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 28 September 2017

In

The Council Chamber
Sevenoaks Town Council Offices
Bradbourne Vale Road
Sevenoaks
TN13 3QG

Kent Community Health NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 28 September 2017
in The Council Chamber
Sevenoaks Town Council Offices, Bradbourne Vale Road, Sevenoaks, TN13 3QG

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 27 July 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 27 July 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report • Sustainability and Transformation Plan Update • To approve the Trust Vision and Missions	Chief Executive	

2.	BOARD ASSURANCE/APPROVAL	
2.1	To receive the Quality Committee Chairman's Assurance Report • To approve the Terms of Reference	Chairman, Quality Committee
2.2	To receive the Audit and Risk Committee Chairman's Assurance Report	Chairman, Audit and Risk Committee
2.3	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse
2.4	To receive the Monthly Quality Report	Chief Nurse
2.5	To receive the Finance Report – Month Five	Director of Finance
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To approve the Mortality Review Policy	Medical Director
2.8	To approve the Trust Constitution	Corporate Services Director
2.9	To appoint the Senior Independent Director	Corporate Services Director
2.10	To approve the proposal for the formation and Terms of Reference of a Workforce Committee	Director of Workforce, Organisational Development and Communications

Kent Community Health NHS Foundation Trust

2.11	Policies for Ratification • Gender Identity At Work • Induction • Managing Sickness Absence • Organisational Change	Director of Workforce, Organisational Development and Communications

3. REPORTS TO THE BOARD

3.1	To receive the Safeguarding Annual Report 2016/17 • To approve the Slavery and Human Trafficking Statement	Chief Nurse
3.2	To receive the Monthly Mortality Report	Medical Director
3.3	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.4	To receive the Six Monthly Freedom to Speak Up Guardian's Report	Director of Workforce, Organisational Development and Communications
3.5	To receive the Emergency Preparedness, Resilience and Response Annual Assurance Process 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 30 November 2017; The Oak Room, Oakwood House, Maidstone ME16 8AE

Kent Community Health
NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10am on Thursday 27 July 2017
in the 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 Paul Bentley, Chief Executive Peter Conway, Non-Executive Director Richard Field, Non-Executive Director Steve Howe, Non-Executive Director Gill Jacobs, Deputy Director of Finance Louise Norris, Director of Workforce, Organisational Development and Communications Dr Sarah Phillips, Medical Director David Robinson, Non-Executive Director Lesley Strong, Deputy Chief Executive/Chief Operating Officer Ali Strowman, Chief Nurse Jennifer Tippin, Non-Executive Director.
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Corporate Services Director

27/07/1 **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.

27/07/2 **Apologies for Absence**

Apologies were received from Pippa Barber, Non-Executive Director; Gordon Flack, Director of Finance; and Bridget Skelton, Non-Executive Director

The meeting was quorate.

27/07/3 **Declarations of Interest**

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

27/07/4 **Minutes of the Meeting of 25 May and 29 June 2017**

The Board **AGREED** the minutes.

27/07/5 **Matters Arsing from the Meeting of 25 May and 29 June 2017**

The Board **RECEIVED** the Matters Arising.

27/07/6 **Chairman's Report**

Mr Griffiths announced that Mr Robinson would be retiring from the Board in September 2017. Mr Robinson had had the additional responsibility as Senor Independent Director and over the coming weeks, Ms Davies would be facilitating the process to appoint a new Senior Independent Director from amongst the Non-Executive Directors. Once a consensus had been reached incorporating the views of the Governors, a nomination would be put forward to the Board for approval.

27/07/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

In response to the tragic event at Grenfell Tower, the Trust had undertaken an additional review of fire safety across the properties it operated from, with particular emphasis on inpatient facilities. It was confirmed that systems and controls were fit for purpose and that that sites that the Trust operated from were not at serious risk from fire. NHS Property Services were undertaking the assessment of the fire compartmentalisation.

In response to a question from Mr Conway regarding support from the Trust's major landlord, NHS Property Services, Mr Bentley confirmed that the Trust continued to seek additional assurance from them and continued to liaise with them.

The Trust had appointed two new Clinical Directors, Dr Chandra Hedge and Dr Raj Hembrom. The latter would be the Trust's new Lead Medical Appraiser and the Board thanked Dr Emma Fox for her contribution to the role.

The Executive Team continued to engage with staff at a number of workshops around the organisation. These had been well-attended and provided good feedback. Since the Board had met in July 2017, NHS England and NHS Improvement had announced that they would be integrating their management structure after September 2017. The local NHS was experiencing high demand. Staff had been responding well to the pressures placed on them which was reflected in the continued high satisfaction scores for the Trust as well as a low number of reported

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

27/07/8 **Sustainability and Transformation Plan (STP) Hurdle Criteria**

Dr Phillips presented the report to the Board for approval.

Once the report had been presented to the Boards of all the local NHS providers and clinical commissioning group (CCG) governing bodies, approval would be sought from the STP Programme Board. Approval was being sought from the Board for the hurdle criteria rather than the options that resulted from them. Mr Griffiths reminded the Board of how the hurdle criteria were used in the process to reach a preferred option which would go to public consultation. Dr Phillips confirmed that the hurdle criteria had been developed with a high degree of engagement from clinicians and the public. It had been used successfully in other parts of the country.

Clarification of a number of points was sought by Mr Field and Mr Conway including the twelve hour maximum waiting time on a trolley and the Musculoskeletal Physiotherapy pathway. Ms Tippin commented that the number of criteria was large which could have implications for achieving a successful outcome. She also questioned how it would be judged that the criteria had been met. There was further consideration made of the criteria as set out in the papers and the financial sustainability that was forecast.

In response to a comment from Mr Field regarding accessibility to services for the public using both private and public transport, Dr Phillips confirmed that if travel time by whatever means was greater than one hour for the public to access the service, then the scheme would not be considered.

It was agreed to circulate the link to the evaluation criteria following that day's meeting.
Action – Dr Phillips

The **BOARD** approved the Sustainability and Transformation Plan Hurdle Criteria, subject to its comments being fed back to the STP Programme Board.

27/07/9 **Quality Committee Chairman's Assurance Report**

Mr Howe presented the report to the Board for assurance.

The Committee had met in June and July 2017. The Annual Safeguarding Report and Annual Infection Prevention and Control Report had both been presented to the Committee and were commended to the Board. Directorate exception reports had been received and the Queen Victoria Memorial Hospital (QVMH), Herne Bay, was rated as Moderate Concern. The Executive Team was monitoring the community hospital closely and providing management support. The Committee would continue to monitor the hospital's performance. End of Life Care training was improving and it was expected that the Trust would be compliant by September 2017.

There had been lessons learned from recent Serious Incidents in the Trust. In the Dental Services, the World Health Organisation check list had been introduced. With regards to the cross-infection outbreak that had occurred at QVMH, improved training for cleaning staff had been introduced across the Trust. The Committee continued to review the clinical aspects of the risk registers and the Board Assurance Framework on a quarterly basis and there were no concerns. The Non-Executive Directors had carried out a Quality Impact Assessment Cost Improvement Programme visit to Tonbridge Cottage Hospital. This was their second visit of the 2017/18 programme and they had been pleased with the outcome of the visit.

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

27/07/10 **Integrated Performance Report**

Ms Strong presented the report to the Board for assurance.

The Corporate Scorecard for the Trust was showing a good level of performance across the full range of Key Performance Indicators (KPIs). There was one red rated KPI which related to Delayed Transfers of Care. The Board had received regular updates on the actions to reduce these and the new targets that had been set. The majority of the KPIs continued to improve.

In response to a question from Mr Howe regarding whether the Length of Stay KPI should be reviewed as the Trust was consistently meeting its target, it was agreed that this would be undertaken.

In response to a question from Mr Griffiths regarding whether the step up and step down Length of Stay targets should be separated out, it was agreed that an analysis would be carried out and the findings reported to the Board.
Actions – Ms Strong

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

27/07/11 **Monthly Quality Report**

Ms Strowman presented the report to the Board for assurance.

With regards to fill rates in June 2017, the increase in bed stock due to the temporary changes at the Kent and Canterbury Hospital had had an impact but had been safely staffed using temporary staff. More widely, additional health care assistants had been rostered to increase general capacity. Patients with mental health needs and in particular, dementia, had received enhanced observation as part of a new protocol that was currently being piloted. The Trust's Dementia Strategy would be relaunched in the near future. The number of shifts that had had only one Registered Nurse rostered was confirmed. With regards to SafeMed Incidents, the number of incidents was low and had been either rated as low or no harm. A small

number of medication prescribing incidents had occurred at Westbrook Integrated Care Centre. The Pharmacy Team was investigating these and the Board would receive an update on its findings. With regards to pressure ulcers, a summary of the current position was provided and it was confirmed that the Pressure Ulcer Task Force continued to meet to review all incidents. With regards to falls and falls with fractures, a summary of the current provision was provided. Work continued to reduce the incidents of falls in the community hospitals and align the Trust with best practice in falls prevention. With regards to infection prevention and control (IPC), the IPC Team were closely monitoring and challenging cleaning. Patient experience feedback continued to be very positive at over 97 per cent. Services received both positive and negative feedback. There had been an increase in the number of complaints in June. It was too early to say if this was a trend, but early indications were that it was a spike. All complaints were risk assessed and the majority had been found to be low risk.

In response to a question from Mr Howe regarding the threshold of the Green to Amber rating for Day Fill Rates, it was agreed to assess whether the threshold was appropriate. The correlation between under and over staffing and patient harm was considered and it was agreed that an analysis would be undertaken of the over-staffed shifts where there had been an incident.
Action – Ms Strowman

In response to a question from Richard Field regarding what action was taken when a number of harms were reported on the same day, Ms Strowman confirmed the enquiries she undertook with the matron of the ward. With regards to SafeMeds, the Chief Pharmacist was responsible for carrying out investigations.

In response to a question from Richard Field regarding the complaints that had been received from service users in relation to access to dentristy in the newly tendered services, Ms Strowman explained that this had been reviewed at the Dental Service's monthly Performance Review meeting that month. The indication was that the local community was unhappy with some of the changes that had taken place as a result of the service moving to a new provider. The service was working hard to embed the new service as quickly as possible. It was unclear what the complaint levels had been previously under a different provider.

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

27/07/12 **Finance Report (Month 3)**

Ms Jacobs presented the report to the Board for assurance.

The Trust had achieved a surplus year-to-date which was ahead of plan. The forecast was to reach a small surplus in line with the plan and control total. The Trust had scored the maximum 'One' rating against the Use of Resource rating metrics. With regards to the 2017/18 CIP, the Trust had

achieved savings. Although these were slightly behind target, it was forecast to reach the planned savings at year end. With regards to the Trust's cash position, this was strong. The capital expenditure position was confirmed. The agency spend continued to remain within target.

The Board **RECEIVED** the Finance Report.

27/07/13 Workforce Report

Ms Norris presented the report to the Board for assurance.

There were four areas of performance that had been rated red in June. With regards to turnover, there had been an increase over recent months and work was underway to establish the underlying causes and identify where interventions could be made. In relation to the absence rate, this appeared to be strongly linked to the prevalence of service changes. With regards to the vacancy rate, some vacancies were being held due to organisational change and were skewing the metric. For the agency metrics, spend on agency was positive and the overall fill rate was good. There had been some non-compliance with using framework agencies in June which had impacted negatively on the current position. With regards to STP posts, the Trust was holding some appointments and it was planned to remove the data from the figures. The Trust's appraisal rate and compliance with statutory and mandatory training was at its highest ever rate.

In response to a comment from Mr Conway regarding the trends and reversals in performance of the aforementioned metrics, Ms Norris explained that the absence rate was close to the Trust's target. Overall performance was good, but an increase in absences was not unexpected when services were undergoing organisational change. Of particular concern to the Executive Team was the turnover rate, which had previously experienced a positive downward trend. Deep dives in east Kent were underway to establish the cause. With regards to vacancies, the removal of held vacancies from the data would provide a true figure of the vacancy rate.

The Board **RECEIVED** the Workforce Report.

27/07/14 Community Hospitals Safer Staffing Review Report

Ms Strowman presented the report to the Board for approval.

A review of safer staffing was carried out twice a year. The results of the most recent review indicated that there had been a rise in the acuity of patients in the community hospitals in the last six months. However after triangulating the audit results with other data sources, ward managers concluded that their staffing numbers continued to be acceptable although two requests were made. These were an increase in night time staffing at Sevenoaks Hospital by one health care assistant; and the recruitment of a part-time therapeutic worker to work with patients on a range of daytime

activities at Faversham Cottage Hospital and Victoria Hospital, Deal. The cost for each of the proposals was detailed in the report.

In response to a question from Mr Griffiths regarding the financial impact of the increase in staffing on contracts, Mr Bentley confirmed that there would be no additional funds from the CCGs as the Trust was on a block contract. The business case was predicated on investing in staff and service development.

The Board approved the changes to the safer staffing levels and agreed a pilot to improve therapeutic activities in inpatient wards in community hospitals.

The Board **APPROVED** the Community Hospitals Safer Staffing Review Report.

27/07/15 **Policies For Ratification**

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

- Maintaining High Professional Standards Policy

The Board **RATIFIED** the policy.

27/07/16 **Infection Prevention and Control Annual Report 2016/17**

Ms Strowman presented the report to the Board for assurance.

The Quality Committee had received the report earlier that month.

The Board **RECEIVED** the Infection Prevention and Control Annual Report 2016/17.

27/07/17 **Seasonal Infection Prevention and Control Report – Summer**

Ms Strowman presented the report to the Board for assurance.

The Quality Committee had received the report earlier that month.

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

27/07/18 **Equality and Diversity Annual Report**

Ms Norris presented the report to the Board for assurance and approval.

In response to a question from Ms Tippin regarding the Trust's response to gender pay, Ms Norris confirmed that the remuneration of all Board members was reported in the Trust's Annual Report. The NHS also operated a job evaluation scheme to ensure that all jobs were fairly graded.

The Board **RECEIVED** the Equality and Diversity Annual Report.

The Board **APPROVED** the Equality Objectives for 2017/18.

27/07/19 **Medical Appraisal and Revalidation Annual Report 2016/17**

Dr Phillips presented the report for assurance and approval.

The Trust was fully compliant with the medical appraisal process. No concerns had been identified. Some improvements to the system were planned in order to enhance the process in future years.

Mr Griffiths commented that he had had some concerns regarding the negative comments in the report. Dr Phillips indicated that some comments had referred to service pressures and operational issues and going forward she expected to introduce a mechanism that would allow issues to be dealt with in a more timely manner.

In response to a question from Mr Field regarding the employment of locum doctors by the Trust, Dr Phillips confirmed that locum doctors were employed. Recruitment was carried out by the Internal Bank. All pre-employment checks were carried out by the Internal Bank or by the framework agency that was used. TIAA, the Trust's Internal Auditors carried out audit checks on the framework agencies. Clarification of the responsibility for performance management was given.

It was agreed to confirm who was required to sign the Statement of Compliance and for the document to be circulated electronically to the Board.
Action – Dr Phillips

The Board **RECEIVED** the Medical Appraisal and Revalidation Annual Report 2016/17.

The Board **APPROVED** the Statement of Compliance, following circulation to the Board following that day's meeting.

27/07/20 **Any Other Business**

There was no further business to discuss.

27/07/21 **Questions from Members of the Public Relating to the Agenda**

There were no questions from the public.

The meeting closed at 11.42am.

27/07/22 **Date and Venue of the Next Meeting**

Thursday 28 September 2017 at 10am in the Council Chamber, Sevenoaks Town Council Offices, Bradbourne Vale Road, Sevenoaks TN13 3QG

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 27 JULY 2017 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Sustainability and Transformation Plan Hurdle Criteria	To circulate the link to the evaluation criteria.	Dr Phillips	Action complete.
Integrated Performance Report	• To review the target for the Length of Stay Key Performance Indicator. • To carry out an analysis of the step up and step down Length of Stay and report the findings to the Board.	Ms Strong	Agenda item.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Quality Report	• To assess whether the threshold of the Green to Amber rating for Day Fill Rates was appropriate. • To analyse the over-staffed shifts where there had been an incidents	Ms Strowman	• There is no national agreed cut off. Other Chief Nurses tend to use 95 per cent as their green rating, some use lower, but think it is important to set the bar high. • Included in the Quality Report.
Medical Appraisal and Revalidation Annual Report 2016/17	• To confirm who was required to sign the Statement of Compliance. • To circulate the Statement of Compliance to the Board.	Dr Phillips	• The Chief Executive or Chairman is required to sign the Statement of Compliance. • Action complete.

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 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. In addition, following a consultation with staff a refresh on the Trust's Vision, Mission and Goals is proposed.

Proposals and /or Recommendations
To approve the Trust Vision, Mission and Goals.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed? Not Applicable.

Paul Bentley, Chief Executive	Tel: 01622 211903
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Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
SEPTEMBER 2017

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

Patients

1. One care plan has benefits for our patients and our staff

We have devised a new personalised care plan that is more focused on shared goals and measureable outcomes for patients, and which is shorter and simpler for people using it. We have sought the views of the team on how to improve the plan so it was consistent for everyone. The new version is available electronically on the trust's community information system. It will help meet patient expectations, more clearly describe the role which patients play in their own care to enable patients to get better faster and also make sure we consider the very important role of carers too.

2. Access sexual health services for all

A new project, called Apple Tree Clinic, to support clients with a learning disability or difficulty in accessing our sexual health services has been launched. When someone rings the sexual health appointment line, they ask for Apple Tree Clinic. Colleagues know the client will need a longer appointment and that easy read information is provided for the consultation. We worked with East Kent Mencap to translate our sexual health information into easy read format to make this possible.

Staff

1. Staff flu vaccination campaign

The annual campaign to encourage our workforce to have the free flu vaccination commenced in September. This year, we are issuing a voucher for colleagues to be able to have the vaccination at one of the participating pharmacies across our geography.

2. Senior Leaders Conference

The Senior Managers' Conference took place in mid-September focussing on 'leading a culture of empowered, devolved responsibility'. Almost 100 colleagues joined together for the workshops, we explored our vision for devolved responsibility within KCHFT. Senior colleagues looked at how they could support this change and what next steps were necessary. We will hold a similar conference for a wider group of colleagues in November.

3. Freedom to Speak Up Ambassadors

Our Management Committee agreed a proposal from the Trust's Freedom to Speak Up Guardian that in line with a number of other NHS Trusts we recruit and train some Speaking Up Ambassadors. There will be an induction day on 23 October and we will recruit Ambassadors from all levels of the organisation, both clinical and non-clinical. There will be a Speaking Up week in early November, followed by a visit from the National Freedom to Speak Up Guardian, Dr Henrietta Hughes, on 4 December.

4. #yesyoucan innovate first winner

It can be the simplest idea, but if it works, that is innovation as Debrah Phythian has shown at Faversham Cottage Hospital. It's why she is the first winner of our first #yesyoucan innovate monthly reward scheme for anyone at the trust who can demonstrate they have put an innovative idea into practice, which is making a difference to patient care. In Debrah's case, the change was using a permanent pen on white fridge magnets to recognise patients with a catheter who were receiving IPC visits and checks.

Partnerships

1. Investment in lab will generate new business for KCHFT and NHS

Our new purpose-designed orthotics lab is now open for business. The department, known as Discovery Orthotics, designs and manufactures custom-made insoles for clinical teams in Kent and beyond, transforming the lives of patients. I recently visited the new production lab at Discovery Park in Sandwich. Clients include NHS trusts, as far afield as Wales. The work to open the facility is a real testament to the team with great support from colleagues in estates and Information technology.

Paul Bentley
Chief Executive
September 2017

Kent Community Health
NHS Foundation Trust

STRATEGY: MISSION, VISION AND GOALS

1. **Introduction**

1.1 KCHFT's mission, vision, values and brand were created more than six years ago. During this time, there has been considerable change in the NHS landscape.

1.2 Since the publication of the NHS Five Year Forward View, we have started to move from a climate of competition and choice to more integrated working, often supported by formal partnerships. The launch of the Kent and Medway Sustainability and Transformation Plan (STP) and the nature of our services mean we have the opportunity to play a key role in developing partnerships in Kent and Medway and our strategy needs to reflect this approach.

1.3 KCHFT's values were refreshed in 2016, in response to staff feedback which said they were too long and not easy to understand. During the CQC inspection in 2014, the trust received feedback that some staff did not know our values.

1.4 Last year, work started to refresh the trust's mission, vision, goals and branding to reflect the new direction of travel. During the past couple of months, we have been consulting with staff to develop a new mission, vision, goals, priorities and branding, which more accurately reflects and effectively communicates our strategy.

2. **Our current mission and vision**

2.1 Your **mission** statement is the reason for your existence and defines your business and approach.

2.2 Our current mission is to provide high quality, value for money, community-based services to prevent people from becoming unwell; avoid going into hospital; or to leave earlier; and to provide support closer to home.

2.3 An effective **vision** statement describes the future position of the organisation and what success would look like.

2.4 Our current vision is ***'to be the provider of choice by delivering excellent care and improving the health of our communities.'***

3. Developing our mission and vision

3.1 In June and July, we ran a survey via flo asking for feedback on three options for our mission and vision, which had been developed during staff engagement sessions.

3.2 Almost 100 people responded, with a 50/50 split of clinical and non-clinical roles, with colleagues suggesting an amalgamation of options.

3.3 The three options were also tested at EADs staff engagement session on 11 July 2017.

3.4 Feedback included:

- Keep it short and don't try to cover everything
- Our mission should cover our patients, staff and our partners
- It's important that we reflect we are here to empower people to look after themselves and encourage ownership
- We need to take into account we can't always make people better and not everyone can leave an active life, but we can do something to help them live well.
- Including the wellbeing of staff and patients in any statement was important.
- We must mentioned working with all agencies and people's families to integrate care.
- Including adults and children is important.

3.5 The mission and vision were refined and tested further and more than 70 per cent of people said they 'absolutely' or very closely reflected what our mission and vision should be.

4. Our proposed mission and vision

4.1 Our proposed mission is to **empower adults and children** to live well, be the **best employer** and **work with our partners** as one.

4.2 Our proposed vision is a community which **supports each other** to **live well.**

5. Our current goals

5.1 Our **goals** were initially developed as part of our foundation trust application and were refreshed in 2015. They reflect the five domains of the NHS outcomes framework and are:

- **Preventing people from becoming unwell** and dying prematurely by improving the health of the population through universal targeted services

- Enhancing 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
- Helping people **recover from periods of ill health** or following injury through the provision of responsive community services
- Ensuring that people have a **positive experience of care** and improved health outcomes by delivering excellent healthcare
- Ensuring people receive **safe care** through best practice.

6. Developing our goals and priorities

6.1 During August and September, staff were asked to rate potential strategic goals. The options they were given were:

- To **prevent** ill health.
- To support patients **at home.**
- To provide **specialist** community services.
- To **integrate** services.
- To deliver **high quality** care.
- To be the **best employer.**
- To develop **sustainable** services.

6.2 These options were developed through a review of previous strategic documents and research into other organisations, across all sectors of the NHS and outside of healthcare. In particular, to reflect partnership working, it was important we had close alignment with the goals of the STP and other Kent and Medway partners. Discussions were had with the Executive Team and the Management Committee to produce a shortlist of options that people felt reflected the trust's work and aims.

6.3 Internally, the goals needed to align with the existing People Strategy, published last year, and be developed in conjunction with the Quality Strategy. Alignment with the Quality Strategy is work in progress.

6.4 The feedback from the senior leaders and staff, through flo, included:

- Four to five goals would be best as it's difficult to remember too many
- Goals should be linked to STP priorities
- Prevention should definitely be included
- High quality is very important
- What does best employer mean? This is already in the mission
- The 'at home' and 'specialist' goals could be combined but specialist is associated with a particular group of services in the organisation, it needs to be broader.
- Integration – this could mean internal or external service integration.

6.5 The overwhelming feedback from staff was they wanted a very clear visual strategy on a single page that could be easily referenced during their work and at team meetings.

6.6 To support the goals, priorities for 2017/18 were also developed.

7. Our proposed goals

7.1 Our proposed goals are:

- Prevent ill health
- Deliver high-quality care at home and in the community
- Integrated services
- Develop sustainable services.

8. Our proposed priorities

8.1 To enable us to deliver our goals, priorities have been developed for 2017/18, from which service and individual objectives will be developed.

8.2 Our proposed priorities for 2017/18 are:

- Research**, innovate** and continually improve to be **affordable** and deliver safe care with the **best outcomes**.
- **Engage and empower** patients and carers as **active partners** to support health, wellbeing and independent living.
- Nurture **leadership**, support **staff development** and foster flexibility and adaptability to **recruit and retain** the right workforce.
- Established formal **partnerships** to enable joint working across **health and social care.**

9. Branding and values

9.1 In 2016, we refreshed our values from five into four, following feedback from staff who said the acronym, **Care**, would help them to remember our values – **Compassionate, Aspirational, Responsive and Excellent**. These have already been signed off by the Board.

9.2 This has been used to develop our branding 'We Care', which is being developed across all materials to develop a strong look and feel for the organisation. It also provides an umbrella for our charity brand, *i care*.

10. Recommendations

10.1 It is recommended the updated vision, mission and strategic goals, in the proposed strategy on a page in Appendix 1, be approved by the Board.

Rachel Jennings, Associate Director of Strategy and Delivery
Julia Rogers, Assistant Director of Communications and Engagement

21 September 2017

Appendix 1: Proposed KCHFT strategy on a page

NHS
Kent Community Health
NHS Foundation Trust

Our strategy

Our vision

A community which supports each other to live well.

Our mission

To empower adults and children to live well, to be the best employer and work with our partners as one.

Our goals

- Prevent ill health
- Deliver high-quality care at home and in the community
- Integrate services
- Develop sustainable services

Our priorities for 2017/18

- Research, innovate and continually improve to be affordable and deliver safe care with the best outcomes.
- Engage and empower patients and carers as active partners to support health, wellbeing and independent living.
- Nurture leadership, support staff development and foster flexibility and adaptability to recruit and retain the right workforce.
- Establish formal partnerships to enable joint working across health and social care.

Our values

Compassionate · Aspirational · Responsive · Excellent

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Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 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 meeting held on 12 September 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 SEPTEMBER MEETING

Introduction

The Quality Committee, operating under new Terms of Reference, met on 12 September 2017 and received assurance reports from the recently established Patient Safety and Clinical Risk Group chaired by the Chief Nurse; the Patient Experience Group also chaired by the Chief Nurse; and the Clinical Effectiveness Group chaired by the Medical Director.

The membership of the Committee comprises of three Non-Executive Directors (NEDs), one of whom is appointed by the Board as Chairman; the Chief Executive, the Medical Director, the Chief Nurse and the Chief Operating Officer. On this occasion, the (NED) Chairman of the Finance, Business and Investment Committee was also in attendance.

General

Much of the focus of the meeting was given to reviewing the role of the sub-committees and ensuring that the governance and assurance responsibilities towards the Board would be met. It was agreed that a NED would visit and observe each of the sub-committees over the course of the next few months to provide assurance about the level of challenge and scrutiny and it was also requested that the Medical Director establish a more formal role in the provision of assurance to the committee regarding operational activity and concerns.

Patient Safety and Clinical Risk (PSCR)

Much of the information reported by the PSCR group is available to Board members through the Integrated Performance Report and the role of the Quality Committee is to provide additional scrutiny and challenge and to highlight areas of concern to Board members.

It was noted that Queen Victoria Memorial Hospital (QVMH), Herne Bay had had a fluctuating high-risk score on clinical indicators and performance metrics since April/May 2017 and it was of concern that in spite of a number of mitigation measures, patient experience scores are reduced and there had been a recent failure by local management to provide safety thermometer information. The Committee noted that the Executive was providing additional clinical leadership cover to the hospital and quality inspections were planned. However, there was

concern expressed about the length of time it has taken to address these local issues.

End of Life training compliance levels continue to improve and the Committee looks forward to receiving assurance that the Trust is fully compliant with Care Quality Commission (CQC) recommendations and standards within the next month.

Patient Experience

It is of note that that when 'benchmarked' against other community trusts the Trust has a significantly lower number of complaints than others and for three of the six months of a recent review period the Trust had the lowest number of complaints from this cohort.

Clinical Effectiveness

The Clinical Effectiveness Group held their inaugural meeting in July 2017. The group will meet bi-monthly and provide a quarterly report to the Board. Key areas of focus, in the next few months, will be input into the Trust's Clinical Strategy, promotion of a Quality Improvement culture, development of quality priorities and input to the revision of the Research and Development strategy.

SC Howe CBE
Chairman Quality Committee
14 September 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.1
Subject:	Quality Committee Terms of Reference
Presenting Officer:	Steve Howe, Committee Chair

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary (including purpose and context)

The Chief Nurse and Medical Director are preparing a revised Quality Strategy for Kent Community Health NHS Foundation Trust.

The attached Terms of Reference has been proposed for the Quality Committee which will meet a minimum of ten times per year, be chaired by a Non-Executive Director and provide a Chair's Assurance Report to the Board when it meets formally. The Committee approved the Terms of Reference at its September 2017 meeting.

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.

Ali Strowman, Chief Nurse	Tel: 01622 211919
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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.
2.0	Draft	06.06.2017	Ali Strowman, Chief Nurse	Full revision

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
1.1	25.05.2017	KCHFT Board	March 2018
2.0	12.09.2017	Quality Committee	March 2018
2.0		Board	

1.0 ROLE

Purpose:

The Quality Committee is established as a Committee of the Board of Kent Community Health NHS Foundation Trust (the Trust). The aim of the Quality Committee is to provide assurance to the Board of Directors that there is an effective system of risk management and internal control across the clinical activities of the organisation that support the organisation's objectives and the Trust's ability to provide excellent quality care by excellent people.

Objectives:

Specific responsibilities of the Quality Committee include:

Providing assurance that the risks associated with the Trust's provision of excellent care are identified, managed and mitigated appropriately. In doing so, the Quality Committee may consider any quality issue it deems appropriate to ensure that this can be achieved.

Providing assurance to the Board by:

- Ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes for patients and service users;
- Reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the CQC, NHSLA and the NHS Performance Framework.
- Reviewing quality risks which have been assigned to the Quality Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances;
- Reviewing the Annual Quality Report ahead of its submission to the Board for approval.
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents" and how well any recommended actions have been implemented.

The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board.

Reviewing how lessons are disseminated, learnt and embedded in KCHFT.

2.0 ASSURANCE

Assurance to:
KCHFT Board.

Groups:
Patient Safety and Clinical Risk Group
Clinical Effectiveness Group
Patient Experience Group

3.0 DECISION MAKING

The Quality Committee is directly accountable to the Board of Directors. At each formal meeting the Chairman of the Quality Committee will report to the Board. Minutes of committee meetings will be reported directly to the Board of Directors.

The Quality Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Quality Committee.

The Quality Committee is further authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise if it considers this necessary.

4.0 MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The minutes of each Committee meeting will be reported to the Board of Directors. A summary of the minutes of each meeting will be included in the next public board agenda.

Where a significant risk emerges either through a report or through discussion at a Committee meeting, this will be reported to the Board by the Committee Chair. The outcomes of any 'Deep Dive Reviews' will be reported to the Board and any follow up action kept under review by the Committee.

The Quality Committee has three formal sub-groups- the Clinical Effectiveness Group; the Patient Safety and Clinical Risk Group and the Patient Experience Group and will receive reports from these groups monthly.

5.0 GOVERNANCE

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

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

The agenda will be prepared for the Committee Chair with input from the Committee members and other regular attendees, who may propose items for inclusion in the agenda. Items for inclusion in the agenda will be submitted a minimum of two weeks prior to the meeting. The agenda with associated meeting papers will be distributed to members of the Committee one week prior to the meeting. The date for the next meeting will be arranged and distributed to all members within one month of the meeting. The date for the next meeting will be arranged and distributed to all members with the draft minutes.

A standard agenda as follows will be used by the Quality Committee may include the following items:

- Apologies for absence
- Declarations of interest
- Minutes of last meeting
- Action log
- Presentation from a service on a quality improvement initiative
- Progress against Quality Priorities
- Summary assurance report from Clinical Effectiveness Group
- Summary Assurance report from Patient Safety and Clinical Effectiveness Group
- Summary assurance report from Patient Experience Group
- Committee reports for assurance
- Red flag and Early Warning Trigger Tool (EWTT) report
- Any other business
- Date of next meeting

Membership:
The Members of the Quality Committee shall comprise three Non-Executive Directors, one of whom will be Committee Chair, the Chief Executive, the Chief Nurse, the Medical Director, and the Chief Operating Officer. In the absence of the Committee Chair and with the agreement of the other attending members' one of the other Non-Executive Directors will chair the meeting.

Executive Directors along with any other appropriate attendee will be invited to attend by the Committee Chair when the Committee is discussing areas of risk or operation that fall under their direct responsibility.

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

Quorum:
The quorum shall be four members, of which at least two must be Non-Executive Directors and two must be Executive Directors.

Frequency of Meetings:
The Quality Committee will hold a minimum of ten meetings each year to ensure it is able to discharge all its responsibilities.

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. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

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 Quality Committee will review these Terms of Reference on an annual basis as part of a self- assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Board of Directors approval.

