward	100.00%	0.00%	3	1	2	0	0	0	0
Summary	96.06%	2.46%	203	145	50	2	5	0	1

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.3
Subject:	Mortality Annual Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)

Attached is the Annual Mortality Summary Report for KCHFT (January 16 to December 16). You can see that the crude death rate is lower towards the end of the year. This is more likely due to transfer of provider for the community hospital in Swale in 2015 from KCHFT to Virgin.

Following the National Review of end of life care: More Care, less pathway (2013) Kent Community Health NHS Foundation Trust (KCHFT) instigated a procedure to review all deaths within our community hospitals. The process was to ensure high quality care and to review deaths within the hospitals to identify any areas of concern and to learn lessons to improve care and treatment. This process has expanded over time and KCHFT has now established a Mortality Surveillance Group (MSG) to provide assurance to the Trust Board that there is a robust review process in place relating to patient mortality Trust wide and that there are processes which ensure lessons are learnt where care for a dying patient has been sub-optimal. The MSG meets monthly.

The CQC's report (Learning, candour and accountability (December 2016) describing the findings from their review of how NHS trusts identify, investigate and learn from the deaths of people under their care. Key findings from CQC report include opportunities to learn from patient deaths are being missed and too many families are not being included or listened to when an investigation takes place. The report calls for the NHS and national bodies to recognise the need to improve the way deaths are investigated for the benefit of families and future patients. KCHFT MSG will lead on developing key recommendations following the report's findings for the Trust.

Within the Mortality Surveillance Group (MSG) Part 1 (attended by commissioners) data is analysed. This data, produced by "Dr Foster" identifies relevant coding data. Analysis of 8 trusts, (known as a 'benchmarking club') with similar demographics to KCHFT, identified that KCHFT is statistically 'as expected' within the report data.
The MSG has reviewed all deaths within the Trust which have occurred within our community hospitals since 1 April 2016. The data for Quarter 3, 2016 shows that during the 3 month period of 1 October to 31 December 2016 there were 17 deaths reported within community hospitals, consistent with Q2. In 2015 for the same period (Q3) there were 18 deaths.

Proposals and /or Recommendations
To note the report

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required/no significant change. 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.

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MORTALITY SUMMARY REPORT

Kent Community Health NHS Foundation Trust

Report Date	4th April 2017
Account Manager	Penny Booysen
Area	South England
Contact details	Penny.booysen@health.telstra.com
Prepared by	Penny Booysen

Contents

1. Executive Summary

1.1. BACKGROUND

The report will provide an overview of mortality using the Standardised Mortality Ratio. The intention of the report will be to present intelligence with potential recommendations for further investigation. This report should be used as an adjunct to supplement other pieces of work completed within the Trust and not used in isolation.

1.2. METHODS

Using routinely collected hospital administrative data derived from Hospital Episode Statistics (HES) and analysed in Quality Investigator, in-hospital mortality was examined for all inpatient admissions to Kent Community Health NHS Foundation Trust for the 12-month time period January 2016 to December 2016, unless otherwise stated.

Risk adjustment is derived from the 10-year period up to September 2016. Statistical significance is determined using 95% confidence intervals.

2. Mortality Analysis

2.1. KCHFT ALL ADMISSIONS (SMR)

The SMR is a calculation used to monitor death rates. The standardised mortality ratio is the ratio of observed deaths to expected deaths, where expected deaths are calculated for a typical area with the same case-mix adjustment. The SMR may be quoted as either a ratio or a percentage. If the SMR is quoted as a percentage and is equal to 100, then this means the number of observed deaths equals that of expected. If higher than 100, then there is a higher reported mortality ratio.

The following data is derived from data recorded by Kent Community Hospital for the time period analysed and includes all admissions. The benchmark used is September 2016*.

- There are 2331 spells to Kent Community in the rolling 12-month period. Of these 2149 are super spells **. There are 133 observed mortalities against an expected 170.9 making the overall SMR 77.8 (CI: 65.2-92.3) and 'below expected' (fig.1.0).
- No month is considered statistically higher than expected.
- The crude death rate, looking at the last spell in the superspell to count the actual number of deaths to KCHFT is 75 or 3.49%. (fig.3.3)

FIG.1.0 - KCHFT SMR FOR ALL ADMISSIONS JANUARY 2016 TO DECEMBER 2016

Trend (month)	Superspells	Spells	Observed	%	Expected	%	O-E	RR	Low	High
All	2,149	2,331	133	6.2%	170.9	8.0%	-37.9	**77.8**	65.2	92.3
Jan-16	164	168	19	11.6%	16.4	10.0%	2.6	115.8	69.7	180.9
Feb-16	172	189	20	11.6%	14.5	8.4%	5.5	138.3	84.5	213.6
Mar-16	149	162	13	8.7%	15.1	10.2%	-2.1	85.9	45.7	146.9
Apr-16	205	228	9	4.4%	16.9	8.2%	-7.9	53.2	24.3	101.1
May-16	195	213	10	5.1%	13.2	6.7%	-3.2	76.0	36.4	139.8
Jun-16	199	225	4	2.0%	13.8	6.9%	-9.8	**29.0**	7.8	74.3
Jul-16	206	231	11	5.3%	15.3	7.4%	-4.3	71.8	35.9	128.6
Aug-16	202	220	11	5.4%	11.9	5.9%	-0.9	92.4	46.1	165.5
Sep-16	180	191	9	5.0%	15.5	8.6%	-6.5	58.2	26.6	110.6
Oct-16	144	151	10	6.9%	12.7	8.8%	-2.7	78.7	37.7	144.7
Nov-16	170	179	8	4.7%	12.2	7.2%	-4.2	65.7	28.4	129.6
Dec-16	163	174	9	5.5%	13.5	8.3%	-4.5	66.8	30.5	126.8

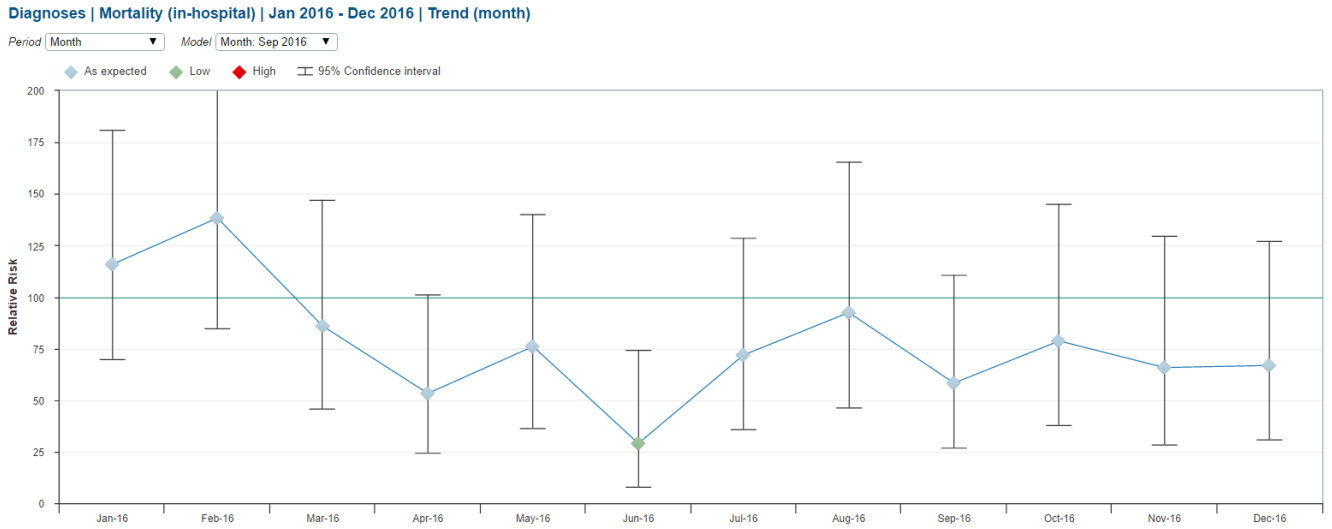

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FIG. 2.0—ALL ADMISSIONS SMR BY ADMISSION SOURCE JANUARY 2016 TO DECEMBER 2016

Admission source	Superspells	Spells	Observed	%	Expected	%	O-E	RR	Low	High
All	2,149	2,331	133	6.2%	170.9	8.0%	-37.9	77.8	65.2	92.3
NHS other provider - general/young disabled/A & E	1,878	2,056	111	5.9%	157.3	8.4%	-46.3	70.6	58.1	85.0
The usual place of residence	255	259	21	8.2%	12.5	4.9%	8.5	167.5	103.7	256.1
Non-NHS run hospital	5	5	0	0.0%	0.4	7.1%	-0.4	0.0	0.0	1036.4
Local authority Part 3 residential accommodation	4	4	0	0.0%	0.3	6.7%	-0.3	0.0	0.0	1372.8
NHS run nursing, residential care or group home	3	3	0	0.0%	0.1	4.0%	-0.1	0.0	0.0	3066.9
Non-NHS (other than LA) run residential care home	2	2	0	0.0%	0.3	13.0%	-0.3	0.0	0.0	1415.0
Non-NHS (other than LA) run hospice	1	1	0	0.0%	0.1	5.2%	-0.1	0.0	0.0	7096.7
Temporary place of residence	1	1	1	100.0%	0.0	2.6%	1.0	3900.8	51.0	21703.5

* Risk adjustment is derived from the 10-year period up to September 2016. Statistical significance is determined using 95% confidence intervals unless otherwise stated.

** A superspell is the collected term of all the related, or linked, spells for a single patient; this figure can never be greater than the spell. A spell of care is the period of time a patient spends within one hospital trust before being discharged

- The admission source analysis shows that patients admitted from NHS providers accounted for 87.3 % of all activity to KCHFT, whilst admissions from 'the usual place of residence' accounted for 11.8%.
- Admissions from 'the usual place of residence' are also considered statistically significant as the number of observed deaths exceeds the expected deaths and both upper and lower confidence intervals are above 100.
- There are 21 observed deaths reported against an expected 12.5. Of these 12 were recorded as mortalities KCHFT accounting for a crude rate percentage of 0.04% of all KCHFT activity.
- The SMR graph tracked over 3 years, the SMR has remained within or below the 'as expected' range.

FIG. 3.0 — SMR BY YEAR FOR 3 YEARS FOR ALL ADMISSIONS ROLLING MONTH

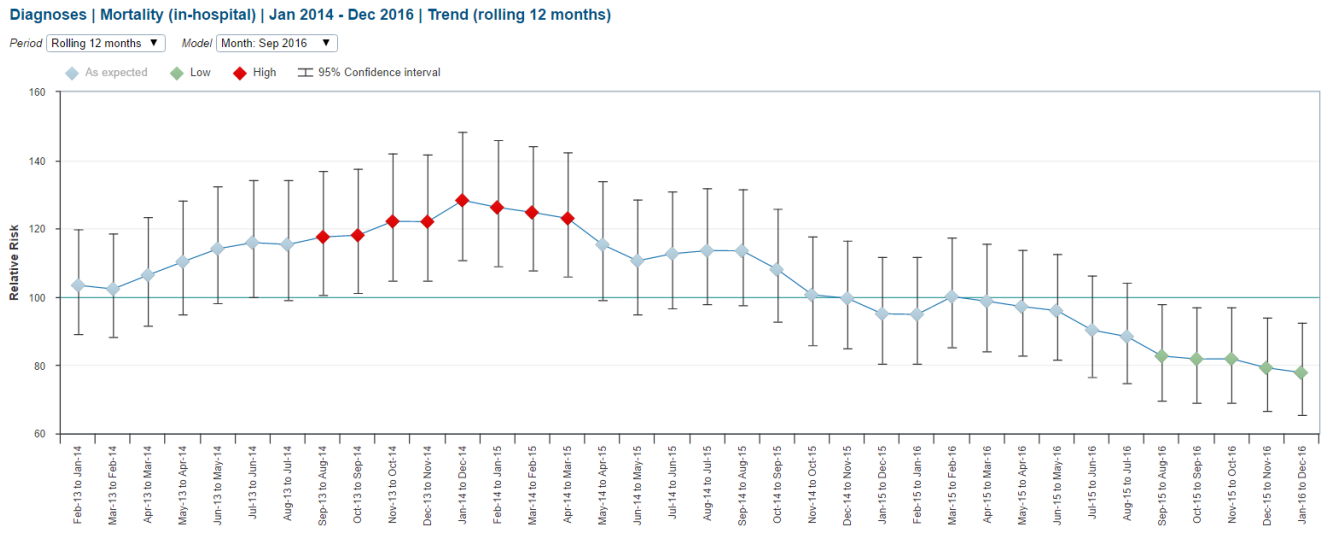

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FIG. 3.1 — SMR CRUDE DEATH RATE FOR ALL KCHFT ACTIVITY ROLLING 12-MONTH TREND

