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 30 March 2017

At

The Committee Room

Tonbridge and Malling Council Offices
Gibson Building
Gibson Drive
Kings Hill
West Malling
Kent
ME19 4LZ

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 30 March 2017
in Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling Kent
ME19 4LZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Chairman	
1.2	To receive any Apologies for Absence	Chairman	
1.3	To receive any Declarations of Interest	Chairman	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 26 January 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 26 January 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report	Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Quality Committee Chairman's Assurance Report	Chairman, Quality Committee	

Agenda

2.2	To receive the Audit and Risk Committee Chairman's Assurance Report	Chairman, Audit and Risk Committee
2.3	To receive the Charitable Funds Committee Chairman's Assurance Report	Chairman, Charitable Funds Committee
2.4	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse
2.5	To receive the Finance Report – Month 11	Director of Finance
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To receive the Quality Report	Chief Nurse
2.8	To approve the 2017/18 Finance Plan • Final Revenue and Capital Budgets 2017/18 • Operating Plan • 2017/18 Cost Improvement Programme	Director of Finance Chief Operating Officer/Deputy Chief Executive
2.9	To receive the 2016 Staff Survey Report	Director of Workforce, Organisational Development and Communications
2.10	To receive the Kent and Medway Sustainability and Transformation Plan Update Report	Chief Executive
2.11	To approve the People Strategy	Director of Workforce, Organisational Development and Communications

2.12	To approve the Risk Management Strategy	Corporate Services Director
2.13	Ratification of Policies • Professional Registration Policy • Annual Leave Policy • Annualised Hours Guidance • Probationary Period Policy • Ordinary Parental Leave Policy • Shared Parental Leave Policy • Maternity and Maternity Support Parental Leave Policy • Adoption/Surrogacy Leave Policy • Disciplinary Procedure Review Policy	Director of Workforce, Organisational Development and Communications

3. REPORTS TO THE BOARD

3.1	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.2	To receive the Seasonal Infection Prevention and Control Report – Winter • Infection Prevention and Control Declaration – December 2016	Chief Nurse
3.3	To receive the Six Monthly Freedom to Speak Up Guardian's Report	Director of Workforce, Organisational Development and Communications
3.4	To receive the Annual Use of Trust Seal 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 25 May 2017 Room 6 and 7 Trinity House, 110-120 Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ

Kent Community Health NHS
NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10.00 am on Thursday 26 January 2017
in The Colin Jackson Suite, The Julie Rose Stadium, Willesborough Road, Kennington, Ashford, Kent TN24 9QX

Meeting held in Public

Present:	David Griffiths, Chairman Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Gordon Flack, Director of Finance Peter Maskell, Medical Director Louise Norris, Director of Workforce, Organisational Development and Communications David Robinson, Non-Executive Director Bridget Skelton, 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

26/01/1 **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.

26/01/2 **Apologies for Absence**

Apologies were received from Peter Conway, Non-Executive Director; Richard Field; and Steve Howe, Non-Executive Director.

The meeting was quorate.

26/01/3 **Declarations of Interest**

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

26/01/4 **Minutes of the Meeting of 24 November 2016**

The Board **AGREED** the minutes.

26/01/5 **Matters Arising from the Meeting of 24 November 2016**

Audit and Risk Committee Chairman's Assurance Report – Ms Strong confirmed that once the draft Internal Auditor's (TIAA) report had been received, it was discussed with Mr Conway and Mr Howe. With regards to the verbal report from TIAA to the Committee, some of the issues had already been mitigated by the managers. The actions in the report suggested that there was not such a risk to the Trust as had initially been thought. An update had been provided on both agency and staffing and what mitigation had been put in place to ensure safety for each of the caseloads. The Committee would receive a further report at its meeting in February 2017. It was agreed that the action would remain open until the Non-Executive Directors had reported formally to the Board.
Action – Mr Conway

The Board **RECEIVED** the Matters Arising.

26/01/6 **Chairman's Report**

Mr Griffiths presented a verbal report to the Board.

Mr Griffiths and Mr Bentley had recently met Lord Carter at the request of NHS Improvement (NHSI). Following Lord Carter's 2016 Review into acute hospital operational productivity and performance, a similar review would be carried out into community services and an invitation had been extended to Lord Carter to visit the Trust.
Mr Griffiths had also attended a meeting of the Chairs of the Trusts involved in the Kent and Medway Sustainability and Transformation Plan (STP).
A number of service visits had been undertaken and there was a positive attitude amongst staff generally and more specifically regarding the Community Information System.

The Board **RECEIVED** the Chairman's Report.

26/01/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board.

With regards to winter pressures, these continued to be significant. Attendance numbers had increased compared to the same period in the previous year. The contribution of the Trust's teams and those working alongside in other Trusts was acknowledged in maintaining services.
With regards to contract negotiations, teams throughout the Trust had worked hard to ensure that the heads of terms on all the substantial contracts had been completed by the deadline in December 2016.
With regards to the delivery of services in Edenbridge, a public consultation

led by the West Kent Clinical Commissioning Group was close to being launched.
Ms Strowman and Mr Bentley had met with the Care Quality Commission (CQC). This was a regular meeting and the CQC had not identified any issues of concern.
The Executive Team had also met with NHSI. This was a regular monitoring meeting and NHSI had been satisfied with the Trust's current quality, financial and workforce position.
Dr Sarah Phillips had been appointed Medial Director of the Trust and would be replacing Dr Peter Maskell who was leaving to take up a new appointment with Maidstone and Tunbridge Wells NHS Trust. Ms Strong had been appointed as Chief Operating Officer for the Trust and Ms Claire Poole had been appointed as Deputy Chief Operating Officer.

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

26/01/8 **Quality Committee Chairman's Assurance Report**

Mr Robinson presented the report to the Board for assurance.

With regards to the Quality Impact Assessments (QIA) of the Cost Improvement Programme (CIP), the Quality Committee had responsibility to monitor them. Deep dives took place at regular intervals and Non-Executive Directors visited services to meet staff to gauge how well they had been involved in the development of the QIA and its implementation and assessment. A recent visit had taken place to Deal Long Term Services where it had been found that the risk assessments of the schemes were accurate. Ms Barber had joined the visit and had been pleased with the process in place and the response from staff. She suggested that it would be worthwhile to measure the impact of the QIAs throughout the year, which in turn could be shared with the commissioners.

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

26/01/9 **Charitable Funds Committee Chairman's Assurance Report**

Ms Tippin presented the verbal report to the Board for assurance.

The Committee had met the previous day and approved the 2015/16 Annual Accounts. Prior support for the accounts had been received by the External Auditors. The accounts showed a net reduction in funds. There had been an increase in income. Funds in the restrictive category were being proactively used. An annual report to the Board would be produced and presented at its meeting in May 2017. A report had been received from the Communications Team who was responsible for the marketing of the Trust's Charity, i care and the current Children's Directorate appeal for a Sensory Room. In order to reach the ambitious target, further support was needed to drive it forward and the team had been asked to produce an action plan for the Committee at its meeting in April 2017. A presentation had been made by the Fund Manager of the May Sosbe Legacy fund at

Sheppey Community Hospital. Spending had allowed for an improvement in equipment and facilities. Future agenda items had been agreed and the Committee would review its Terms of Reference and committee effectiveness at its meeting in April 2017.

In response to a question from Mr Griffiths regarding whether the Sheppey Community Hospital fund had been transferred to Virgin Care which was now responsible for the ward at Sheppey Community Hospital, Mr Flack explained that the fund had been retained by the Trust as it was still responsible for other services in the hospital. Ms Tippin added that the new provider had been informed of its obligation to retain equipment bought by the fund in the unit.

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

26/01/10 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

With regards to the national Key Performance Indicators (KPIs), the Trust was achieving the majority of these including the Referral to Treatment waiting times target. Performance against the waiting times target in the Minor Injuries Units had recently dipped from 100 to 99 per cent. The Trust continued to achieve well above the level that it was commissioned to deliver and the constitutional target. The Trust continued to meet its patient safety targets.
With regards to the recording of long term condition activity, there had been some improvement following some further technical improvements. The November data indicated that the number of average contacts was rising.
With regards to admission avoidance, the figures indicated a significant improvement on the previous year's performance. Overall, there was an improvement on delivery of service and patient outcomes.
With regards to the End of Life Care KPI, there had been an improvement and it was now rated Amber. The performance trajectory was encouraging.
The linkage between Length of Stay and Delayed Transfers of Care continued to be problematic.
A Never Event had been recorded. This was disappointing and was the first time such an incident had been reported by the Trust. The Board had discussed the incident at its December 2016 Board meeting.
Health visiting performance was improving and it was expected that target for new born visits would be met in Month 9.

In response to a question from Ms Tippin regarding the Never Event, Ms Strowman provided an update. She confirmed that a root cause analysis was underway and that an external specialist had been appointed to provide scrutiny that best practise was being followed in the investigation. The relevant external agencies had been informed at the time of the incident and a hazard notice had been sent to all the dentistry teams.

In response to a question from Ms Barber regarding partnership working to improve bed occupancy in east Kent, Ms Strong confirmed that the Trust was working closely with East Kent Hospitals University NHS Foundation Trust. It had participated in the joint super discharge week in December 2016 as well as implementing safer patient bundles. Infection outbreaks which had led to the temporary closure of beds had handicapped efforts periodically.

In response to a question from Ms Barber regarding the effectiveness of the Integrated Discharge Teams, Ms Strong confirmed that they were working well in west Kent. In east Kent, the team was transitioning to Trust management and there was an opportunity for to implement some improvements.

In response to a question from Ms Barber regarding statutory and mandatory training compliance, specifically moving and handling client and community hospital fire training, Ms Norris explained that the data in the report related to November 2016. The most current data indicated an improvement. The issues relating to moving and handling client had been predominantly in west Kent and there was an expectation that full compliance would be achieved in March 2017. With regards to community hospital fire, this had achieved full compliance in the last few days.

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

Home First Programme Key Performance Indicators

The Board had requested that a suite of KPIs be drawn up to measure the performance of the Home First Programme in both west and east Kent. A further KPI developed by Kent County Council would be introduced at a later date.

In response to a question from Ms Skelton regarding how the Trust would be able to identify the areas of performance in the pathway that it could affect, Ms Strong explained that the KPIs had been agreed by all the partners. She indicated that it would be difficult to extrapolate those that were specifically relevant to the Trust and suggested that an alliance model with appropriate governance would be more appropriate. Ms Skelton suggested that the Board should monitor the dashboard closely. Mr Griffiths asked for further clarity. Ms Tippin suggested that the number of measures should be reduced to a more manageable number where there were clearer and less complex lines of accountability. Mr Flack reflected that the metrics followed national guidelines and as confidence grew in the programme, the number would be reduced.

In response to a question from Mr Robinson regarding the patients who were rejected from the accessing the Home First programme, Ms Strong confirmed that they would remain with the acute trust.

In response to a question from Ms Barber regarding referrals made out of hours and at weekends, Ms Strong confirmed that the Local Referral Units would be available to manage those.

The Board **APPROVED** the Home First Programme Key Performance Indicators.

26/01/11 **Quality Report**

Ms Strowman presented the report to the Board for assurance.

The fill rates for agency staff in December 2016 had been more challenging than in November 2016 due to the impact of the Christmas holidays. Only one incident had occurred when one Registered Nurse had been on duty. The number of avoidable pressure ulcers continued to reduce and the Quality Committee was receiving a monthly report to monitor performance. The Pressure Ulcer Task Force Group was meeting every fortnight and there was good engagement from staff. Two Serious Incidents had been reported in December 2016. There had been no avoidable Grade Two pressure ulcers in December 2016. Overall, there was a downward trend in all grades of pressure ulcers.
With regards to Falls, there was a downward trend, although more work needed to be done. Unusually, two falls had resulted in fractures in December 2016. The Trust had been invited to participate in a collaborative Falls project which was now underway.
With regards to the monthly Quality Surveillance Meeting (QSM), information and data from the Early Warning Trigger Tool continued to be utilised and the Quality Committee would receive a report from the QSM at its February 2017 meeting. With regards to medication incidents, reporting had improved and there was evidence that harms were reducing. The highest category of incident was omitted medication in both the community hospitals and community services teams. A process was in place for following up such incidents and ongoing monitoring.
With regards to patient experience performance, the Trust continued to perform well. The Friends and Family Test had reported a score of 96.93%. The majority of patients indicated that they would recommend their friends and family. All comments both positive and negative were fed back to frontline staff and were acted upon.
With regards to patient outcomes, the Mortality Surveillance Group met monthly to review all deaths in community hospitals. The number of reported deaths remained stable compared to previous months and was below average as gauged by Dr Foster. The CQC had released a report on learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England. This along with a gap analysis would be discussed at the February 2017 Quality Committee meeting. The Clinical Audit programme was currently running 199 audits and the Audit and Risk Committee would receive a report at its February 2017 Committee meeting. The National Institute for Clinical Excellence ad issued fourteen guidance/standards in December 2016 and these would be reviewed.
In response to concerns from Ms Barber regarding the high number of

agency only shifts at Tonbridge Cottage Hospital, Ms Strowman explained that considerable agency was allocated on the therapy unit. Where that was the case, the Registered Nurse would be a substantive member of staff or a regular agency nurse familiar with the unit.

The Board **RECEIVED** the Quality Report.

26/01/12 **Finance Report (Month 9)**

Mr Flack presented the report to the Board for assurance.

The Trust had achieved a surplus year to date which was ahead of plan. Based on this performance, the Trust has forecast to report a small increase in its surplus at year end which would be ahead of the revised control total. However, the underlying surplus despite receiving additional incentive funding was still small. Agency performance had been good that month and the Trust would come in under its target. With regards to capital expenditure programme, it was expected that it would be fully utilised by year end following the approval of a large project by the Finance, Business and Investment (FBI) Committee the previous day. With regards the 2016/17 CIP, it was expected that the Trust would achieve the full plan by the year end. With regards to the Use of Resource Rating the Trust continued to receive the maximum 'One' rating and the Trust's performance had also been endorsed by NHSI.

Ms Tippin highlighted that the FBI Committee had been supportive of the Orthotic Lab business case that had been presented by the Podiatry Team the previous day. She cautioned that there was considerable work still to be done to achieve the proposed outcomes in the business case and that the Committee would monitor the project closely. The Committee had also requested that a risk mitigation report and a sales and marketing plan were presented to it.

In response to a question from Ms Barber regarding backlog maintenance of estates assets, Ms Davies confirmed that this would continue and that a plan was in place.

2017/18 Contract Report

Full contracts had been signed with all the main commissioning groups. This also included the refreshment of ongoing contracts. The contract with the east Sussex commissioners was still outstanding but it was expected that it would be signed in February 2017.

In response to a question from Mr Griffiths regarding the outcome of the contracting round, Mr Flack confirmed that the agreements provided a stronger framework and a better expectation of scale for the Trust.

The Board **RECEIVED** the Finance Report.

26/01/13 Workforce Report

Ms Norris presented the report to the Board for assurance.

The report provided the Board with an update on the current workforce position as at December 2016. There had been improvements in six of the metric on the previous month. Unfortunately, fill rates had been reduced for temporary staff as demand had exceeded supply. While the turnover and vacancy rate performance had been good, the absence rate was increasing and work was underway to address this.

In response to a question from Ms Skelton regarding the reasons why staff had left the Trust to join other organisations, Ms Norris indicated that this would be investigated further as would other aspects of the data.

It was agreed that the Board would receive further information at the February 2017 Board meeting in relation to sickness absence levels.
Action – Ms Norris

The Board **RECEIVED** the Workforce Report.

26/01/14 Sustainability and Transformation Plan Update Report

Mr Bentley presented the report to the Board for assurance.

All the Executive Directors were involved in STP work streams. A Case for Change report was in preparation and it was expected to be complete, subject to final confirmation, at the end of February 2017 or early March 2017.

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

26/01/15 Trust Constitution

Ms Davies presented the report to the Board for approval.

The Board was asked to consider amendments to the Constitution which had been approved by the Council of Governors at its meeting held in November 2016. This included the removing of terms regarding holding positions on two Governing bodies currently where there was no significant conflict of interest.

The Board **APPROVED** the Trust Constitution.

26/01/16 Six Monthly Staffing Establishment Report

Ms Strowman presented the report to the Board for approval.

Because there was no nationally validated tool available for use in community settings, the Trust had developed its own tool drawing on the

principles of work undertaken nationally related to calculating safer staffing levels. A summary of the methodology and the process that was applied was provided. The most recent review had found that acuity had decreased since the previous review and that through benchmarking against other Trusts, the Trust was more generous in its patient to Registered Nurse/health care assistant ratio. The data suggested that there could be a reduction in health care assistants on some wards. This recommendation had been discussed with and agreed by the operational teams. The data would be monitored and triangulated with the Early Warning Trigger Tool and the Patient Experience Report on an ongoing basis. A full review would take place in six months' time or earlier if the data suggested that there was an adverse effect from the implementation of the recommendation.

In response to a question from Ms Barber regarding whether the reductions in the east Kent community hospitals would lead to a restriction in the patients that were admitted, Ms Strowman indicated that this was unlikely as the new staffing levels were a reflection of the Registered Nurse/health care assistant ratio and that many of the patients were admitted for rehabilitation. If their acuity changed, staffing would change. It was agreed that Ms Strowman would investigate the reasons for the differential in acuity between east and west Kent community hospitals.
Action – Ms Strowman

In response to a comment from Mr Griffiths regarding the development of future models of care in the community hospitals, Dr Maskell added that work was underway within the STP on the future utilisation in the community hospitals. Currently, the hospitals would continue to admit patients who were medically stable.

Ms Tippin was concerned that with the decrease in staffing levels, there would be additional pressure on the system in some units particularly in east Kent. Ms Strowman commented that all the data had been sense checked by local community hospital managers who were satisfied that it was correct. With regards to west Kent, the layout of the ward also had an impact on the staffing levels. Overall, staffing was monitored on a daily basis and where an increase in patient acuity was flagged, a change in staffing levels was implemented.

The Board **APPROVED** the Six Monthly Staffing Establishment Report.

26/01/17 Any Other Business

Mr Griffiths thanked Dr Maskell for his contribution to the Trust during his tenure as Medical Director and wished him well in his new appointment.

There was no further business to discuss.

26/01/18 Questions from Members of the Public Relating to the Agenda

There were no questions from the public.

The meeting closed at 11:38am.

26/01/19 Date and Venue of the Next Meeting

Thursday 30 March 2017 at 10.00 am in The Committee Room, Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

Kent Community Health NHS
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 26 JANUARY 2017 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Audit and Risk Committee Chairman's Assurance Report	In response to the internal audit, the Executive Team to carry out some focussed work and agree actions on the safety aspect of safe staffing, and bring back assurance to the Board within two weeks of the meeting. The Chair of the Audit and Risk Committee then to decide if reasonable assurance has been provided.	Ms Strong and Ms Strowman Mr Conway	Ms Strong, Ms Norris and Ms Strowman met with Non-Executive Directors (NEDs) Mr Conway and Mr Howe. The TIAA report was discussed along with the actions completed and outstanding concerns. The NEDs were assured of the actions taken and would report back to the Board accordingly. This action would remain open until the Audit and Risk Committee had met in February 2017. (No further action required at this stage from Ms Strong. Mr Conway is taking to the ARC in February 2017)
Workforce Report	To present further information on sickness absence levels at the February 2017 Board meeting.	Ms Norris	Action complete.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Six Monthly Staffing Establishment Report	To investigate the reasons for the differentials in acuity between east and west Kent community hospitals.	Ms Strowman	In west Kent, the matrons' and their managers' professional judgement was that the wards should be kept as they were. In east Kent, the Head of Service and ward Sisters supported reductions.

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	1.7
Subject:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	☐	Assurance	X

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

Proposals and /or Recommendations
Not Applicable.

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

Paul Bentley, Chief Executive	Tel: 01622.211903
	Email: paul.bentley@kentcht.nhs.uk

Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
MARCH 2017

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

Partnerships

1. Contracts

The Trust has been successful in being awarded contracts for musculoskeletal services in both East Sussex and North Kent, the former on a five year contract and the latter as a pilot for one year triaging orthopedic patients into services.

A number of other new contracts are commencing from April including two five year contracts in London Community Dental Services and Kent Emotional Wellbeing and Mental Health Service (including current school nursing).

The Trust is set to receive an additional £0.5m allocation from sustainability funds, so is forecasting a year end surplus in 2016-17 of £3.7m, £1m better than plan. The £0.5m underlying improvement is largely the better than target agency staff spending and one off improvements in estates costs. This surplus will be reinvested and used to part fund the capital programme of £4.1m next year. This is being presented to the Board for approval as part of the 2017/18 budget package.

2. Staff Survey

The Trust is somewhere people enjoy working, according to the findings of the 2016 NHS Staff Survey.

KCHFT's performance improved in seven key findings, including the percentage of people who believed the organisation provides equal opportunities for career progression, the number of staff who felt unwell due to work-related stress in the past twelve months and the number of colleagues satisfied with the quality of work and care they are able to deliver.

The Trust's score also improved in terms of the percentage of staff who said they felt recognised and valued by managers and the Trust. Overall, the Trust scored well, with 90 per cent of those taking part saying they agreed their role made a difference to patients and service users.

This is a really positive result and I look forward to building on this success.

3. Senior Leaders Conference

This month we opened up our Senior Managers' Conference to commissioners and our partners to explore some of the ways in which we can truly co-design our services for a better future.

It was a fantastic event with more than 120 people including presentations from Philippa Hunt from NHS England's New Care Models Team, Caroline Selkirk, who is leading Kent and Medway Sustainability and Transformation Plan's local care models and outlined the progress made, and Dr John Ribchester who joined us to talk about the success of Encompass in Whitstable.

I was delighted that we could be joined by representatives from the community and voluntary sector with presentations from Mike Barrett, Chief Executive at Porchlight and Kent Fire and Rescue, who gave us tangible examples of how we can work together in the future.

Patients

1. Let's discuss diabetes

More than 100 people attended the Westgate Hall in Canterbury on Saturday (18 March) for our *Let's discuss diabetes* morning.

As the first event dedicated to our FT members, we teamed up with East Kent Hospitals University NHS Foundation Trust to bring together organisations which support people living with diabetes, including the Paula Carr Trust, Diabetes UK, Carers Support, PS Breastfeeding and Hypo Hounds from the voluntary sector. They were supported by our Podiatry, Health Improvement, Dietetics, Dementia and the Paediatric Diabetes teams from the NHS.

This was also an opportunity for people to meet their local governors and we have other events planned for later in the year.

2. One Shop Ashford

Since the last time we met, KCHFT in conjunction with Kent County Council and Ashford Borough Council have opened the new One You shop in Park Mall, Ashford.

As a further example of partnership working, the shop will be open every Tuesday to Saturday, and is for anyone who wants to get advice and support on getting more active, quitting smoking, eating a healthy diet or just want to feel better about life. There will also be the opportunity to have an on-the-spot NHS Health Check. Our Health Improvement Team members will be in the shop every day, along with other KCHFT teams and local voluntary sector organisations.

3. Specialist Wound Medicine Centre

I was delighted to officially open our latest specialist wound medicine centre at Victoria Hospital in Deal this month. This service is made possible through the very generous support of the League of Friends.

The centre, which opened its doors at the end of October, has already treated nearly fifty patients. Its daily clinic means every patient in Deal with a chronic, complex or surgical wound will now have access to specialist care.

The donation from the Deal Hospital League of Friends, included specialist chairs, couches and trolleys, and hopes to expand to a second clinic room later in the year.

We have launched a number of wound medicine centres during the past couple of years, with more planned, and each one of them makes a difference to the quality of care our patients receive. For some patients, who have struggled for years it relieves their pain and gives them back their mobility and this is testament to the excellent care of our teams.

Paul Bentley
Chief Executive
March 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 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 7 March 2017. It also summarises the outcome of the review of the February 2017 meeting papers by members of the Committee meeting. The Committee had not formally met that month due to the absence of the Medical Director and Chief Nurse. In addition, the paper summarises the Extraordinary Quality Committee meeting which was held on 27 January and 17 February 2017 to review the Quality Impact Assessments for the 2017/18 round of Cost Improvement Programme plans.

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 FEBRUARY AND MARCH 2017 MEETINGS

Introduction

Papers for the February committee were reviewed by members, but no formal meeting was held as absence of the Medical Director and Chief Nurse meant that the Committee would not be quorate.

Extraordinary meetings were held on 27 January and 17 February 2017 to review the Quality Impact Assessments (QIA) for the 2017/18 round of Cost Improvement Programme Plans (CIP)

Quality Impact Assessment

The Committee reviewed the QIA risk scores proposed by the Medical Director and Chief Nurse and were satisfied that the newly introduced process was robust. The Committee recommends that the Board accept those QIA presented to the Committee, but noted there were still outstanding schemes for 2017/18 which were still to go through the review process. The assurance 'Deep Dives' conducted by the Non-Executive Directors would continue with an early focus on enabling activity.

DATIX

The Committee had called for a paper to give assurance about the use of DATIX, the risk management software, used within the Trust. This was in response to intelligence gained from Patient Safety Walkabouts and a concern that the Trust appeared to be a low reporting organisation. The report demonstrated that policy and procedures appeared robust. The comparatively low numbers of incidents reported was explained by the KCHFT approach to only reporting attributable incidents, which was not necessarily the approach taken by other trusts. It was felt there was still improvement that could be made regarding feedback to staff, once investigations were complete, and this aspect would be continue to be monitored as part of Patient Safety Walkabouts.

Quality Surveillance

The Committee noted that there were moderate concerns reported regarding Health Visiting Referral To Treatment (RTT) timings and Queen Victoria Memorial Hospital, Herne Bay infection control following the February Quality Surveillance Meeting.

Care Quality Commission (CQC) Compliance

The Committee was disappointed to note that the End of Life care audit had revealed that training will not be compliant by the end of March 2017 as expected.

Policies Ratified
The Committee ratified the following policies:

a. Covert Administration of Medicines and The Administration of Medicines in Food
b. Non-Medical Prescribing
c. Viral Haemorrhagic Fever and Ebola
d. Access
e. Professional Appearance

SC Howe CBE
Chairman, Quality Committee
10 March 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 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 February 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

AUDIT AND RISK COMMITTEE CHAIRMAN'S ASSURANCE REPORT FOLLOWING FEBRUARY 2017 MEETING

Procedural	Third meeting of current financial year to consider regular updates from the auditors, risk, finance and legal. In addition, follow up on previous outstanding items, deep dives on IT themed risks and cyber security.
Auditors' Updates	Internal Audit (IA) – Limited assurance reports on cyber security and consultant job plans and clinical supervision (see later comments). Nurse staffing arrangements' limited assurance follow up now resolved. 3 overdue audit recommendations all currently being evidenced to confirm remediation Counter Fraud – Patient originated fraud increasing in Acutes. Scale and risk for KCHFT to be ascertained External Audit – AR and A Plan received and agreed Clinical Audit – Satisfactory and on target trajectory. Dawn asked to consider e2e clinical audit implications particularly as integrated services become more prevalent.
Risk Management	Risk Register – Sustainability and Transformation Plan (STP) risk re-articulated and will need further refinement as the Plan progresses. Amber status of cyber security and de-escalation of delayed discharges both challenged. ''Ongoing'' actions classification to be removed. Two new risks agreed: pressure ulcers and cyber security Corporate Assurance and Risk Management (CARM) Group – some concern that local risk registers are not being maintained/used, particularly in Adults, and policy maintenance slipping (>20% out of date). ARAC to receive further assurance on both at next meeting. STP: Committee not able to review the Risk Register Risk Management Strategy: update approved.
Legal and Regulatory Compliance	Legal Services Report - satisfactory Monitor Licence Deep Dive – review of all deep dives to date and overall risk assessment undertaken. Now considered low risk so deep dives to be undertaken annually going forwards.
Financial Reporting and Controls	1) Updates on single tender waivers, losses and special payments and retrospective orders received including proposed write off of £12k of 'bad debts and claims abandoned''. Underlying business arrangements to be reviewed to prevent re-occurrence 2) Standards of Business Conduct: satisfactory 3) new IR35 arrangements (contractors' tax arrangements): low risk for Trust and being addressed.

Deep Dives	1) Cyber security – a number of reports and plans received. All actions arising from the limited assurance report have/are being remediated. Further TIAA review underway to consider best practice and gap from this for KCHFT. Three key conclusions – remediation activity needs to be business not IT led, some of the proposed actions are not being implemented quick enough and the Board should agree a cyber security risk appetite 2) IT themed risks - a cross cutting review generally OK but assurance required that the various risks and issues identified are being remediated in a timely fashion 3) Datix Process and Usage: satisfactory assurance received.
Updates	Contractual Arrangements for Medical Employees: progress now being made on this long running issue (both practice and documentation). Acting Medical Director provided verbal assurance that all risks have/are being addressed and there is no possibility of a Maidstone and Tunbridge Wells NHS Trust (MTW) manslaughter charge type event (ie. accreditation and documentation). TIAA will do a follow up to check remediation of the limited assurance report.
Other	Annual Governance Statement: reviewed and minor suggestions made. In good shape. Terms of Reference Review: reviewed and recommendation is that there are no changes apart from giving the ARAC the authority to consider STP items.
Board Actions Required	ARAC recommends that the Board receives (1) an update on cyber security and helps frame a risk appetite together with action prioritisation, and (2) the STP Risk Register.
Date of Next Meeting	May 2017 (including consideration of Annual Report and Accounts 2016/17).

Peter Conway
Chairman, Audit and Risk Committee
February 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.3
Subject:	Charitable Funds Committee Chairman's Assurance Report
Presenting Officer:	Jennifer Tippin, Chair of the Charitable Funds Committee

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context):
The paper summarises the Charitable Funds Committee meeting held on 25 January 2017.

Proposals and /or Recommendations:
The Board is asked to receive the Charitable Funds Committee Chairman's Assurance Report.

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

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

Charitable Funds Committee Assurance Report

Kent Community Health
NHS Foundation Trust

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

Introduction

The Charitable Funds Committee met on the 25 January 2017.

The main purpose of the meeting was to approve the annual accounts for the year ending March 2016. Prior support for the accounts had been received by the relevant auditors. The Committee approved the annual accounts which showed a net reduction in funds to £573k.

The Committee agreed to produce an annual report reflecting the work done during the period and outlining some of the great stories achieved which will be reviewed at the Board during 2017.

In addition the Committee reviewed the progress made by the Marketing Team in driving support for both the Trust's charity and children's appeal. Whilst recognising that this is a long term investment, the Committee would like to see more progress, particularly for the children's appeal, and has requested a progress report at the next committee meeting.

The Committee has recently decided to hear presentations from Fund Managers on the work they have been driving. During this meeting, the Committee heard about the improvements to equipment and facilities at Sheppey Community Hospital arising from the May Sosbe legacy.

Finally the Committee reviewed future agenda items for the next meeting scheduled for April 2017. The committee terms of reference and overall effectiveness is also due to be reviewed at the next meeting.

Jennifer Tippin
Chairman, Charitable Funds Committee
January 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.4
Subject:	Integrated Performance Report (Part 1)
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context)

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

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

Part One of the report contains the following sections:

- Key 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
NHS Foundation Trust

Integrated Performance Report - 2016/17
Part 1

March 2017
April 2015 - February 2017 data

Excellent care, healthy communities

Integrated Performance Report

Contents

Key and Glossary of Terms

+ve = Positive - improvement on last month

-ve = Negative - A decline on last month

stat = Static - No Change

	Off Target		As per KPI Target
	On Target		Stretch target achieved

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

KCHFT Corporate Scorecard 2016/17

Strategic Goals

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

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
1.1	Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)	77.3%	74.1%	-3.1%	100.0%	-25.9%	100.0%	N/A	-ve
1.2	Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)	75.0%	102.7%	27.7%	100.0%	2.7%	100.0%	N/A	-ve
1.3	Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks	57.9%	82.0%	24.1%	95.0%	-13.0%	95.0%	N/A	-ve
1.4	Health Visiting - Increase the uptake of New Birth Visits by 14 days	70.7%	84.8%	14.1%	85.0%	-0.2%	95.0%	N/A	-ve
1.5	School Health - Reception Children Screened for Height and Weight	96.6%	91.7%	N/A	90.0%	N/A	95.0%	N/A	+ve
1.6	School Health - Year 6 Children Screened for Height and Weight	96.0%	95.0%	N/A	90.0%	N/A	95.0%	N/A	+ve

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

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
2.1	LTCs (including Health Trainers) Teams Contacts: YTD as % of YTD Target	75.7%	91.7%	16.0%	100.0%	-8.3%	100.0%	N/A	+ve
2.2	LTCs Teams - Did Not Attend Rate: DNAs as a % of total activity.	0.8%	1.6%	0.9%	4.0%	-2.4%	3.0%	4.0%	-ve

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

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
3.2	Total Time in MIU & WiC Service: Less than 4 hours	99.96%	99.95%	0.0%	95.0%	5.0%	99.5%	99.5%	-ve
3.3	Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways	100.0%	99.7%	-0.3%	95.0%	4.7%	98.0%	96.8%	+ve
3.4	Allied Health Professionals Referral to Treatment Times (RTT)	92.1%	92.8%	0.7%	95.0%	-2.2%	98.0%	97.6%	+ve
3.5	Access to GUM: within 48 hours (Monthly Target 100%)	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	N/A	stat
3.7	Bed Occupancy: OBDs as a % of available bed days	88.8%	88.5%	-0.3%	87.0%	1.5%	91.7%	87.9%	+ve
3.8	Length of Stay (Median Average)	24.2	22.0	-2.1	21.0	1.0	21.0	25.6	+ve
3.9	Delayed Transfers of Care as a % of Occupied Bed Days	13.8%	12.1%	-1.7%	3.5%	8.6%	3.5%	11.8%	-ve

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

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
4.1	Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate	25.3%	26.5%	1.3%	15.0%	11.5%	25.0%	30.7%	+ve
4.4	End of Life Care: Percentage of patients dying in their preferred place.	100.0%	84.9%	-15.1%	90.0%	-5.1%	95.0%	83.2%	+ve
4.5	ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.	93.1%	85.6%	-7.5%	80.0%	5.6%	90.0%	N/A	-ve

KCHFT Corporate Scorecard 2016/17

Strategic Goals

5. Ensure people receive safe care through best practice

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
5.2	Infection Control: C.Diff (Target <6 cases in year) (Target YTD)	1	6	5	5	1	5	N/A	-ve
5.6	Safety Thermometer: % harm free care New Harms	99.0%	97.8%	-1.1%	95.0%	3%	97.5%	96.3%	-ve
5.7	Never Events: FOT as % of Annual Target	0	1	1	0	1	0	N/A	-ve
5.8	NICE guidance: New NICE Guidance reviewed within required timescales following review of publication.	100.0%	100.0%	0.0%	100.0%	0%	100.0%	N/A	stat

Enabling Strategies

Finance and Commercial

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
6.1	Income & Expenditure - Surplus (%)	1.5%	1.4%	-0.1%	1.0%	0.4%	1.0%	1.0%	stat

Workforce

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
7.1	Sickness Rate	3.97%	4.31%	0.34%	3.90%	0.41%	3.75%	4.58%	-ve
7.4	Mandatory Training: Combined Compliance Rate	94.1%	92.5%	-1.6%	85.0%	7.5%	92.5%	88.4%	+ve

IM&T

KPI Ref	KPI Description	15/16	16/17	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
8.2	Data Quality: NHS Number Completeness across clinical systems	100.0%	100.0%	0.01%	95.0%	5.0%	99.9%	98.5%	+ve

Executive Summary: Supporting Narrative - March Report 2016/2017

Quality

Infection Control: MRSA & C-Difficile: There have been two Clostridium difficile toxin positive infections in February both at QVMH Hospital on Heron ward. Early investigations suggest these cases were unavoidable, and due to the antimicrobial treatments received in the Acute sector, where both were separately treated for sepsis. However, as both cases occurred in 48 hours of each other a potential period of Increased incidence has been declared, and potential links are being investigated. Ribotyping has been requested,and the initial case is not linked to previous cases on the ward, however, we are still awaiting confirmation of the latest case. This means that the Trust have breached the internal target of no more than 5 cases

Workforce

Sickness: The cumulative sickness absence rate for the financial year to February 2017 was 4.31% which is up from 4.28% at M10. The sick rate in February was 4.31%, a decrease of 0.79% from last month. The total FTE days lost for the rolling year to February equates to an average of 9.66 days sickness lost per employee, up from last month. The proportion of FTE lost to short-term sickness has decreased to 52.6%, compared to 57.6% in January

Mandatory Training: There is now 1 area which is non-compliant. This is: 1. Moving and Handling: Client which has increased to 80.5%.