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

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.2
Subject:	Audit and Risk Committee Chairman's Assurance Report
Presenting Officer:	Peter Conway, Chair of the Audit and Risk Committee

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):
The Report summarises the Audit and Risk Committee meeting held on 15 September 2017.

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

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

Peter Conway, Non-Executive Director	Tel: 01622 211900
	Email:

Kent Community Health
NHS Foundation Trust

Note to Kent Community Health NHS Foundation Trust Board
From Peter Conway, Chair Audit and Risk Committee

Subject: Audit and Risk Committee (ARAC) meeting - 15 September 2017

Procedural	Third meeting of current year to consider regular updates from the auditors, risk, legal and finance. In addition, follow up on previous outstanding items plus deep dives on New Models of Care, Cyber Security, Management of Risk Pan-Government and Learnings from the Deloitte Report on Gloucestershire Hospital.
Matters Arising	Corporate Policies – 17% of policies out of date. Further work needed to establish the 'normal' number and then recommend to Board a tolerance level CIS – ARAC to deep dive interoperability at a future meeting CIPs – ARAC view and post Senior Mangers' Conference is that CIPs 2018/19 need an overhaul in terms of approach and application.
Auditors' Updates	Grant Thornton – nothing to report at this stage in the annual cycle. Liz Jackson going on maternity leave and Chris Long has left so Paul Hughes to be lead with Trevor Greenlee the Engagement Manager TIAA – 17/18 Plan agreed (days from 225 to 180 giving rise to savings of £15k). 5 management actions (3 important priority) overdue so ARAC agreed a new policy henceforth whereby owner of overdue actions to attend ARAC to explain Counter Fraud - follow up activity agreed post the Bribery Act presentation to Board. ARAC to review in 6 months so it can provide assurance to the Board ahead of the Annual Report and Accounts sign off May 2018. Clinical Audit – KPIs continue to improve. ARAC to have a closer look at (1) Dental (issues with take on in London and clarification around inherited clinical audit plan/activity) and (2) CIS being an enabler for clinical audit recording.
Risk Management	BAF to be updated for: -gaps in controls and the logical flow through to actions arising -a higher residual risk for the challenges with Property Services providing evidence of regulatory compliance for all their buildings. To be re-assessed after paper due to Board this month and the articulation of a risk appetite -a better articulation of the cyber-security and CIS risks.

Legal and Regulatory Compliance	Claims Management – continued successful defence albeit it is more difficult to defend in the (several) instances where there has been poor record keeping. Trust solicitor to consider claims experience/risks/rewards/costs of the insurance with NHSLA with a view to formulating a revised policy and risk appetite Standards of Business Conduct – positive assurance received GDPR – compliance with New General Data Protection Regulation required by Q2 2018. ARAC to consider in February 2018.
Financial Reporting and Controls	Single Tender Waivers – substantial increase in number (+6) and value (+£2.1m) seen quarter on quarter with some not being agreed by Finance/Procurement but ''accepted'' as they arose under our choice of partner(s) as part of tenders for new services (eg. CXK for £1.8m under Therapeutic Intervention Service bid). SFIs, data reporting and timescales for Procurement involvement to be amended to reflect this. Meantime, ARAC satisfied that there is a robust and transparent process with full visibility of outcomes.
Deep Dives	Cyber Security Pleasingly TIAA reported ''IT management have demonstrated sound judgement and risk management….'' Good progress against agreed action plan with patching of higher-risk areas complete and a solution found for secure web sites. Going forward, ARAC to consider cyber security risks arising from connected and third parties New Models of Care Risk Registers provide partial assurance but timeliness and relevance of actions need greater precision. Community Nurses appear several times. ARAC to receive an update at November meeting Management of Risk pan-Government Ideas prompted by this central review include swapping BAFs with Derbyshire Community FT and seeing what the NHS provide by way of a BAF in its Board Papers Gloucestershire Hospitals Exercise undertaken to consider applicability of Deloitte's recommendations to KCHFT. ARAC recommends the Board supports: -encouragement of Exec to occasionally attend meetings outside of their line responsibilities -review of NED Board sub-committee membership to encourage rotation and cross-fertilisation whilst preserving subject-matter expertise.
Future Activity and Deep Dives	As well as the various items detailed above, ARAC to consider at its November Meeting -Social Value (Sustainability) Reporting, and -Medical Device Management.
Other	-

Board Actions Required	Board to note the various Audit Assurances and ARAC's broad range of planned activity. Board to consider the recommendations under Gloucestershire Hospitals above.
Date of Next Meeting	15 November 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.3
Subject:	Integrated Performance Report
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 and 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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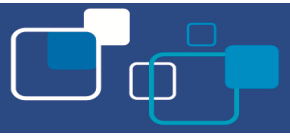
Kent Community Health
NHS Foundation Trust

Integrated Performance Report - 2017/18
Part 1

September 2017
April 2016 - August 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 2017/18

Strategic Goals

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

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
1.1	Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)	80.2%	97.2%	17.0%	100.0%	-2.8%	100.0%	N/A	+ve
1.2	Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)	100.3%	106.1%	5.8%	100.0%	6.1%	100.0%	N/A	+ve
1.3	Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks	85.2%	89.2%	4.0%	85.0%	4.2%	90.0%	N/A	+ve
1.4	Health Visiting - Increase the uptake of New Birth Visits by 14 days	85.8%	90.7%	4.9%	90.0%	0.7%	95.0%	N/A	+ve
1.5	School Health - Reception Children Screened for Height and Weight	93.9%	97.3%	N/A	90.0%	N/A	95.0%	N/A	+ve
1.6	School Health - Year 6 Children Screened for Height and Weight	95.4%	95.7%	N/A	90.0%	N/A	95.0%	N/A	+ve

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

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
2.1	LTCs (including Health Trainers) Teams Contacts: YTD as % of YTD Target	93.7%	98.5%	4.7%	100.0%	-1.5%	100.0%	N/A	+ve
2.2	LTCs Teams - Did Not Attend Rate: DNAs as a % of total activity.	1.6%	1.5%	-0.2%	4.0%	-2.5%	3.0%	4.0%	+ve

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

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
3.2	Total Time in MIU & WiC Service: Less than 4 hours	99.94%	99.85%	-0.1%	95.0%	4.8%	99.5%	99.5%	-ve
3.3	Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways	99.6%	99.5%	-0.1%	95.0%	4.5%	98.0%	96.8%	+ve
3.4	Allied Health Professionals Referral to Treatment Times (RTT)	92.8%	96.2%	3.4%	95.0%	1.2%	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	88.6%	91.2%	2.6%	87.0%	4.2%	91.7%	87.9%	+ve
3.8	Length of Stay (Median Average)	21.6	19.5	-2.1	21.0	-1.5	21.0	25.6	-ve
3.9	Delayed Transfers of Care as a % of Occupied Bed Days	12.1%	13.5%	1.4%	9.5%	4.0%	3.5%	6.0%	-ve

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

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
4.1	Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate	23.7%	21.3%	-2.4%	20.0%	1.3%	30.0%	30.7%	-ve
4.4	End of Life Care: Percentage of patients dying in their preferred place.	86.3%	86.7%	0.4%	95.0%	-8.3%	95.0%	83.2%	-ve
4.5	ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.	85.0%	88.0%	3.0%	80.0%	8.0%	90.0%	N/A	+ve

KCHFT Corporate Scorecard 2017/18

Strategic Goals

5. Ensure people receive safe care through best practice

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
5.2	Infection Control: C.Diff (Target <6 cases in year) (Target YTD)	7	1	-6	2	-1	2	N/A	+ve
5.6	Safety Thermometer: % harm free care New Harms	97.7%	96.9%	-0.8%	95.0%	2%	97.5%	96.3%	+ve
5.7	Never Events: FOT as % of Annual Target	1	0	-1	0	0	0	N/A	stat
5.8	NICE guidance: New NICE Guidance reviewed within required timescales following review of publication.	100.0%	100.0%	0.0%	100.0%	0%	100.0%	N/A	stat

Enabling Strategies

Finance and Commercial

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
6.1	Income & Expenditure - Surplus (%)	1.7%	1.4%	-0.3%	1.0%	0.4%	1.0%	1.0%	-ve

Workforce

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
7.1	Sickness Rate	4.30%	4.20%	-0.10%	3.90%	0.30%	3.75%	4.58%	-ve
7.4	Mandatory Training: Combined Compliance Rate	94.7%	94.2%	-0.5%	85.0%	9.2%	92.5%	88.4%	+ve

IM&T

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
8.2	Data Quality: NHS Number Completeness across clinical systems	100.0%	100.0%	-0.02%	95.0%	5.0%	99.9%	98.5%	-ve

Executive Summary: Supporting Narrative - September Report 2017/2018

Quality

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

Workforce

Sickness: The cumulative sickness absence rate for the financial year to August 2017 is 4.20% which up from 4.10% at M4. The sickness rate in August was 4.28%, a decrease of 0.13% from last month. The total FTE days lost for the rolling year to August equates to an average of 9.85 days sickness lost per employee, up from last month. The proportion of FTE lost to short-term sickness has decreased to 38.6%, compared to 43.4% in July

Mandatory Training: There is currently one Mandatory Training area which is under the 85% target - Moving and Handling: Client, which has decreased to 84.9%

Finance

Income & Expenditure and Financial Risk Rating: The Trust achieved a surplus of £1,238k (1.4%) to the end of August. Pay has underspent by £4,390k to date, and non-pay and depreciation/interest have overspent by £206k and £162k respectively. Income has under-recovered by £3,862k.

Access

Sexual Health Services, MIU 4-Hour wait and 18 week referral to treatment pathways: currently these targets are all being met at a Trust level, with 98.3% completed RTT pathways within 18 weeks and 99.4% incomplete RTT pathways within 18 weeks for M4. Paediatrics has worsened slightly in M4 to 93.2%, compared to 93.8% of children seen within 18 weeks in M3

Referral to Treatment Times for all Allied Health Professionals when measured against the 18 week threshold shows 95.6% of patients being seen within this timescale for July 2017, 1% down on the M3 position. Podiatric Surgery, MSK (West Kent Block), Adult SLT and Continence were below 90% compliance with 18 weeks RTT for July

National Targets

Stop Smoking: The stretch target set by KCC is 3750 quits. KCC have set a minimum target of 3400 quits. Month 1 -3 data is showing that we are on track to meet our target of 3400 quits.

Health Checks: The service is was slighly under its target for month 1 but over-achieved in subsequent 3 months. The service does have some hurdles to overcome with the Health Improvement restructure. It is putting various plans in place to help reduce any shortfall. For example, we are working hard to improve work place checks, we have organised a successful mini HC week in Shepway and have arranged pop up events in supermarkets and shopping centres. Most areas of checks are performing well; especially GP delivered checks. KCHFT core checks are slightly below target, but work is happening to help increase the uptake. This has been on an upward trend for the last 3 months. This includes identifying two year trends of under-performing GP practices and having discussions with them about changing contract types and working with the Wellbeing People to deliver checks in town centres over the coming months. The team have also organised shopping centre checks, KCHFT staff checks, and have arranged workplace checks for P and O ferries.

Community Hospitals

There were 192 admissions to the Community Hospitals in July and bed occupancy stood at 91.7%. There were a total of 731 bed days lost due to delayed transfers of care (15.3% of total occupied bed days). The average length of stay (median) was 20.1 days in Month 4.

Bed Occupancy (Target range 87-92%): The Kent wide occupancy rate across all hospitals was 91.7% in July, up from June and within the ideal threshold of 87% to 92%. Bed occupancy has generally increased due to pressures in the whole system and the need to facilitate patient discharges from acute hospital beds.

Length of Stay (LOS) - Median (Target 21 days): Performance against the median average length of stay target continues to be under target at 20.1 days, up slightly from M3 (18.8 days)

Delayed Transfer of Care (DTOC) days as percentage of total bed days (Target 3.5%): Delayed Transfers of Care has increased in M4 and remains above the target at 15.3% (13.5%). This relates mainly to high levels at all hospitals, with all sites being above the 3.5% target with the exception of Hawkhurst and Edenbridge. This is split between 8.9% KCHFT responsibility and 6.4% Social Services/Other

Activity

KCHFT's clinical services carried out 176,018 contacts (This figure includes various currencies e.g. face to face contacts, telephone contacts, group sessions, Units of Dental Activity), of which 11,960 were MIU attendances, during July 2017. KCHFT is below target at Month 4 (-3.1%), mainly due to low activity in Dental and LD. Performance against 2017/18 contract targets has been summarised at Service Specification level below:

Service & Currency	M4 Actual	YTD Actual	YTD Target	YTD Variance	Contract BRG	Trend
Long Term Conditions	53,589	213,271	216,626	-1.5%		
Intermediate Care	20,634	84,188	85,442	-1.5%		
MIU Attendances	11,960	45,779	38,178	19.9%		
Community Hospital Admissions	192	770	607	26.9%		
Community Hospital Occupied Bed Days (WK)	2,199	8,237	8,456	-2.6%		
Community Hospital Occupied Bed Days (EK)	2,580	9,822				
Specialist and Elective Services	27,794	113,375	116,857	-3.0%		
Learning Disabilities - Face to Face	2,927	12,246	14,670	-16.5%		
*Children's Universal Services	28,939	120,124				
Children's Specialist Services	12,558	54,277	57,282	-5.2%		
Dental Service - All currencies	12,475	46,084	58,546	-21.3%		
Health Trainers	171	1,078	1,004	7.4%		
All Services and Currencies (Contracted)	**144,499**	**579,305**	**597,667**	**-3.1%**		

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

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

Adults: Long Term Conditions (LTC) contacts are 1.5% (3,355 contacts) below at M4. Intermediate Care and Rehab Services (ICT) are 1.4% below target (1,248 contacts) with the targets adjusted for 17/18. Activity for the planned care services is 3% under target for the year (all currencies).

Children and Young People: It should be highlighted that the contract for Health Visiting does not have an activity target (hence the target and variance being greyed out). Health Visiting are measured against specific KPIs, although these still require a certain level of activity to ensure compliance with KPIs such as New Birth Visits, 1 year and 2 1/2 year development checks. Therefore is useful to see overall activity levels to highlight any major changes. Collectively the Childrens Specialist Clinical Services are 9.1% below target at M4, mostly attributed to West Kent Special Schools and ITAC in East Kent.

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.4
Subject:	Quality Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context):

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

- Sevenoaks and Queen Victoria Memorial Hospital (QVMH) had staffing levels below 95%.
- There were no avoidable pressure harms in August
- There is an overall reduction in all falls and falls resulting in moderate or severe harm.
- Patient experience remains extremely positive.

Proposals and /or Recommendations:

The Board is asked to note the report.

Relevant Legislation and Source Documents:

No. High level position described and no decisions required.

Ruth Herron, Deputy Chief Nurse	Tel: 01622 211900
	Email: Ruth.Herron@nhs.net

MONTHLY QUALITY REPORT

1. Patient Safety

Workforce Data and Quality Metrics

1.1. The information below relates to August fill rates per community hospital ward broken down by day and night for registered and unregistered staff. The fill rate for registered nurses has reduced slightly from July, producing a total fill rate of 97% for RN's day shifts (104% last month). This is due to less overstaffed shifts in comparison to July where Deal and Faversham were both overstaffed by over 10% due to escalation beds being open. Night shift fill rates for RN's have also dropped at 98% from 105%, again this is largely influenced by a drop in overstaffing at Deal. All escalation beds are now closed. There is no agreed national rating system, so the Chief Nurse will provide commentary on areas less than 95%.

1.2. Only QVMH Hospital had an RN day shift fill rate of below 95% and Sevenoaks was the only hospital with an RN fill rate 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 at risk of falling or with dementia. Where the staff bank are unable to fill requested shifts, a clear process for requesting the use of agency nurses is in place with scrutiny and sign off by executive team members following discussion with senior clinical staff.

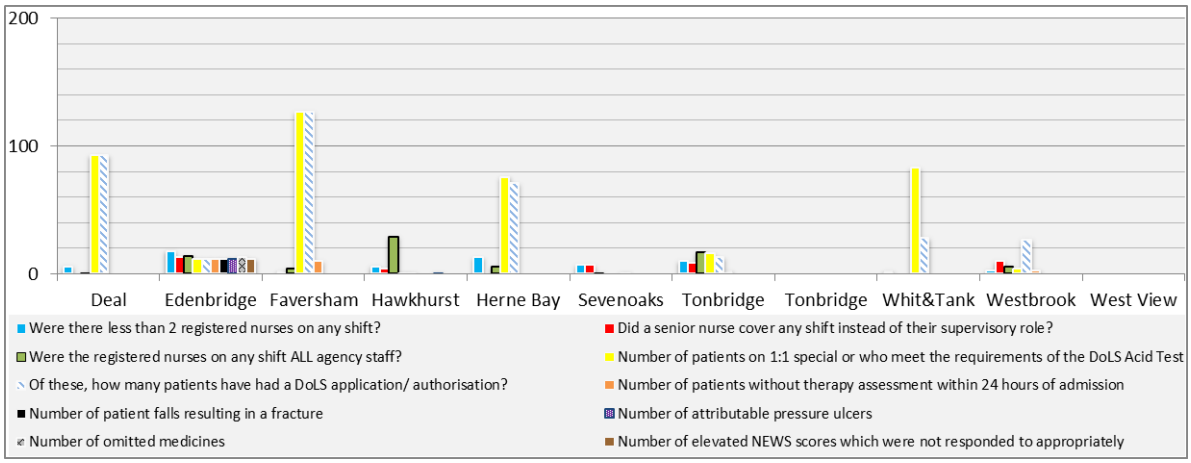
Figure 1:

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Faversham	96.0%	153.8%	98.4%	136.4%	930	892.5	1395	2145	682	671	682	930
Deal	99.2%	131.7%	104.8%	101.6%	930	922.5	1395	1837.5	682	715	682	693
QVMH	88.7%	128.0%	95.2%	103.2%	930	825	1395	1785	682	649	682	704
Whit &Tank	98.4%	127.1%	96.8%	100.0%	930	915	1162.5	1477.5	682	660	682	682
Sevenoaks	96.0%	111.3%	93.5%	100.0%	930	892.5	1395	1552.5	682	638	682	682
Tonbridge - Goldsmid	102.4%	107.7%	98.4%	164.5%	930	952.5	1162.5	1252.5	682	671	341	561
Tonbridge - Primrose (HCA% includes some RN activity)	N/A	88.7%	N/A	94.6%	0	0	1395	1237.5	0	0	1023	968
Hawkhurst	100.0%	109.1%	98.4%	98.4%	930	930	1395	1522.5	682	671	682	671
Edenbridge	96.0%	121.0%	96.8%	96.8%	930	892.5	930	1125	682	660	341	330
Total	**97%**	**120%**	**98%**	**107%**	**7440**	**7223**	**11625**	**13935**	**5456**	**5335**	**5797**	**6221**
	Over 90% Fill Rate			65% to 90% Fill rate				Less than 65%				

HCAs are above planned staffing on almost all wards. There continue to be a high number of patients requiring 1-1 support, particularly in the east of the county (Fig 2). Some of this is related to an increase in the number of inpatients with mental health needs and work continues to review how we support patients with dementia.

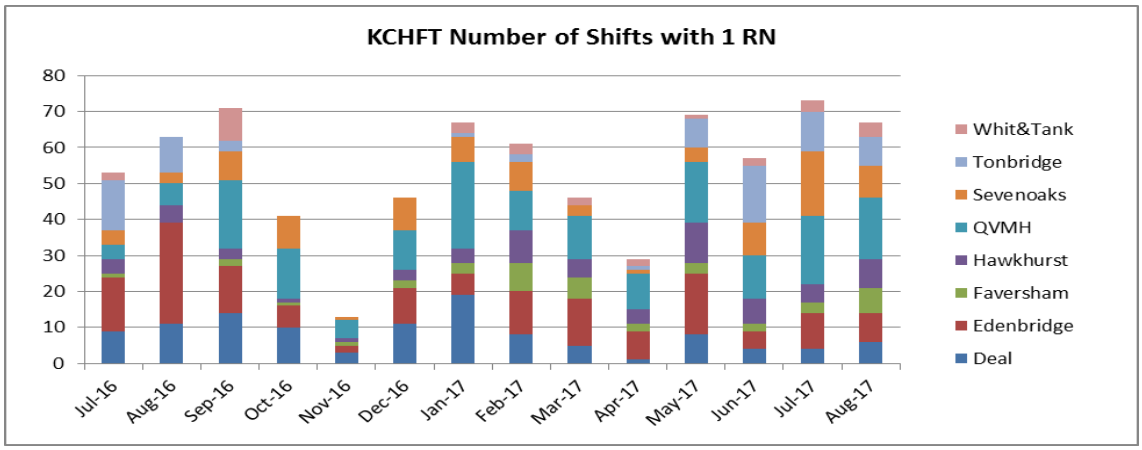
All wards are required to submit a Red Flag assessment each day, identifying any key quality indicators for safe patient care. Below is a summary of red flags raised in the month of August 2017. Where there are difficulties in filling shifts with the potential of impacting on patient safety, these are escalated to the operational lead that day and a number of measures are taken to ensure safety.

Figure 2:



1.3 In August 65 shifts had 1 RN on duty (excluding Primrose) and this is a decrease from July where 73 shifts had 1 RN on duty.
QVMH, Sevenoaks, Tonbridge and Edenbridge were the wards that were most challenged in filling RN shifts. The table below shows the trend in respect of shifts where 1 RN is present across the Trust.

Figure 3:



1.4 The fill rates for the integrated units at Westbrook and Westview are set out below. KCHFT have set staffing levels for the service but these have yet to be adopted by the wards due to historical funding arrangements.

	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
Westbrook	77.9%	67.4%	100.0%	67.4%	1627.5	1267.5	2325	1567.5	682	682	2325	1567.5
West View	55.8%	82.5%	103.6%	75.0%	1627.5	907.5	2100	1732.5	616	638	1232	924

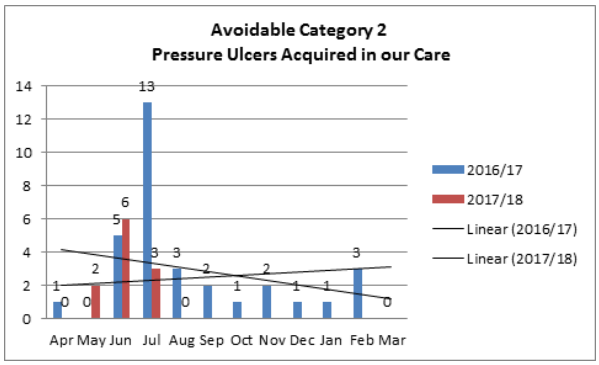
1.5 West view has 21 shifts with just 1RN on while Westbrook just had 1.

1.6 Within the KCHFT shifts with 1 RN safety was maintained by implementation of an established escalation process. Of the 65 shifts with 1 RN, there were clinical incidents on 8 of these shifts, all of which were low or no harm. Incidents are fully investigated and lessons learnt are shared. We continue to monitor this data closely.

Hospital	Type of Incident	Impact on Patient
Hawkhurst Community Hospital	Fall	Low Harm
QVMH	Fall	No Harm
Tonbridge Cottage Hospital	Fall	No Harm
Tonbridge Cottage Hospital	Fall	No Harm
Faversham CH	Fall	No Harm
Edenbridge CH	Medication omitted	No Harm
Westview	Medication error	No Harm
Westbrook	Medication Omitted	No Harm

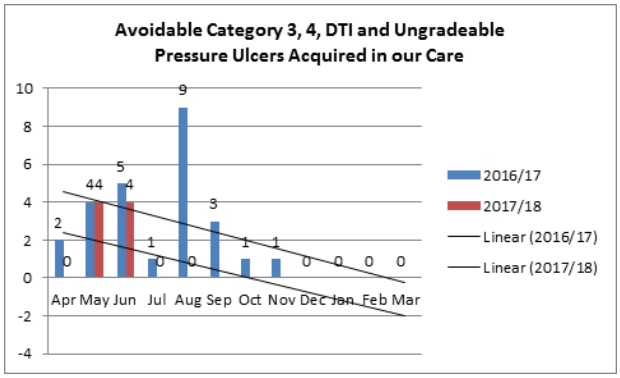
1.7 Category 2 Pressure Ulcers

There have been no category 2 pressure ulcers acquired in our care during the month of August.



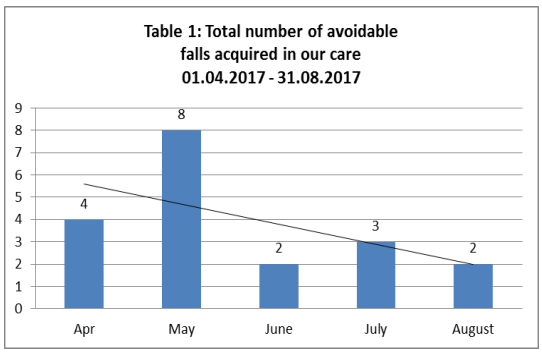
1.8 Category 3, 4 and ungradeable pressure ulcers

There have been no confirmed avoidable serious harms acquired in our care during the month of August.



1.9 Falls

There were 42 falls reported in August of which two were found to be avoidable - this is a reduction from the previous month where 3 reported falls were found to be avoidable.



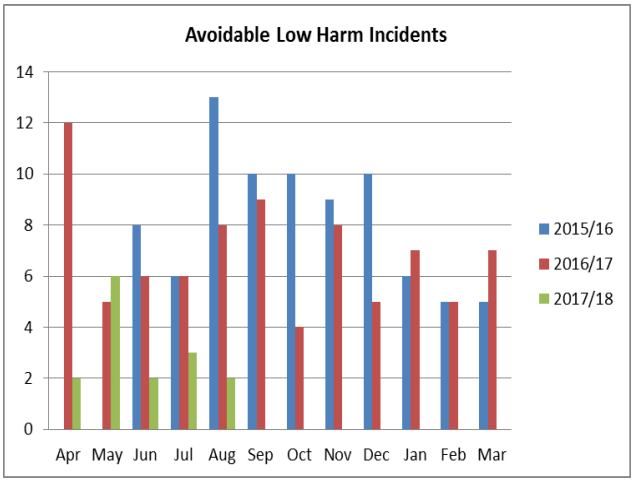
No serious incidents were declared in August as a result of a fracture.

The Trust has taken part in the NHSI falls collaborative - the 6 key improvement areas are being up scaled across the community hospitals.

1.10 Medication Incidents

There were 28 avoidable medication incidents which were acquired in our care that were investigated in August 2017(26 in July 2017). The highest reported category of avoidable incidents is omitted medication making up 39% of the total number of medication incidents

Of the 28 incidents that occurred during August, 93% resulted in 'no harm' to the patient and 7% resulted in ‘low harm’. The table below shows the number of low harms**.**



1.11 Infection, prevention and control

Gram negative surveillance continues and the team are working closely with the Acute trusts, PHE and the CCG's to implement Kent wide changes to drive improvements across the county.

In July across Kent there were 146 E coli bacteraemias, and 18 cases where KCHFT provided care in the previous 28 days, predominant factors from community input were catheterised patients and those with chronic leg wounds, one case had repeated catheterisations which may have contributed to the bacteraemia.

There were 43 Klebsiella bacteraemias, only 1 patient with input from KCHFT for a catheter change, and 15 pseudomonas cases, with 2 having involvement from KCHFT, but in neither case were these significant.

In East Kent, KCHFT, EKHUFT and the CCG infection prevention and control leads have agreed to trial the NHSI draft paperwork to assess Trust and health economy preparedness for implementing changes required to reduce these bacteraemias. Also, as part of the ongoing work, the East Kent organisations are planning a 'deep dive' of 30 cases to review in depth care provision to focus learning for future and this will take place over the next 8 weeks.

There have been no MRSA bacteraemias in KCHFT, however, the IPC team have been working closely with the podiatry service to review their MRSA screening protocols and skin debridement protocols to further reduce risk of at risk patients developing MRSA bacteraemias. Compliance to MRSA screening has continued to be 100% across the organisation following the changes in screening sites, with no increase in positive results.

Cleaning in Faversham and Hernebay hospitals have met the national standard this month, however Sevenoaks remains below target. The Hotel Services team have recruited in these areas, and training alongside the IPC team is underway across the organisation for domestic staff.

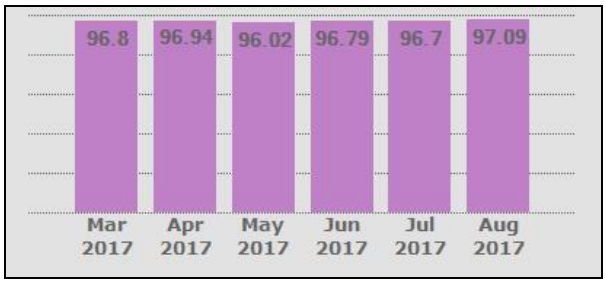
2.0 Patient Experience

2.1 Meridian Patient Experience Survey results for August 2017

4,704 surveys were completed by patients using KCHFT services throughout August with a strong combined satisfaction score of 97.09%. This includes 1,815 short NHS FFT MIU surveys that achieved a positive overall satisfaction score of 97.13%.

Volumes

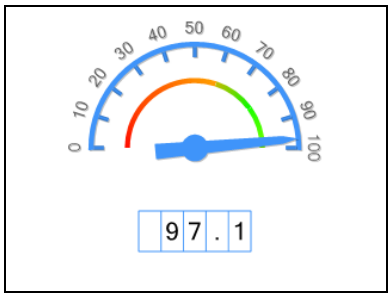
Aggregated monthly survey scores



Survey volumes have dropped over the last 3 month period. It is usual to see a reduction in the amount of surveys completed in August due to the holiday period.

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

Combined result from all questionnaires submitted between 1-Aug-2017 and 31-Aug-2017	Number of questionnaires submitted between 1-Aug-2017 and 31-Aug-2017
97.09%	**4,704**



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

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.55%	0.79%	4660	3871	675	50	17	20	27
Summary	97.55%	0.79%	4660	3871	675	50	17	20	27

2.2 Selection of positive feedback

Lymphoedema Service - Shepway	I am well treated. Everything is explained to me. I always get full explanation of treatments, measuring etc. Staff are friendly, I am at ease while at the clinic.
Dental Service - St Leonards Hospital	Very person centred and friendly - eased my daughter through her initial fear pre-treatment. Very patient with her and very informative.
Exercise Referral Scheme - Deal	Excellent information and communication from instructor, very friendly and understanding.

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

Service	**FFT response**	**Notes and reason given for response**
Dental (Adults and Children) – Appleby	Extremely Unlikely	**Comment:** My daughter not coming to this dentist anymore. Not happy, appointment keep cancelling.
Area Clinical Manager: They have had to cancel some appointments due to 3 clinicians being unwell at the same time. Other dentists have provided cover whenever possible and a dental therapist has been employed to ease some of the pressure during through the re-structure		

Minor Injury Unit (Royal Victoria Hospital, Folkestone)	Extremely unlikely	Reason chosen as to why: • Staff attitude **Comment:** Booked in at 4.50 with an autistic child who needs x-ray. Was told may need x-ray. watched several go in who didn't look to need it, wasn't seen
Matron: A child was booked in at 16.35 but left before being seen so notes unavailable. Child was out of area. X-ray shuts at 5pm and machines are switched off at 16.50. Lots of fractures are treated and patients are asked to return when x ray is open. If patient is examined too quickly things can be missed or an x ray is taken when not needed.		

2.3 Selection of actions completed in August 2017

Comment/ complaint	**Service**	**Recommendation for improvement / action to be taken**
Complaint	East Sussex Children's Integrated Therapy Service	Family member unhappy with comments made by Occupational Therapist at tribunal / Referrals to be discussed and monitored through clinical supervision. Lessons learned discussed with staff from the joint Complex Needs and Universal Speech & Language Therapy Teams.
Meridian feedback	Sexual Health	Client has suggested that a play area is needed in the waiting room to keep children occupied. Play table is now in the waiting area and available for use.

2.4 PALS enquiries for August 2017

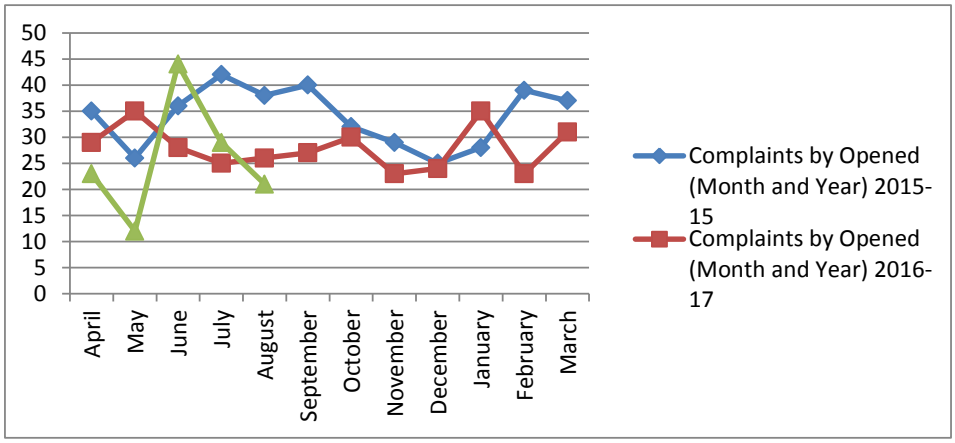
PALS received a total of 685 enquiries in August compared with 671 in July. Of these 162 were compliments compared with 95 in July.