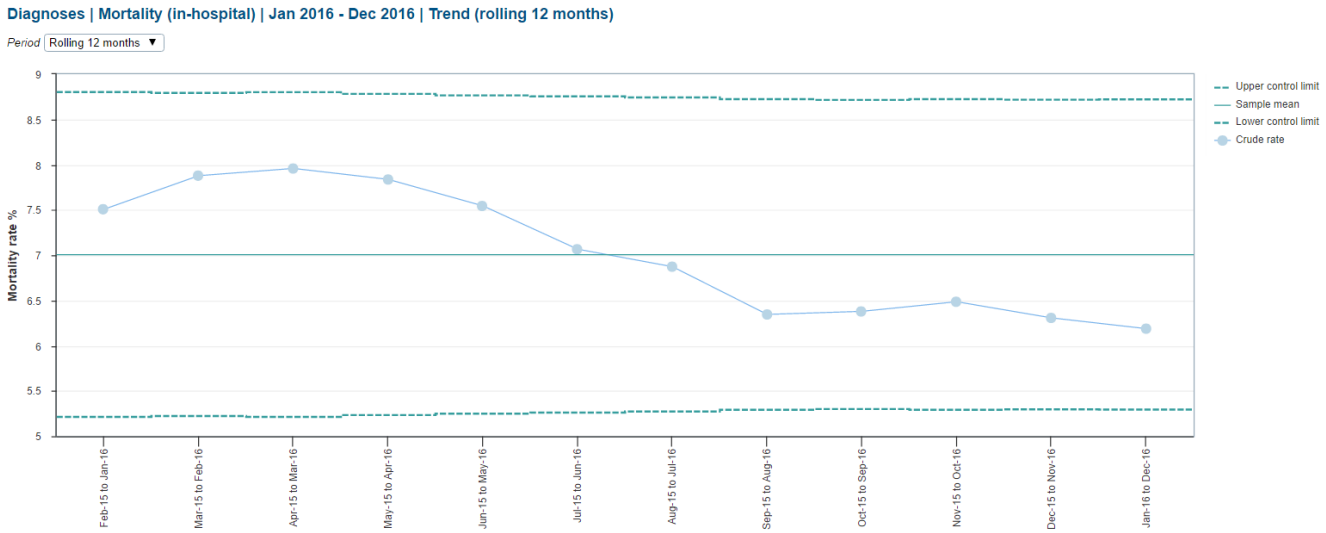

FIG. 3.2 — SMR CRUDE DEATH RATE FOR PATIENTS ADMITTED FROM ACUTE PROVIDERS, THEN TRANSFERRED BACK (ACUTE) AND DIED 12-MONTH TREND

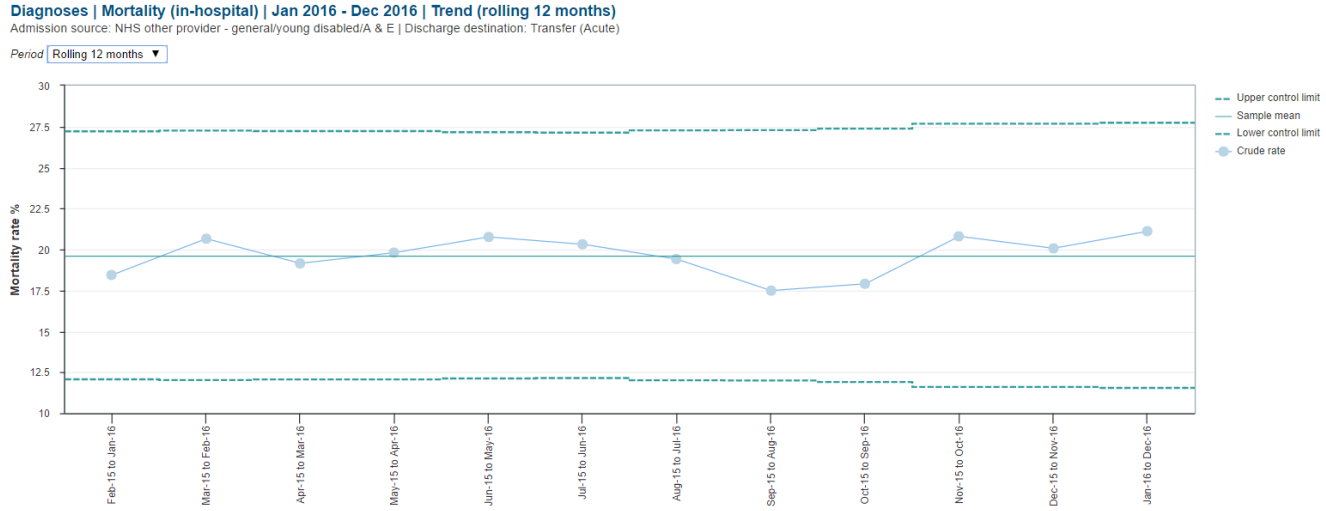

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FIG. 3.3 — SMR CRUDE DEATH RATE FOR PATIENTS WHO DIED AT KCHFT 12-MONTH TREND

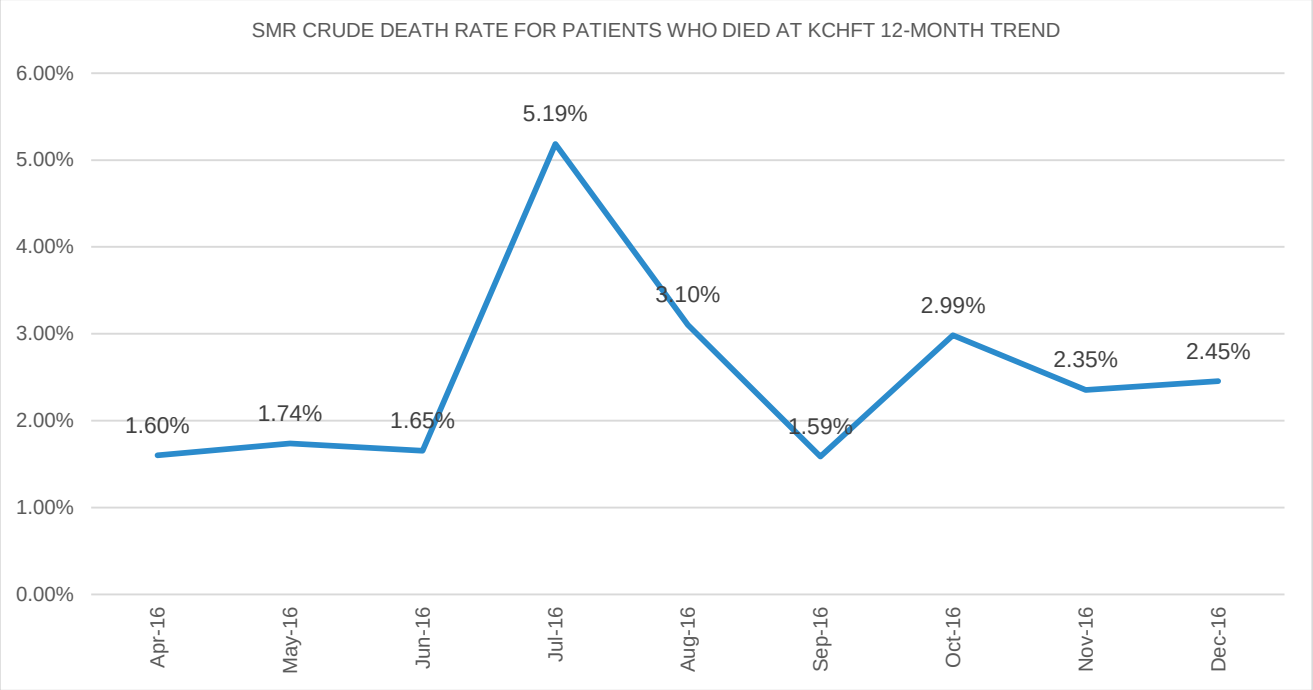
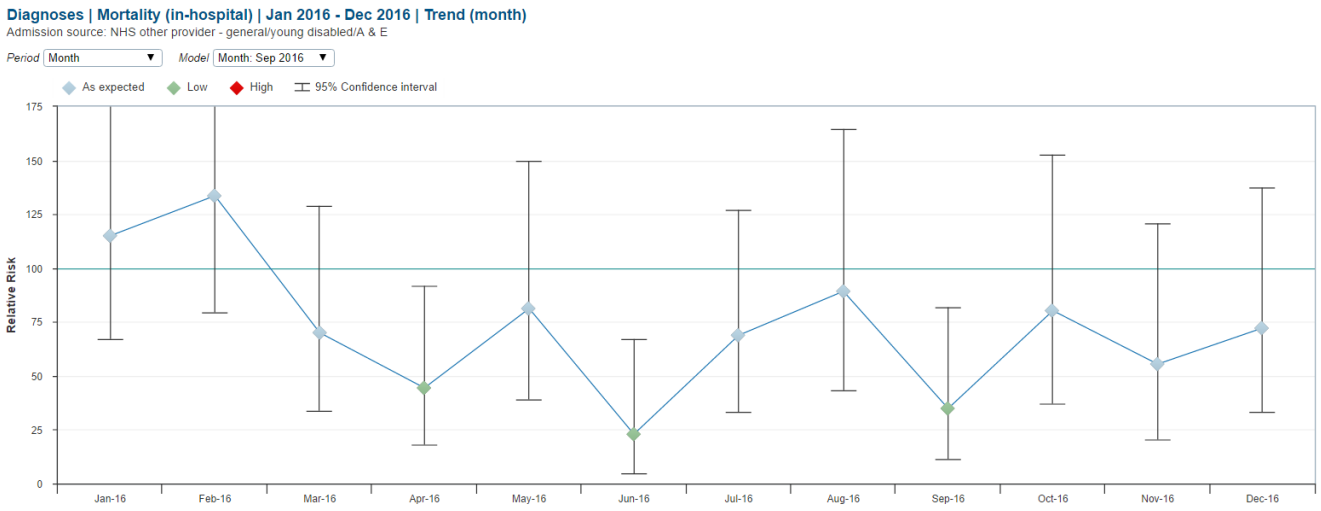


FIG.4.0: ANALYSIS OF ADMISSIONS FROM NHS PROVIDERS 'STEP-DOWNS'



Trend (month)	Superspells	Spells	Observed	%	Expected	%	O-E	RR	Low	High
All	1,896	2,056	114	6.0%	158.3	8.3%	-44.3	**72.0**	59.4	86.6
Jan-16	147	150	17	11.6%	14.8	10.1%	2.2	115.0	67.0	184.2
Feb-16	139	155	18	12.9%	13.5	9.7%	4.5	133.6	79.2	211.2
Mar-16	132	142	10	7.6%	14.3	10.8%	-4.3	70.0	33.6	128.8
Apr-16	188	209	7	3.7%	15.8	8.4%	-8.8	**44.4**	17.8	91.5
May-16	176	193	10	5.7%	12.3	7.0%	-2.3	81.2	38.9	149.5
Jun-16	179	203	3	1.7%	13.1	7.3%	-10.1	**22.9**	4.7	67.0
Jul-16	183	205	10	5.5%	14.5	7.9%	-4.5	68.8	33.0	126.6
Aug-16	179	194	10	5.6%	11.2	6.3%	-1.2	89.2	42.8	164.2
Sep-16	157	166	5	3.2%	14.4	9.1%	-9.4	**34.8**	11.3	81.4
Oct-16	125	131	9	7.2%	11.2	9.0%	-2.2	80.3	36.7	152.4
Nov-16	144	151	6	4.2%	10.8	7.5%	-4.8	55.4	20.3	120.7
Dec-16	147	157	9	6.1%	12.5	8.5%	-3.5	72.2	33.0	137.0

- Analysis of Step-down patients shows that there are on average 158 patients admitted as step-downs each month. This is an increase compared to the previous report. April 16 remains the busiest month with 188 patients.