Finance

Income & Expenditure and Financial Risk Rating: The Trust achieved a surplus of £ 3,010k (1.4%) to the end of February. Cumulatively pay and depreciation/interest have underspent by £3,690k and £191k respectively. Income has over-recovered by £328k and non-pay is £3,675k overspent.

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 99.65% completed RTT pathways within 18 weeks and 99.96% incomplete RTT pathways within 18 weeks

Referral to Treatment Times for all Allied Health Professionals when measured against the 18 week threshold shows 94.2% of patients being seen within this timescale for January 2017, donw slightly on the December position. Continence, Wheelchairs, MSK West Block and Podiatric Surgery were all below 90% compliance with 18 weeks RTT for January

National Targets

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

Health Checks: The Health Checks team have met the checks performance target from KCC for the first three quarters of the year. The service is on 101% of the 46% uptake target. All areas of checks have performed well; GP delivered checks and KCHFT core checks have both improved on this time last year and there has been an increase in overall checks compared to the same period last year.

Community Hospitals

There were 179 admissions to the Community Hospitals in January and 4,600 occupied beds days from a possible 4,918 bed days, therefore, bed occupancy stood at 93.5%. There were a total of 668 bed days lost due to delayed transfers of care (14.5% of total occupied bed days). The average length of stay (median) was 19.5 days across all hospitals in Month 10.

Bed Occupancy (Target range 87-92%): Bed occupancy increased to 93.5% in Month 10, with only Westbrook House falling below the 87% target occupancy.

Length of Stay (LOS) - Median (Target 21 days by year end): Performance against the median average length of stay target remains slightly above target, for M10 this increased to 19.5 days. (22 YTD)

Delayed Transfer of Care (DTOC) days as percentage of total bed days (Target 3.5%): Delayed Transfers of Care has increased in M10 and remains above the target at 14.5% (12.1% YTD). This relates mainly to high levels at all hospitals, with all sites being above the 3.5% target with the exception of Westbrook House and Hawkhurst. This is split between 10% NHS responsibility and 4.5% Social Services/Other

Activity

KCHFT's clinical services carried out 135,267 contacts (This figure includes various currencies e.g. face to face contacts, telephone contacts, group sessions, Units of Dental Activity), of which 8,550 were MIU/WiC attendances, during January 2017. KCHFT is below target at Month 10 (-0.1%), mainly due to under-performance in LTC, Podiatry and Learning Disabilities. Performance against 2016/17 contract targets has been summarised at Service Specification level below:

Service & Currency	M10 Actual	YTD Actual	YTD Target	YTD Variance	Contract BRG	Trend
Long Term Conditions - Face to Face	57,273	611,562	666,952	-8.3%		
Intermediate Care - Face to Face	21,694	261,365	260,922	0.2%		
Intermediate Care - Attendances	8,550	99,868	91,004	9.7%		
Intermediate Care - Occupied Bed Days	90	1,342	1,394	-3.7%		
Planned Care - Face to Face	26,953	268,085	212,486	26.2%		
Learning Disabilities - Face to Face	3,471	31,728	36,236	-12.4%		
*Children's Universal Services - Face to Face	30,763	303,935				
Children's Specialist Services - Face to Face	14,965	133,449	129,418	3.1%		
Dental Service - UDAs	7,104	69,362	80,302	-13.6%		
Health Improvement Services - Face to Face	305	3,746	2,504	49.6%		
All Services and Currencies (Contracted)	**142,371**	**1,498,530**	**1,499,945**	**-0.1%**		

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

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

Adults: Long Term Conditions (LTC) contacts are 8.2% (54,813 contacts) below the year to date target, This is due to a continued under-reporting in some areas. Intermediate Care and Rehab Services (ICT) are 0.2% above target (443 contacts) with the targets adjusted for 16/17. Activity for the planned care services is 5.6 % under target for the year to M10 (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 1.2% above target at M9. This includes activity where there is no target. Against target only the services are 12.1% below target for M9, mostly attributed to West Kent Special Schools and ITAC in East Kent. The West Kent Special Schools target will be adjusted for 17/18

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.5
Subject:	Month 11 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 February 2017.

The Trust achieved a surplus of £3,010k year-to-date (YTD) which was £532k better than plan. The Trust is forecasting to reach a surplus of £3,710k, £1m ahead of the control total of £2,710k. Of the £1m improvement, £500k relates to an improvement in the Trust's forecast position and £500k is STF (strategic and transformation fund) incentive funding. The Trust is also likely to be given additional strategic and transformation funding by the end of the financial year, the amount is not yet known, which will increase the surplus further.

Key Messages	
Surplus: The Trust achieved a surplus of £3,010k (1.4%) to the end of February. Cumulatively pay and depreciation/interest have underspent by £3,690k and £191k respectively. Income has over-recovered by £328k and non-pay is £3,675k overspent.	●
Continuity of Services Risk Rating: EBITDA Margin achieved is 2.5%. The Trust scored 1 against the new Use of Resources Rating, the best possible score.	●
CIP: £7,344k of savings has been achieved to February against a risk rated plan of £7,652k which is 4% behind target. Full year savings of £583k have been achieved on a non-recurrent basis, all other schemes are recurrent.	●
Cash and Cash Equivalents: The cash and cash equivalents balance was £17,573k, equivalent to 28 days expenditure. The Trust recorded the following YTD public sector payment statistics 97% for volume and 94% for value.	●

Capital: Spend to January was £2,192k, representing 70% of the YTD plan. The Trust is expecting to deliver its planned capital expenditure of £4.1m.	●
Agency: Agency spend was above trajectory for February but is forecast to remain within the annual trajectory.	●

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.

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Kent Community Health
NHS Foundation Trust

FINANCE REPORT – FEBRUARY 2017 (MONTH 11 of 2016-17)

The Trust achieved a surplus of £3,010k year-to-date (YTD) which was £532k better than plan. The Trust is forecasting to reach a surplus of £3,710k, £1m ahead of the control total of £2,710k. Of the £1m improvement, £500k relates to an improvement in the Trust's forecast position and £500k is STF (strategic and transformation fund) incentive funding. The Trust is also likely to be given additional strategic and transformation funding by the end of the financial year, the amount is not yet known, which will increase the surplus further.

Dashboard

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	3,010	2,478	532
Year End Forecast £k	3,710	2,710	1,000

The Trust achieved a surplus of £3,010k to the end of February.

Pay and depreciation/interest have underspent by £3,690k and £191k respectively. Non-pay is £3,675k overspent and income is £328k over-recovered.

Use of Resource Rating — Rag rating: Green

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

The Trust has scored the maximum '1' rating against the new Use of Resource rating metrics and is forecast to achieve this rating for the full year.

CIP — Rag rating: Amber

	Actual / Forecast	Plan	Variance
Year to Date £k	7,344	7,652	-308
Year End Forecast £k	8,342	8,342	0

The Trust achieved CIPs of £7,344k to the end of February against a plan of £7,652k, which is 4% behind target.

Despite the shortfall year to date, the Trust is forecasting to achieve the full plan of £8,342k by the end of the year.

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	17,573	18,418	-845
Year End Forecast £k	17,894		

Cash and Cash Equivalents as at 28 February 2017 stands at £17,573k, equivalent to 28 days expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	2,192	3,126	934
Year End Forecast £k	4,109	4,109	0

Capital Expenditure year to date is £2,192k and represents 70% of the YTD plan.

The full year forecast has been retained at the full year plan value of £4,109k with the expectation that all the funds will be utilised in 16-17.

Agency Trajectories — Rag rating: Green

	External Agency and Locum Expenditure	Trajectory M11 (£)	Spend Less Than Trajectory	Adverse or Favourable Variance to Trajectory
Total Trust Position/ Trajectory	503,590	412,606	- 90,984	**A**

The monthly trajectory was £1.1m in April, dropping by approximately £60k each month (reflecting a targeted reduction across all areas month on month) until October, when the trajectory fell by a further £207k, reflecting the loss of North Kent services (£142k) and Darent House (£65k) which was expected to open for the first six months of the year. The year to date trajectory is £8,308m and the Trust has spent £7,576m to date on agency costs.

1. Income and Expenditure Position

The position for February was £115k favourable compared to the plan. The in-month performance comprised an underspend on depreciation/interest of £2k and an over-recovery on income of £433k, partly offset by overspends on pay and non-pay of £39k and £281k respectively. The summary income and expenditure statement is shown below:

	FEB ACTUAL £'000	FEB BUDGET £'000	FEB VARIANCE £'000	% VARIANCE	YTD ACTUAL £'000	YTD BUDGET £'000	YTD VARIANCE £'000	% VARIANCE
CCGs - Non Tariff	11,119	11,036	84	0.8%	133,227	133,290	-62	0.0%
CCGs - Tariff	267	319	-52	-16.3%	3,209	3,338	-130	-3.9%
Charitable and Other Contributions to Expenditure	26	6	20	311.7%	123	99	24	24.7%
Department of Health	0	0	0	0.0%	0	0	0	0.0%
Education, Training and Research	165	190	-25	-13.2%	2,079	2,087	-8	-0.4%
Foundation Trusts	269	284	-15	-5.2%	3,178	3,156	23	0.7%
Income Generation	83	13	70	519.8%	581	209	372	177.7%
Injury Cost Recovery	22	23	-1	-2.6%	341	252	89	35.5%
Local Authorities	3,915	3,883	32	0.8%	42,006	42,480	-474	-1.1%
NHS England	1,415	1,234	180	14.6%	13,320	13,136	184	1.4%
NHS Trusts	507	525	-18	-3.4%	4,385	5,537	-1,152	-20.8%
Non NHS: Other	80	93	-13	-13.8%	964	1,032	-69	-6.7%
Non-Patient Care Services to Other Bodies	76	31	44	141.1%	1,261	638	623	97.6%
Other Revenue	255	147	108	73.6%	2,367	1,642	725	44.2%
Private Patient Income	48	29	19	64.3%	502	320	182	56.9%
Sustainability and Transformation Fund	151	151	0	0.0%	1,659	1,659	0	0.0%
INCOME Total	**18,397**	**17,964**	**433**	**2.4%**	**209,203**	**208,875**	**328**	**0.2%**
Administration and Estates	2,520	2,587	67	2.6%	28,240	29,300	1,060	3.6%
Healthcare Assistants and other support staff	1,742	1,813	71	3.9%	20,774	21,556	782	3.6%
Managers and Senior Managers	725	811	86	10.6%	8,260	8,837	576	6.5%
Medical and Dental	665	639	-25	-4.0%	7,061	7,149	88	1.2%
Qualified Nursing, Midwifery and Health Visiting	4,470	4,720	250	5.3%	53,902	55,981	2,079	3.7%
Scientific, Therapeutic and Technical	2,580	2,604	24	0.9%	28,956	30,604	1,649	5.4%
Employee Benefits	535	0	-535	-100.0%	1,840	0	-1,840	-100.0%
CIP Target Pay	0	109	109	100.0%	0	-91	-91	-100.0%
East Kent Savings	0	-12	-12	100.0%	0	-253	-253	-100.0%
North Kent Savings	0	-72	-72	-100.0%	0	-362	-362	-100.0%
PAY Total	**13,238**	**13,199**	**-39**	**-0.3%**	**149,032**	**152,721**	**3,690**	**2.4%**
Audit fees	4	5	1	13.8%	38	55	17	31.8%
Clinical Negligence	33	33	0	1.2%	360	365	4	1.2%
Consultancy Services	-164	-101	63	-62.4%	447	193	-254	-131.9%
Education and Training	6	58	52	89.4%	573	813	240	29.5%
Establishment	510	333	-178	-53.4%	8,657	6,587	-2,070	-31.4%
Hospitality	0	1	1	120.2%	6	7	1	14.9%
Impairments of Receivables	0	0	0	0.0%	-9	0	9	0.0%
Insurance	3	1	-2	-169.4%	19	13	-6	-49.8%
Legal	-77	-77	0	0.3%	245	286	41	14.2%
Other Auditors Remuneration	0	0	0	0.0%	0	0	0	0.0%
Other Expenditure	13	11	-2	-16.0%	127	120	-7	-6.2%
Premises	1,729	1,260	-469	-37.2%	15,340	14,399	-941	-6.5%
Research and Development (excluding staff costs)	0	1	1	100.0%	0	9	9	100.0%
Services from CCGs	0	0	0	0.0%	2	0	-2	0.0%
Services from Foundation Trusts	0	0	0	0.0%	9	17	7	44.1%
Services from Other NHS Trusts	43	38	-6	-14.8%	474	415	-58	-14.0%
Supplies and Services - Clinical	2,027	2,171	144	6.6%	22,264	22,032	-233	-1.1%
Supplies and Services - General	85	137	52	38.2%	1,233	1,478	245	16.5%
Transport	387	400	13	3.3%	5,086	4,627	-459	-9.9%
CIP Target Non Pay	0	48	48	100.0%	0	-218	-218	-100.0%
NONPAY Total	**4,600**	**4,319**	**-281**	**-6.5%**	**54,871**	**51,196**	**-3,675**	**-7.2%**
EBITDA	559	446	113	25.4%	5,301	4,959	342	6.9%
EBITDA %	3.0%	2.5%	-0.6%		2.5%	2.4%	104.4%	
DEPRECIATION/AMORTISATION	226	232	6	2.4%	2,342	2,547	205	8.0%
INTEREST PAYABLE	0	0	0	0.0%	4	0	-4	0.0%
INTEREST RECEIVED	2	6	-4	-60.9%	56	66	-10	-14.9%
SURPLUS/(DEFICIT)	**335**	**220**	**115**	**52.3%**	**3,010**	**2,478**	**533**	**21.5%**
SURPLUS %	-1.8%	-1.2%	-0.6%		-1.4%	-1.2%	-0.3%	

Table 1.1: Trust Wide Variance against Budget in month and YTD

2. Risk Ratings

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

3. Cost Improvement Programme

Year to date CIP target (£k)	Year to date CIP Achieved (£k)	Year to date variance – negative denotes an adverse variance (£K)	Full year CIP target (£k)	CIP Achieved (£k)	Full year CIP forecast (£k)	Full Year Total CIP	Full year variance (£k) – negative denotes an adverse variance
7,652	7,344	-308	8,342	8,133	209	8,342	0

Table 3.1: Cost Improvement Programme Performance

The cost improvements required this year amount to £8,342k (3.7% of annual income).

YTD achievement is 4% behind plan with £7,344k removed from budgets at month eleven against a risk rated year to date plan of £7,652k. Of the total CIP for the year, £583k has been achieved on a non-recurrent basis with all other savings recurrent.

The CIP contingency of £1,188k for the year-to-date is reported as achieved savings and accounts for 16.2% of the YTD achievement.

The forecast is to deliver the full £8,342k CIP target.

4. Statement of Financial Position and Capital

	At 31 Mar 16 £000's	At 31 Jan 17 £000's	At 28 Feb 17 £000's	Variance Analysis Commentary
NON CURRENT ASSETS:				**NHS & Non NHS - Invoiced Debtors (net of bad debt provision)**
Intangible assets	48	23	21	The in-month increase is in main due to the raising of invoices in
Property, Plant & Equipment	15,394	15,211	15,268	M11 for previously accrued income with Medway CCG, West Kent
Other debtors	154	0	0	CCG, C&C CCG and Ashford CCG.
TOTAL NON CURRENT ASSETS	**15,596**	**15,234**	**15,289**	
CURRENT ASSETS:				**NHS Accrued Debtors**
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	11,641	10,618	12,191	The in-month decrease is principally due to the raising of invoices
NHS Accrued Debtors	888	6,100	4,711	for the previously accured income as outlined in the above.
Other debtors	1,977	4,037	4,001	
Total Debtors	**14,506**	**20,755**	**20,904**	**Non NHS - accrued creditors falling due within 1 year**
Cash at bank in GBS accounts	5,470	3,335	1,546	The in-month decrease is primarily due to the reported payments
Other cash at bank and in hand	58	42	27	made to NHSPS in February as part settlement of the o/s 15-16
Deposit with the National Loan Fund (Liquid Investment)	17,500	20,000	16,000	and 16-17 rental invoices.
Total Cash and Cash Equivalents	**23,026**	**23,377**	**17,573**	
TOTAL CURRENT ASSETS	**37,532**	**44,132**	**38,477**	**Provisions**
CREDITORS:				The in-month increase is in main due to a revision to the
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-2,248	-1,499	-1,862	redundancy provision following updates received.
NHS - accrued creditors falling due within 1 year	-4,672	-3,511	-3,528	
Non NHS - accrued creditors falling due within 1 year	-16,803	-21,464	-14,668	**Cash and Cash Equivalents**
Other creditors	-5,896	-6,233	-5,835	The in-month reduction in cash is as a result of the payments
Total amounts falling due within one year	**-29,620**	**-32,708**	**-25,893**	made to NHSPS in February as part settlement of the o/s 15-16
NET CURRENT ASSETS	**7,912**	**11,424**	**12,583**	and 16-17 rental invoices.
TOTAL ASSETS LESS CURRENT LIABILITIES	**23,510**	**26,658**	**27,872**	
Total amounts falling due after more than one year	**0**	**0**	**0**	
PROVISION FOR LIABILITIES AND CHARGES	**-1,022**	**-1,495**	**-2,374**	
TOTAL ASSETS EMPLOYED	22,488	25,163	25,499	
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	-2,612	-2,612	-2,612	
Income and expenditure reserve	-19,110	-21,785	-22,121	
Revaluation Reserve	-766	-766	-766	
TOTAL TAXPAYERS EQUITY	- 22,488	- 25,163	- 25,499	

Table 4.1: Statement of Financial Position, February 2017

	Total Assets	Total Liabilities	Assets/ Liabilities
Mar-16	53,130	30,641	1.73
Apr-16	53,592	31,054	1.73
May-16	55,219	32,630	1.69
Jun-16	54,514	31,237	1.75
Jul-16	56,839	33,298	1.71
Aug-16	57,325	33,498	1.71
Sep-16	59,160	35,016	1.69
Oct-16	60,044	35,658	1.68
Nov-16	55,963	31,331	1.79
Dec-16	56,752	31,871	1.78
Jan-17	59,366	34,202	1.74
Feb-17	53,766	28,267	1.90

Table 4.2: Assets and Liabilities

	Financial Period												
Financial Ratio/Metric	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Liquidity ratio days	12	11	11	11	12	13	14	14	15	15	16	16	17
Trade Receivables days	21	22	22	25	20	18	19	21	18	16	20	19	22
Trade Payables days	68	80	94	103	99	109	103	103	106	73	93	115	71
CAPEX (% of plan)	81.2%	88.6%	42.1%	20.3%	31.7%	25.1%	38.5%	46.8%	45.9%	59.3%	55.3%	64.2%	70.1%

Table 4.3: Balance Sheet Metrics

4.1 Capital

The table below shows the Trust's total expenditure on capital projects for the year to date 2016-17. As at M11, capital expenditure YTD was £2,192k, representing 70% of the YTD plan. The full-year forecast of £4,109k expects that all funds will be utilised in 16-17.

Capital Projects	M11 Actual YTD £000's	M11 Plan YTD £000's	M11 Variance to plan	Full Yr Forecast	Full Yr Plan £000's	Full Yr Variance	Variance Analysis Commentary
Estates Developments	375	373	-2	910	1,231	321	YTD spend is primarily related to the completed works for Exchange House, Tunbridge Wells Hub (Cornerstones), Churchill Centre and Shearway (IT Accommodation). As at M11, the FOT for the area of Estates Developments has been reduced following the reported delay in the commencement of the Orthotics Site works and confirmation received that the Hawkhurst Hospital floor works will no longer proceed in 16-17 due to operational requirements.
Backlog Maintenance	137	346	209	137	396	259	YTD underspend is in main due to a number of planned schemes now confirmed, as no longer to proceed in 16-17. The FOT reflects the most up-to date position from the Estates Capital Planning Manager and no further expenditure is expected in this area for the remainder of 16-17.
IT Rolling Replacement & Upgrades	1,341	1,857	516	2,417	1,932	-485	YTD underspend is in main due to the delay in commencement of a number of Projects including Wound Care Management System, SAN storage purchase/installation and the Papercut/Printing solution. The FOT reflects the most up-to date position advised from the IT Projects Manager with regards to the revised value and timing of spend and includes the finalised expenditure for the purchase of the additional 2000 tablets approved by the CIS Board and the confirmation of schemes no longer to proceed in 16-17. As at M11, the FOT includes a contingency for further investment in IT hardware and schemes to enhance operability and remote access.
Dental SBU	249	300	51	249	300	51	YTD expenditure includes the completion of works at Appleby, New Street and Church Hill dental surgeries. No further capital expenditure in relation to Dental projects is expected in 16-17.
Other Minor Schemes	90	250	160	396	250	-146	YTD spend includes the purchase of a Hoist system at TCH and a bariatric leg couch for Vicarage Lane Clinic; the agreed M1 staff capitalisation costs associated with the final implementation of the Trust Intranet/Internet; and the initial equipping/fit-out of Clover House (Sexual Health site). The FOT includes the planned M12 equipment purchases in line with new service awards (mobilisation) and service improvements.
Total	**2,192**	**3,126**	**934**	**4,109**	**4,109**	**-**	

Table 4.4: Capital Expenditure February 2017

Gordon Flack
Director of Finance
March 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.6
Subject:	Workforce Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

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

Report Summary

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

Proposals and /or Recommendations

The Board is asked to note the current position on workforce performance.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. This is an assurance report and no decisions required/no significant change.

The Workforce Report in itself will have no impact on people with any of the nine protected characteristics.

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

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

NHS
Kent Community Health
NHS Foundation Trust

WORKFORCE REPORT

1. Report Summary

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

2. Overview

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

Month	February 2017		
Direction (Better/Worse)	Metric	Target	Current Position
↓	Turnover (12 mths to February)	10.50%	14.62%
↓	Absence (2016/17 cumulative)	3.90%	4.31%
↓	Vacancies	5.00%	7.75%
↑	Fill Rate Overall	No target set (rated on 75%)	96.14%
↓	Fill Rate Bank	No target set (rated on 30%)	57.76%
↓	Agency spend as a proportion of the trajectory (February, without contingency)	< 100%	135%
↑	Agency shifts - Framework agency used - compliant with price cap	100%	91.50%
↑	Average Recruitment Time in Weeks (in February 2017)	< 7 Weeks	5.51wks
↓	Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target)	85%	88.7%
N/A	Number of suspended staff	No target set	6
↔	Appraisals (annual figure)	85%	95.7%
N/A	Trust Headcount (at 28 February 2017)	No target set	4,980
↓	Number of Starters (February)	No target set (based on 74 av. 12 mths to February)	61
↑	Number of Leavers (February)	No target set (based on 63 av. 12 mths to February)	49

3. Performance Commentary

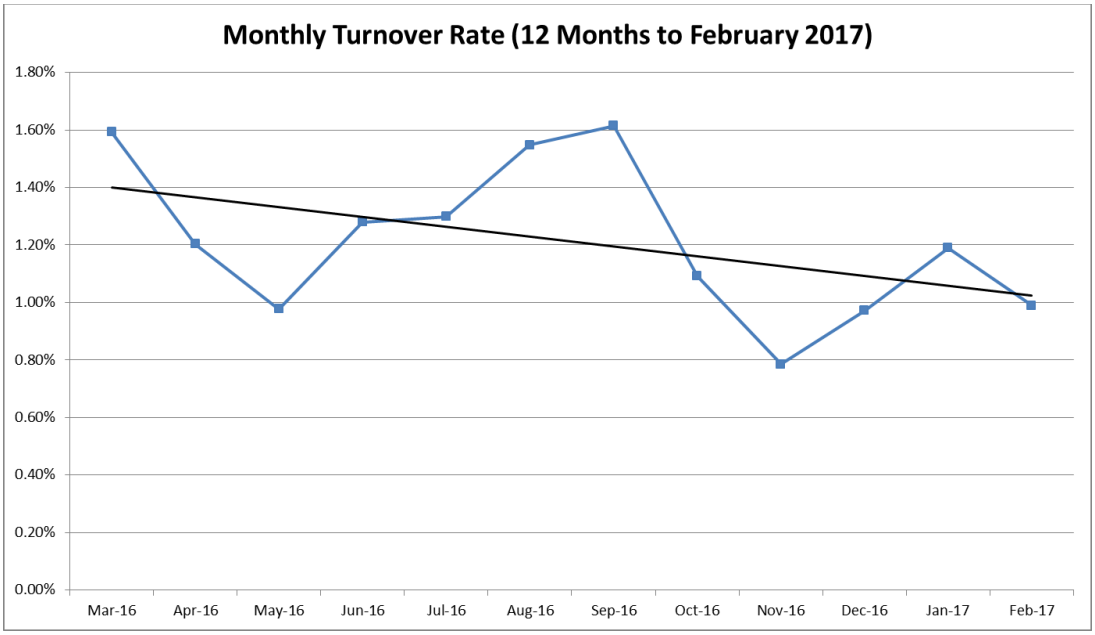
Turnover

3.1 The turnover rate for the 12 months to February 2017 is 14.62%, which is an increase on January's figure. This turnover data excludes TUPE transfers.

3.2 Whilst the figure for the 12 months has increased compared to the 12 months to January, Figure 1 below shows that individual month performance for February 2017 has fallen to 0.99% from 1.19% last month. This will be because February 2016 data has fallen out of the 12 month reporting period as time moves forward; that month saw a low turnover figure meaning that the average for the year has now increased slightly.

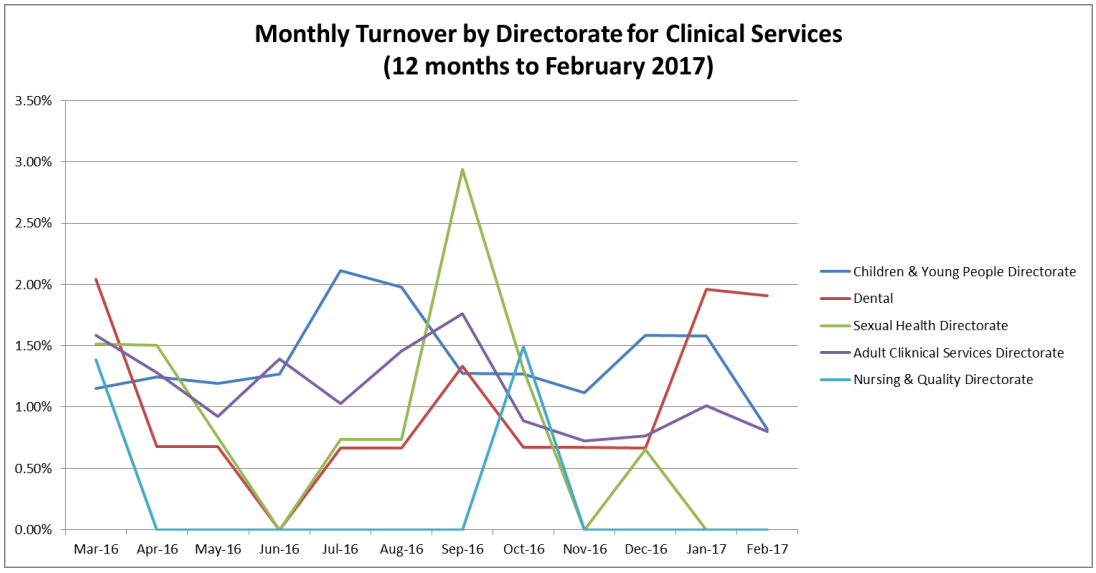
3.3 Month on month data shows a downward trend in the turnover rate. The turnover figures presented here exclude TUPE transfer leavers.

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



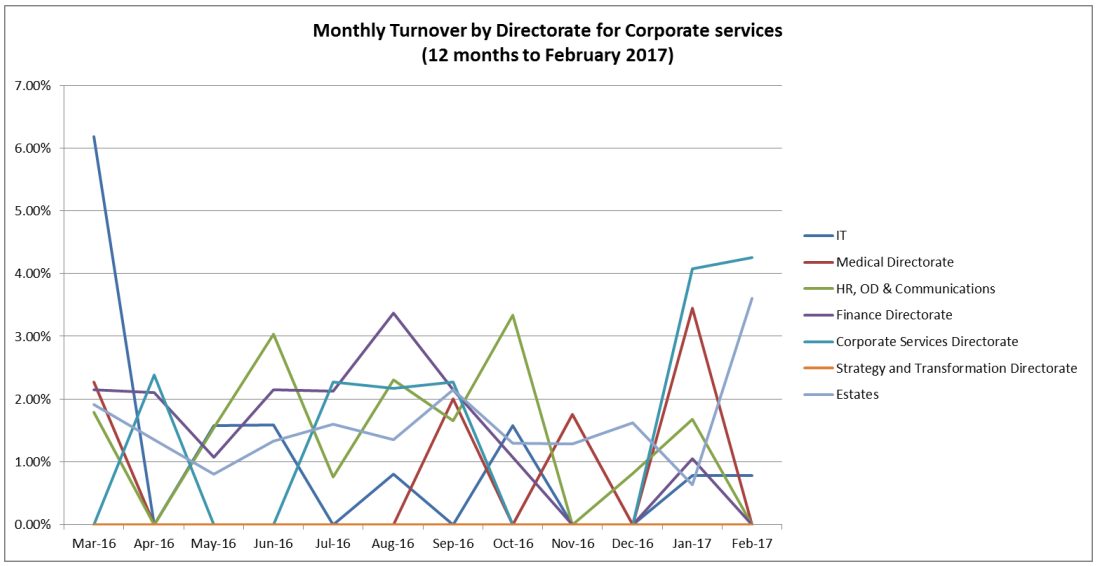
3.4 Fig. 2 below shows turnover by directorate for clinical services. The highest turnover rate in February 2017 was Dental at 1.91% (down from 1.96% in January). This was followed by Children and Young People at 0.82% (down from 1.58% in January 2017) and Adult Clinical Services 0.80% (down from 1.01% the previous month).

Fig.2: Monthly Turnover by Directorate for Clinical Services (12 months to February 2017)



3.5 Fig. 3 below shows turnover by directorate for corporate services. In February 2017 Corporate Services had the highest turnover rate at 4.26%, up from 4.08% the previous month. This was followed by Estates at 3.61% (up from 0.64%) and IT at 0.78% (the same rate as January 2017).

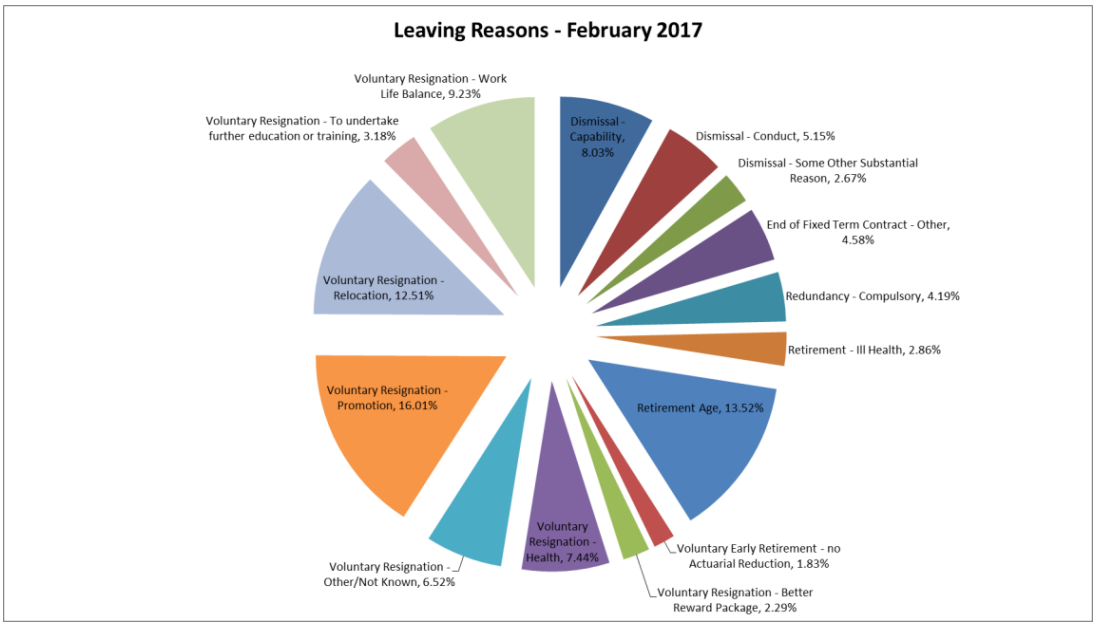
Fig.3: Monthly Turnover by Directorate for Corporate Services (12 months to February 2017)



Leaving Reasons

3.6 Fig. 4 below shows leaving reasons for the month of February 2017 alone. As last month, voluntary resignation for promotion was the highest reason at 16.01% (compared to 23.3% in January). This was followed by retirement age (13.52%) and voluntary resignation for relocation (12.51%).

Fig.4: Leaving reasons – February 2017



3.7 Fig. 5 below shows the latest picture on leaving reasons over the past 12 months to February 2017. The figures shown represent the actual number of leavers. TUPE transfers have been excluded from these figures. Resignation for work life balance reasons was the top reason with 160 leavers. This was followed by retirement age with 107 leavers and voluntary resignation for promotion also with 107 leavers. Forth highest reason is relocation.

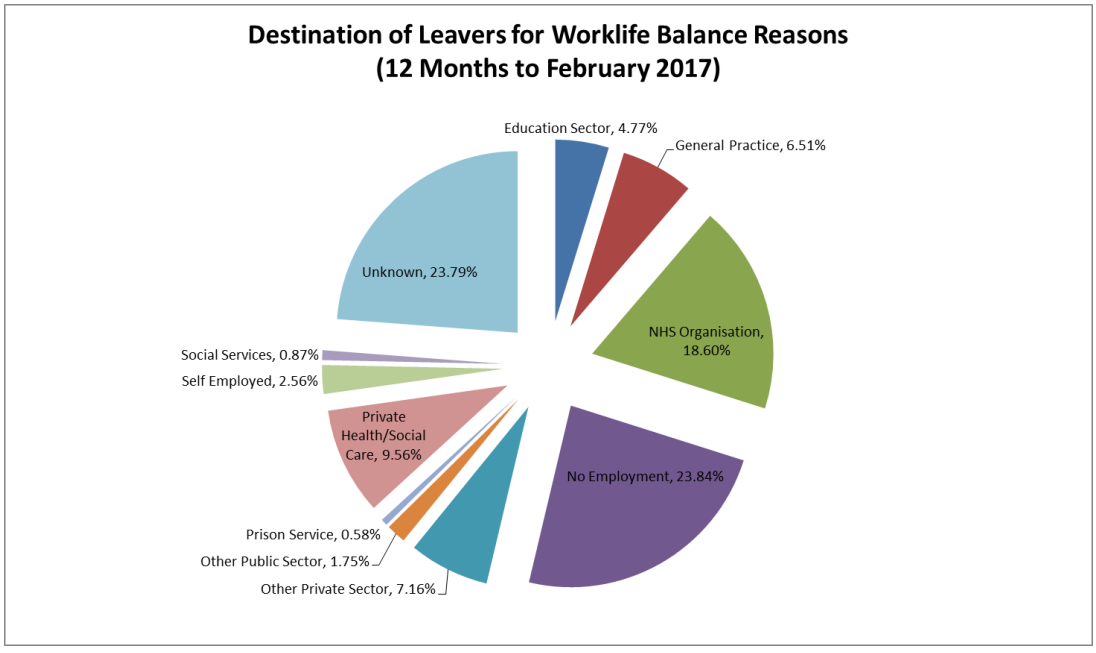
3.8 For the rolling year to February 2017 there were 773 leavers excluding TUPE transfers.

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

3.9 Fig 6. below shows the destination of worklife balance leavers during the year to February 2017. The largest destination was no employment which constituted 23.84% of the total February leavers. This was followed by those for whom we do not know their destination at 23.79%. For those who we do know about, 27 went to employment in NHS organisations (18.6%) followed by 15 going into Private Health/ Social Care (9.56%).

3.10 We are sampling those who left in November for reported work-life balance reasons to see if we can establish if there was anything that the Trust could have done to prevent the member of staff from leaving. In November there were 8 leavers in this category. Unfortunately once people have left it is very difficult to connect with them and get further feedback. Of the 8 only two have responded to phone calls and emails. One individual worked in the Dental service and was based in Faversham. After 2 years in post her role was moved to Sandwich and the additional travel time adversely impacted on her life so she resigned. Otherwise she enjoyed her job and would have been happy to stay. The second case was more complicated in that she originally worked through an agency at 18.5 hours and accepted a role with the Trust working 22.5 hours. She advised us that 18.5 hours was not an option afforded her. Whilst she worked for the Trust she could not manage the workload in those hours which led to increased childminding costs and stress and it impacted negatively on her health leading to her resignation.