PALS have received numerous calls this month from patients unable to get through to the Podiatry Service to make an appointment and who have not received a reply to messages left. They have explained the service is undergoing change which is creating some short term issues they are working to resolve. PALS have passed patient details to the service to contact patients to book an appointment.

2.5 Complaints data for August 2017

In August 2017 there were 21 complaints for services, compared to 29 in July 2017 and of these 2 were multi-agency complaints.

The following graph demonstrates a gradual reduction in complaints received.



Themes and trends of complaints

Adult services

Clinical treatment - 5 complaints in this category.

- Lack of support and physiotherapy and care plan by ICT
- Unhappy with level of physiotherapy provided
- Query on EOL care and syringe driver
- Unhappy with treatment provided at MIU
- Comments requested on referral to A&E when visited MIU

Referrals, appointments, admissions, discharges and transfers - 3 complaints in this category.

- Unhappy that discharged from service for health and safety reasons
- Unhappy patient discharged from service lack of account individual's situation
- Unhappy with discharge from service and lack of communication to family

Access to treatment and medication - 3 complaints in this category.

- Unhappy with referral process for hip and knee problems

- Unhappy with delay in nursing visit
- Unhappy that treatment only provided on shoulder when also had back problems

Values and behaviours - 3 complaints in this category:

- Unhappy with porters
- Unhappy with difficulties contacting service and that staff attitude
- Unhappy that staff did not help patient when having difficulties dressing

Communication - 2 complaints in this category.

- Unhappy that with discharge from community nursing team.
- Unhappy with letter sent to GP with change of medication as not what had been agreed at appointment

Children and Young People's Services

Clinical treatment - 2 complaints in this category.

- Unhappy with delays and communication with getting extraction
- Unhappy with health visiting assessment

Referrals, appointments, admissions, discharges and transfers – 1 complaint in this category

- Unhappy with waiting times for dental appointment.

Access to treatment and medication – 1 complaint in this category.

- Unhappy with continence products

Values and behaviours – no complaints in this category.

Communication - 1 complaint in this category.

- Unhappy with letter received from health visiting team

3.0 Patient Outcomes

3.1 Audit

Key Performance Indicators (KPIs)

The annual target is for 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year. The position for 2017-18 has improved since last year (71%).

Key Performance Indicators – Actions Stepped Target	April Target >35%	May Target >35%	June Target >55%	July Target >65%	August Target	Achieved
1. Due audit recommendations implemented - KPI 4.6 Target April >35%	43%	61%	51%	75%	78%	Yes
2. Actions overdue by more than	3%	0%	6%	0%	5%	Yes

3 months - PI 36 Target <=10%						
3. Actions overdue by more than 6 months - PI 37 Target <=5%	3%	0%	0%	0%	0%	Yes

Clinical Audit Reporting

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

Key Performance Indicators – Reporting Target 50%	**April**	**May**	**June**	**July**	**August**	**Achieved**
Receipt of full report within specified timeframe following receipt of dashboard	15%	40%	44%	50%	50%	Yes

3.2 Research

The Kent Surrey and Sussex Clinical Research Network (CRN) has continued to fund 3 posts within KCHFT including a joint research delivery post with EKHUFT.

3.3 National Institute for Clinical Excellence (NICE)

The number of NICE guidance/ standards that were issued in August 2017 was twenty-five. The number of guidance/standards issued in May 2017 that were due for assessment in August 2017 was twelve in total. Seven of the guidance/ standards issued were deemed applicable to at least one service throughout the trust and five were assessed as not applicable.

Ali Strowman
Chief Nurse
August 2017

Contributions from the Nursing and Quality Team
Audit and Performance teams

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.5
Subject:	Month 5 Finance Report
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context)

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

The Trust achieved a surplus of £1,238k year-to-date (YTD) which was £160k 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 £1,238k (1.4%) to the end of August. Cumulatively pay has underspent by £4,390k and non-pay and depreciation/interest have overspent by £206k and £162k respectively. Income has under-recovered by £3,862k.	●
Continuity of Services Risk Rating: EBITDA Margin achieved is 2.8%. The Trust scored 1 against the Use of Resources Rating, the best possible score.	●
CIP: £1,411k of savings has been achieved to August against a risk rated plan of £1,699k which is 17% behind target. The full year savings target of £4,271k is forecast to be achieved in full.	●
Cash and Cash Equivalents: The cash and cash equivalents balance was £22,920k, equivalent to 39 days expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 96% for value.	●
Capital: Spend to August was £1,332k, representing 75% of the YTD plan.	●
Agency: Agency spend was below trajectory for August.	●

Proposals and /or Recommendations
The Board is asked to note the contents of the report.
Relevant Legislation and Source Documents
Monitor NHS Foundation Trusts Annual Reporting Manual 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
	Email: Gordon.flack@nhs.net

Kent Community Health
NHS Foundation Trust

FINANCE REPORT – AUGUST 2017 (MONTH 5 of 2017-18)

The Trust achieved a surplus of £1,238k year-to-date (YTD) which was £160k better than plan. The Trust is forecasting to reach a surplus of £3,026k in line with plan which is supported by £1,759k of sustainability and transformation funding.

Dashboard

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	1,238	1,078	160
Year End Forecast £k	3,026	3,026	0

The Trust achieved a surplus of £1,238k to the end of August.

Pay has underspent by £4,390k to date, and non-pay and depreciation/interest have overspent by £206k and £162k respectively. Income has under-recovered by £3,862k.

The forecast is to deliver a surplus of £3,026k in-line with the plan for the year.

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 M5 2017-18.

CIP — Rag rating: Amber

	Actual	Plan	Variance
Year to Date £k	1,411	1,699	-288
Year End Forecast £k	4,271	4,271	0

The Trust achieved CIPs of £1,411k to the end of August against a plan of £1,699k, which is 17% behind target.

81% of the total annual CIP target has been removed from budgets to month five.

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	22,920	21,299	1,621
Year End Forecast £k	21,559		

Cash and Cash Equivalents as at 31st August 2017 stands at £22,920k, equivalent to 39 days operating expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	1,332	1,770	438
Year End Forecast £k	4,179	4,179	0

Capital Expenditure year to date is £1,332k, representing 75% of the YTD plan.

Agency Trajectories — Rag rating: Green

	M5			Year to Date		
	Actual £	Trajectory £	Variance £	Actual £	Trajectory £	Variance £
External Agency Expenditure (inc. Locums)	331,255	723,333	392,078	1,658,378	3,616,667	1,958,289
Locum Expenditure	64,377	106,250	41,873	307,410	531,250	223,840

1. Income and Expenditure Position

The position for August was £7k favourable compared to plan. The in-month performance comprised an underspend on pay of £1,073k, partly offset by overspends on non-pay and depreciation/interest of £50k and £25k respectively, and an under-recovery on income of £991k. The summary income and expenditure statement is shown below:

	AUGUST ACTUAL £'000	AUGUST BUDGET £'000	AUGUST VARIANCE £'000	% VARIANCE	YTD ACTUAL £'000	YTD BUDGET £'000	YTD VARIANCE £'000	% VARIANCE
CCGs - Non Tariff	10,130	10,879	-749	-6.9%	52,134	54,912	-2,778	-5.1%
CCGs - Tariff	247	474	-227	-47.9%	1,395	1,931	-536	-27.8%
Charitable and Other Contributions to Expenditure	9	6	3	61.9%	41	28	13	46.9%
Department of Health	0	0	0	0.0%	0	0	0	0.0%
Education, Training and Research	209	202	7	3.3%	998	964	34	3.5%
Foundation Trusts	259	306	-47	-15.5%	1,359	1,423	-64	-4.5%
Income Generation	-15	13	-28	-212.8%	122	66	56	85.2%
Injury Cost Recovery	32	27	6	21.8%	189	133	55	41.5%
Local Authorities	4,021	4,031	-10	-0.2%	20,170	20,275	-105	-0.5%
NHS England	1,756	1,978	-222	-11.2%	9,044	9,767	-722	-7.4%
NHS Trusts	551	353	198	56.1%	2,456	2,549	-93	-3.7%
Non NHS: Other	124	87	37	42.6%	604	496	108	21.7%
Non-Patient Care Services to Other Bodies	65	44	20	46.0%	293	227	66	29.2%
Other Revenue	182	188	-6	-3.1%	872	909	-37	-4.0%
Private Patient Income	49	23	26	113.0%	257	115	142	123.2%
Sustainability and Transformation Fund	117	117	0	0.0%	498	498	0	0.0%
INCOME Total	**17,737**	**18,727**	**-991**	**-5.3%**	**90,431**	**94,293**	**-3,862**	**-4.1%**
Administration and Estates	2,510	2,701	191	7.1%	12,752	13,226	474	3.6%
Healthcare Assistants and other support staff	1,835	1,904	70	3.7%	9,108	9,500	392	4.1%
Managers and Senior Managers	798	791	-6	-0.8%	3,872	4,150	278	6.7%
Medical and Dental	728	830	103	12.4%	3,875	4,079	203	5.0%
Qualified Nursing, Midwifery and Health Visiting	4,292	4,639	347	7.5%	22,168	23,463	1,295	5.5%
Scientific, Therapeutic and Technical	2,425	2,554	129	5.0%	12,389	13,338	949	7.1%
Employee Benefits	-256	0	256	100.0%	-1,300	0	1,300	100.0%
CIP Target Pay	0	62	62	100.0%	0	-64	-64	-100.0%
East Kent Savings	0	-55	-55	-100.0%	0	-326	-326	-100.0%
North Kent Savings	0	-22	-22	-100.0%	0	-110	-110	-100.0%
PAY Total	**12,331**	**13,404**	**1,073**	**8.0%**	**62,864**	**67,254**	**4,390**	**6.5%**
Audit fees	5	5	0	3.8%	24	25	1	3.8%
Clinical Negligence	41	41	0	0.9%	206	207	2	0.8%
Consultancy Services	56	17	-40	-237.5%	150	79	-71	-88.9%
Education and Training	66	80	14	17.2%	289	379	90	23.7%
Establishment	796	738	-57	-7.8%	3,735	4,214	479	11.4%
Hospitality	4	0	-4	-800.6%	12	2	-10	-451.2%
Impairments of Receivables	0	0	0	0.0%	-86	0	86	0.0%
Insurance	2	1	0	-35.1%	13	6	-7	-122.2%
Legal	22	26	4	16.3%	149	129	-19	-15.0%
Other Auditors Remuneration	0	0	0	0.0%	0	0	0	0.0%
Other Expenditure	9	10	1	7.6%	44	50	6	11.5%
Premises	1,240	1,327	87	6.6%	6,905	6,631	-274	-4.1%
Research and Development (excluding staff costs)	0	0	0	100.0%	0	2	2	100.0%
Services from CCGs	0	0	0	0.0%	0	0	0	0.0%
Services from Foundation Trusts	0	0	0	0.0%	0	0	0	0.0%
Services from Other NHS Trusts	83	65	-19	-28.8%	394	297	-97	-32.8%
Supplies and Services - Clinical	2,070	2,066	-5	-0.2%	10,517	10,346	-171	-1.7%
Supplies and Services - General	90	105	14	13.8%	431	530	99	18.7%
Transport	425	423	-2	-0.5%	2,214	2,118	-95	-4.5%
CIP Target Non Pay	0	-45	-45	-100.0%	0	-224	-224	-100.0%
NONPAY Total	**4,910**	**4,860**	**-50**	**-1.0%**	**24,997**	**24,792**	**-206**	**-0.8%**
EBITDA	495	463	33	7.0%	2,570	2,247	323	14.4%
EBITDA %	2.8%	2.5%	-0.3%		2.8%	2.4%	-8.4%	
DEPRECIATION/AMORTISATION	263	240	-23	-9.7%	1,348	1,199	-148	-12.4%
INTEREST PAYABLE	-1	0	1	0.0%	0	0	0	0.0%
INTEREST RECEIVED	3	6	-3	-50.0%	15	30	-15	-49.6%
SURPLUS/(DEFICIT)	**236**	**229**	**7**	**3.0%**	**1,238**	**1,078**	**160**	**14.8%**
SURPLUS %	-1.3%	-1.2%	-0.1%		-1.4%	-1.1%	-0.2%	

Table 1.1: Trust Wide variance against budget in month

2. Risk Ratings

The Trust has scored a 1 against this rating.

3. Cost Improvement Programme

Year to date CIP target (£k)	Year to date CIP Achieved(£k)	Year to date variance – negative denotes an adverse variance (£K)	Full year CIP target (£k)	CIP Achieved (£k)	Full year CIP forecast (£k)	Full Year Total CIP	Full year variance (£k) – negative denotes an adverse variance
1,699	1,411	-288	4,271	3,460	810	4,271	0

Table 3.1: Cost Improvement Programme Performance

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

YTD achievement is 17% behind plan with £1,411k removed from budgets at month five against a risk rated year to date plan of £1,699k. This position is improved from a shortfall of 22% to month four. Of the total CIP removed from budgets for the year, all savings have been achieved recurrently.

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

4. Statement of Financial Position and Capital

	At 31 Mar 17 £000's	At 31 July 17 £000's	At 31 Aug 17 £000's	Variance Analysis Commentary
NON CURRENT ASSETS:				
Intangible assets	238	362	410	
Property, Plant & Equipment	16,717	16,614	16,591	
Other debtors	68	61	60	
TOTAL NON CURRENT ASSETS	**17,023**	**17,037**	**17,061**	
CURRENT ASSETS:				
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	13,715	13,965	11,825	**NHS & Non NHS - Invoiced Debtors (net of bad debt provision)**
NHS Accrued Debtors	2,026	2,233	2,171	The in-month decrease is primarily due to the receipt in August of the
Other debtors	2,604	3,478	3,471	previously reported late payment of the M3 SLA value with KCC for CYP
Total Debtors	**18,345**	**19,676**	**17,467**	Services; payment received from West Kent CCG and SKC CCG for the
Cash at bank in GBS accounts	2,118	4,062	1,894	invoices raised in respect of 16-17 NHSPS market rate increases; and
Other cash at bank and in hand	49	37	26	credit notes raised to KMPT in settlement of the historic Facilities
Deposit with the National Loan Fund (Liquid Investment)	17,000	17,000	21,000	invoices.
Total Cash and Cash Equivalents	**19,166**	**21,099**	**22,920**	
TOTAL CURRENT ASSETS	**37,511**	**40,775**	**40,387**	
CREDITORS:				
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-5,322	-3,318	-2,534	
NHS - accrued creditors falling due within 1 year	-3,234	-2,336	-2,429	
Non NHS - accrued creditors falling due within 1 year	-8,283	-14,400	-15,012	**Non NHS - accrued creditors falling due within 1 year**
Other creditors	-6,993	-6,511	-6,275	The in-month increase is due to accruals applied for a further month's
Total amounts falling due within one year	**-23,832**	**-26,565**	**-26,251**	NHSPS costs.
NET CURRENT ASSETS	**13,679**	**14,210**	**14,136**	
TOTAL ASSETS LESS CURRENT LIABILITIES	**30,702**	**31,247**	**31,197**	
Total amounts falling due after more than one year	0	0	0	
PROVISION FOR LIABILITIES AND CHARGES	-3,584	-3,127	-2,842	
TOTAL ASSETS EMPLOYED	27,118	28,120	28,356	
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	-2,612	-2,612	-2,612	
Income and expenditure reserve	-23,740	-24,742	-24,978	
Revaluation Reserve	-766	-766	-766	
TOTAL TAXPAYERS EQUITY	- 27,118	- 28,120	- 28,356	

Table 4.1: Statement of Financial Position, August 2017

	Total Assets	Total Liabilities	Assets/ Liabilities
Aug-16	57,325	33,498	1.71
Sep-16	59,160	35,016	1.69
Oct-16	60,044	35,658	1.68
Nov-16	55,963	31,331	1.79
Dec-16	56,752	31,871	1.78
Jan-17	59,366	34,202	1.74
Feb-17	53,766	28,267	1.90
Mar-17	53,651	27,417	1.96
Apr-17	54,618	27,263	2.00
May-17	54,639	27,048	2.02
Jun-17	55,962	28,135	1.99
Jul-17	57,812	29,693	1.95
Aug-17	57,448	29,092	1.97

Table 4.2: Assets and Liabilities

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	M5 Actual YTD £000's	M5 Plan YTD £000's	M5 Variance to plan	Full Yr Forecast	Full Yr Plan £000's	Full Yr Variance	Variance Analysis Commentary
Estates Developments	824	766	-58	1,342	1,676	334	Actual expenditure YTD relates to works on the Orthotics Site, the completion of the Sevenoaks Wound Care Centre and works relating to service relocation at Wrotham Rd/Rochester Rd.
Backlog Maintenance	202	355	153	700	455	-245	Actual expenditure YTD primarily relates to the Hawkhurst Flooring Project which has progressed in advance of plan.
IT Rolling Replacement & Upgrades	260	507	247	1,664	1,556	-108	Actual expenditure YTD relates to Licensing Upgrade requirements and Switches.
Dental SBU	-6	142	148	223	242	19	Actual expenditure YTD relates to VAT refunds for 16/17 Capital Projects
Other Minor Schemes	52	0	-52	250	250	0	Actual expenditure YTD relates to an upgrade of the Trust's Qlikview reporting capabilities.
Total	**1,332**	**1,770**	**438**	**4,179**	**4,179**	**-**	

Table 4.3: Capital Expenditure August 2017

Gordon Flack
Director of Finance
September 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.6
Subject:	Workforce Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	☐	Assurance	X

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

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

Relative Legislation and Source Documents:
None.
Has an Equality Analysis (EA) been completed?
No. An EA is not required for a report of this nature as the detail is monitored by the Staff Partnership Forum.

Louise Norris	**Tel**: 01622 211905
Director of Workforce, Organisational Development and Communications	**Email**: louisenorris@nhs.net

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

2. Overview

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

Month	Aug-17			
Direction (Better/Worse)	Metric	Target	Current Position	6mth Trendline (Mar to Aug 2017)
↑	Turnover (12 mths to Aug)	10.50%	15.30%	
↓	Absence (2017/18 cumulative)	3.90%	4.20%	
↓	Vacancies	5.00%	7.72%	
↓	Fill Rate Overall	No target set (rated on 75%)	81.63%	
↓	Fill Rate Bank	No target set (rated on 30%)	67.08%	
↓	Agency spend as a proportion of the trajectory (Aug, without contingency)	< 100%	45.80%	
↓	Agency shifts - Framework agency used - compliant with price cap	100%	87.9%	
↓	Average Recruitment Time in Weeks (in Aug 2017)	< 7 Weeks	5.89wks	
↑	Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target)	85%	102.3%	
N/A	Number of suspended staff	No target set	2	
↑	Appraisals (annual figure)	85%	98.5%	
N/A	Trust Headcount (at 31 Aug 2017)	No target set	4,877	
↑	Number of Starters (Aug)	No target set	64	
↓	Number of Leavers (Aug)	No target set	70	

3. Performance Commentary

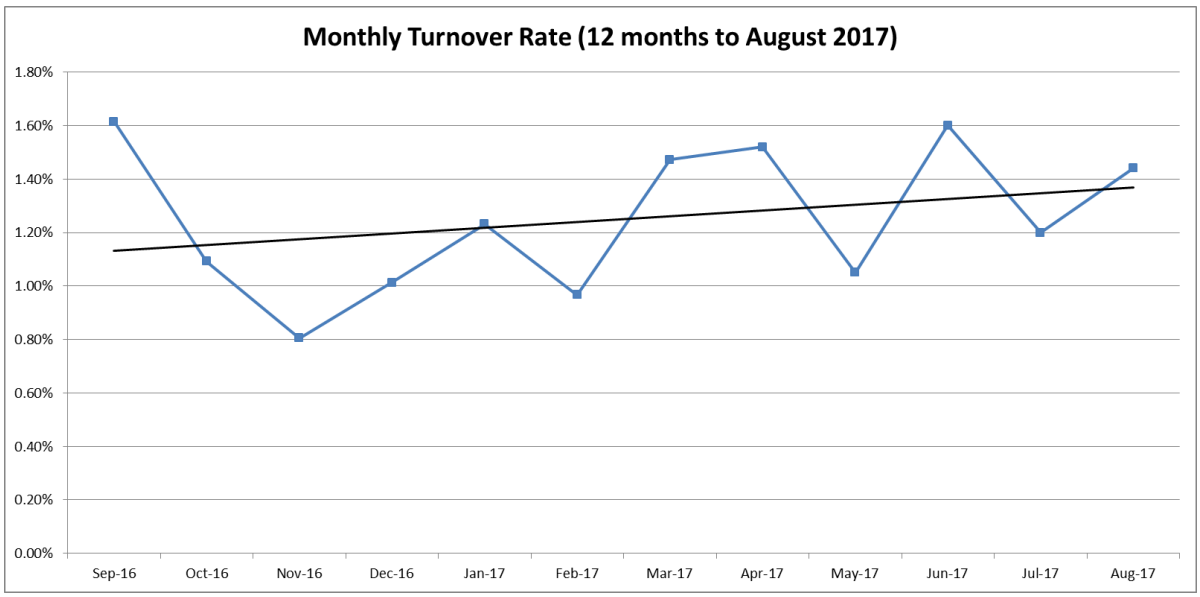
Turnover

3.1 Turnover is rated red this month. The turnover rate for the 12 months to August 2017 is 15.30% which is a decrease from July's 15.32% and above the target of 10.50%. This turnover data excludes TUPE transfers.

3.2 Figure 1 below shows turnover for the month of August, which stands at 1.44% compared to 1.20% the previous month.

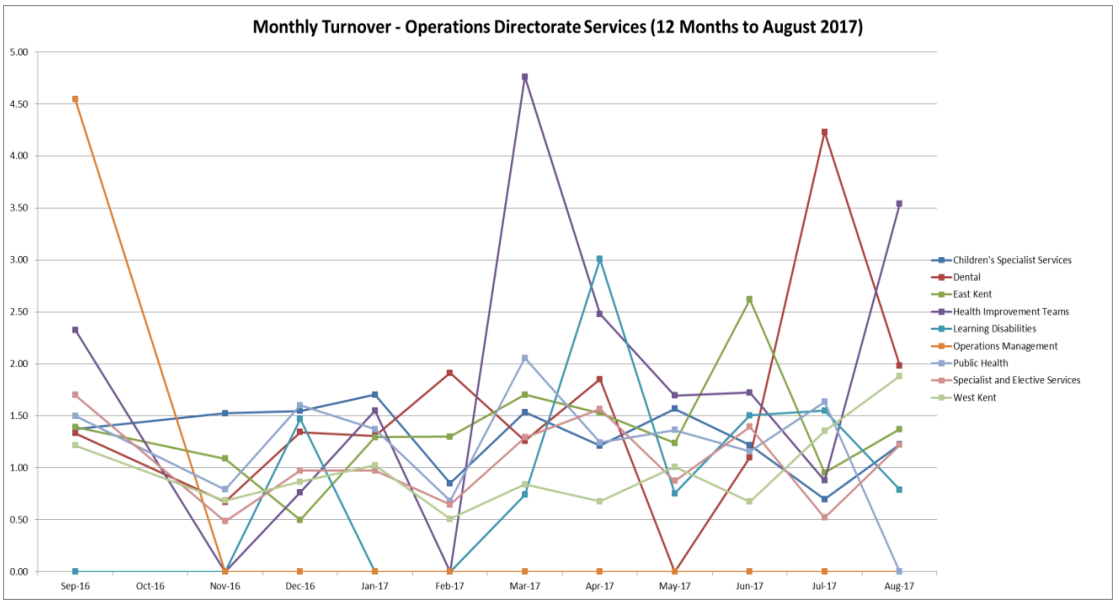
3.3 The trend line for turnover is currently showing an upward trend in turnover performance.

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



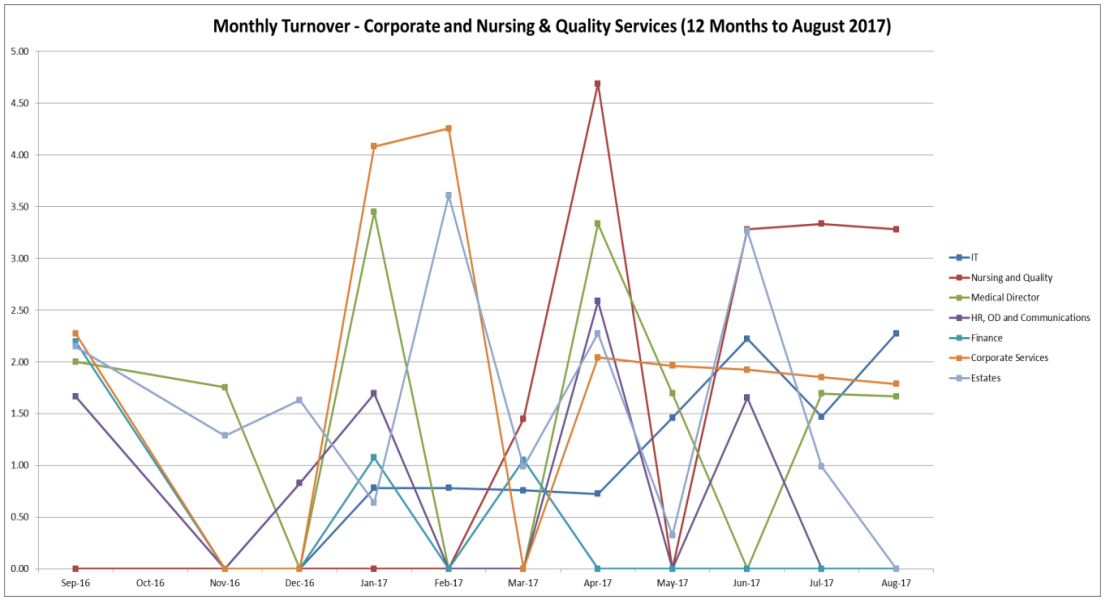
3.4 Fig. 2 below shows turnover for services within the Operations Directorate. In August 2017, Health Improvement Teams had the highest turnover rate at 3.54%; this was an increase from the 0.88% the previous month. It is the second highest rate for the team over the past 12 months with the exception of March 2017 which saw a rate for the team of 4.76%. The second highest turnover rate was in Dental with 1.98%, albeit a substantial reduction from the previous month's 4.23% (although at 1.98% this is the team's second highest rate in 12 months). Third highest turnover is West Kent with a rate of 1.88%, an increase on the previous months 1.35% and the highest rate for the locality in the past 12 months. The highest proportional increase in turnover was for the Health Improvement Team, followed by Specialist and Elective Services which saw an increase in turnover from 0.52% in July to 1.22% this month. The largest proportional fall in turnover performance was for Public Health which fell from 1.63% in July to 0.00% this month, followed by Dental.

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



3.5 Fig 3. below shows turnover by directorate for other Trust services. These are primarily corporate related services but also include Nursing and Quality. The highest turnover rate within this group in August 2017 was Nursing and Quality at 3.28%, although this was a slight decrease from July's 3.33%. The second highest turnover rate was in IT with a rate of 2.27%, up from 1.47% in July. Third highest was Corporate Services with 1.79%, although this was a reduction on the previous month's 1.85%. The highest proportional increase in turnover was in IT whilst the largest proportional fall was in Estates where turnover fell from 0.99% to 0.00% this month. Three Directorates (HR, OD and Comms, Finance and Estates) had a turnover rate of 0.00% this month.

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

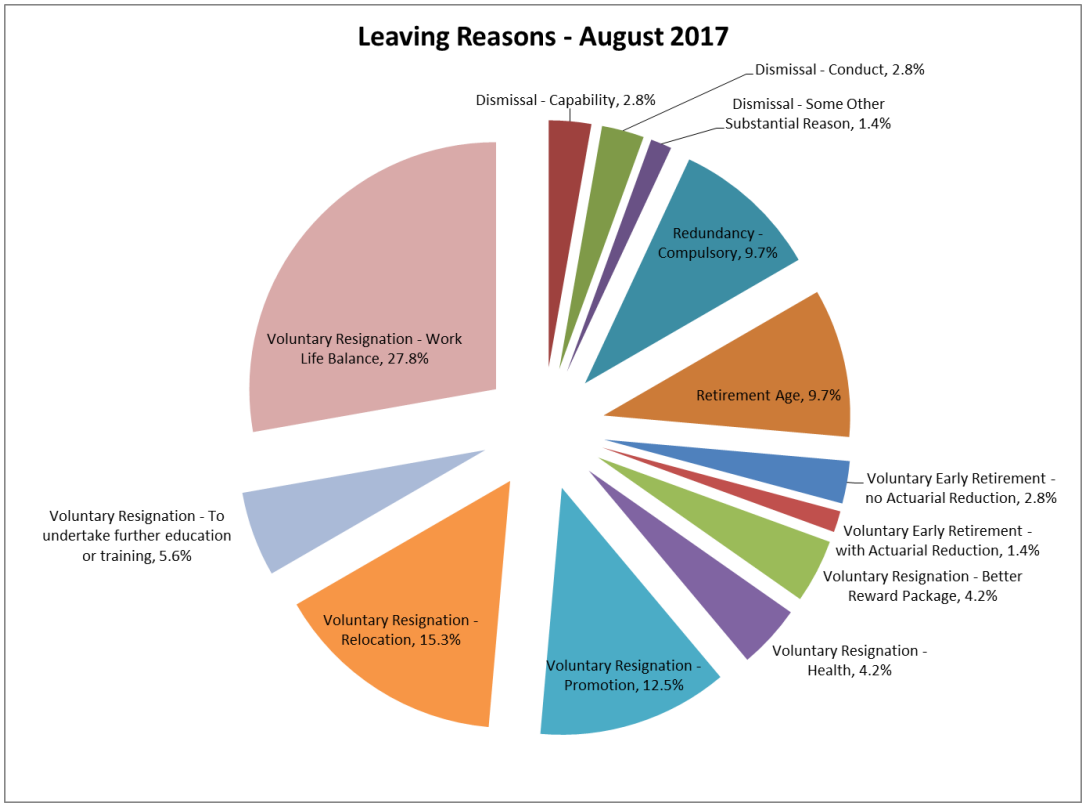


Leaving Reasons

3.6 There were 70 leavers in August 2017 compared to 59 in July 2017. There were 64 starters in August.

3.7 The figure below shows leaving reasons for August 2017. The largest number of leavers were those for work life balance reasons (27.8%). Staff voluntarily resigning because of relocation was in second place at 15.3%. In third place was voluntary resignation because of promotion at 12.5%. These top three stated reasons together constitute 55.6% of leavers.

Fig.4: Leaving reasons – August 2017



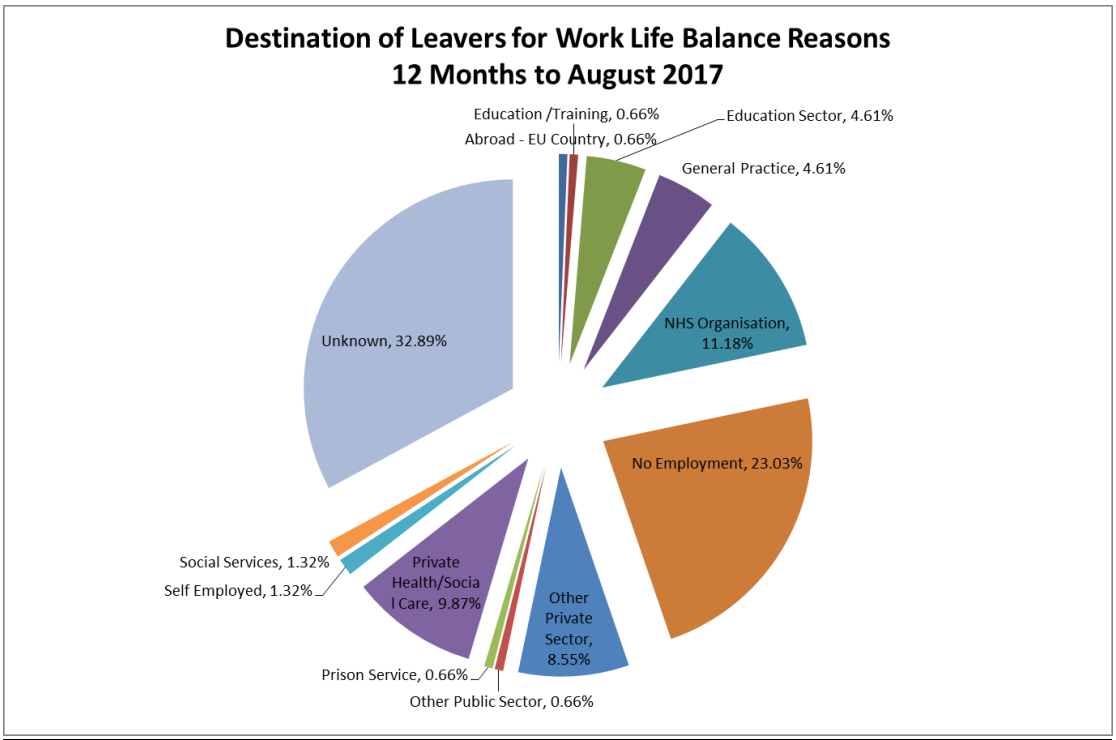
3.8 Looking at the trend over the year as a whole, Fig. 5 below shows the latest picture on leaving reasons over the past 12 months to August 2017. The figures shown represent the actual number of leavers. TUPE leavers are not included.