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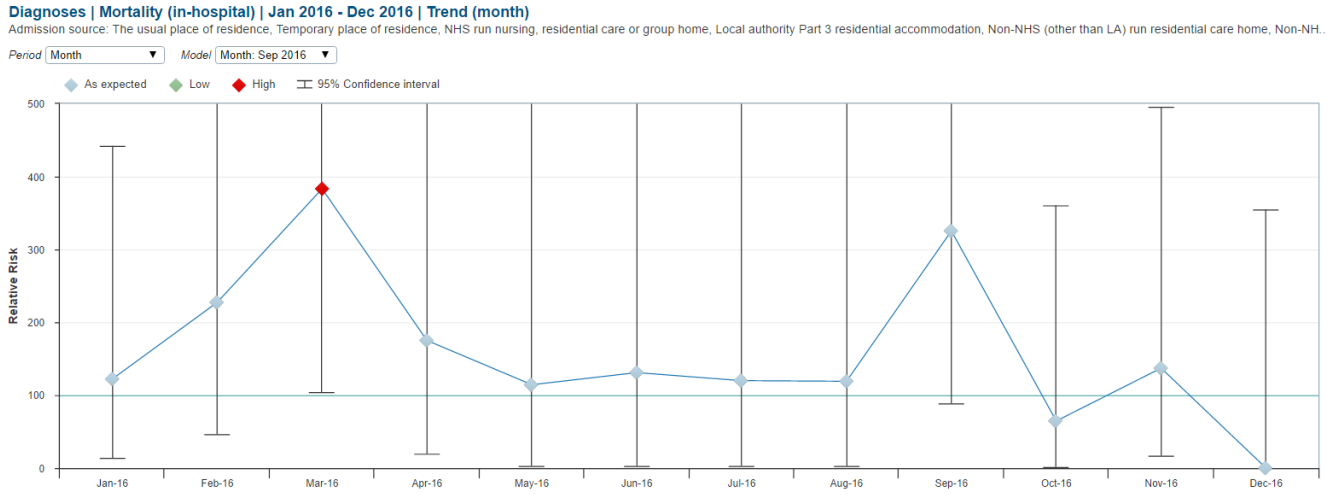
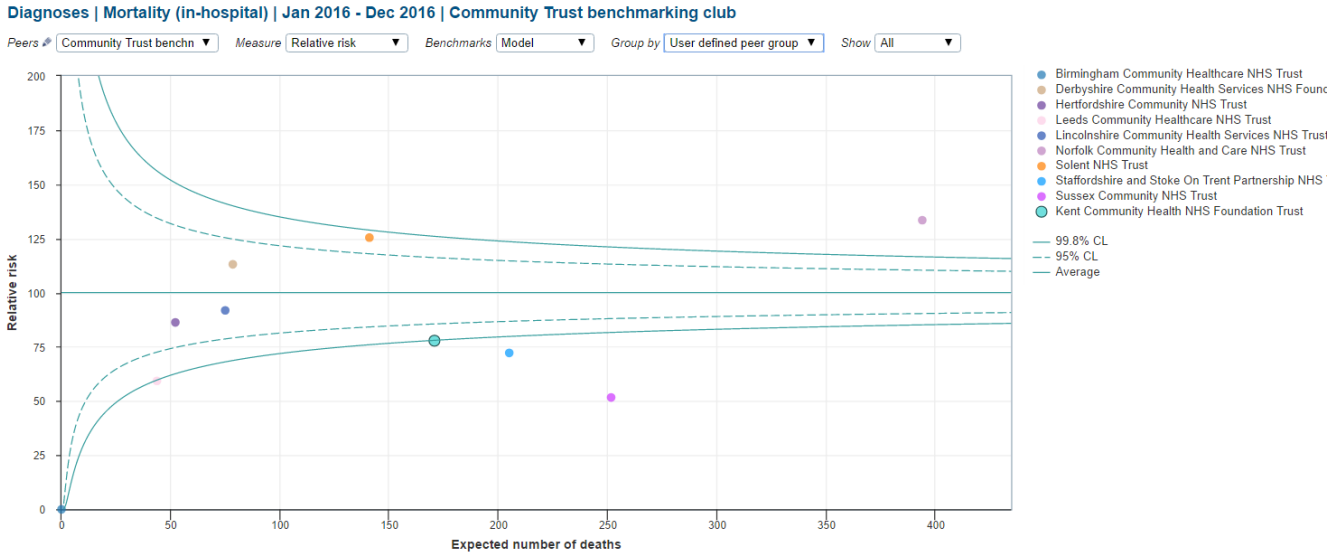
- Of the ‘Step-Up’ patients, there was an average of 22.8 per month.
- March 16 is the only month, which is statistically significant, with four observed deaths against an expected 1.0.

FIG.5.0: ANALYSIS OF ADMISSIONS FROM NON-ACUTE SOURCE ‘STEP-UPS’



Trend (month)	Superspells	Spells	Observed	%	Expected	%	O-E	RR	Low	High
All	274	275	22	8.0%	13.7	5.0%	8.3	160.3	100.5	242.7
Jan-16	18	18	2	11.1%	1.6	9.1%	0.4	122.2	13.8	441.3
Feb-16	34	34	3	8.8%	1.3	3.9%	1.7	227.4	45.7	664.4
Mar-16	20	20	4	20.0%	1.0	5.2%	3.0	383.3	103.2	981.3
Apr-16	18	19	2	11.1%	1.1	6.3%	0.9	175.1	19.7	632.3
May-16	20	20	1	5.0%	0.9	4.4%	0.1	114.4	1.5	636.4
Jun-16	22	22	1	4.5%	0.8	3.5%	0.2	131.0	1.8	728.9
Jul-16	26	26	1	3.8%	0.8	3.2%	0.2	120.0	1.6	667.5
Aug-16	26	26	1	3.8%	0.8	3.2%	0.2	119.1	1.6	662.6
Sep-16	25	25	4	16.0%	1.2	4.9%	2.8	325.4	87.6	833.2
Oct-16	20	20	1	5.0%	1.5	7.7%	-0.5	64.6	0.9	359.6
Nov-16	28	28	2	7.1%	1.5	5.2%	0.5	137.1	15.5	495.2
Dec-16	17	17	0	0.0%	1.0	6.1%	-1.0	0.0	0.0	353.7

FIG.6.0 – PEER COMPARISON TABLE FOR KCH FOR ALL ADMISSIONS AGAINST OTHER COMMUNITY PEERS JANUARY 2016 TO DECEMBER 2016



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Community Trust benchmarking club	Superspells	Spells	Observed	%	Expected	%	O-E	RR	Low	High
All	24,161	25,449	1,343	5.6%	1413.1	5.8%	-70.1	95.0	90.1	100.3
Staffordshire and Stoke On Trent Partnership NHS Trust	6,607	6,796	148	2.2%	205.1	3.1%	-57.1	72.2	61.1	84.8
Sussex Community NHS Trust	3,705	3,849	130	3.5%	252.0	6.8%	-122.0	51.6	43.2	61.3
Norfolk Community Health and Care NHS Trust	3,537	4,090	526	14.9%	394.2	11.1%	131.8	133.4	122.3	145.4
Derbyshire Community Health Services NHS Foundation T...	3,130	3,186	89	2.8%	78.7	2.5%	10.3	113.1	90.8	139.2
Kent Community Health NHS Foundation Trust	2,149	2,331	133	6.2%	170.9	8.0%	-37.9	77.8	65.2	92.3
Lincolnshire Community Health Services NHS Trust	1,931	1,963	69	3.6%	75.1	3.9%	-6.1	91.8	71.5	116.3
Hertfordshire Community NHS Trust	1,317	1,391	45	3.4%	52.2	4.0%	-7.2	86.3	63.0	115.5
Solent NHS Trust	1,107	1,154	177	16.0%	141.1	12.7%	35.9	125.4	107.7	145.4
Leeds Community Healthcare NHS Trust	651	662	26	4.0%	43.9	6.7%	-17.9	59.3	38.8	86.9
Birmingham Community Healthcare NHS Trust	27	27	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	52058.9

- There are 10 Trusts in the peer group with reported data for the time period analysed.
- 2 out of 10 Trusts are statistically higher than expected in terms of relative risk.
- Overall, the peer group is statistically 'as expected'.
- Four Trusts are statistically below expected.
- KCHFT is statistically 'below expected'.

3. SITE ANALYSIS

Sites included in the analysis below:

Faversham Cottage Hospital (RYYAL)

Victoria Hospital (RYYCH)

Sevenoaks Hospital (RYYD9)

Whitstable & Tankerton Hospital (RYYCM)

Queen Victoria Memorial Hospital (RYYC3)

Hawkhurst Cottage Hospital (RYYD6)

Tonbridge Cottage Hospital (RYYDC)

Edenbridge Hospital (RYYD4)