Fig.6: Destination of Leavers for Work-life Balance Reasons 12 months to February 2017



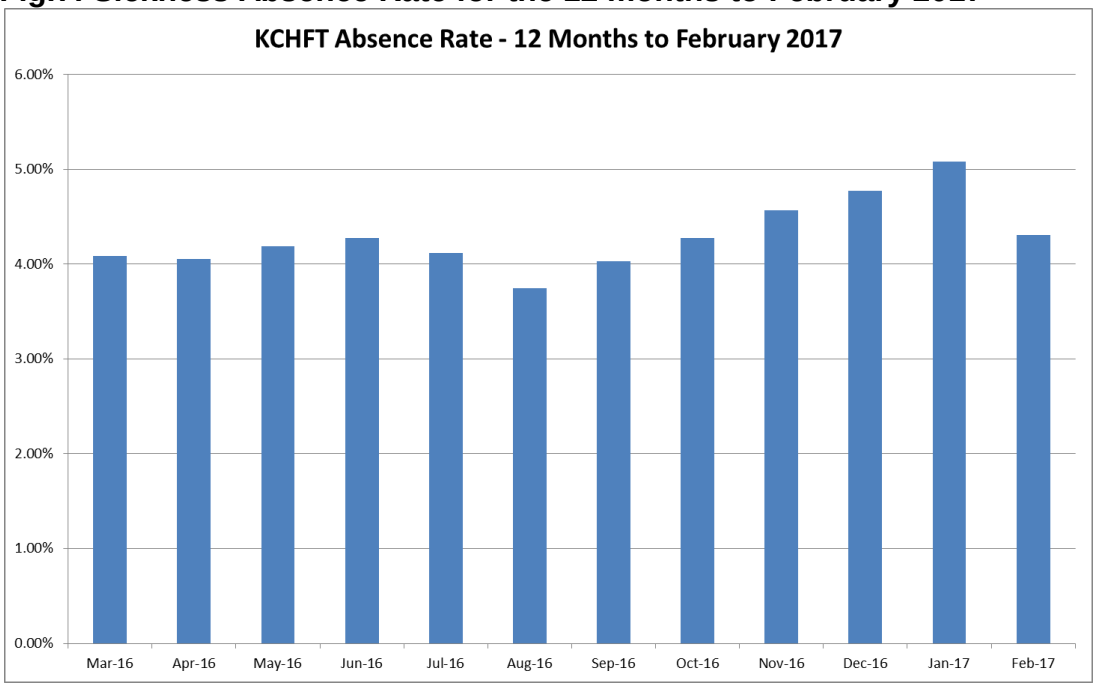
Sickness Absence

3.11 Performance in the eleven months of the 2016/17 financial year to February 2017 stands at 4.31% compared to a recalculated rate of 4.30% for January. This is above the target of 3.90%. The sickness rate for the 12 months to February 2017 stands at 4.17% which is above the same period the previous year (the 12 months to February 2016) of 3.96%.

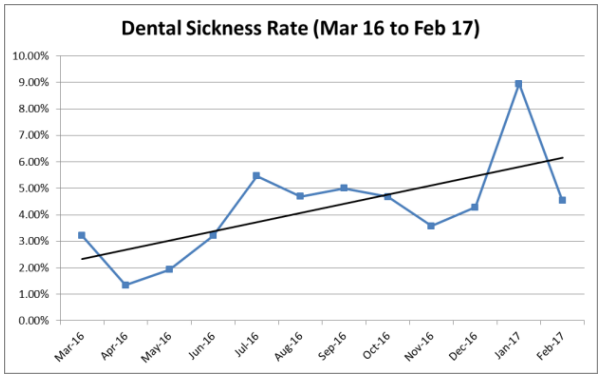
3.12 February's rate of 4.31% is above the 2.09% reported the previous month. Data for January 2017 was run prior to the mid-month point following the month being reported on which means that the figures did not incorporate all sickness data. As stated in January's report, the timing of the report meant that the figure was underreported.

3.13 The Trust is continuing with deep dives in those areas where performance is significantly above target.

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



3.14 Fig 8 below shows sickness absence by clinical directorates for February 2017. As in January, Dental had the highest sickness rate of the clinical directorates. The current February Dental figure is 4.53% compared to an updated January figure of 8.95%. Dental sickness for the past 12 months is shown separately in the chart to the right. Deep dives have taken place and further meetings will be arranged; it is envisaged that these should reduce sickness absence. Children and Young People had the second highest sickness figure at 4.24% compared to an updated figure of 4.54% for January.



3.15 Fig.9 below shows sickness absence by corporate directorates for February 2017. The Estates Directorate sickness rate is 5.64% in February, a decrease from January's revised figure of 7.05%. The Corporate Services directorate had the second highest sickness rate at 4.63% compared to January's updated figure of 3.13%. The Medical Directorate had the third highest sickness rate at 3.65%, currently down from January's updated figure of 6.48%.

Fig.8: Sickness Absence by Directorate (Clinical) 12 months to February 2017

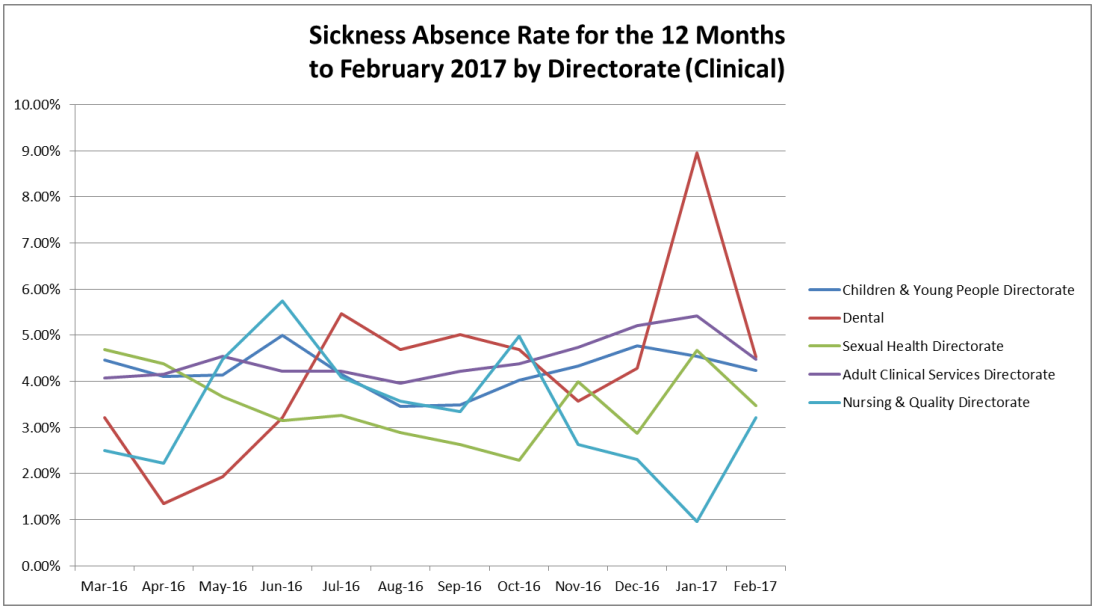
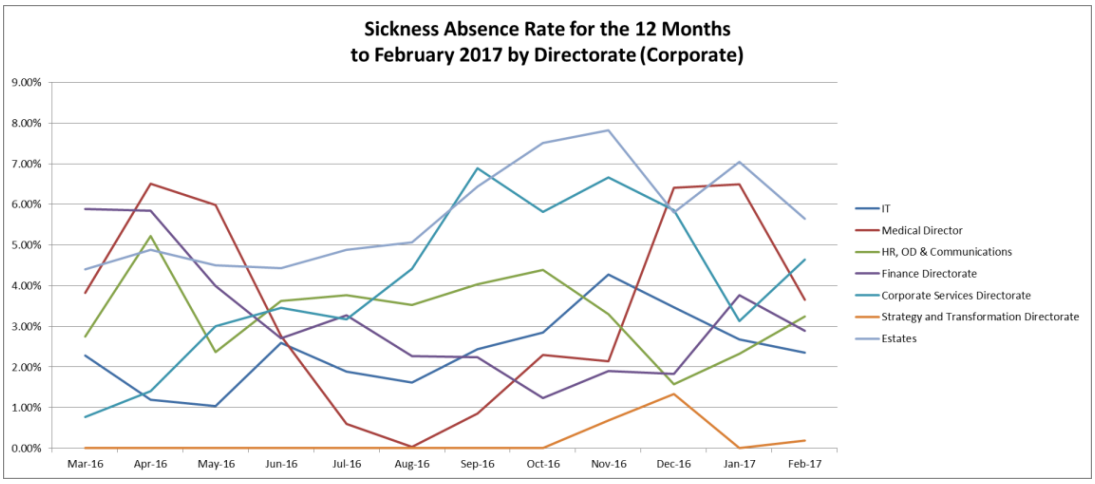


Fig.9: Sickness Absence by Directorate (Corporate) 12mths to February 2017

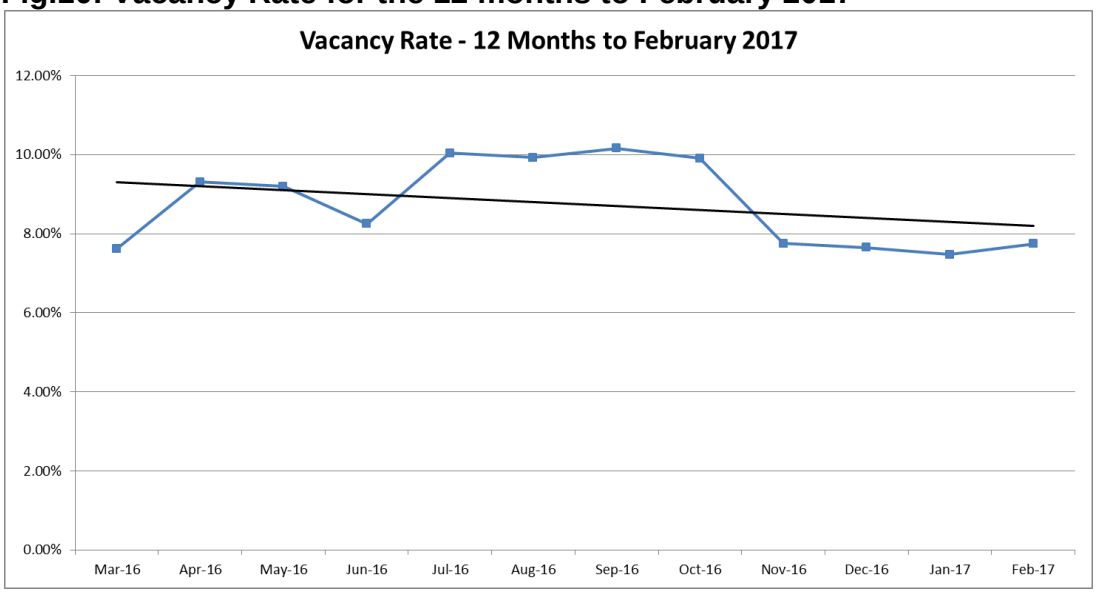


Vacancies

3.16 Fig.10 shows that the vacancy rate for the trust stands at 7.75% for February 2017 which is an increase from January's 7.47%. The rate of 7.75% is the fourth lowest rate in the past 12 months.

3.17 Work is underway in relation to establishing rotational posts with other trusts in order to help reduce vacancies at Band 5 and Band 6. We are working with Kent and Medway Partnership Trust (KMPT) East Kent University Hospitals Trust and Maidstone and Tunbridge Wells NHS Trust (MTW). The rotation with KMPT has now been agreed and we will be advertising posts in the next two weeks.

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



3.18 Fig. 11 shows the number of vacancies has increased from to 330.67 WTE in January to 342.93, an increase of 12.26 WTE in vacant posts.

3.19 Fig. 12 shows that whereas there was an increase in the number of contracted staff last month (of 17.50 WTE) this month the number of contracted staff has fallen by 14.04 WTE. The establishment has reduced slightly from 4,425.85 WTE in January 2017 to 4,424.07 WTE in February, a reduction of 1.78 WTE.

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

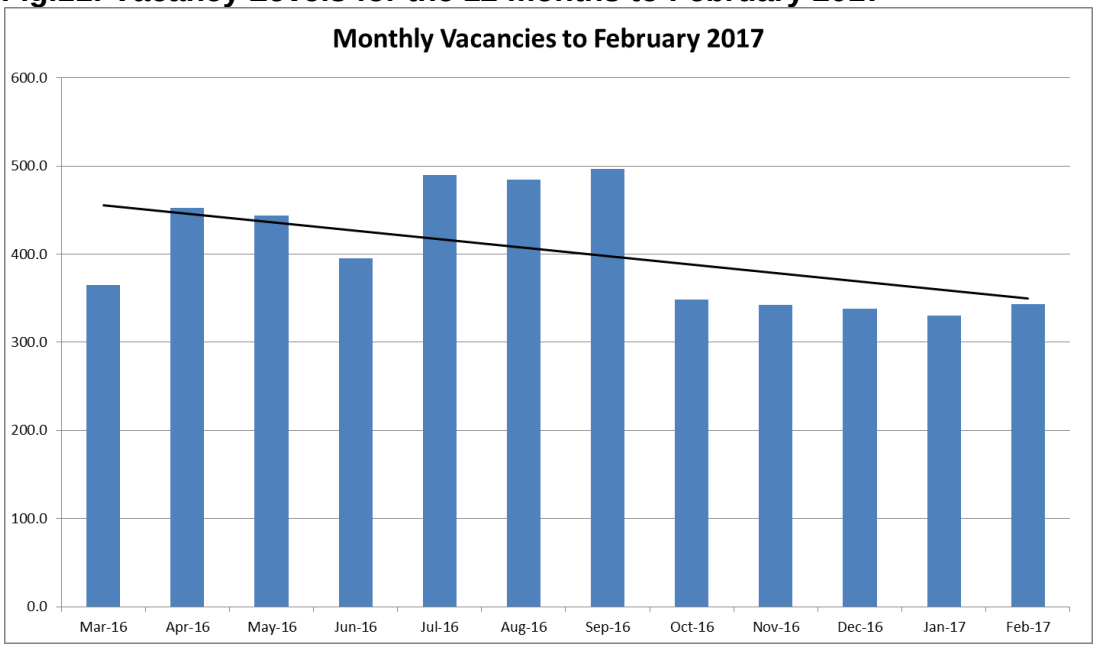
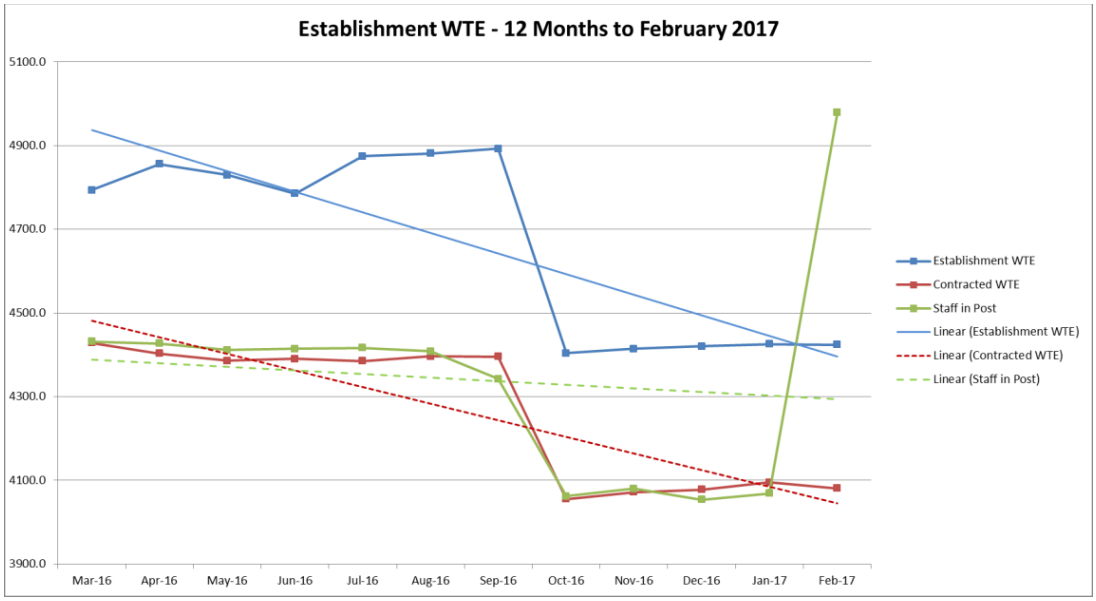


Fig. 12: Establishment in February 2016 to February 2017



Temporary Staff Usage

3.20 The table below shows shifts for February 2017 filled by agencies.

	Framework		Non Framework		Total
	Price cap breach	Price cap compliant	Price cap breach	Price cap compliant	
Number of shifts	102	1388	23	4	1517
Percentage	6.72%	91.50%	1.52%	0.26%	100.00%

3.21 In February 2017, 91.50% of shifts were filled using framework agencies which are compliant with the price cap, up from 90.45% the previous month. (and up from 86.36% in December). There continues to be upward performance on this measure with a target of 100%; the rating will move from red to amber at 95%.

3.22 In February 2017 a total of 98.22% of shifts were filled using framework agencies, up from 97.49% last month. As well as the 91.50% of shifts compliant with price caps, a further 6.72% of shifts were booked with framework agencies who do not meet the price cap.

3.23 The remainder of shifts were filled using non framework agencies which do (0.26%) and do not (1.52%) adhere to the price cap. This represents 1.78% of shifts in total, a positive reduction from the 2.51% of shifts in January and the 5.85% of shifts in December.

3.24 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.

3.25 Data for agency spend can be shown a number of ways:

- In the scorecard a figure is presented for agency spend in February 2017 alone without the contingency fund of £39,399. With a spend of £503,590 against a trajectory of £373,206 this therefore represents a spend of 135%.

- If you include the contingency fund then in February 2017 there is a spend of £503,590 compared to a trajectory of £412,606. This represents a spend of 122% with the contingency built in.

- The chart below shows agency spend for the year to date (from April 2016 to February 2017). Without the contingency money the spend for the year to date is 97.58%. This is a spend of £1,110,052 compared to a trajectory of £1,651,638.

- With the contingency of £544,322 this is a spend of £1,110,052 against a trajectory of 2,195,959. This represents a spend of 91.19%.

Directorate and Locality	External Agency and Locum Expenditure YTD (£)	Trajectory YTD (£)	Adverse or Favourable Variance to Trajectory
Adult Clinical Services	6,466.06359	6,112.23450	A
Children & Young People	1,163,306	851,926	A
Corporate Services	5,248	23,553	F
Dental Services	1,715	-36	A
Estates	105,246	157,897	F
Finance Directorate	6,298	36,502	F
HR, OD & Communications	11,066	12,880	F
IT	76,599	100,989	F
Nursing & Quality	8,719	3,903	A
Sexual Health	-1,214		F
Reserves	-266,931		F
Add Darent House for 6 months		464,026	F
Total Directorate Position/Trajectory	**1,110,052**	**1,651,638**	F
Contingency	**0**	**544,322**	F
Total Trust Position/Trajectory	**1,110,052**	**2,195,959**	F

4. Recommendations

4.1 The Board is asked to note the current position on workforce performance.

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

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting – Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.7
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. There was an improved fill rate in February of 96% for RN's. Tonbridge and Edenbridge did not meet the 95% fill rate standard. A number of patients required 1:1 care in the community hospitals. There continues to be an improving position in respect of pressure ulcers. Two falls resulted in a fracture in February constituting Serious Incidents. There were two new cases of C.difficile on Heron ward. Patient experience remains positive.

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

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

Ali Strowman, Chief Nurse	Tel: 01622 211900
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Quality Report

QUALITY REPORT

1. Patient Safety

Workforce Data and Quality Metrics

1.1. The information set out in figure 1 below relates to February fill rates per community hospital ward broken down by day and night for registered and unregistered staff.

1.2. The fill rate for registered nurses has improved from January, producing a total fill rate of 96% for RN's day shifts (93% last month) and over 100% for HCA's. Tonbridge has increased the planned RN numbers to 3 for an early and late to manage the additional therapy beds and support the non-registered Assistant Practitioners on the unit, this will remain in place until the Assistant Practitioners are able to undertake mediation responsibilities.

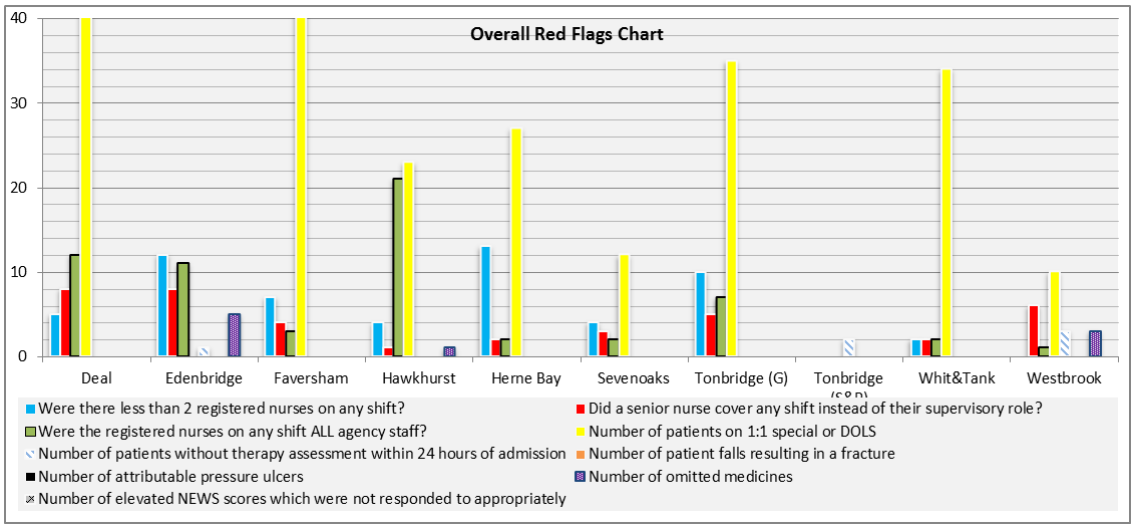
1.3. There is no agreed national community staffing rating system yet, so the Chief Nurse will provide commentary on any areas less than 95% within community hospitals. Edenbridge, Tonbridge, Sevenoaks, and QVMH all had RN day shifts where the planned staffing fell below 95%, reflecting the continued high demand for temporary staff during the current winter pressure period. Where RN shifts were unable to be filled by bank or agency the wards increased the use of HCA staff to increase general capacity and this is reflected in the high percent of HCAs. Additional to this HCAs were contracted 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: Fill rates

	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	107.1%	173.2%	96.4%	150.0%	840	900	1260	2182.5	616	594	616	924
Deal	97.3%	181.0%	98.2%	173.2%	840	817.5	1260	2280	616	605	616	1067
QVMH	94.6%	130.4%	91.1%	125.0%	840	795	1260	1642.5	616	561	616	770
Whit &Tank	100.0%	155.7%	96.4%	121.4%	840	840	1050	1635	616	594	616	748
Sevenoaks	93.8%	109.5%	98.2%	100.0%	840	787.5	1260	1380	616	605	616	616
Tonbridge	89.9%	142.9%	96.4%	107.1%	1260	1132.5	1680	2400	616	594	924	990
Hawkhurst	103.6%	120.6%	94.6%	96.4%	840	870	1237.5	1492.5	616	583	616	594
Edenbridge	86.6%	125.0%	98.2%	100.0%	840	727.5	840	1050	616	605	308	308
Total	**96%**	**143%**	**96%**	**122%**	**7140**	**6870**	**9848**	**14063**	**4928**	**4741**	**4928**	**6017**
	Over 90% Fill Rate			65%to90% Fill rate				Less than 65%				

1.4. All wards are required to submit an assessment each day, identifying any key quality indicators for safe patient care (the red flag report). This highlights to the Executive Team any issues relating to safe staffing levels or key metrics including falls, medication incidents or high proportions of agency staff. Figure 2 below provides a summary of red flags raised in the month of February 2017 and demonstrates the high numbers of additional 1-1 support required.

Figure 2: Red Flag report

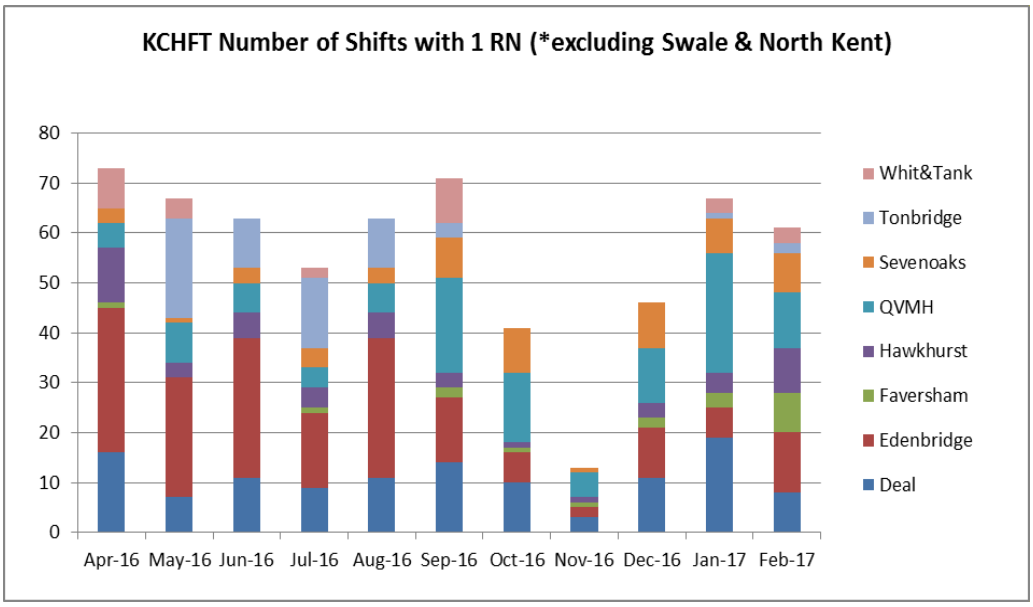


1.5. There has been an increase in the number of patients requiring 1-1 support, this is mainly due to an increase in the number of inpatients with cognitive impairment. Whilst the wards are doing their upmost to adapt the way they work to increase support for these patients, there has been the need to request additional staff. Work is underway to review how we support patients with dementia.

1.6. Where there are difficulties in filling shifts with the potential of impacting on patient safety, these are escalated to the operational lead that day and a number of measures are taken to ensure safety. These include:

- move staff from other wards to provide cover
- offer staff opportunity to work when they are not on duty
- convert supervisory time to clinical time
- move rapid response or the night teams to be based at the same site
- ensure the minor injuries units, where these are located in the same building, are aware the ward has one nurse on duty so they are prepared to respond immediately should they be called request to operationalize staff within the Clinical Education and Standard Team

Figure 3: Shifts with 1 RN



1.7. In February, 61 shifts had less than the planned staffing for RNs on duty, this is a improved position from January (67). Edenbridge and Tonbridge were the wards most challenged in filling RN shifts and this is reflected in their lower fill rates. Operational managers have reported that difficulty in filling shifts fill related to stopping block booking for agency staff at Tonbridge and Edenbridge, and although once this problem was identified and block booking was resumed, the regular agency staff had found shifts elsewhere. Staff booked through other agencies during this period frequently failed to appear for duty and this left the ward with less than planned numbers.

1.8. Within these shifts, safety was maintained by operational managers by implementing the measures stated in figure 1.6.above. Of the 61 shifts with less than planned RN numbers there were clinical incidents on 10 of these shifts (Figure 4), all of which were low or no harm incidents. Whilst there cannot be a definitive correlation drawn between reduced numbers of RNs and incidents (as incidents happen on shifts where the full complement of staff are present), we continue to monitor this closely.

Figure 4: Incidents on the shifts with 1 RN

Hospital	Incident date	Type	Impact
Hawkhurst	02.02.17	Fall	Low Harm
Hawkhurst	10.02.17	Sutures not removed	No Harm
Hawkhurst	13.02.17	Fall	Low Harm

Hawkhurst	15.02.17	Fall	No Harm
QVMH Hospital	04.02.17	Fall	No Harm
QVMH Hospital	13.02.17	Fall	No harm
QVMH Hospital	18.02.17	Fall	No Harm
QVMH Hospital	27.02.17	Fall	No Harm
Whit & Tank Hospital	23.02.17	Fall	No Harm
Edenbridge	14.02.17	2 medication errors	Both no Harm

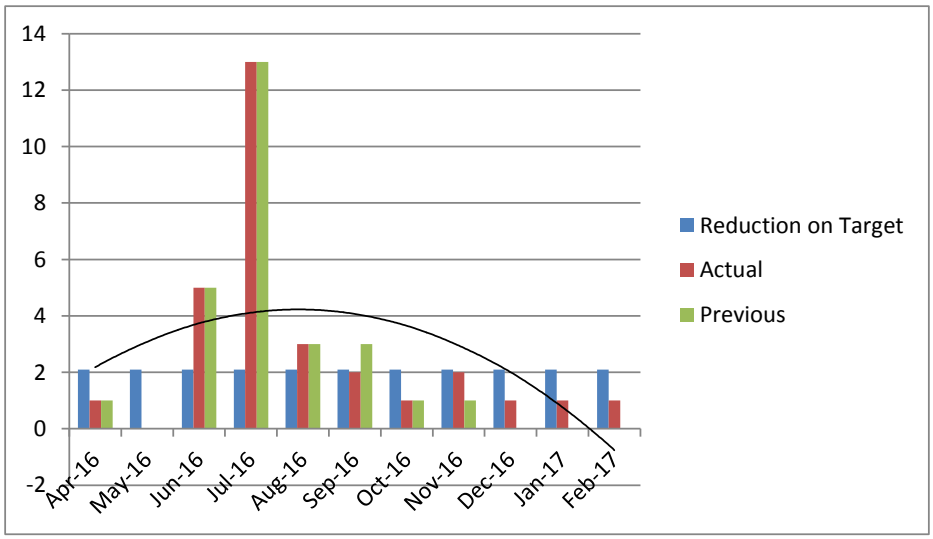
1.9. **Pressure Ulcers**

A detailed report on pressure ulcer harms is submitted monthly to the Quality Committee. The Pressure Ulcer Taskforce Group, established by the Chief Nurse in November 2016, continues to meet every 2 weeks to progress initiatives and prevention strategies in pressure ulcer management and gain assurance that all possible interventions are being implemented to prevent harm to our patients. Monthly highlight reports are submitted by each locality to evidence progress, actions and audit outcomes. There have been no new serious incidents reported this month. All of the RCA reports for deep tissue injury (DTI), ungradeable pressure ulcers, category 3 and 4's continue to be signed off by the Chief Nurse. Action plans are in place within all localities which are monitored and discussed at the Pressure Ulcer Taskforce meetings. A pressure ulcer strategic plan is now in place for the organisation.

Category 2 pressure harms

There was one confirmed avoidable category 2 pressure ulcer reported in February and this is under investigation. There were an additional three category 2 pressure ulcers reported in January. Following investigation, one has been confirmed as avoidable and was due to lack of early assessment. There are 58 outstanding category 2 investigations to be completed.

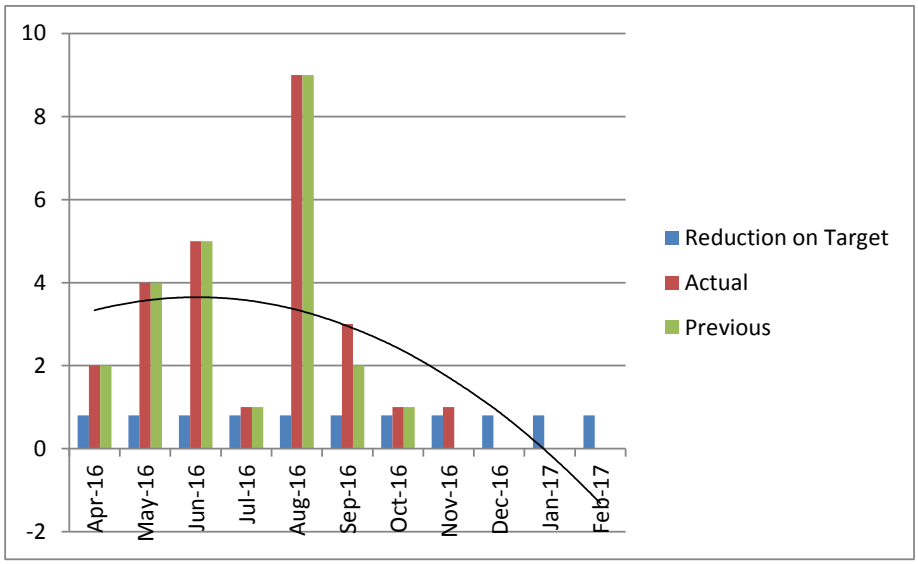
Figure 5: Category 2 pressure ulcers



Category 3, 4 and ungradeable pressure harms

There have been no new category 3 and above harms in February. There are 71 outstanding incidents (category 3; 4; ungradeable; deep tissue injury) to be investigated.

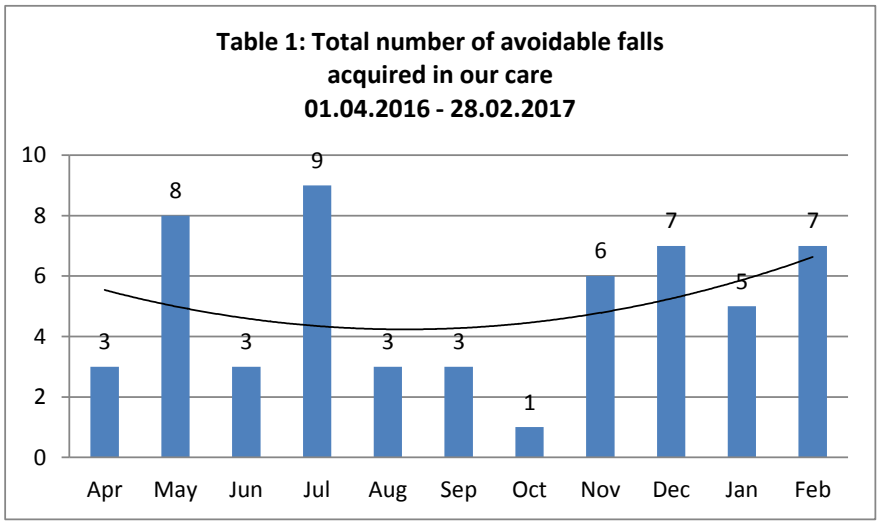
Figure 6: Category 3, 4 and ungradable pressure ulcers



1.10. **Falls**

There were 57 falls reported across KCHFT in February. There were 7 which were found to be avoidable, i.e. not all elements of the Falls Bundle were in place. This is an increase from the previous month where 5 falls acquired in our care were found to be avoidable (Fig. 7).

Figure 7: Number of avoidable falls acquired in our care



Two serious incidents were declared in February as a result of falls resulting in a fracture, one patient in Hawkhurst and one in Tonbridge Cottage Hospital. In both cases Root Cause Analyses are underway to determine if these were avoidable and to identify lessons to be learned.

1.11. The Trust continues to be part of the NHSI Falls Collaborative looking at measures to improve our position on falls with harm. Additionally, the first falls prevention and awareness week took place in February, activities to promote falls awareness were held across the community hospitals as well as at the *One You* Health and Wellbeing shop. A new top tips education resource has been launched for staff to build their knowledge regarding falls prevention.

1.12. **Infection, prevention and control (IPC)**

The Trust has breached its target of no more than 5 Clostridium difficile infections for 2016/17. Two cases were reported in QVMH in February totalling 6 cases this year to date. An RCA is currently underway to look at lessons to be learnt.

There have been no further outbreaks of respiratory infections, however on Heron ward 5 patients developed diarrhoea, and given the C-dif cases, 2 bays were closed. No other patients have grown any microbiological pathogens.

Bed closures in community hospitals

Heron Ward	Ward closed on 16/2/16. Re-opened on 17.2.17.	2 cases of clostridium difficile toxin positive. 3 other patients with	5 patients affected (2 confirmed clostridium difficile toxin positive)

QVMH	One bay remained closed until 1/3/17	diarrhoea unknown cause.	

1.13. **Quality Surveillance**

The Quality Surveillance Meeting (QSM) meets monthly to review all metrics including the service early warning trigger tools (EWTT), and key performance indicators relating to quality as well as soft intelligence. All elements of the EWTT are scrutinised by the group and actions are requested to understand more detail where services appear to be experiencing difficulties. Nursing and Quality teams and Medicines Management continue to provide intensive support to those areas giving cause for concern to ensure quality and safety issues are identified and rectified quickly.