3.9 Resignation for work life balance reasons remains as the top reason with 152 leavers (up from 149 last month). This was followed by voluntary resignation for promotion reasons with 103 leavers (up from 99). In third place are leavers because of retirement age with 102 leavers (down from 106). If other forms of retirement are taken into account this increases to 134 leavers related to retirement (down from 139 last month). In fourth place is voluntary resignation for relocation reasons with 73 leavers (down from 74). Together these four reasons constitute 430 or 55.41% of leavers for the 12 months to June (462 or 59.54% if all forms of retirement are taken into account).

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

3.10 Fig. 6 below shows the destination of work life balance leavers during the year to August 2017. The top destination of leavers remains no employment at 23.03% of leavers (down from 24.2% last month). The second most popular destination for leavers was NHS organisations at 11.18% (down from 10.1%) followed by Private Health/Social Care at 9.87% (up from 10.1% from last month) and 8.55% other private sector providers (up from 8.05%). These top four destinations remain the same as last month. The Trust does not know the destination of 32.89% of work life balance leavers (up from 32.21% last month). Our Payroll provider SBS has been asked to ensure that data for destinations for leavers is recorded wherever possible.

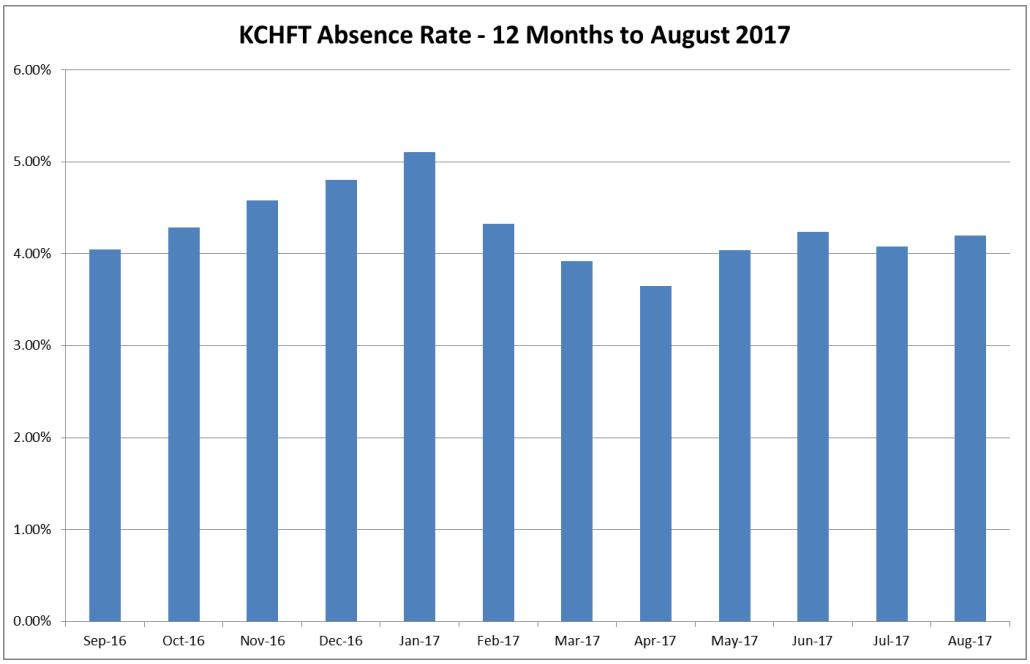
Fig.6: Destination of Leavers for Work Life Balance Reasons 12 months to August 2017



Sickness Absence

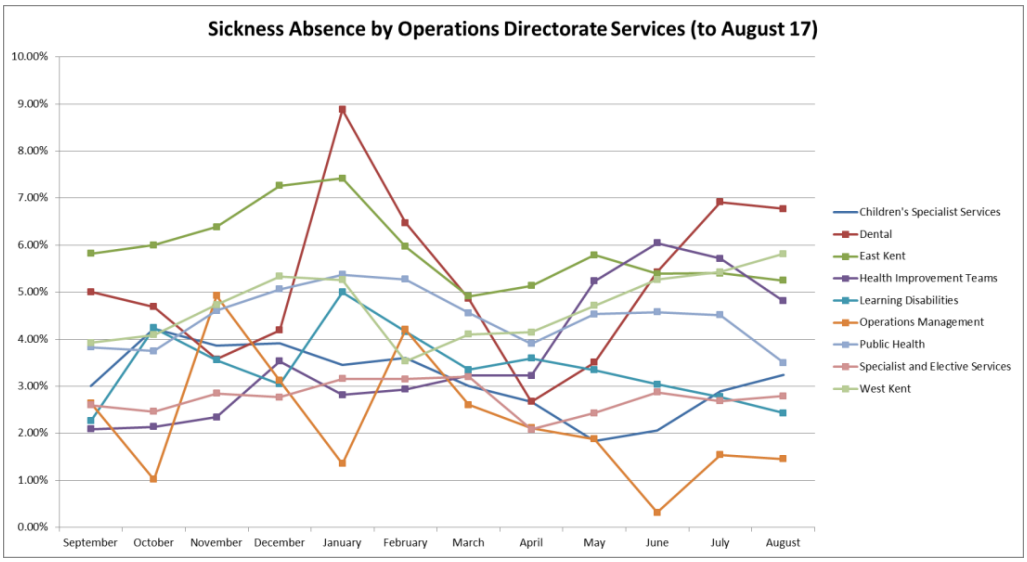
3.11 Sickness absence is rated amber for August 2017. Cumulative sickness absence for 2017/18 is 4.20% to date which is above the target of 3.90% (and down from 4.08% last month). Sickness absence performance for August 2017 alone was 4.27% (down from 4.08% for July 2017; this figure is coincidentally the same for cumulative and individual July performance). Fig 7 below shows the absence rate for each individual month during the past 12 months.

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



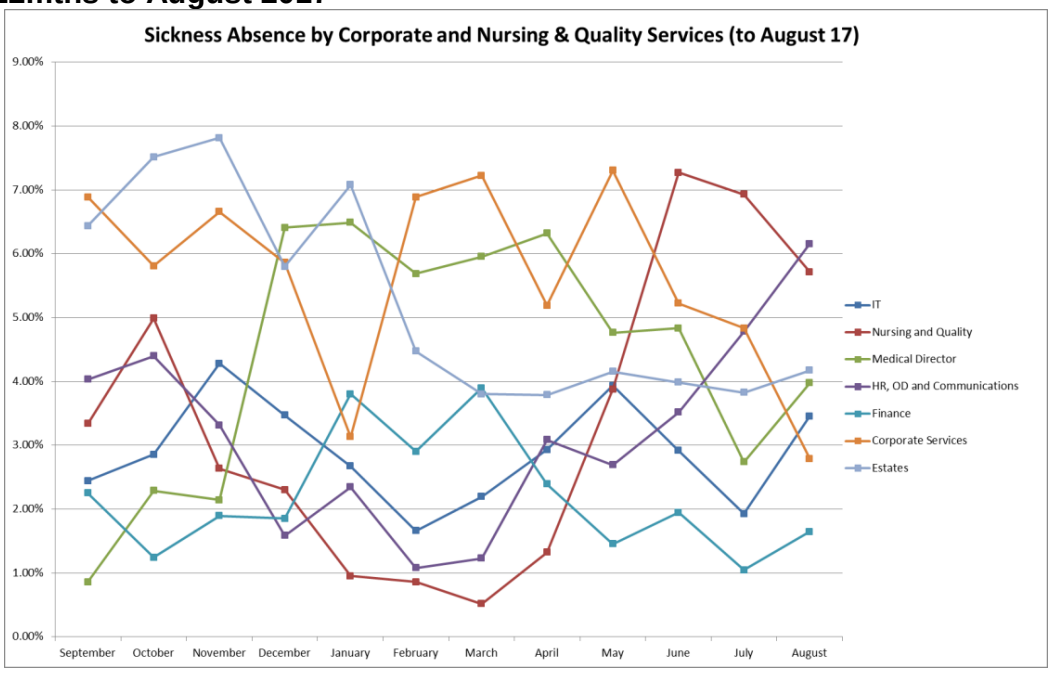
3.12 Fig 8. below shows sickness rates within the Operational Directorate. Dental had the highest sickness rate in August 2017 at 6.77%, down from 6.91% the previous month. West Kent had the second highest sickness rate at 5.81%, up from 5.42% in in July. Performance in the locality fell to 3.53% in February 2017 and has steadily increased since then. The third highest sickness rate was East Kent at 5.25%, down from 5.40% in July. Operations Management had the lowest sickness rate for August 2017 at 1.45%, followed by Learning Disabilities with 2.43%. The largest proportional increase in sickness was in Children's Specialist Services where sickness increased from 2.90% to 3.24% this month; this is the highest rate for the service in this financial year. The largest proportional fall was in Public Health with a decrease from 4.51% to 3.50%.

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



3.13 Fig.9 below shows sickness absence by corporate directorates and Nursing and Quality for August 2017. HR, OD and Comms had the highest sickness rate at 6.16%, up from 4.78% in July. This is the highest rate for the directorate in the past 12 months. The second highest sickness rate was in Nursing and Quality with a rate of 5.71%, down from 6.93% the previous month (and 7.27% in June). Third highest sickness was Estates with a rate of 4.17%, down from 3.82% the previous month. The highest proportional increase in sickness was in IT with an increase in the sickness rate from 1.93% last month to 3.45% in August. The largest proportional decrease was in Corporate Services where the rate in August 2017 was 2.79%, a fall from 4.83%.

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



Training Compliance

3.14 Training compliance is at 102.3% and is therefore rated green for August 2017 (this is up from 98.3% last month).

3.15 Data for this measure is reported with various topics included together in the one figure (an aggregated figure). Some of these topics are new requirements such as Dementia training and the Trust is required to train all staff by a future date. At August 2017 the Trust has trained more staff than it is required to at this point in the rollout of the new requirements; specifically these new requirements are Dementia (target 2020) and Prevent (target 2018). This has resulted in a figure above 100% as the number of trained staff for these topics has exceeded the target required.

3.16 Monthly targets are set for each topic and they are each calculated based on the number of staff in the target group each month (as this fluctuates with recruitment and internal moves within the Trust for example). Annual targets are not used because services raised the issue that the measure might be green for where they should be that month when overall performance was red and at the start of the year performance would also be red.

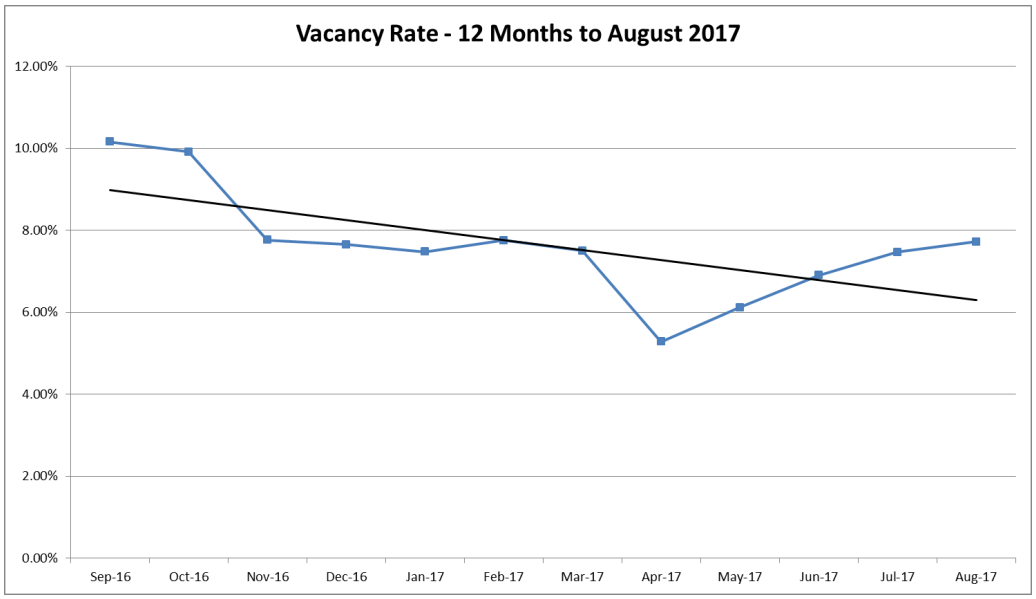
3.17 Areas of training rated amber are outlined below:

- **Client handling** has moved from green to amber in August 2017. There is a 0.6% drop which amounts to 13 people. It would have required three people to have completed the training to maintain green status. There were courses taking place in August that were cancelled due to under-subscription and which could have accommodated the training need. These had been through the under-subscribed course escalation process whereby staff are contacted if they are non-compliant and these courses have vacant seats. As well as cancelling courses, the Trust has run quite a few well below capacity.

Vacancies

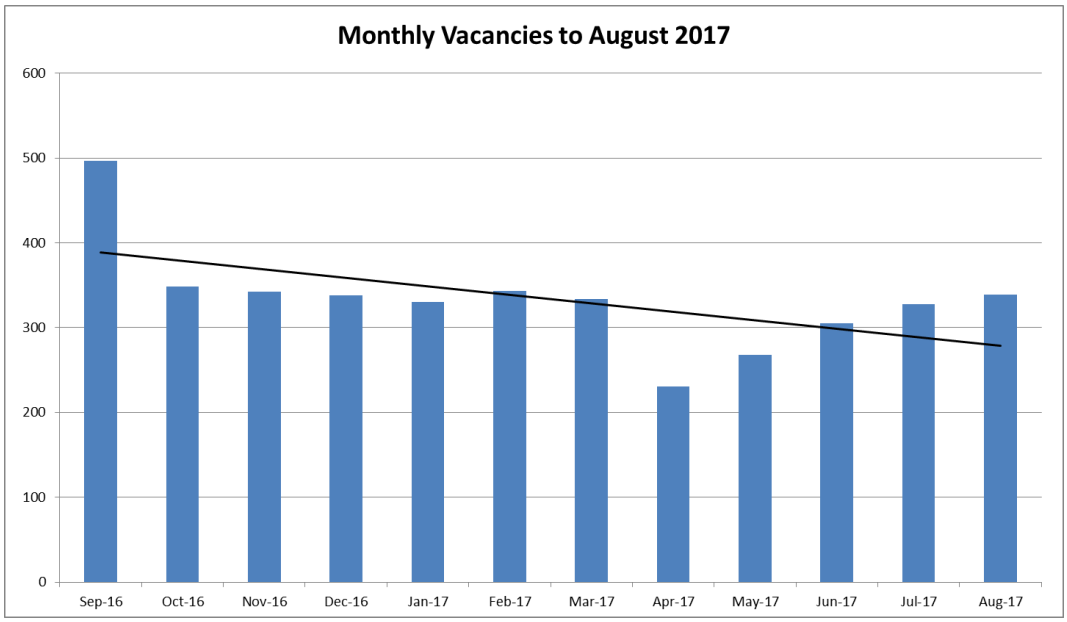
3.18 The vacancy rate for August 2017 is 7.72% compared to a target of 5.0%, which means performance has been rated as red this month. The rate has increased to 7.72% from 7.46% in July. August's figure is the highest rate for the past five months, having steadily increased from 5.28% in April 2017. Fig. 10 below shows performance over the past 12 months with a decrease in the rate during the latter part of 2016/17 (reducing to 7.50% in March 2017). This has been followed by the steady increase in the first part of 2017/18. Currently, the overall downward trend is still being maintained because of 2016/17 data.

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



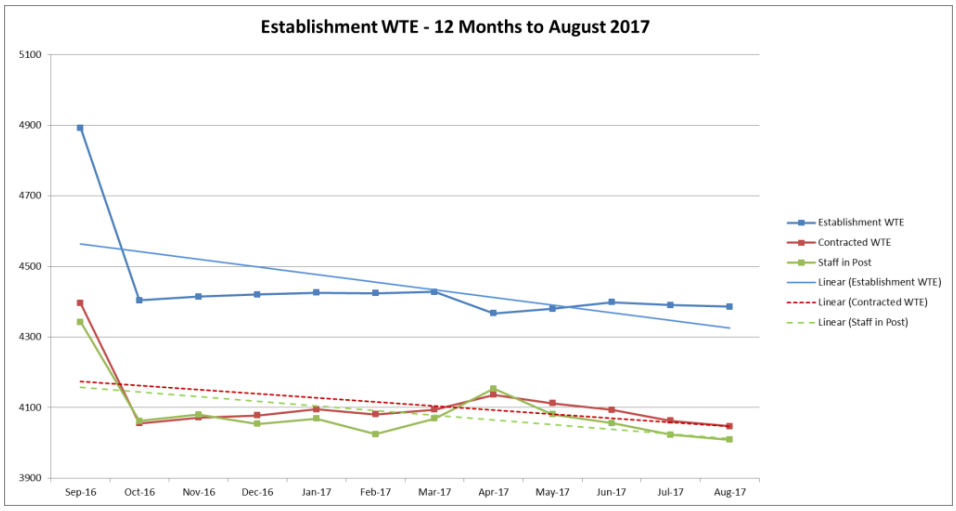
3.19 Fig. 11 below shows the number of vacancies has increased from 327.65 WTE in July to 338.69 WTE in August 2017.

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



3.20 Fig. 12 below shows there was a 4.61 WTE reduction in the establishment from 4390.66 WTE in July to 4386.05 WTE in August 2017. This is a 0.1% decrease. There was a 15.65 WTE (or 0.4%) reduction in contracted staff from 4063.01 WTE to 4047.36 WTE. With the reduction in contracted WTE proportionately greater than the reduction in establishment this has led to an increase in the vacancy rate of 0.26 percentage points (or 3.5%).

Fig. 12: Establishment: September 2016 to August 2017



3.21 Fig. 13 below shows the vacancy rates for different services. Four Directorates have vacancy rates above the Trust 5% target (Estates at 5.3%, Finance at 5.4%, HR, OD and Comms at 8.3% and Operations at 9.7%). Within the Operations Directorate the highest vacancy level is within West Kent which has a 15.7% vacancy rate. This is followed by Learning Disabilities with a 13.4% rate and Specialist and Elective Services with a 10.8% vacancy rate.

	Budget	Contracted	Vacancy	Rate
Corporate Services	**46.8**	**45.9**	**-0.9**	**-2.0%**
Corporate Assurance & Legal	5.2	6.2	1.0	19.2%
Corporate Services	30.2	27.9	-2.3	-7.6%
Executive Teams	11.4	11.8	0.4	3.3%
Estates	**216.3**	**204.7**	**-11.6**	**-5.3%**
Estates Management	28.5	26.3	-2.2	-7.6%
Hotel Services	168.7	161.9	-6.8	-4.0%
Site Overheads	19.1	16.5	-2.6	-13.5%
Finance Directorate	**94.3**	**89.2**	**-5.1**	**-5.4%**
Finance	70.1	68.0	-2.1	-3.0%
Performance & Business Intelligence	7.6	7.4	-0.2	-2.6%
Finance and IT Management	5.0	4.0	-1.0	-20.0%
Business Development and Service Improvement	11.6	9.9	-1.8	-15.1%
HR, OD & Communications	**126.0**	**115.5**	**-10.5**	**-8.3%**
Communication & Patient Engagement	14.6	13.3	-1.3	-8.7%
Human Resources	108.4	99.2	-9.2	-8.5%
Management of Human Resources	3.0	3.0	0.0	0.0%
IT	**121.3**	**121.9**	**0.6**	**0.5%**
IT	121.3	121.9	0.6	0.5%
Medical Director	**50.5**	**50.0**	**-0.4**	**-0.8%**
Medical Director	19.3	15.4	-3.9	-20.4%
Medicines Management	31.2	34.7	3.5	11.3%
Nursing & Quality	**59.5**	**57.2**	**-2.3**	**-3.9%**
Clinical Governance	10.4	9.4	-0.9	-8.9%
Infection Prevention & Control	3.6	3.6	0.0	0.0%
Safeguarding	21.3	20.0	-1.3	-6.3%
Professional Standards.	6.9	6.9	0.0	0.0%
Practice & Quality Excellence	17.4	17.3	0.0	-0.2%
Operations	**3725.4**	**3362.8**	**-362.5**	**-9.7%**
Childrens Specialist Services	499.9	463.3	-36.6	-7.3%
Dental	219.2	212.6	-6.6	-3.0%
East Kent	907.3	816.1	-91.2	-10.1%
Health Improvement Teams	101.2	97.0	-4.3	-4.2%
Learning Disabilities	130.4	112.9	-17.5	-13.4%
Operations Management	12.6	11.4	-1.2	-9.5%
Public Health	731.0	675.8	-55.2	-7.5%
Specialist & Elective Services	542.4	483.7	-58.7	-10.8%
West Kent	581.3	490.0	-91.3	-15.7%
Reserves	**-54.0**	**0.0**	**54.0**	**-100.0%**
Provisions	0.0	0.0	0.0	0.0
Reserves	-54.0	0.0	54.0	-100.0%
Grand Total	**4386.1**	**4047.4**	**-338.7**	**-7.7%**

3.22 Looking at the operational area with the highest vacancy level, West Kent, the staffing area vacancy levels are shown below. Medical and Dental has the highest rate at 43.4% followed by Qualified Nursing and Midwifery staff at 17.4%.

	Budget	Contracted	Vacancy	Rate
Administration and Estates	75.14	64.81	-10.33	-13.7%
Healthcare Assistants and Other Support Staff	179.2	149.22	-29.98	-16.7%
Managers and Senior Managers	12	11.88	-0.12	-1.0%
Medical and Dental	9.1	5.15	-3.95	-43.4%
Qualified Nursing, Midwifery and Health Visiting	263.35	217.52	-45.83	-17.4%
Scientific, Therapeutic and Technical	44.15	41.42	-2.73	-6.2%
Grand Total	**581.3**	**490**	**-91.3**	**-15.7%**

Temporary Staff Usage

3.23 The table below shows shifts for August 2017 filled by agencies. The number of shifts filled with framework agencies compliant with the price cap is 87.9%, down from 91.8% last month and rated red. The measure becomes amber at 95%.

	Framework Agency		Non Framework Agency		Total
	Price Cap Breach	Price Cap Compliant	Price Cap Breach	Price Cap Compliant	
Number of shifts	93	1092	57	0	1242
Percentage	7.5%	87.9%	4.6%	0.0%	100.0%

3.24 Performance against this measure has seen a steady downward trend since April 2017 but is within the context of significant upward performance achieved on this measure during the past year from 34.48% in April 2016 to 95.05% in April 2017 (a 176% increase).

3.25 Whilst performance has proportionately decreased, the number of actual shifts filled which were price cap compliant has increased from 1046 last month to 1092 this month, a 4.4% increase in shifts. The number of shifts filled through Framework Agencies with a price cap breach was 93 compared to 43 last month (a 116% increase). Therefore, as well as the 87.9% of shifts compliant with price caps, a further 7.5% of shifts were booked with framework agencies who do not meet the price cap. In August 2017 a total of 95.4% of shifts were therefore filled using framework agencies, a slight decrease from 95.6% last month.

3.26 This measure has a target of 100%. As performance is now on the approach towards this, inevitably there will be some fluctuations in performance as we seek to weed out the remaining shifts filled by other means; these will be the harder areas to reduce.

3.27 The remainder of shifts were filled using non framework agencies which do not (4.6%) adhere to the price cap. This is an increase from 4.4% the previous month.

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

3.29 Fig. 13 on the following page shows agency spend for August 2017 compared to data available for last year in advance of a trajectory being established for

2017/18. For Month 5 agency spend is £331,255. This is 45.80% of the comparative data target (including the contingency fund).

Fig. 13. Agency spend for August 2017

Directorate and Locality	External Agency and Locum Expenditure M5 (£)	Trajectory M5 (£)	Adverse or Favourable Variance to Trajectory
Operations	318,614	453,147	F
Childrens Specialist Services	36,289	70,744	F
Audiology Service	0	173	F
East Sussex Childrens Integrated Therapy Services (CITS)	0	12,304	F
Integrated Therapy and Care Services	10,489	10,776	F
Kent Looked After Children Service	0	0	F
Paediatrics Service	25,800	27,691	F
Specialist Community Childrens Nursing Services	0	3,061	F
Universal SLT Services	0	16,738	F
Dental	0	1,408	F
East Kent	95,099	188,094	F
Ashford Community Hospitals	1,145	794	A
Canterbury Community Hospitals	36,284	25,923	A
SKC Community Hospitals	12,574	10,964	A
Thanet Community Hospitals	9,826	22,179	F
East Kent Management	-3,385	24,362	F
Ashford Intermediate Care	0	10,340	F
Canterbury Intermediate Care	21,852	21,857	F
Thanet Intermediate Care	0	12,322	F
SKC Intermediate Care	9,400	24,628	F
Ashford LTC	2,312	7,148	F
Canterbury LTC	4,455	7,723	F
SKC LTC	4,542	16,957	F
Thanet LTC	0	2,750	F
East Kent ICT & Community Hospitals Management	0	1	F
Management of SKC & Thanet LTC	0	68	F
SKC MIU	0	79	F
Integrated Discharge Team	-3,906	0	F
Health Improvement Teams	6,320	111	A
Learning Disabilities	4,377	13	A
North Kent	45	0	A
Operations Management	0	302	F
Public Health	-163	6,180	F
East Kent Sexual Health Service	0	31	F
Health Visiting	-163	4,023	F
Immunisations – Kent	0	731	F
Management of Public Health Services	0	769	F
Management of Sexual Health	0	194	F
Medway Sexual Health Services	0	63	F
North Kent Sexual Health Services	0	16	F
School Nursing	0	354	F
Specialist & Elective Services	5,665	19,639	F
West Kent	170,980	166,656	A
Community Hospitals West Kent	66,901	76,114	F
Add Additional Ward - Primrose Ward	5,600	5,600	F
Intermediate Care Services West Kent	68,030	61,993	A
Long Term Service West Kent	18,164	15,343	A
Management of West Kent Locality (ACS)		3,004	F
Minor Injury Units West Kent	12,284	4,601	A
Corporate Services	5,800	819	A
Estates	3,604	13,576	F
Finance	1,612	880	A
HR, OD & Communications	0	961	F
IT	3,210	3,154	A
Medical Director	-133	0	F
Nursing & Quality	160	184	F
Reserves	-1,612	0	F
Total Directorate Position	**331,255**	**472,722**	F
Contingency		**250,611**	F
Total Directorate Position/Trajectory based on last year Trajectory	**331,255**	**723,333**	F

4. Conclusions

4.1 Whilst the position on turnover and absence has improved this month, both measures need continued attention. The vacancy rate is increasing month on month during this financial year, now at 7.7% having been at 5.3% at the start of the year. Over the past four months the number of starters has been below the number of leavers and this has impacted headcount which has reduced from 4,977 to 4,877 currently.

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

September 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.7
Subject:	Mortality Review Policy
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	X	Assurance	☐

Report Summary
The policy was presented to the Quality Committee at its September 2017 meeting. Comments from the Quality Committee and the Mortality Surveillance Group have been taken into account.

Proposals and /or Recommendations
The Board is asked to approve the Mortality Review Policy.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
Yes and is available through the Engagement Team.

Dr Sarah Phillips, Medical Director	Tel: 016211 211900
	Email:

Mortality Review Policy

Document Reference No.	
Status	Draft
Version Number	8.2
Replacing/Superseded policy or documents	This is a new policy
Number of Pages	25
Target audience/applicable to	Clinical Staff and Managers, Trust Board and Directors.
Author	Dr Sarah Phillips, Medical Director and Sonia Kinnair, Mortality Review Project Lead
Acknowledgements	Dr Arokia Antonysamy, Deputy Medical Director and Claire Fletcher, Medical Directorate Development Lead
Contact Point for Queries	Medical Directorate 01622 211923
Date Ratified	September 2017
Date of Implementation/distribution	
Circulation	Policy Dissemination/Intranet
Review date	March 2018
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EXECUTIVE SUMMARY

This policy gives guidance on how the Trust responds to and learns from deaths of patients who die under its management and care.

The policy covers the processes involved in responding to the death of a patient and its approach to undertaking case record reviews. It describes categories and the selection of deaths in scope for case record review. It also covers training and monitoring of the processes described. The policy is based on national guidance, and aims to take learning from deaths in different settings, including inpatient deaths (community hospitals) and other community settings.

Scope and purpose of policy

This policy has been developed following the recommendations made by the National Guidance on Learning from Deaths (2017). Other national publications have also been used to guide the content of this policy. The scope of reviews will include all community hospital inpatient deaths, all deaths in the community under the care of KCHFT's 'Home Treatment Service', any patients who die under our care with serious mental health needs, all children and all patients with learning disability. With regard to the deaths of patients with a learning disability, the independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015 (Mazars report 2015) reported key findings and recommendations on improving mortality surveillance. The Care Quality Commission (CQC) in July 2016 commenced a process specifically to identify 'How can we ensure that NHS trusts have robust and effective mechanisms in place to investigate the deaths of patients/service users that allows learning to be quickly embedded to improve care within organisations and for the system as a whole?' In response to this, the National Quality Board published the National Guidance on Learning from Deaths in March 2017. In light of these publications, KCHFT wanted to ensure that the care received by people prior to death is of the highest standard. This policy was therefore developed to provide guidance to clinicians and managers on how to review the care given to the patient before death and to the family/carer after death. The policy also describes how we will identify and share learning with the wider Trust from the care provided to our patients.

With regard to the deaths of children, all child (under 18) deaths are investigated by a multi-discipline group involving Kent Safeguarding Children Board (KSCB). This provides a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child giving an overview of all child deaths in the KSCB area. Learning from all deaths including child deaths and patients with learning disability will be shared with the Mortality Surveillance Group (MSG). The process for reviewing child deaths and those with learning disability precede this policy and will continue, but the MSG within KCHFT will review all learning.
Perinatal or maternal deaths are not applicable to our trust. Whilst we are not a provider of mental health services, should any deaths take place where the patient had a diagnosis of severe mental health needs, the case will be reviewed. Where the review of a death is led by another organisation KCHFT will participate in the review as needed and share any learning via the MSG.

The policy will be reviewed in six months to assess the quality of the process and to consider increasing the scope of deaths reviewed. In time it is hoped that the Trust will work with GP's to include in scope the review of end of life care patients and other community deaths to capture the whole picture of care.

Governance Arrangements

Directorate or Function Governance Group responsible for developing document	Medical Directorate
Circulation group	Intranet, Policy Distribution
Authorised/Ratified by Governance or Function Group	Quality Committee
Authorised/Ratified On	September 2017
Review Date	Early review at 6 months then 3 years from ratification
Review criteria	This document will be reviewed prior to review date if a legislative change or other event dictates.

Key References

National Guidance on Learning from Deaths, National Quality Board
Implementing the Learning from Deaths framework: key requirements for trust boards
Using the Structured Judgement Review Method, Royal College of Physicians

Related Policies/Procedures

These are key policy documents upon which the policy relies for further guidance and best practice.

Title	Reference
CARE AFTER DEATH POLICY	QC015
END OF LIFE CARE POLICY	
VERIFICATION OF DEATH POLICY	QC011
DETERIORATING PATIENT POLICY	QC004
SERIOUS INCIDENTS POLICY INCLUDING NEVER EVENTS	QCS027
TRANSFER OF CARE	QC003
DUTY OF CANDOUR	

Document Tracking Sheet

Version	Status	Date	Issued to/Approved by	Comments/Summary of Changes

Summary of Changes

CONTENTS

1.0 INTRODUCTION

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 aims 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 oversee this process and provide assurance to the Trust Board that patient mortality review is appropriately undertaken and learning acted upon. As previously mentioned, the independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015 (Mazars report 2015) reported key findings and recommendations on improving mortality surveillance. The Care Quality Commission (CQC) in July 2016 commenced a process specifically to identify 'How can we ensure that NHS trusts have robust and effective mechanisms in place to investigate the deaths of patients/service users that allows learning to be quickly embedded to improve care within organisations and for the system as a whole?' In response to this, the National Quality Board published the National Guidance on Learning from Deaths in March 2017. This policy seeks to address the guidance given in these publications. The focus is intended to be on meaningful learning and sharing ways to improve care. The process of review is described in this policy. It defines the deaths "in scope" for review and how relatives and carers are invited to contribute.

Deaths in Scope for Review

Processes for review of deaths in community settings are not nationally well defined, and this policy seeks to focus reviews of deaths on learning whilst introducing a systematic approach. This policy comes into effect from September 2017 and all deaths 'in scope' will be reviewed by using the adapted Prism 2 mortality review tool which has been further modified to include consideration of serious incidents and complaints. This scope includes all inpatient deaths in community hospitals, all deaths in the community under the care of KCHFT's 'Home Treatment Service' and any patients who die under our care with serious mental health needs. As described above, all children and all patients with learning disability will be reviewed by separate processes and this policy describes how the learning is shared. This would include all patients in community hospitals and the Home Treatment Service where a complaint or serious incident has been raised in the last 8 weeks before death. Should another organisation review a death and suggest KCHFT reviews its care, a minimum of a Level 2 mortality review will take place. Any learning shared from another organisation will be reviewed by the MSG and shared more widely as appropriate. Learning from reviews that reveals opportunities for learning for other organisations will be also be shared with that organisation.

In addition to the planned reviews of this mortality review policy, a review will need to be undertaken when the role of Medical Examiners is established.

