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 29 March 2018

In

The Oak Room
Oakwood House
Maidstone
Kent
ME16 8AE

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 29 March 2018
The Oak Room, Oakwood House, Maidstone Kent
ME16 8AE

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 25 January 2018	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 25 January 2018	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 Patient Story	Chief Nurse	
2.2	To receive the Quality Committee Chair's Assurance Report • Annual Infection Prevention and Control Declaration	Chair of Quality Committee	

2.3	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee
2.4	To receive the Charitable Funds Committee Chair's Assurance Report	Deputy Chair of Charitable Funds Committee
2.5	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive Chief Nurse
2.8	To receive the Monthly Quality Report	Chief Nurse
2.9	To receive the Finance Report Month Eleven	Director of Finance
2.10	To approve the 2018/19 Finance Plan • Final Revenue and Capital Budgets 2018/19 • Capital Plan 2018/19	Director of Finance
2.11	To approve the Standing Financial Instructions	Director of Finance

3. REPORTS TO THE BOARD

3.1	To receive the approved Minutes of the Charitable Funds Committee meeting of 25 October 2017	Deputy Chair of the Charitable Funds Committee
3.2	To receive the Quarterly Infection Prevention and Control Report	Chief Nurse
3.3	To receive the Quarterly Patient Experience Report	Chief Nurse

Kent Community Health NHS Foundation Trust

3.4	To receive the Risk Management Strategy	Corporate Services Director
3.5	To receive the Use Of The 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 24 May 2018
Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

Kent Community Health
NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10am on Thursday 25 January 2018
in The Council Chamber, Sevenoaks Town Council Offices, Bradbourne Vale Road, Sevenoaks Kent TN13 3QG

Meeting held in Public

Present:	David Griffiths, Chairman Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Gordon Flack, Director of Finance Steve Howe, Non-Executive Director Louise Norris, Director of Workforce, Organisational Development and Communications Dr Sarah Phillips, Medical Director Lesley Strong, Deputy Chief Executive/Chief Operating Officer Jennifer Tippin, Non-Executive Director
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Corporate Services Director

25/01/1 **Introduction by Chair**

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

25/01/2 **Apologies for Absence**

Apologies were received from Peter Conway, Non-Executive Director, Richard Field, Non-Executive Director, Bridget Skelton, Non-Executive Director and Ali Strowman, Chief Nurse.

The meeting was quorate.

25/01/3 **Declarations of Interest**

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

25/01/4 **Minutes of the Meeting of 30 November 2017**

The Board **AGREED** the minutes.

25/01/5 **Matters Arising from the Meeting of 30 November 2017**

The Board **RECEIVED** the Matters Arising.

25/01/6 **Chairman's Report**

Mr Griffiths confirmed that he and other members of the Board had met with senior members of Kent County Council (KCC) to discuss the work they were jointly undertaking in the public health arena. A positive, working relationship was developing which was welcomed.

Mr Griffiths had visited the East Sussex Children's Integrated Therapy and Equipment Service and School Health Services. He had received a warm response from the teams who had told him how much they enjoyed being part of the Trust.

Mr Griffiths announced that he would be retiring as Chairman of the Trust. Although the date for this was yet to be confirmed, the process to recruit his successor was underway.

The Board **RECEIVED** the Chairman's verbal report.

25/01/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

In response to a question from Mr Griffiths regarding whether the Trust could complete its flu vaccination programme using the quadrivalent influenza vaccine rather than the trivalent flu vaccine, Dr Phillips indicated that the former had not been recommended centrally and that the vaccination programme would continue to use the trivalent flu vaccination.

Members of the Board supported Mr Bentley's suggestion that the mandatory vaccination of healthcare workers against influenza should be lobbied for in future years.

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

25/01/8 **Chief Operating Officer's Winter Report**

Ms Strong presented the report to the Board for assurance.

In response to a question from Mr Howe regarding whether there had been opportunities for admission avoidance, Ms Strong indicated that there had been. Therapists had been assigned to A&E departments to sign post appropriate patients to more appropriate services. With regards to the provision of step-up beds, although the community hospitals could take these referrals from GPs, there was little opportunity to do this because of the high level of patient flows from the acute hospitals.

In response to a question from Mr Griffiths as to whether there were any further contingency plans to manage the winter pressures, Ms Strong explained that additional escalation beds were still being opened at sites including Sheppey Community Hospital. The Trust was managing this particular ward as other local providers had been unable to assist. The ward would be staffed with agency staff, but to ensure Trust standards were maintained on the unit, some Trust staff would be transferred on a temporary basis. The Care Quality Commission (CQC) had been notified and the service had been registered.

In response to a question from Ms Barber regarding the provision of seven day therapy in the community hospitals, Ms Strong confirmed that the winter pressures on the system had prevented this from being provided. She suggested that once the pressures eased, there would be an opportunity to reflect both internally and as a whole system on the impact the pressures had had on services. This would include the seven day therapy provision in community hospitals.

The Board thanked all the staff for the dedicated work they had undertaken as part of the system response to the winter pressures on services.

The Board **RECEIVED** the Chief Operating Officer's Winter Report.

25/01/9 **Patient Story**

Ms Norris presented the video to the Board for assurance.

In response to a question from Mr Griffiths regarding how many families were supported by the Trust's Home-based Short Breaks Service, it was agreed that this would confirmed.
Action – Ms Strong

In response to a question from Dr Phillips regarding the location of the supported families in east and west Kent, it was agreed that this would be confirmed along with the structure of the team.
Action – Ms Strong

It was agreed to confirm if there were any other similar services offered by the Trust.
Action – Ms Strong

The Board **RECEIVED** the Patient's Story.

25/01/10 **Quality Committee Chair's Assurance Report**

Mr Howe presented the report to the Board for assurance.

The Committee had met on 11 December 2017. The new meeting structure was beginning to make a real difference in providing assurance to the Committee. Ms Barber confirmed that she had observed the new Local Safety Standards for Invasive Procedures (LocSSIP) process in action

when she had visited the London Dental Service and was confident that it was being well used.

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

25/01/11 **Strategic Workforce Committee Chair's Assurance Report**

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

The Committee had met on 23 January 2018. A range of topics had been discussed. Although this was only the second time that the Committee had met, it was bedding in well and tackling some challenging issues.

The Board **RECEIVED** the Strategic Workforce Committee Chair's Assurance Report.

25/01/12 **Charitable Funds Committee Chair's Assurance Report**

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

The Committee had met that morning. The 2016/17 Annual Report and Accounts had been approved. The accounts had reported an annual reduction in the closing balance of the unrestricted funds. No legacies had been received. It had previously been agreed to invest in raising more funds to boost the unrestricted fund. This was taking longer to gain results than originally estimated and the Committee would review whether to continue investing in this support at its next meeting.

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

25/01/13 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

In response to a question from Ms Barber regarding what strategies were being put in place to improve the number of patient survey returns in the community hospitals and minor injuries units, Ms Strong indicated that this was being addressed with those services through their monthly performance reviews.

In response to a question from Ms Barber regarding what learning had been taken from the improved performance for Delayed Transfers of Care (DToC) in west Kent compared to east Kent, Ms Strong commented that a discharge co-ordinator had been appointed in west Kent. In east Kent, a similar appointment had been made but this was more recent and it had been too early for this second appointment to influence the reported performance. Services in east Kent were caring for a greater number of patients with dementia compared to west Kent and this was an influencing factor.