1.14. Two of the four community hospitals in East Kent remain on minor concern. The Queen Victoria Memorial Hospital remains on moderate concern with intensive support for the leadership team. A robust action plan is in place action plan for all four community hospitals which is monitored regularly. The operational managers and the Patient Safety Facilitator for the area are continuing to provide support to all units.

1.15. Community Nursing teams in Maidstone (West Kent locality) continue on minor concern with an improving picture.

1.16. A written and verbal update to the Quality Committee is provided by the Medical Director.

1.17. **Medication Incidents**

The adjusted figures for 2016/17 demonstrate that the overall reporting of medication incidents has remained similar to the previous year. The number of low harm incidents continues to decrease and there have been no moderate or severe harms.

Figure 8: Acquired in our care SafeMed incidents with no harm

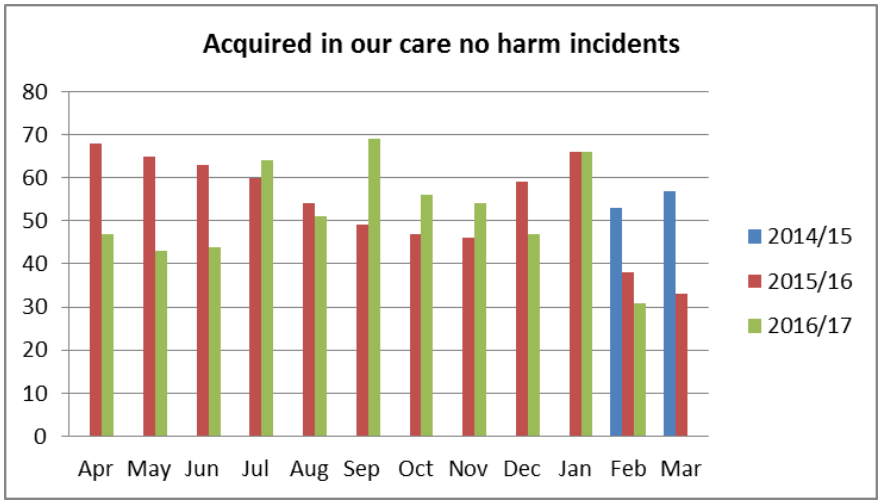
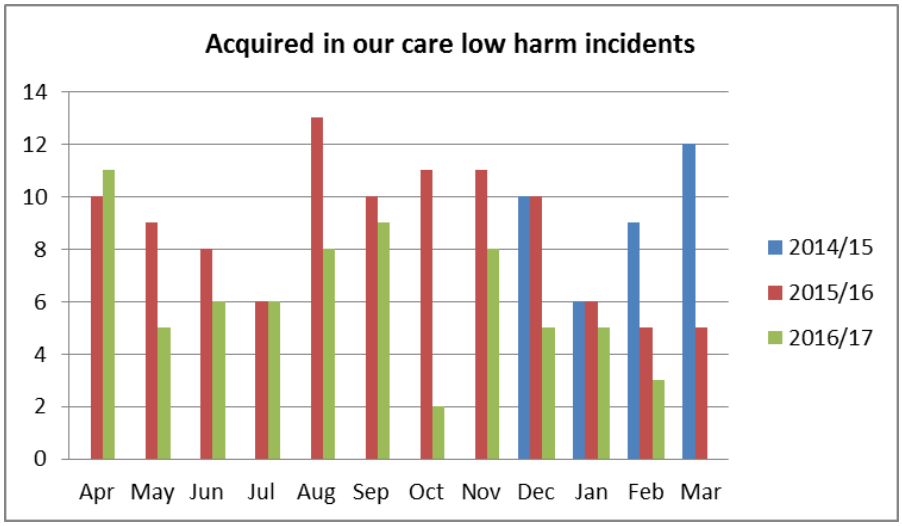


Figure 9: Acquired in our care SafeMed incidents with low harm



There have been 34 incidents reported in February. The highest reported category of incidents is omitted medication making up just over a quarter of the total medication incidents. The majority of these incidents were no harm, with the remainder low harm. The low harms relate to wrong quantity and adverse reaction when the drug was used as intended. Omitted doses in community hospitals are reported daily by the red flag report and followed up by the nursing and quality and pharmacy teams. There is a yearly Omitted Dose Audit which demonstrates that KCHFT has a very low omitted dose rate in the hospitals when benchmarked with other community trusts. Missed doses are discussed at the Medication Governance Meeting and actively followed up by a pharmacist.

2. Patient Experience

2.1. The Trust continues to achieve a high volume of patient feedback resulting in a very positive 96.78% patient satisfaction score. In addition to the 3,541 surveys indicated below, a further 2,006 NHS Friends and Family Test (FFT) short paper surveys were completed in MIUs throughout February resulting in a total of 5,547 surveys).

Figure 10: Overall Patient Satisfaction rate

Combined result from all questionnaires (excluding the short NHS FFT survey) submitted between 1 February and 28 February 2017	Number of questionnaires submitted between 1 February and 28 February 2017
96.78%	3,541

Word cloud (selection of key words used within Meridian survey responses) for February 2017:

NHS FFT Trust Score for February

The vast majority of feedback through Friends and Family Test was very positive.

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.57%	0.53%	5434	4451	851	71	12	17	32

Selection of positive feedback in February

Intermediate Care Team - Canterbury	Everything was dealt with efficiently and speedy. Everyone I met was kind patient and helpful. My exercise lady was always happy and smiley and made exercising fun and always punctual.
Cardiac Rehabilitation – Thanet	This service has given me so much confidence in myself and the NHS staff have been wonderful. They're so friendly and always put a smile on my face. The weekly talks were also very useful.
Diabetes Nursing - Dover/Deal	The diabetes specialist nurse has been most helpful in giving information about my condition and in making changes to the management of it - a vital service.
Heart Failure Specialist Nurses - Thanet	Always punctual and extremely caring. The Nurse always makes me feel settled and discusses all aspects of my condition and treatment.
Complex Care Nurses - Tunbridge Wells	The care I receive is second to none, I could not be better treated or looked after and also I am listened to. I feel it is important to know that notice is taken if you have something to say.
Children's Integrated Therapy Services - Hastings, Bexhill and Rother)	We are fortunate to have the best Physio in East Sussex, who had supported my son throughout his illness/diagnosis and beyond - fantastic service!

2.2. **Selection of Negative Feedback in February**

- It's a long time and pain consuming slow process. Dental (Adult): HMP Swaleside - Swale
- Extremely difficult to make an appointment, can't get through on the phone, rang almost 20 times was either engaged or diverted. Open very few days and hours, when finally came to walk in had to wait almost two hours. (Sexual Health Service – Ashford)
- The minor injuries unit at Deal used to provide a good service, the waiting time has really deteriorated over the last year or so.(Minor injuries Deal)
- I think that this place is very miserable. Staff are lovely and very caring. (Sevenoaks Hospital)
- Called to check the insoles were at clinic before and was told yes. Arrived and the insoles are at Herne Bay - XX was very apologetic and helpful as always but this is not the first time this has happened.(Podiatry Rainham).
- Clearer communication regarding visit times and days. This has been very sporadic and sometimes failed to visit when expected. (Community Nursing Canterbury East).

2.3. **Key themes of feedback this month:**

- Clinical treatment
  People making podiatry appointments felt the process and referral criteria were not clear. This is with the service for action.
- Referrals, appointments, admissions, discharges and transfers
  There was feedback from a few patients in regards cancelled appointments, the new booking system for phlebotomy and appointment waits. As a result the service is exploring alternative ways of booking appointments including choose and book.
- Access to treatment and medication
  There was feedback regards continence products and feeling there was a delay in supply. This is with the service for action.
- Communication
  We were told by patients that they did not always receive clear contact details on letters and instead contacted the PALS services.
  There were some families who felt information within letters they received gave incorrect information. This is with the service for action

2.4. **Selection of actions to address feedback completed in February**

- Podiatry Service: a new process was implemented to ensure that when clients attend clinic for their insoles that they are available for collection. This action was raised as a result of feedback received from patient who arrived at clinic to collect insoles, after checking by telephone and told they were available, only to find they were not.
- Community Learning Disability Team (CLDT): 69 members of staff have received End of Life training to enable them to give more suitable support to their clients and carers, if relevant. This action was raised as a result of feedback from carers in a residential home, feeling that they are not supported by CLDT staff with their residents that are at their end of life.

3. Patient Outcomes

Mortality Surveillance

The mortality surveillance group meeting reviewed data supplied by Dr Foster in February 2017 which shows that Mortality in-hospital data is 'as expected'. There were 5 deaths within the community hospitals, all were expected and were receiving end of life care. Data up to October 2016 for all admissions into the community hospitals showed there are fewer deaths than expected for step-down treatment.

3.1. **Clinical audit programme 2016-17**

Currently there are 167 clinical audits on the audit programme. A total of 65 audits have been completed i.e. all actions have been implemented. Of the 88 audits scored using the risk score matrix, 73% achieved full or significant assurance.

Forward Planning

The annual audit programme for 2017/18 will be ratified at the Trust Clinical Audit Group on the 31st March 2017. The process for forward planning involves close working with directorates and corporate services to systematically prioritise topics for inclusion in the annual audit programme. Patient partners were also consulted with in January for their input into the audit programme for 2017/18.

Development Areas

Following a benchmarking exercise that was undertaken via consultation with Trusts on the South East Clinical Effectiveness Network and via the Contact, Help, Advice and Information Network (CHAIN) we have revised our process for reporting and have introduced a simplified SBAR report which is to be preceded by dashboard reporting with key risks and assurance rating due within 30 days of the audit. This will ensure that there is faster escalation and action for those reports which have shown poor compliance or significant areas of concern.

The Audit Team have presented at the national Clinical Audit Conference on the successful continual development of clinical audit within KCHFT.

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

The number of NICE guidance/ standards that were issued in February 2017 was eighteen. Guidance has a due date of 3 months from release and responses are not due until May 2017.
The number of guidance/standards issued in November 2016 that were due for assessment in February 2017 was seventeen in total. Eight of the guidance/ standards issued were deemed applicable to at least one service throughout the trust and nine were assessed as not applicable.
Of the sixteen responses from different services that identified guidance/ standards as applicable, the following assessments have been completed;

- Twelve still remain under initial review and have not yet been fully assessed
- Two have been identified as fully compliant
- Two have been identified as partially compliant, and are awaiting actions to be completed.

Ali Strowman Chief Nurse

March 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:	30 March 2017
Agenda Item:	2.8
Subject:	Final Revenue and Capital Budgets 2017/18
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	X	Assurance	☐

Report Summary (including purpose and context)
This paper shows the final income and expenditure budgets and capital plan for 2017/18. The income and expenditure budgets show that the Trust is planning to make a surplus of £3,026k in 2017/18, supported by £1,759k of STF funding, and is planning to spend £4,179k of capital.
Proposals and /or Recommendations
The Trust Board is asked to approve these budgets.

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. 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.

Gill Jacobs, Deputy Director of Finance	Tel: 01622 211931
	Email: gill.jacobs@kentcht.nhs.uk

FINAL REVENUE AND CAPITAL BUDGETS 2017/18

1. Summary

This paper presents the Board with the 2017/18 budgets for approval. It describes the assumptions made in arriving at these budgets.

2. Introduction

The 2017/18 budget has been built up from the rollover 2016/17 budget, and using the following assumptions:

- The budget delivers a surplus of £3,026k, 1.4%, including £1,759k of STF funding (0.6% excluding STF funding)
- The capital plan is affordable without external borrowing
- The Trust is not reliant on non-recurrent CIP or other savings in order to meet its targets
- Budgets are sufficient to deliver safe and effective services

A budget setting framework, which included the principles for budget-setting, was agreed by the Finance, Business and Investment Committee in November 2016 and has been implemented in calculating 2017/18 budgets.

Budgets are based on the month nine full year budget adding in any full year effects from 2016/17 (related to service developments, decommissioning and non-recurrent items), removing unachieved CIP, adding inflation and incremental progression costs, and removing unutilised reserves. Where relevant, budgets have been aligned to rotas (particularly for wards and cleaning staff). All enhancements have been budgeted in line with actual work patterns.

3. Summary Income and Expenditure Budgets for 2016/17 and 2017/18

Table 3.1 shows the summary income and expenditure budgets for 2016/17 and 2017/18.

Account Group	Closing Budget 16/17	Opening Budget 17/18
Income	-226,201	-221,334
Pay	165,811	163,721
Non-Pay	54,974	51,780
Depreciation and Interest	2,707	2,807
Grand Total	**-2,710**	**-3,026**

Table 3.1: Summary Income and Expenditure Budgets

4. Income and Expenditure and WTE Budgets for 2016/17 and 2017/18 – By Directorate

Table 4.1 below shows the income and expenditure budgets by directorate for 2016/17 and 2017/18 noting some income is devolved to directorate level.

Directorate	Closing Budget 16/17	Opening Budget 17/18
Adult Clinical Services	93,983	77,427
Children & Young People	40,792	41,450
Corporate Services	3,499	3,412
Dental	3,606	10,759
Estates	16,346	15,127
Finance Directorate	2,749	2,814
HR, OD & Communications	3,959	3,667
IT	6,136	6,339
Medical Director	2,003	1,937
Sexual Health	7,928	8,011
Strategy and Transformatio	254	272
Central Income	-192,652	-187,772
Reserves	2,394	7,163
Nursing & Quality	3,588	3,563
Depreciation	2,707	2,807
Grand Total	**-2,710**	**-3,026**

Table 4.1 Income and Expenditure Budgets by Directorate

Table 4.2 below shows the WTE budgets by directorate for 2016/17 and 2017/18.

Directorate	Closing Budget 16/17	Opening Budget 17/18
Adult Clinical Services	2,315	2,363
Children & Young People	1,164	1,103
Corporate Services	43	43
Dental	134	222
Estates	206	207
Finance Directorate	89	88
HR, OD & Communications	134	114
IT	120	113
Medical Director	49	49
Sexual Health	129	130
Strategy and Transformatio	5	4
Reserves	-54	-54
Nursing & Quality	65	60
Grand Total	**4,400**	**4,443**

Table 4.2 WTE Budgets by Directorate

The budgets for 2017/18 include the following changes from the 2016/17 budgets:

- The full year effect of developments and service changes commencing in 2016/17. These include the full year effect of the loss of North Kent Adult Community Services (£11.7m reduction in income and costs) and the full year effect of the Medway Sexual Health contract (£0.4m increase in income and costs).
- Removal of the Wheelchair contract (£6m income reduction and £1m loss of contribution to overheads and surplus)
- New London Dental contracts (£6m income and £0.3m contribution to overheads and surplus)
- EK CCG reductions re savings schemes agreed in 2016/17 contract (-£1.2m)
- EK CVs for SLT and Community Geriatricians (+£0.2m)
- Removal of West Kent provision for cost per case underperformance (+£0.5m)
- Additional MIU income in West Kent (+£0.2m)
- Reduction in Health Visiting contract (-£0.1m)
- £0.3m reduction in surplus in respect of the new school nursing contract
- £0.5m reduction in surplus in respect of the new health and well-being contract

The CIP target for 2017/18 is £4.3m - equivalent to 2.4% of the operating expenditure budgets.

Demographic funding of £1.4m is included reflecting the funding CCGs have identified within the 2017/18 contracts for demographic growth not related to specific service developments.

A pay award of 1% (£1.5m) has been added to pay budget together with a £1.3m uplift for incremental drift, reflecting the change in pay costs associated with staff moving through the pay scale and any new staff starting on a different pay increment to staff that have left the Trust.

A tariff inflator of 0.1% has been added to all income, excluding income from Kent County Council. The 0.1% uplift is as per the national NHS planning guidance.

5. Cost Pressures

£1.5m of cost pressures have been funded, including £0.6m for the new apprenticeship levy, plus £0.9m of directorate pressures.

6. Contingency

£0.8m is being held as a contingency to cover risks – including non-delivery of CIPs and CQUIN and EK savings and to cover any STP expenditure.

7. Capital Plan

Table 7.1 below shows the capital plan for 2017/18 which totals £4.2 million. The capital programme will be financed by £2.8m depreciation plus £1.4m generated from retained surpluses.

	£k
Routine maintenance	455
Estates developments	736
Estates developments - CIP enablement	940
IT developments	269
IT rolling replacement	1,287
Dental new business mobilisation, surgery upgrades and equipment	242
Other equipment purchases and minor schemes	250
Total	**4,179**

Table 7.1 - Capital Plan for 2017/18

8. Recommendation

The Trust Board is recommended to approve these budgets.

Gordon Flack
Director of Finance
17 March 2017

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST ANNUAL PLAN 2017/18

Sustainability and Transformation Plan (STP)

The Kent and Medway health and care system is seeking to deliver an integrated health and social care model that focuses on delivering high quality, outcome focused, person centred, coordinated care that is easy to access and enables people to stay well and live independently for as long as possible in their home setting.

Core to this is the number one priority of developing Local Care bringing together primary, community, mental health and social care. This fundamentally aligns with the Trust's strategic goals focussing on:

- Supporting primary care - Our teams will work with GPs at a locality level to build strong local extended teams
- Home First- We will dedicate our time, resources and expertise so more people are treated at home
- High-quality specialist care - Each of our specialist services will be of a high standard and organised in the most efficient and effective way for patients
- Prevention - We will build a frontline workforce where everyone has skills in prevention and access to specialists.

Membership

Our Council of Governors forms an integral part of the governance structure within the Trust and is the 'voice' of local people, setting the direction for the future of our services based on members' views. The Governors regularly attend Board meetings.

Approach to activity planning

The Trust has implemented a Community Information System and whilst this has had teething problems resultant in under recording of activity in 2016/17 will deliver the level of information to inform capacity planning at a greater level of detail than historically has been the case. The in-year impact of the change has resulted in a pragmatic approach to activity plan setting for 2017-19 with only minor adjustments to 2016/17 targets.

The Trust has moved some services to a cost and volume basis from block and due to the recording issues agreed with the commissioner in West Kent to rebase on an outturn projection. This agreement is subject to a cap and collar 5% in order to limit risk on both parties as this is a recent move away from a block contract.

Approach to workforce planning

Our people strategy is an enabling strategy to deliver our vision of care, achieve the Trust's strategic objectives and be ready for future changes and challenges. It outlines the aims and intentions as to how we will recruit, retain and engage staff as partners to unlock their potential, to fully support and realise the achievement of the Trust five year strategy and the STP across the Kent and Medway Health care Economy. It outlines how we plan to build and maintain the culture, capacity and capability required to meet the challenges we face in the years ahead and continue to deliver high quality patient centred care, with staff setting the pace where they work in their teams and professions.

Our aims of the people Strategy are:

- Leading: To nurture leadership skills at every level to create a well-led organisation where staff are engaged

- Supporting: To create a culture where people are motivated and supported to perform at their best

- Improving: To recruit, retain and foster continuous improvement, flexibility and adaptability to meet changing demands

In common with many other organisations the Trust has significant nursing retention and recruitment challenges. In 2015 the Board agreed the recruitment and retention strategy. The strategy detailed a number of actions to achieve delivery.

Despite the progress of implementing the action plan the current vacancy level in the Trust is above target of 5 %. However, levels of recruitment are high. On average 65 new staff join the Trust each month. The main challenge is the level of retention across the Trust; turnover is currently 14.56 % but has seen a significant downward trajectory over the last 12 months. Significant progress has been made against the actions which have led to a reduction in turnover during 2016/17. However retention remains a key challenge which is addressed through the Trust People Strategy and focused Retention Strategy. The key actions to improve retention include:

- Deep dives to understand better those that are leaving for work life balance reasons so that these issues can be addressed to reduce turnover
- Further development of the role focussing on workforce engagement
- Clear career pathways to enable staff to be able to see how they can progress their careers within the Trust.
- Wider participation of young people joining the Trust

- Career pathways for unregistered staff to enable them to become registered nurses
- Improved ways of recognising and rewarding staff to ensure they feel valued by the Trust
- All clinical staff to understand the level of competence required in their role and be signposted to how these can be developed
- Clinical leaders to be competent to meet the demands of their role
- Appropriate staffing levels to meet patient needs
- Staff to be clear about the task that they are required to deliver
- The Trust to understand why staff are leaving and develop focussed action plans
- New staff feel valued, have the necessary equipment to undertake their role and feel supported.
- Continued development of the “back to the floor” programme
- Devolvement of decision making and accountability to the front line
- Participation in the NHS Employers retention programme.

Overall workforce numbers in 2017/18 increase by around 1.0% on 2016/17 levels (43 WTEs), consisting of a reduction of 71 WTEs due to Cost Improvement Plans (CIPs) and an increase of 114 WTEs due to a net gain in services as a result of tender wins in dental services in London (partially offset with reductions in staff as a result of tender losses (wheelchairs) and reductions in the Health Visiting contract) and service developments such as home first. In 2018/19 workforce numbers remain at the same level as 2017/18 as reductions in WTEs due to CIPs are assumed to be offset by demographic growth in community services, in line with the STP.

Expenditure on agency staff is planned to be £7.6m in 2017/18 and 2018/19 which is within the trajectory of £8.68m. The Trust has made significant reductions in agency expenditure in 2016/17 and expects to maintain those reductions.

Approach to quality planning

The Trust approach to quality remains ambitious for the population in further improving quality standards as a well-led organisation and is developing a quality improvement plan. This plan includes further enhancements to:- support carers involved in supporting end of life care; sign up to safety priorities to further reduce harm and support an open and transparent culture; and staff engagement to support staff experience of contributing to improvements in care.

National Clinical Audits - We have developed a strong research and audit team who ensure compliance with appropriate national clinical audits. The team monitors progress and delivery against national timescales, and are continuing to develop capacity to increase engagement in terms of patients numbers who can be involved in national audit.

Seven Day Services - The Trust already delivers seven day services and has enhanced its 'out of hours' services including use of technology such as 'cloud communications' to deliver responsive services. The Trust has already integrated out of hours services with day services to ensure seamless handover, provides rapid response service, clinics at weekends for example MSK and additional therapy services to community hospitals on Saturdays. The Trust in alliance with other organisations IC24 and Maidstone and Tunbridge Wells Hospital delivers a Home Treatment Service in west Kent which is a rapid response service to enable patients to stay in the community. This is being promoted elsewhere in Kent as part of development of the 'Home First' model. The Trust is exploring the use of MIUs to deliver planned care such as wound management to support primary care and the Trust has been part of the Prime Minister's challenge fund project in Folkestone alongside primary care. These models will be built upon as part of the STP work streams.

Safe Staffing - Safe staffing is monitored on a daily basis and managed at operational level. When there is concern regarding number of staff or skill mix this is escalated through the managerial structure and action is taken to mitigate risk which would include employment of temporary staff, moving staff between teams, prioritising workload and as a final resort the temporary closure of beds. Using the national tools for acute settings as reference we have developed a bespoke tool to calculate appropriate safe staffing levels in our community hospital wards. The wards undertake a daily assessment of their wards to alert managers when staffing is sub optimal, this is recorded along with any harms that have occurred on that date to allow triangulation. We are at the final stages of developing an IT tool to standardise an approach to monitoring safe staffing in community nursing teams and to implement this in early in 2017.

Mortality reviews and Serious Incidents - Mortality in the community hospitals is scrutinised by the Mortality Review Group chaired by the Medical Director and informed by a Dr Foster mortality report. The Trust has been implementing a new medical model and has invested in community geriatricians. All inpatient deaths, expected and unexpected, are reviewed involving close Multi-Disciplinary Team (MDT) review followed by Medical Director and Chief Nurse scrutiny. This creates an increased open and learning culture as well as shared learning across the Trust. We are continuing to develop our processes in relation to undertaking serious incidents (SI) and have recently developed a more succinct investigation process. Each SI is reviewed at our weekly serious incident review meeting which is chaired by the Chief Nurse and attended by senior members of the operational and nursing and quality teams and a Non-Executive Director. The clinical team with the SI present the report and establish the 3 most important areas for learning which are cascaded out to clinical teams via the services governance meetings and the staff intranet.

Anti-Microbial Resistance - We have a robust infection and control governance (IPC) process led by our Assistant Director of IPC. The monthly governance meeting is chaired by the Chief Nurse and all incidents including outbreaks are reviewed for lessons learned. We held a very successful IPC

conference for our organisation and wider health partners this year. The event was called 'What if the drugs don't work' it highlighted the serious issue of antimicrobial resistance. We have a Trust wide antimicrobial group and are planning to recruit to an antimicrobial pharmacy post.

Infection Prevention and Control- We continue to be part of a system wide HCAI group (Health Care Associated Infection) with acute colleagues in infection control. We are having discussions regarding surveillance and the role for community providers who do not accommodate on site labs. We also have a CAUTI group (Catheter Associated Urinary Tract Infection) where we are looking at taking urine specimens in the community setting before prescribing in an attempt to ensure samples are taken to confirm an infective organism and prescribe the correct antibiotic for this. We are using the catheter care bundle documentation and piloting this in the community

Sepsis - We are establishing a new pathway for the management of Sepsis, a working group is taking this forward led by the Assistant Director of IPC. This is a new piece of work and will draw services together and ensure we have a standardised approach to preventing and managing potential sepsis.

Falls and Pressure Ulcers - We have established senior leads for falls and pressure ulcers and have a strong safety culture in place with an aspiration for year on year reductions in avoidable harms. All new incidences of harms are reviewed at our monthly Safe Care meetings. Reports on harms are submitted to the Quality Committee and will form part of a new and revised Quality Report which will be submitted to the Board monthly. Any pressure ulcer or fall which is attributable to KCHFT is treated as a serious incident and investigated as such. Due to an increase in pressure harms, following very successful reductions, we have a taskforce focused on pressure ulcers which is attended by a mix of senior staff and clinical leaders and meets bi weekly to review all new harms and to monitor a turnaround action plan.

Patient Experience - We collect an extensive amount of patient experience information through the Meridian IT system. This is collected in a very user friendly format using Ipads. We are currently reviewing how we manage and maximise the learning from patient experience data and from complaints. Our Patient Experience group meets quarterly and is chaired by the Chief Nurse and this is also being reviewed to increase patient participation. We have a goal that over 96% of patients would recommend the Trust services to friends and family and we are aspiring to ensure patients and carers are engaged in service development.

End of Life - CQC rated us as good but identified areas to improve around end of life care, including the need to improve completion of Do Not Attempt Resuscitation orders, provision of equipment to end of life patients and auditing of end of life care plans. We implemented an improvement plan to address these issues and this is now substantially complete.

Commissioning for Quality and Innovation (CQUINs) - We have reviewed the national CQUINs and will be working with commissioners on those which are appropriate for us as a community provider. There are a number that we are having further discussions about including health and wellbeing, improving assessment of wounds and personalised care planning and support.

Health Promotion- we are asking people about their health and wellbeing at their first assessment and we have a target that 100% of new mothers will be offered a mini mental health assessment.

All our staff have completed dementia awareness training.

We are fully engaged at many levels of the STP including our medical director co-chairing the Clinical Board so we will ensure our priorities align with these.

Triangulation - The Trust has developed an early warning system that looks at the triangulation of Key Performance Indicators from quality, activity (including productivity) and finance that are prepared in dashboard form for each service and reviewed monthly at the Quality Surveillance Group (QSG - Chaired by the Medical Director). The Quality Surveillance group report formally to Quality Committee (Chaired by NED), which reports to the Board. The Board receive a monthly Integrated Performance Report which includes exceptions from the early warning system as well as an inpatient safer staffing report and the KPIs in the Integrated Performance Report. The QSG will instigate actions where Early Warning Trigger Tools (EWTTs) and soft intelligence suggest concerns from this triangulation and this could involve deep dives and support from corporate quality teams.

Approach to financial planning

The Trust has a track record of delivering internally consistent plans and resultant in the authorisation as a Foundation Trust on 1st March 2015 following rigorous assessment, and which has made a major contribution to maintaining a strong financial performance since being licensed.
Financial forecasts and modelling - We have had a strong financial position since our inception in 2011/12, when we achieved a surplus of £1.5m. A surplus of £2.2m was achieved in 2012/13 and £2.5m in 2013/14. In 2014/15 we delivered a further £2.8m surplus and a £3.5m surplus in 2015/16 and on course to deliver £3.7m in 2016/17 (£1m better than plan), cumulatively £16.2m. The Trust has Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) margin below the norm with a lower asset base than most trusts given most estate is leased from NHS Property Services.

Our plan for 2017/18 delivers a £1.267m underlying surplus, representing a 0.6% margin. Together with Sustainability and Transformation Funding of £1.759m will deliver the control total issued of £3.026m surplus (1.4% margin). This will be maintained in 2018/19.

Account Group	Closing Budget 16/17	Opening Budget 17/18
Income	-226,201	-221,334
Pay	165,811	163,721
Non-Pay	54,974	51,780
Depreciation and Interest	2,707	2,807
Grand Total	**-2,710**	**-3,026**

The forecast 2017/18 and 2018/19 risk ratings show the Trust to meeting the best risk rating of 1 out of 4.

Plan Risk Ratings		01FOTPY Forecast Out-turn 31/03/2017 Year Ending Rating	01PLANQ1 Plan 30/06/2017 Q1 Rating	01PLANQ2 Plan 30/09/2017 Q2 Rating	01PLANQ3 Plan 31/12/2017 Q3 Rating	01PLANQ4 Plan 31/03/2018 Q4 Rating	01PLANCY Plan 31/03/2018 Year Ending Rating	01PLANFY Plan 31/03/2019 Year Ending Rating
Capital Service Cover rating	+	1	1	1	1	1	1	1
Liquidity rating	+	1	1	1	1	1	1	1
I&E Margin rating	+	1	1	1	1	1	1	1
Variance From Control Total rating	+	1	1	1	1	1	1	1
Agency rating	+	1	1	1	1	1	1	1
Plan Risk Rating after overrides	+	1	1	1	1	1	1	1

Our financial strategy for 2017/18 and 2018/19 is to continue to deliver services to each of our existing commissioners providing the best value for money and to respond to tenders where they fit with the Trusts core purpose. We will continue to provide existing and developing new services aligned to the STP plans.

Our expenditure plans for 2017/18 are based on 2016/17 budgets which have been adjusted for non-recurrent items, full year effect of developments started in 2016/17, pay and non-pay inflation, CIP plans for 2017/18, cost pressures and the effects of service developments and services decommissioned or lost in 2017/18. Inflation is assumed at 2.1% in line with the national planning guidance. Budget setting work indicates these assumptions are consistent with local inflationary pressures.

Income

Our income plans are based on agreed contracts for 2017/18 and 2018/19 in north, west and east Kent.

The Trust has contracts with the County Council until 2017 and April 2018 after local extensions agreed prior to implementation of tendering. The terms of the extension have required 10% reduction in financial values.

Our total planned income for 2017/18 is £221.3m and comprises £215.2m operating income from patient care activities and £6.1m other operating income.

We have five main Clinical Commissioning Groups (CCGs) contracts (Ashford, Canterbury, South Kent Coast, Thanet and West Kent) which are greater than £10m with Kent County Council our largest non NHS commissioner.

The four CCGs in East Kent require savings of £3.4m from our contract over 2017/18 offset by potential to make £3.4m in incentive payments for delivery of transformation schemes.

Pay Expenditure and Agency

Pay expenditure in 2017/18 is planned at £163.7m and comprises £153.3m relating to substantive staff, £2.8m relating to bank staff and £7.6m relating to agency and locum staff. The planned agency costs and locum costs are within the cap level of £8.7m. This represents maintaining the reduction of £4.4m, 33% in locum and agency costs from 2015/16 levels supported by the national application of agency rules. The Trust has given notice on a service (East Sussex Looked After Children) that was unsustainable due to the high use of agency medical staff and continues to promote the use of its internal bank as the preferred temporary staff recruitment. A 1% pay award has been included plus national apprenticeship changes and local incremental awards.

We estimate a £2.2m inflationary pay pressure in 2017/18, based on a 1% pay award and a 0.4% uplift relating to incremental drift and the costs associated with administering the NHS Pension Scheme. In addition there is a cost pressure of £0.7m (0.5% of pay) associated with the apprenticeship levy. Overall, the uplift is in line with the expected pressure in the central planning guidance.

Non-pay Expenditure

Non-pay operating expenditure is planned at £51.8m. This includes inflation of 6.7% on drugs, 2.1% on CNST and 2.3% on other operating expenses. Overall, this is slightly less than with central expectations (by £256k in total) as the Trust spends less on drugs as a community trust.

Efficiency savings for 2017/18

The Trust has a focussed and robust efficiency savings programme concentrating on cost reduction. Whilst the Lord Carter review did not look at the community sector the learning has and will be taken into account in the trust plans and agency rule changes and better procurement are embedded in the plan.

Planned CIPs for 2017/18 total £4.3m 2% of operating expenses, of which £2.6m are pay CIPs and £1.4m are non-pay CIPs. Revenue generating schemes represent a further £0.3m. The CIP plans have been risk rated to ensure they do not impact on the quality of services.

The cost improvement programme focus on three areas of efficiency and transformation: operational efficiencies, transforming service models and transformational enablers. This section gives a high level overview of these three areas, with some examples.

Operational efficiencies - The Five Year Forward View has been the focus for business planning; with the challenge of reduced funding in real terms, at the same time ensuring quality and safety are paramount. There has been a concerted effort to further review skill mix, seek partnership arrangements to augment service provision and ensure pathways are integrated to maximise efficiencies, increase patient experience and share risk.

Major service transformation - All the operational services are engaged with partner trusts and commissioners in implementing new transformational models that drive better patient experience and outcomes, whole system collaboration, greater efficiencies, such as new models of working, further reductions in length of stay within community hospitals, reductions in duplication through integration, and more innovative approaches to the workforce such as working with the voluntary sector.

Transformational Enablers - A range of estates, workforce, IT, Nursing and Quality, commercial and other enablers underpin the operational efficiency and major service transformation schemes in collaboration with the STP.

Our capital plan for 2017/18 of £4.2m and comprises the following schemes.

	£k
Routine maintenance	455
Estates developments	736
Estates developments - CIP enablement	940
IT developments	269
IT rolling replacement	1,287
Dental new business mobilisation, surgery upgrades and equipment	242
Other equipment purchases and minor schemes	250
Total	**4,179**

No external borrowing is required to fund the programme with £2.8m depreciation and £1.4m cash reserves.

In 2018/19 the capital expenditure plan is £3.5m, comprising, £2m for estates developments and maintenance, £1m for IT rolling replacement, £150k for dental developments, £100k for IT developments and £250k for other minor schemes.

Our cash position for 2017/18 is expected to be good, with cash balances between £18.5m and £20.7m at end of each quarter. The cash position will be improved to £24.6m in 2018/19.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.9
Subject:	2016 Staff Survey Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	☐	Assurance	✓

Report Summary (including purpose and context):

Kent Community Health NHS Foundation Trusts' performance improved in seven key findings, including the percentage of people who believed the organisation provides equal opportunities for career progression, the number of staff who felt unwell due to work-related stress in the past 12 months and the number of colleagues satisfied with the quality of work and care they are able to deliver.

The Trust's score also went up in terms of the percentage of staff who said they felt recognised and valued by managers and the trust. Overall, the Trust scored well, with 90 per cent of those taking part saying they agreed their role made a difference to patients and service users.

In total, 2,567 colleagues participated in the survey, which is a response rate of 55 per cent.

It revealed that the number of people who would recommend the organisation as a place to work had increased from 3.71 in 2015 to 3.72 in 2016 (the maximum score is five). Staff motivation also increased and so did the percentage of colleagues reporting good communication with senior managers, which went up by three per cent to 35 per cent.

The Trust's overall staff engagement scored stayed the same as it was in 2015 at 3.78. In fact, the Trust had many key findings that remained unchanged or, in some cases improved, where nationally, scores fell for comparable organisations.

In 26 out of 27 key findings the Trust was rated average or above. There was only one key finding where the Trust was below average, compared nationally with other similar providers; which was around staff attending work in the past three months despite feeling unwell because they felt pressure. The Trust score was 63 per cent, with the national average at 56 per cent.

Proposals and /or Recommendations:
The Board is asked to: •Note the results of the 2016 annual staff survey •Note the implementation of the 2015 action plan.

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

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

Kent Community Health
NHS Foundation Trust

2016 STAFF SURVEY REPORT

1. Introduction

1.1 This report presents a summary of the findings of the 2016 National NHS Staff Survey conducted by Kent Community Health NHS Foundation Trust (KCHFT).