1.1 Equality, Diversity and Inclusion

The Death by indifference report (Mencap, 2007) identified stories of six people with a learning disability who died unnecessarily. Macmillan (2003) identified four key barriers

that restrict access to services: physical, professional, emotional and social, cultural or religious/spiritual. For people with a learning disability, specific knowledge and attitudinal beliefs around the learning disability itself are important features that may impinge access to end of life care.

People with a learning disability are often lost behind barriers that are compounded to make access to end-of-life care and support difficult. Such barriers may indeed be worsened if you are an older person with a learning disability (Jenkins, 2005) experiencing, for example, dementia (Frey, 2006). People with a learning disability are a vulnerable population generally, but particularly so when it comes to loss, dying, death and bereavement (Read and Elliott, 2003).Communication and the provision of information are essential tools of good quality care. All patients, carers and staff should be given full assistance to ensure understanding. This assistance will take many forms and media. These principles should be enshrined in all formal documents.

1.2 Kent Community Health Foundation Trust is committed to ensuring that patients whose first language is not English receive the information they need and are able to communicate appropriately with healthcare staff. It is not appropriate to use relatives to interpret for family members who do not speak English. There is an interpreter service available and staff should be aware of how to access this service.

1.3 The privacy and dignity rights of patients must be observed whilst enforcing any care standards e.g. providing same sex carers for those who request it. (Refer to Privacy and Dignity Policy). All forms of communication (e.g. sign language, visual aids or other means) which ensures the patient understands should be considered. This includes people who may have a pre-existing or co-existing specific communication difficulty such as aphasia. Publications in different languages or different formats can be produced through the Communications and Engagement Team and a translation service should be made available where required.

1.4 Staff must be aware of personal responsibilities under Equality legislation, given that there is a corporate and individual responsibility to comply with Equality legislation. This also applies to contractors when engaged by the Trust, for NHS business. Differing tools should be utilised to assess and manage an individual's needs/wishes dependent on their needs. For example recognised pain tools should be utilised when planning care and suitable tools for learning disability, dementia etc. such as DISDAT should be utilised.

1.5 **Equality Analysis**

1.6 Kent Community Healthcare NHS Foundation Trust is committed to promoting and championing a culture of diversity, fairness and equality for all our staff, patients, service users and their families, as well as members of the public.

1.7 Understanding of how policy decisions, behaviour and services can impact on people with 'protected characteristics' under the Equality Act 2010 is key to ensuring quality and productive environments for patient care and also our workforce.

1.8 Protected Characteristics under the Equality Act 2010 are:

- Race
- Disability
- Sex
- Religion or belief
- Sexual orientation (being lesbian, gay or bisexual)
- Age
- Gender Re-assignment
- Pregnancy and maternity
- Marriage and civil partnership

1.9 To ensure full involvement and understanding of the patient and their family in the options and decision making process about their care and treatment, all forms of communication (e.g. sign language, visual aids, interpreting and translation, or other means) should be considered and made available if required. Advice should be sought from specialist teams as appropriate such as the speech and language therapy team.

1.10 The privacy and dignity (human rights) of patients must be considered alongside any care standards, in recognition of the fundamental link between good health care and equality.

1.11 It is also important for the Trust to look to the future and ensure that it remains equitable to all, by considering elements that may be outside current legislation, such as financial deprivation, educational discrimination, class exclusion and many other elements.

2.0 ROLES AND RESPONSIBILITIES

2.1 Kent Community Health NHS Foundation Trust is committed to providing safe and effective care to their patients.

2.2 Organisational Duties and Responsibilities

- The Trust Board has overall responsibility for ensuring compliance with all legal and statutory duties, along with best practice including having an overview of this mortality review process and has knowledge of the learning that emerges from the reviews that drive improvements in care.
- The Chief Executive has ultimate responsibility for ensuring that the Trust has robust policies and procedures in place for reviewing all incidents of mortality.
- The Chairperson of KCHFT is responsible for ensuring that there is an identified non-executive lead for overseeing the implementation of the National Guidance.
- The Medical Director is the executive lead and is responsible for ensuring that there is a comprehensive mortality policy, ensuring that deaths are reviewed appropriately and where needed actions are taken and learning disseminated.

- Community Services Directors are responsible for ensuring there are arrangements for reviewing patient mortality and for working with Ward Managers to ensure reviews are completed
- Ward Managers must make arrangements for case notes to be available when a case review is allocated to them. Ward Managers are responsible and should lead the MDT Peer Mortality Review Meetings where necessary for cases requiring review. The MDT Lead will be from a different hospital than the one where the death took place for inpatients deaths.
- The Mortality Review Project Lead is responsible for identifying the MDT lead within one working day of the death
- All healthcare professionals should be involved with the mortality review process. This involvement could range from simply being aware of the outcome of such reviews in so far as they affect their area of practice to full involvement in the production of reviews and implementation of recommendations.

2.3 Family and Carer Involvement

- All bereaved families will receive written information after the death of a loved one that sign-posts them to sources of support. It also invites them to contact the Trust if they have any feedback they would like to give about the care their loved one received. At the time of case record review any feedback from carers and families will be included in the review.
- When the case record review process highlights a more in depth investigation would be beneficial,(Level 3) we will proactively invite involvement of the deceased person's family and carers.
- We will do this by contacting family and carers, to compassionately inform them that the investigation is taking place, what to expect, how they can be involved and the reasons for the investigation.
- This includes giving bereaved families and carers the opportunity to provide positive feedback, ask questions or share concerns in relation to the quality of care received. We will listen, we will note their comments or concerns, we will ask for their input on some specific areas of their experience. We may ask to meet with them or talk to them by phone. This is to make sure that the family and carers are at the centre of the review of the care of their loved one if they wish to be involved.

2.4 Death of a patient with a Learning Disability

Each death of a person with a learning disability receiving KCHFT service must be notified to LeDeR Programme Team (by telephone 0300 7774 774 directly to a member of the central LeDeR programme team, or via the Programme's secure web-based portal, which can be accessed through the LeDeR website or via the following link:
http://www.bristol.ac.uk/sps/leder/notify-a-death/

Once confirmed the death is notified to the Local Area Contact within the CCG (where the person was resident) and then allocated to a Local Reviewer. An Initial Review is completed for all deaths of people with learning disabilities that meet the inclusion criteria for the LeDeR programme, i.e. that the person is aged 4 years or over and has learning disabilities. All information regarding

the Initial Review is accessed, edited and completed via the secure web based portal of the LeDeR Review System.

The Local Reviewer will make a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated. Once the mortality review (Intial Review/Multidisciplinary) has been completed this is shared with the Local Area Contact within the CCG who will forward to the LeDeR Team for quality assurance. Each mortality review (Initial Review or Multidisciplinary review) is presented by the Local Area Contact at the Kent and Medway Strategy Meeting. The review and findings, themes, trends, best practice actions, are then disseminated for review at the Trusts Mortality Surveillance Group

2.4 **Mortality Surveillance Group** (MSG)

MSG oversees process of the mortality review, scrutinizes learning from deaths, triangulates shared learning, good practice and concerns. An exception report is sent to the Clinical Effectiveness Group (CEG) which in turn provides assurance to the Quality Committee and Trust Board.

Any relevant shared learning from the KSCB reviews of children or the SAB (Safeguarding Adult Board) adults reviews will be included at the MSG when submitted by the Safeguarding Team.

The MSG will offer advice on changes in external guidance, training and development or any other improvements based on Mortality Review Process.

The MSG will oversee appropriate training for the delivery of the mortality review process as laid out in this policy. Specifically all MDT leads will take part in an initial workshop within 4 weeks of the start date of this policy to familiarise themselves with the process and policy.

Training will also cover the role of the Mortality Review Project Lead and the designated in the mortality review process. The patient engagement team will receive training on the new process and policy.

The MSG will provide a quarterly report to the trust board in January, April, July and October 2018. This report will be a highlight/exception report including a summary of learning along with total number of deaths in scope, total number of deaths reviewed and level of the reviews, number of investigations that came from them. Number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care. Themes and issues identified from review and investigation (including examples of good practice) Actions taken in response, actions planned and an assessment of the impact of actions taken. This report will also include a quarterly report from Dr Foster benchmarking data.

3.0 Mortality Review Process

When a death occurs in one of the Trust's community hospitals a Datix notification will alert the Mortality Review Project Lead, who will inform (within one working day)

the MDT lead to make arrangements for the MDT meeting to take place. The MDT lead will usually be a ward manager or team lead from a different hospital to the one where the death occurred if an inpatient. The patient's case notes will be collected/sent to the appropriate location for the review within 3 working days of the death. The MDT will consist of a Ward Manager, Senior Clinician (usually Geriatrician or other Doctor) and a member of staff with another discipline (such as a therapist).

The MDT will then review the patients case notes and complete a level 1 review, where required a level 2 review will also be completed. If at any stage the MDT decide that the case requires a level 3 review (investigation) the MDT Lead will contact the Patient Safety Team. In line with Trust policy all unexpected deaths will receive an initial review to clarify if a serious incident has occurred.

When complete the mortality review information will be collated by the Mortality Review Project Lead for the MSG dashboard and to collate lessons learnt and the actions that have been identified.

If an external organisation carries out a mortality review of a patient that was on the KCHFT caseload and shares any learning, this will be shared with the Mortality Surveillance Group.

4.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

Monitoring Table:

Policy Lead	Element(s) to be monitoring	Ensuring Implementation	Frequency of monitoring	Reporting arrangements
Medical Director or Deputy Medical Director	Deaths within community hospitals	Dr Foster benchmarking	Monthly	Report to Mortality Surveillance Group
Medical Director or Deputy Medical Director	How many deaths have takent place, what proportion have been reviewed at what level, number of expected and unexpected deaths	Datix reporting and Dashboard	Monthly	Dashboard to MSG and CEG
Medical Director or Deputy Medical Director	Completed actions from reviews	Action plan monitoring	Monthly	Spreadsheet to MSG and CEG

5.0 EXCEPTIONS

There are no exceptions for this policy.

6.0 REFERENCES

Mazars Report (2015)
National Guidance on Learning from Deaths, National Quality Board.
Learning Disabilities Mortality Review (LeDeR) Programme
Implementing the learning from Deaths framework: key requirements for trust boards

Appendix 1

Mortality Review Form - Level One

To be completed within seven days after death

COMPLETE FOR ALL DEATHS

Patient Information

First Name:	
Last Name:	
Date of Birth	
Date of Death	
Age at death (years)	
NHS Number	
Ethnicity	
Sex M/F	

Community Hospital Death

Location of Death:	
Length of stay (days):	

Where was the patient admitted from:

- Patients home ☐
- Nursing or residential home ☐
- Acute Hospital ☐
- Other

Community Death

Location of Death:	
Date of referral to service:	

Did the patient have a severe mental illness? Yes ☐ No ☐

Did the patient have a diagnosis of a learning disability? Yes ☐ No ☐

If yes, please inform the LeDeR lead by contacting 0300 777 4774 or https://www.bris.ac.uk/sps/leder/notification-system/

Mortality Review Form - Level One (continued)

COMPLETE FOR ALL DEATHS

1. Did the patient have confusion/memory problems at any point in their hospital stay/ while on case load?

   ☐ Yes ☐ No

2. If yes, was a diagnosis of the confusion/memory problems established? Please tick

   ☐ No diagnosis of type of confusion/memory problems apparent

   ☐ Dementia alone

   ☐ Delirium alone

   ☐ Delirium superimposed on dementia

   Other type of confusion/memory problems please specify

3. Patient condition immediately prior to the illness that led to this admission/referral. Please select

   ☐ Fully independent

   ☐ Independent in personal care, but needing help with other activities of daily living
   ☐ Dependent on others for personal care (washing, dressing, eating etc)

   ☐ Unable to determine; no relevant information in notes (direct or implied)

4. If transferred from another hospital was SBAR received and appropriate reason for transfer given?

   ☐Yes ☐No ☐N/A (Community referral)

5. Was a completed NEWS sheet received with the patient that had been completed within 30 minutes of the transfer?
   ☐Yes ☐No ☐N/A (not transferred from hospital)

6. Were the family/carer asked whether they had any questions/concerns with the care provided?
   ☐Yes ☐No

7. Was there a DNA CPR in place? ☐ Yes ☐ No
8. When was the DNA CPR last reviewed? DD/MM/YYYY ☐ Not reviewed

9. Is there evidence that the family/carer has been given the bereavement leaflet?

   ☐ Yes ☐ No ☐ N/A no family/carer known

Mortality Review Form - Level One (continued)

1. A problem in healthcare is defined as **'any point where the patient's healthcare fell below an acceptable standard and led to harm'**. Considering all that you know about this patient's admission, were there any problems in healthcare (including any problems before admission/referral)

   ☐ No evidence of problems in healthcare
   ➡ please go to the Overall Quality of Care Final Section
   ☐ Some evidence of problem/s in healthcare
   ➡ please complete the next question

2. In your judgement, is there some evidence that the patient's death was avoidable if the problem/s in healthcare had not occurred?

   ☐ No, death was definitely not avoidable
   ➡ please go to the Overall Quality of Care Final Section

   ☐ At least slight evidence the death may have been avoidable
   ➡ Please complete a level 2 review

Mortality Review Form – Level Two

Detailed review of problems in healthcare

Please provide information on the following areas, including points where there were problems in healthcare. Please state what happened and what should have happened.

Significant Medical History:

Medication:

Actions taken from observations:

Mortality Review Form - Level Two (continued)

After reviewing this case in detail, please rate the strength of evidence for the avoidability of the death:

☐ 2 Slight evidence for avoidability

☐ 3 Possibly avoidable but not very likely, less than 50-50 but close call

☐ 4 Probably avoidable, more than 50-50 but close call

☐ 5 Strong evidence for avoidability

☐ 6 Definitely avoidable

Please record reasons justifying the judgement you have made

Mortality Review Form – Level Three

Level 3 – Are there any additional concerns that the team feel should be further investigated/possible serious incident? If so please contact the Serious Incident Team via kchft.SeriousIncident@nhs.net ☐ Yes ☐ No

Mortality Review Form – Level One and Two

COMPLETE FOR ALL DEATHS

Overall Quality of Care

General Quality of Care and End of Life Care

Considering all that you know about this patients admission, how would you rate the **overall quality of healthcare** received by the patient from this trust? This question recognises that a problem in care causing patient harm can occur against a backdrop of overall good quality care, and the converse, a patient may experience poor overall quality of care without obvious harm. For this question, do not consider healthcare prior to the admission that ended in the patient's death or give detail of a specific problem in care causing harm, which were entered in Part C.

☐ Excellent
☐ Good
☐ Adequate
☐ Poor
☐ Very poor

End of Life Care

If the patient was recognised at high risk of dying (whether this was days or hours before death) OR, for patients who were not recognised as at high risk of dying, the last 48 hours of their life.

1. Was the patient subject to any intrusive or invasive procedures that were **not** in their best interest at the end of life?
   ☐ Yes
   ☐ No
   ☐ Unable to determine

2. Was there evidence of discussion of the end of life care with family/friends/carers?

   ☐ Yes, evidence of discussion
   ☐ No, discussion appeared appropriate and feasible, but no evidence it took place
   ☐ Not appropriate/not feasible to discuss with family/friends/carers

How adequate were the records in providing information to enable judgements of problems in care?

- ☐ Medical records were adequate to make a reasonable judgement
- ☐ Some deficiencies in the records (specify)
- ☐ Major deficiencies (specify)
- ☐ Severe deficiencies, impossible to make judgements about problems in care

Please use this space to specify any deficiencies in the medical records

Area identified	Best Practice	Lessons learnt

Details of those involved in the review (minimum of 3 people)			
Name	**Signature**	**Designation**	**Base/Hospital**
Total time taken to complete review (minutes)?			

Mortality Review Action Plan – complete for all deaths

No.	Identified Issue/ Area of Concern	Action required (what is required and who is involved)	Responsible person for action	Date to be completed by	Progress
1					
2					
3					
4					
5					
6					

Adapted from Prism validated review tool

Appendix 2

Mortality Review Process Flowchart

Day of death

- Ward staff record the incident on to Datix
- Datix notification goes to the Mortality Project Review Lead
- The MDT Lead, Community Services Directors PA's and the project review Lead (if an unexpected death the datix notification will also go to the Serious Incident team to establish if the case needs to be reviewed as a serious incident or not)

Within seven days of death

- The MDT Lead (Ward Manager or HTS staff) selects location for MDT Peer Review and requests patient case notes to be send to selected location within 3 working days from the patients death
- The MDT Lead will select the other members for the peer review to include a clinician and another disipline. (eg. therapist from the hospital concerned)
- The MDT Peer Review Meeting takes place within seven days of patients death

MDT Peer Review Meeting

- MDT review the case notes and complete level 1 of the mortality review , dependant on the decision made by the team a level 2 in-depth review will then be completed if any evidence of problems in healthcare are identified.
- If the MDT decide a level 3 investigation is required they will contact the Serious Incident Team that day (IF NOT ALREADY IDENTIFIED AT TIME OF DEATH)

Within 30 days of death

- The findings and actions from the MDT Peer Review meeting are shared with the hospital/ward concerned in departmental quality meetings
- Any completed SI/RCA investigation is provided to the MSG for shared learning

Mortality Surveillance Group Meeting

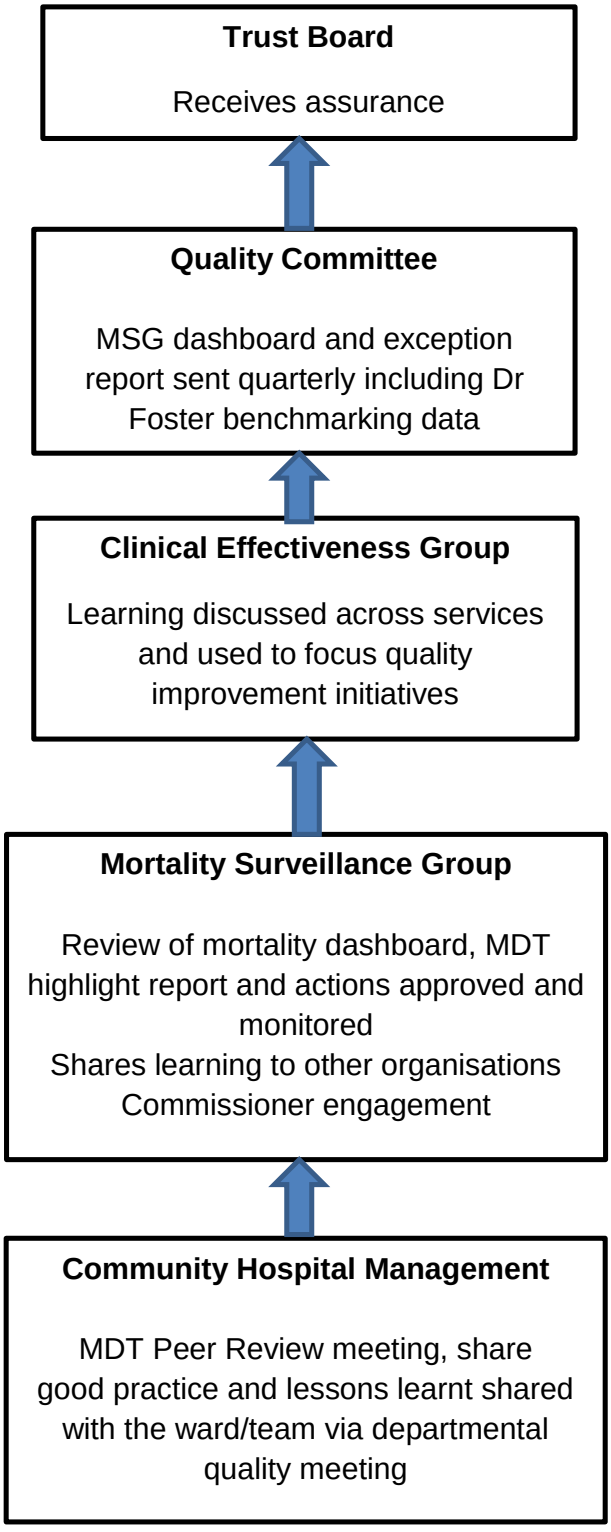
- Data from all MDT Peer Review Meetings held the previous month will be presented in the Mortality Dashboard including actions to be completed and learning to be shared.

Shared learning reporting process

- Dashboard and shared learning to be presented at the Clinical Effectiveness Group and on to the Quality Commitee via an exception report and Trust board AS APPROPRIATE IN CEG EXCEPTION REPORT

Appendix 3

Mortality Surveillance Reporting Flowchart



Appendix 4 Letter to bereaved relatives and carers

Death of your loved one in our care

We understand that losing a loved one is very difficult, even when their death is expected. We want to make sure that you feel able to give us any feedback you may have about their care, especially towards the end of their life. If you do have any comments or concerns please let us know. You can do this in two ways:

- Speak to a team leader or Matron of the service involved in your loved ones' care
- Speak to the Trust's Customer Care Team on 0300 123 1807
- Email our Customer Care Team at kcht.cct@nhs.net

Reviewing the care of your loved one

The Trust has a process in place to routinely review the care records of every person who dies in our community hospitals. We also follow national guidance and will review a proportion of deaths that happen under our care in people's homes or outpatient settings, for example those with a learning disability. This is not necessarily because something went wrong. We want to continually improve the care we give and learn from our staff and the families and carers of patients who die in our care. This learning can then be shared.

Involving you in the case record review process.

If we have received any feedback from you (as outlined above) this will be included in the case record review.

When someone's death is unexpected or there is cause for concern a fuller investigation will take place.

For example where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision.

Involving you in the 'Learning from Deaths' investigation process

When our local standard case record review process highlights a more in depth investigation would be beneficial or the national framework requires this , we will involve you in the investigation process.

This includes giving you the opportunity to provide positive feedback, ask questions or share concerns in relation to the quality of care received by your loved one. We will listen, we will note your comments or concerns, we will ask for your input on some specific areas of your experience. We may ask to meet with you or talk to you by phone. This is to make sure you are at the centre of the investigation into the care of your loved one.

Outcome of the investigation

After the investigation process is finished we will share the outcome with you. We have a duty of candour which means if we identify mistakes these will be shared with you. We will also share with you what we believe went well and we would welcome your comments on this too. The case investigation process should help us to find out what went well, in addition to areas for improvement. This way we can learn and improve.

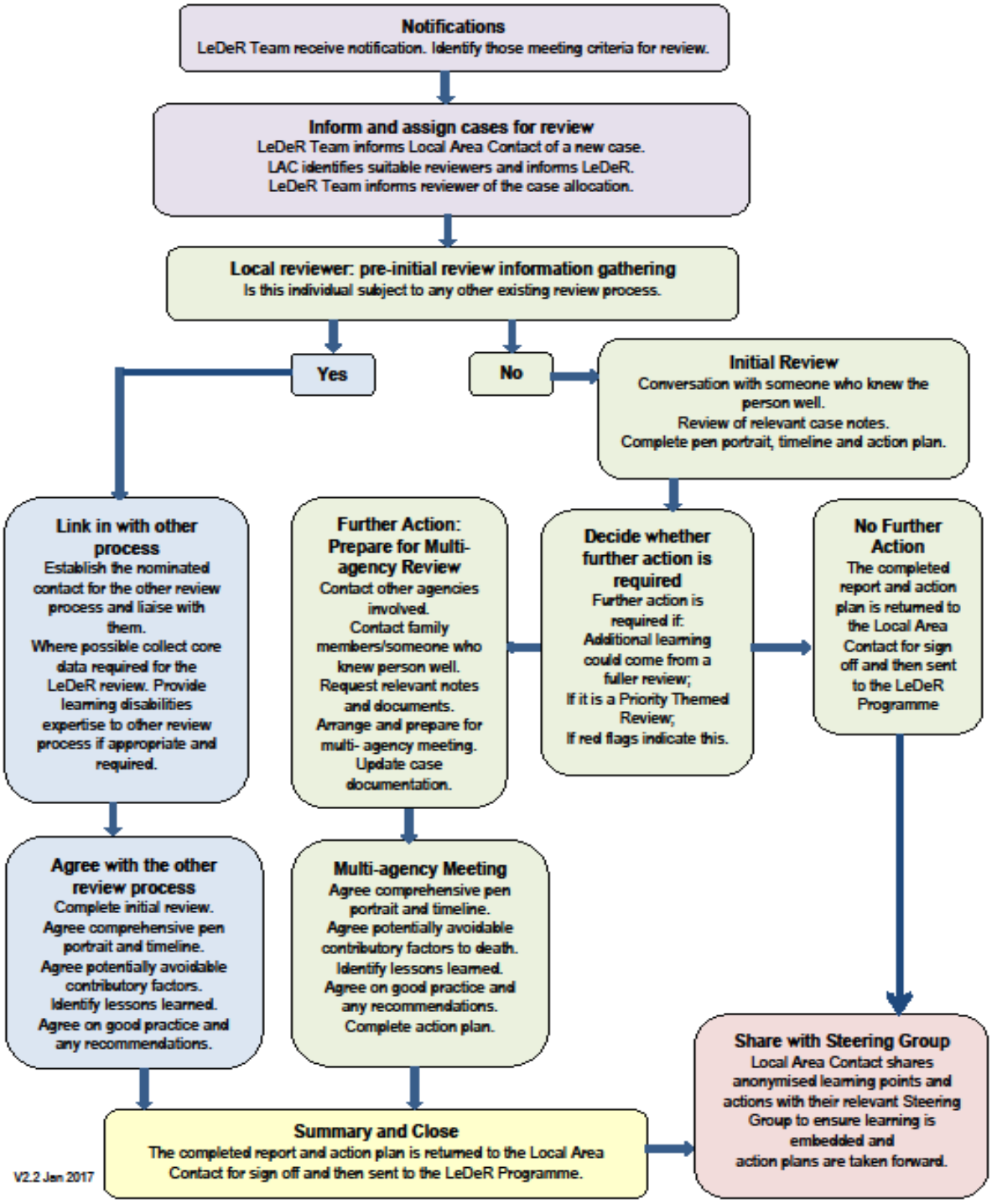
Any questions?

Please talk to the member of staff who gave you this leaflet if you have any immediate comments or concerns or don't understand what will happen next. Their name and contact details are below:

Learning Disabilities Mortality Review (LeDeR) Programme

NHS England

LeDeR Process Flowchart



Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.8
Subject:	Trust Constitution
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	X	Assurance	

Report Summary (including purpose and context):

This report summarises the position on appointed Governors.
The Trust has been unable to secure nominations from Kent County Council for any position other than the Public Health representative and the Kent Police position has been vacant for some time.

Due to the difficulty in securing these nominations, appropriate organisations have been identified as potential alternatives for appointing governors. There are;

- Kent Association of Head Teachers
- Kent Fire and Rescue
- Age UK
- Medway Council

This change would require amending the Constitution.

Proposals and /or Recommendations:

The Board is asked to approve the proposed changes to the Constitution.

Relevant Legislation and Source Documents:

Has an Equality Analysis (EA) been completed? No. High level position described. 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.

Natalie Davies, Corporate Services Director	Tel: 01622 211900
	Email: natalie.davies1@nhs.net

Kent Community Health
NHS Foundation Trust

TRUST CONSTITUTION

1. Introduction

This report presents the proposed changes to the Trust's Constitution to the Board for approval. The Council of Governors approved the amendments at their meeting held on August 2017. As the proposed changes are in relation to the Governors, this change will also require approval at the Annual Members Meeting

2. Process

The proposed amendments are in relation to the Appointed Governors.

The Trust was established with seven Appointed Governors in the Council. These are:

Four Kent County Council (KCC) Governors

- One representative from Education or Children's Services;
- One representative from Adults Services;
- One representative from Public Health;
- One representative of the Councillors.

Three Partnership Governors:

- One representative from the Kent Universities
- One representative from Kent CAN
- One representative from Kent Police

The Trust has been unable to secure nominations from Kent County Council for any position other than the Public Health representative and the Kent Police position has been vacant for some time.

The Council was asked to consider the organisations who were invited to nominate an Appointed Governor. The existing Appointed Governors undertook a review, recommending a long list of potential organisations. This long list was considered by the Executive and a proposal was brought back to the Council Meeting in August for approval.

3. Proposed Changes

The Council and the Executive fully support retaining three current Nominating Organisations:

- Kent Universities
- KCC Public Health
- Kent CAN

Given the nature of KCHFT and the principles of partnership working under which we operate, potential options for Appointing Organisations were numerous with many different positive reasons for inclusion.

3.1 Kent Association of Head Teachers

A Governor bringing the educational perspective and representing the views of younger people across Kent focussing on their social and educational needs would be enormously valuable to the Trust.

3.2 Kent Fire and Rescue

The imperative to work much more closely with other agencies in Kent, related to people's welfare, and the joint working opportunities we have with Kent Fire and Rescue within the STP, seem to make this a highly desirable invitation.

3.3 Age UK

A representative from Age UK would give the Council and the Trust a perspective on the Trusts' largest and rapidly growing client group; the elderly and particularly bring a social care perspective.

3.4 Medway Council

The integration of care between health and social care is highlighted and supported across the system as a fundamental tenant in the way that services need to be developed. Additionally, having an 'out of area' Appointed Governor from Medway Council provides the Trust with a wider perspective in terms of regional demographics and existing support offered by council services. Thus the Trust will be better placed to develop an understanding of how our services may compliment and work jointly with the services offered by Medway Council.

4. Recommendation

The Board is asked to approve the proposed changes to the Constitution.

Natalie Davies
Corporate Services Director
September 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.9
Subject:	Appointment of Senior Independent Director
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary
The Trust's Senior Independent Director (SID), Mr David Robinson will be retiring from the post of Non-Executive Director (NED) at the end of September 2017.

Proposals and /or Recommendations
Accordingly, the Board is required to appoint a NED to fulfil this role.

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

Natalie Davies, Corporate Services Director	Tel: 01622 211904
	Email: Natalie.davies1@nhs.net

Kent Community Health
NHS Foundation Trust

APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

SEPTEMBER 2017

1. Introduction

The Trust's Senior Independent Director (SID), Mr David Robinson will be retiring from the post of Non-Executive Director (NED) at the end of September 2017. Accordingly, the Board is required to appoint a NED to fulfil this role.

2. The Role of the SID

The NHS Foundation Trust Code of Governance makes a recommendation to appoint a Senior Independent Director for the Trust. The principle responsibility of the SID is to act as a conduit to the Board of Directors for the communication of concerns which have failed to be resolved through the normal channels of the Chairman, the Chief Executive or the Director of Finance, or for which such contact is inappropriate.

The SID will undertake the Chairman's appraisal and in doing this will hold an annual meeting with NEDs, without the Chairman present, and will also meet with other stakeholders. It is important that the SID is seen to be independent of the Chairman and should not, therefore, be appointed by the Chairman.

3. Process

Over the previous months, expressions of interest have been sought from the current Non-Executive Directors. The Council of Governors has been asked for its views and recommendations as have the Executive and Non-Executive Directors.

4. Recommendation

The Board is asked to appoint Bridget Skelton to the role of Senior Independent Director.

Natalie Davies
Corporate Services Director
September 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.10
Subject:	Workforce Committee Terms of Reference
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	X	Assurance	

Report Summary (including purpose and context)
The Board has agreed to establish a workforce Board sub-Committee. The paper proposes the Terms of Reference for the committee.

Proposals and /or Recommendations
The Board is invited to agree the Terms of Reference.

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

Louise Norris, Director of Workforce, Organisational Development and Communications	Tel: 01622 211905
	Email: louisenorris@nhs.net

Kent Community Health NHS
NHS Foundation Trust

Terms of Reference
Strategic Workforce Committee

1. Purpose

The Strategic Workforce Committee (The Committee) will support the Board, Chief Executive and Executive to create and maintain Kent Community NHS Foundation Trust at the place where people want to work, delivering high quality care to our patients.

To keep abreast of the strategic context in which the Trust is operating in, the consequences and implications on the workforce.

2. Responsibilities

The Committee is responsible for providing assurance to the board of directors by:

2.10 Overseeing the development and implementation of the Trust's people strategy, ensuring that the Trust has robust plans in place to support the ongoing development of the workforce;

2.11 Reviewing the Trust's plans to identify and develop leadership capacity and capability within the Trust, including talent management;

2.12 Ensuring that there is a workforce plan in place, to ensure that the Trust has sufficient staff, with the necessary skills and competencies to meet the needs of the Trust's patients and services users;

2.13 Ensuring that the Trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the Trust's contractual obligations;

2.14 Receiving assurance that the Trust has an appropriate pay and reward system that is linked to delivery of the Trust's strategic objectives, outcomes and desired behaviours;

2.14 Ensuring that the training and education provided and commissioned by the Trust is fully aligned to the Trust's strategy;

2.15 Ensuring that there are mechanisms in place to support the mental and physical health and well-being of the Trust's staff

2.16 Receiving information on strategic themes relating to employment issues, ensuring they are understood and actioned;

2.17 Ensuring that the Trust is compliant with relevant legislation and regulations relating to workforce matters.

2. Membership

The Committee will be appointed by the Board. The Committee will be chaired by a Non-Executive Director together with Director of Workforce, Organisational Development and Communications, Chief Operating Officer, Chief Nurse, Medical Director, Deputy Director of Workforce, and other officers will attend as required.

3. Quorum

A minimum of 4 members will constitute a quorum.