Fig 7.0: KCHFT Sites Superpsells April 16 to Dec 16

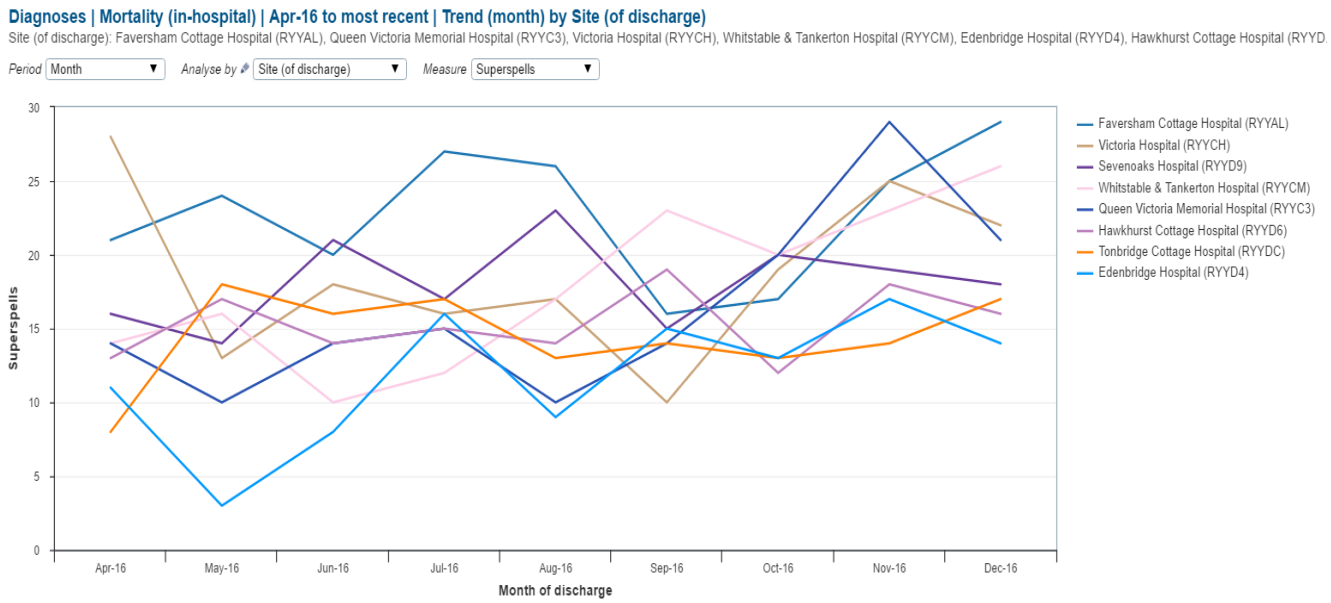

Fig 7.1: KCHFT 8 Sites Crude death rate 9-month trend April 16 to Dec 16

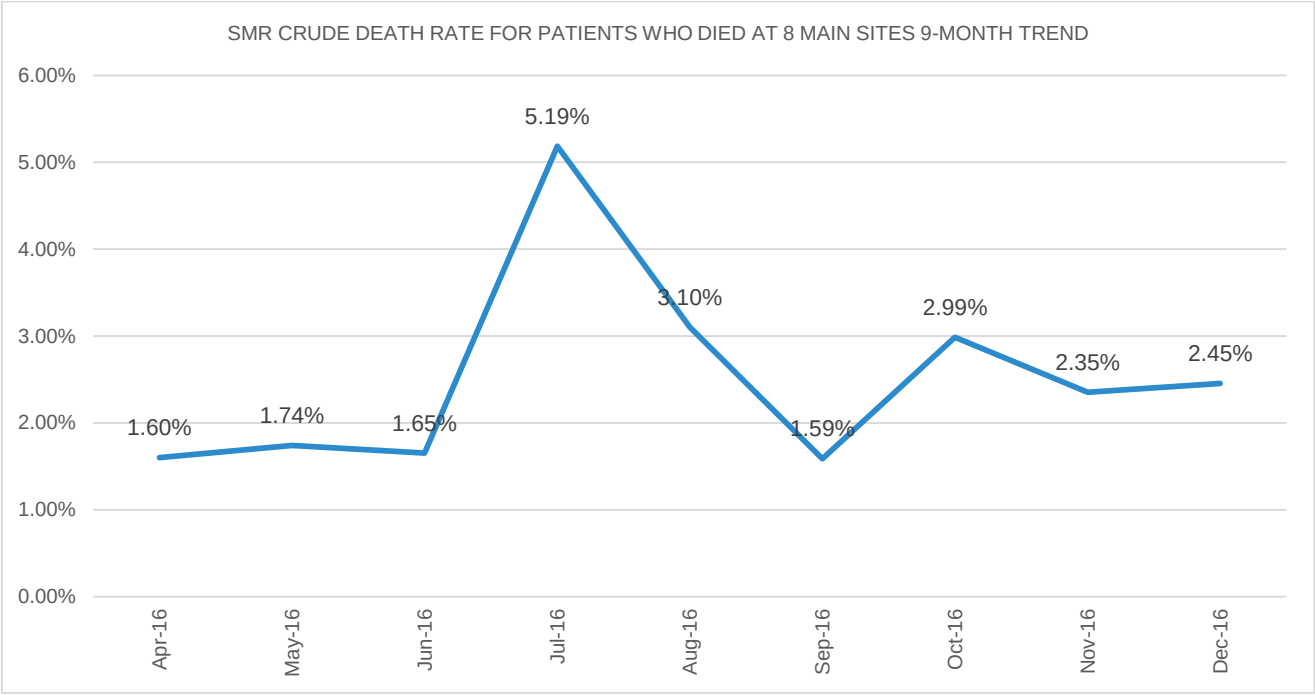

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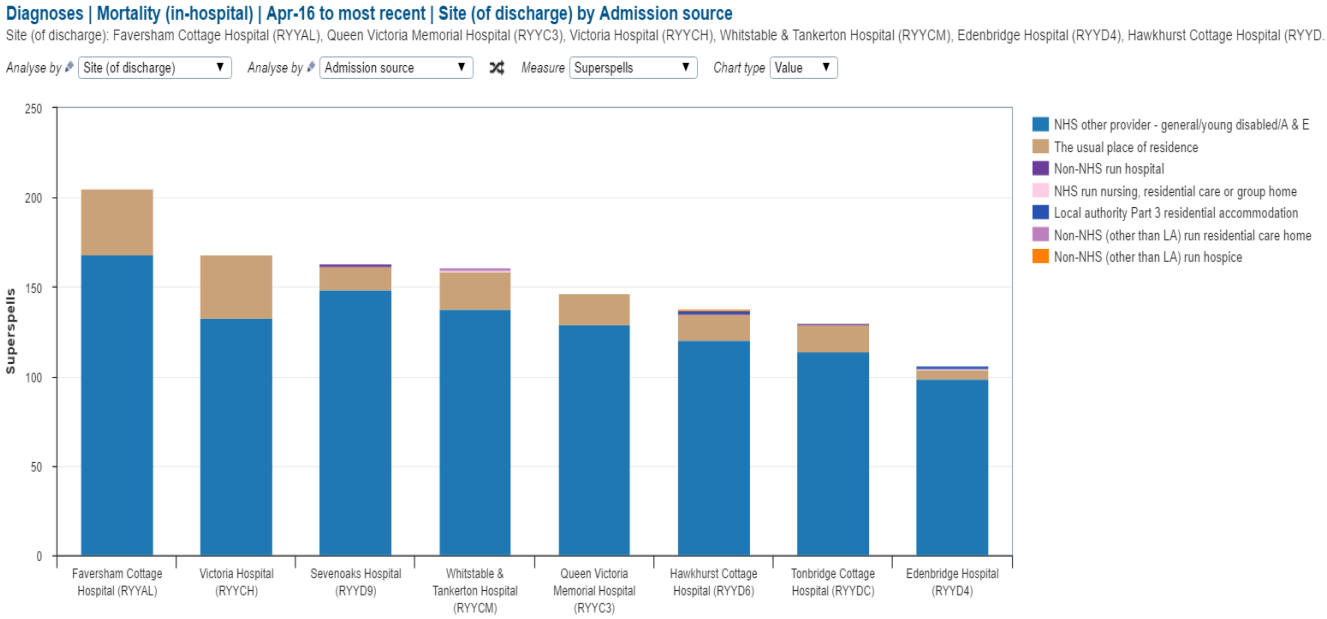
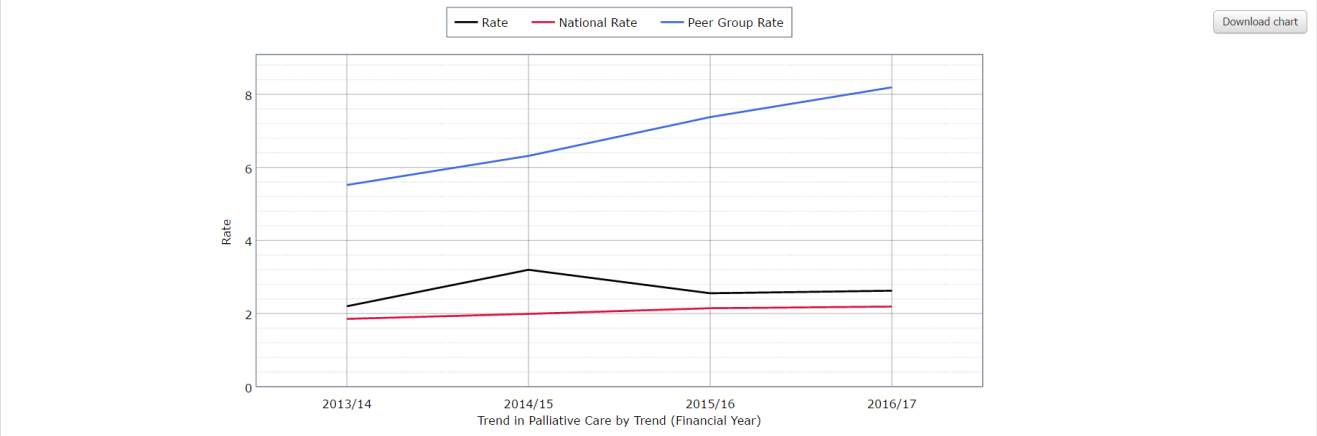
Fig 8.0: KCHFT Sites of discharge by admission source Superpsells April 16 to Dec 16



4. Palliative Care Coding rate

For each financial year we calculate the proportion of a trust's SMR super spells excluding day cases which are coded as having palliative care, this is the observed value shown. The expected value is the proportion nationally for the equivalent mix of diagnosis and admission type. The trust's index value is calculated as observed/expected x 100.

Trend (Financial Year)	Spells	Observed	Rate (%)	National Rate (%)	Peer Group Rate (%)
2013/14	2,411	53	2.20	1.85	5.52
2014/15	2,346	75	3.20	1.99	6.31
2015/16	2,153	55	2.55	2.14	7.38
2016/17	1,791	47	2.62	2.19	8.19



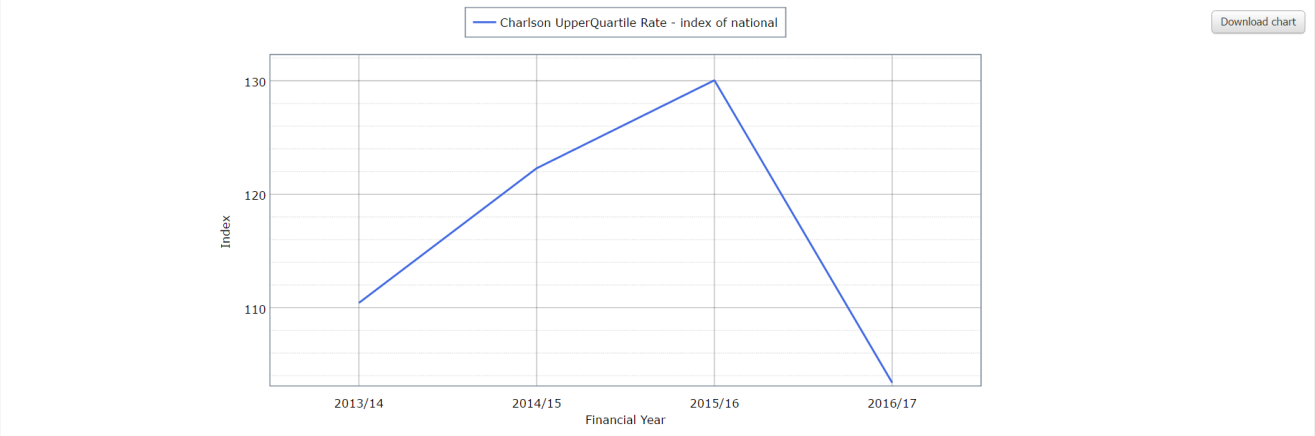
- KCHFT palliative care coding rate is 2.26 % for all diagnosis for FYTD 16/17.
- The national rate is 2.19 %. The peer group rate is 8.19 %.

5. Charlson Co-morbidity

For each financial year we calculate the proportion of a trust's SMR spells where the Charlson index for the diagnosis-dominant episode is in the national upper quartile for that diagnosis and admission type, this is the observed value. The expected value is the equivalent proportion nationally i.e. 25%. The trust's index value is calculated as the observed/expected x 100.

- The Charlson comorbidity upper quartile rate for KCHFT is 25.8 % and as an index of the national are 103 for FY 16/17.

	2013/14	2014/15	2015/16	2016/17
Charlson comorbidity upper-quartile rate	27.6%	30.6%	32.5%	25.8%
Charlson rate as index of national	110	122	130	103



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Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.4
Subject:	Clinical Audit Annual Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):

The annual clinical audit programme for 2016/17 was approved at the Trust Clinical Audit Group in March 2016.

In terms of performance during 2016/17:

- 230/240 actions were implemented as a result of clinical audit which means that as a Trust we exceeded our KPI of 95% completion of due audit recommendations.
- Our performance benchmarks well with other Trusts however improvements are required in terms of reporting timeframes.

In terms of achievements during 2016/17:

- We revised our reporting process to ensure faster escalation of more serious issues and will monitor the impact of this in the Trust Clinical Audit group.
- A representative from KCHFT is now leading the South East Clinical Effectiveness Network.
- A third successful Clinical Audit & Research Conference was held with attendees from across the local health economy demonstrating our commitment to partnership and collaboration.
- Presented at national clinical audit conference on continually developing the clinical audit process.
- Launched narrated and filmed presentations in order to promote shared learning (these are not restricted to clinical audit)

Priorities for 2017/18:

- Support Directorates to deliver the annual audit programme.
- Further refine and enhance PPI in clinical audit.
- Ensure that clinical audit is aligned to and supports the requirements of the STP process.

Proposals and /or Recommendations:

The Board is asked to note the contents of this report and that Directorates have worked hard to ensure the successful delivery of the key performance indicator targets for clinical audit. Directorates are to be congratulated as through their efforts the Trust has achieved 96% implementation of all due audit recommendations.

Relevant Legislation and Source Documents:

Has an Equality Analysis been completed?

No. High level position described and no decisions required.

Dawn Nortman, Head of Clinical Audit and Research	Tel: 01233 667943
	Email: Dawn.Nortman@kentcht.nhs.uk

CLINICAL AUDIT ANNUAL REPORT

1 Introduction

This report provides details of:

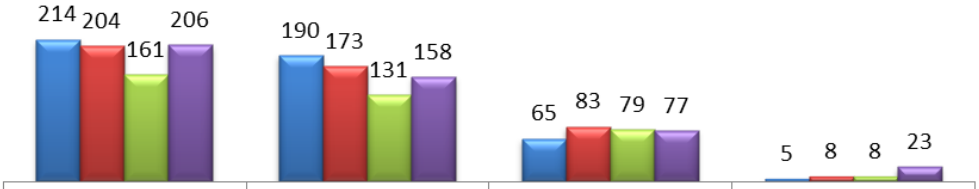
- The Clinical Audit Programme 2016/17
- Programme Effectiveness
- Performance Against Key Performance Indicators (KPIs)
- Achievements in 2016/17
- Priorities for 2017/18

2 Clinical Audit Programme 2016/17

The annual audit programme was reviewed and approved at the Clinical Audit Group in March 2016. The audit programme opened in April 2016 with 73 clinical audit projects carried over from the previous audit year. The year closed with 206 clinical audit projects in the audit programme at the end of March 2016. 158 (77%) of the audits were fully supported by the department. Advice was provided by the department on a further 30 (19%).

77 (37%) clinical audit projects were completed within the audit year. A clinical audit project is recorded as completed when every single action identified from the audit is implemented or exception reported as appropriate. The remaining projects (102) were carried over onto the 2016/17 audit programme or removed if they had been withdrawn (24). Three projects were moved to “Other projects”, which include service evaluations and surveys. The Clinical Audit Programme for 2017/18 was approved in March 2017 by the Trust Clinical Audit Group and consists of 185 audits. A comparison with previous years is shown below.

Comparison of the clinical audit programme from 2013/14 to 2016/17



	Number of projects	Number of fully supported audits	Clinical audit projects completed	Clinical audit projects discontinued
2013-14	214	190	65	5
2014-15	204	173	83	8
2015-16	161	131	79	8
2016-17	206	158	77	23

(N.B. The process for discontinuing audits that have not started has become more stringent hence the large increase in discontinued projects in 2016-17).

At the end of 2016/17 61% of projects provided a rating of Full or Significant Assurance compared to 74% or projects in 2015/16 and 54% of projects in 2014/15.

A review of the top 5 reasons for clinical audit in 2016/17 shows the programme was focussed in the following areas:

- A requirement to assess our compliance against national priorities including national audit and NICE Guidance.
- Local priority monitoring (which may contribute to local KPIs).
- Corporate assurance including providing evidence for CQC.
- Commissioning priorities including providing evidence and assurance against our CQUIN targets.
- Risk issues including serious incidents and re-audits of Limited and No Assurance Audits from 2015/16.