2. Results of the National Staff Survey 2016

2.1 All participating organisations must follow a standard methodology and must fulfil minimum requirements.

2.2 KCHFT decided to undertake a full census of staff for the 2016 survey which meant that 5222 staff were issued with a self-completion questionnaire. Like 2015 the full census data was used to enable benchmarking with similar organisations to take place. The results from the KCHFT questionnaires were used by the Picker Institute Europe to benchmark KCHFT with 17 other community trusts across England. These results are publicly available and used by the Care Quality Commission when assessing organisations relating to compliance with essential standards of quality and safety. The survey also demonstrates our delivery against the NHS Constitution.

2.3 The results are summarised and presented in the form of the 32 national Key Findings. The 32 Key Findings are structured under nine headings:

- Appraisal and support for development
- Equality and diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and experience

The detailed report of the 2016 sample survey results for KCHFT can be downloaded from: www.nhsstaffsurveys.com

3. Key Findings of the 2016 survey results based on the KCHFT census

3.1.1 **Response Rate**
Of the 5222 questionnaires sent out, 2567 staff surveys were returned. The response rate for the Trust was 55% in 2016 which is above average when compared to other community trusts.

3.1.2 The 2016 response rate for the Trust is less than in 2015 (57%). For each of the Key Findings, the community trusts in England were placed in order from 1(top ranking) to 20 (bottom ranking).

3.2 Summary of Key Findings

The table below shows the year on year changes in Key Findings since the Trust has been running the survey:

Rating	2012	2013	2014	2015	2016
Better than average	8	12	8	12	14
Average	15	10	16	10	17
Worse than average	5	6	5	7	1
Deteriorated		2	1	1	0
Improved		0	2	4	7

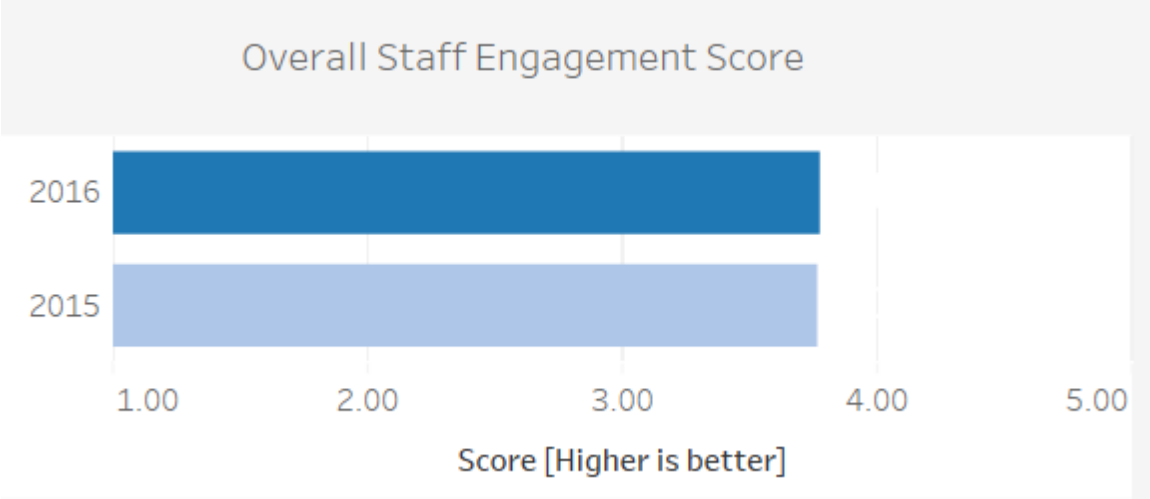
Table 1

3.2.1 It can be seen that in 2016 KCHFT the number of Key Findings in the 'better than average' category has increased by 2. Average scores increased by 7 to 17. Scores in the worst than average decreased by 7 to 1. No scores deteriorated.

3.3 Overall Staff Engagement

3.3.1 The overall staff engagement score represents staff members' perceived ability to contribute to improvements at work, their willingness to recommend the organisation as a place to work or receive treatment, and the extent to which they feel motivated and engaged with their work. As detailed in Chart 1 below, the overall engagement score has increased since from 2015 to a score of 3.78.

Chart 1



3.3.2 This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement:

Key Findings	Change since 2015 survey	Ranking compared with all Community Trusts
Overall Staff Engagement	No change	Average
KF1. Staff recommendation of the Trust as a place to work or receive treatment	No change	Average
KF4. Staff motivation and work	No change	Average
KF7 Staff ability to contribute towards improvements at work	No change	Average

Table 3

3.3.3 It should be noted that whilst there has been no change in KCHFT scores since 2015 KF4 and KF7 have improved from below average to average as our national comparators scores reduced.

3.3.4 **Contributions to improvements**

73% of staff agreed or strongly agreed that there are frequent opportunities for them to show initiative in their role, and 77% reported that they are able to make suggestions to improve the work of their team or department. A slightly lower proportion, 56%, said they are able to make improvements happen in their area of work.

3.3.5 **Recommendation of the organisation**

71% of staff agreed or strongly agreed that care of patients/service users is their organisation's top priority, and 59% said they would recommend their organisation as a place to work. When asked whether they would be happy with the standard of care provided by their organisation if a friend or relative needed treatment, 73% of staff agreed or strongly agreed.

3.3.6 **Motivation and engagement**

Over half of all staff (58%) reported that they often or always look forward to going to work, with 72% of staff feeling enthusiastic about their job. Seventy-eight percent of staff also felt that time passes quickly whilst they are at work.

3.4 Appraisals and Support for Development

3.4.1 This year's survey indicated that appraisals and development reviews are common within the Trust with 94% of all staff undergoing one in the last 12 months. This figure has increased since 2015 which was recorded as 92% and is currently 5% above the bench mark for other Community trusts. Over the last few years the Trust has seen a continuous improvement in the number of appraisals completed with 86% being recorded in 2012.

3.4.2 Staff assessments of the quality of appraisals follow a very similar pattern. For example, 74% of staff who had had a recent appraisal said that it 'definitely' or 'to some extent' helped them to improve how they did their job.

3.4.3 With regard to the quality of non-mandatory training, learning or development, 84% of staff who had had recent training agreed that it had enabled them to perform in their role more effectively and a similar proportion (81%) felt that the training allowed them to provide a better experience for patients or service users.

3.5 Equality and Diversity

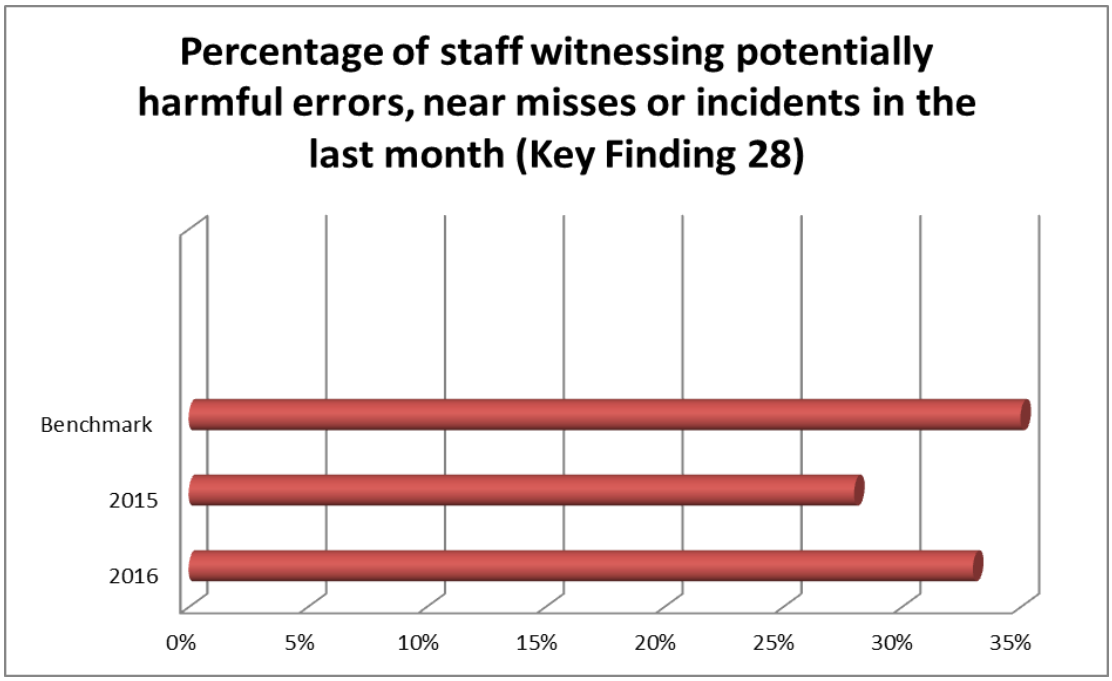
3.5.1 In 2016, 3% of staff reported that they have faced discrimination from patients or service users this has remained the same from the last report. The proportion of staff who reported facing discrimination from their team or managers was one percent higher at 6%.

3.5.2 Ninety- two percent of staff reported that they believe their organisation acts fairly with respect to promotion or progression.

3.6 Errors and Incidents

3.6.1 In this year's survey, 11% of staff reported seeing an error or incident that could have harmed staff, while a quarter of staff (15%) witnessed an error or incident that could have harmed patients or service users. The majority (97%) of staff who had witnessed an error or incident said that it had been reported, either by themselves or by a colleague.

Chart 2



3.6.2 When asked whether their organisation treated staff involved in near misses, errors and incidents fairly, more than half of all staff (55%) reported that this is the case, but 38% responded that they 'neither agreed nor disagreed' and 3% said they 'didn't know'. Ninety- two percent agreed or strongly agreed that their organisation encourages staff to report incidents. When incidents are reported, 74% of staff felt that action is taken to prevent the incident happening again, and only 3% disagreed that this is the case. In addition, 52% of staff reported that their organisation gives feedback to staff about any changes that have been made in response to the reported incident, with 8% disagreeing that this happens.

3.6.3 Findings on unsafe clinical practice were similar, with 73% of staff feeling secure in raising any concerns they may have regarding clinical practice. Sixty- four percent of staff had confidence that their organisation would address their concerns if they were raised.

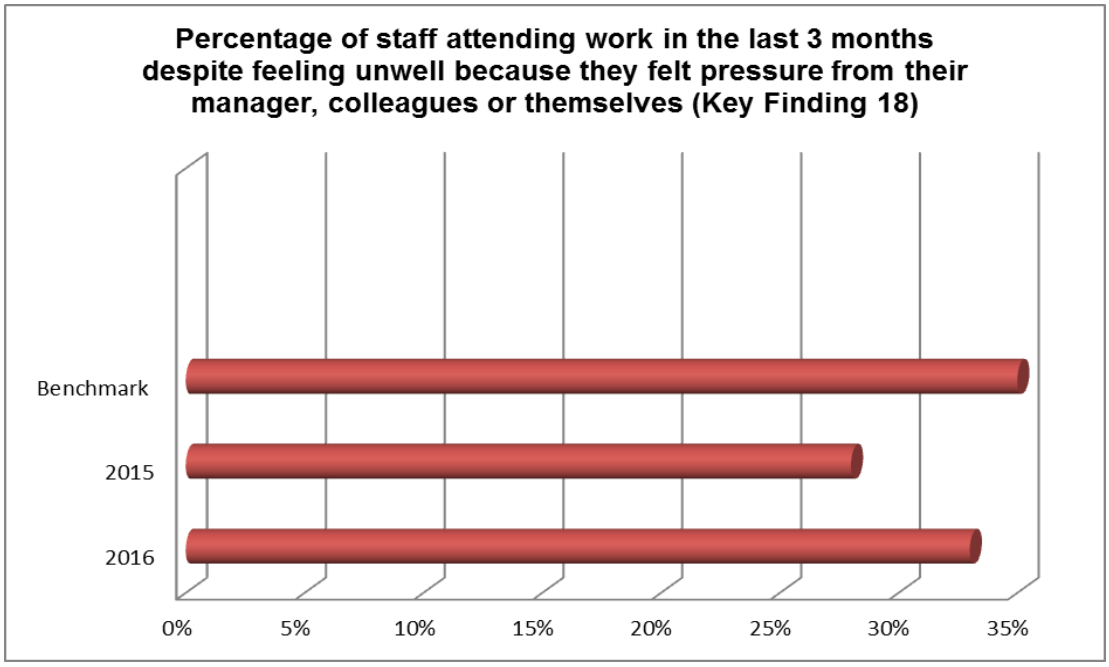
3.7 Health and Wellbeing

3.7.1 In the 2016 survey staff were asked about a number of aspects that contribute to the overall theme of health and wellbeing, including managerial and organisational interest in staff health, musculoskeletal problems, and stress. The majority of staff reported positively on organisational and managerial interest in staff health and wellbeing. Approximately half of the staff (54%) reported that their manager took a positive interest in their individual health and wellbeing, and 30% said that their organisation 'definitely' or 'to some extent' took positive action on health and wellbeing.

3.7.2 Overall, a quarter (22%) of staff reported experiencing musculoskeletal (MSK) problems as a result of work activities.

3.7.3 In 2016 the proportion of staff who reported feeling unwell due to work related stress is at its lowest since 2012, at 33%. However, 54% reported coming to work in the previous three months despite feeling unable to perform their duties or the requirements of their role. The majority of staff acknowledged that this was a result of pressure from themselves (93%) rather than from other colleagues (17%) or their manager (26%).

Chart 3



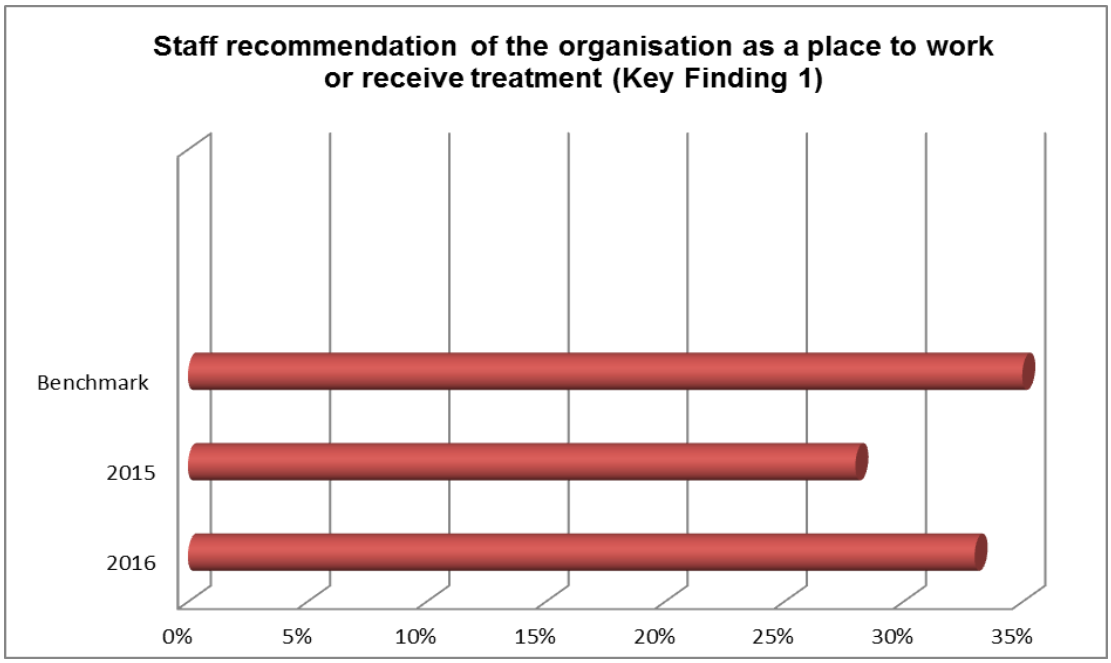
3.8 Working Patterns

3.8.1 Forty-three percent of staff were satisfied with the flexible working opportunities provided by their organisation. Sixty percent of staff reported working unpaid additional hours each week. The percentage of staff working any extra hours (paid or unpaid) has increased by 1% between 2015 and 2016.

3.9 Job Satisfaction

3.9.1 Staff recommendation of their organisation as a place to work or receive treatment has gradually increased since 2012, as shown in Chart 6. On a scale of one to five, trusts received an average staff recommendation rating of 3.57 in 2012, increasing to 3.75 in 2016. Scores differ between trust types, with the highest 2016 rating provided by staff at specialist acute trusts (4.09) and the lowest by staff at ambulance trusts (3.44). However, scores at all trust types have improved since 2012.

Chart 4



3.9.2 Effective team working is an important component of staff experience, and the survey showed generally favourable results for questions on this topic. For example, 60% of staff agreed that their team has a set of shared objectives, with 53% of staff reporting that they felt their team meets often enough to discuss how effective they are at working together.

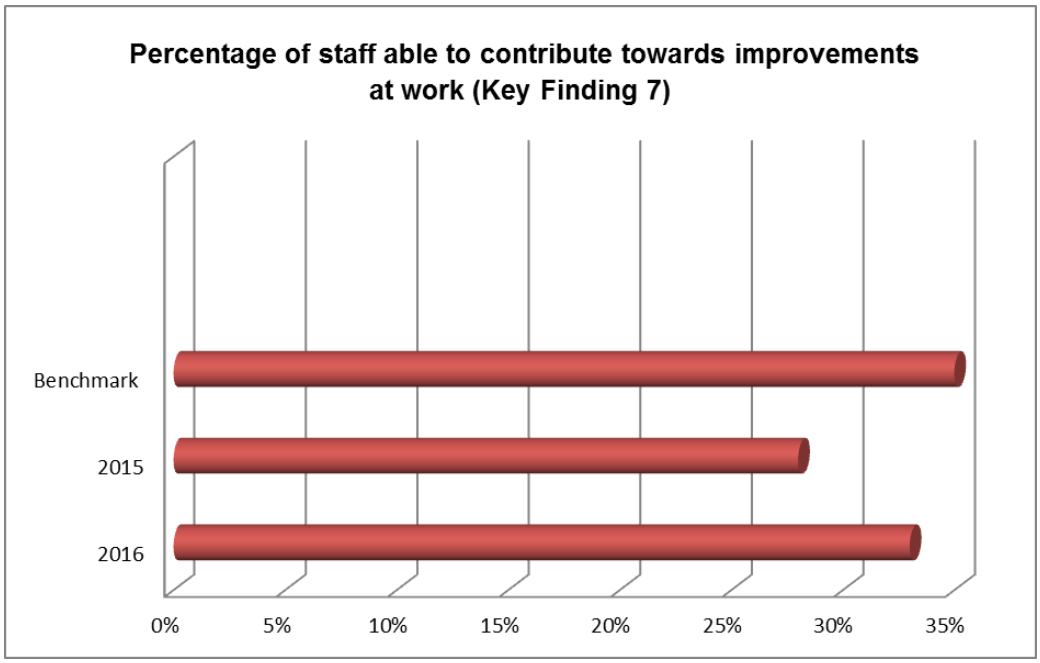
3.9.3 With regard to motivation 31% of staff reported feeling enthusiastic about their job, and 43% felt that time passes quickly whilst they are at work, with 59% reporting that they often or always look forward to going to work.

3.9.4 The majority (87%) of staff feel happy with the level of support they receive from their work colleagues. However, many staff felt unable to meet all the conflicting demands on their time at work: 43% agreed/ strongly agreed that they are able to manage these demands, whilst 33% disagreed. Furthermore, 60% of staff felt that they have adequate supplies or equipment to do their job effectively. In terms of understaffing 35% of staff agreed (and 44% disagreed) that there are enough staff at their organisation for them to do their job properly.

3.9.5 Thirty-three percent of staff reported that they are satisfied with their level of pay.

3.9.6 Staff in the NHS should be given the opportunity to be involved in their work and decisions that affect them. Three-quarters of staff (75%) agreed that they are able to make suggestions to improve the work of their team or department, with 70% feeling that there are frequent opportunities for them to show initiative in their role.

Chart 5

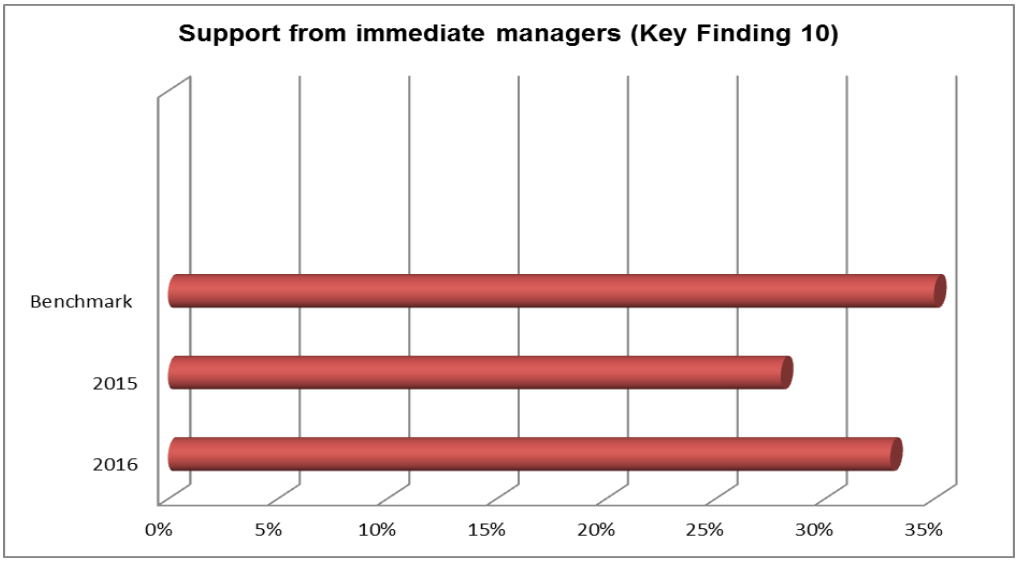


3.10 Managers

3.10.1 The survey included questions about the extent to which staff feel valued for their work and the recognition their personal contribution receives. Over two-thirds of staff (73%) agreed that they feel valued by their immediate manager.

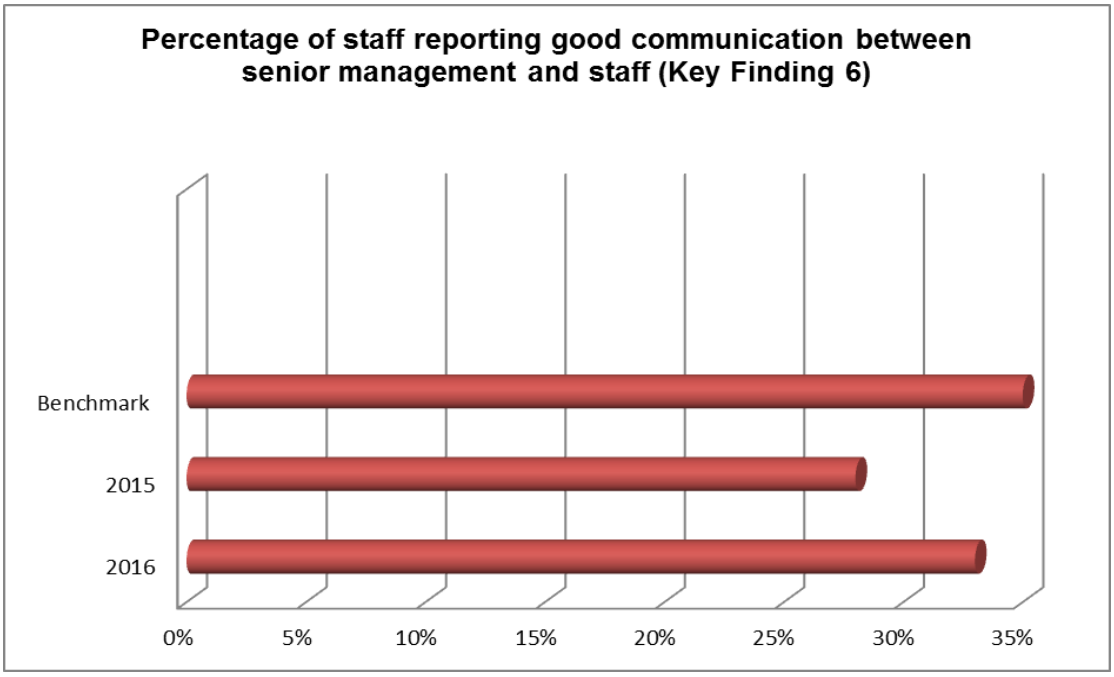
3.10.2 Seventy- eight percent of staff agreed that their immediate manager encourages their staff to work as a team and can be counted on to help with difficult tasks at work (74%). Fewer staff agreed that their immediate manager gives clear feedback (64%) and asks for staff opinions before making decisions that affect their work (55%).

Chart 6



3.10.3 Over four-fifths (88%) of staff reported that they know who the senior managers are at their organisation, less than half (41%) agreed that communication between senior management and staff is effective. Even fewer staff (36%) felt that senior management tries to involve staff in important decisions, and only 33% reported that senior managers act on the feedback given by staff.

Chart 7



3.14 Patient Care and Experience

3.14.1 Patient and service user experience is an important element of the services that NHS organisations provide. Ninety- eight per cent agreed that their organisation collates patient and service user feedback. Sixty- six percent of staff said that they receive regular updates on patient/service user experience in their team, whilst just over half (54%) said that this feedback is used to make informed decisions. The majority of respondents (81%) agreed that they are able to do their job to a standard they are personally pleased with, but somewhat fewer staff (65%) reported feeling able to deliver the care they aspire to. Ninety percent of staff agreed that their role makes a difference to patients/service users.

3.15 Violence, Harassment and Bullying

3.15.1 In 2016, 15% of staff reported that they have experienced physical violence from patients, relatives or members of the public in the last 12 months. In contrast, nearly all staff who participated in the survey reported that they have never experienced violence from a colleague (87%) or their manager (90%) in the last 12 months.

3.15.2 Whilst 15% of staff have experienced physical violence from patients, relatives or the public in the last 12 months, a slighter higher proportion of staff (19%) reported experiencing harassment or bullying from other colleagues in the last 12 months.

3.16 Top and Bottom Ranking Scores for Key Findings

3.16.1 The table below identifies the top five Key Findings for KCHFT that are positive compared to other community trusts in England.

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**92%**	**90%**
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months.	**34%**	**38%**
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**3.84**	**3.79**
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	**93%**	**92%**
KF16. Percentage of staff working extra hours	**67%**	**71%**

Table 4

3.16.2 The table below identifies the bottom five ranking scores for Key Findings that are least favourable compared with other community trusts in England.

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.74**	**3.76**
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**3.83**	**3.85**
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	**63%**	**56%**
KF13. Quality of non-mandatory training, learning or development	**4.04**	**4.08**
KF7. Percentage of staff able to contribute towards improvements at work	**69%**	**70%**

Table 5

3.16.3 Of KCHFT's five bottom ranking scores only one is worse than the national average and the only area where the Trust had a negative in comparison to the national average. One of our bottom five KF13 is also one of our most improved findings.

3.17 Largest local changes since 2015 Survey

3.17.1 No key findings have deteriorated since the 2015 survey.

3.17.2 Five key findings have improved since the 2015 survey:

Key Finding	Trust Score 2015	Trust Score 2016
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	**37%**	**34%**
KF14. Staff satisfaction with resourcing and support	**3.29**	**3.38**
KF13. Quality of non-mandatory training, learning or development	**3.99**	**4.04**
KF12. Quality of appraisals	**3.03**	**3.12**
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.69**	**3.74**

Table 6

3.17.3 There were more Key Findings that have improved compared with 2015.

3.18 Focus on the bottom five ranking Key Findings scores as described in section 3.4.2 above.

3.18.1 This section looks at each of the bottom ranking scores Key Findings and breaks this down to individual question level.

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF31. Staff confidence and security in reporting unsafe clinical practice	**3.74**	**3.69**

Table 7

3.18.2 This Key Finding is compiled from questions 13b and 13c.

Question	Trust Score 2015	Trust Score 2016	National 2016 average for Community Trusts
13b. I would feel secure raising concerns about unsafe clinical Practice.	**69%**	**73%**	**74%**
13c. I am confident that the organisation would address my concern.	**61%**	**64%**	**63%**

Table 8

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF2. Staff satisfaction with the quality of work and care they are able to deliver	**3.83**	**3.85**

Table 9

3.18.3 This Key Finding is compiled from the answers to questions 3c, 6a and 6c. This has not statistically improved nor has it deteriorated.

Question	Trust Score 2015	Trust Score 2016	National 2016 average for Community Trusts
3c. I am able to do my job to a standard I am personally pleased with	**76%**	**77%**	**77%**
6a. I am satisfied with the quality of care I give to patients/service users	**89%**	**81%**	**81%**
6c. I am able to deliver the patient care I aspire to	**64%**	**65%**	**65%**

Table 10

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	**63%**	**56%**

Table 11

3.18.4 This Key Finding is compiled from the answers to questions 9d and 9g. The scores for these questions have broadly remained the same and the finding still remains worse than average. This is the only question where the response is worse than average.

Question	Trust Score 2015	Trust Score 2016	National 2016 average for Community Trusts
9d. Percentage of staff who in the last three months had gone to work despite not feeling well enough to perform their duties	**68%**	**66%**	**59%**
9g. Percentage of staff who had put themselves under pressure to come to work	**92%**	**93%**	**93%**

Table 12

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF13. Quality of non-mandatory training, learning or development	**4.02**	**4.07**

Table 13

3.18.5 This Key Finding has increased since 2015. The Key Finding comprises of questions 18b and 18d. Responses to both these questions have improved.

Question	Trust Score 2015	Trust Score 2016	National 2016 average for Community Trusts
Q18b. It has helped me to do my job more effectively	**84%**	**84%**	**85%**
Q18d. It has helped me to deliver a better patient/service user experience	**80%**	**81%**	**84%**

Table 14

Key Finding	Trust Score 2016	National 2016 average for Community Trusts
KF7. Percentage of staff able to contribute towards improvements at work	**69%**	**70%**

Table 15

3.18.6 Questions 4a, 4b and 4d make up this Key Finding. KCHFT's score on all 4 questions is about the same as it was in 2015, though there is a slight reduction in response to 9d.

Question	Trust Score 2015	Trust Score 2016	National 2016 average for Community Trusts
4a. There are frequent opportunities for me to show initiative in my role	**70%**	**70%**	**72%**
4b. I am able to make suggestions to improve the work of my team/department	**75%**	**75%**	**76%**
4d. I am able to make improvements happen in my area of work	**53%**	**55%**	**55%**

Table 16

3.19 Comparing 2016 Survey results against those areas targeted in the 2015 KCHT Action Plan

3.19.1 Last year the Board agreed that the action plan should focus on the five bottom ranking scores and where there had been a decline from the 2015 scores. In addition that the focus of work should be around engagement and a cultural shift to ensure that the Trust values were translated into management and leadership actions.

Key Finding	2015	2016	Change	Ranking
Percentage of staff agreeing that their role makes a difference to patients/service users	89%	90%	No change	Average (2015 average)
Quality of non-mandatory training, learning or development	3.99	4.04	Increase	Above average (2015 below average)
Percentage of staff able to contribute towards improvements at work	68%	69%	No change	Average (2015 average)
Staff confidence and security in reporting unsafe clinical practice	3.69	3.74	Increase	Average (2015 below average)
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	65%	63%	No change	Below average (2015 below average)

3.19.2 The good news is that the Trust has improved in areas it identified last year as key measures of success: however only two have statistically improved.

4. Action Planning

4.1 There is only one Key Finding where the trust is performing below average. The trust appears to be achieving above average score in all Key Findings.

Each locality and directorate has also been asked to analyse their specific findings and develop an action plan to address key areas of concern. Our Communication Plan includes presentation of findings to key groups (Board/Exec/Senior Managers/JNCC) and communication to all staff groups, involving them in making sense of the findings and developing action plans for their areas. Findings are being discussed within each locality/ directorate (including Corporate Services) with action plans developed, agreed and monitored.

5. Conclusion

5.1 Overall, the survey findings for 2016 are very positive and there have been some real improvements year on year in some key areas. Whilst there have been improvements on the scores the areas of staff feeling able to contribute to improvements at work, feeling satisfied with the quality of care they deliver, their overall motivation at work increased and is average when compared to other organisations. Our engagement score stayed the same however, nationally scores fell for comparable organisations, so we increased to average.

5.2 It is important that we continue to strive to improve all scores, actions are followed through so that staff do understand that what they have to say really does matter and that as a Trust we do listen and we do act on feedback. These findings and action plans do need to be shared with staff and monitored on a regular basis.

6. Recommendation

6.1 The Board is asked to:

- Note the results of the 2016 annual staff survey,
- Note the implementation of the 2015 action plan
- Support the proposed development of an organisation level action plan for all Directorates which focuses on key finding 1,4 and 7.

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

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.10
Subject:	Sustainability and Transformation Plan Update Report
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)

This report updates on the latest developments of the Kent and Medway Sustainability and Transformation Programme.

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 decision required.

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

Kent Community Health
NHS Foundation Trust

KENT AND MEDWAY SUSTAINABILITY AND TRANSFORMATION PLAN UPDATE REPORT

1. Introduction

This brief report updates the Board on the latest developments arising from the STP, as with previous reports the board will be aware that the STP is an on-going programme of work and therefore this is a reflection of the work up and including mid-march 2017.

2. Case for Change

A great deal of progress has been made preparing the case for change, this provides an assessment of where health and social care provision is now, and is prepared in an accessible format for wide use, the document draws on the analysis of the clinicians and broader leaders who have worked on the STP. I anticipate that the document will be published by the time the board meet and I will ensure copies are available.

3. Local Care Development

The approach to local care, which is describing the model for looking after patients outside of acute hospitals continues, it seeks to identify and then respond to the patients and service users who have heath needs, drawing upon a stratified approach, albeit acknowledging that patients have multiple and sometimes interlinked health needs. The work in now being 'tested' with partners and I will report back to the board on progress.

4. KCHFT's Role in the STP

The most recent period has since an increase in the pace of the STP, and the emergence of crisper governance for the plan. I am grateful to the Board for the support of the STP, and for the significant numbers of the team in the Trust who are directly involved in shaping the plan. As we have discussed before the STP will be the 'roadmap' of how we deliver health and social care in the county for the next five years and as such shaping it is key.

5. **Conclusion**

The report is for the Board to note and I welcome questions or observations on the report and moreover the plan itself.

Paul Bentley
Chief Executive
March 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.11
Subject:	People Strategy
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	X	Assurance	☐

Report Summary (including purpose and context)

This five-year People Strategy will help to build our reputation as the Top NHS employer in Kent setting out our commitment to our people. It has three main aims to enable us to recruit, retain and engage staff. To achieve this we will

- nurture leadership skills at every level to create an engaged well-led organisation
- create and maintain a culture where people are retained and supported to perform at their best
- to foster continuous improvement, flexibility and adaptability to meet changing demands including recruiting and retaining the right workforce.

The steps that are going to be undertaken to achieve the strategy are detailed together with the measures of success.

Proposals and /or Recommendations

The Board is recommended to approve the strategy.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

Yes

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

NHS
Kent Community Health
NHS Foundation Trust

People strategy

2017 to 2021

Louise Norris
Director of Workforce, Organisational Development and Communications

Contents

Strategy

This five-year People Strategy will help to build our reputation as the best NHS employer in Kent and sets out our commitment to our people. It has three main aims to enable us to recruit, retain and engage staff.

To achieve this we will:

- nurture leadership skills at every level to create an engaged well-led organisation
- create and maintain a culture where people are retained and supported to perform at their best
- to foster continuous improvement, flexibility and adaptability to meet changing demands including recruiting and retaining the right workforce.

Our pledge

Our pledge is to create and maintain Kent Community Health NHS Foundation Trust (KCHFT) as the place where people want to work, delivering excellent care to our patients.

We firmly believe our trust belongs to our people – but not just the people we care for, the people who work here. They are our most valued asset and the best resource we have to deliver all that is required of us. They shoulder enormous responsibility for the lives of patients and their working life must reflect this; they should be trusted, sensibly managed and duly recognised for their contribution.