4. Administration

Administration and the recording of minutes of the Management Committee meeting is the responsibility of the Committee Secretary.

5. Frequency of Meetings

The Workforce Committee will meet bi monthly.

6. Reporting

The Workforce Committee will report to the Board.

7. Review

These Terms of Reference will be formally reviewed annually or sooner if required.

To ensure the Workforce Committee complies with its Terms of Reference, compliance will be monitored through the following methods:

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of Trust workforce strategy	Annual Board report	Board	Annual
Frequency of attendance	Attendance register of each meeting	Committee Secretary will report to the Committee Chair	Annually

Date Approved: 2017

Review Date: 2018

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	2.11
Subject:	Policies for Ratification
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	x	Assurance	

Report Summary (including purpose and context):
The policies presented for ratification are: • Gender Identity at Work Policy • Induction Policy • Managing Sickness Absence Policy • Organisational Change Policy

Proposals and /or Recommendations:
The Board is asked to ratify these policies.

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

Louise Norris, Director of Workforce, Organisational Development and Communications	Tel: 01622 211905
	Email: Louisenorris@nhs.net

Kent Community Health
NHS Foundation Trust

RATIFICATION OF POLICIES

1. Introduction

1.1 KCHFT policies have been revised and the Board is asked to ratify these policies.

2. Policies for ratification

2.1 The policies presented for ratification are –

- Gender Identity at Work Policy
- Induction Policy
- Managing Sickness at Work Policy
- Organisational Change Policy

2.2 The above policies are available electronically if required prior to the meeting of the Board.

2.3 **Gender Identity at Work Policy**
The main changes to this policy are:

- Sections 6.44, 6.45, 6.5.1 and 6.12.1 have been amended.

Induction Policy

The main changes to this policy are:

a. To include a brief outline of the major changes in the document that this document is replacing; for example:
   a. a new Section added to ensure compliance with equality and diversity requirements;
   b. paragraph number x-y, relating to “specific subject” has been removed;
   c. new paragraphs numbered a-c defining levels of observation have been introduced.

b. This is an existing policy updated to reflect the new policy format, to include EDI. Changes are renumbering of some elements and the removal of Appendix, which will enable changes to the induction programme to be made when required without the need to change the policy each time.

c. Removal of the first section of the table 8.2 as this is not a process that happens as described.

d. Inclusion of the preceptorship, care certificate and managers induction days.

Managing Sickness Absence at Work Policy
The main changes to this policy are:

- ER teams monitoring and compliance added
- Section 4.0 Managing all absences added
- GP fit note explanation added
- Table 4.5 removed
- Section 4.8 added to include planned sickness absence

Organisational Change Policy
The main changes to this policy are:

- Updated onto new template
- Incorporated pay protection policy and appeals against organisational change

3. Process of developing and consulting on policies

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

a. The policy is written by the Policy Owner

b. Consultation within the appropriate Directorate to seek further professional input

c. Policies are placed on to Flo for two weeks for general consultation and the feedback collated by Staffside and fed back to policy authors

d. Approval from the appropriate committee or group. See consultation and sign off sheet attached below

e. Board ratification

4. Recommendation

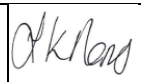
4.1 The Board is asked to ratify the above policies.

Louise Norris
Director of Workforce, Organisational Development and Communications
September 2017

Kent Community Health
NHS Foundation Trust

POLICIES – CONSULTATION AND SIGN OFF

Policy Title	Consultation With	Signature of the Chair(s)	Signature of Director with Responsibility
Gender Identity at Work Policy	HR Team All staff through Flo SPF	Louise Norris Director of Workforce, OD and Communications Neil Sherwood Staffside Convenor	Louise Norris Director of Workforce, OD and Communications
Induction Policy	HR Team All staff through Flo SPF	Louise Norris Director of Workforce, OD and Communications Neil Sherwood Staffside Convenor	Louise Norris Director of Workforce, OD and Communications

Managing Sickness at Work Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Staffside Convenor	 Louise Norris Director of Workforce, OD and Communications
Organisational Change Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Staffside Convenor	 Louise Norris Director of Workforce, OD and Communications

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	3.1
Subject:	Safeguarding Annual Report
Presenting Officer:	Ali Strowman, Chief Nurse

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

Report Summary (including purpose and context)
The Board is asked to consider this report, the purpose of which is to provide assurance to the Quality Committee that robust corporate and operational safeguarding arrangements are in place, including actions to mitigate any identified risks.

Proposals and /or Recommendations
The Board is asked to accept this report as Assurance that robust corporate and operational safeguarding arrangements are in place, including actions to mitigate any identified risks. The Board is also asked to approve the Slavery and Human Trafficking Statement.

Relevant Legislation and Source Documents
• KCHFT Local Quality Schedule 4 log for 2016-17 • Intercollegiate Guidance (2014) • Prevent Duty (2015) • Working Together to Safeguard Children (2015) • MCA 2005 • CQC Time to listen (2016) • CQC Safeguarding - Inspectors handbook (2016) • KSCB Multi Agency audit – Early Help (2016) • Case Review RS Round table discussion (2016) • NSPCC Children in Care and Harmful Sexual Behaviours (HSB) (2016) • National Police Chiefs Council – FGM mandatory reporting 2016
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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	Email: Juliebeavers@nhs.net

Kent Community Health
NHS Foundation Trust

Kent Community Health
NHS Foundation Trust

Safeguarding Annual Report for 2016/17

Executive Summary

The Board of Kent Community Health NHS Foundation Trust (KCHFT) is assured that, during 2016/17, the following arrangements were in place to safeguard and protect our service users/patients, whether they were children, young people or adults at risk.

- We had lead safeguarding children professionals, who fulfilled the statutory requirements of Working Together to Safeguard Children (2015).
- We had lead safeguarding adults professionals, who ensured the requirements of the Mental Capacity Act 2005, the Care Act 2014 and *Prevent Duty Guidance: for England and Wales* (2015) were delivered.
- The Board level Executive Lead with the responsibility for safeguarding was the Chief Nurse, who is a standing member of the Kent Safeguarding Children Board and the Kent and Medway Safeguarding Adults Board.
- A Safeguarding Governance Framework was in place, including a Safeguarding Assurance Group, which was chaired by the Chief Nurse.
- The Board regularly received and responded to information about safeguarding incidents and investigations, including monthly exception reports from operational directorates, quarterly reports via the Quality Committee and annually, in the form of an annual report on Safeguarding.
- The Board was routinely informed of all significant safeguarding concerns, which provided opportunity for them to review the effectiveness of the organisation's response, whilst providing clear safeguarding leadership.
- We were actively involved in the Local Safeguarding Boards, which has helped us set our organisation's priorities and ability to protect vulnerable people from harm and abuse. Included within this multi-agency working were whole system reviews of safeguarding procedure and partnership, both of which evidenced good practice in place at frontline and corporate levels.
- We were continually concerned about the safety of vulnerable adults and children under our care and demonstrated that interventions to identify and protect vulnerable people are in place, to reduce the risk of actual harm, including the identification of and appropriate referrals to social care; incident reporting/investigations that provided opportunity for us to learn from significant events and change practice; early assessment and provision of early interventions; access to specialist support and advice around emerging safeguarding themes, eg, child sexual exploitation, Female Genital Mutilation, counter-terrorism, Modern Slavery and Human Trafficking, from clinicians who are highly experienced in working with young people and adults at risk.
- Whilst the level of Adult Safeguarding referrals implicating the Trust during 2016/17 saw an improvement against last year, work with our frontline services to

reinforce the importance of the holistic, compassionate care that our service users need and should expect to receive from all of our practitioners remains a priority, particularly work within the Community hospitals. Within this pledge, we included further reduction of incidents of avoidable harm to patients receiving our care and achieved our aspirations from last year that no future cases of adult neglect be attributed to our care.

- Decisions being made by professionals were in the best interests of the service users/patients, including robust application of Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) legislation. The service has developed and published a Friends and Family leaflet for DoLS to assist staff to support families to have a better understanding of the Deprivation of Liberty. There is continuing work to ensure Trust's compliance with DoLS legislation, by keeping abreast of changes as they occur and translating the legislative developments into practical guidance for frontline staff, specifically in light of the Law Commissions proposed Liberty Protection Safeguards.
- All Case Reviews and Domestic Homicide Reviews were investigated, lessons were identified and improvements implemented in a timely way. We routinely shared the lessons identified nationally and locally through safeguarding supervision, training and assurance reporting, to strengthen embedding of learning into frontline practice.
- We provided access to robust health assessments for Looked After Children, including the provision of initial health assessments to Unaccompanied Asylum Seeking Children (UASC) placed in independent living within Kent and the UASC Receiving Centre in Appledore.
- All eligible staff groups had access to regular safeguarding supervision, with additional arrangements in place to support staff seeking *ad hoc* advice or guidance on specific issues or cases.
- All eligible staff within Kent Community Health NHS Foundation Trust were supported in accessing their mandatory and essential-to-role safeguarding training. Compliance was monitored centrally and reported to the Board.
    - 95% of staff were compliant with safeguarding children training
    - 93% of staff were compliant with safeguarding adults training
    - 93% of staff were compliant with MCA training
    - 92% of staff were compliant with *Prevent* training
- Our internal safeguarding systems, processes and procedures to provide controls for identifying and responding to vulnerability and risk were in place. This was included in the *Safeguarding Operational Strategy*, training and supervision policies, *Safeguarding Operational Manual* and supporting procedures that meet the requirements of section 11 of the Children Act 2004, *Working Together to Safeguard Children* (2015), Mental Capacity Act 2005*, MCA Deprivation of Liberty Safeguards* (2007), *Safeguarding Adults: The Role of Health Service*

Managers and their Boards (2011), Care Act 2014 and *Care and Support Statutory Guidance* (2014).

- We met our statutory requirements in relation to pre-employment clearance of all new staff, including enhanced Disclosure and Barring Service checks. Compliance was monitored centrally.
- We continually questioned the extent to which Safeguarding is embedded into our organisation, including access to training; internal assurance visits; audits to demonstrate safeguarding procedures were appropriately used to identify, escalate and respond to safeguarding concerns.
- A safeguarding audit programme was in place, which provided the Board (and the Trust's Audit Committee) with assurance that safeguarding systems and processes were working effectively.

Conclusion

The safeguarding agenda within the Trust continued to be very busy during 2016/17, in terms of clinical services' roles and responsibilities, changes in Safeguarding legislation and the on-going development of the Trust's safeguarding assurance work.

Areas of strength for 2016/17 included robust management and monitoring of our DoLS applications and the development of the Friends and Family leaflet for DoLS.

Although neglect remains the largest area of abuse within the Trust, there was a reduction in the number of cases reported compared to 2015/16.

Significant improvement in SG training compliance and an appetite to benchmark ourselves against key national and local reports and initiatives, in an effort to identify areas of learning that may be of benefit to the Trust and its service users. Overall, safeguarding training corporate compliance levels for 2016/17 were all over 90%.

CRU health has been flexible, proactive and resilient in a constantly changing environment, to ensure optimum use of resources and improved outcomes and has worked hard to ensure that their knowledge and skills are updated, to provide a specialist resource to professionals and agencies during interactions within CRU and with external agencies/providers.

Safeguarding training has been reviewed and emerging areas of safeguarding (CSE and Trafficking, FGM and Prevent) have been incorporated into the Trust training programmes, DVA has also been embedded into training packages following the addition of the abuse category of DVA within the Care Act 2014.

Early assessment and identification of needs continues to be embedded in frontline practice, within the Trust's Public Health services.

Following the successful award to KCHFT for the delivery of Sexual Health Services in Medway during 2016/1017, KCHFT now delivers a range of Sexual Health services across Kent and Medway.

A review of roles and responsibilities within the Community Paediatrics service, including demand and capacity of clinicians, has resulted in all substantive Community Paediatricians being trained to undertake IHAs. This has increased capacity within our existing medical establishment and with successful recruitment this has ensured the service can flex capacity to meet demand.

LAC Service supported to develop information sharing data base in regard to Young people at Risk of CSE and to record CSE risk assessments undertaken and actions completed. This has also enabled timely information sharing within the Trust's LAC service and with the CSE Lead.

The SG service is committed to ensuring that Modern Slavery and human trafficking is recognised by all employees and is seen under the umbrella of "Safeguarding is everyone's responsibility". Trust SG practitioners have attended Modern Slavery training to gain a greater understanding of the national picture and challenges that Modern Slaver/Human Trafficking brings to the Safeguarding arena; ensuring Modern Slavery awareness is included in all levels of the Trust's safeguarding training.

The reduction of serious incidents of a safeguarding concern from 24 last year to 18 this year demonstrates improvement towards reducing avoidable harm to patients. SG practitioners have developed strong working relationships with the Serious Incident Team supporting triangulation of information and supporting/improving lessons learnt across the Trust.

A Prevent workspace was created to bring together all the information and up-to-date news on Counter Terrorism, so that all Trust staff can be kept abreast of the same. The Guidance from NHS England on Prevent Freedom of Information (FoI) requests was successfully incorporated into the KCHFT FoI Policy.

Successful implementation of the SG supervision model in Sexual Health services and provision of group safeguarding supervision within adult services post SI, ad-hoc or by team request has increased and positive feedback has been received.

The Trust continued to maintain, sustain and build upon existing safeguarding monitoring and assurance arrangements and there was a sustained improvement in the assurance demonstrated across the organisation over the past year. The Trust

has continued involvement in audits and self-assessment frameworks with our multi-agency colleagues to peer review our performance against a number of self-assessment frameworks to evidence the Trust's compliance against its statutory safeguarding responsibilities ensuring the Trust does not work in isolation, but rather in a joined-up manner with partners in the Kent health and social care economy.

Partnership working across the local health and social care community continues to be strong and can be evidenced by the Trust's on-going work with the KSCB and KMSAB partners.

Recommendations

- That in receiving this report, the Quality Committee notes the successes for 2016/17, the key actions for 2017/18 and recommends the report to the Trust Board.
- That the Quality Committee receives and reports to the Trust Board, future safeguarding assurance updates as agreed/requested.

Caroline Ferguson
Assistant Director of Safeguarding
May 2017

Kent Community Health NHS Foundation Trust

APPENDIX ONE
Safeguarding Declaration

The Board of Kent Community Health NHS Foundation Trust (KCHFT) is assured that the following arrangements are in place, in line with the recommendations of the Care Quality Commission, to ensure that systems and processes are in place to safeguard all our patients whether they are children, young people or adults.

- Kent Community Health NHS Foundation Trust meets its statutory requirements in relation to Disclosure and Barring Service (DBS) checks for all new employees. Compliance is monitored centrally and there is an escalation process, including referrals to the DBS.

- Kent Community Health NHS Foundation Trust has a *Safeguarding Operational Strategy* and supporting policies and systems in place, that meet the requirements of *Working Together to Safeguard Children* (2015), Care Act 2014, *Care and Support Statutory Guidance* (2014), Mental Capacity Act 2005 and Local Safeguarding Board, multi-agency safeguarding procedures.

- Safeguarding training, which includes the requirements of the Mental Capacity Act/DoLS, the Children Act 2004, the Care Act 2014 and *Prevent*, is mandatory within the organisation induction programme for all new employees and refreshed at 3 yearly "essential-to-role" updates for eligible staff.

- Kent Community Health NHS Foundation Trust is committed to ensuring that the application of the Mental Capacity Act 2005 is embedded in service delivery. This includes the Deprivation of Liberty Safeguards amendment in 2007 and the Supreme Court ruling of 2014. KCHFT is proactive in assessing all potential DoLS cases and making the relevant applications and, where upheld, notifying the CQC of such authorisations.

- The Board level Executive Lead with the responsibility for safeguarding in Kent Community Health NHS Foundation Trust is the Chief Nurse, who is a standing member of the Kent Safeguarding Children and Adults Boards.

- Kent Community Health NHS Foundation Trust has lead safeguarding professionals - Named Doctors and Nurses for Safeguarding Children and Safeguarding Specialist Advisers, to fulfil the statutory requirements of *Working Together to Safeguard Children* (2015).

- Kent Community Health NHS Foundation Trust has lead safeguarding professionals – Named Nurses for Safeguarding Adults and Safeguarding Specialist Advisers, to fulfil the statutory requirements of the Mental Capacity Act 2005, the Care Act 2014 and the *Care and Support Statutory Guidance* 2014.

- Kent Community Health NHS Foundation Trust has a Safeguarding Assurance Group, which is chaired by the Chief Nurse.

- There are effective processes for following up children who miss outpatient appointments and for “flagging” children for whom there are safeguarding concerns.

- The Board reviews Safeguarding, via the Quality Committee, on a monthly exception reporting basis by operational services, which is supported by a quarterly organisation-wide Safeguarding Assurance Report and annually, when the Trust Board will receive a Safeguarding Annual Report. In addition, a rolling programme of internal assurance visits take place across the organisation and local compliance reports are produced to feedback on key findings and recommendations.

- Kent Community Health NHS Foundation Trust has a safeguarding audit programme in place, which provides the Board (and the Trust’s Audit Committee) with assurance that safeguarding systems and processes are working effectively. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.

- Kent Community Health NHS Foundation Trust is actively involved in partnership working with Kent County Council and other local agencies, in relation to the development and provision of multi-agency arrangements to safeguard and protect adults and children.

1 April 2017

Kent Community Health
NHS Foundation Trust

Kent Community Health NHS Foundation Trust

APPENDIX TWO
Slavery and Human Trafficking Statement

Our organisation

We are one of the largest NHS community health providers in England, serving a population of about 1.4 million. We employ 5,000 staff, including doctors, community nurses, physiotherapists, dieticians and many other healthcare professionals. We became a foundation trust on 1 March 2015.

We were formed on 1 April 2011 from the merger of Eastern and Coastal Kent Community Services NHS Trust and West Kent Community Health.

Our budget is around £234millon. We procure goods and services from a range of providers. Contracts vary from small one-off purchases to large service contracts.

Arrangements to prevent slavery and human trafficking

We are committed to ensuring there is no modern slavery or human trafficking in our supply chains or any part of our business activity.

Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding strategy and arrangements.

Our arrangements

Safeguarding

Our commitment to ensure no modern slavery is reflected in a number of our policies and procedures. These include our adults and children Safeguarding Operational Strategy and Safeguarding Operational Manual, which have been developed and maintained within the national and local safeguarding children governance and accountabilities frameworks. It includes guidance on initial contact with a suspected human trafficking victim and the National Referral Mechanism.

Training and promotion

Our safeguarding training includes role relevant modern slavery awareness and understanding to reflect the Department of Health's project around Provider Responses, Treatment and Care for Trafficked People (PROTECT).

Suppliers/tenders

The trust complies with the Public Contracts Regulations 2015 and uses the mandatory Crown Commercial Services Pre-Qualification Questionnaire on procurements, which exceed the prescribed threshold. Bidders are required to confirm their compliance with the Modern Slavery Act.

Sub-contracts

Our procurement and contracting team is qualified and experienced in managing healthcare contracts and have receive appropriate briefing on the requirements of the Modern Slavery Act 2015, which includes:

- requesting evidence of their plans and arrangements to prevent slavery in their activities and supply chain
- using our routine contract management meetings with our providers, to address any issues around modern slavery

- implementing any relevant clauses contained within the Standard NHS Contract.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2018.

Paul Bentley
Chief Executive

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	3.2
Subject:	Monthly Mortality Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

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

Report Summary

The attached data is received monthly from Dr Foster. Future reporting of mortality data will be quarterly in line with new mortality review policy and the Board should expect the first quarterly report to come in January. As described in the Mortality Review Policy (also on agenda) this new quarterly report will meet new guidance for NHS trusts. It will include a dashboard showing

- the number of deaths in scope for potential review
- the number of deaths subject to case record review (as described in the mortality review policy)
- number of deaths investigated under the Serious Incident framework or Level 3 reviews as described in the policy (and declared as serious incidents)
- number of deaths that were reviewed/investigated and as a result considered more likely than not to be due to problems in care
- a quarterly report from Dr Foster which includes detailed statistical analyses and benchmarking will also be attached but separate from the dashboard.

The accompanying quarterly report will include themes and issues identified from review and investigation (including examples of good practice) and actions taken in response, actions planned and an assessment of the impact of actions taken.

The attached data for this Board meeting is the most up to date received from Dr Foster. Whilst the Doctor Foster data is updated monthly it provides data over a rolling 12 month period. It is limited in that it only looks at numbers of deaths of inpatients and compares them against expected deaths for a typical area with the same case mix. It is reassuring to note that the data does not raise any concerns about SMR for patients in our community hospitals. The new process of mortality review in conjunction with this externally benchmarked data will help us to make sure learning from deaths is meaningful and drives continuous improvement.

Proposals and /or Recommendations

It is recommended that the Committee:

- Note these findings
- Provide relevant information/assurance to the Trust Board.

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

Dr Sarah Phillips, Medical Director	Tel: 01622 211900
	Email: sarahphillips4@nhs.net

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MORTALITY SUMMARY REPORT

Kent Community Health NHS Foundation Trust

Report Date	25th August 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 June 2016 to May 2017, unless otherwise stated.

Risk adjustment is derived from the 10-year period up to February 2017. 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 February 2017*.

- There are 2258 spells to Kent Community in the 12-month period to May 17. Of these 2117 are super spells **. There are 121 observed mortalities against an expected 167.5 resulting in an SMR 72.2 (CI: 60.0 – 86.4) and 'below expected' (fig.1.0).
- No month is considered statistically higher than expected.
- The crude rate, looking at the last spell in the superspell is 56 or 2.6%. (fig.3.3)

FIG.1.0 - KCHFT SMR FOR ALL ADMISSIONS JUNE 2016 TO MAY 2017

Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	2,117	100.0%	2,258	121	5.7%	167.5	7.9%	-46.5	72.2	60.0	86.4
Jun-16	217	10.3%	225	5	2.3%	16.0	7.4%	-11.0	31.2	10.1	72.8
Jul-16	209	9.9%	231	11	5.3%	16.0	7.7%	-5.0	68.7	34.3	123.1
Aug-16	204	9.6%	220	11	5.4%	12.6	6.2%	-1.6	87.5	43.7	156.7
Sep-16	181	8.5%	192	10	5.5%	16.3	9.0%	-6.3	61.4	29.4	112.9
Oct-16	148	7.0%	155	10	6.8%	13.2	8.9%	-3.2	75.7	36.3	139.3
Nov-16	167	7.9%	176	8	4.8%	11.8	7.0%	-3.8	68.0	29.3	134.1
Dec-16	166	7.8%	181	16	9.6%	12.9	7.8%	3.1	124.1	70.9	201.6
Jan-17	142	6.7%	149	13	9.2%	15.5	10.9%	-2.5	84.1	44.8	143.9
Feb-17	161	7.6%	177	13	8.1%	14.8	9.2%	-1.8	87.6	46.7	149.9
Mar-17	187	8.8%	197	8	4.3%	14.6	7.8%	-6.6	54.8	23.7	108.1
Apr-17	162	7.7%	173	10	6.2%	10.9	6.7%	-0.9	91.5	43.8	168.3
May-17	173	8.2%	182	6	3.5%	12.9	7.5%	-6.9	46.4	17.0	101.1

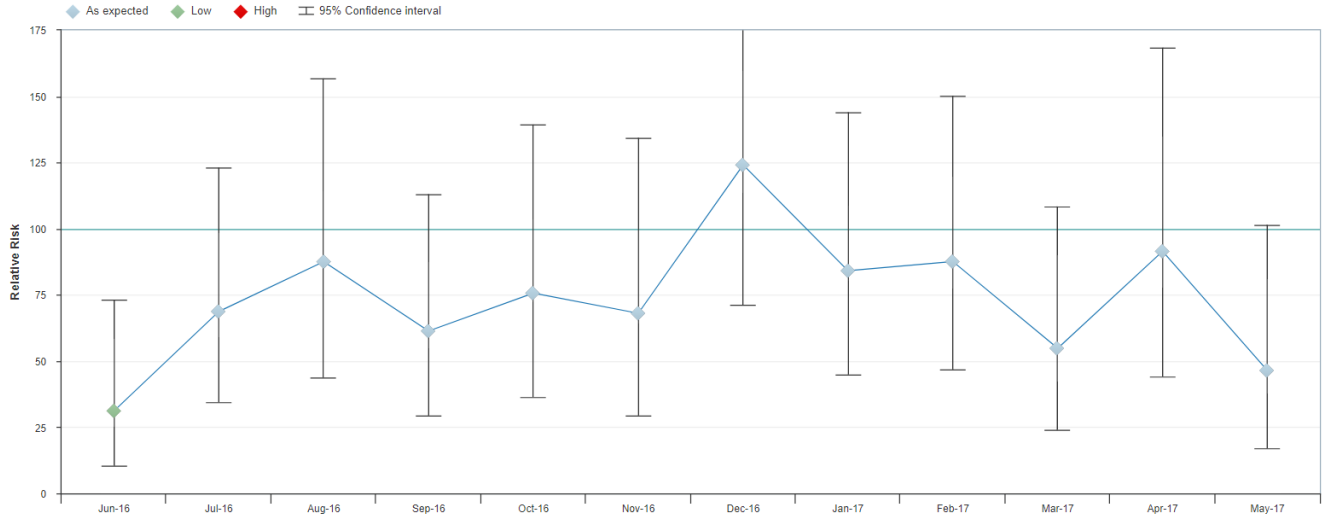

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FIG. 2.0—ALL ADMISSIONS SMR BY ADMISSION SOURCE JUNE 2016 TO MAY 2017

Admission source	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	2,117	100.0%	2,258	121	5.7%	167.5	7.9%	-46.5	72.2	60.0	86.4
NHS other provider - general/young disabled/A & E	1,879	88.8%	2,016	107	5.7%	155.3	8.3%	-48.3	68.9	56.5	83.3
The usual place of residence	224	10.6%	228	14	6.3%	11.1	5.0%	2.9	125.7	68.7	211.0
Non-NHS (other than LA) run residential care home	4	0.2%	4	0	0.0%	0.4	9.8%	-0.4	0.0	0.0	937.8
Local authority Part 3 residential accommodation	3	0.1%	3	0	0.0%	0.2	7.0%	-0.2	0.0	0.0	1742.0
NHS run nursing, residential care or group home	3	0.1%	3	0	0.0%	0.2	5.3%	-0.2	0.0	0.0	2325.9
Non-NHS run hospital	3	0.1%	3	0	0.0%	0.2	7.3%	-0.2	0.0	0.0	1665.7
Non-NHS (other than LA) run hospice	1	0.0%	1	0	0.0%	0.1	5.4%	-0.1	0.0	0.0	6743.9

** Risk adjustment is derived from the 10-year period up to February 2017. 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 88.8 % of all activity to KCHFT, whilst admissions from 'the usual place of residence' accounted for 10.6%. This is slightly higher than previously reported by 0.4%.
- Admissions from 'the usual place of residence' are considered statistically 'as expected'.
- 'The usual place of residence' there are 14 observed deaths reported against an expected 11.1. Of these 9 were recorded as mortalities at KCHFT accounting for a crude rate percentage of 0.4% of all KCHFT activity.
- The SMR graph tracked over 3 years, the SMR has remained within or below the 'as expected' range for the last 26 data points.

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

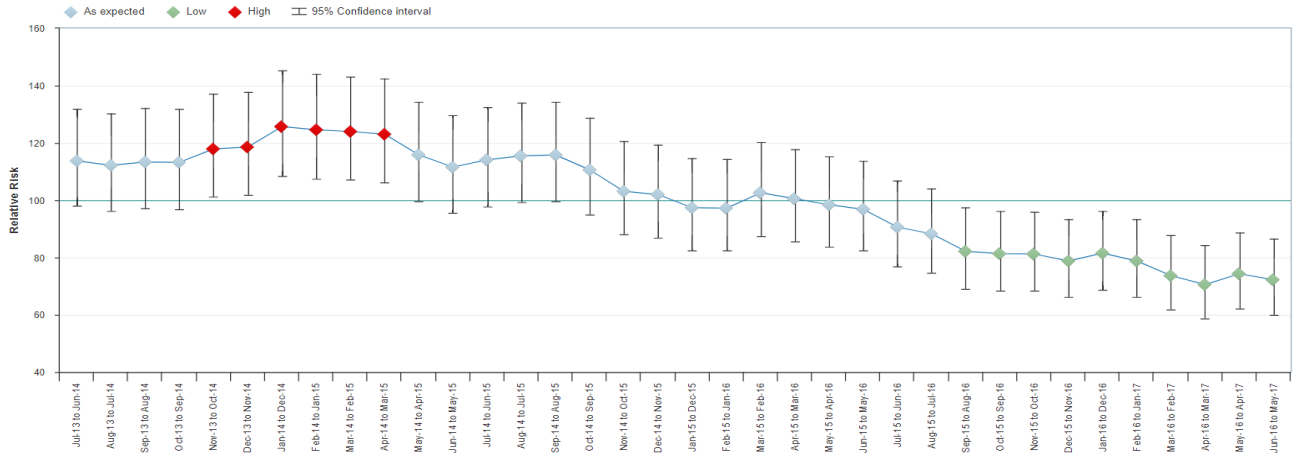

FIG. 3.1 — SMR CRUDE RATE FOR ALL KCHFT ACTIVITY ROLLING 12-MONTH TREND

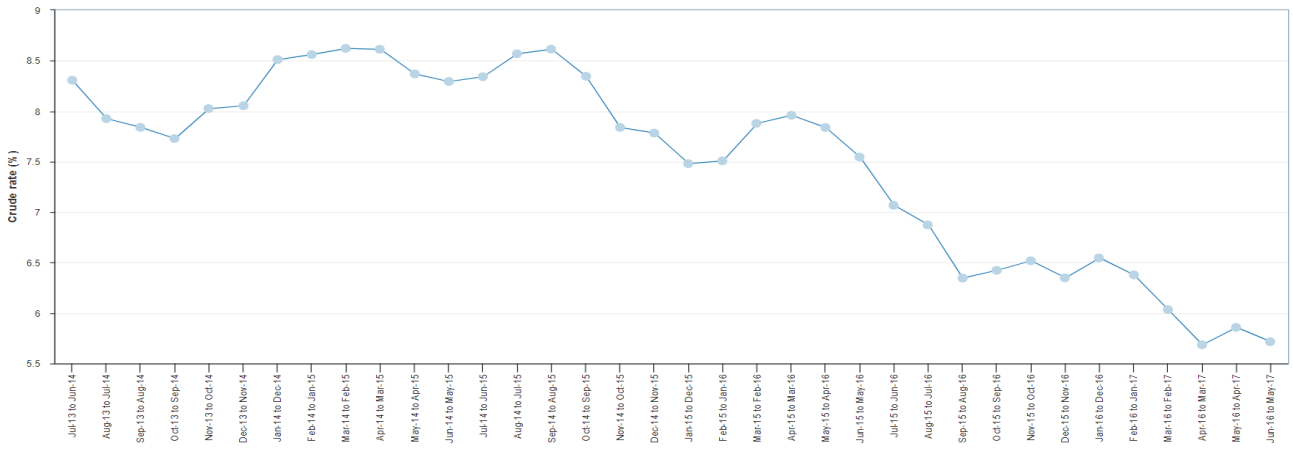

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FIG. 3.2 — SMR SPELL VOLUMES ROLLING 12-MONTH TREND FOR PATIENTS ADMITTED FROM ACUTE PROVIDERS, THEN TRANSFERRED BACK (ACUTE) WHO THEN SUBSEQUENTLY AND DIED IN HOSPITAL WITHIN 30 DAYS