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

25/01/14 **Monthly Quality Report**

Ms Norris presented the report to the Board for assurance.

In response to a question from Ms Tippin regarding why the annual target for implemented clinical audit recommendations was 95 per cent and not 100 per cent, Ms Davies commented that this had been discussed by the Audit and Risk Committee. It had been recognised that the outstanding five per cent reflected that some recommendations were no longer relevant. Mr Griffiths suggested that a redefinition was required such that 100 per cent were actioned or deemed no longer relevant. It was agreed to inform Ms Strowman of the suggested redefinition.
Action – Dr Phillips

It was agreed that the Clinical Effectiveness Group would scrutinise current reported clinical audit performance and report its findings to the Quality Committee.
Action – Dr Phillips

Following a comment from Dr Phillips that clinical audit performance had improved following the introduction of a new recording template, Ms Barber confirmed that she had observed this when she had attended an Audit meeting recently.

In response to a question from Ms Tippin regarding whether all the clinical audit actions had been completed the previous year, it was agreed that this would be investigated.
Action – Dr Phillips

Mr Howe confirmed that he had written to the Governors who had asked for assurance regarding the recent number of reported medical administration incidents.

In response to a question from Ms Barber regarding the reliability of the patient call bells in the community hospitals, Ms Davies confirmed that there was a capital programme underway to improve the performance and reliability of the call bells in all of the Trust's community hospitals. With regards to the current contingency measures, it was agreed that Ms Strowman would be asked to confirm this.
Action – Ms Strong

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

25/01/15 **Finance Report (Month 9)**

Mr Flack presented the report to the Board for assurance.

Mr Flack highlighted the dispute issues that the Trust was currently experiencing with the clinical commissioning groups (CCGs). Although one

had been resolved, the other was still in mediation.

Mr Griffiths commented that the Board welcomed that the Trust's strong financial position was being used to clear the backlogs in some services.

The Board **RECEIVED** the Finance Report.

25/01/16 **Workforce Report**

Ms Norris presented the report to the Board for assurance.

The report would be republished to clarify a number of points.
Action – Ms Norris

Ms Tippin put forward a number of questions with regards to the upward trajectory for turnover as it signalled to her various issues for the Trust. In response to her question as to whether the Trust was carrying out scenario planning, Ms Norris indicated that different services had different issues which triggered turnover. It was important to distinguish between planned and unplanned leavers. The Trust needed to particularly tackle the latter. NHS Improvement (NHSI) had recently published guidance on reducing turnover and its recommendations were being reviewed. Mr Bentley added that the Trust had recently authorised the recruitment of fifty non-registered generic workers and a number had been appointed. There was evidence that turnover was having an impact on patient experience. With regards to mitigations and actions, a lifting of the pay cap would be welcome. Further applications of new technology could also ease the pressure on maintaining current staffing levels. With regards to scenario planning, it was suggested that this would be undertaken by the Strategic Workforce Committee. Ms Strong highlighted that this Committee had discussed the apprenticeship scheme for nurses.

In response to a comment from Ms Barber regarding whether the Trust had a strategy in place to address turnover, Ms Norris highlighted the People Strategy which had previously been approved by the Board. Its supporting action plan which set out timescales and targets had been agreed by the Strategic Workforce Committee that week. An update on its progress would be provided at the next Committee meeting in March 2018.

Dr Phillips suggested that there was evidence that a Quality Improvement programme had a positive impact on staff experience at work and this could lead to staff achieving a better work/life balance.

The Board **RECEIVED** the Workforce Report.

25/01/17 **Safer Staffing Review**

Ms Norris presented the report to the Board for approval.

The Board **APPROVED** the recommendations set out in the Safer Staffing Review.

25/01/18 **Mortality and Learning From Deaths Report**

Dr Phillips explained the process for Mortality reporting.

As the paper had not been circulated formally to the Board, Mr Griffiths suggested that it was received at the March 2018 Public Board meeting. It was agreed that, in the meantime, the Quarter Three data would be published on the Trust's public website following scrutiny by the Mortality Surveillance Group.
Action – Dr Phillips

The Board **RECEIVED** the Mortality and Learning From Deaths Report.

25/01/19 **Half Yearly CQUIN Programme 2017/19 Report**

Mr Flack presented the report to the Board for assurance.

In response to a question from Mr Howe regarding the Trust's current performance against the wound assessment CQUIN Indicator, Mr Flack explained that there had been some teething problems with the new Wound Matrix software. The issues had been identified and addressed and an improvement in performance was expected.

In response to a comment from Mr Griffiths regarding the number of Amber ratings in the report, Mr Flack highlighted that all the indicators were being monitored closely and actioned where possible. He expected the Trust's position to recover by year end.

The Board **RECEIVED** the Half Yearly CQUIN Programme 2017/19 Report.

25/01/20 **Any Other Business**

There was no further business to discuss.

25/01/21 **Questions from members of the public relating to the agenda**

There were no questions from the public.

The meeting closed at 11.35am.

25/01/22 **Date and Venue of the Next Meeting**

Thursday 29 March 2018; The Oak Room, Oakwood House, Maidstone Kent ME16 8AE

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 25 JANUARY 2018 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Patient Story	To confirm the number of families that were supported by the Trust's Home-based Short Breaks Service.	Ms Strong	Home based short breaks are only offered in the East of Kent and are proportionate to the funding provided by each CCG. Currently we are supporting 24 families of children that are under the age of 5. Children above this age are in school and have access to residential respite services, which are an integrated provision between KCC/KCHFT across 5 units in Kent.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Patient Story	To confirm the location of families across east and west Kent, along with the structure of the team. To confirm if there were any other similar services offered by the Trust.	Ms Strong	The HCA's that provide home based short breaks are also linked to the residential units (hub and spoke model) and this gives continuity for the children and their families and supports transition. In terms of structure, the homebased short breaks service is led by a band 7 children's nurse who undertakes the assessment and reviews of children on the caseload and works to match the HCA support worker to each family. In addition the band 7 nurse line manages our practice educators working within the residential units, thus strengthening the hub and spoke provision. The homebased HCA support workers are band 3's who have had additional training to become competent in delivering support to children with complex needs include enteral feeding, suctioning, tracheostomy care etc.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Monthly Quality Report	• To inform Ms Strowman to redefine the annual target relating to clinical audit recommendations to be implemented within the report. • For the Clinical Effectiveness Group to scrutinise the current reported performance of clinical audit and report its findings to the Quality Committee. • To investigate whether all the clinical audit actions had been completed the previous year.	Dr Phillips	Ms Strowman has confirmed that the Monthly Quality Report has been changed to reflect this until the audit issue has been resolved within the team.
Monthly Quality Report	To ask Ms Strowman to confirm the current contingency measures that were in place regarding the call bells in the community hospitals.	Ms Strowman	Call bell issues are treated as a P1 request with NHS Property Services for repair. There is a planned replacement cycle for all call bell systems in community hospitals, due to commence post winter.
Workforce Report	To republish the Workforce Report.	Ms Norris	Action complete.
Mortality and Learning From Deaths Report	To publish the Quarter Three data on the Trust's public website following scrutiny by the Mortality Surveillance Group.	Dr Phillips	Action complete

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
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
To note the report.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No. High level position described and no decisions required. The paper has no impact on people with any of the nine protected characteristics*.
*** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.