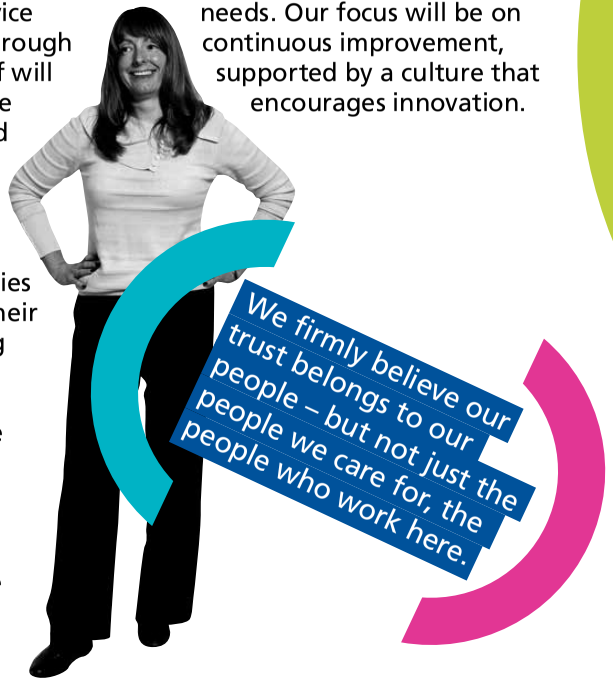
By fulfilling this strategy, we will be able to play a major part in Kent and Medway's Sustainability and Transformation Plan to deliver NHS England's Five Year Forward View of better health, better patient care and improved NHS efficiency.

We want to create an organisation where staff will feel empowered to act in line with the values we live and the contribution we make to health and wellbeing, as well as build our reputation as a top employer. This will help to shape our unique identity as a trust.

We expect our leaders and managers to liver and breathe our values, lead and inspire our people to deliver great patient care and empower their teams to take action. We expect all staff to embed the values in everything that they do. We should make every patient and service user contact count. Through this, patients and staff will recognise KCHFT as the best place to work and receive treatment.

By recognising and rewarding high performance, promoting opportunities for staff to progress their careers and by looking after their health and wellbeing we will create a culture where people are motivated and supported to perform at their best. We know there is a great deal of evidence that staff experience significantly impacts on patient experience. High levels of staff engagement will help to improve patient safety, patient satisfaction and the trust's performance.

In addition, we need to recruit and retain a workforce with the right skills and values to meet current and future health care needs. Our focus will be on continuous improvement, supported by a culture that encourages innovation.



Context and background

To understand the complexity of our people challenges, the following sections set out the context and challenges at both a national and local level.

Our vision

Kent Community Health NHS Foundation Trust is responsible for providing a wide range of community based NHS services for adults and children in Kent. Our 5,500 staff deliver care in people's own homes, nursing homes, GP surgeries, clinics, community hospitals and in mobile units.

Our vision is to deliver excellent care and to improve the health of the communities we serve. We aim to provide high quality, value for money, community-based services.

We will:

- work with GPs in each locality to build high performing local integrated teams, based around groups of general practices which prevent people from becoming unwell
- dedicate time, resources, expertise and leadership to fully implement the Home First service across Kent.
- ensure patients and clinicians have access to high quality specialist community services
- make a step change impact in prevention and health promotion in Kent.

KCHFT exists to serve patients and service users as part of a wider health and social care system in Kent and Medway.

We expect our leaders and managers to live and breathe our values, lead and inspire our people to deliver great patient care and empower their teams to take action.

Our challenges nationally and locally

As we look ahead, we see four key challenges facing the NHS nationally and locally in Kent, which mean the way services are provided needs to change.

- Demand for care is rising. The population is projected to grow by five per cent in Kent in the next five years. The largest population growth is 85+ bringing increasing needs to health and social care.
- Resources are limited. There will continue to be very limited growth in resources for the NHS for the foreseeable future, set against rising costs of care. Kent has an NHS budget of approximately £3.4b. Across Kent all NHS providers face significant financial challenges. Funding for council-provided services is reducing due to budget pressures.
- Recruiting and retaining sufficient skilled staff continues to be very challenging, and leads to extensive use of temporary staff. The combination of rising demand, limited resources and these workforce pressures is that services across the whole system are under severe pressure and struggling to meet their objectives in primary, community, mental health, acute and social care.
- Patients don't consistently experience the very best care. Services are often fragmented, there are unwarranted variations in the quality and performance across the county, and there are inequalities in the health and outcomes of the populations we serve.

Kent and Medway plans

The Kent and Medway Sustainability and Transformation Plan (STP) describes how local services will evolve and become sustainable over the next five years – delivering in Kent and Medway the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

The Five Year Forward View and the Kent and Medway STP envisage new organisational forms such as Multi-Specialty Community Providers (MCPs) being established to deliver the new care models.

The STP becomes the overarching plan for health and care services in Kent and our plans for Kent Community Health NHS Foundation Trust are designed to support the local health and social care system to deliver the STP.

Delivering the vision through our people

Our people strategy is an enabling strategy to deliver our vision of care, achieve the trust's strategic objectives and be ready for future changes and challenges. It is in the context of increased scrutiny, austerity, changing models of care and increasing demand for improved standards of care that our people strategy for 2017-2021 has been written. It outlines how we will recruit, retain and engage staff to unlock their potential and fully realise the achievement of the trust's five year strategy.

It outlines how we build and maintain the culture, capacity and capability required to meet the challenges we face in the years ahead and continue to deliver high-quality patient-centred care, with staff setting the pace where they work in their teams and professions.

Our aims of the people strategy are:

Each of these three aims has programmes of work to deliver them. These programmes are outlined in detail in this document. An implementation plan, which is reviewed annually, supports the overall delivery of our People Strategy and gives clear goals, timescales and measures of success that will be reviewed and refreshed on a quarterly basis. For assurance this will be reported to the Board quarterly.

Each aim is described in more detail in the following sections together with the outcomes required and, most importantly, what the organisation will look like when we have it right and our measures of success.

Engaging and leading:

To nurture leadership skills at every level to create a well-led organisation where staff are engaged

Retaining and supporting:

To create a culture where people are motivated and supported to perform at their best

Recruiting and improving:

To recruit, retain and foster continuous improvement, flexibility and adaptability to meet changing demands.

1. Engaging and leading our people

Our leaders are role models for our values. This starts at Board level and continues through all levels of the organisation. They make the objectives of the trust clear. They inspire and motivate people to deliver against the objectives and are trusted by people at KCHFT.

We want to create leaders and managers who inspire our diverse range of staff to make a positive difference to the lives of others. Leaders and managers will cultivate an environment of effective teamwork, valuing contributions as well as engaging and empowering staff through a supportive culture.

They will ensure all our people feel able to speak up, challenge and take forward changes for the benefit of patients and fix the issues which prevent our patients getting the care they deserve. All these elements are vital for how we drive safe, compassionate care.

Line managers are pivotal to ensure that all our staff speak up for the benefit of our diverse range of patients or whether staff fear repercussions and blame if concerns are expressed.

Frontline employees see what happens on the ground, both good and bad, and must not be afraid to speak out. Managers and leaders should work with staff from all walks of life with a variety of beliefs and insights empowering them to contribute to their roles and increase staff engagement.

1a. Living the values

To create our desired culture our values must be lived and breathed. The organisation's values are demonstrated at that heart of everything it does and they shape the way it operates at every level.

Our values are:

Compassionate:
We put patients and service users at the heart of everything we do. Our service empowers them, meets their expectations and caters for their needs. We have a positive attitude. We're kind and polite. We understand diversity. We're respectful, patient and tolerant. We make each other feel truly valued. It's at our core. Our colleagues feel cared for and are engaged with our vision and values. This is true for all of us, whatever our role.

Aspirational:
We feel empowered and we empower our patients and clients. We strive to continuously improve. Our focus is on research and generating ideas and innovations. We're adaptable to change. We share information, resources and ideas to deliver excellent outcomes for our patients. We're open, transparent and we think creatively.

Responsive:
We listen. We act. We communicate clearly. We do what we say we will. We build effective relationships and take account of other's opinions. We plan our care with patients and clients and work across organisational boundaries. We are responsive to our commissioners and stakeholders. We co-design services. We have effective working relationships in our teams and across internal boundaries. We apply these principles every day. This makes us feel valued and empowered and it makes our care better for patients.

Excellence:
We strive to deliver the best care we can. We provide high quality services and want the best for our patients. We lead by example. We support. We grow a culture of excellence in our teams. We challenge complacency and tackle inappropriate behaviour. We strive to continuously be better for our patients and each other.

We will create a well-led values-driven organisation by:

- clearly communicating the trust's core values and how they should be applied
- supporting managers to lead and develop people in line with our values through a comprehensive management development programme
- consciously considering and acting in line with the values when making decisions
- encouraging each other to demonstrate values in the way we behave
- creating a culture of openness and trust where people consistently behave in line with our values.

1b. Leading and inspiring our people

Managers will set clear organisational objectives. They will inspire and motivate people to deliver these objectives.

We will achieve this by:

- providing clarity around our purpose, vision and objectives and ensuring individual objectives are tied into organisational objectives
- having clear and regular two-way communication via team meetings, 1:1s and clinical supervision
- ensuring a consistent level of trust at all levels of the organisation by making sure everyone has the appropriate level of power to make the decisions they need to
- every leader being an effective role model, leading by example and being trustworthy
- being passionate and delivering our objectives, motivating and supporting people to deliver against them
- motivating and inspiring people to achieve results above and beyond what is expected of them
- supporting managers so they know what is expected of them so they can lead, manage and develop people effectively
- reviewing and refreshing the Leadership and Management Programmes to make sure they reflect our values, behaviours and strategic direction
- developing our leaders to help them move towards a clinically-led organisation based on accountability, devolved responsibility and a more commercial outlook, driven by high quality care and value for money for the taxpayer
- working with the Board to continually develop Executive and Non-Executive Directors
- developing, implementing and testing a process to attract, identify and retain talent.
- Identify leaders of the future who can operate in a new organisational environment characterised by innovation and rapid change, working in partnerships to deliver transformational leadership
- developing and embedding a talent management system supported by clear, visible, career pathways.

1c. Engaging and empowering our people

We will develop a culture of trust and ownership, where people feel engaged and empowered to make decisions and act upon them. They will make decisions based on values, not on self-interest.

We will achieve this by:

- devolving decision-making and accountability to the closest point to patient care
- giving our people access to the knowledge and information they need to do their job well
- empowering them to identify ways to improve how they do their job
- encouraging staff to lead and have the opportunity to develop their leadership skills through talent management processes
- ensuring they are consulted and involved in decisions which impact on them as an individual and the service they deliver
- trusting and supporting people to make decisions in line with their level of responsibility
- involving people when establishing their level of decision making in line with their role.

Measuring success of engaging and leading our people

We will know we have achieved this strategic aim when:

- increased number of staff recommend KCHFT as a place to work and for treatment for their friends and family year-on-year (Staff Friends and Family Test baseline treatment (87%) work (67%))
- people feel comfortable challenging behaviours that are inconsistent with the trust's values and people are held to account (Performance indicators increase, complaints about staff attitude reduce)
- future leadership capabilities are defined in line with the trust's values and leaders meet these challenges – improved KPI results in EWTT
- the number of people empowered to challenge the status quo to improve the trust performance increases (#yesyoucan initiatives)
- we consistently achieve 95% target of completed appraisals
- we improve the staff engagement score year-on-year (NHS Staff Survey baseline 3.76)
- we increase participation rates in leadership development programmes each year
- we achieve 50 per cent of Staff Survey key findings scoring 'above average' by 2021 on a year-by-year phased basis (NHS staff survey baseline 37.5%)
- turnover rates are reduced by 1 per cent year-on-year (Baseline 15.27%).

2. Retaining and supporting our people

We are committed to recognising individuals and teams for their hard work and the effort that they put in to provide high-quality patient care. They are passionate, dedicated and skilled people who deserve to be recognised for their contribution. We want to make sure the recognition and reward is clear and appropriate, creating a culture of appreciation where people are motivated to perform at their best.

We want targeted, tailored interventions that will demonstrate how the workforce, including leadership and management, will be redesigned and developed to meet the needs of our patients and our services. We will enhance opportunities for staff to progress their careers and further develop their skills to be at the leading edge of community healthcare provision.

The health and wellbeing of our people is really important to us. We recognise our staff can only provide high-quality care, if they feel supported in their own health and wellbeing. We also recognise that if our staff are role models of health and wellbeing, they will inspire our patients and their careers and make ‘every contact count’.

2a. Recognising and rewarding high performance in our people

We will recognise individuals and teams for their contribution.

To achieve this we will:

- design roles to create interesting work to help people develop the skills and capabilities required for progression
- design roles that have clear accountability, decision making and avoid duplication of effort across teams to help people work together to achieve our objectives
- regularly review policies and practices to improve and speed up decision-making and increase individual ownership
- involve people in how we recognise and reward people
- create a culture where people feel valued and are recognised for their behaviour as well as their performance
- design a programme of talent spotting to nurture growth
- recognise and reward high performing people through a range of local and trust-wide schemes such as WOW, Outstanding Behaviour Exhibited (OBE).

2b. Looking after our people

Our staff are role models of health and wellbeing. They will inspire our patients and their carers and make every contact count.

To achieve this we will:

- support a pro-active health and wellbeing programme for our people, recognising the responsibility our staff have to self-care and to look after their own health and wellbeing
- develop innovative and creative ways that staff can take care of their health and wellbeing at work and empower staff to share these ideas and implement them.

2c. Development of our people

We will continually enhance opportunities for staff to progress their careers and further develop their skills.

To achieve this we will:

- provide a statutory and mandatory training framework that ensures staff and patient safety, and organisational compliance
- improve the training provision for our Band 1 to 4 staff, including the development and expansion of our apprenticeship programme and the introduction of an innovative values-based training programme
- teach and train our workforce to improve their IT capabilities so our clinical and non-clinical IT systems are used effectively
- develop innovative and creative methods of learning, including the use of new technologies to reflect individuals' requirements, and to improve the efficiency and quality of their learning experience
- provide a programme of buddying, mentoring and coaching to support development
- use patient experience feedback and adverse incidents as a tool for learning and improvement
- develop a learning and development strategy
- support professional development with Higher Education Institutions.

Measuring success of retaining, supporting and developing our people

We will know that we have achieved this strategic aim when:

- we will increase the number of apprentices year-on-year and establish a baseline
- the number of applications for the staff award scheme increase annually (baseline 148)
- levels of engagement in the annual staff survey improve year-on-year (baseline 3.76)
- we increase year-on-year the percentage of staff agreeing their role makes a difference to patients/service users (NHS staff survey baseline 89%)
- we increase year-on-year staff satisfaction with the level of responsibility and involvement (NHS staff survey baseline 3.84)
- we maintain/increase the trust's rate of compliance with statutory and mandatory training requirement (NHS staff survey baseline 85%)
- increase the quality of non-mandatory training, learning or development year-on-year (NHS staff survey baseline 3.99)
- we increase the percentage of staff who report positively on the quality of non-mandatory training, learning or development (NHS Staff Survey baseline 3.99)
- we achieve and sustain Trust attendance targets (Trust target 3.90%)
- we achieve gold level Workplace Health Award
- we increase the rating of staff on organisation and management interest in and action on health/ wellbeing (NHS staff survey baseline 3.68)
- we improve the percentage of staff who recommend the trust as a place to work year-on-year (NHS Staff Survey baseline 67%).

3. Recruiting and improving our people

The changing NHS landscape requires a workforce with greater flexibility and transferable skills. The diversity of our employees as a fair representation of the local community is essential to the way we work, absorbing the cultural perspectives of the community and deepening our understanding of healthcare needs. We are committed to working in partnership with local organisations.

Recruiting and retaining high quality staff is a significant challenge for the trust to ensure it can deliver high quality care with the right number of staff, with the right skills and values. We want to create a talent pipeline to make sure we have skills and capability to deliver our ongoing business objectives.

Strategic analysis and planning of workforce needs will enable the trust to flex in line with peaks and troughs of activity planning for future service demand. Managers will recruit within budgets ensuring efficient, safe provision of patient care, using current and temporary workforce across the trust.

Increased technology and accurate workforce information will help to identify potential shortages in skill mix requirements. Improved information will also allow targeted interventions in areas such as sickness or turnover and areas of concern based on employee relations data. Services will be reviewed, planned and designed around safe patient care.

KCHFT will lead staff beyond compliance with mandatory training to life-long development. Appraisals will be used in pursuit of excellence with all staff performance expected to achieve their maximum potential.

High performing teams will be developed with transparent processes to support those who need it. A performance framework will enable staff accountability for enhancing their own contribution.

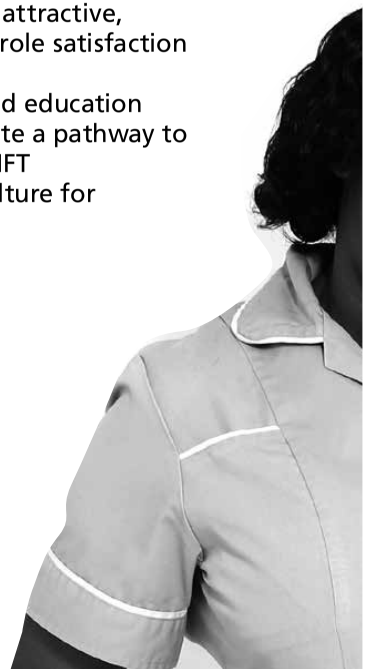
3a. Recruiting and retaining

We will have the right number of staff with the right number of skills and values, and colleagues will want to stay with the organisation and progress their career.

We will develop a creative and innovative recruitment plan, which reduces our vacancies.

To achieve this we will:

- develop and embed a strong employer brand that is recognisable across the south east of England and beyond
- develop a creative and innovative annual recruitment plan, which results in the reduction of vacancies
- develop values-based approach to recruitment
- reduce our dependency on agency staff by recruiting to vacancies
- design roles to meet the changing needs of our populations
- develop roles that are attractive, based on feedback of role satisfaction of our workforce
- work with partners and education establishments to create a pathway to employment with KCHFT
- create a supportive culture for new starters.



3b. Delivering continuous improvement

Our focus is on continuous improvement. People use internal and external sources to create new ideas and approaches, supported by a culture that encourages innovation.

To achieve this we will:

- use information from internal and external sources to improve how we manage and develop our people
- support people to take reasonable risks when trying new and innovative approaches
- make sure people know how they can contribute to improving their performance and ways of working within the trust
- create opportunities for everyone to identify areas for improvement and act on them.

3c. Creating sustainable success

We will focus on the future and will be responsive to change. Change is viewed as business as usual where mistakes are viewed as an opportunity for learning.

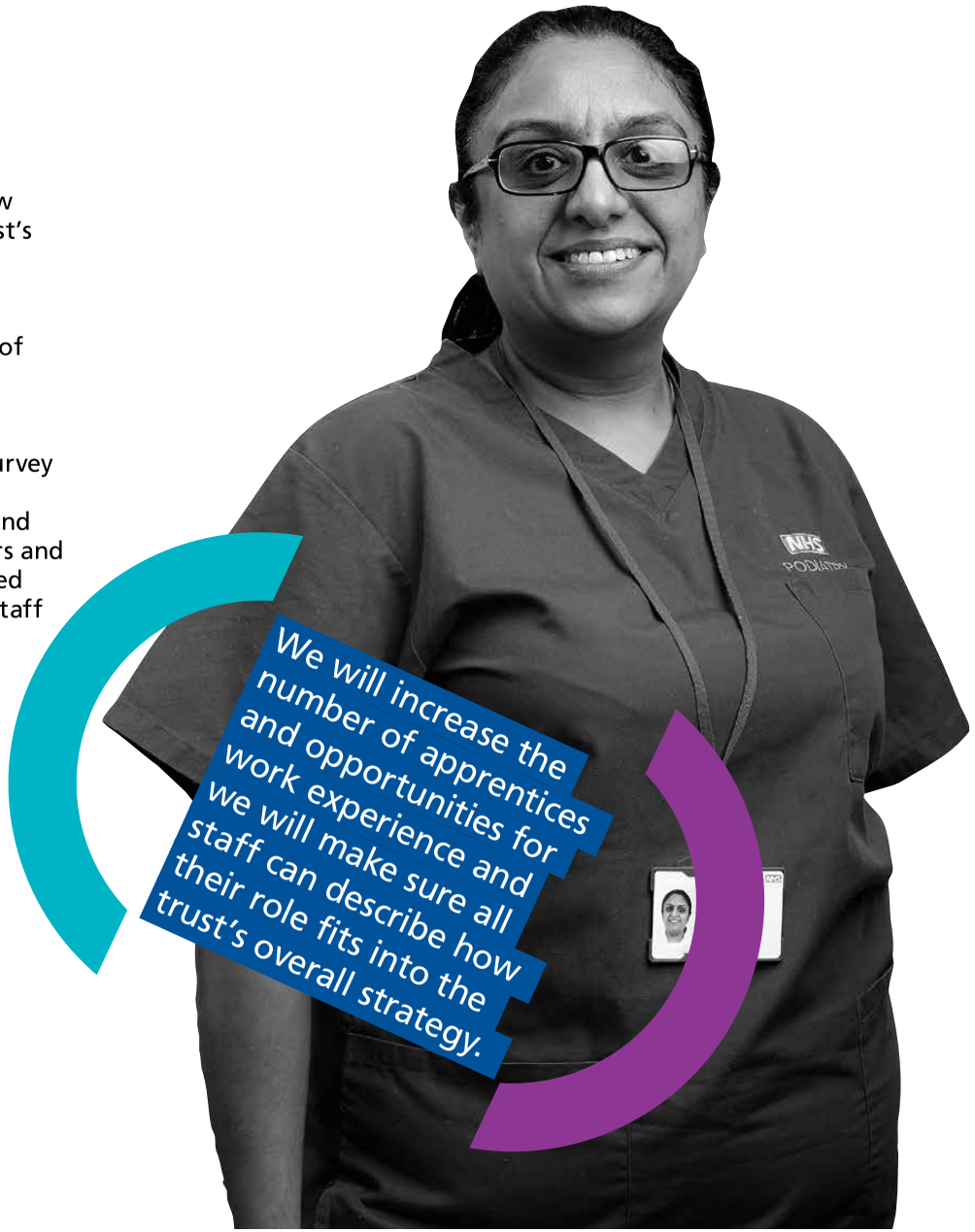
To achieve this we will:

- communicate future priorities and benefits of changes in a clear, transparent and accessible way
- create a baseline and continually measure and monitor the benefits of the change
- adapt and ensure change can continue in the face of ongoing fluctuations in staff, leadership, organisation structures
- ask, listen, value and act on staff comments and concerns to ensure staff support change
- horizon-scan to ensure we are at the forefront of innovation
- ensure senior and clinical leaders take on responsibility for change
- openly communicate success and failures, which will be used as opportunities to learn and improve
- involve our workforce in all changes and ensure it reflects the population it serves.

Measuring success of recruiting and improving our people

We will know that we have achieved this strategic aim when:

- we increase the number of apprentices and opportunities for work experience
- we increase the number of staff who recommends KCHFT as a place to work (Staff Friends and Family Test baseline 67%)
- we reduce our agency expenditure to ensure reliance on agency staff is less than four per cent of pay bill
- our vacancy factor drops to 5% or below
- our staff can describe how their role fits into the trust's overall strategy
- issues raised by staff are published together with the actions taken as part of #yesyoucan feedback
- staff engagement scores increase year-on-year, measured by NHS Staff Survey (baseline 3.76)
- we increase recognition and value of staff by managers and the organisation, measured by the staff survey (NHS staff survey baseline 3.49).



Conclusion

We want to be the best NHS employer in Kent. Our pledge to staff is to create and maintain Kent Community Health NHS Foundation Trust as the place where people want to work, delivering excellent care to our patients and clients.

Our people strategy is an enabling strategy to deliver our vision of care, achieve the trust's strategic objectives and be ready for future changes and challenges. It outlines the aims and intentions as to how we will recruit, retain and engage staff as partners to unlock their potential, to fully support and realise the achievement of the trust's five year strategy. Much work is already underway to deliver the strategy, however the scale and pace needs to quicken and sharpen if the strategy is to be fully realised.

Every year a set of key workforce deliverables will be developed and agreed and then progress against these will be tracked and monitored. This will ensure that progress against the People Strategy is made.

This monitoring and tracking will take place through a range of mechanisms including:

- the trust's Board which will receive regular reports on progress against our annual objectives, key performance indicators on workforce within the monthly workforce report and integrated performance report
- our Workforce and Education Committee which will provide regular updates and reports to be monitored by the Executive Team.

00464 Produced by the Communications and Marketing Team www.kentcht.nhs.uk

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.12
Subject:	Risk Management Strategy
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	X	Assurance	☐

Report Summary (including purpose and context)

This strategy aims to ensure that there is a consistent approach to Risk Management across the organisation by embedding it into the Trust's processes. As such and to ensure its relevance the Risk Management Strategy is reviewed on an annual basis. Version 3.3 of the strategy was approved in February 2016 so the annual review is now due.

The Corporate Services Directorate has reviewed the strategy and had incremented the version number to 3.4 to reflect the minor revisions made. Key revisions are summarised below:

- Update to section 4.1.4 to include The Golden Thread with revised Trust values
- Inclusion of links to relevant documents on Flo and removal of Appendices

The strategy was then presented to the Audit and Risk Committee who approved the document subject a minor revision, this has been made and the version number incremented to 3.5.

Proposals and /or Recommendations

The Board is asked to approve version 3.5 of the Risk Management Strategy.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

Yes.

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Kent Community Health NHS
NHS Foundation Trust

Risk Management Strategy

Document Reference No.	CQS017
Status	Final
Version Number	Version 3.5
Replacing/Superseded policy or documents	Version 3.4
Number of Pages	26
Target audience/applicable to	All staff
Author	Head of Risk
Acknowledgements	Natalie Davies
Contact Point for Queries	Rhiannon.adey@kentcht.nhs.uk
Date Ratified	
Date of Implementation/distribution	
Circulation	Policy dissemination / Flo
Review date	February 2018
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EXECUTIVE SUMMARY

This strategy aims to ensure that there is a consistent approach to Risk Management across the organisation by embedding it into the Trust's processes.

We all manage risks in our daily lives almost subconsciously – assessing whether it is safe to cross the road or weighing up whether we need to wear a coat or take an umbrella with us when we leave the house. In terms of business, we need to have a risk management process that is consistent and repeatable across the organisation, allowing us to prioritise our action plans to ensure our objectives are achieved.

Identification and management of risk should be seen as a positive step towards ensuring the Trust achieves its objectives; it is far safer to identify a risk, establish the controls in place, risk assess and develop an action plan to mitigate the risk if required than continue with the status quo.

This strategy describes how intelligence can be gained from incidents, complaints and claims to feed in to the Risk Management Process. It also describes the process for managing and assessing risk, which should be consistent across the organisation.

As well as providing a description of the procedural processes required to conduct risk management, the strategy also sets out a longer term plan to further integrate risk management within the culture of the organisation. The strategy will be reviewed on at least an annual basis, and more frequently if required.

Governance Arrangements

Governance Group responsible for developing document	Risk Management
Circulation group	Intranet, Policy Distribution
Authorised/Ratified by Governance Group/Board Committee	Audit and Risk Committee
Authorised/Ratified On	
Review Date	February 2018
Review criteria	This document will be reviewed prior to review date if a legislative change or other event dictates.

Key References

Annual Governance Statement – Guidance (Department of Health, 2012)
Governing the NHS: A guide for NHS boards (Department of Health and NHS Appointments Commission, 2003)
Management of Risk: Guidance for Practitioners (Office of Government Commerce)

Related Policies/Procedures

Title	Reference
Incident Policy	CQS016
Health and Safety Policy	HS012
Serious Incident Policy and Procedure (including Never Events)	CQS027
Lone worker Policy	HS015
Violence and Aggression Policy	HS012
Infection Control Policy	IPC001
Education and Workforce Development Policy	HR016

Document Tracking Sheet

Version	Status	Date	Issued to/approved by	Comments / summary of changes
3.0	Approved	28/02/2013	Trust Board	Published
3.1	Approved	20/02/2014	Audit and Risk Committee	Minor amendments including insertion of definition of tolerated risk, update to governance group responsibilities and risk categories.
3.2	Approved	26/02/2015	Audit and Risk Committee	Minor amendments including revision to risk appetite section, moving of definitions to the back of the policy, removal of duplication and a reduction in the number of appendices included (removal of Risk Assessment template which can be found on StaffZone and removal of risk register and BAF template which don't need to be included within the strategy).
3.3	Approved	25/02/2016	Board	Minor amendments to the strategy
3.4	Approved subject to amendment as noted in 3.5	15/02/2017	Audit and Risk Committee	Updated wording of strategic goals Updated golden thread to include new Trust values Removal of appendices and link to documents on Flo
3.5	Pending approval	30/03/2017	Board	Amendments to sections 4.2.5 – 4.2.7 to clarify wording of risks across multiple services

CONTENTS

1.0 INTRODUCTION

1.1 Risk management refers to the process for identifying and assessing risks, and then planning and implementing the appropriate response to control the risk.

1.2 To be effective, a consistent approach needs to be adopted to allow risks of all sources to be:

- Identified – in terms of what could affect the achievement of objectives, and then described to ensure there is a common understanding of the risk.
- Assessed – to enable the organisation to understand what the impact of the risk is and how much priority should be given to mitigating it.
- Controlled – the process of identifying an appropriate response, assigning an owner and then executing and monitoring the effectiveness of these controls.

1.3 Risk Management must be integrated into the normal business processes, and practiced continuously; it is not a one off exercise.

1.4 To be successful, staff at all levels must be aware of their responsibilities and be committed to them.

1.5 What is a risk?

1.5.1 Risk is the possibility that loss or harm will arise from a given situation. In the context of this strategy, this encompasses anything from the possibility of injury to an individual patient or member of staff to anything which impacts upon the Trust's ability to fulfil its aims and objectives.

1.6 What is risk management?

1.6.1 Risk Management is defined as a proactive approach to the:

- Identification of risks;
- Analysis and assessment of the likelihood and potential impact of risks;
- Elimination of those risks that can be reasonably and practicably eliminated;
- Control of those risks that cannot be eliminated by reducing their impact to an acceptable level.

1.6.2 Risk management informs the decision as to whether a risk should be Treated, Tolerated, Terminated or Transferred.

1.7 Why manage risk?

1.7.1 Risk taking is inherent in everything the Trust does: treating patients, determining service priorities, managing a project, purchasing new medical equipment, taking decisions about future strategies, or even deciding not to take any action at all.

1.7.2 In the NHS risks are managed continuously – sometimes consciously and sometimes without realising it. But often risks are not managed systematically and consistently. There is a need, therefore, to adopt a systematic and consistent approach to risk management which encompasses all the Trust's functions and activities and supports the delivery of high quality, value for money services for patients. This strategy aims to do that and is therefore based on current best practice in the field of risk management.

1.8 Who this strategy applies to

1.8.1 This strategy applies to the management of risks faced by the Trust in conducting all areas of its business and is therefore intended for use by all persons engaged in work on behalf of the Trust.

1.8.2 This strategy can also be applied to risks to patients, visitors and those relating to the organisation's service relationships with partner organisations and third parties where these impact on the organisational objectives. Although the management of key strategic risks is monitored by the Trust Board, all operational risks are managed on a day to day basis by employees guided by professional standards and organisational policies, procedures and practices.

1.9 Aims and objectives of this strategy

1.9.1 The Trust's vision is to be the provider of choice by delivering excellent care and improving the health of our communities.

1.9.2 To achieve this vision, the Trust's strategic goals focus on improving health outcomes by seeking to:

(1) We will support children to have the best start in life and everyone to keep healthy throughout their lives – by improving the health of the population with our partners through universal targeted services.

(2) We will empower people to live and age well – by enhancing the quality of life for people with long-term conditions by providing integrated services with our partners to enable them to manage their condition and maintain their health.

(3) We will help people to recover well – from periods of ill health or following injury through the provision of responsive community services, joined up with our partners' urgent care pathways.

(4) We will make sure that people have a positive experience of care – and improved health outcomes by delivering excellent health care.

(5) We will ensure people receive safe care – through best practice

1.9.3 This strategy supports that mission by setting out the strategic direction for Kent Community Health NHS Foundation Trust (KCHFT) to manage risks systematically and consistently across the organisation. It underpins the Board's commitment to mitigate risk by ensuring a robust risk management system is implemented.

1.9.4 This strategy applies across the organisation, identifying the organisational structure and reporting systems for the management of risk as well as articulating the roles and responsibilities of Committees and Operational Groups and that of key individuals and managers.

1.9.5 The strategy describes:

- How the principles of risk management will be further embedded into the culture of the organisation by using the intelligence gained from incident, complaints and claims reporting to inform risk management.
- Action that is taken to identify, assess and manage risk in a consistent way across the organisation.
- How lessons are learned from actual and potential risks, incidents, complaints and claims.
- The approach that should be taken towards the management of risk however it is identified.

1.10 Organisational Context

1.10.1 The Trust's Five Year Strategy defines the Strategic Goals which guide decisions on the organisation's future and help to prioritise competing requirements. This strategy provides a framework to ensure that any risks to the achievement of the objectives are identified and managed; the principal objective of risk management is to ensure that KCHFT can deliver the intentions outlined in the Five Year Strategy safely.

1.10.1 KCHFT appreciates that the management of risk is based on an element of prediction. Consequently, however robust the process, there can never be an absolute guarantee that untoward events will not occur. However, practicing risk management ensures it is much less likely that an untoward incident will occur, and this strategy intends to build on existing good practice to bring together the intelligence gained from incident, complaints and claim reporting to provide a holistic approach.

1.10.2 There are a number of related policies and strategies which should be read in conjunction with this Risk Management Strategy. These include:

- Incident Policy
- Serious Incident Policy and Procedure (including Never Events)
- Customer Care Policy
- Claims Management Policy
- Health and Safety Policy
- Business Continuity Plan
- Lone worker Policy

- Violence and Aggression Policy
- Security Management Policy

1.11 Equality, Diversity and Inclusion

1.11.1 Communication and the provision of information are essential tools of good quality care. 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. These principles should be enshrined in all formal documents.

1.11.2 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 recommended 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.

1.11.3 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).

1.11.4 Kent Community Health NHS Foundation Trust is committed to ensuring that information is provided in accessible formats and communication support is met for people (patients, carers, parents/guardians) with a disability, impairment or sensory loss. The Accessible Information Standard (AIS) is a legal requirement of the Equality Act which applies to all organisations included within the Health and Social Care Act.
https://www.england.nhs.uk/ourwork/patients/accessibleinfo/. Guidance on professional support services for the Trust is available in the Accessible Information Policy.

1.11.5 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.

1.12 Equality Analysis

1.12.1 Kent Community Healthcare NHS 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.

1.12.2 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.

1.12.3 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

1.12.4 An equality analysis should be completed whilst a policy is being drafted and/or reviewed in order to assess the impact on people with protected characteristics. This includes whether additional guidance is needed for particular patient or staff groups or whether reasonable adjustments are required to avoid negative impact on disabled patients, carers or staff.

1.12.5 The Equality Analysis for this policy is available upon request by contacting the Engagement Team via kchft.equality@nhs.net.

2.0 ROLES AND RESPONSIBILITIES

2.1 This section defines the duties of key individuals with responsibility for risk management as well as defining the organisation's overall risk management structure.

2.2 Chief Executive

2.2.1 The Chief Executive, as the accountable officer, is the individual with overall responsibility for ensuring an effective risk management system is in place and resourced.

2.2.2 The Chief Executive:

- Designates responsibility and authority to the Executive Team to ensure the necessary organisational structure and resources to implement policies and effectively manage risks.

- Is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems to manage risks and maintain quality service provision are operating effectively.

- Through the responsibility delegated to the Directors, is aware of all key decisions made within the Trust. They ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, including the means by which effectiveness of action to reduce risk and maintain quality and patient safety is monitored.

- Uses this information to provide assurance to the Board in the Annual Governance Statement that risk is managed and mitigated regardless of source as far as is reasonably practicable.

- Identifies to the Trust Board by means of the BAF where a risk may need to be accepted by the Trust Board and those risks which may affect the ability of the Trust to meet its strategic objectives.

2.3 Corporate Services Director

2.3.1 The Corporate Services Director has accountability delegated from the Chief Executive to ensure that robust risk management systems and processes are in place. The Corporate Services Director manages the Board Assurance Framework, with the Chief Nurse and Medical Director leading on clinical risk management and the Director of Finance leading on financial risk management.

2.4 Directors

2.4.1 Directors are responsible for:

- Ensuring the risk management process is operational within their directorate. All staff must be made aware of the risks within their work environment and of their personal responsibilities within the risk management process.
- Reviewing all high level risks and ensuring that a plan to implement adequate controls within appropriate timescales is in place.
- Approving the decision to terminate an activity which is giving rise to a risk which cannot be adequately controlled.
- With their operational teams, reviewing and managing their Directorate Risk Register on a monthly basis.

2.5 Assistant Directors / Community Service Directors

2.5.1 Assistant Directors / Community Service Directors are responsible for:

- Ensuring that risk management processes, including Risk Registers, are in place within their service.
- Reviewing all high and medium level risks and ensuring that a plan to implement adequate controls within appropriate timescales is in place.