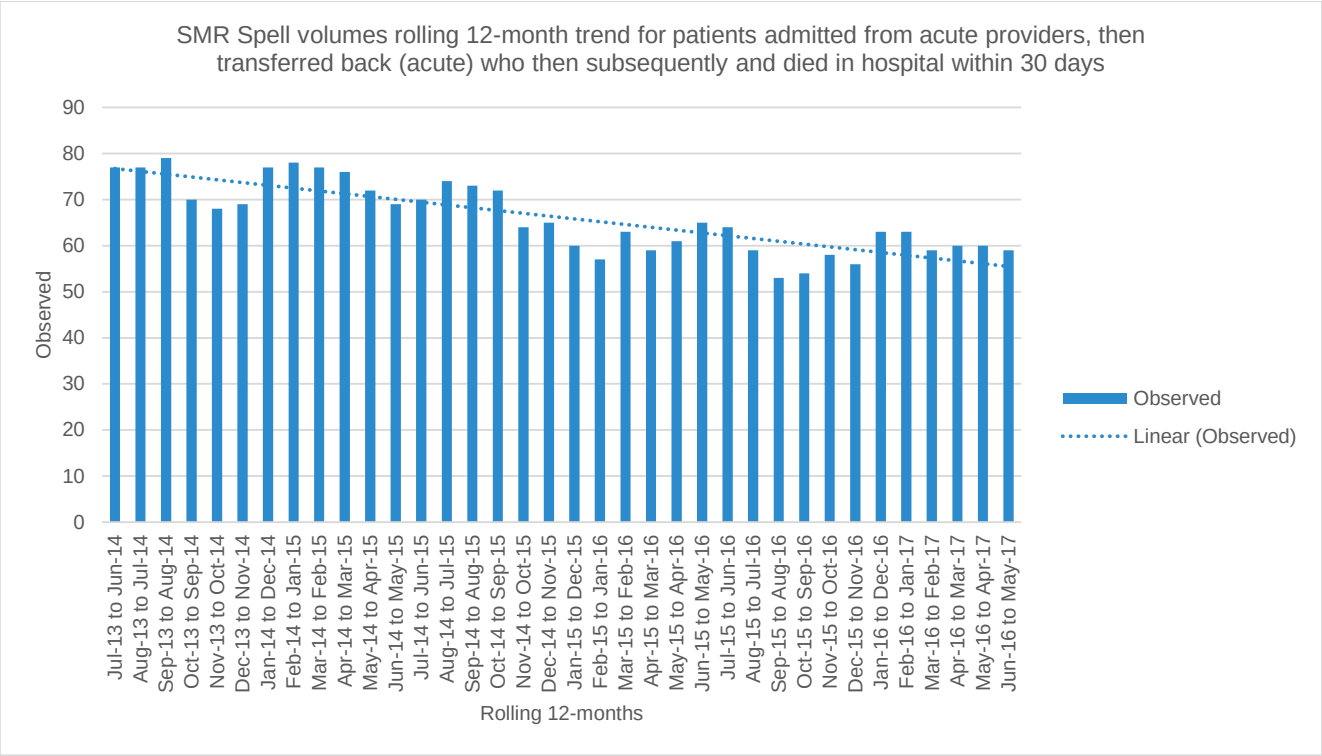

FIG. 3.3 — SMR CRUDE RATE FOR PATIENTS WITH A DISCHARGE DESTINATION OF DEATH 12-MONTH TREND

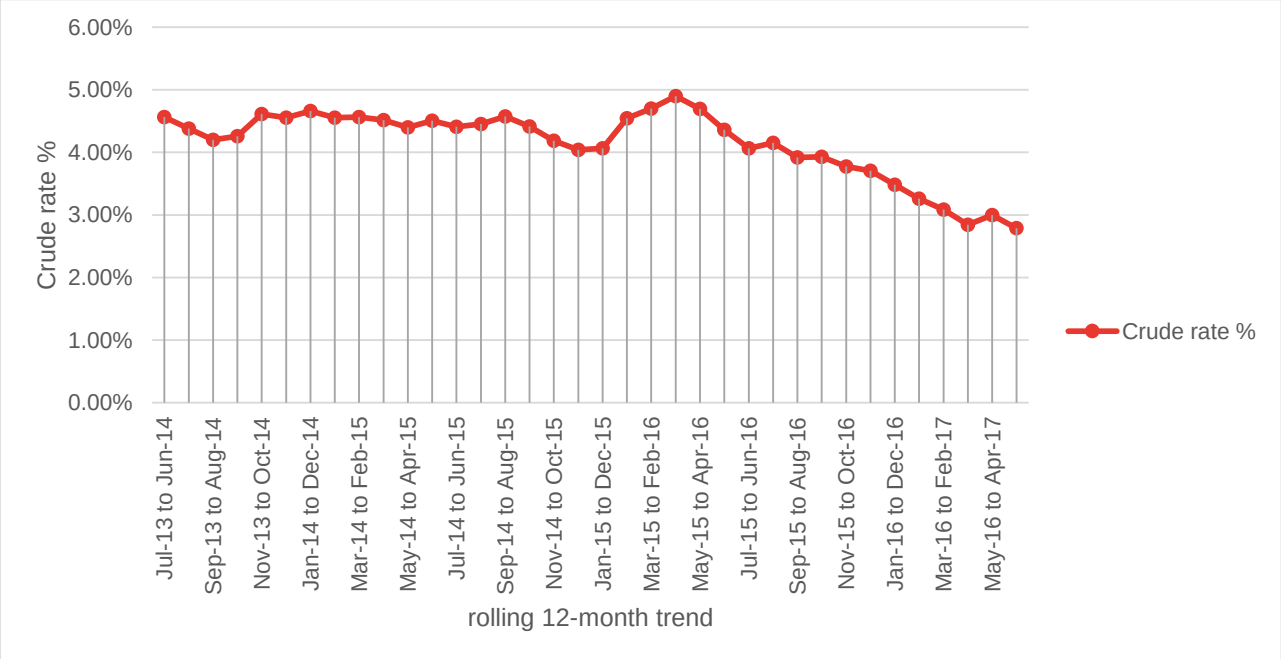

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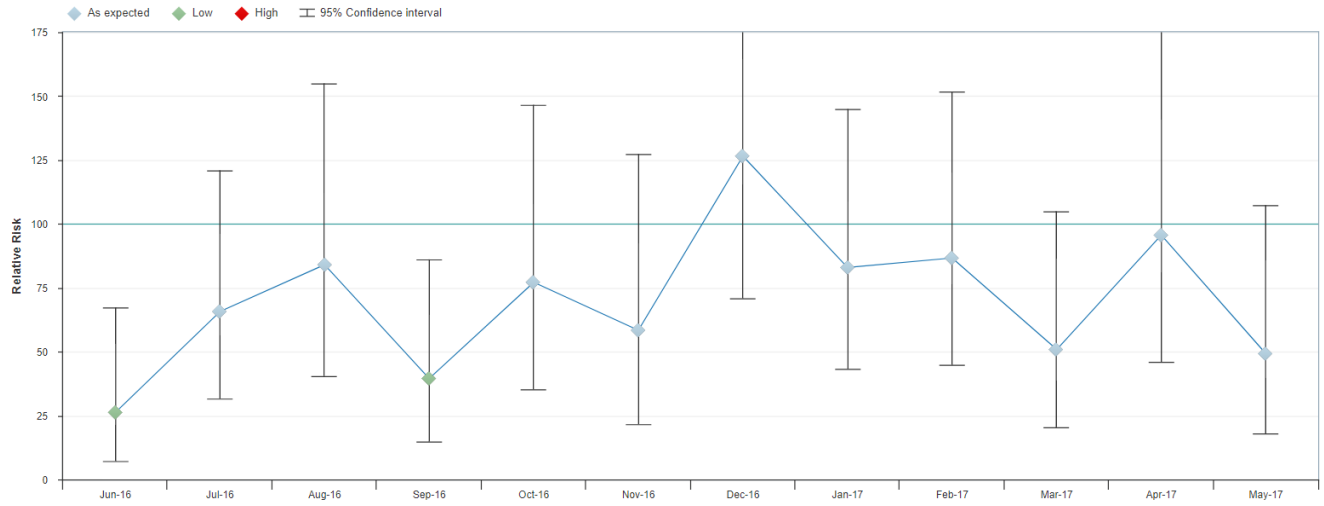
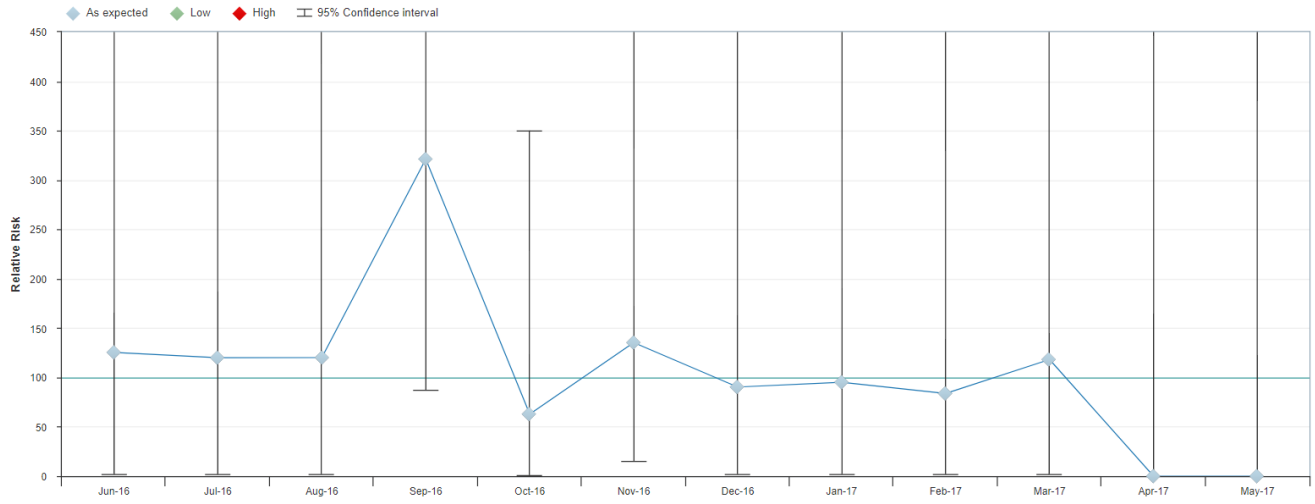
FIG.4.0: ANALYSIS OF ADMISSIONS FROM NHS PROVIDERS 'STEP-DOWNS'



Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	1,892	100.0%	2,016	107	5.7%	156.1	8.3%	-49.1	68.5	56.2	82.9
Jun-16	195	10.3%	203	4	2.1%	15.2	7.8%	-11.2	26.2	7.1	67.2
Jul-16	185	9.8%	205	10	5.4%	15.2	8.2%	-5.2	65.7	31.5	120.9
Aug-16	181	9.6%	194	10	5.5%	11.9	6.6%	-1.9	84.0	40.3	154.6
Sep-16	158	8.4%	167	6	3.8%	15.2	9.6%	-9.2	39.5	14.5	86.0
Oct-16	128	6.8%	134	9	7.0%	11.7	9.1%	-2.7	77.1	35.2	146.5
Nov-16	141	7.5%	150	6	4.3%	10.3	7.3%	-4.3	58.4	21.4	127.1
Dec-16	151	8.0%	163	15	9.9%	11.9	7.9%	3.1	126.5	70.8	208.7
Jan-17	130	6.9%	136	12	9.2%	14.5	11.1%	-2.5	82.9	42.9	144.9
Feb-17	143	7.6%	156	12	8.4%	13.8	9.7%	-1.8	86.7	44.8	151.4
Mar-17	171	9.0%	180	7	4.1%	13.8	8.1%	-6.8	50.9	20.4	104.8
Apr-17	150	7.9%	160	10	6.7%	10.5	7.0%	-0.5	95.6	45.8	175.8
May-17	159	8.4%	168	6	3.8%	12.2	7.7%	-6.2	49.2	18.0	107.2

- Analysis of Step-down patients shows that there are on average 158 patients admitted as step-downs each month. This is slightly lower than the same previously reported figure. June 16 is the busiest month with 195 patients.
- Of the 'Step-Up' patients, there was an average of 21.0 per month.

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



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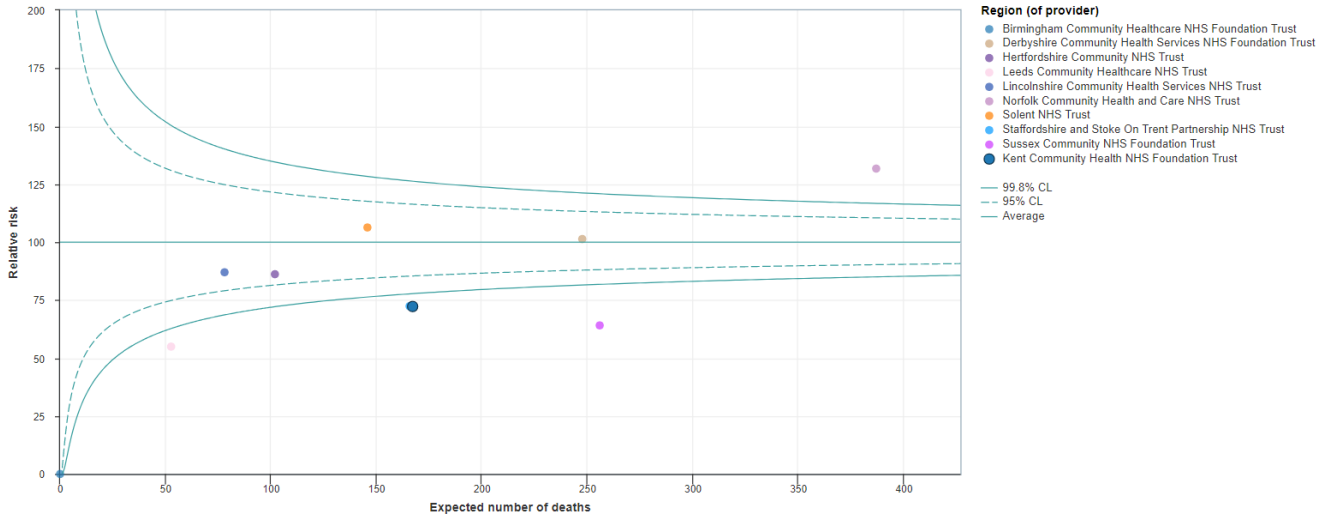
Trend (month)	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	242	100.0%	242	14	5.8%	12.3	5.1%	1.7	113.7	62.2	190.9
Jun-16	22	9.1%	22	1	4.5%	0.8	3.6%	0.2	125.4	1.7	697.8
Jul-16	26	10.7%	26	1	3.8%	0.8	3.2%	0.2	119.9	1.6	667.3
Aug-16	26	10.7%	26	1	3.8%	0.8	3.2%	0.2	120.1	1.6	668.3
Sep-16	25	10.3%	25	4	16.0%	1.2	5.0%	2.8	321.3	86.5	822.6
Oct-16	21	8.7%	21	1	4.8%	1.6	7.6%	-0.6	62.8	0.9	349.5
Nov-16	26	10.7%	26	2	7.7%	1.5	5.7%	0.5	135.3	15.2	488.6
Dec-16	18	7.4%	18	1	5.6%	1.1	6.2%	-0.1	90.3	1.2	502.3
Jan-17	13	5.4%	13	1	7.7%	1.1	8.1%	-0.1	95.2	1.3	529.6
Feb-17	21	8.7%	21	1	4.8%	1.2	5.7%	-0.2	83.7	1.1	465.9
Mar-17	17	7.0%	17	1	5.9%	0.8	5.0%	0.2	118.2	1.6	657.5
Apr-17	13	5.4%	13	0	0.0%	0.6	4.6%	-0.6	0.0	0.0	609.8
May-17	14	5.8%	14	0	0.0%	0.7	5.2%	-0.7	0.0	0.0	502.5

FIG.6.0 – PEER COMPARISON TABLE FOR KCH FOR ALL ADMISSIONS AGAINST OTHER COMMUNITY PEERS JUNE 2016 TO MAY 2017



Community Trust benchmarking club	Superspells	% of All	Spells	Observed	%	Expected	%	O-E	RR	LO	HI
All	28,500	100.0%	30,127	1,506	5.3%	1602.8	5.6%	-96.8	**94.0**	89.3	98.9
Derbyshire Community Health Services NHS Foundation Trust	8,069	28.3%	8,253	251	3.1%	247.7	3.1%	3.3	101.3	89.2	114.7
Staffordshire and Stoke On Trent Partnership NHS Trust	5,913	20.7%	6,092	120	2.0%	165.8	2.8%	-45.8	**72.4**	60.1	86.6
Sussex Community NHS Foundation Trust	3,721	13.1%	3,981	164	4.4%	255.9	6.9%	-91.9	**64.1**	54.7	74.7
Norfolk Community Health and Care NHS Trust	3,421	12.0%	4,033	510	14.9%	387.2	11.3%	122.8	**131.7**	120.6	143.7
Kent Community Health NHS Foundation Trust	2,117	7.4%	2,258	121	5.7%	167.5	7.9%	-46.5	**72.2**	60.0	86.4
Hertfordshire Community NHS Trust	1,763	6.2%	1,920	88	5.0%	102.1	5.8%	-14.1	86.2	69.2	106.2
Lincolnshire Community Health Services NHS Trust	1,731	6.1%	1,764	68	3.9%	78.2	4.5%	-10.2	87.0	67.6	110.4
Solent NHS Trust	983	3.4%	1,023	155	15.8%	145.8	14.8%	9.2	106.3	90.3	124.5
Leeds Community Healthcare NHS Trust	730	2.6%	751	29	4.0%	52.8	7.2%	-23.8	**54.9**	36.8	78.9
Birmingham Community Healthcare NHS Foundation Trust	52	0.2%	52	0	0.0%	0.0	0.0%	-0.0	0.0	0.0	18802.8

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

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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)

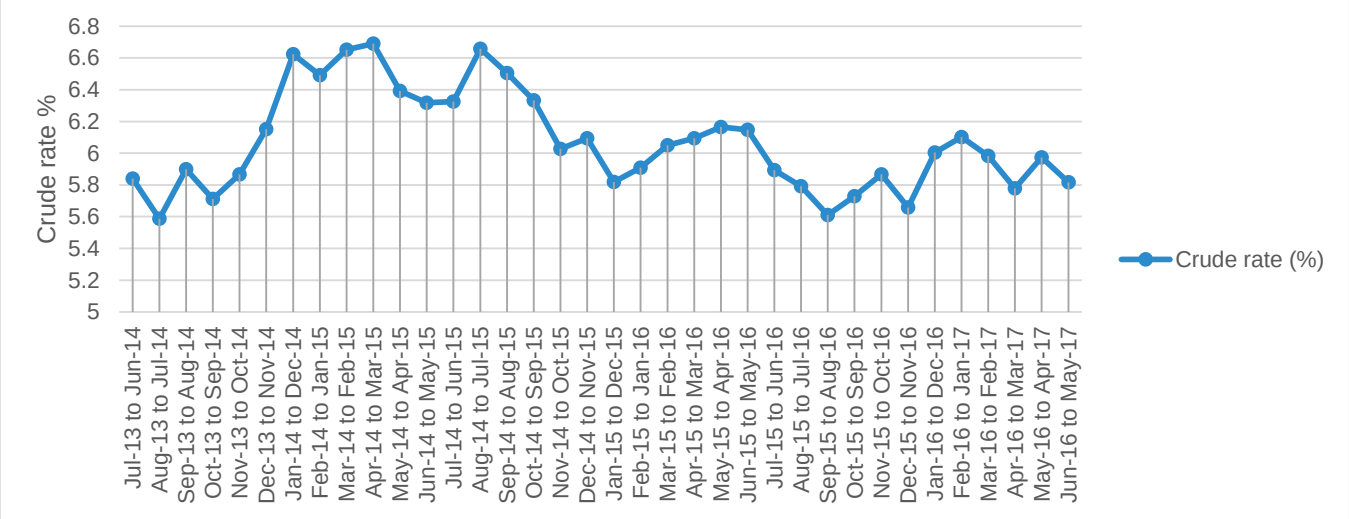
Tonbridge Cottage Hospital (RYYDC)

Edenbridge Hospital (RYYD4)

Fig 7.0: KCHFT Sites Superpsells June 2016 to May 2017

Trend (month)	Faversham Cottage Hospital (RYYAL)	Whitstable & Tankerton Hospital (RYYCM)	Victoria Hospital (RYYCH)	Queen Victoria Memorial Hospital (RYYC3)	Sevenoaks Hospital (RYYD9)	Tonbridge Cottage Hospital (RYYDC)	Hawkhurst Cottage Hospital (RYYD6)	Edenbridge Hospital (RYYD4)
Jun-16	17.4	9.1	13.6	13.6	15.9	12.9	10.6	6.8
Jul-16	19.9	8.8	12.5	11.0	12.5	12.5	11.0	11.8
Aug-16	19.8	13.7	13.0	8.4	17.6	9.9	10.7	6.9
Sep-16	12.6	18.1	8.7	11.0	11.8	11.0	15.0	11.8
Oct-16	12.3	14.5	14.5	14.5	14.5	11.6	8.7	9.4
Nov-16	15.0	13.8	14.4	17.4	11.4	7.2	10.8	10.2
Dec-16	17.5	15.7	13.3	12.7	10.8	12.0	9.6	8.4
Jan-17	15.5	12.0	16.9	13.4	11.3	9.9	8.5	12.7
Feb-17	16.1	22.4	9.3	13.7	13.0	8.7	7.5	9.3
Mar-17	18.7	12.8	13.4	11.2	12.3	13.4	10.2	8.0
Apr-17	21.6	14.8	8.0	13.0	11.1	16.7	7.4	7.4
May-17	17.3	17.9	15.6	10.4	8.1	13.3	6.9	10.4

Fig 7.1: KCHFT 8 Sites Crude death rate 12-month trend June 2016 to May 2017



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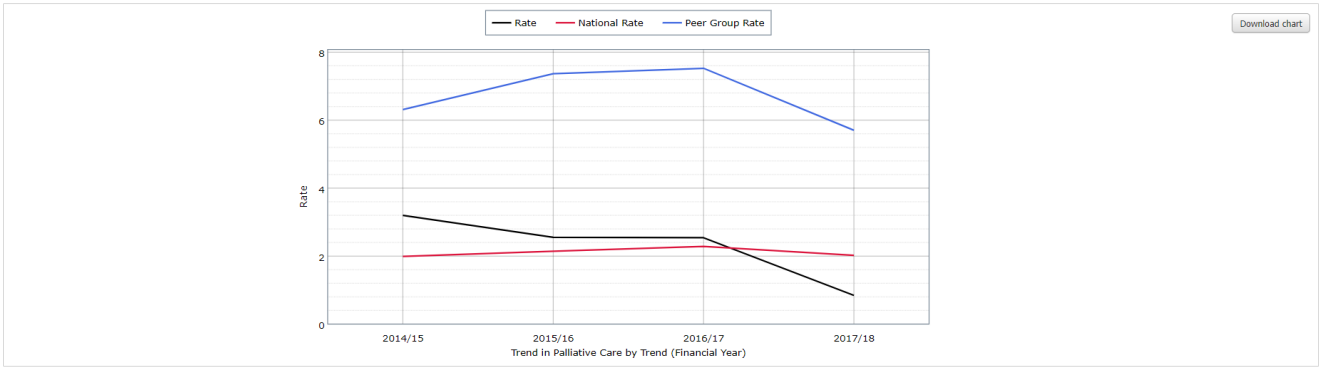
4. Palliative Care Coding rate

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.

- KCHFT palliative care coding rate is 0.85% for all diagnosis for FYTD 17/18.
- The national rate is 2.02%. The peer group rate is 5.70%.

Trend (Financial Year)	Spells	Observed	Rate (%)	National Rate (%)	Peer Group Rate (%)
2014/15	2,346	75	3.20	1.99	6.31
2015/16	2,153	55	2.55	2.14	7.37
2016/17	2,323	59	2.54	2.28	7.53
2017/18	355	3	0.85	2.02	5.70

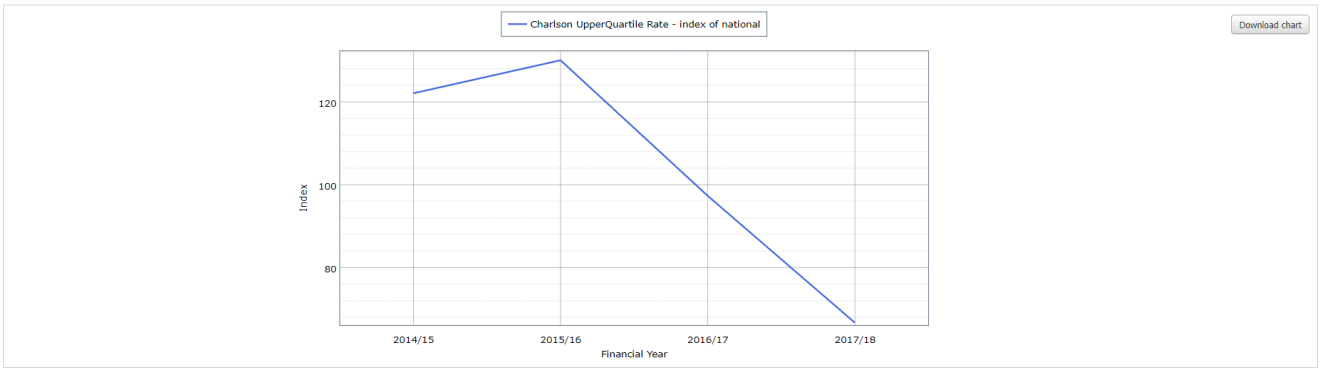


5. Charlson Co-morbidity

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 16.7% and as an index of the national is 67 for FY 17/18.

	2014/15	2015/16	2016/17	2017/18
Charlson comorbidity upper-quartile rate	30.5%	32.5%	24.3%	16.7%
Charlson rate as index of national	122	130	97	67



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Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	3.3
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):

This report summarises the position for patient experience in Quarter 1.

- 97% of patients are positive about their experience of care with KCHFT.
- The Friends and Family Test demonstrates an extremely positive recommend rate of 98%.
- The number of complaints is a decrease on Q4 2016/17 and shows a downward trend over the last year.
- There is good evidence that services are proactively responding to patient concerns.

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.

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Kent Community Health
NHS Foundation Trust

PATIENT EXPERIENCE REPORT
Quarter 1 2017/18

1. Situation

1.1 This report provides the Quality Committee 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. This report details the feedback for Quarter 1, 1 April to 30 June 2017.

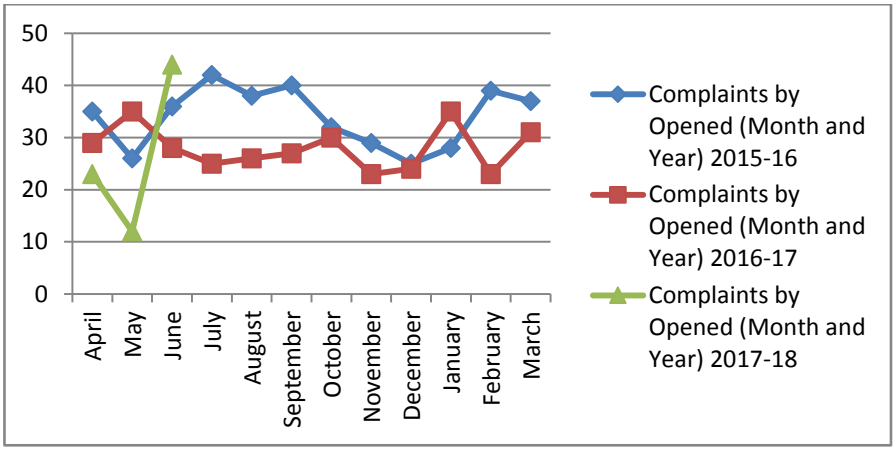
2. Background

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. 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 reflects the number of complaints per 10,000 contacts. There is an overall reduction Q1 this year (79) to Q1 last year (93), although the monthly figures are more irregular. The 79 complaints received in Q1 is also a decrease on Q4 (90). Part of the reason behind the increase in complaints in June is that 5 multi-agency complaints were received from EKHUFT (1 in May), and 4 comments received by PALS in May could not be resolved locally and have been logged as complaints in June.

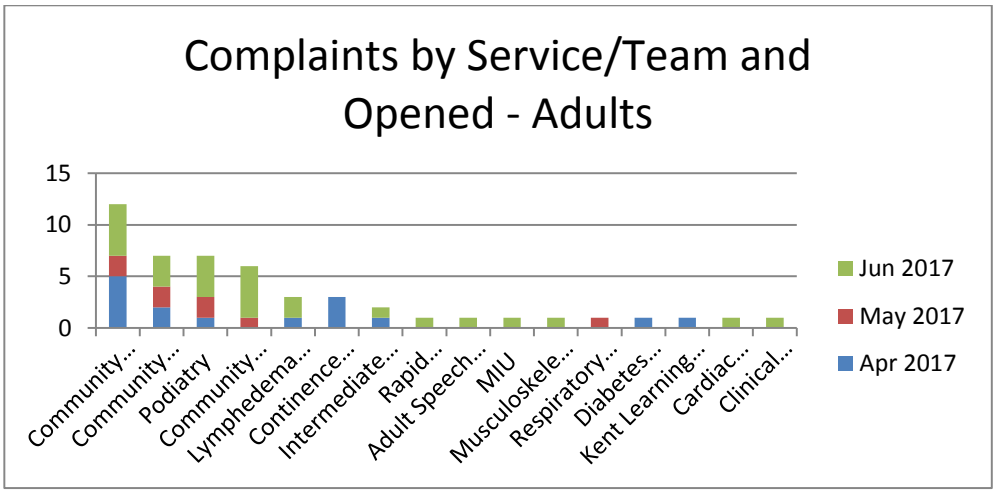


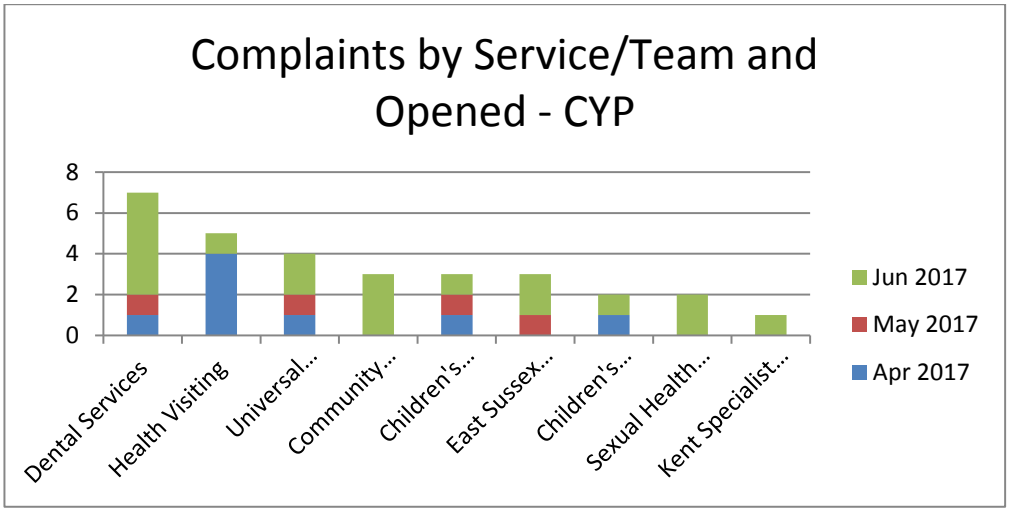
3.2 **Benchmarking against other providers**

KCHFT have benchmarked with other Community Trusts via the Benchmarking Trust and has a considerably lower number of complaints than others (appendix 1). The Trust is well below the average when compared with others and for 3 of the 6 months had the lowest number of complaints. This data reflects the information shared by Healthwatch who have confirmed that they receive very few negative comments about the Trust.

3.3 Complaints across services

The number of Q1 complaints by service is set out in the chart below. Community Nursing services continue to receive the highest number, this is the service with the most patient contacts. The Dental service is operating a newly commissioned service in London which has changed access criteria and patients are not yet used to this. they have also , this includes different levels of access has opened new sites in London Increases are evident in Chronic Pain and Podiatry services. Complaints from the continence service following the change in supplier and products have stopped indicating patients are now more content with the service. The higher number of complaints in June is spread across several services.





3.4 **Themes and details**

Complaints may have more than one aspect so may be detailed in two categories below.

Clinical Treatment

During the quarter there were 23 complaints that fell into this category, a significant increase on Q4 which had 13. These complaints were 17 for adult services, 4 for children's services, 1 for Dental and 1 for sexual health and included:

- Delay of 2 year children's check
- Unhappy that service wanting to discharge long term terminal patient from service
- Unhappy with dental care provided
- Unhappy with care provided after cancer operation regarding home visits and dressings used
- Unhappy with treatment at MIU
- Unhappy that no diagnosis for autism given x 2
- Patient care at Westview
- Comments requested on role of Tissue Viability nurses and how they liaise with community nursing teams
- Querying why patient got sepsis only days after discharged from community nursing
- Unhappy with delay in changing catheter
- Unhappy with pain management by chronic pain service
- Unhappy with podiatry treatment and care by service x 2
- Query on removal of vacuum pump by nurses
- Query on missed fracture when inpatient
- Comments requested on care provided by cardiac team
- Unhappy that coil fitted incorrectly
- Not listening to mother at health visitor appointments and child now deceased
- Query on information given by dietetics staff in hospital regarding thickening liquids
- Query on care provided in hospital and need to transfer to acute hospital
- Unhappy with the lack of physio in hospital
- Family querying fracture not diagnosed in hospital until insisted on x-ray

Admissions, discharges and transfers

During the quarter there were 8 complaints (5 in adult services and 3 in children's services) for Q1, a decrease of 18 in the previous quarter. Complaints that fell into this category include:

- Issues relating to patient discharge from the community nursing teams for home visits
- Unhappy with discharge from community hospital x 2
- issues relating to discharge from Lymphoedema and Chronic Pain services x 2
- Unhappy that therapy has been withdrawn as child now home schooled
- Unhappy with waiting times x 2

Access to treatment and medication

During the quarter there were 21 complaints that fell into this category (14 for adult services and 4 for children's services, 2 Dental and 1 Sexual Health). The majority of these concerns were in relation to:

- Unhappy with the new continence provider / new products not fit for purpose x 4
- Unhappy with delay in getting dental appointment after our referral
- Unhappy with lack of support from nursing and ancillary services
- Unhappy with sexual health service and felt staff passed onto others to avoid treating.
- Unhappy with wait for equipment for child
- Unhappy with MSK Physiotherapy provided
- Issues with delays and difficulties getting podiatry appointments x 3
- Unhappy with delay in getting chronic pain appointment
- Unhappy that there is only one day during working hours that clinic is available
- No visit to administer insulin
- No appointments available as dental surgery closed and as patient has HIV no staff can treat
- Lack of adult speech and language appointments
- Delay in receiving speech and language therapy
- Actions agreed with family not followed up
- Unhappy with role of complex care nurse
- Unhappy with delay in receiving catheter care

Values and behaviours

During the quarter there were 13 complaints that fell into this category (7 in adult services and 4 in children's services and 2 in Dental), a similar number to Q4. These concerns included:

- Staff attitude x 5
- No consent to vision and screening test
- Discrimination as patient in wheelchair
- Poor handling of patient records
- Unhappy to have to pay for patient transport x 2
- Breach of confidentiality x 3

Communication

During the quarter there were 14 complaints that fell into this category (5 in adult services, 7 in children's services and 2 in Dental), a decrease from 22 in Q4. The concerns were in relation to:

- Unhappy that information shared with one parent and not the other
- Lack of support or contact from health visitor
- Wanting clinical letter to GP changed

- Unhappy that patient record changed incorrectly
- Unhappy in receiving ante natal letter after miscarriage
- Lack of information to family about respiratory care
- Telephone never answered at Dental Surgery and not aware of transfer of provider
- Lack of communication by speech and language team
- Unhappy that no emergency dental appointment booked
- Incorrect letters sent with wrong appointments dates on x 2
- Difficulty in contacting service as mail box full
- Poor communication with children's community nursing service
- Unhappy that patient weighed and measured without consent

4. Ombudsman Cases

4.1 There are currently no complaint cases with the Ombudsman.

4.2 During the quarter we received 1 Ombudsman ruling and the case was not upheld. EKHUFT was leading on this complaint and it involved KCHFT as the patient was unhappy with rehabilitation care and treatment received in a community hospital following a stay in EKHUFT.