Paul Bentley, Chief Executive	Tel: 01622 211903
	Email: p.bentley@nhs.net

Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
MARCH 2018

As previously I wanted to highlight to the Board the following significant developments since my last formal report during the Board meeting in January 2018, my regular practice is to categorise the report into patients, our staff and partnership.

Staff

1. Going above and beyond during winter

NHS heroes – never was there a truer description of #TeamKCHFT than during this winter – with two bouts of snow and a water shortage, due to numerous burst pipes.

Walking miles in the snow to see patients, sharing lifts and 4x4s to get into work, camping out at our hospitals or clinics, coming in on their days off and working in places other than their usual bases, their efforts were astounding.

Whether it's been to reach children needing chemotherapy or seeing some of our elderly, they showed true grit and determination and, what I am most proud of, real camaraderie and team work as we all pulled together to provide the best care for our most vulnerable patients.

Clinical or corporate, everyone played their part and should be congratulated for their efforts.

2. Being the best employer

When compared with 17 other community trusts across the country, our Staff Survey Result were positive, but I want us to be better for our staff.

The Trust Board takes the Staff Survey feedback as an absolute priority and we will be taking action. I'm disappointed that some of the steps we have taken to improve things haven't had more of a positive impact for our exceptional workforce.

One of things we have done already this month is launch a new talent pool to support the development of exceptional colleagues in their careers. It's part of our commitment to make KCHFT the best employer.

We are looking to develop a pool of people who will be ready for their next career move in the next 12 months, so we can provide them with development options to help them reach that stage and improve the quality of care we provide.

3. Our quality strategy

The Quality Strategy has been published and is available on our website. It lays out how we will meet our quality objectives until 2020 and our approach to the quadruple aim. In March, more than 100 of our senior leaders came together for out conference to discuss our priorities and how we move from quality assurance to quality improvement.

Partnerships

1. New medical school for Kent and Medway

KCHFT welcomes the announcement of a new medical school for Kent and Medway.

The bid for a medical school was submitted by Canterbury Christ Church University and the University of Kent in November and the announcement was made by the Higher Education Funding Council for England and Health Education England on 20 March.

It will be the county's first ever medical school, bringing together the existing centres of excellence in health and medical education provided by the two universities, and local healthcare organisations, to offer a new model of patient-focused medical education. The emphasis on ensuring students undertake placements outside of acute hospitals in the early years of their education is to the highlighted and welcomed.

2. Bringing Buurtzorg to Kent and Medway

KCHFT is delighted to be working with Kent County Council and Medway Community Healthcare on a four-year research project to transform the delivery of community care, guided by the principles of Buurtzorg.

The UK is one of three countries – including France and Belgium – taking part. The project has been approved and funded by the Interreg 2 Seas Programme 2014 – 2020 (co-funded by the European Regional Development Fund).

Transforming Integrated Care in the Community (TICC) hopes to provide a

solution to some of the clinical, social and financial challenges associated with our ageing population, budget pressures and our workforce.

Kent and Medway will be starting with three pilots sites in Edenbridge, Canterbury/Ashford and in Medway.

Buurtzorg is a nurse-led model of holistic care that revolutionised community care in the Netherlands. The model was founded in 2007 by Jos de Blok starting with one team of four nurses increasing to 850 Buurtzorg teams within 10 years. One of the models defining features is that the nursing teams self-manage.

The model has been successful in the Netherlands with the highest client and staff satisfaction rates, and generating savings of 40 per cent to the Dutch healthcare system. Despite the success of the Buurtzorg model in the Netherlands it has not been successfully replicated in other countries, which this project will look to address.

3. Alliance Agreement for Learning Disability across Kent

KCHFT has signed an alliance agreement along with Kent County Council and Kent and Medway NHS and Social Care Partnership Trust to provide Learning disabilities services across Kent.

Patients

1. Health visitors to provide infant feeding support model

Kent County Council has commissioned our Health Visiting Service to deliver infant feeding support, including breastfeeding, as part of the Healthy Child Programme.

This builds on work we already do and provides an opportunity for us to improve our offer to families, as health visiting is a universal service available to every family with a child of pre-school age.

The service visits 96 per cent of new births in Kent - seeing 17,298 women and their babies. Jinny Robinson, Clinical Services Manager for Public Health Services will be working with Irene Sanyauke, Head of Health Visiting and Family Nurse Partnership and key service leads to oversee the transition to the new model.

2. ChatHealth launched in Kent

A text service for young people aged 11-to-19-years-old launched in March. Following the success of ChatHealth in our East Sussex work, Kent School Health Service has now adopted the scheme, which offers a confidential text message service for young people to contact a school nurse with any health questions or concerns.

We want to give young people the opportunity to get in touch in as many ways as possible. ChatHealth has a proven track record and we can help with any concerns they may have such as, stress, sexual health, feelings of depression or anxiety and healthy lifestyle advice.

Paul Bentley
Chief Executive
March 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.2
Subject:	Quality Committee Chair's Assurance Report
Presenting Officer:	Steve Howe, Chair of the Quality Committee

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context):
The paper summarises the Quality Committee meetings held on 2 and 20 February and 20 March 2018.

Proposals and /or Recommendations:
The Board is asked to receive the Quality Committee Chair'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 CHAIR'S ASSURANCE REPORT FOLLOWING THE FEBRUARY AND MARCH MEETINGS 2018

Introduction

The Quality Committee met on 20 February and 20 March 2018.

Sub-Committees

Assurance reports were received from Patient Safety and Clinical Risk Group (PSCRG), the Patient Experience Group (PEG) and the Clinical Effectiveness Group (CEG).

Staffing

The current position regarding clinical staff turnover and vacancies coupled with an apparent rise in reported Serious Incidents (SIs), over the reported period, continues to give rise for concern and will be closely monitored for impact on quality and safety.

Mortality Report

The Committee received assurance that the new processes being implemented to review mortality within community hospitals were in line with national guidance and that a focus was to be placed on learning that came from these reviews.

Non-Attributable Pressure Ulcers

The Committee had requested an assurance report regarding the classification and monitoring of pressure ulcers classified as non-attributable. It is of note that in the period April 2016 to January 2017, the Trust classified 3440 pressure ulcers (the largest component being Category 2) as non-attributable and over the same period 2017/18 there were 3232. Unavoidable pressure ulcer harms are determined when the following information has been evidenced:

- All risk assessments have been completed and monitored
- Patient information has been shared
- Pressure ulcer prevention strategies considered and acted upon
- Education of patient/carer
- Risks of non-concordance explained.

The Head of Tissue Viability conducts deep dives and reviews to ensure that the Trust is compliant with internal policy and NHS guidance and all serious harms reported as unavoidable are reviewed by the Serious Incident Team. The Committee was assured that all unavoidable harms that were reviewed had been reported accurately.