2.6 Heads of Service

2.6.1 Heads of Service are responsible for:

- Ensuring that risk management processes, including Risk Registers, are in place within their service.
- Ensuring that the risk management process is embedded within their service, which will include ensuring that all teams and departments produce, or contribute to a Risk Register and submit it by an agreed deadline.
- Reviewing and approving all risks raised by their service, and recording the action plan.

- Consulting the relevant subject matter expert when determining controls and producing an action plan to reduce the risk further.

- The management of all low rated risks.

2.7 Team / Department Managers

2.7.1 Team / Department Managers are responsible for:

- Ensuring that risk management processes, including Risk Registers, are in place within their service.

- Ensuring that the risk management process is embedded within their team.

2.8 All employees

2.8.1 All employees have responsibilities with respect to risk management. All employees are responsible for:

- Familiarizing themselves with this strategy

- Reporting risks to their line manager.

- Reporting near misses and incidents as described in the Incident Policy

- Reporting risks appropriately where staff are concerned that a member of staff or patient may be involved in a terrorist activity or is being radicalised. Further information can be sought from the Safeguarding Service.

- Being aware of known risks within their working environment – team / department managers will be able to inform employees of these.

- Being familiar with emergency procedures for their area of work.

- Complying with policies and procedures and not to interfere with or misuse any equipment which is provided for health and safety purposes.

- Attending any relevant training as advised by their line manager.

2.9 Head of Risk

2.9.1 The development and implementation of risk management processes will be overseen by the Head of Risk who will work with and gain additional support from other members of the Corporate Services Directorate.

2.10 Organisation Risk Management Structure

2.10.1 Kent Community Health NHS Foundation Trust Board:

- Owns the organisation's Risk Management Strategy.
- Defines the organisation's overall risk appetite.
- Receives sufficient assurance that the Risk Management Strategy is being adhered to.
- Monitors and acts on escalated risks.
- Demonstrates that it takes reasonable action to assure itself that the Trust's business is managed efficiently through the implementation of controls to manage risk.
- Appoints the Audit and Risk Committee to confirm the risk appetite for identified risks and to provide assurance that appropriate action is taken to control risk in line with the risk appetite.
- Appoints the Quality Committee to provide assurance and be assured that appropriate action is taken to control all aspects of clinical risk.

2.10.2 Audit and Risk Committee

2.10.2.1 The committee is responsible for the oversight of the system of control in the organisation and for providing assurance to the Board that the system of risk management is effective.

2.10.2.2 The Board has delegated responsibility for the detailed scrutiny of the Board Assurance Framework (BAF) to its Audit and Risk Committee (ARC). The Committee seeks to assure the Board that effective risk management systems are in place. It achieves this by managing the development of the Risk Management Strategy, internal and external audit reviews, calling Executive Directors in to account for their risk portfolios and by monitoring the BAF at each of its meetings.

2.11 Quality Committee

2.11.1 The committee has delegated responsibility from the Board for the management of patient safety and clinical effectiveness. The Operational Directorates' Quality Groups meet monthly and report their outputs into the Quality Committee, providing assurance that clinical risks are managed appropriately.

2.11.2 The Quality Committee's key responsibilities are to:

- Provide advice to the Board on the escalation of quality and safety risks onto the Corporate Risk register/Board Assurance framework.
- Review high level risks on the Trust clinical risk register which relate to patient safety and recommend appropriate actions
- Receive progress and assurance reports from the Nursing and Quality Directorate on the Monitor Quality Governance Framework action plan.

- Receive specific highlight reports that relate to deviations from quality standards with the actions that are to be implemented, together with the method of assurance.

2.11.2.1 Where new risks are reported to the Committee, these are presented by the responsible Director and members of the Committee evaluate the assurance provided.

2.12 Finance, Business and Investment Committee

2.12.1 This is a Committee of the Board and is chaired by a Non-Executive Director. The committee is responsible for the in depth scrutiny of the high level finance, business and investment activity in the Trust on behalf of the Board and for the provision of assurance in relation to these areas. This will include the identification of risks in these areas and ensuring that these risks are escalated to the Board as appropriate through direct reporting, the Executive team and the Assurance framework.

2.13 Executive Team Meeting

2.13.1 The meeting is chaired by the Chief Executive. The operational management of risk is central to the Executive Team's role which performance manages the BAF by reviewing it in detail on a monthly basis. The Executive Team are responsible for validating all newly identified high risks to ensure risks are accurately described and rated.

2.13.2 The purpose of the review is to establish for each risk:

- Whether the risk is accurately described
- Whether the ratings represent the organisation's exposure to the risk, given the current controls
- Whether the risk meets the BAF threshold
- Whether the risk can be linked in a parent/child relationship to an existing risk on the BAF.

2.13.3 In addition, the Executive Team will review the risks described on the BAF to ensure that they accurately describe the organisations risk exposure: where new high risks arise, the Director responsible for mitigating the risk should ensure this is added to the BAF through the executive team meetings and on advice of the CARM.

2.14 Corporate Assurance and Risk Management Group

2.14.1 The Corporate Assurance and Risk Management (CARM) Group reviews risks and incidents identified from all directorates across the Trust, and ensure that they are adequately described on the risk register. Additionally the group identifies themes and trends amongst low and medium graded risk, which, when combined may present a higher risk than indicated by their individual risk rating. Areas of concern are escalated to the Executive Team as appropriate.

2.15 Operational Directorates' Quality Groups

2.15.1 Operational Directorates' Quality Groups are chaired by the respective Director, and review all newly identified and high rated risks on a monthly basis. All risks are discussed and those new risks which cannot be mitigated are approved for escalation on to the organisation-wide risk register. The Group will also review patient safety performance including complaints, claims and incident data and patient feedback. Where additional risks are identified, the group will ensure these are added to the risk register. Highlight reports will be provided to the Quality Committee, including assurance of achievement against quality standards.

2.16 Links between Assurance Committees

2.16.1 In order for the risk process to be effective, clear links are established between the Board Committees (Audit and Risk, Quality, FBI). This is achieved in several ways:

2.16.2 There is joint membership between the Audit and Risk Committee, the Quality Committee and the FBI Committee. These ensure that the breadth of context is clearly understood across the Board Committees.

2.16.3 The Board assurance framework is considered by both the Quality and Audit and Risk Committees, ensuring a shared understanding of risk across the organisation.

2.16.4 All Board committee minutes are a standing item on the Board agenda.

3.0 RISK MANAGEMENT FRAMEWORK

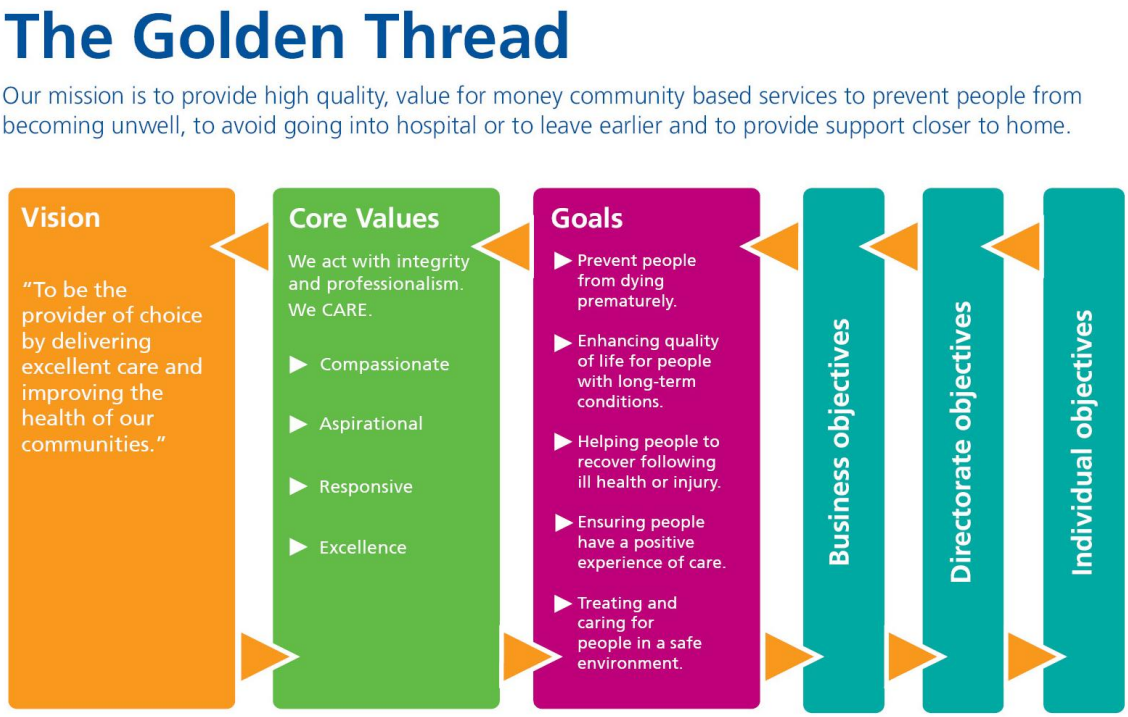
3.1 The purpose of this framework is to enable KCHFT to apply a consistent approach to identifying, assessing, evaluating and responding to risk. It should be applied to all types of risk, including the non-achievement of an objective, or the impact of a complaint, incident or claim.

3.2 The Board will identify the organisation's strategic objectives in the form of the Five Year Strategy, and from this an annual set of directorate and business objectives will be defined.

3.3 This will allow service, team and individual objectives to be determined.

3.4 The achievement of individual objectives links through directorate, business, and strategic goals contributing to the organisation achieving its vision and core values. The failure of an individual to achieve an objective could ultimately lead to a team/service failing to deliver on its own objectives. This is shown visually within the "Golden Thread"

- Figure 1 – The "Golden Thread" linking the organisation's vision, core values, goals, strategic objectives, business objectives, directorate objectives, service and individual objectives:



3.5 The goals within the golden thread represent the organisation's strategic objectives, and as such the risks to the achievement of these are articulated on the BAF.

3.6 Risk Assessment and Management Process

3.6.1 The process outlined below will ensure that substantial risks to the achievement of strategic objectives are escalated to the relevant Group and beyond if necessary.

3.6.2 Risks will be identified on an on-going basis and will be assessed and managed according to this process.

3.6.3 A consistent approach throughout the organisation will ensure risks can be effectively discussed and communicated, with a common basis of understanding, and will ensure that actions to treat risk are prioritised correctly.

3.7 Identifying Risk

3.7.1 Everyone is responsible for identifying risk within their area of responsibility.

3.7.2 Risks can be identified after an adverse event has occurred, known as reactive risks, or before an event has occurred, known as potential risks.

3.7.3 Risks can be identified from a variety of sources. The following is as example of different methods of identifying risk. (Please note this list is not exhaustive):

- Potential non-achievement of objectives
- Claims
- Complaints
- Incidents, including Serious Incidents

- Near Misses
- Audits
- Care Quality Commission Quality Risk Profile
- Health and Safety Law
- Legislation
- Patient feedback

3.7.4 A generic Risk Assessment Form is available on the Health and Safety pages of KCHFT intranet. These documents can be used prior to adding risks to Datix.

3.8 Analysing Risk

3.8.1 When describing the risk, the **cause** and **impact** of the risk occurring, in relation to a specified objective should be clearly stated.

3.8.2 Once a risk has been clearly written, controls can be identified and plans can be put into place to reduce the likelihood or the consequence of it occurring.

3.8.3 If there are plans in place already to reduce the risk, these are known as “controls”. If plans will be put in place in the future, this is known as the “action plan”.

3.9 Assessing Risk

3.9.1 Risks are rated based on controls that are already in place; the action plan to gain further control in the future does not affect the current risk rating so should not be considered.

3.9.2 The risk rating is established by looking at the two elements of the risk: the severity level of the impact (between 1 and 5, with 1 being insignificant and 5 being catastrophic) and the likelihood of the consequence occurring (between 1 and 5, with 1 being rare and 5 being almost certain).

3.9.3 When considering the severity level of the impact, the most likely impact should be used. In most cases this would not be the most extreme level.

3.9.4 Multiplying the severity level of the impact by the likelihood of the impact occurring provides the risk rating. The risk rating will therefore be a value between 1 and 25.

3.9.5 KCHFT uses a 5x5 (five by five) risk matrix, when assessing risk you should refer to the process on the intranet here.

3.9.6 When risks are initially assessed, both the initial and current risk rating will be the same, but as actions progress and the risk is reassessed, the current rating should reduce. In exceptional circumstances, if actions are unsuccessful or circumstances change, the residual rating may increase.

3.10 Categorising Risk

3.10.1 Risks will be categorised according to their effect: a full list of potential risk effect categories is on the intranet here.

3.10.2 The categorisation determines the functional area to which the risk is reported to and allows integrated reporting across incidents, complaints, claims and risk.

3.11 Risk Appetite

3.11.1 The risk appetite refers to the organisation's attitude towards risk taking which dictates the amount of risk that it considers acceptable. The risk appetite will depend on the type of risk.

3.11.2 Unnecessary risk in relation to patient safety will not be tolerated, but the risks associated with a business venture should be weighed up against the potential benefits of the course of action. Hence the risk appetite for different risks, even within the same category, may vary.

3.11.3 The assessment of appetite is informed by factors such as:

- impact on patients or staff
- value of assets lost or wasted in the event of adverse impact
- stakeholder perception of impact
- cost of control
- extent of exposure
- The balance of potential benefits to be gained or loses to be withstood.

3.11.4 Risk appetite is graded as 'medium', 'low' and 'very low'. This is linked to the 5 by 5 matrix used in the organisation although it is not the absolute rating of an assessed risk which is the most important factor but whether or not the risk is regarded as tolerable in the context of potential benefits. Therefore, the risk treatment option will vary dependent on the particular risk.

3.11.5 The risk appetite, link to the 5 by 5 rating and risk treatment options are defined in the table below:

Risk Appetite	5 by 5 rating	Risk treatment
Very low appetite	1 to 4	Tolerate
Low appetite	4 to 9	Treat / Transfer / Tolerate
Medium appetite	8 to 12*	Terminate/ Treat / Transfer / Tolerate

3.12 Treating Risk

3.12.1 Based on the risk assessment, the Head of Service will decide an appropriate risk response:

- Treat the risk (the most common response) – in which case an action plan to gain further control will be written.
- Tolerate the risk, in which case no further action will be taken to reduce the risk, although the risk should still be documented along with a detailed description of the controls, as the effectiveness of these will need to be monitored.
- Terminate the activity giving rise to the risk.

- Transfer the risk – place the hazard and associated risks under the control of a body outside the organisation who have the necessary system and competencies to effectively manage the risk. It may also be possible to transfer risk actions between directorates if the risks can be more easily addressed with the skill set in the alternative directorate. This will be determined and agreed at CARM.

3.12.2 Any decision to tolerate, transfer or terminate an activity that gives rise to a risk will be taken following the completion of a suitable action plan, or after an on-going action plan has been unable to mitigate the risk. Decisions to tolerate, transfer or terminate an activity must be documented on Datix.

3.12.3 Action plans must include a deadline for completion, and a named individual responsible for completing the actions. Where deadlines are not met, it is acceptable for these to be extended, but deadlines should not be extended routinely. The extension of action plans is monitored by the Risk Management Team and reported to the Corporate Assurance and Risk Management Group.

3.12.4 As actions are completed, they become additional controls. As controls change the risk should be reassessed. If the controls are effective then the current risk rating should decrease. The Risk Management Team will monitor the effectiveness of action plans by comparing the initial risk rating with the current risk rating.

3.13 Adding / Updating a Risk on a Risk Register

3.13.1 The Risk Register is a 'live' document that is maintained electronically on the Datix Risk Management System. Directors, Heads of Service and designated support staff all have access to Datix, and amendments can be made at any time to ensure the information is current.

3.13.2 Risks must be reviewed regularly and at least on a bimonthly basis. Where review deadlines lapse, the Risk Management Team will follow this up.

4.0 RISK ESCALATION AND FEEDBACK

4.1 The Trust has a whole system approach to risk management, in which risks that are identified and listed on local risk registers are escalated for approval to Heads of Service, Community Service Directors / Assistant Directors, then on to the Director and Executive Team dependent on the risk rating. All risks are recorded on the Datix risk management system.

4.2 Department and Team

4.2.1 Dependent on the size of the service, the first level of risk register will be team or service. This should be determined by the Head of Service. Where multiple risk registers exist for a single service; a service or discipline Governance Group must be established to receive reports from the Risk Management Team.

4.2.2 All risks will be reviewed by Head of Service for validation and approval. This process is facilitated by Datix.

4.2.3 Heads of Service will record whether any details of the risk have changed and will ensure an effective risk assessment has taken place, based on the controls that are currently in place.

4.2.4 Risks rated 8 or above or those which the group especially wish to highlight will be escalated to the relevant Operational Quality Group where the risk response and actions to mitigate the risk will be discussed. Additional intelligence from incident, complaints and claims will be reported to the group.

4.2.5 The Operational Quality Group will validate these risks and ensure that the risk rating accurately reflects the exposure to risk. This will be recorded on Datix. Where a similar risk is being reported by multiple services, this will be reassessed according to the impact on the organisation as a whole, and a Trust-wide action plan drafted.

4.2.6 The lead director of each Operational Quality Group will be responsible for ensuring that Trust-wide action plans are documented, along with a description of the Trust-wide risk. The lead director will delegate this responsibility to a member of their team as appropriate.

4.2.7 Links between a Trust-wide risk and a service / directorate risk contributing to it will be recorded within Datix to aid future monitoring. Until the corporate action plan begins to control the risk, each service will remain responsible for managing the risk.

4.2.8 As a minimum, all graded high graded risks will be reviewed by the Director responsible for the service, who may decide to contact the Head of Service regarding the management of the risk.

4.2.9 Following review by the Director responsible for the Service, risks that remain high graded are escalated to the Executive Team.

4.3 Executive Team

4.3.1 The Executive Team ensure risks are adequately described and rated. Where risks are confirmed as high graded, they are escalated to the BAF.

4.3.2 Risks which are escalated to the BAF are reported to the Audit and Risk and Quality Committees. Risks will also be reviewed by other relevant Groups/Committees according to the risk categorisation.

4.3.3 Whenever risks are escalated, the service (or Directorate) representatives will feedback the outcome of these discussions to the Head of Service, who will update Datix accordingly.

4.3.4 The Risk Escalation and Feedback Process is represented visually on the intranet here.

4.4 Management responsibility for different levels of risk within the organisation

4.4.1 Heads of Service are responsible for validating all risk assessments, and for ensuring that sufficient controls are in place. Risks which are rated as high will be reported to the Director responsible for the service raising the risk by exception. The

Head of Service should ensure that an action plan to gain further control is documented, taking advice from the subject matter expert where applicable.

4.4.2 Risk Grade:

Risk Rating:	Risk Grade:	Immediate escalation:
12 to 25*	High Risks	Director
8 to 12	Medium Risks	Head of Service
1 to 6	Low Risks	Team / Department Manager/ Head of Service

*risks with an impact rating of 4 and likelihood rating of 3 are classified as high risk; risks with an impact rating of 3 and likelihood rating of 4 are classified as medium risk.

4.4.3 Where risks cannot be immediately mitigated, they should be added to the relevant risk register.

5.0 TRAINING AND AWARENESS

5.1 A key challenge in implementing this strategy is ensuring that all staff are aware of what this strategy requires of them.

5.2 A Health and Safety course including risk awareness is available through the Learning and Development department for those with overall responsibility for the health and safety of their staff.

5.3 The Head of Risk meets individually with Executive Directors to ensure that risk management remains an effective on-going process within their Directorate. Advice and support is provided with regard to implementing the processes defined within this strategy, and all high graded risks are reviewed and updated as appropriate. Where the need is identified, additional training sessions are arranged.

5.4 Additional adhoc training and awareness sessions are delivered on a targeted basis by arrangement with the Corporate Services Directorate.

6.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***
Effectiveness of the organisational risk management structure detailing all those committees/sub committees/ groups which have some responsibility for risk	Review of Organisational Group Minutes – spot checking of agendas and feedback from Board. Attendance at Operational Group meetings by members of the Corporate Services Directorate Annual assessment of Committee effectiveness.	Corporate Services Directorate Committee/ Internal Audit	On-going Annual
Process for Board or high level committee review of the organisation-wide risk register	Review of Committee Minutes Assurance Framework and Risk Management Audit	Head of Risk Internal Audit	Six monthly Annual
Process for the management of risk locally, which reflects the organisation-wide risk management strategy	As part of the process for developing and maintaining the organisation-wide risk register, risk registers are are reviewed monthly, demonstrating this process is working effectively. Where problems are identified these will be followed up by the Head of Risk. Minutes of Directorate Group minutes will be reviewed to ensure reports are being reviewed. Assurance Framework and Risk Management Audit	Risk Management Team CARM Internal Audit	Six monthly Quarterly Annually
Manager's knowledge of this policy with specific reference to the authority of all managers with regard to managing risk	CARM membership and quality of the risk registers	Corporate Services Directorate CARM Chair	Annually
Quality and effectiveness of Board Assurance Framework and risk management processes	Audit of framework	Internal Audit	Annually

7.0 EXCEPTIONS

7.1 There are no exceptions to this policy.

8.0 GLOSSARY & ABBREVIATIONS

8.1 Glossary:

Term	Meaning
Action Plan	Something that is going to be done to mitigate the risk (to reduce the likelihood or the consequence of it occurring). An action plan will be on-going over a specified period of time and will be owned by an individual
Board Assurance Framework (BAF)	The Board Assurance Framework (BAF) is a tool to assist the Board in assessing and mitigating the principal risks to the achievement of strategic objectives. . The tool also identifies gaps in control measures and gaps in assurances, as well as providing a means to monitor the work that is being done to mitigate the risk. The BAF is comprised of strategic risks identified against the strategic goals defined in the Five Year Strategy in addition to risks identified against the achievement of business and operational objectives. To provide assurance that these risks are being effectively managed, the BAF details the controls in place to mitigate each risk, any gap in control, assurance of the controls' effectiveness, the actions planned and being executed together with the date by when the actions are due to be completed. Each action on the BAF is given a Red, Amber, and Green (RAG) status. This enables actions that have either breached their initial target completion date or are considered unachievable to be identified more readily, and enables action owners to be held to account.
Control	Something that is already in place to reduce the consequence or likelihood of a risk effect occurring. If a control will be put in place in the future then this forms part of an "action plan" and is not considered a control.
Datix	Datix is the computerised Risk Management Tool used by KCHFT. It brings together information from risk, incidents, complaints and claims and facilitates reporting between these disciplines.
Gross Risk Rating	The risk identified at the point the risk is initially recorded. This rating will reflect controls in place at the time the risk was identified
Net Risk Rating	The level of risk currently remaining, given the controls currently in place. This risk rating should reduce as actions identified are implemented
Risk Rating	Once the impact and likelihood of a risk being realised has been evaluated, multiplying the consequence score by the likelihood score will give the risk rating: a value between 1 and 25

Term	Meaning
Risk Register	A Risk Register summarises information gained from the risk management process. It provides a description of the risk, the current controls in place, the current risk rating, a summary of the action plan, the date by when the actions are due to be completed by, the person responsible for completing the actions as well as the residual risk rating. It is used to communicate information about Risk around the organisation. Risk Registers are produced from Datix, the computerised Risk Management Tool used by KCHFT.
Risk Response	Describes whether the risk will be Treated, Tolerated, Terminated or Transferred. Commonly known as the “Four T’s”.
Tolerated risk	The Trust tolerates risks under the following circumstances: • The risk score is in line with the corporate risk appetite. • Further controls are prohibitive for reasons of cost, resources or operational constraints. • The Trust has developed all possible internal controls and is reliant upon third party activity to further reduce the risk. Where risks are tolerated above the corporate risk appetite, they remain under review. The Trust will implement further controls as soon as circumstances allow.

8.2 Abbreviations:

Abbreviation	Meaning
BAF	Board Assurance Framework
CARM	Corporate Assurance and Risk Management Group
KCHFT	Kent Community Health NHS Foundation Trust

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	2.13
Subject:	Ratification of Policies
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary (including purpose and context)
This report presents the following policies for ratification: Professional Registration Policy Annual Leave Policy Annualised Hours Guidance Probationary Period Policy Ordinary Parental Leave Policy Shared Parental Leave Policy Maternity and Maternity support Paternity Leave Policy Adoption/Surrogacy Leave Policy Disciplinary Procedure Review Policy

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

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
Yes and available electronically
*** 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: louise.norris@kentcht.nhs.uk

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 –

a) Professional Registration Policy
b) Annual Leave Policy
c) Annualised Hours Guidance
d) Probationary Period Policy
e) Ordinary Parental Leave Policy
f) Shared Parental Leave Policy
g) Maternity and Maternity support Paternity Leave Policy
h) Adoption/Surrogacy Leave Policy
i) Disciplinary Procedure Review Policy

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

2.3 *Professional Registration policy*
The main changes to this policy are:

- A tightening of the escalation process to senior management for those staff whose registration is due to expire within the month.
- Changing the action taken against staff whose registration expires from downgrading to suspension without pay and formal disciplinary action. This brings all clinical staff into line with the action currently taken against Medical and Dental staff.

Annual Leave Policy
The main changes to this policy are:

- The policy template format and logo have been amended to reflect legislation and current Trust custom and practice that bank holidays are not carried over in the event of long term sickness absence.

- The inclusion of entitlements to leave for Medical and Dental staff and amended to reflect agreement on leave for Speciality Doctors at LNC.
- The format has been changed to reduce the document length, moving the buying and selling leave process and application.

Annualised Hours Guidance

- This guidance has been produced in order to provide managers with additional guidance on annualised hours arrangements.

Probationary Period Policy
The main changes to this policy are:

- The format has been amended to a standard policy form.
- The scope and purpose has been added with clarity that probationary policy applies to Medical and Dental staff as well as AFC employees and those employed on Fixed term contracts and via local agreements.
- The Appeal procedure and probationary review hearing format has been added.
- Reference to ATP has been included and the record form has been removed.

Ordinary Parental leave Policy
The main changes to this policy are:

- The policy name has changed from Parental leave to ordinary parental leave to reflect HR practice since the implementation of shared parental leave.
- Legislative entitlement changes are now reflected in the policy.
- The entitlement has increased for parents to request leave up to the 18th birthday of each child (previously 14th birthday for children without disability and 18th birthday for children with disabilities). Entitlement of 18 weeks unpaid leave for parents of children without disabilities, increased from 13 weeks.
- The policy template format has been updated.

Shared Parental Leave Policy
The main changes to this policy are:

- The policy format has been updated policy template format.
- No changes have been made to the entitlements or process.

Maternity and Maternity Support Paternity Leave Policy
The main changes to this policy are:

- The policy name has changed from Maternity and Paternity policy to Maternity and Maternity support (paternity) leave to reflect the statutory eligibility of partners including same sex relationships.
- Reference to Additional paternity leave have been removed and replaced by Shared parental leave provisions, outlined in the Trust Shared parental leave policy.
- The phraseology has been updated to reflect the above and the Trust Foundation Trust status.

Adoption/Surrogacy Leave Policy
The main chances to this policy are:

- The phraseology has been reviewed and the Trust name has been updated.
- There have been minor content changes to reflect the Trust policy template.

Disciplinary Procedure Review Policy
The main chances to this policy are:

- Clarity relating to the full range of potential appeal outcomes has been amended to ensure consistency with the Trust generic appeals policy and Trust practice (paragraph 14.5 in this policy)
- The conduct list has been updated to accurately reflect the Trust view on seriousness of conduct offences and action in relation to failure to update professional body registration in particular.
- Appendix 1 has been updated to provide improved clarity of the hearing procedure.
- An additional Appendix has been added to clearly outline the Appeals procedure for Managers.

3. Process of developing and consulting on policies

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

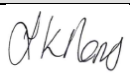
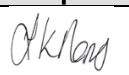
a. The policy is written by the Policy Owner
b. Consultation within the appropriate Directorate to seek further professional input
c. Policies are placed on to StaffZone for two weeks for general consultation and the feedback collated by Staffside and fed back to policy authors
d. Approval from the appropriate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

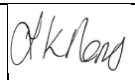
4. Recommendation

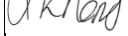
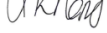
4.1 The Board is asked to ratify the above policies.

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

POLICIES – CONSULTATION AND SIGN OFF

Policy Title	Consultation With	Signature of the Chair(s)	Signature of Director with Responsibility
Professional Registration Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications
Annual Leave Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications

Annualised Hours Guidance	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications
Probationary Period Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications
Ordinary Parental Leave Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications

Shared Parental Leave Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications
Maternity and Maternity support Paternity Leave Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications

Adoption/Surrogacy Leave Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications
Disciplinary Procedure Review Policy	HR Team All staff through Flo SPF	 Louise Norris Director of Workforce, OD and Communications  Neil Sherwood Deputy Staffside Convenor and Vice Chair (Staffside)	 Louise Norris Director of Workforce, OD and Communications

Kent Community Health NHS
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	3.1
Subject:	Quarterly Patient Experience Report (Quarter Three)
Presenting Officer:	Ali Strowman, Chief Nurse

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

Report Summary (including purpose and context):
The Trust received 77 complaints, compared to 79 in quarter two. Complaints per 10,000 contacts were down on the previous two years' data for the quarter. Feedback was received from 15,522 patients who completed a survey. The Trust's NHS Friends and Family (FFT) score for the quarter shows that 97.71% of our patients / carers would recommend us to their friends and family. The overall patient satisfaction score for the quarter is high at 96.76 %.

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

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

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

Kent Community Health NHS Foundation Trust

QUARTERLY PATIENT EXPERIENCE EXCEPTION REPORT

1. Situation

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

1.2 Kent Community Health NHS Foundation Trust is committed to improving patient experience. Our key values are to ensure good care that meets our organisational values: compassion, aspirational, responsive and excellence. All our staff hold responsibility to deliver care that is safe, effective and provide patients and their families with a positive experience. This report details the feedback for Quarter 3, 1 October to 31 December 2016.

2. Background

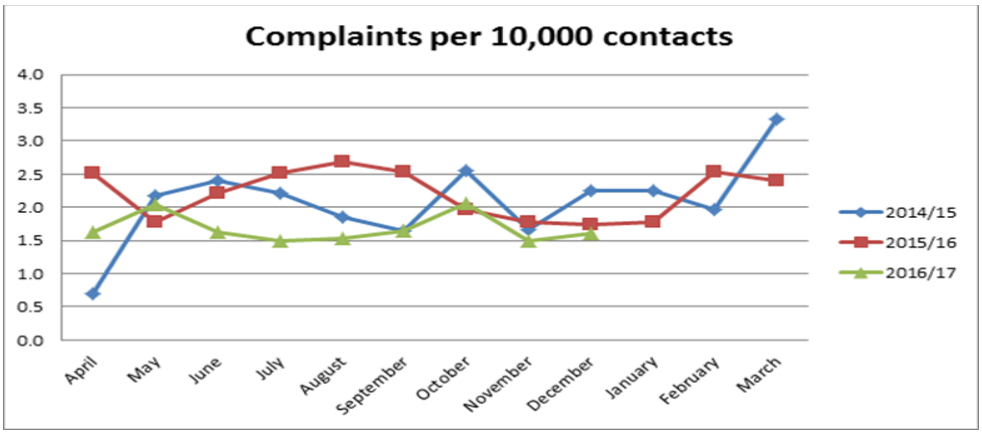
2.1 The Care Quality Commission, as the independent regulator in England, registers and inspects services to ensure they meet fundamental standards of care, including how caring and responsive organisations are to those in their care. Having a good experience of care, treatment and support has increasingly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

3. Assessment

3.1 Complaints

Positively, data demonstrates that there has been a downward trend in the in the number of complaints received by the Trust over the past 3 years, and the number of complaints received each month is fairly static.

Complaints per 10,000 contacts, based on average monthly contacts



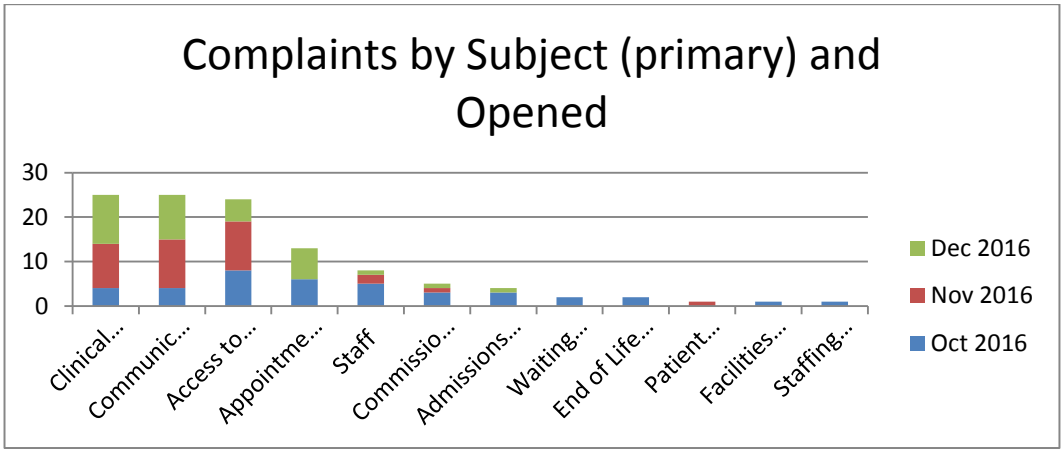
3.2 Benchmarking against other providers

Benchmarking with other Community Trusts shows that month on month KCHFT (the orange bar) is well below the group average for numbers of complaints received. It is pleasing to note that this is a consistent picture over the six month period July-December 2016 and remains low in comparison to the other providers.

Benchmarked complaints per 1000 WTE staff

3.3 Complaints Received

There were 77 complaints for quarter 3 and these are set out by subject in the graph below (note: some complaints may cover more than one area). The chart demonstrates that throughout the last three months the numbers of complaints were fairly consistent for each month (23, 27, and 27).The complaints are broken down into themes with clinical treatment being the reason for the highest number of complaints into the Trust.



3.4 Key themes of complaints

- Clinical Treatment

  Complaints that fall into this category may involve aspects of clinical care provided by health professionals, medical nursing or allied health professionals. They involve complaints about the patient's diagnosis and treatment, complications that may arise either during or after treatment, patient falls, nutrition and hydration, infection control measures, hygiene, and pressure area care. During the quarter there were 26 complaints that fell into this category, which included:
  - Querying the level of care a patient receives
  - Unhappy with the treatment provided
  - Staff did not recognise deteriorations/slow development
  - Unhappy with diagnosis and that missed diagnosis
  - That treatment was stopped
  - Unhappy with outcome of surgery
  - Delay in contacting ambulance service
  - Lack of nursing input following discharge from acute hospital

- Admissions, Referrals, Discharges and transfers

  During the quarter there were 4 complaints that fell into this category.
  - Unhappy with tone of letter
  - Unhappy that discharged from service after did not attend appointment
  - Unhappy that discharged from community hospital too soon

- Access to treatment and medication
  During the quarter there were 24 complaints that fell into this category. The majority of these concerns were in relation to:
  - Unhappy with new booking system
  - Unhappy with delay in receiving HIV medication
  - Unhappy regarding closure of clinic
  - Unhappy with the waiting time for treatment, equipment or onto correct pathway
  - That patients with disabilities wait too long for urgent dental treatment
  - Not receiving a home visit
  - Appointment being cancelled
  - Unhappy that flu vaccinations not received

- Values and behaviours
  This category may include complaints about staff attitude, professional behaviour, failure of staff to introduce themselves and breaches of confidentiality. During the quarter there were 8 complaints that fell into this category. These concerns included:
  - Feeling comments made by staff member were rude
  - Unhappy with verbal statement staff member made
  - Attitude of staff

- Communication
  During the quarter there were 25 complaints that fell into this category. The concerns were in relation to:
  - Letter for appointment sent to patient for antenatal review following a miscarriage
  - Lack of contact and unhappy about booking system
  - Difficulty in making telephone contact
  - Information on external internet searches incorrect
  - Family unhappy for patient to be told that they were dying
  - Communication issues between professionals and with family

4. Ombudsman Cases

4.1 There are currently two open complaint cases with the Ombudsman, these are being formally investigated and are in relation to a patient transfer and inpatient treatment relating to nutrition and hydration.

4.2 During the quarter we have received two Ombudsman rulings and both cases were not upheld. These cases related to the care of an end of life patient and to a transfer of care issue.

4.3 We are pleased to note that the numbers of cases being referred to the Ombudsman remain low and that the two cases that were not upheld suggests that the Trust complaints process is effective and the Trust fully investigates complainants received.