3 Programme Effectiveness

An effective clinical audit programme is developed and delivered within KCHFT through:

- **The forward planning process** through which the annual audit programme is developed. This includes discussion of internal and external drivers, PALs data (complaints, compliments, patient experience), NICE Guidance, Claims, Risk issues (including review of incidents, examination of trends and review of BAF). All limited or no assurance audits from the year are subject to re-audit in the next year's programme.
- **Clarity of accountabilities** at operational and Trust level. Our clinical audit policy clearly outlines area of responsibility in terms of overall Trust responsibility, Executive leadership, responsibility for ensuring the audit process is working and effective and responsibility for assessing risks to quality identified through audit. The policy also outlines operational and Directorate responsibilities and reporting mechanisms.
- **Infrastructure to support monitoring**. There are a number of databases to support management and delivery of the audit programme and facilitate the production of reports on programme status and action plan monitoring. These are reviewed by Directorate groups on a monthly basis and by the Trust Clinical Audit Group on a quarterly basis.
- **Pathways for escalation** when problems arise. There are clear pathways for escalation when there are delays with the conduct of audit.
- **Key performance Indicators** – which are in place to monitor the implementation of actions as you cannot deliver an effective audit programme without implementation of recommended actions.

3.1 Examples of Actions to Improve the Quality of Healthcare

As reported in our Quality Accounts the reports of all local clinical audits with an action plan in place were reviewed by the provider in 2016/17. KCHFT intends to take (or has already implemented) the following actions to improve the quality of healthcare provided:

- Podiatric surgery service to introduce Peer checking to ensure that medication, allergies and next of kin etc. have all been documented at first consultation at pre-operative assessment.(P/038/16)
- Relevant heads of service to be informed to update their risk registers to reflect the risk that arises as a result of a failure to demonstrate compliance with Trust policy on obtaining written delegated consent.(P/050/16)
- Revise consent form for the use of acupuncture to include two new tick boxes as prompts to provide patients with Patient Information leaflet and Visual Analogue Scale (P/017/16)
- As a result of the Lower Limb audit the Tissue Viability Nurses will develop and distribute a standardised wound pack for staff until it becomes available on CIS. This will support the management of wounds. The clinical pathway to be re-launched. (P/039/16A)
- Speech and Language service to create screening assessment for auditory discrimination to ensure robust screen to ensure client meets criteria for entry (P/023/16)
- Monthly SSKIN audits to be undertaken for Long term services and community hospitals to gain assurance that the SSKIN model and prevention strategy has been fully implemented (P/009/16)
- Development of a learning resource pack for people with learning disabilities and their immediate carers / families. This will help patients improve early identification of clinical conditions, improved pain symptom management and self-management of condition (P/040/16)
- To further provide an opportunity for clients to access the Domestic Violence and Abuse service all Red book inserts with the information relating to domestic abuse to be provided at every visit. In addition to email all Nursery Nurses to show domestic abuse page in red book to presenting parent. (P/065/15)

3.2 Areas of Good Practice

Areas of good practice and positive outcomes for patients identified by local clinical audit include:

- **Self-Care re-audit Q1** – Compliance with standard for distributing written care information to the patient/carers rose from 20% in the first audit to 70% in the re-audit. This was following the recommendation for health and social

care co-ordinators to assist and feedback upon discharge of patients from community hospitals

- **Adherence to Podiatric Surgery WHO safety checklist (Aug 2016)** - 100% compliance recorded in 3 out of 4 sections of the checklist. The final section recorded 94% compliance.

- **Re-audit of hydration in community hospitals/nursing Swale** - The audit demonstrates compliance with expected standards for nutrition and hydration across community hospitals and community services in Swale. In 100% cases a nutrition and hydration assessment was undertaken on admission to the ward where a risk was identified a care plan was in place and this was regularly reviewed. Where a nutrition and hydration concern was identified a fluid chart was in place.

- **Surgical Safety Checklist Audit** - In response to the World Health Organisation second Global Patient Safety Challenge, 'Safe Surgery Safe Lives,' a new Surgical Safety Checklist was published in 2008. The National Patient Safety Agency and National Reporting and Learning Service adapted the checklist for use in England and Wales. WHO Surgical Checklist - 13 observations took place across the 3 sites. All sites were 100% compliant.

- **East Kent Lower Limb Audit** demonstrated good compliance with:
    - Initial risk assessments and care planning
    - First Choice dressing and product selection
    - Appropriate use of silver and steroidal products
    - Referrals to podiatry and other professionals/MDTs
    - Clinical actions e.g. screening and wound swabs if wounds not progressing

- **Re-audit of hydration in the community hospitals** - This was the second re-audit following a limited assurance rating from both the initial audit and first re-audit. The findings from this round of data collection highlight that 100% of patients with an identified hydration concern have a care plan in place to address the concern. To ensure that all patients admitted to a community hospital are given an initial hydration assessment, an action will be put in place which requires ward manager to provide monthly assurance documentation to achieve this.

- **Re-audit of Adult Epilepsy Nursing Service Person Centred Care Planning** - This is the second round of data collection for this audit, following a limited assurance rating in 2015. This audit showed improvement in documenting historic accident and emergency attendance in epilepsy patients, as well as risk and priority areas of the patient. Some areas of

documentation could be improved; an action to draft a new patient letter template to prompt clinical staff to record missing areas has been identified.

- **UNICEF Baby Friendly Initiative - Infant Feeding Staff Audit** - UNICEF baby friendly accreditation is recognised worldwide. This initiative was put in place to increase the rates of breastfeeding mums and ensure consistent training for Health Visitors across the trust. KCHFT Health Visitor Service have applied to be accredited as Baby Friendly from UNICEF. The findings from this audit helped inform the training package developed to increase the knowledge of staff and for health visitors to be accredited. The infant feeding leads in the service have developed and are delivering this training regularly. The aim is to train all health visiting staff within 2 years. The audit is a rapid cycle audit being repeated every three months.

- **American Society of Anaesthesiologists (ASA) Physical Classification Audit** – This was undertaken against NICE Guidance 45 Routine preoperative tests for elective surgery. The audit was undertaken in podiatry and focused on those with ASA grades 1 or 2, and found that all routine tests recommended (full blood count, kidney function etc.) for healthy patients or those with mild system diseases were performed in line with the NICE guidance. The audit showed:
    - Full compliance in all areas
    - Routine preoperative testing is embedded within the department
    - All patients were given an assessment in accordance with the NICE Guidance.

- **Re-audit of Internal Musculoskeletal physiotherapy documentation** – Since the last audit there were:
    - Improvements in both recording of investigations (67% -85%), in social history (92% -98%), and all aspects of the recording of a physical examination.
    - The use of outcome measures has improved (78% – 83%) with the most common being range of movement and visual analogue scale.
    - 98% of cases demonstrated a working hypothesis or diagnosis.
    - More accurate recording of patient demographic data.

- **Surveillance of Children with Downs Syndrome** - Children with Downs Syndrome should have review of Audio, Thyroid Function Test (TFT) and annual review. This audit collected data for the whole of child's case record. The audit showed that the percentage of children who had received annual review progressively decreased as the child got older. As a result of this audit the audit lead will discuss with the appointments team to book the review dates in advance based on the child's birth month. The audit lead will also liaise with Paediatric Audiology and Paediatric Ophthalmology to agree

amended Downs Syndrome guidelines to ensure mandatory audiology and ophthalmology annual reviews.

This is a sample of the actions and improvements already being implemented from the local clinical audits undertaken and completed in 2016/17.

Areas of good practice and quality improvement are:

- Discussed at Directorate Audit/Quality Groups
- Discussed at Trust Clinical Audit Group.
- Highlighted in Weekly Bulletin.
- Summaries on Flo.
- Cascaded by project leads and Directorate Audit Leads.
- Celebrated at events such as the Clinical Audit & Research Conference.

4 Performance against KPIs

At the end of 2016/17 230 actions designed to improve the quality of care for our patients had been implemented as a result of clinical audit.

1.Due audit recommendations implemented	Q1		Q2		Q3		Q4	
	Target >35%		Target >75%		Target >80%		>95%	
	%	Figures	%	Figures	%	Figures	%	Figures
Trust Total	63	55/88	72	108/151	91	174/191	96	230/240
2. Actions overdue > 3 months	Target <10%							
Trust Total	14	12/88	5	8/151	2	4/191	1	2/240
3. Actions overdue > 6 months	Target <5%							
Trust Total	3	3/88	3	7/191	1	2/191	0	0/240

For 2016/17 the Trust achieved 96% implementation of due recommendations compared with:

- 92% in 2015/16
- 90% in 2014/15
- 85% in 2013/14

Trust wide and Directorate figures are reported to the Performance Team on a bi-monthly basis and reviewed at Directorate Audit Groups and the Trust Clinical Audit Group. These figures show that for 2016/17 Adults Directorate and Nursing & Quality combined were responsible for 55% of all due recommendations and achieved 98% and 94% success respectively in implementing these which is a significant accomplishment.

Actions to address quality issues centred on the following 5 areas:

- Audit, re-audit and monitoring – both formal and informal processes including rapid cycle audit where required
- Dissemination/Discussion – both internally and externally
- Changes to documentation – both development of new documentation and amending existing documentation e.g. development and introduction of checklists.
- Training – including training attendance, e-learning and development of new packages
- Policy – both changes to policy and implementation of new policy

5 Benchmarking Performance/Practice with other Trusts

A call for benchmarking information was sent out to the South East Clinical Effectiveness Network (SECEN) and to those signed up to received audit information on the Contact, Help, Advice and Information Network (CHAIN) run by NHS Improving Quality. Seven Trusts replied these included:

- Maidstone and Tunbridge Wells NHS Trust
- Somerset Partnership NHS Foundation Trust
- Queen Victoria NHS Foundation Trust
- Kent and Medway NHS & Social Care Partnership Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Berkshire Healthcare NHS Foundation Trust
- Northampton General Hospital

KPI Action Plan Monitoring		
Elements:	**KCHFT**	**Benchmarking**
Implementing Actions	• Monitor all actions through to completion.	• No monitoring of actions. • No monitoring. Updates requested when re-audit due. If not completed re-audit not allowed. • Currently 300 overdue actions. • Monitor all actions through to completion.
Definition for Audit Completion	• When all actions are implemented and evidence supplied to Clinical Audit Team. • Once complete feedback form sent asking Project Leads to assess if the audit has made a difference.	• When a report and action plan received. • When second cycle of data collection undertaken, improvement seen and action plan produced. • When actions completed – evidence not requested.
Monitoring Timeframe of overdue actions	• Monitor due actions implemented. • Actions overdue by over 3 months. • Actions overdue by over 6 months.	• No. • Yes for national and specific inter-service projects. • Only if they are care pathway audits.
% of Audits Completed	• 92% in 2015/16	• Unable to identify • 1 Trust but figure not given.

Shadow KPI Timeliness of Reporting		
Elements:	**KCHFT**	**Benchmarking**
Timeliness of Reporting	• Shadow KPI in effect around reporting within 30 days. Currently 27%. • Working on systems to improve process.	• Different expectations for different audits. 80% of report within timeframes (timeframes variable). • Only chase up "Trust" audits – 38 on plan. Do not measure timeliness but overall good compliance. Do not follow up "other" audits. • Aim to get reports and action plans within 3 months. • Huge variation between specialties. • Pragmatic approach to timeliness of reporting dependent on reason for delays.
Escalation of issues with reporting	• Escalation within Directorate Audit/Quality Groups. • Escalation at Trust Clinical Audit Group. • Added to Medical Directorate Risk Register.	• As per KCHFT. • Abandon project if issues with getting report.

In terms of benchmarking KCHFT compares well in terms of monitoring completion of actions being the only Trust that monitors all actions through to completion and also collects evidence to support this. Only one of the seven other Trusts replying monitors all actions through to completion. Our success in this area has meant that KCHFT has presented on this nationally at Healthcare Events Conferences and more locally at the South East Clinical Effectiveness Network meetings. KCHFT has also been used by the Healthcare Quality Improvement Partnership as a case study.

In terms of benchmarking around reporting KCHFT has a more stringent shadow KPI in place than other Trusts, however, with limited success. One of the Trusts replying to the call for information achieves 80% reporting within timeframes (although those timeframes are less stringent than KCHFTs). We have met with this Trust to discuss their system and lessons we can learn from this.