Local Safety Standards in Invasive Procedure (LocSSIP)

The Managing Director of Dental Services briefed the Committee on the actions that had been put in place following the never event and serious incident involved in the wrong identification and extraction of teeth. The Committee was assured that the introduction of revised evidence-based policies and protocols coupled with staff training and improved clinical line management would greatly reduce the likelihood of similar errors occurring in the future. The Committee ratified the Local Policy for Clinical Dental Care. Non-Executives have been invited to take part in a visit/deep dive to confirm best practice is being followed and close this item which had been of concern to the Board.

Chaperone Policy

Following two recent Serious Incidents, confirmation was sought that the Trust's Chaperone Policy remained fit for purpose. Assurance was provided by the Chief Nurse.

Patient Experience

It was pleasing to note that some 5,280 Meridian surveys were completed in January 2018 with a strong combined satisfaction score of 97.05%.

Infection Prevention and Control Declaration 2018

The Committee received the quarterly Infection Prevention and Control (IPC) Report for assurance and reviewed the annual IPC Declaration on behalf of the Board (included with the Board papers). It is recommended that the Board endorses this declaration.

End of Life Care Progress Report

The End of Life Consultant prepared a progress report to coincide with the end of her tenure. This highlighted progress that the Trust has made in palliative and end of life care. It is noted that the Trust can now evidence quality improvement in all measured areas.

Medical Devices

The issue of audit of maintenance of medical devices was referred to the Committee for review and monitoring by the Audit and Risk Committee.

- The key issue seems to be one of recording maintenance on ILeader rather than maintenance not being conducted appropriately. A total of 2727 out of 10757 are currently shown as 'out of date' on the system.
- Assurance has been given that reports from teams, deep dives and random spot checks have not identified equipment that is in use inappropriately.
- The action plan requires the recruitment of an additional Band 2 member of staff to input data onto ILeader giving priority to High Risk devices such as syringe drivers and suction unit.

- Procurement of a new records system for EME devices is to be given priority.

We Care Visits

Initial reports on We care Visits are highlighting the value of this process. It is noted that further work is required to improve the understanding of self-assessment. Early evidence shows staff concerns about staffing levels, the Community Information System (CIS) and working environment. While notable practice includes learning culture and end of life care.

SC Howe CBE
Chair, Quality Committee
21 March 2018

Kent Community Health NHS Foundation Trust

INFECTION PREVENTION AND CONTROL DECLARATION 2018

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 policy 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 Work plan

- Kent Community Health NHS Foundation Trust has a bi-monthly Infection Prevention and Control Sub 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 receives 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.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.3
Subject:	Audit and Risk Committee Chair'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 2018.

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 CHAIR'S ASSURANCE REPORT

The Audit and Risk Committee (ARAC) meeting was held on 15 February 2018.

The Committee received positive assurance on:

Area	Assurance
Board Assurance Framework (BAF)	The BAF captures the key risks. More focus needed on timeliness and relevance of actions
Internal Audit	''Reasonable Assurance'' reports received on 1) Pressure Ulcers (that processes are effective to help minimise reported incidents) 2) Cost Improvement Plans (that effective governance arrangements are in place for both management and delivery). 3) Business Intelligence Reporting (that an information architecture is in place and widely adopted). Emerging risks from TIAA's wider work - all have been or are being addressed. One outstanding ''urgent'' recommendation regarding Data Quality of KPIs audit. This was delayed for CIS scoping. No longer applicable so outstanding audit work to re-commence as soon as possible. TIAA tender across Kent Community Health NHS Foundation Trust (KCHFT) – Maidstone and Tunbridge Wells NHS Trust (MTW) – Kent and Medway Partnership Trust (KMPT) agreed. Underpinning plan for 2018/19 to be circulated out of committee and agreed at next meeting.
Counter Fraud	Good grip on proactive and reactive work. KCHFT benchmarks well to TIAA's ''Cross Trust Review of Single Tender Waivers''. 2018/19 Plan agreed.
External Audit	Audit Plan for year end March 2018 agreed. There are no significant changes in process nor reporting requirements from last year.
Clinical Audit	85% of audit recommendations completed (target 90%). Since last ARAC, two audits with limited assurance. Remediation of both on track. Quality Improvement aspects of Clinical Audit being considered in conjunction with the East London Trust.

Area	Assurance
Clinical Audit (continued)	Dawn is also convening a working group to consider CIS potential.
Cyber Security	Positive assurance received across the whole of the agreed action plan including third party suppliers and where third parties connect into the KCHFT network.
Dental	Deep dive undertaken of Dental Risk Register. Positive assurance received.
Legal Services	Good management of all aspects of clinical and non-clinical negligence claims, inquests, coroners' reports, Health and Safety Executive (HSE) reporting, commercial claims and property related incidents.
Risks in Partnership Working	Useful scoping/discussion paper covering the Partnership Framework with Kent County Council (KCC). With one or two additions/tweaks, it is a useful template to consider potential partnership risks arising in other areas.
Standards of Business Conduct	Comprehensive and satisfactory.
General Data Protection Regulation (GDPR)	Positive assurance received that the Trust will be ready for 25 May 2018. Further work will be required after this date as greater clarity/guidance is received.
Finance (various)	Satisfactory reports for Single Tender Waivers, Retrospective Requisitions, Losses and Special Payments and Annual Accounting Policies Review (no proposed changes).

Areas for concern and/or where the Committee need further assurance:

Area	Assurance	Next Steps
Sustainability Strategy and Action Plan	Greater specificity and focus needed. Proposed targets in line with wider NHS targets. Management Committee is guiding the content of the Sustainability Report in the Annual Report and Accounts.	Updated and refined action plan to be submitted to Management Committee by end of February. ARAC to consider again in six months.

Area	Assurance	Next Steps
NHS Improvement Licence	Annual review undertaken.	Update needed for next meeting bringing together the evidence for positive assurance and dates when ARAC undertook deep-dives.
Sustainability and Transformation Partnership (STP) Risk Register	Long and incomplete register adding little value. Some significant gaps.	To receive again in six months in the hope that it has improved and can help us in our pan-Kent health economy governance and risk management.
CIS - Risk Register Deep Dive	Useful update from Gordon Flack covering latest Advanced Health and Care (AHC) position, STP progress with a Kent Care Record and inter-operability	A paper on the strategic options for the Trust to be prepared for April Board Strategy and Development (BSD) day.

Peter Conway
Chair, Audit and Risk Committee
20 February 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.4
Subject:	Charitable Funds Committee Chair's Assurance Report
Presenting Officer:	Richard Field, Deputy 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 2018.

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

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

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

Kent Community Health
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

The Charitable Funds Committee met on 25 January 2018 at The Council Chamber, Sevenoaks Town Council Offices, Sevenoaks.

The Committee approved the 2016/17 Charitable Funds' reports and accounts.

The Committee received assurance from the Trust's external auditors, Grant Thornton, that the accounts had been independently reviewed.

The Committee discussed the net reduction in funds and agreed that a cost benefit analysis into the investment in fundraising support should be undertaken. In addition further fundraising would be considered for the year 2017/18.

The Committee noted the comments from one of the governors in relation to the future funding of the Trust's staff awards from the unrestricted funds of the Trust's charity.

A review of the fundraising plan for 2018 will take place in April 2018.

Jennifer Tippin
Chair of the Charitable Funds Committee
March 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.5
Subject:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Non-Executive Director

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

Report Summary (including purpose and context)
The paper summarises the Strategic Workforce Committee meeting held on 23 January 2018.