5. Response Times

5.1 The timescale for responding to each complaint is dependent upon the nature of the issues raised and the level of investigation required. For the majority of complaints the Trust aims to respond within 25 working days. For more complex complaints, for example those involving a number of different specialties, organisations or a serious incident that require a root cause analysis, a longer timescale for the response is agreed with the complainant allowing time to undertake a thorough and fair investigation – this may take up to 60 working days to complete. The Trust now works to a response of 60 working days for multi-agency complaints that it is leading on. During the year the Trust responded to 90% of all complaints within the timescale initially agreed. Where delays occurred regular contact was made with the patient/family to keep them updated. In the last 3 months 93% of complaint responses met the set 25 day (internal) timeline.

6. Complaint Feedback

6.1 The Trust surveys complainants after the complaint is closed in order to get feedback on the way the complaint was handled. Despite encouraging feedback increasing the response rate remains a focus for improvement, in Q3 there was only 1 response to the survey. However feedback from this survey was 100% satisfactory.

7. The Customer Care Team (PALS)

7.1 Customer care enquiries are contacts from patients or family members that can be easily remedied by the service concerned. The Customer Care Team contact the service to ask them to make contact with the caller and resolve the issue. This enables services to proactively manage issues as they arise, and it reduces the number that become a complaint.

Key themes from PALS feedback were:

- Child Immunisation Service. The calls were mainly concerning the on-line consent form and the process to receive the vaccination
- The transfer from Medway Community Healthcare to KCHFT for podiatry services in regards access and contact information
- Several emails/calls from parents who are unhappy with the National Child Measurement Programme letters they have received, the wording of which suggests that their child is overweight

Feedback is shared with teams directly and via the appropriate Quality forums.

8. Compliments

Services are encouraged to log compliments. The table below shows the compliments logged in Q3. It is estimated that there is substantially more feedback that is not shared centrally and therefore this is a snapshot of the compliments across KCHFT.

Directorate	Written Compliments	Verbal Compliments	Total
Adults	103	46	149
Adults – Health Improvement & Self-Management	52	43	95
Children and Young People	37	38	75
CYP- Dental	4	3	7
CYP – Sexual Health	11	23	34
Other Directorate	1	-	1
TOTAL	**208**	**153**	**361**

The data in this format is purely collected as numbers and does not currently demonstrate the richness of some of the feedback that is received. Examples of feedback received by way of cards to services are below:

"You always treated dad with kindness and patience. In their last couple of weeks of life I received exceptional support and kindness"

"I want to express my deepest gratitude to you all. You showed great respect and care. I also felt supported by you in my role as his carer."

8.1 Friends and Family Test data

8.2 The Trust maintains an excellent overall patient experience score for Q3 at 96.8%. This was based on 15,522 surveys. This is consistent with the score of 96% in Q2. There were fewer survey responses and this can be explained by the change in contracts meaning there will be fewer responses from Swale and North Kent after September 2016 .

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8.3 The Trust's NHS Friends and Family Test (FFT) score for Q3 remains very high at 97.71% reporting they would recommend, this is consistent to Q2 at 97.64%.
Of the 14,891 people who answered the FFT question a very small percentage of patients reported they are unlikely or extremely unlikely to recommend us.

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

Quarter 2	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Trust	97.64%	0.49%	17491	14267	2812	218	48	37	109

8.4 The 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	97.71%	1.00%	698	570	112	5	5	2	4
Canterbury and Coastal	97.77%	0.56%	1797	1409	348	14	6	4	16
Dartford, Gravesham and Swanley	96.90%	0.19%	1063	838	192	17	1	1	14
Dover, Deal and Shepway	98.34%	0.36%	2771	2310	415	16	8	2	20
East Sussex	95.29%	1.18%	170	122	40	5	1	1	1
Maidstone, Malling, West Kent and Weald	96.95%	0.50%	3177	2541	539	46	10	6	35

Clinical Commissioning Group	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Medway	97.54%	1.40%	285	232	46	2	1	3	1
Other	96.29%	0.71%	566	393	152	8	2	2	9
Swale	99.51%	0.15%	3256	2977	263	8	1	4	3
Thanet	94.86%	0.72%	1108	791	260	33	1	7	16
Summary	**97.71%**	**0.46%**	**14891**	**12183**	**2367**	**154**	**36**	**32**	**119**

The highest positive responses are in the Dover, Deal and Shepway region and all areas are over 94% for patients who would recommend KCHFT services.

The following chart sets out data for services commissioned outside of the Kent and Sussex clinical commissioning groups. These services see lower numbers of patients therefore it should be noted that numbers of responses are lower.

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	60.00%	0.00%	5	0	3	2	0	0	0
Dental (Adult): Colnbrook Immigration Removal Centre	88.89%	0.00%	9	4	4	1	0	0	0
Dental (Adult): Dover Immigration Removal Centre - Dover	100.00%	0.00%	1	0	1	0	0	0	0
Dental (Adult): Harmondsworth Immigration Removal Centre	72.73%	0.00%	22	9	7	2	0	0	4
Dental (Adult): HMP Maidstone - Maidstone	85.71%	0.00%	7	5	1	0	0	0	1
Dental (Adult): HMP Standford Hill - Swale (Isle of Sheppey)	80.00%	0.00%	5	3	1	1	0	0	0
Dental (Adult): HMP Swaleside - Swale (Isle of Sheppey)	92.31%	0.00%	13	7	5	1	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
Dental (Adults and Children) - Appleby Centre	98.44%	0.93%	321	234	82	0	2	1	2
Dental (Adults and Children) - Shrewsbury Centre	98.86%	0.57%	176	129	45	0	0	1	1
Looked After Children Nursing Service - KOLA	100.00%	0.00%	2	1	1	0	0	0	0
Looked After Children Nursing Service - OLA	33.33%	0.00%	3	0	1	1	0	0	1
Specialist Nurse Practitioner for Looked After Young People	100.00%	0.00%	1	1	0	0	0	0	0
Summary	**96.29%**	**0.71%**	**566**	**394**	**151**	**8**	**2**	**2**	**9**

8.5 The table below shows the FFT scores for Minor Injury Units (MIUs) in Q3. All are demonstrating that over 98% of patients would recommend KCHFT services.

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)	99.43%	0.14%	699	629	66	1	1	0	2
Minor Injury Unit (Community Hospital in Edenbridge)	98.60%	0.60%	501	436	58	3	2	1	1
Minor Injury Unit (Community Hospital in Sevenoaks)	98.58%	0.43%	704	625	69	5	1	2	2
Minor Injury Unit (Gravesham Community Hospital)	98.44%	0.00%	192	161	28	3	0	0	0
Minor Injury Unit (Royal Victoria Hospital, Folkestone)	98.23%	0.56%	1073	876	178	7	5	1	6
Minor Injury	99.52%	0.00%	1042	941	96	4	0	0	1

MIUs	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Unit (Sheppey)									
Minor Injury Unit (Sittingbourne)	99.83%	0.06%	1776	1678	95	2	0	1	0
Summary	99.15%	0.23%	5987	5346	590	25	9	5	12

8.6 The table below shows the FFT scores for the community hospital wards for Q3. These are showing high levels of satisfaction with five of the hospitals achieving over 100% and the remainder being above 95%.

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	95.74%	0.00%	47	38	7	1	0	0	1
Community Hospital (Edenbridge)	100.00%	0.00%	17	16	1	0	0	0	0
Community Hospital (Faversham)	100.00%	0.00%	21	14	7	0	0	0	0
Community Hospital (Hawkhurst)	100.00%	0.00%	29	22	7	0	0	0	0
Community Hospital (Herne Bay) - Heron Ward	95.92%	2.04%	49	33	14	1	1	0	0
Community Hospital (Sevenoaks)	100.00%	0.00%	25	14	11	0	0	0	0
Community Hospital (Tonbridge) - Goldsmid Ward	100.00%	0.00%	15	11	4	0	0	0	0
Community Hospital (Whitstable and Tankerton) - Friends Ward	100.00%	0.00%	14	8	6	0	0	0	0
Summary	98.16%	0.46%	217	156	57	2	1	0	1

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

Examples of negative feedback and actions include:

- Extremely unlikely to recommend however positive responses to all survey questions (Child and Adult Therapy Service – Gravesham).
- Extremely unlikely "Every time I had a question the health visitor did not know the answer! Google was more informative. Weigh on sessions were of little use." The Locality Clinical Manager has advised Team Coordinators to make staff aware of this feedback.(Health Visiting – Thanet)
- Unlikely "I was seen on time well after waiting ten minutes to be seen at reception and I have changed it to unlikely." Clinical area manager highlighted this was due to staff sickness and a notice has now been displayed informing patients when there is currently no receptionist that the dental nurses are covering the reception area as well as surgery. Dental (Adults and Children) - Appleby Centre
- Extremely unlikely "Because they would need a hospital referral." Physiotherapy (MSK) - Sevenoaks Hospital
- Unlikely "Unable to treat my injury or health problem. No x-ray was taken of my probably broken toe". Service advised that this was a primary care issue and the service does not treat this conditions anymore. Service feedback states "Patients have been very angry over Christmas as they are unable to see a GP and because the service used to treat Primary care patients get very cross when they are told they have to ring 111".(Minor Injury Unit Royal Victoria Hospital, Folkestone).
- Unlikely "Walked up to hospital and note on door saying service moved. Poor communication. Disorganised - waited 2.5 hours after being told an hour wait. Medway hospital much more organised." The service has advised that waiting times are regularly updated hourly or sooner if needed. This has been communicated to the reception staff and has also been suggested that they make patients aware of the waiting time upon arrival at the reception. This is being monitored by the reception team and they will flag up any concerns with the clinic managers. (Sexual Health Service – Chatham).

The patient experience team support the teams in developing their improvement plans and for monitoring actions. Timescales for areas requiring improvement are set appropriately to meet specific, time limited and measurable objectives.

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

Locality	Returns	Communi-cation	Co-ordinated Care	Equality and Diversity	Given necessary info	Involved in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
Ashford (Locality)	664	98.61%	92.50%	99.20%	98.72%	99.10%	98.85%	99.20%
Canterbury and Coastal (Locality)	1763	98.51%	92.37%	99.83%	97.09%	96.04%	98.54%	99.57%
Dartford, Gravesham and Swanley	1007	97.21%	-	99.69%	99.01%	98.99%	99.19%	100.00%
Dover, Deal and Shepway	972	98.07%	92.09%	99.57%	97.52%	98.54%	98.62%	98.92%
East Sussex (Locality)	213	99.01%	-	100.00%	98.92%	98.21%	99.37%	99.31%
Maidstone, Malling, West Kent and Weald	1875	97.14%	94.82%	99.16%	96.72%	97.91%	98.77%	99.17%
Medway (Locality)	288	97.11%	90.00%	99.64%	96.42%	98.10%	99.65%	100.00%
Other	571	97.54%	-	95.30%	98.98%	97.47%	97.81%	99.65%
Swale (Locality)	440	97.63%	-	99.54%	98.39%	98.38%	99.07%	99.78%
Thanet (Locality)	1018	98.32%	91.10%	99.44%	96.77%	97.70%	99.00%	99.61%
Trust Total	**8704**	**97.87%**	**92.84%**	**99.26%**	**97.56%**	**97.79%**	**98.80%**	**99.46%**

The areas where there is no data is due to the patient surveys not having questions that demonstrate co-ordinated care. These are surveys for example that may have been developed for areas such as out-patient clinics.
These findings show for the 8704 returns that levels of positive responses on the key seven areas are high with all but co-ordinated care scoring above 97%.

8.9 Key Words (from Meridian data)

This data shows that there is recognition from our service users that our services are good, helpful and friendly.

9. NHS Choices / Patient Opinion comments

9.1 There were 31 comments on NHS Choices and Patient Opinion during the quarter. A selection of these are listed below:

- I recently visited this hospital for a blood test. The staff were so friendly. I didn't feel well and the team really looked after me. Even after I left their area they came and checked I was ok. The nurse who did my test even went out of their way to get some Lucozade and also put a fan on me! Great service (Gravesend Phlebotomy).
- I have had two knee replacement operations since February this year and have both times been referred to Herne bay for Physio. Both times I have found that the staff including the person at reception through to the Physiotherapists are all without exception, understanding, helpful, caring and very professional. It has been a pleasure to deal with them. (MSK Herne Bay).
- I'm appalled at the level of service my daughter and I received at Sevenoaks MIU today. We attended three days ago with my daughter's swollen and sore toe, to be told it was "probably" a soft tissue injury and given the usual advice to rest, elevate the foot, apply ice packs and take ibuprofen and it should improve after a couple of days. An X-ray couldn't be done as it was after that dept. had closed for the day. When it hadn't improved after three days, and in fact was worse, we visited Sevenoaks MIU again. we were then taken to see a nurse who quite abruptly and rudely told us that they wouldn't be looking at my daughter's toe again as she had already been seen three days ago by their colleague. We saw our GP who gave it a thorough examination and referred us to Darenth Valley Hospital for an X-ray to rule out a fracture something that could quite easily have been done at Sevenoaks MIU. Thankfully, I have the diagnosis that it is not in fact broken. What a complete and utter waste of ours and everyone else's time.

One of the challenges of making improvements following this feedback is not always having the full details of the person leaving feedback. Actions can be taken if there is enough data captured. The number of comments left may also be related to other service providers due to the fact that multiple services are often co-located in NHS buildings. It is positive that data is shared in a forum available for all to see as part of the Trusts open approach.in line with this data is also shared on our Trust website and updated monthly to reflect

feedback for individual services with a score for the service friends and family test data. The feedback is overall positive on these sites and should be taken as a small snapshot of overall patient feedback.

10. Actions from closed complaints and Patient Experience feedback

From the service improvement plans the following actions have been completed:

- A new leaflet giving clear information on assessment and expectations was devised following feedback that a patient was unhappy that she was 'forced' to do more than she was capable of and not allowed to take breaks within the assessment. (South East DriveAbility)
- Individual training and support has been provided on fundamental and advanced communication skills in end of life care to a community nurse. A further workshop was delivered to the whole team around involving patients and their families in difficult conversations at the end of life by our end of life care facilitator. This action was undertaken following feedback from a patient's family on care at end of life (community nursing).
- Pain assessment tool being utilised following patient complaint regarding pain not being treated (community hospital)
- Spot audits being undertaken to review dressings and treatment following complaint that home visits for replacement of dressings were missed (community nursing)
- Information, process and guidance updated for immunisations
- 'Taking a swab' information and guidance for patients revised (Sexual Health services)

Actions are shared with the relevant quality meetings to enable learning across the Trust.

11. Recommendations

The Trust Board is asked to note the report and recommend any required changes in reporting to provide appropriate assurance.

Mary Kirk
Head of Practice Excellence and Quality
February 2017

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	3.2
Subject:	Seasonal Infection Prevention and Control Report – Winter
Presenting Officer:	Ali Strowman – Chief Nurse /Director of Infection Prevention and Control

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

Report Summary (including purpose and context):

This paper provides a summary of infection prevention and control activity between 1 October 2016 and 28 February 2017.

- There have been 6 attributable *Clostridium difficile* infections in the organisation breaching our target of no more than 5. Two Cases appear to be cross infection.
- 4 MRSA bacteraemias where KCHFT staff have provided care have been investigated in this time.
- Trust Compliance with hand hygiene training was reported as 87.7%, and mandatory training 95% in January. Compliance amongst clinical staff dropped to 84% for hand hygiene, but remained 95% for mandatory training.
- The Trust is currently achieving the planned reduction target of 5% in both CAUTI's, and UTI's.
- There were multiple 3 outbreaks of infection during this time.
- The Trust Occupational Health provider is currently completing the project to assess staff immunity status following transfer of data from the previous supplier.
- A decontamination assurance visit has been undertaken to IHSS by the Trust Independent Authorised Engineer and the Assistant Director of Infection Prevention and Control for KCHFT, with full compliance found.
- The Water Safety and antimicrobial stewardships committees continue to meet.
- The SEPSIS group is planning to roll out training and resources for identification of SEPSIS in April/May 2017.

The Board is also asked to receive the Trust's Infection Prevention and Control Declaration for 2016.

Proposals and /or Recommendations:
For assurance only

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

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

SEASONAL INFECTION PREVENTION AND CONTROL REPORT – WINTER

1. Introduction

The content of this report was presented and discussed at he Quality Committee on 7 March 2017.

2. Clostridium difficile

The Trust had a target of no more than 6 cases of *Clostridium difficile* infection in 2016/17 and no level 3 lapses in care – this was reduced to 5 when North Kent provision moved. The Trust has now breached this with 6 reported cases, 4 were identified in Heron Ward, 2 were deemed unavoidable; however 2 were reported in 3 days of each other, with the same ribotyping, highly suggestive of cross infection. An SI has been declared, a Period of increased incidence has also been declared, and a full investigation, and actions are currently underway. Full MVLA test results will provide absolute information on whether or not these cases were cross infection, which has been requested, however results may not be received for approximately 8 weeks.

3. MRSA

4 cases of MRSA bacteraemia have been investigated where KCHFT staff have provided care, 2 have not been attributed to KCHFT, and there were no lessons to be learned, 2 cases are still awaiting the full Post infection review meetings to be held, but are not expected to highlight issues for KCHFT.

4. Training

Trust Compliance with hand hygiene training was reported as 87.7%, and mandatory training 95% in January. Compliance amongst clinical staff dropped to 84% for hand hygiene, but remained 95% for mandatory training.

5. UTI's and CAUTI's

The target for 2016/2017 is to reduce both Hospital acquired CAUTI's and UTI's by 5% compared to 2015/16, therefore the target for the year is <131 UTI's and <25 CAUTI's to reflect the reduction in the second 2 quarters of inpatient beds by 1/3.

Overall we are currently on trajectory to achieve both targets, and have presented the work we have implemented at a national conference.

6. Incidents and Outbreaks

There were multiple outbreaks affecting our inpatient units over the winter months, closing many beds in the units. The IPC team plan to hold pre-outbreak season meetings in 2017 to try and plan for cohort bays in units going forward.

7. Occupational Health

Work is now ongoing with staff immunity status checks after transfer of information from the previous provider highlighted that limited information was available - HR are managing this contract and processes.

8. Decontamination

Lisa White and Bob Kingston (The Trust Independent Authorised Engineer for Decontamination) visited the two IHSS sites to complete independent audits and checks on 12/1/17 and found good compliance in both sites. A full report is awaited, and will be tabled here, and presented to the Medical Devices and Decontamination Committee.

The two dental services, returning to local reprocessing, plan to commence this towards the end of February 2017.

9. Water Safety Committee

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

10. Antimicrobial Stewardship

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

11. SEPSIS

The SEPSIS algorithms have been PILOTED in both Adult and Childrens services, and plan to launch the sepsis project in April/May dependent on resource availability.

12. Influenza Vaccination

The Trust Flu vaccination programme has now completed formal clinics. However ad hoc staff can still request vaccines. Total patient facing staff compliance reached 53%, our highest rate yet.

Lisa White
Assistant Director of Infection Prevention and Control
13 March 2017

INFECTION PREVENTION AND CONTROL DECLARATION DECEMBER 2016

The Board of Kent Community Health NHS Foundation Trust is assured that the following are in place, in line with the Hygiene Code.

- Kent Community Health NHS Foundation Trust meets statutory requirements in relation to the Hygiene Code.

- Kent Community Health NHS Foundation Trust has an Infection Prevention and Control strategy and policies in place to ensure best practice and to reduce HCAI's

- All staff within Kent Community Health NHS Foundation Trust are provided with infection prevention and control training on induction, and regularly through employment, which includes practical training and assessment in hand hygiene. The training is mandatory for all staff, and compliance is monitored centrally and reported to the Board.

- The Board level Executive Lead with the responsibility for infection prevention and control in Kent Community Health NHS Foundation Trust is the Chief Nurse/Director of Infection Prevention and Control (DIPC) ensuring that Infection Prevention and Control is prioritised on the quality agenda.

- Kent Community Health NHS Foundation Trust has an Infection Prevention and Control Team with responsibility for delivering the Infection Prevention and Control Strategy.

- Kent Community Health NHS Foundation Trust has a bi-monthly Infection Prevention and Control Committee which is chaired by the Chief Nurse/DIPC.

- There is an annual audit programme, to monitor compliance with the Infection Prevention and Control policies and guidelines.

- The Board reviews Infection Prevention and Control data across the organisation on a monthly basis, via the Performance Report. The Quality Committee receive a full report from the Assistant Director of Infection Prevention and Control quarterly which is then presented to the Board by the DIPC. The Trust Board receives an annual report on Infection Prevention and Control.

Ali Strowman
Chief Nurse
March 2017

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	3.3
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 October 2016 to March 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
	Email: kchft.speakup@nhs.net

Kent Community Health
NHS Foundation Trust

FREEDOM TO SPEAK UP GUARDIAN – REPORT OF FIRST SIX MONTHS
October 2016 to March 2017

1. Introduction

1.1 Appointing a Freedom to Speak Up Guardian in every NHS trust is one of the key actions recommended by Sir Robert Francis QC in his report 'Speaking Up' published in February 2015. It has also led to the setting up of a National Guardian Office and Dr Henrietta Hughes being appointed as National Guardian.

1.2 Sir Robert Francis QC has urged NHS Boards and managers to welcome staff raising concerns, in the same way as staff are encouraged to report incidents. Staff should still initially raise concerns with their manager or a more senior manager, but if this does not lead to an investigation or action or the staff member feels this will not due to previous experience or other concerns, they can contact the Freedom to Speak Up Guardian for advice and support. It's all about creating a more open culture that puts patient and staff safety at the heart of what we do.

1.3 No-one should experience discrimination or be victimised for speaking up, but we know fear of this can prevent staff from doing so. But it's the right thing to do for our patients. It's the right thing to do for our staff.

1.4 This report covers the period 1 October 2016 to 22 March 2017.

2. Summary of cases

2.1 Appendix 1 contains a summary of the seven cases dealt with to date. Three were informal and four required the FTSU Guardian to either escalate or support staff to escalate. There were two further cases received this week which are linked, but these have not been included as full details are not yet available. However they both concern a culture of bullying by a manager. The main themes of concerns raised to date are:

- Attitude and behaviour of managers – bullying culture
- Failure of middle managers to resolve concerns that are raised locally

3. Fostering a culture of openness

3.1 The Freedom to Speak Up Guardian has a key role in fostering a culture of openness. Sometimes this will mean highlighting what Sir Robert Francis refers to as "uncomfortable truths". However, if we don't know about staff's concerns we can't resolve them. Speaking up is always the right thing to do.

3.2 Staff who have sought advice from the FTSU Guardian generally express relief that they have been listened to. By being thanked for speaking up and by being assured that they will be supported, staff will begin to feel safer to speak up.

3.3 A number of staff who have raised concerns directly with the FTSU Guardian have asked to remain anonymous to the senior manager the issue is escalated to. Therefore the FTSU Guardian will be one of the few people to hold this information; which will never be shared without the staff members' express permission, except if there was a serious risk to patient or staff safety or required to do so by the police.

3.4 Speaking Up materials have been produced to promote the FTSU Guardian role and encourage staff to say something if they see something they feel isn't right. The Freedom to Speak Up policy extends to agency staff and to volunteers. There is a dedicated page on flo which will go live next week. Posters, postcards, business cards and badges are available with the FTSU Guardian phone number and email address. Examples of these materials will be available at the Board meeting. A slide on 'Speaking Up' is now included at corporate induction for new staff.

4. Recommendations

The Board is asked to note this report.

Karen Edmunds
Freedom to Speak Up Guardian
22 March 2017

Quarter concern raised in	Main theme of concern	How received	Directorate	Nature of concern	Action plan for responding	Progress/outcome/comments
Q3 16-17	1. Attitudes and behaviours	In person to FTSUG	Adults	Two team leaders concerned about management practices, including actions related to a SI investigation.	Staff fed back that day that they had met with the senior manager who had agreed to investigate. They are happy with this outcome.	FTSG advised staff to raise with Head of Service. Reassured them they were right to raise their concerns.
Q3 16-17	1. Attitudes and behaviours	Anonymous letter to CEO	Not known	Anonymous letter from staff member about admin reviews and admin staff not feeling valued.	CEO will include in blog when Speaking Up campaign is launched.	FTSUG advised to include response in CEOs blog about Speaking up.
Q3 16-17	1. Attitudes and behaviours	In person to FTSUG	Children and Young People	Concerns raised by students re: alleged bullying culture in a service. Issue raised with manager outside of the service who then sought advice from FTSUG.	Agreed can be dealt with informally at this stage. Practice Facilitator will gather further evidence, but will also discuss informally with Practice Teachers at their next forum. Once student has completed their study Practice Facilitator will support them to raise formally if they wish to.	FTSUG advised to deal with as a speaking up issue, but can be dealt with informally at this stage. It's about challenging and changing the culture that has developed in the service in relation to students and how they are managed.
Q3 16-17	1. Attitudes and behaviours	By email via staffside	Children and Young People	Staff member has raised a concern about the behaviour of a senior colleague, and subsequently about their manager's handling of the concern. Has escalated the concern a more senior manager and remains unhappy with the outcome.	FTSUG to discuss concerns with senior manager and agree a way forward.	FTSUG contacted senior manager by email on 21.12.16 asking to discuss the concerns, how they've handled the concerns and how the staff member feels about the lack of support. FTSUG spoke to senior by phone on 21.12.16. FTSUG assured there has been a robust investigation. Emailed staff member with conclusion. Followed up check they are ok. They replied to say managers being more supportive and they would not hesitate to raise a concern with FTSUG again and thanked for help.

Quarter concern raised in	Main theme of concern	How received	Directorate	Nature of concern	Action plan for responding	Progress/outcome/comments
Q3 16-17	5. Quality and safety	Email to FTSUG	Adults	Concerns raised in clinical supervision session about patient safety and management failure to address these concerns. Individuals involved may still be practicing.	As had been raised to CSD level, FTSUG advised staff member to approach Chief Nurse or Deputy Chief Nurse.	Deputy Chief Nurse will review specific cases. Will put in place a more robust framework regarding referrals to NMC, and all need to go through Chief Nurse in future. FTSUG suggested this case could be a case study to promote the benefits of speaking up. Deputy Chief Nurse agreed. 10.3.17 Emailed for an update. Staff member replied saying they have confidence in DCN who is looking into the concerns and staff member is grateful for the help.
Q4 16-17	4. Policies, procedures and processes	Email to FTSUG	Finance	Concern regarding inappropriate use of legacies, where the legacy has been left for a specific purpose but has been used to fund items or activities outside of the use stipulated.	As had been raised to Director level, FTSUG advised staff member to raise with CEO. Staff member reluctant to raise direct and asked FTSUG to raise on their behalf.	CEO appointed Director of Finance to investigate. On 17.3.17 staff member received letter by email with outcome of investigation which founds that funds had not be allocated correctly. This has been rectified and CEO is assured it will not happen again. Staff member is happy with this outcome.
Q4 16-17	6. Patient experience	Email to FTSUG	Adult Specialist Services	Concern regarding lack of receptionist at Lymphoedema and Podiatry clinics. Staff are concerned for safety of vulnerable patients. Staff are worried that nothing is being done to improve the patient experience. Staff have raised with managers. No resolution found despite ideas to resolve being suggested by Health, Safety and Security.	As staff wish to remain anonymous, FTSUG agreed with staff that she'd raise it with the Assistant Director with responsibility for both services.	FTSUG emailed Assistant Director with outline of issues. Explained concern was raised anonymously and that whilst solutions had been proposed by Health & Safety and Security these had not yet been acted upon by the services. Assistant Director will investigate. In meantime they will look into the possibility of volunteers to 'meet and greet' patients.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	30 March 2017
Agenda Item:	3.4
Subject:	Annual Use of Trust Seal Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context):
To update the Board on the use of the Trust Seal, submit the Register of Sealings for the period April 2016 to March 2017.

Proposals and /or Recommendations:
The Board accepts the record at Appendix 1 as a true representation of the Register of Sealings for the period April 2016 to March 2017.

Relevant Legislation and Source Documents:
Has an Equality Analysis been completed?
No. High level report and no decision required.

Gina Baines, Assistant Trust Secretary	Tel: 01622 211906
	Email: gina.baines@kentcht.nhs.uk

Kent Community Health
NHS Foundation Trust

ANNUAL USE OF TRUST SEAL REPORT

1. Introduction

The purpose of this report is to update the Board on the use of the Trust Seal and show the Trust's Register of Sealings from April 2016 to March 2017.

2. Background

Best practice for Governance and Assurance requires that a record is maintained detailing those occasions when the official Seal of the Trust is fixed to documents. It also requires that a report of all such Sealings should be made to the Board at least annually, together with details of signatories. Appended to this report is the register of all occasions in which the Trust Seal has been applied to documents, together with the Officer/s Attesting the Sealing and to whom the document was disposed. In accordance with best practice this record is presented for information.

3. Recommendation

It is proposed that the Board accepts the record at Appendix 1 as a true Register of Sealings for the period April 2016 to March 2017 (inclusive).

Gina Baines
Assistant Trust Secretary
22 March 2017

Kent Community Health NHS
NHS Foundation Trust

The Register of the Trust Seal 2016/17

No	Date of Sealing	No of copies sealed	Description of Document	Parties	Relating to	Names of persons attesting sealing	How document disposed of
Lease	07.06.2016	1	Lease	Colsilverbird A S.A.R.L and Kent Community Health NHS Foundation Trust	Unit J Concept Court Shearway Business Park, Folkestone CT19 4RH	Gordon Flack (Director of Finance) Nicky Lucey (Director of Nursing and Quality	Documents returned to Interim Property Lease Manager 07.06.2016
Licence for Alterations	07.06.2017	1	Licence for Alterations	Colsilverbird A S.A.R.L and Kent Community Health NHS Foundation Trust	Unit J Concept Court Shearway Business Park, Folkestone CT19 4RH	Gordon Flack (Director of Finance) Nicky Lucey (Director of Nursing and Quality	Documents returned to Interim Property Lease Manager 07.06.2016
*Resealing							
Lease*	16.06.2016	1	Lease	Colsilverbird A S.A.R.L and Kent Community Health NHS Foundation Trust	Unit J Concept Court Shearway Business Park, Folkestone CT19 4RH	Gordon Flack (Director of Finance) Louise Norris (Director of Workforce, OD and Communications)	Documents returned to Head of Legal KCHFT 16.06.2016
Licence for Alterations*	16.06.2016	1	Licence for Alterations	Colsilverbird A S.A.R.L and Kent Community Health NHS Foundation Trust	Unit J Concept Court Shearway Business Park, Folkestone CT19 4RH	Gordon Flack (Director of Finance) Louise Norris (Director of Workforce, OD and Communications)	Documents returned to Head of Legal KCHFT 16.06.2016
Licence	20.09.2016	1	Licence	Asset Sky Limited; Medway Council and Kent Community Health NHS Foundation Trust	Ground Floor Unit, Clover Street, Chatham, Kent E4 4DT	Lesley Strong (Deputy Chief Executive) Claire Poole, Acting Director of Operations, Children and Young People	Documents returned to Bevan Brittan, Fleet Place House London - special delivery

Sublease	20.09.2016	1	Sublease	Medway Council and Kent Community Health NHS Foundation Trust	4 Clover Street, Chatham, Kent ME4 4DT	Lesley Strong (Deputy Chief Executive) Claire Poole, Acting Director of Operations, Children and Young People	Documents returned to Bevan Brittan, Fleet Place House London - special delivery
Lease	22.09.2016	1	Lease	Mardan (Norwich) Ltd and Kent Community Health NHS Foundation Trust	Offices on First Floor, Joynes House, New Road, Gravsend, Kent	Lesley Strong (Deputy Chief Executive) Ruth Herron (Acting Director of Nursing and Quality)	Documents returned to Bevan Brittan, Fleet Place House London - special delivery
Lease	29.11.2016	1	Lease	George Archibald Wilson Kent Community Health NHS Trust	Car Park at Plot 6, Lakes View International Business Park, Island Road, hersden, Canterbury	Lesley Strong (Deputy Chief Executive) Gordon Flack (Director of Finance)	Documents returned to Bevan Brittan, Birmingham - special delivery
Lease	12.12.2016	1	Lease	Northdown One Management Company Limited, Heref Regional Limited and Kent Community NHS Foundation Trust	110 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP
Lease	12.12.2016	1	Lease	Northdown One Management Company Limited, Heref Regional Limited and Kent Community NHS Foundation Trust	120 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP
Deed of Surrender	12.12.2016	1	Deed of Surrender	Northdown One Management Company Limited, Heref Regional Limited and Kent Community NHS Foundation Trust	110 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP
Deed of Surrender	12.12.2016	1	Deed of Surrender	Northdown One Management Company Limited, Heref Regional Limited and Kent Community NHS Foundation Trust	120 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP
TR1	12.12.2016	1	Land Registry Transfer of Whole of Registered Title(s) TR1	Heref Regional Ltd and Kent Community NHS Foundation Trust	110 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP
TR1	12.12.2016	1	Land Registry Transfer of Whole of Registered Title(s) TR1	Heref Regional Ltd and Kent Community NHS Foundation Trust	120 Eureka Park, Ashford, Kent, TN25 4AZ	Gordon Flack (Director of Finance) Ali Strowman (Chief Nurse)	Documents returned to Capsticks Solicitors LLP

Lease	23.02.2017	1	Lease	Discovery Park Ltd and Kent Community Health NHS Foundation Trust	Warehouse C, Building 819, Discovery Park, Sandwich, Kent	Gordon Flack (Director of Finance); Louise Norris (Director of Workforce, OD and Communications)	Document returned by special delivery to Captsticks 1 St Georges Road London SW19 4DR
Lease	21.03.2017	1	Lease	Michael and Caroline Deer and Kent Community Health NHS Foundation Trust	7 Church Hill, Ramsgate	Ali Strowman (Chief Nurse) and Paul Bentley (Chief Executive)	Documents returned to Bevan Brittan 2 Fleet Place Holborn Viaduct London EC4M 7RF
Lease	21.03.2017	1	Lease	Community Health Partnerships Ltd and Kent Community Health NHS Foundation Trust Medway Community Estates Ltd	Lordswood Community Health Living Centre Sultan Road Lordswood ME5 8TJ	Ali Strowman (Chief Nurse) and Paul Bentley (Chief Executive)	Documents returned to Estates Team KCHFT Trinity House Ashford

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 30 March 2017
in Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling Kent
ME19 4LZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Chairman	
1.2	To receive any Apologies for Absence	Chairman	
1.3	To receive any Declarations of Interest	Chairman	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 26 January 2017	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 26 January 2017	Chairman	
1.6	To receive the Chairman's Report	Chairman	Verbal
1.7	To receive the Chief Executive's Report	Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Quality Committee Chairman's Assurance Report	Chairman, Quality Committee	

2.2	To receive the Audit and Risk Committee Chairman's Assurance Report	Chairman, Audit and Risk Committee
2.3	To receive the Charitable Funds Committee Chairman's Assurance Report	Chairman, Charitable Funds Committee
2.4	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/Deputy Chief Executive Chief Nurse
2.5	To receive the Finance Report – Month 11	Director of Finance
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To receive the Quality Report	Chief Nurse
2.8	To approve the 2017/18 Finance Plan • Final Revenue and Capital Budgets 2017/18 • Operating Plan • 2017/18 Cost Improvement Programme	Director of Finance Chief Operating Officer/Deputy Chief Executive
2.9	To receive the 2016 Staff Survey Report	Director of Workforce, Organisational Development and Communications
2.10	To receive the Kent and Medway Sustainability and Transformation Plan Update Report	Chief Executive
2.11	To approve the People Strategy	Director of Workforce, Organisational Development and Communications

Kent Community Health NHS Foundation Trust

2.12	To approve the Risk Management Strategy	Corporate Services Director
2.13	Ratification of Policies • Professional Registration Policy • Annual Leave Policy • Annualised Hours Guidance • Probationary Period Policy • Ordinary Parental Leave Policy • Shared Parental Leave Policy • Maternity and Maternity Support Parental Leave Policy • Adoption/Surrogacy Leave Policy • Disciplinary Procedure Review Policy	Director of Workforce, Organisational Development and Communications

3. REPORTS TO THE BOARD

3.1	To receive the Quarterly Patient Experience Exception Report	Chief Nurse
3.2	To receive the Seasonal Infection Prevention and Control Report – Winter • Infection Prevention and Control Declaration – December 2016	Chief Nurse
3.3	To receive the Six Monthly Freedom to Speak Up Guardian's Report	Director of Workforce, Organisational Development and Communications
3.4	To receive the Annual Use of Trust Seal 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

Kent Community Health
NHS Foundation Trust

6. DATE AND VENUE OF NEXT MEETING

Thursday 25 May 2017 Room 6 and 7 Trinity House, 110-120 Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