6 Achievements 2016/17

The work of the Clinical Audit Department has been focussed in 2016/17 on the following priority areas:

- Providing evidence for assurance (internal and external)
- Linking Clinical Audit with Risk Issues and Quality Priorities
- Improving the quality of action plans
- Forward Planning
- Prioritising National Institute of Care Excellence (NICE) Guidance for audit

Additional achievements during 2016/17 include:

- **Improving Reporting Processes** - Reviewing and revising the format of executive summaries and full audit reports in order to facilitate quick turn around of results and better highlight any patient safety risks. Following issues with reporting deadlines i.e. shadow KPI a new system for ensuring timely reporting was agreed at the Trust Clinical Audit Group in January 2017. Under this new system a dashboard report is produced within 30 days with agreed timescales for full report and action plan based on the level of assurance:
  - **Full/Significant Assurance**: Within 60 days of dashboard report
  - **Limited Assurance**: Within 30 days of dashboard report
  - **No Assurance**: Within 14 days of dashboard report

  The result of this change will be monitored at the Trust Clinical Audit Group.

- **Networking and Driving the National Clinical Audit Agenda –** One of our Facilitators became the Chair of the South East Clinical Effectiveness (SECEN). This network brings together colleagues to share good practice, provide peer support and influence the national quality agenda. The Chair of SECEN also feeds into the National Quality Improvement Network which helps to drive the national clinical audit agenda.

- **Holding a third successful Clinical Audit and Research Conference** in November 2016 with approximately 130 attendees including our partners across the health economy including KCC, acute, community and primary care colleagues.

Image: Paul Bentley awarding first prize to Dr Mun Yee Tung (on behalf of Dr Emma Fox) for her poster on Sexual Health Screening and Risk Assessment Audit.

- **Presenting Nationally** - Presenting on continually developing the clinical audit process at a national clinical audit conference in London. Also booked to present at a national conference in October 2017 on ensuring clinician engagement with quality improvement activities and clinical audit in particular.

- **Promoting Shared Learning** - As noted in previous reports cross-cutting themes identified through an analysis of all reports and action plans continue to identify issues around communication, documentation, holistic care and the practical application of training. The recurrence of these issues within clinical audit echoed the experience across the Trust and suggested that further work is required on cascading and embedding learning. This led to the introduction

of narrated and filmed presentations (with the assistance of Comms for filming) which the Clinical Audit & Research Department produces for clinical audit and other quality improvement areas. To date the following have been launched on Flo:

- Painting Pain which looks at experience of living with chronic pain (Research)
- Infection Prevention and Control in our community hospitals (Audit)
- Tissue Viability (Innovative training through use of models)

6 Priorities 2017/18

In 2017/18 the main priority for the Department remains supporting Directorates to deliver the annual audit programme. In addition to this core business objective the clinical audit function will also be putting systems in place to:

- Further refine and enhance the process for patient involvement in clinical audit. Despite changes introduced in 2016/17 further work is required in this area. We will be working in tandem with the Patient Engagement Team and patient representatives on this.
- Ensure that clinical audit clinical audit is aligned to and supports the requirements of the STP process where needed.

7 Requested Board Actions

The Board is asked to note the contents of this reports and recognise that in terms of more localised activity Directorates are to be congratulated for implementing actions and embedding change of practice. This has resulted in the successful delivery of the key performance indicator targets for clinical audit.

Dawn Nortman
Head of Clinical Audit and Research
18 May 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.5
Subject:	Six Monthly Public Engagement and Equality Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary
The report provides a summary of public engagement and equality activity and outcomes since January 2017.

Proposals and /or Recommendations
To note the report

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. There is an Equality Analysis in place on the current Communication and Engagement Strategy. This report concerns the implementation of certain aspects of this strategy.

Karen Edmunds, Head of Engagement	Tel: 01233 667816
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Kent Community Health
NHS Foundation Trust

PATIENT AND PUBLIC ENGAGEMENT REPORT – MAY 2017

1. Introduction

- This report provides the Board with assurance that the Trust is engaging with patients and the public including those we find harder to reach and ensuring they are involved in on-going service improvement.

- The Trust has a statutory duty to consult patients and the public on all significant changes to services. Consultation may range from informing people and seeking comments and concerns to full public consultation. Best practice is for services to be co-designed with patients / service users and staff as partners.

- The Trust continues to engage with patients, public and other stakeholders in a variety of ways including getting new patient / public representatives for several committees, continuing to listen to young people about the ways they want to be involved, working in partnership with KCC and our services on supporting migrant communities to better engage with health services and working with the Trust's Governors to reach the membership and wider public.

2. Engaging with young people

- From September 2016 to May 2017 187 young people completed our survey on how they want to be engaged and involved. Young people said they would like both a virtual forum and to be involved with a forum that meets. They are keen that their involvement helps them to develop new skills as well as make a difference.

- We have established a steering group to take forward this work, with membership from KCHFT, East Kent Hospitals, Healthwatch Kent and the Oasis Academy. Other Trusts have been invited and it's hoped that some of them will get involved. Some partners will have an advisory role including Medway Foundation Trust and the Kent Cancer Collaborative. The first step will be to set up a virtual NHS Youth Forum later this year, followed by an event.

3. Migrant Communities

- The Roma Community Network established in 2014 in partnership with KCC has now become a Migrant Communities Network, hosted by KCHFT, with membership of 286 professionals.

- A Steering Group supports this work, and its members along with Health Improvement and Public Health are now developing a series of bids to the Depart of Communities and Local Government's 'Controlling Migrant Fund' to provide cultural awareness training for staff, specialist health trainers, health visitors and school nurses and support to capture data on the health experiences of migrant communities in Kent.

4. **Membership**

- During January to 4 May 2017 the Trust's public membership increased, bringing the total public membership to 13,262, of which 1,983 are out of area members. Of the total membership, 854 are from Black and Minority Ethnic communities, 290 are aged 19 or under, and 513 are aged over 80.

MEMBERSHIP	
District	**Members**
Canterbury	**1861**
Maidstone	**1390**
Swale	**1226**
Ashford	**1083**
Dover	**1018**
Thanet	**956**
Sevenoaks	**938**
Tonbridge & Malling	**770**
Shepway	**717**
Gravesham	**530**
Dartford	**426**
Tunbridge Wells	**364**
Out of catchment	**1983**
Total members	**13262**

- The Engagement team, along with the Governor Support Office and the Public Governor for Dover, held our first Members event, in partnership with East Kent Hospitals. The theme was 'Let's talk about Diabetes'. The aim was to engage our public members, raise the profile of our Governors and improve public understanding of diabetes and how to live well with it. The event took place on Saturday 18 March in Canterbury. Over 80 members / public attended and there was very positive feedback about the information stands, speakers and the expert panel who were there to answer questions. Governors present were able to engage with the public and members. We live-streamed the presentations and Question and Answer session and subsequently this, along with the Hypo Hounds short film we made on the day, have been viewed over 1,800 times on social media. A further event for members and the public will take place in the late autumn in west Kent.

5. Patient Engagement

- We continue to support staff to engage with and involve the public and patients. Examples include new members for the Community Hospital Patient Experience Groups, the Medway Sexual Health Public Advisory Group and Thanet Adult Speech and Language Therapy Forum (SALT) Forum. There is a huge benefit to having patient / public representatives at the table when issues are discussed, as the lay person brings a different perspective to the debate and helps us to focus on how changes should benefit patients and their families.

- The Patient Engagement Network (PEN) has 94 individual members and 22 voluntary and community sector members. These representatives get involved in a range of activities from PLACE visits, to being a member of a forum or committee, to taking part in interview panels for staff.

- We held an information session for Patient Engagement Network (PEN) members on Freedom to Speak Up. The aim was to increase volunteer awareness of speaking up as they are covered by the Trust's Freedom to Speak Up policy. Although on the day only five volunteers and one public Governor attended, there was very useful discussion, with very positive feedback.

- We helped to train 26 patient / public representatives for this year's PLACE visits and attended a number of visits to support staff who had not been involved in PLACE before.

- We held a focus group with PEN members and staff looking at the new NHS Identity guidance and how KCHFT will adopt this. Their feedback has resulted in us changing the designs around our values, to emphasise they are about people.

- Supported the Kent Continence Service to hold their first patient involvement forum. The aim of the forum is to involve patients and carers in an on-going way to develop and improve the service. The forum has two patient/public representatives and has met once. They've they have reviewed the written correspondence for the service. They would like a KCHFT 'shouldn't have to wait to use a toilet' card. Continence equipment providers use them at moment, but the patient reps have suggested our staff to hand them out too.

6. Partnership

- We have delivered a series of presentations on the NHS and how it works to women's and migrant groups across Kent. This helps people who the NHS finds harder to reach to understand better how the NHS works and how to access services appropriately. Feedback from those attending is that all feel it's improved their knowledge and understanding.

- We have supported the Oasis Academy careers event to encourage young people in Sheppey to get involved in their NHS as members or to consider a career in the NHS. The Academy has offered to host our first NHS Youth Forum later this year.

7. Equality and Diversity

- We made links with Maidstone and Tunbridge Wells NHS Trust (MTW) to help us develop work on transgender issues. They have allowed us to attend one of their staff awareness sessions and shared their Transitioning at Work policy with us. We have consulted with staff and the LGBTQ Staff Network on our own version of a policy and this is now due to go to the Staff Partnership Forum in June. As part of implementing the policy we are planning to hold awareness sessions for staff as these have been proven to be very useful for staff at MTW.

- We assisted a number of colleagues with an Equality Analysis (EA) on policies. EAs are a requirement of our public sector duty and help to assess any potential negative impact of a new policy or revised policy or process or change on people with any of the nine protected characteristics. Once identified they can be addressed to reduce the risk of discrimination.

- We continue to deliver Equality and Diversity training at corporate induction every two weeks and to deal with queries from colleagues concerning equality issues.

- We continue to support the three Staff Networks – Black and Minority Ethnic (BME), Disability and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ). February was LGBTQ History Month, with daily blogs about LGBTQ history on flo and a successful quiz night which raised over £300 for the Trust's charity icare. On 10 May the Staff Networks held an afternoon tea at Trinity House to celebrate National Staff Networks Day and raise awareness of the role of staff networks. The event was attended by over 40 staff, including some community nursing staff who popped in for a much needed cuppa and cake.

- We have been working to ensure the Trust complies with the Accessible Information Standard (AIS). This has included:
  - Materials to help to raise staff awareness: Staff poster, prompt cards, pens, bookmarks, staff handbook and managers' presentation pack. Managers' pack will be expected to be shared at team meetings and cascaded down to staff. From 6 March roadshows have been held across the patch to help staff understand the requirements.
  - The public website and flo has dedicated pages about AIS

- Our electronic patient record software - CIS - is currently being updated and we are working with services to set up a generic form that can be used to meet the AIS requirements
- A new contract is in place with the Kent Association for the Blind (KAB) to provide the Trust with an audio and braille transcription service
- Meeting organisations working with disabled people, such as Action on Hearing Loss to provide us with specific expert advice.

Karen Edmunds
Head of Engagement
15 May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.6
Subject:	Annual Information Governance Report 2016/17
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary (including purpose and context)
This report has been prepared to provide assurance that the Information Governance (IG) Team has evidenced year on year improvements for the Trust in terms of compliance, performance against national benchmarks and through independent audit.

Proposals and /or Recommendations
The Board is asked to continue championing IG throughout the organisation, through dissemination of positive messages and continued engagement with the training, policies and procedures. To note the forthcoming changes during 2017/18 to data protection regulations and full implementation of the GDPR by May 2018. To note the level of compliance for the annual toolkit assessment, at 88%, and training compliance for the year ending 31 March 2016 at 90.3%. To note the level of substantial assurance, with no further recommendations, provided by TIAA following the mandatory annual IG Audit

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed? No. High level position described and no decisions required. Paper has no impact on people with any of the nine protected characteristics.

Natalie Davies, Corporate Services Director	Tel: 01622 211904
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Kent Community Health
NHS Foundation Trust

INFORMATION GOVERNANCE ANNUAL REPORT 2016/17

1. Introduction

Effective information governance is required to underpin safe person-based care and support the quality, efficiency and, transparency agendas; and it is essential that this is delivered. Kent Community Health NHS Foundation Trust (the Trust) continues to develop an IG framework that delivers the necessary systems, processes and behaviours that support improved capture and sharing of information, whilst at the same time ensuring that those elements of IG relating to the secure and appropriate handling of confidential and sensitive information are also satisfied.

This report has been prepared to provide assurance that the IG team has evidenced year on year improvements for the Trust in terms of compliance, performance against national benchmarks and through independent audit.

Furthermore during the coming months changes in data protection legislation will also be implemented which will focus on strengthening and unifying data protection for individuals within the EU. Further information is provided in section 7.

2. Information Governance Toolkit Assessment (IGTA)

The Trust uses the IGTA to measure its performance against IG requirements, and to confirm whether information is handled correctly, and protected from unauthorised access, loss, damage and destruction. The IGTA is based on an annual self-assessment with three submissions to the Department of Health each year in July, October and March.