Proposals and /or Recommendations
The Board is asked to receive the Strategic Workforce Committee Chair's Assurance 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.

Bridget Skelton, Non-Executive Director	Tel: 01622 211900
	Email:

Kent Community Health
NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report describes the business conducted at the Strategic Workforce Committee on 23 January 2018 indicating the Non-Executive Director challenges made and the assurances received, residual concerns and/or gaps in assurance, with work outstanding.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Workforce Report	The Committee discussed the issues behind the data presented in the Workforce Report, specifically how the definition of retention data now includes those moving to the Bank, and the red rating for sickness and retention.	Whether pushing down the Service reports to the service operation meeting was improving ownership of the workforce challenge? When would this situation really start to hurt and how would we spot that?	There is on going work on retention, the services all have local action plans and the data and actions are followed up and challenged regularly. All our early warning tools would provide information in enough time to take any action required. (Red flags if shifts not covered)	Further work to understand the high turnover data in Dental Services will be done to better understand the specific issues related to that business.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Community Staffing Levels	A verbal update was received on the issues raised at the last meeting with regard to long term Safer Staffing and to report on work continuing with Meridian. Useful lessons have been learnt looking at community staffing levels in West Kent, resulting in achieving greater contact numbers and stronger teamwork, so similar work has begun in East Kent.	Are there organisational wide lessons that should be learnt from working with Meridian?	Positive impact collecting data to highlight effective working methods, providing greater ability to share resources, and skill mix. This learning is being spread from west to east.	Work with Meridian is on going. **Ongoing work creating new Staffing models, with alternative skill mixes**.
Nurse Validation Report	An assurance report was received, showing since nurse validation was introduced there have only been two staff members who have not met the timelines for revalidation.		The two cases were explored, explanations understood and the issues rectified. TIAA, internal auditors, demonstrated significant assurance.	

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Workforce Race Equality Standard (WRES) Report	The WRES requires every NHS organisation to publish workforce data annually. At KCHFT our total Black and Minority Ethnic (BME) workforce is 10.75% which is an increase from 9.76% of the workforce the previous year. We have no outlying data compared to national figures.	Are we comfortable there is no discrimination at the KCHFT?	BME staff remain statistically less likely to be appointed at interview, and more likely to be subject to formal disciplinary, and less likely to feel that the Trust provides equal opportunities for career progression. All of these issues are being addressed in an action plan.	Given Dental Services has a high number of BME staff, further work is on going to see if there is any correlation and lessons to learn.
Enabling Black and Minority Ethnic (BME) Nurse Progression Report	A national report on enabling BME nurse and midwife progression into senior leadership was presented, with six priorities highlighted.	How we matched up against each of the six priorities?	There is a BME action plan that picks up some of these.	Check KCHFT action plan against the six priorities in the national paper.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Staff Survey Report	Early findings from the Staff Survey were presented. The response rate was 62%, an increase on 5% from last year. 34 questions received the same response as last year, 23 decreased and 30 improved. Looking at any changes above 1% there were 7 decreases and 18 increases. This is a good initial reaction, demonstrating improvement in engagement and management which were the two key areas of work from last year's survey.	How we compare to other Trusts? Do we have explanations for areas that have decreased?	We do not have the comparative data yet to compare to other trusts. We can not do anything about pay only about recognition and appreciation. We understand why staff feel under pressure, we need to help them find ways of managing this and ensure they feel supported.	Further analysis required when the next set of data is available to more specifically identify areas that enhanced staff morale last year and recommend areas for focus during 2018.
Health and Wellbeing Report	The Health and Wellbeing Report described a lot of activity to promote better health and wellbeing. The committee then explored how this had unfortunately not resulted in not achieving the CQUIN.	Why the CQUIN had not been achieved with so much activity and commitment? Why 38% in 2017 thought the organisation took positive action on health and wellbeing and only 37% this year? To what extent estates could help?	Question whether staff see the creation of the choir as health and well being. Could improve communications branding health and well being initiatives better i.e. standing desk. Potentially include health and wellbeing in team briefs. Estates are included in the work plan.	Explore how promotion of health and wellbeing staff survey questions can more be more closely linked with real activity like the step challenge.

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Apprentice Nurse Pathways	The Committee discussed a report describing alternative apprentice nurse pathways. Nurse training pathways are changing with bursaries being removed and places restricted. New pathways involve different costs/benefits and raise different issues for implementation.	The impact of changes to the current system is unknown but the challenge around the shortage of nurses is known and getting worse. What is KCHFT plan to address this? What would it take to recruit 50 – 100 nurses rather than 5 – 10?	**Further work has been requested to set out a substantial programme to train nurses using potentially a number of different apprentice routes**.	A proposal is being prepared which will require investment to attract the nurses, and provide the infrastructure that will ensure the training programme is successful. The work will also explore whether this should be an STP wide initiative, work with one other Trust and set out investment, risk and issues to enable the Board to approve a plan.
People Strategy Implementation Plan	The action plan was presented to the Committee. Each item is now aligned with strategic aims, has an owner accountable for its delivery with a time line.	Are the actions on individual performance objectives? How are the actions that support the People strategy reviewed?	Individual performance objectives include actions from the strategy except at senior level where they are part of larger operational objectives.	
National Workforce Strategy	The Committee discussed their first impressions of the draft national strategy and explored how we would respond. Less description explaining justifying a situation would be better replaced with creative, and pragmatic solutions.			

Workforce item	Report /key points	Challenges	Assurance	Residual issues gaps in controls or assurance - work outstanding
Focus, Forward Plan, Any Other Business		A request to be updated on STP workforce issues and priorities.		

Items for the Board to specifically note:

The two main most important areas the Strategic Workforce Committee are focused on are ‘new nursing models’, and an urgent plan of scale to source and train nurses.

No recommendations.

No policies were ratified.

Bridget Skelton
Chair, Strategic Workforce Committee
January 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.6
Subject:	Workforce Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

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

Report Summary (including purpose and context)

This report provides the Board with an update on the current workforce position as at February 2018. It contains performance information on a variety of metrics which include absence, turnover, agency usage, vacancies and training compliance.

Proposals and /or Recommendations

Turnover and sickness rates have reduced but vacancies continue to increase which has led the Trust to pursue a variety of programmes designed to reduce this in future.

The Board is asked to note the current position on workforce performance and the current actions being taken.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. High level position described and no decision required.

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

Kent Community Health
NHS Foundation Trust

Workforce Information Board Report
Reporting Period February 2018

1. Report Summary

This report provides the Board with an update on the current workforce position as at February 2018. It contains performance information on a variety of metrics which include absence, turnover, agency usage, vacancies and training compliance. The report is an 'exception' report; it contains narrative relating to those metrics against which KCHFT is performing below target and what actions have been taken to improve performance.