5. Response Times

5.1 The Trust aims to respond to complaints within 25 working days and for more complex complaints/cases within 60 working days. During Q1 the Trust responded to 84% of all complaints within the timescale initially agreed. Some of the delays have been caused by challenges in accessing patient records held by the acute trusts. The Information Governance Team are working on this. Where delays occurred regular contact was made with the patient/family to keep them updated.

6. Complaint Feedback

6.1 The Trust surveys complainants after the complaint is closed in order to get feedback on the way their complaint was handled. In Quarter 1 there were 2 responses to the Trust's survey sent to complainants. This is a low number and reflects the situation with other local health providers.

7. The Customer Care Team (PALS)

7.1 When the Customer Care Team receives an enquiry or concern they contact the service to ask them to resolve the issue, and to 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:

- People who want to contact the service but have misread the contact details
- Verbal Compliments

8. Compliments

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

Directorate	Written Compliments	Verbal Compliments	Total
Adults	126	35	161
Adults – Health Improvement & Self-Management	32	64	96
Children and Young People	24	28	52
CYP- Dental	-	-	-
CYP – Sexual Health	13	28	41
Other Directorate	1		1
TOTAL	**196**	**155**	**351**

Complimentary comments:

- I think an angel sent you. When we were going through a difficult time in our lives you made us laugh and smile. You always got time to listen and you have not always seen us at our best frame of mind. We will miss your visits. A big thank you. You should be proud of what you do.
- A huge, huge thank you for your upmost kindness, your dedication, professionalism, your wonderful patience towards my dear mother, we shall miss your team and your friendliness each day. We wish you continuous success and a very happy safe 2017. You're all stars.
- Thank you for all you did for (patient name), and the support you have given me. Without you I wouldn't have been able to manage as well as I did. You are a credit to the role of nurses.
- I think you're very genuine and you really care about the people you work with. You treat me as an individual.
- Thought I had died and gone to heaven. Everyone is so kind helpful and patient & happy working so well together. Your care is priceless.
- Thank you for this service without clinics like this people like myself with long term chronic illness and disabilities would not get any support or very little with feet issues. I am showed so much care and compassion and understands my condition. She is a valuable member of staff and I do not know where I would be without this treatment.

8.1 **Patient Experience**

Meridian data

The Trust's overall patient experience score for quarter 1 is 96.55% based on 18,115 completed surveys. There was a small increase in survey returns when compared with quarter 4 of 2016/17 (18,034 surveys) where the satisfaction score was 96.9%.

8.3 The Trust's NHS Friends and Family Test (FFT) score demonstrates an extremely positive recommend rate of 97.66% responses, which is consistent with the last quarter (97.28%).

16,824 people answered the FFT question, with a minority of 95 patients being unlikely or extremely unlikely to recommend. The below tables allow comparison of Q4 2016/17 with Q1 2017/18.

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q4 2016/17	**97.28%**	**0.65%**	**16,401**	**13,389**	**2,566**	**214**	**51**	**55**	**126**
Q1 2017/18	**97.66%**	**0.56%**	**16,824**	**13,887**	**2,544**	**193**	**46**	**49**	**105**

8.4 Tables showing further breakdown of the FFT score can be seen in the appendix. These findings demonstrate high levels of satisfaction within the services. All surveys which receive an unlikely or extremely unlikely response to the FFT question are recorded are included in Quality Group reports and teams will take action where there is negative feedback, if possible.

Examples of negative feedback and actions include:

Service	FFT question response	Reason for negative FFT response	Action taken
Children's Audiology (Hearing Service) - Gravesend	Extremely unlikely	The Paediatric Audiologist – (staff named removed by Patient Experience Team) was the most arrogant Health Person I have ever encountered. I am very angry and was very upset by his actions. Although he treated my child ok he would not let me ask questions, he talked over the top of me and also spoke to me without any respect. At one point he referred to my child's visit as TIME WASTING!	Treated as a complaint and resolved – the clinician rang the parent, apologised and explained he was trying to advise the best pathway for the child.
Community Nursing - Canterbury East	Unlikely	When my catheter was dislodged and then removed recently in the morning a phone call was made to the nurses but it was not until 8pm that night that the situation was resolved. The nurses from Herne Bay / Dover excellent, more difficulties with Canterbury.	The service has reviewed the way in which administrators deal with incoming calls to the team. Calls are now prioritised and discussed with the senior clinician on duty in order to triage and then forwarded to staff tablets, for visits to take place appropriately in a timely matter. The team has also received support from other services to cover some staffing shortfalls and this remains a high priority on a daily basis.
Continence Project Team - West Kent	Unlikely	Pads are not as good as Hartmans. Night pad I'm having wet underwear, day one ok. Not happy having to pay 10p per minute for phone call to Tena.	The service has offered a continuation of the previous product and the suppliers will be changing their telephone number to a local rate.

Dental (Adult and Children) - Five Elms Medical Centre	Unlikely	The booking system, now centralised, is not up to standard. Long wait, Incorrect appointment booked. Difficult to get hold of.	The service will have designated reception staff at each site which will enable patients to book appointments immediately following their consultation appointment. A new telephone system is will be being installed which will enable easier telephone.

8.6 Patient experience is measured across seven key areas. The table below demonstrates overall scores with extremely positive responses. There are three areas which are less positive; the most prominent of these is 'Other' but this relates to one service where the client/patient answered 'don't know'.

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)	673	96.91%	91.28%	99.22%	98.62%	98.23%	98.91%	99.06%
Canterbury and Coastal	1520	98.17%	93.79%	99.59%	96.62%	98.43%	98.00%	99.52%
Dartford, Gravesham and Swanley	1053	96.44%	-	99.81%	97.56%	98.38%	98.83%	99.62%
Dover, Deal and Shepway	1124	98.31%	89.20%	99.33%	97.45%	98.45%	98.74%	99.01%
East Sussex (Locality)	361	98.87%	100.00%	99.50%	96.10%	98.56%	100.00%	100.00%
External Pharmacies (Locality)	206	-	-	-	-	-	-	-
Maidstone, Malling, West Kent and Weald	2095	98.22%	95.45%	99.59%	97.28%	98.57%	98.96%	99.10%
Medway (Locality)	384	95.28%	83.33%	98.35%	96.71%	98.62%	98.32%	98.26%
Other	251	98.80%	50.00%	97.78%	100.00%	98.74%	100.00%	100.00%
Swale (Locality)	542	97.70%	92.86%	99.62%	99.52%	98.58%	98.85%	99.54%

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
Thanet (Locality)	1143	98.62%	94.17%	99.63%	96.93%	97.97%	98.62%	99.82%
Trust Total	**9114**	**97.88%**	**93.76%**	**99.48%**	**97.38%**	**98.41%**	**98.77%**	**99.36%**

9. Actions

The below actions are a selection from closed complaints and Meridian feedback:

Sexual Health Service, Ashford
Following feedback from patients who said they were unable to make an appointment as telephone calls went straight into an answer message, the service updated the message directing callers to the 0300 central booking line number.

Phlebotomy service, QVMH, Herne Bay
The service implemented various actions to improve the appointment system for their patients. This was as a result of feedback from unhappy patients who had been turned away, as occasionally happened when the service operated the ticket system and too many patients arrived on the same day. Some of the actions taken as a result include:

- Installation of an additional telephone line and moving to a Voice Over Internet Phone (VOIP) telephone system whereby there is a loop and phone message informing patients that the phones are busy. There will be no holding system or answer phone message put in place.
- A generic email account has been set up to make it easier for reception and healthcare staff to request urgent blood tests for patients, particularly during peak periods when urgent/fasting blood tests are offered (email address not for public use).
- A message has been added onto the KCHFT website and NHS Choices informing patients of the new appointment system. GP surgeries have been updated with the new appointment system information and signage has also been amended in the outpatient main reception and clinic area.

Intermediate Care, Ashford
Following a complaint regarding missed visits the service now has their caseloads on CIS, and the patients are allocated to staff via the CIS system to the staff tablet. The patient will stay on the staff member's system until they have taken them off, i.e. when they have seen them. It will be very clear to staff if they have missed a patient. The system also shows on the main computer which patients have or have not been seen. A fail safe back-up is also being brought in by teams so patient lists will be emailed to staff via secure email to cover the event of CIS / power failing.

Community Nutrition Service, Whitstable Health Centre
Feedback received from patients saying there are no clear instructions on how to book in on their arrival at the clinic. The service now has a poster on display that clearly informs patients of the process to follow when attending the clinic for an appointment.

10. NHS Choices / Patient Opinion comments

10.1 There were **36** comments on NHS Choices and Patient Opinion during the quarter. A selection of these is listed below. Services have been alerted to negative comments and will be taking action.

Edenbridge Minor Injury Unit
Visit on Easter Sunday
Visited as concerned about my sons cast on his arm. Lovely receptionist - so friendly. Nurse made us feel so welcome and was great with our son. The nurse put aside any fears about us wasting time and was really amazing. Thank you! All this on Easter Sunday!

Phlebotomy Service, QVMH, Herne Bay
A long wait at the phlebotomy clinic
Booked up for 8am appointment and given number 18. Arrived at 7.45 and only on number 9. Door was stuck meaning people couldn't get in and were queueing outside. Finally got my 8am appointment at 8.20. The nurse was run off their feet. Apparently they were short staffed. How about admin not fully booking up their day then if you know you're short? Please, please, please bring back the old system. The other 7 people in the waiting room seemed to agree.

Deal Minor Injury Unit
Excellent Deal minor injuries
I had to attend minor injuries at deal hospital today, what an amazing team they have there, I was seen so quickly, I know if had been busy would have taken longer, cannot thank all members enough, you hear people complaining about the NHS, I cannot give enough praise and thanks to them

Dental Service, New Street, Sandwich
Brilliant dentist, amazingly poor receptionist!
I travel some miles to attend New Street dentist practice and while I couldn't be more pleased with the dentist and hygienist, the receptionists are beyond rude! No one likes a trip to the dentist and being looked down on and patronised by the receptionists who make it abundantly clear that being young disabled and on benefits makes me of little worth is rather stressful and hurtful. I don't enjoy being tutted at like errant school child when trying to make them aware of my medical history and I certainly don't enjoy being dismissed like three year in need of time out while on the phone to them.

Sheppey Minor Injury Unit
Anonymous gave Minor injuries unit at Sheppey Community Hospital a rating of 2 stars
30 min wait on the board but actually 1.5 hour wait! Was advised 30min wait but waiting 1.5 hours with a child. Others seemed to book in and go straight round. Unacceptable.

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. 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.

11.2 A report published by Healthwatch was presented to KCHFT in June 2017.The report summarises all the feedback they have from the public from January to March 2017. There were 6 individual experiences reported to them during this time. 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.

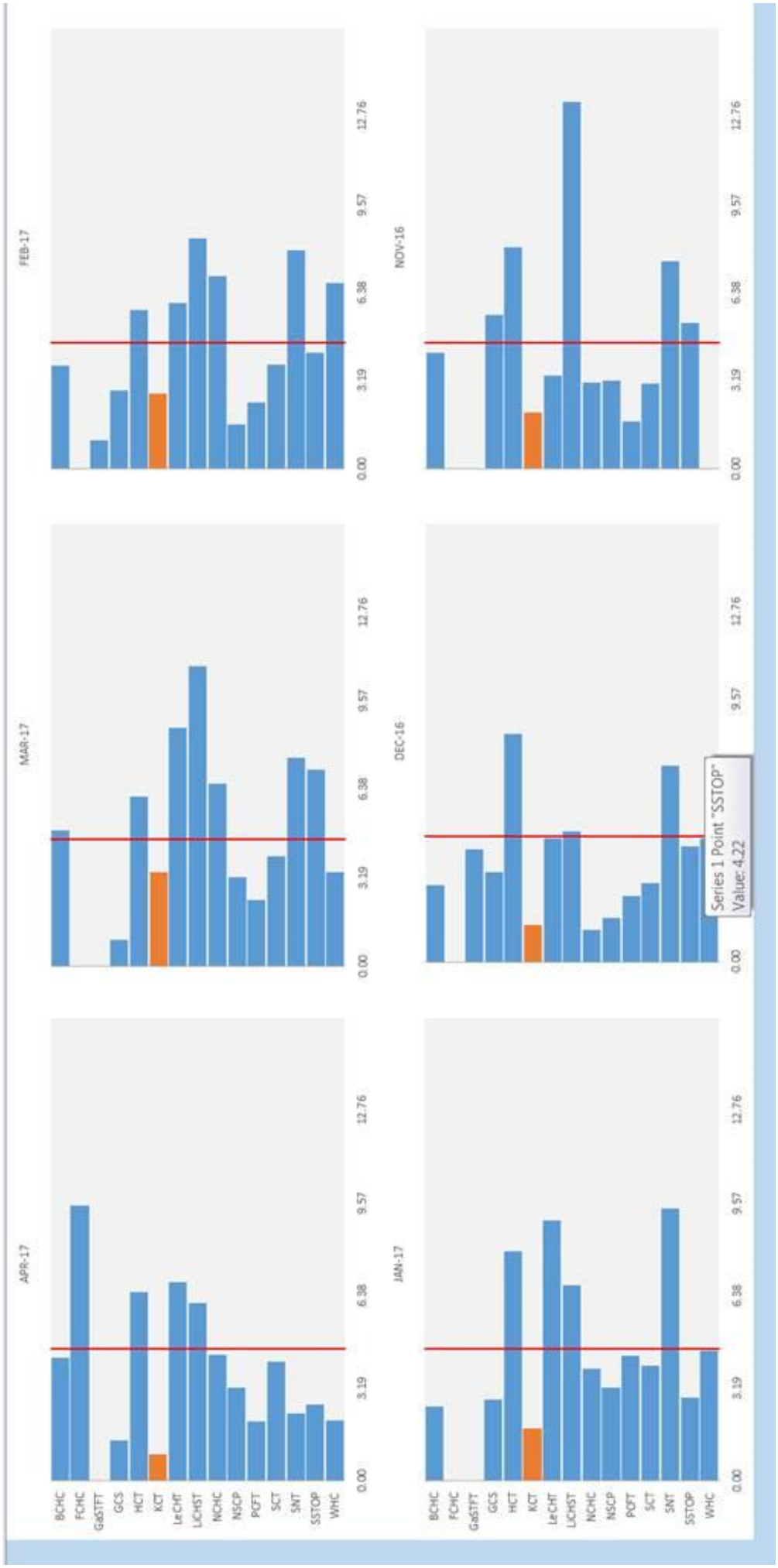
12. Recommendations

The Quality Committee are asked to note the report.

Ruth Herron
Deputy Chief Nurse
July 2017

Kent Community Health
NHS Foundation Trust

Appendix 1 Benchmarking of the number of formal complaints, per 1,000 WTE budgeted staff November 2016 to April 2017 (KCT is KCHFT)


APR-17
MAR-17
FEB-17
JAN-17
DEC-16
NOV-16
BCHC
FCHC
GdSTFT
GCS
HCT
KCT
LeCHT
LCHST
NCHC
NSCP
PCFT
SCT
SNT
SSTOP
WHC
0.00
3.19
6.38
9.57
12.76
Series 1 Point "SSTOP"
Value: 4.22

Appendix 2

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)	97.01%	0.88%	568	432	119	6	4	1	6
Canterbury and Coastal	97.41%	0.63%	1586	1257	288	21	3	7	10
Dartford, Gravesham and Swanley	97.64%	0.62%	1781	1494	245	15	8	3	16
Dover, Deal and Shepway	98.75%	0.47%	3205	2644	521	20	9	6	5
East Sussex (Locality)	89.77%	2.51%	518	306	159	24	5	8	16
Maidstone, Malling, West Kent and Weald	97.26%	0.48%	3358	2746	520	50	7	9	26
Medway (Locality)	95.97%	1.34%	372	289	68	7	1	4	3
Other	96.43%	0.79%	252	176	67	3	1	1	4
Swale (Locality)	99.01%	0.20%	3950	3601	310	24	4	4	7
Thanet (Locality)	96.35%	0.81%	1234	942	247	23	4	6	12
Summary	97.66%	0.56%	16824	13887	2544	193	46	49	105

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%	1	1	0	0	0	0	0
Community Chronic Pain - Hillingdon	100.00%	0.00%	21	12	9	0	0	0	0
Dental (Adult and Children) - Five Elms Medical Centre	92.31%	7.69%	13	7	5	0	1	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
Dental (Adult and Children) - Hainault Health Centre	100.00%	0.00%	2	2	0	0	0	0	0
Dental (Adult and Children) - Langthorne Health Centre	100.00%	0.00%	10	10	0	0	0	0	0
Dental (Adult and Children) - Loxford Polyclinic	100.00%	0.00%	9	8	1	0	0	0	0
Dental (Adult and Children) - South Hornchurch Health Centre	100.00%	0.00%	10	6	4	0	0	0	0
Dental (Adult and Children) - St Leonards Hospital	88.89%	11.11%	9	8	0	0	0	1	0
Dental (Adult and Children) - The Barkantine Centre	100.00%	0.00%	8	6	2	0	0	0	0
Dental (Adult and Children) - Vicarage Fields Health Centre	100.00%	0.00%	9	6	3	0	0	0	0
Dental (Adult): Harmondsworth Immigration Removal Centre	100.00%	0.00%	16	8	8	0	0	0	0
Dental (Adult): HMP Maidstone - Maidstone	100.00%	0.00%	3	3	0	0	0	0	0
Dental (Adult): HMP Swaleside - Swale (Isle of Sheppey)	100.00%	0.00%	4	1	3	0	0	0	0
Dental (Adults and Children) - Appleby Centre	96.43%	0.00%	56	44	10	1	0	0	1
Dental (Adults and Children) - Shrewsbury Centre	93.33%	0.00%	75	50	20	2	0	0	3
Frequent Service User	100.00%	0.00%	1	0	1	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
Manager									
KM CAT Service - Adult Team	100.00%	0.00%	5	4	1	0	0	0	0
Summary	96.43%	0.79%	252	176	67	3	1	1	4

The table below shows the FFT scores for Minor Injury Units (MIUs) in the first quarter.

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)	99.64%	0.36%	839	753	83	0	2	1	0
Minor Injury Unit (Community Hospital in Edenbridge)	99.23%	0.00%	517	418	95	4	0	0	0
Minor Injury Unit (Community Hospital in Sevenoaks)	98.78%	0.30%	656	591	57	2	1	1	4
Minor Injury Unit (Gravesham Community Hospital)	99.72%	0.28%	715	665	48	0	2	0	0
Minor Injury Unit (Royal Victoria Hospital, Folkestone)	98.44%	0.50%	1410	1112	276	14	3	4	1
Minor Injury Unit (Sheppey)	99.24%	0.00%	1322	1230	82	7	0	0	3
Minor Injury Unit (Sittingbourne)	99.80%	0.05%	2026	1929	93	2	1	0	1
Summary	99.29%	0.20%	7485	6698	734	29	9	6	9

The following shows FFT scores for community hospital in-patients in the first 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	100.00%	0.00%	19	16	3	0	0	0	0
Community Hospital (Edenbridge)	94.59%	2.70%	37	25	10	1	1	0	0
Community Hospital (Faversham)	100.00%	0.00%	38	24	14	0	0	0	0
Community Hospital (Hawkhurst)	100.00%	0.00%	25	19	6	0	0	0	0
Community Hospital (Herne Bay) - Heron Ward	96.15%	0.00%	26	17	8	1	0	0	0
Community Hospital (Sevenoaks)	97.14%	0.00%	35	20	14	1	0	0	0
Community Hospital (Tonbridge) - Goldsmid Ward	100.00%	0.00%	15	14	1	0	0	0	0
Community Hospital (Whitstable and Tankerton) - Friends Ward	100.00%	0.00%	16	14	2	0	0	0	0
Summary	98.10%	0.47%	211	149	58	3	1	0	0

There are no surveys on the system for Community Hospital (Tonbridge) Somerhill and Primrose Ward. They are now collecting patient feedback.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	3.4
Subject:	Six Monthly Freedom to Speak Up Guardian's Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

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

Report Summary (including purpose and context)
The report provides the Board with a summary of concerns raised by staff under the Freedom to Speak Up policy from April 2017 to September 2017. These are concerns logged by the Freedom to Speak Up Guardian and do not include issues raised locally with managers and then resolved by them.

Proposals and /or Recommendations
To note the report

Relevant Legislation and Source Documents
Freedom to Speak Up Policy
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.

Karen Edmunds, Freedom to Speak Up Guardian	Tel: 0300 123 4489
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Kent Community Health NHS Foundation Trust

FREEDOM TO SPEAK UP GUARDIAN'S REPORT
22 March 2017 to 12 September 2017

1. Introduction

1.1 The Trust has had a Freedom to Speak Up Guardian (FTSUG) in post for 12 months. There are a range of promotional materials about Speaking Up, a page on Flo and a screensaver. To date the FTSUG has logged and been involved in 18 cases, made presentations about speaking up to the EADs and Heads of Service, 13 frontline teams, patient/public representatives (volunteers) and public governors. We are now developing a 'Speaking Up Ambassadors' programme.

1.2 The National Guardian, Dr Henrietta Hughes, will be visiting the Trust on 4 December 2017. Freedom to Speak Up will be assessed by the CQC under the 'Well Led' domain.

1.3 This report covers the period 22 March 2017 to 12 September 2017.

2. Summary of cases

2.1 Appendix 1 contains a summary of the nine cases dealt with (a slight increase from seven in the previous six months). Three were informal and six required the FTSU Guardian to either escalate or support staff to escalate. One was not pursued under the Freedom to Speak Up policy and so is not included in this report. No concerns were raised anonymously to the FTSU Guardian and most staff made their initial contact with the FTSU Guardian by telephone.

2.2 The main theme of concerns raised during Q1 and Q2 of 2017-18 related to unsafe staffing levels, in particular staff shortages due to sickness, leave and vacancies, including during the summer holiday period.

3. Fostering a culture of openness

3.1 We have reviewed the concerns raised to date and identified the need to:

- Ensure managers are clear about the speaking up process and the support available. We will be producing a guide for managers.
- Engage frontline staff in promoting the benefits of raising concerns at an early stage. We will be recruiting and training Speaking Up Ambassadors.
- Consider the wider benefits of earlier staff engagement during service restructures. This will be discussed with the Organisational Development Business Partners.

4. Recommendations

The Board is asked to note this report.

Karen Edmunds
Freedom to Speak Up Guardian
12 September 2017

Appendix 1: Concerns raised 22 March 2017 to 12 September 2017

Quarter Opened	Status	Main theme of concern	Summary of concern	Directorate	Summary of outcome / actions
Q1 17-18	Completed	5. Quality and safety	Concerns regarding apparent missed insulin injections over a period of time. Reported on Datix but no actions or shared learning and no improvement. Recently had three patients with missed insulin by day staff. Handed to evening staff. When nurse raised with Head of Service claims that they were told not to datix. Staff member is feeling that by raising concerns they are seen as a troublemaker and reports they have experienced alleged bullying behaviour from managers.	Adult Clinical	Advised nurse of options and as it is about patient safety it needs to be escalated quickly, either to Community Services Director (CSD) or Chief Operating Officer (COO). As didn't hear further from staff member, FTSU Guardian raised with CEO who asked the Chief Nurse to investigate. Chief Nurse was due to go on leave and so the Deputy Chief Nurse spoke to staff member and then the service manager. Deputy Chief Nurse identified there had been a misunderstanding. As a result a memo was sent out detailing when an incident should be raised and when this is considered a missed visit. Deputy Chief Nurse then contacted the staff member who is happy with this outcome. The learning from this has been shared at a general level with team leaders and the evening service at the monthly joint meeting. In addition the Pharmacy team have reviewed the datix data to identify any themes and trends. In addition a 'lessons learned' was shared at Adult Quality Group.
Q1 17-18	Completed	3. Staffing levels	Concerns raised re: staff shortages due to staff leaving and sickness absence. Team Co-ordinator has resigned and Locality Manager is perceived by team as hard to engage with. Team members are stressed. They are struggling to cover work of colleagues off sick, plus have vacant posts. Have been putting issues on Datix but no action seems to be taken. Staff are not getting 1:1s in absence of Team Co-ordinator. There is also a SI Investigation going on which is adding to everyone's stress levels	Children and Young People	Staff member escalated by email to Head of Service (HoS) and Assistant Director (AD). AD and HoS met with the team. AD thanked staff member for raising the concerns and assured them that they would try to help. AD updated FTSUG to say meeting went well and they will be putting some restorative supervision in place. Also new staff due to start soon.

Quarter Opened	Status	Main theme of concern	Summary of concern	Directorate	Summary of outcome / actions
Q2 17-18	Completed	3. Staffing levels	Concerns about unsafe staffing levels. Staff member very concerned about patient safety. They stopped taking IV referrals but no other restrictions and managers have left to discretion of frontline staff who to take on caseload. Staff member has talked to the Lead Nurse and is aware that more staff are being recruited, but meantime things are getting really bad.	Children and Young People	Nurse did escalate to team leader. Since then have been using bank staff plus 3 new staff due to start in August. Things much improved. Glad she spoke up.
Q2 17-18	Completed	3. Staffing levels	Concerns about unsafe staffing levels. Staff member is a nurse and is feeling very emotional and considering resigning. Have been covering caseload of neighbouring team and now they themselves need support, but are not getting it. Managers aware and sympathetic but no action being taken. Staff member feels patients are at risk.	Adult Clinical	Staff member escalated to Community Services Director (CSD) by email. CSD met staff member to discuss their concerns, but staff member felt the meeting was not totally productive. Therefore put her remaining concerns in writing to CSD and proposed actions and timescales. Subsequently a colleague of the staff member made the Chief Operating Officer (COO) aware of the concerns. COO discussed with Chief Nurse. COO fed back to FTSUG that staff member has been advised to prioritise caseload and will be fully supported to do this.
Q2 17-18	Completed	3. Staffing levels	Staff feel that current staffing levels are unsustainable and that changes in working practices are causing low morale, high sickness levels and staff are leaving. Staff feel that local managers are not listening. Changes are being imposed.	Children and Young People	FTSUG met with eight staff and summarised their concerns in email back to them. Staff then forwarded concerns to Deputy Chief Operating Officer (DCOO) and CEO. DCOO contacted FTSUG on return from leave and asked FTSTUG to contact staff and offer a meeting next week. Meeting took place with DCOO and Head of Service. A number of issues were identified which will now be addressed by Head of Service with Locality Managers and Team Co-ordinators.
Q2 17-18	Completed	3. Staffing levels	Staff member feels that current staffing levels are unsustainable and that patients are at risk. New staff are due to start in September but the service is at crisis point.	Adult Clinical	FTSUG phoned Chief Operating Officer (COO) and advised of issue. COO phoned staff member and arranged to meet them the next day. COO made Chief Nurse aware. COO advised staff member that they can prioritise the team caseload and will be supported to do this.
Q2 17-18	Completed	3. Staffing levels	Concerned at staffing levels and lack of business continuity plan	Adult Clinical	Informal advice given by FTSGUG that staff member should raise at that day's team meeting, and that a business continuity plan is needed.
Q2 17-18	Completed	1. Attitudes and behaviours	Claim of unreasonable behaviour of manager towards admin staff. Reports of them being rude, belittling in front of others and singling out particular people. Staff member says it has been going on for several years.	Children and Young People	Informal advice given by FTSUG that staff member should escalate to Head of Service. Staff member subsequently decided not to as they are leaving the Trust.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 September 2017
Agenda Item:	3.5
Subject:	Emergency Preparedness, Resilience and Response Annual Assurance Process Report
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary (including purpose and context)

A set of core standards for Emergency Preparedness, Resilience and Response (EPRR) has been in place since April 2013. All organisations who receive NHS funding are asked to carry out an assessment against the NHS Standards for EPRR.

In August 2017 Kent Community Health NHS Foundation Trust (KCHFT) performed a self-assessment and achieved a substantial level of compliance against the EPRR Core Standards.

Proposals and /or Recommendations

For the Board 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. 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.

Natalie Davies, Corporate Services Director	Tel: 01622 211600
	Email: Natalie.davies1@nhs.net

Kent Community Health NHS Foundation Trust

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ANNUAL ASSURANCE REPORT 2017/18

1. Introduction - Assurance Process

A set of core standards for Emergency Preparedness, Resilience and Response (EPRR) have been in place since April 2013. All organisations who receive NHS funding are asked to carry out an assessment against the NHS Standards for EPRR.

In August 2017 Kent Community Health NHS Foundation Trust (KCHFT) performed a self-assessment and achieved a substantial level of compliance against the EPRR Core Standards.

2. Assurance Visit 2017

The NHS North and East London Commissioning Support Unit visited the Trust on 29th August 2017; the meeting was attended by the Head of EPRR and the Assistant Director of Compliance.

The assurance audit was conducted to demonstrate to the commissioners the preparedness of KCHFT against the NHS England EPRR Core Standards.

The audit provided evidence against each of the core standards identified by NHS England as being required to be in place by a community provider.

The investigated areas were;

- EPRR Core Standards
- Deep Dive – Governance
- HAZMAT and CBRN Response

3. Audit Results

Based on the levels of assurance from NHS England the self-assessment demonstrated the Trust meets the requirements for substantial compliance.

The Trust has a robust Lockdown policy in place however site specific Lockdown plans are required to be implemented across sites where the Trust is a tenant. While the Trust has implemented Lockdown plans for Trust occupied areas and staff, this should be discussed at the Local Health Resilience Partnership (LHRP) as KCHFT is a tenant on these sites and a site wide plan covering other tenants and services would be a landlord responsibility.

The Mass Casualties plan is currently in draft and awaiting clarification from the LHRP as to whether it is felt suitable or is a requirement that the KCHFT MIUs would be used as treatment centres in the event of a mass casualty incident in the county.

Robust arrangements are in place that appropriately addresses all of the core standards that the Trust is expected to achieve. This report will be presented to the Board to be agreed and approved.

Kent Community Health
NHS Foundation Trust

Jan Allen
Emergency Preparedness, Resilience and Response Manager
15 August 2017

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 28 September 2017
in The Council Chamber
Sevenoaks Town Council Offices, Bradbourne Vale Road, Sevenoaks, TN13 3QG

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 27 July 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 27 July 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report • Sustainability and Transformation Plan Update • To approve the Trust Vision and Missions	Chief Executive	

Kent Community Health NHS Foundation Trust

2.	BOARD ASSURANCE/APPROVAL	
2.1	To receive the Quality Committee Chairman's Assurance Report • To approve the Terms of Reference	Chairman, Quality Committee
2.2	To receive the Audit and Risk Committee Chairman's Assurance Report	Chairman, Audit and Risk Committee
2.3	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse
2.4	To receive the Monthly Quality Report	Chief Nurse
2.5	To receive the Finance Report – Month Five	Director of Finance
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To approve the Mortality Review Policy	Medical Director
2.8	To approve the Trust Constitution	Corporate Services Director
2.9	To appoint the Senior Independent Director	Corporate Services Director
2.10	To approve the proposal for the formation and Terms of Reference of a Workforce Committee	Director of Workforce, Organisational Development and Communications

Kent Community Health NHS Foundation Trust

2.11	Policies for Ratification • Gender Identity At Work • Induction • Managing Sickness Absence • Organisational Change	Director of Workforce, Organisational Development and Communications

3. REPORTS TO THE BOARD

3.1	To receive the Safeguarding Annual Report 2016/17 • To approve the Slavery and Human Trafficking Statement	Chief Nurse
3.2	To receive the Monthly Mortality Report	Medical Director
3.3	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.4	To receive the Six Monthly Freedom to Speak Up Guardian's Report	Director of Workforce, Organisational Development and Communications
3.5	To receive the Emergency Preparedness, Resilience and Response Annual Assurance Process 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 30 November 2017; The Oak Room, Oakwood House, Maidstone ME16 8AE