The Trust has achieved a minimum level two performance across all requirements. An important aim of the assessment is to demonstrate that the Trust is able to maintain the confidentiality and security of personal information, which in turn will increase public confidence.

The Trust's position has improved during 2016/17 to 88% compliance when compared to 2015/16, which was submitted at 86%.

In November 2016 there were national news reports advising the IGTA was being scrapped, this statement is incorrect. The NHS Digital Chief Operating Officer has advised "I can reassure you that this is not the case. There is a programme of work underway to improve the IGT, to increase its relevance for senior managers, its accessibility for small organisations and its focus on the new data security standards recommended by the National Data Guardian. The changes will also increase the focus on timely reporting of incidents and will reduce administrative burden on NHS organisations. Consultation on the improved approach is underway".

3. **Information Governance Assurance Group (IGAG)**

The IGAG assures the Trust that data protection, confidentiality, information quality, records management and information security is effectively incorporated within the broader IG work-plan.

In conducting its work the Group develops and annually reviews the Information Governance Management Framework (IGMF) together with ensuring that the Trust has effective policies, procedures and management arrangements covering all aspects of IG in line with the overarching IGMF.

The group provide regular exception reports to the Corporate Assurance and Risk Management Group (CARM), which includes reporting to the Senior Information Risk Owner (SIRO) and the Caldicott Guardian (CG).

The Terms of Reference for the IGAG have been amended to include oversight of the implementation of the new EU General Data Protection Regulations by 2018. Further information is included in section 7.

4. **Information Governance Management Framework (IGMF)**

In October 2016 the IGMF was reviewed and updated in accordance with the requirements of the Information Governance Toolkit Assessment (IGTA). The IGMF was simplified through signposting to further information and updating of key personnel responsibilities. This document will be further reviewed in June 2017 in-line with the release of version 15 of the IGTA.

5. **Information Governance Training**

Information Governance Training is mandated by the Department of Health and used to support evidence within the IGTA. Compliance with the training requirement is also a factor which the Information Commissioner's Office takes into account in any dealings with the Trust, as it is seen as an indicator of an organisation's IG and records management maturity.

The Board set a compliance target of 85% of available staff, to account for long term sick leave, maternity leave and staff on secondment, and as of the 31 March 2017 the percentage of staff who have completed the training was 90.3%.

In December 2016 NHS Digital decommissioned the e-learning IG Training Tool, with the decision to replace it with a more up to date version in early 2017. IG will continue to work with the Learning and Development team to ensure staff continue accessing the local IG assessment to maintain high levels of training compliance in the coming months.

6. **Annual IG Audit – TIAA**

This year the format of the annual IG audit was in two parts. The initial review in December 2016 and the follow up assurance work in January 2017.

The final audit report was published in January and the overall opinion was substantial assurance with no further recommendations.

7. **General Data Protection Regulations (GDPR)**

The result of the referendum in June 2016 to leave the EU has not, to date, impacted on the implementation of the EU General Data Protection Regulation. The current Data Protection Act (DPA) 1998 is outdated and does not take account of the technological world we now live in, so legislation needs to change. The new regulation was launched in June 2016 and the Trust will have until May 2018 to fully develop and embed the new requirements. The Information Commissioners Office and the Information Governance Alliance will be providing regular updates with guidance which will be the primary source of reference.

Many of the GDPRs main concepts and principles are much the same as those in the current DPA. The Trust is compliant in all areas of data protection in the IGTA therefore its approach will remain valid under the GDPR and are good foundations on which to build. There are however some new elements and significant enhancements which mean doing some things for the first time and others slightly differently. As the guidance is released and the Trust have a good understanding of the impact of those requirements, progress will be reported and governed by the Information Governance Assurance Group and highlight reports will be sent to the Corporate Assurance and Risk Management Group.

The GDPR 12 step paper published by the Information Commissioner is being developed into a structured work programme for the Trust. This will be enhanced by the publication of sector-specific guidance from the Information Governance Alliance, NHS Digital and the Department of Health during 2017.

8. **National Data Guardian Report**

In June 2016 the National Data Guardian, Dame Fiona Caldicott published her review into data security, consent and public trust. At the same time the CQC published its report into data security in the NHS and the Department of Health has launched a consultation on the findings and recommendations.

No formal directives have yet been made in respect of this, the National Data Guardian's panel is still seeking the views of patients in how their information may be handled.

9. **Information Governance Internal Audits**

In addition to the audit undertaken by TIAA the IG team have also conducted internal audits to provide assurance on compliance with, and implementation of, IG policies, processes, legislation and best practice.

During 2016/17 a total of 16 audits have been undertaken, primarily focussed on Deal Community Hospital, Deal Clinic, Hawkhurst Community Hospital, HR and Employee Relations. The IG Team continues to work with services to ensure that any recommendations are implemented and compliance improved. Of these 12 have been awarded significant assurance, 1 has been referred to EKHUFT as an acute managed service and 2 have limited assurance with outstanding actions. Where limited assurance has been reported the service managers are aware of a time-limit to address any concerns.

10. **Data Quality**

IG launched a data quality campaign “Take the Time, Every time” in late 2016 to improve the number of data quality incidents being reported. It is too early to determine the impact, but services reacted positively to the messages and displayed the posters which supported the screen savers used.

11. **Records Management (RM)**

Between 01 April 2016 and 31st April 2017 there were 62 actual incidents relating to Records Management reported. These include data quality, availability of records and lost records. It is difficult to compare this to last year as the categories of incidents have been changed to further enhance the reporting and incident management process.

The final phase onto CIS is now complete. The transfer to managing electronic clinical records has brought different challenges in terms of data quality and availability of records due to technical issues. However, once these issues have been overcome it is envisaged that the management of clinical records will become far more efficient in the long term. The residual paper records currently stored in over 50,000 archiving boxes centrally will be reviewed and destroyed over the coming years in line with national retention guidelines to reduce the Trust’s archiving budget further.

The transfer of adult services to Virgin raised a number of records management issues. The IG team worked closely with the transferring teams to ensure both a smooth transfer for patients as well as ensuring the Trust retained relevant records to discharge it’s duties under the Data Protection Act. This support will continue for Community Dental services transferring in and the Wheelchair service transferring out in the coming weeks.

The IG team have also supported a number of teams moving from sites in line with the Estates CIP Strategy. This has involved archiving a significant number of records as well as visually checking vacated sites to assure that no confidential information left behind which could lead to fines from the ICO.

Between January and December 2016, 90% of Subject Access Requests and 94% of Freedom of Information requests were responded to within the statutory timescales. There are many factors which have resulted in the delays in response. For SARs they include - delayed response from service, awaiting more information from applicant and difficulty in locating records. For FOIs they were primarily due to managers failing to respond within timeframe.

RM work during 2017 will focus on identifying what information the Trust holds and where. This will provide an inventory in preparation for the GDPR requirements, help challenge that the Trust is holding information in the most efficient way and improve RM practice further in line with the IG toolkit.

12. **Confidentiality**

“Actual” confidentiality incidents are those where a patient or staff’s confidentiality has been breached. A “near miss” is where there was the potential for an actual incident but some intervening factor prevented the breach occurring.

Between April 2016 and March 2017, there were 83 actual confidentiality breaches reported. This is a 38% increase on last year for confidentiality incidents. After analysis, the root causes of the confidentiality incidents are found to be staff not checking details before confidential information is sent, or poor data quality. The IG team launched a data quality campaign at the end of 2016 highlighting the importance of staff checking information before it goes out of the organisation.

Most of the confidentiality incidents noted above did not meet the Information Governance Serious Incident Requiring Investigation Checklist criteria. However, where necessary a thorough root cause analysis was completed to identify weaknesses in processes, and to ensure lessons were learned and disseminated.

13. **Information Governance Incidents**

The table below reflects all IG incidents (actual and near miss) for the period April 2016 to March 2017 with a comparative summary for the previous year. Year-to-date there has been a 9% increase in all incidents reported, but a 25.5% decrease in the number of actual incidents reported.

The data for this financial year was extracted on 2nd May 2017.

Apr 2015	**May 2015**	**Jun 2015**	**Jul 2015**	**Aug 2015**	**Sep 2015**	**Oct 2015**	**Nov 2015**	**Dec 2015**	**Jan 2016**	**Feb 2016**	**Mar 2016**	**Total**
41	36	61	50	37	44	33	38	39	37	38	31	485
April 2016	**May 2016**	**June 2016**	**July 2016**	**Aug 2016**	**Sept 2016**	**Oct 2016**	**Nov 2016**	**Dec 2016**	**Jan 2017**	**Feb 2017**	**Mar 2017**	**Total**
57	45	40	47	51	53	41	42	33	38	43	39	529

14. **Information Governance Serious Incidents Requiring Investigation**

During 2016/17 there has been one Serious Incident reported to the Information Commissioner's Office (ICO). The incident involved the inappropriate disclosure of personal data to an unrelated patient via a text message service from CIS. This is currently under investigation.

15. **Privacy Impact Assessments (PIA)**

Privacy impact assessments (PIAs) are a tool to identify and reduce the privacy risks in any projects that information personal information. A PIA can reduce the risks of harm to individuals through the misuse of their personal information. It can also help to design more efficient and effective processes for handling personal data.

PIAs are currently a requirement of the Information Governance Toolkit, and will become law in May 2018 under the new General Data Protection Regulation.

In 2016/17 there were 13 PIAs completed with a further 7 currently in draft. 1 expired due to no response from the Service and 2 were not required after the initial screening questions were completed.

16. **NHS Mail 2**

2016 saw the transition of the secure NHS Mail facility to NHS Mail 2. The new and improved service resulted in larger capacity in-boxes and a host of other new facilities all of which are now available to staff. IG continue to enforce the Trust policy of sharing all personal confidential information via NHS mail and take all breaches of this policy seriously. All employees of the Trust are encouraged to manage their inbox appropriately to ensure capacity is not affected by poor records management. Decommissioning of kentcht.nhs.uk email is to commence July 2017.

Skype for business for NHS Mail 2 implementation has been deferred until kentcht.nhs.uk email has been decommissioned.

17. **Cyber Security – CareCERT**

Regular reports are sent to the Trust by NHS Digital on behalf of the CareCERT team detailing threats and vulnerabilities to systems which may be in place within the organisation.

The IT/Information Security Lead in the IT department has received CareCERT training and holds a database of threats and vulnerabilities, together with a record of the checks undertaken to ensure required action is taken and controls implemented.

The vulnerabilities acted upon during 2016/7 include:

- NHS Identity agent – engineers testing deployment
- Adobe flash player – engineers testing deployment
- Firefox web browser – staff using Firefox for business purposes asked to log a call with service and update browser to version 47 or later
- Two websites selling ransom-ware have been blocked on firewall
- A network port has been blocked on Kent-wide firewall – if compromised this port could be used to send spam emails
- Two warnings published for all staff on Flo regarding phishing (unsolicited wide-spread) emails
- Vulnerabilities in Wordpress software used in relation to forms on Flo.

18. **Medical Interoperability Gateway (MIG)**

Early in 2016 the IG team supported the project team responsible for implementing the MIG, allowing CIS users to have the option to view, with patient consent, GP records enabling an improved and more holistic approach to the patient's experience. Where a patient has not consented to their information being held on the Spine, the record would not be accessible but further discussions can be had with the patient to explain the benefits of this approach and they can then make an informed decision on the future of their record accessibility when being treated by staff in the Community.

19. **Collaborative Working**

During 2016/17 the IG team continued to work collaboratively with staff both within the Trust and those the Trust work in partnership with to support and actively contribute to maintain good IG compliance. The most notable was the transfer of business to Virgin Care during which there were many lessons learned and new controls developed. These included being more prepared for future movement of records and setting up a records management taskforce,

using current resource, to enable a smoother transition whether records are leaving or coming into the organisation. Additionally, IG have reviewed, updated and made more robust the internal auditing processes to ensure good practice is common place across the Trust.

IG have been operationally hands-on in supporting teams in managing their archiving as this also supports the movement of records and enable faster retrieval in the event of a subject access or Freedom of Information request.

The IG team have also been working with the Commissioners and Acute Trusts in regard to information sharing agreements, patient information management systems, risk stratification processes and patient record management.

As part of the Sustainability and Transformation programme IG have supported the Home First programme and continue to support services setting up referral units, integrated working with social services and supporting plans to change working practise to meet the changing needs of health and social care arrangements.

More recently Corporate Services have been in discussions with the Community Dental Services following the award of business of two large community dental services in north east London. They have both presented some challenges however collaborative working resulted in a smooth transition of IG compliance, training and records management.

20. **Information Risks and Senior Information Risk Owner (SIRO)**
The role of SIRO is held by the Corporate Services Director. The deputy SIRO is the AD Compliance and is also the Chair of the IGAG. Reporting of all IG risks is via the Corporate Assurance and Risk Management Committee (CARM) and IG risks are also discussed at the IGAG.