2. Overview

An overview is outlined on the table below; this indicates trends, targets and achievements. Data is comparative against the previous month and the trend lines show the direction of travel over the last six months (September to present). Each of the metrics has been rated to illustrate performance against the trust target where applicable. An upward arrow indicates better performance. The trend line illustrates current performance against recent performance

Fig 1. Overview

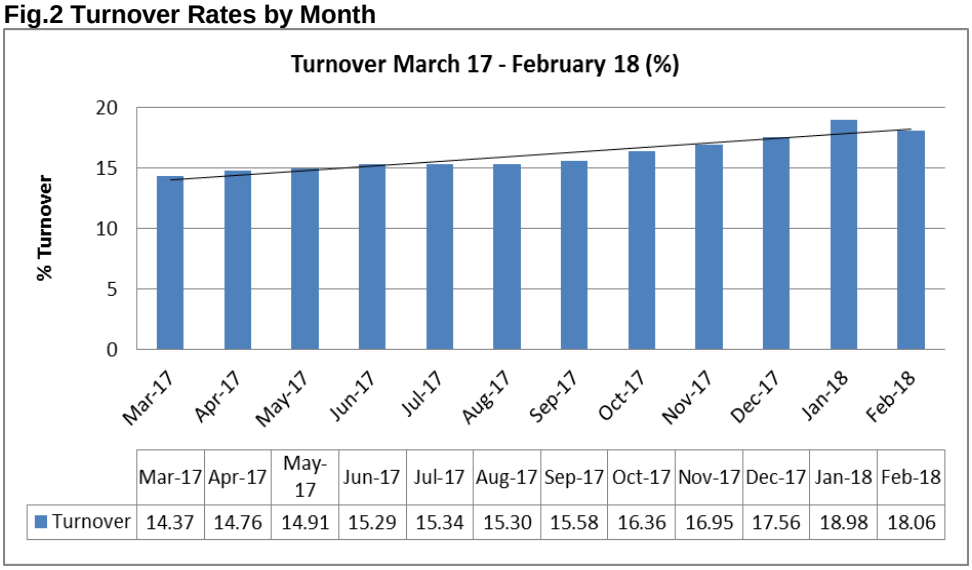
Month	Feb-18			
Direction (Better/Worse)	Metric	Target	Current Position	6mth Trendline (Sept to Feb 2018)
▼	Turnover (12 mths to reporting month)	10.50%	18.06%	
▼	Absence (2017/18 cumulative)	3.90%	4.48%	
▲	Vacancies	5.00%	11.44%	
▼	Fill Rate Overall	No target set (rated on 75%)	82.05%	
▼	Fill Rate Bank (as % of those filled)	No target set (rated on 30%)	58.00%	
▲	Agency spend as a proportion of the trajectory (reporting month, with contingency)	< 100%	51.66%	
▲	Agency shifts - Framework agency used - compliant with price cap	100%	99.66%	
▲	Average Recruitment Time in Weeks (reporting month)	< 7 Weeks	8.32	
▲	Statutory and Mandatory Training (adjusted % for 2 yr Prevent/WRAP target)	85%	98.9%	
▲	Number of suspended staff	No target set	6	
▼	Appraisals	85%	94.8%	
▼	Trust Headcount (as at end of reporting month)	No target set	4,703	
▼	Number of Starters (reporting month)	No target set	49	
▼	Number of Leavers (reporting month)	No target set	58	
▼	% of leavers who are unplanned leavers (reporting month)	No target set	79.31%	
▲	% of leavers who are planned leavers (reporting month)	No target set	20.69%	

3. Performance Commentary

3.1 Turnover

Turnover has gradually increased over the last 12 months although we did see a small reduction in February the figure is still above the Trust target of 10.50%. Nationally Community Trusts are reporting an average turnover of 17%. Trust headcount has reduced from 4729 to 4703 since January a reduction of 26. Nationally community services are reporting a total net loss of staff over the past 12 months of 1130.

Fig.2 Turnover Rates by Month



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Turnover	14.37	14.76	14.91	15.29	15.34	15.30	15.58	16.36	16.95	17.56	18.98	18.06

Turnover by Directorate

Fig 3. Directorate Turnover and Proportion

Directorate	Turnover	Proportion
Nursing & Quality Directorate	27.20%	1.28%
Corporate Services Directorate	19.19%	1.32%
Operations Directorate	18.47%	82.69%
HR, OD & Communications	18.21%	2.49%
Medical Director	17.78%	1.17%
IT	16.91%	2.85%
Estates	13.44%	6.34%
Finance Directorate	8.23%	1.87%

The table above illustrates turnover by directorate throughout the Trust over the last 12 months. Although some areas, such as Nursing and Quality, show a high turnover it needs to be viewed against the size of the directorate as a whole to give it some proportional scale.

The Trust has embarked on the NHS I “Retention Direct Support programme” (launched July 2017) which is targeted and clinically led with the aim to improve turnover rates in the community.

As part of our retention interventions we have embarked on our talent management strategy. All staff who receive an 'outstanding rating' in this year's appraisal will be invited to complete a self-assessment. Those determined to be ready for progression within the next 12 months will be considered by talent boards to establish whether they would benefit from development opportunities as part of our new talent management pool.

This will include tailored developments such as:

- project work
- job shadowing
- mentoring and coaching from managers and peers
- access to programmes such as the Leadership Academy
- role rotation
- participation in communities of practice
- completion of 360° diagnostic assessment and follow up coaching

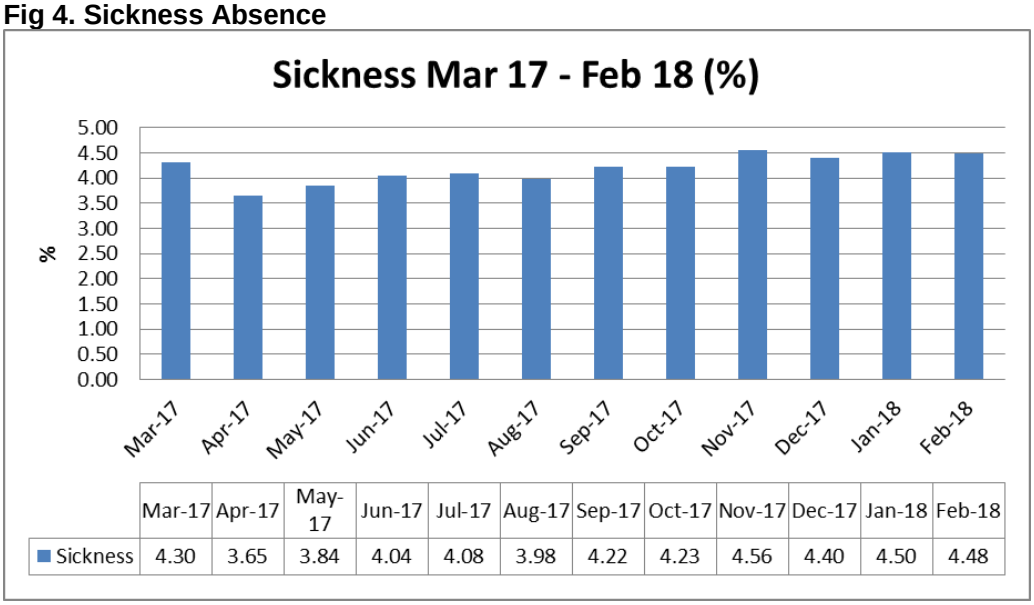
3.2 Starter and Leavers

Of the 49 new starters in February, 58% came from other NHS organisations, 14% from "No employment", and 10% jointly from "Other Public sector" and "Other Private sector". Of the 58% which came from within the NHS 13% came from East Kent University Foundation NHS Trust and 10% from Medway NHS Foundation Trust. The average time to recruit a member of staff was 8.3 weeks a small increase in the figure for January.

Of the 58 leavers in February 22% stated their reason for leaving as "Work life Balance", 15% left on the grounds of promotion and 10% on the basis of relocation. Of the top destinations on leaving 31% declared no employment, 22% Other NHS Organisations and 10% the private health or social care sector. 79% of the leavers in February were seen as unplanned and 21% planned. The planned leavers included fixed term contract, dismissals and an instance of redundancy.

3.3 Sickness Absence

Fig 4. Sickness Absence



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Sickness	4.30	3.65	3.84	4.04	4.08	3.98	4.22	4.23	4.56	4.40	4.50	4.48

Sickness remains above the Trust target of 3.90% but saw a slight decrease from the figure recorded in January (4.48%). Nationally Community Service providers average a sickness rate of 4.68%.

Sickness by Directorate

Fig 5. Sickness Absence by Directorate

Directorate	%
Operations Directorate	4.64%
IT	3.48%
Nursing & Quality Directorate	5.60%
Medical Director	4.16%
HR, OD & Communications	3.29%
Finance Directorate	2.11%
Corporate Services Directorate	2.89%
Estates	4.45%

Finance, IT, HR OD & Communications and the Corporate Services Directorate all recorded sickness below the Trust target. The Nursing & Quality Directorate and Operations Directorate recorded the highest rates at 5.60% and 4.64% respectively.

Sickness Reasons

Fig 6. Sickness Reason

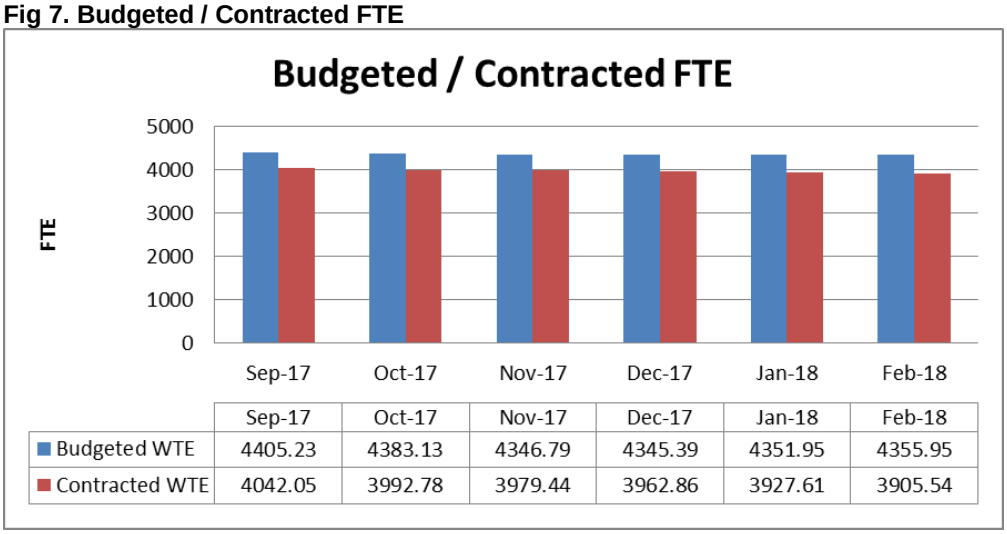
Absence Reason	Total
S13 Cold, Cough, Flu - Influenza	43.48%
S25 Gastrointestinal problems	14.89%
S10 Anxiety/stress/depression/other psychiatric illnesses	10.43%
S16 Headache / migraine	5.38%
S12 Other musculoskeletal problems	5.30%

In February the "Cold, Cough, Flu – Influenza" sickness reason made up over 40% of sickness given although this group is usually the largest reason for absence it is disproportionate in February when compared to the reported figure for 2017 of 27%.

Outbreaks of Flu were reported in the community and community hospitals. The vacination take up rate was good but was effected by the strain of Flu that occurred. In preparation for the next Flu season the Trust are looking at an array of approaches to vacinate staff.

3.4 Establishment and Vacancies

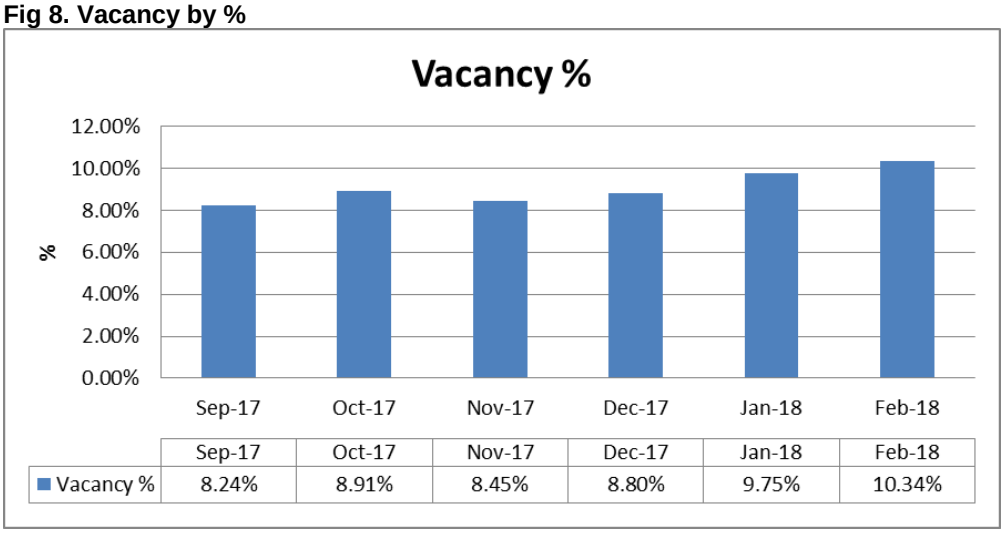
Fig 7. Budgeted / Contracted FTE



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Budgeted WTE	4405.23	4383.13	4346.79	4345.39	4351.95	4355.95
Contracted WTE	4042.05	3992.78	3979.44	3962.86	3927.61	3905.54

KCHFT have seen a small reduction of establishment over the last six month at just over 1%. Contracted FTE has dropped by almost 3.4% over this period; this has led to a gradual increase in vacancies across the Trust as detailed below.

Fig 8. Vacancy by %



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Vacancy %	8.24%	8.91%	8.45%	8.80%	9.75%	10.34%

The Operations Directorate holds the highest number of vacancies at just over 12% with Finance recording a vacancy rate of 11.56%. The Medical Directorate and Corporate Services have the lowest vacancy rates at 1.18% and 1.32% respectively.