The SIRO takes ownership of the Information Risk Policy, acts as advocate for information risk on the Board and provides written advice to the Accountable Officer and regularly receives a risk report at the Corporate Assurance and Risk Committee, which relates specifically to IT and information risks reported by the Information Asset Owners. The IG Compliance Manager also reports risks identified through the mapping of data flows in and out of the organisation.

The IG risk register is regularly maintained and updated with all risks reported to the Senior Information Risk Owner (SIRO) via the CARM, including those raised by Information Security and IT.

21. **Caldicott Guardian (CG) Summary**
The operational CG is Dr Raj Nandi. In recent months the capacity of the operational CG has been reduced from 5 to 2 days per week. The operational CG is supported by the IG team who are also responsible for the logging of all activity in a formal CG log. Data relating to CG advice on disclosure and incidents is held on the Datix system as part of the incident and risk management process.

The Log continues to be monitored and activity reviewed by the IG Assurance Group.

With the advent of the GDPR there is a requirement for the Trust to appoint a Data Protection Officer. Whilst the role will be similar in part to the Caldicott Role there is supplementary training required to ensure the appointee is well-versed in the new regulations and matters relating to data protection. The recommendation has been put to the Board level CG, the operational CG and the SIRO, to combine this requirement with the CG role and develop existing capacity to meet the needs of the regulation. This is currently being discussed and a decision is expected in the coming weeks.

22. **Customer Services Feedback**

An objective set for all support services is to request feedback on the quality and standard of the services offered and received. IG has developed a very concise satisfaction survey and has asked services to contribute to it. https://www.surveymonkey.com/r/R8DRD5L.The responses to date are:

Customer services : Excellent / Very good – 84%
Responsiveness: Excellent / Very good – 86%
Knowledge: Excellent / Very good – 92%
Training: Excellent / Very good – 88%
Support: Excellent / Very good – 84%

23. **Recommendations for the Board**

The Board is asked to continue championing IG throughout the organisation, through dissemination of positive messages and continued engagement with the training, policies and procedures.

To note the forthcoming changes during 2017/18 to data protection regulations and full implementation of the GDPR by May 2018.

To note the level of compliance for the annual toolkit assessment, at 88%, and training compliance for the year ending 31 March 2016 at 90.3%.

To note the level of substantial assurance, with no further recommendations, provided by TIAA following the mandatory annual IG Audit.

Natalie Davies
Corporate Services Director / Senior Information Risk Owner (SIRO)
May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3.7
Subject:	Emergency Preparedness Resilience and Response Annual Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	☐	Assurance	☒

Report Summary (including purpose and context):
This report is to provide assurance to the Board that plans and systems are in place to meet the Trust's obligations with respect Emergency Preparedness, Resilience and Response and relevant statutory obligations under the Civil Contingencies Act 2004. The report sets out the Trusts state of readiness to respond to major incidents and disruptive events that impact on the delivery of services and performance.

Proposals and /or Recommendations:
The Board receives assurance of KCHFT state of preparedness.

Relevant Legislation and Source Documents:
Civil Contingencies Act 2004. NHS England Emergency Preparedness Framework 2013
Has an Equality Analysis been completed? N/A
No. High level position described and no decisions required. Papers have no impact on people with any of the nine protected characteristics.

Natalie Davies, Corporate Service Director	Tel: 01622 211900
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Kent Community Health
NHS Foundation Trust

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT APRIL 2016 – MARCH 2017

1. Introduction

This report describes the work undertaken in 2016/17 on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2015

The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS guidance. All plans have been developed in consultation with partner organisations to ensure cohesion with their plans.

The report covers the following:

- The training and exercising programme delivered
- The continuing development of the emergency planning arrangements
- A summary of incidents the Trust has responded to

2. Risk Assessment

The CCA (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, that preparations are undertaken and that response plans exist. Those risks currently identified on the Kent Community Risk Register with a rating of very high include;

- Influenza-type disease (pandemic)
- Flooding
- Severe weather

As a result of risk assessments with internal services there has been progress made across services in pursuing the necessary actions to control and mitigate the risks. The Head of EPRR has developed a close working relationship with services and assisted in the development of service level business continuity plans, including the community nursing teams, the minor injuries units and the procurement team.

Within this reporting period the Trust has met four times at the combined On Call/EPRR meeting. Attendance by relevant managers/staff at these meetings is challenging, senior management support is sought to ensure resilience and reduce risk.

3. Compliance

EPRR remains a key priority for the NHS and forms part of the NHS Commissioning Board Framework (Everyone Counts; Planning for Patients), the NHS Standard Contract and the NHS Commissioning Board Emergency Planning Framework (2015).

A set of core standards for EPRR have been in place since April 2013. All organisations who receive NHS funding are asked to carry out a self-assessment against the NHS Standards for EPRR. KCHFT completed this exercise during September, and NHS England agreed with KCHFT's assessment that it was fully compliant against these core standards. The Trust was highly commended for this achievement by members of the Local Health Resilience Partnership (LHRP).

4. Partnership working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Kent and Medway Local Health Resilience Partnership (LHRP). The purpose of this group is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England – South, South East.

The LHRP work plan is delivered by the Trust as required. An area of responsibility agreed at the LHRP for the Emergency Preparedness leads across the county is accountability to the local authorities for the medical risk assessment of community events taking place; the Head of EPRR is responsible for the Canterbury and Dover authorities.

5. Planning

5.1 Major Incident Plan

The Major Incident Plan is reviewed annually to ensure it continues to accurately reflect the role of the Trust in a major incident and how this role fits with the plans of other NHS organisations and the emergency services. The Major Incident Plan was reviewed in August 2016 and ratified by the Corporate Assurance Risk Management Committee on behalf of the Executive Management Team

5.2 Emergency Resilience and Business Continuity Policy

The Emergency Resilience and Business Continuity Policy outline's how the Trust will continue to discharge core functions in the event of disruption to

business operations. Each service has its own Business Continuity Plan which is reviewed annually. There is a rolling programme of review and work completed with the Minor Injury Units and the Community Teams and Hospitals.

5.3 Heatwave Plan

The Heatwave Plan for the Trust was updated as required for 2016. The Trust received health watch alerts for the period 1 June - 15th September 2016 and remained at Level 1 preparedness throughout this period. The plan allows for escalation of operational services, and specific actions would be implemented to safeguard patients and staff as necessary.

5.4 Lockdown Policy

The trust is required to have lockdown plans for appropriate sites, such as the Community Hospitals. The Head of EPRR has developed a Lockdown policy and working collaboratively with the Head of Health, Safety and Security to embed this in to the Trust. The Trust seven Minor Injuries Units have completed risk profiles for Lockdown and these will be tested in the forthcoming year.

6. Training and Exercising

In order to comply with our obligations the Trust must undertake a number of emergency preparedness activities; these include a robust training programme facilitated by the Head of EPRR, in the current year the Kent Resilience Forum (KRF) funded a Strategic Leadership event attended by eight of the Trusts senior team.
A rolling programme of exercises designed to test and develop our plans are undertaken. These are:

- a communication test every six months
- a desktop exercise once a year
- a major live exercise every three years

Kent Fire and Rescue have continued to work closely with the EPRR team and a lead from each of the Minor Injuries Units (MIUs), in the reporting year each MIU undertook a live no notice exercise to test the response for patients contaminated with a chemical, lessons learnt from these exercises have enhanced the Trust response plans.

The Trust participated in the annual KRF exercise which took place in September, flooding in the east of the county was the main area of concern, a Rest Centre was activated and KCHFT staff responded by providing a Clinical Response Team.

The National flu pandemic exercise also took place in September, this was led by NHS England and involved colleagues from the National Health Service, Public Health England and the Local Authority.

The Trust has exceeded these requirements in 2016/17.

7. Incidents

Throughout this period there have been a number of failures across the Trust which has involved implementation of Service Level Business Continuity arrangements. A boiler failure at Tonbridge Cottage Hospital in August 2016 evoked a multi-agency sustained response; no negative patient impacts were reported.

In March 2017 Sevenoaks Hospital experienced a lift failure in the Out Patient Building, a lack of communication from the landlord to KCHFT realised the potential for Trust reputational damage, staff evoked business continuity arrangements to ensure continuity of service. No patient complaints were received.

8. Summary

The Trust continued to develop its resilience arrangements throughout 2016/17; in 2017/18 this work will continue, ensuring the Trust maintains the ability to respond to emergencies and business continuity incidents.

Lessons learned and good practice have been identified and shared amongst staff. On-going embedding of the EPRR arrangements remains a key priority.

The focus for the continued development of the service in 2017/18 will be;

- To maintain compliance with the EPRR requirements
- To continue the planned works in respect of Lockdown
- To exercise the MIU departments plans with live exercises focussing on radiation contamination

The Board is asked to note the progress of the service in 2016/17 and endorse the work programme for 2017/18.

Jan Allen
Head of Emergency Preparedness, Resilience and Response
3 May 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	25 May 2017
Agenda Item:	3,8
Subject:	Standards of Business Conduct Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)
The purpose of this report is to update the Board on the following registers: Gifts, Hospitality and Sponsorship 2016/17; Declarations of Interest 2017/18; and the Trust's Declaration of compliance with Fit and Proper Persons 2017/18 for Board members and Governors.

Proposals and /or Recommendations
The Board is asked to note the report

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required/no significant change. 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.

Gina Baines, Assistant Trust Secretary	Tel: 01622 211900
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Kent Community Health
NHS Foundation Trust

STANDARDS OF BUSINESS CONDUCT ANNUAL DECLARATIONS

1. Introduction

The purpose of this report is to update the Board on the following registers: Gifts, Hospitality and Sponsorship 2016/17; Declarations of Interest 2017/18; and the Trust's Declaration of compliance with Fit and Proper Persons 2017/18 for Board members and Governors.

2. Background and Assessment

NHS guidance requires that the Trust maintains a Register of Gifts, Hospitality and Sponsorship. This is kept by the Corporate Services Director's office and is updated when a member of staff declares any offer made to them of gifts, hospitality or sponsorship. It is available on the Trust's public website as required by the Trust's policy, ensuring the Trust meets its obligation to be transparent to the public. Staff names are redacted on the public website in accordance with Data Protection regulations. The complete register is subject to an annual review by the Audit and Risk Committee.

A Register of the Declarations of Interest is held by the Corporate Services Director's office and records all declarations of interest that are made by the Board, Governors and members of staff on an annual basis. An edited version of the register is available on the Trust's public website and details any declared interest of members of the Board and Council of Governors. The Trust has full compliance with Declarations from the Board and Council of Governors for the year 2017/18

A Register of Fit and Proper Persons declarations is held by the Corporate Services Director's office and records all declarations received by members of the Board and Council of Governors annually. Information regarding compliance with this requirement is published on the Trust's public website. The Trust has full compliance with Fit and Proper Persons declarations from the Board and the Council of Governors for the year 2017/18.

The documents on the Trust website are updated periodically in year to reflect new entries on the register.

3. Recommendation

The Board is asked to note the declarations.

Gina Baines
Assistant Trust Secretary
5 May 2017

Kent Community Health
NHS Foundation Trust

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

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 30 March 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 30 March 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report	Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Quality Committee Chairman's Assurance Report	Chairman, Quality Committee	

2.2	To receive the Audit and Risk Committee Annual Report	Chairman, Audit and Risk Committee	
2.3	To receive the Charitable Funds Committee Chairman's Assurance Report • Committee Chairman's Annual Report	Chairman, Charitable Funds Committee	
2.4	To approve the 2016/17 Annual Report and Accounts • 2016/17 Annual Quality Report • Self-Certification with NHS Providers Licence	Director of Finance Chief Nurse	
2.5	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse	
2.6	To receive the Monthly Quality Report	Chief Nurse	
2.7	To receive the Finance Report – Month 1	Director of Finance	
2.8	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications	
2.9	To receive the Kent and Medway Sustainability and Transformation Plan Update Report	Chief Executive	Verbal
2.10	To ratify the Terms of References of Committees • Audit and Risk Committee • Charitable Funds Committee • Finance, Business and Investment Committee • Quality Committee • Remuneration and Terms of Service Committee	Corporate Services Director	

3.	**REPORTS TO THE BOARD**	
3.1	To receive the Seasonal Infection Prevention and Control Report – Spring	Chief Nurse
3.2	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.3	To receive the Mortality Annual Report	Medical Director
3.4	To receive the Clinical Audit Annual Report	Medical Director
3.5	To receive the Six Monthly Public Engagement and Equality Report	Director of Workforce, Organisational Development and Communications
3.6	To receive the Annual Information Governance Report	Corporate Services Director
3.7	To receive the Emergency Planning and Business Continuity Annual Report	Corporate Services Director
3.8	To receive the Standards of Business Conduct Report	Corporate Services 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 27 July 2017
The Committee Room,
Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill,
West Malling Kent ME19 4LZ