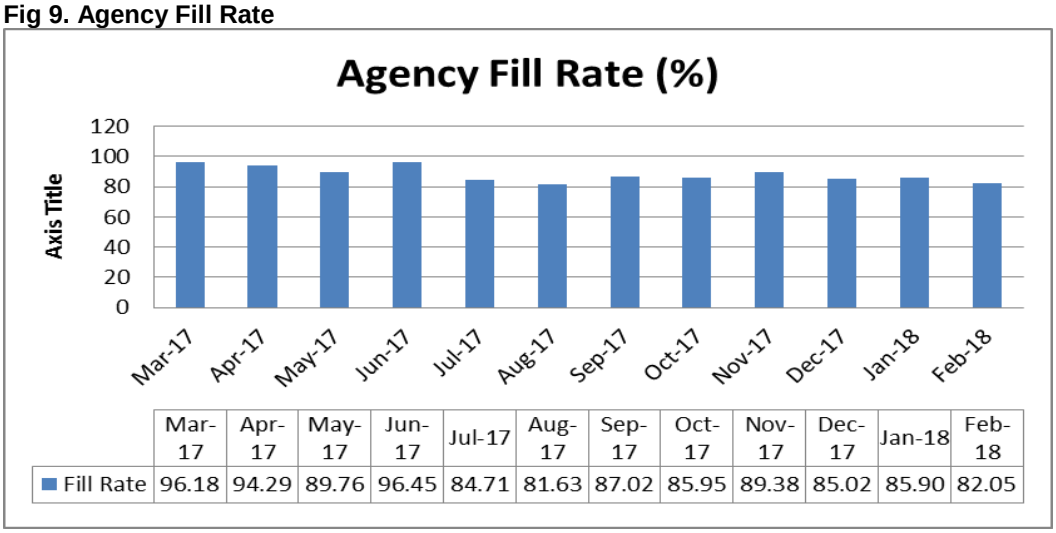
International recruitment is occurring in India and the Philippines. Dates have been set, in April, for Skype interviews for potential recruits in East Kent.

KCHFT is also holding two workshops over the next month to look at skill mix options across the community hospitals and community based teams and is working with Kent Supported Employment Agency to target posts suitable for people with learning difficulties.

The Trust is revisiting its recruitment page and reviewing how it presents its employment offer as a recent analysis has demonstrated that its benefits are equal to or more substantial than private care providers excluding pay and private healthcare benefits.

3.5 Temporary Staff Usage

Fig 9. Agency Fill Rate



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Fill Rate	96.18	94.29	89.76	96.45	84.71	81.63	87.02	85.95	89.38	85.02	85.90	82.05

Despite winter pressure and the Flu season agency fill rates remain in excess of 80% and the Trust was 99.66% compliant with the agency price cap. Bank fill rates rose from 45% in January to almost 52% in February.

3.6 Training Compliance

Mandatory Training rates remained high at 98.9% and appraisal rates were reported at 94.8%.

Sign off of last year's reviews need to be completed by the end of March early April in preparation for the rollout of the new Training, Appraisal and Performance system (TAPS).

4. Conclusion

Turnover and sickness rates have reduced but vacancies continue to increase which has led to Trust to pursue a variety of programmes designed to reduce this in future.

5. Recommendations

The Board is asked to note the current position on workforce performance and the current actions being taken.

Louise Norris
Director of Workforce, Organisational Development and Communications
February 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.7
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. High level position described and no decisions required.

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Kent Community Health
NHS Foundation Trust

Integrated Performance Report - 2017/18
Part 1

March 2018
April 2016 - February 2018 data

In everything we do, we care

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

Executive Summary: Supporting Narrative - March Report 2017/2018

Quality

Infection Control: MRSA & C-Difficile: There has been one Clostridium difficile Toxin positive infection in February at Whitstable and Tankerton Hospital. The case was fully investigated. Currently the ward is awaiting Ribotyping of the stool sample to exclude a possible cross infection from the previous case reported in January.

Workforce

Sickness: The cumulative sickness absence rate for the financial year to February 2018 is 4.53% which is up slightly from 4.5% at M10. The sickness rate in February 2018 was 4.73%, a decrease of 0.69% from last month. The total FTE days lost for the rolling year to February equates to an average of 10.14 days sickness lost per employee, up from last month. The proportion of FTE lost to short-term sickness has decreased to 35.3.1%, compared to 42.1% in January

Mandatory Training: Currently one area of mandatory training is currently not meeting the 85% target: Fire - Community Hospitals which has reduced to 81.8%

Finance

Income & Expenditure and Financial Risk Rating: The Trust achieved a surplus of £3,290k (1.6%) to the end of February. Cumulatively pay has underspent by £11,144k and non-pay and depreciation/interest have overspent by £1,384k and £2,316k respectively. Income has under-recovered by £6,879k.

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 94.42% completed RTT pathways within 18 weeks and 94.06% incomplete RTT pathways within 18 weeks for M10. Chronic Pain has worsened in M10 to 69.3% for complete waits, although the decline in incomplete waits for the Trust is due to an increase in the Chronic Pain waiting list.

Referral to Treatment Times for all Allied Health Professionals when measured against the 18 week threshold shows 94.64% of patients being seen within this timescale for January 2018, a decline on the M9 position. Chronic Pain, ASLT, Continence, Podiatric Surgery, MSK (West Kent Block) and CNRT were below 90% compliance with 18 weeks RTT for M10

National Targets

Stop Smoking: The stretch target set by KCC is 3750 quits. KCC have set a minimum target of 3400 quits.

Health Checks: The service continues to achieve month on month with regard to the target. All areas of checks are on target; GP performance has increased on this time last year and KCHFT core checks are on track to meet the end of year target. The service has also worked hard to source other opportunities to improve outreach Health Checks. These include working with P & O Ferries to support their Health and Wellbeing initiatives, providing Health Checks for eligible staff on board the ships. In addition, regular clinics are being offered at Bluewater shopping centre in partnership with the Fire Safety group. A review of the under-performing GP practices with regard to the 'two year trend' is currently being reviewed to assit planning for next year's contract options. The procurement of the new IT software for Health Checks by KCC and its mobilisation prior to implementation on 1st April 2018 has the potential to affect outcomes related to the target and this has been highlighted regularly. The service is currently working with KCC to construct a plan minimising this risk. Another potential risk for the service with regard to meeting targets is the intended reduction in invite tarfiffs for GPs. The service is working with KCC to minimise this risk.

Community Hospitals

There were 231 admissions to the Community Hospitals in January and 233 discharges, with 174 beds open per day on average

Bed Occupancy (Target range 87-92%): The Kent wide occupancy rate across all hospitals was 91.8% in January, an increase from December and within the ideal threshold of 87% to 92%. Bed occupancy has generally increased due to pressures in the whole system and the need to facilitate patient discharges from acute hospital beds.

Length of Stay (LOS) - Median (Target 21 days): Performance against the median average length of stay target is within the target YTD (20.2 days), and decreased to 17 days in M10

Delayed Transfer of Care (DTOC) days as percentage of total bed days (Target 9.5%): Delayed Transfers of Care has increased in M10 and is below the target for the month at 7.7% (10.6% YTD). Two sites were above target for M10, Sevenoaks (11.5%) and Edenbridge (12.7%). The 7.7% is split between 4% KCHFT responsibility and 3.7% Social Services/Other/Both

Activity

KCHFT's clinical services carried out 183,925 contacts (This figure includes various currencies e.g. face to face contacts, telephone contacts, group sessions, Units of Dental Activity), of which 9,612 were MIU attendances, during January 2018. KCHFT is below target at Month 10 (-0.5%), against contractual targets where applicable. Performance against 2017/18 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	54,108	536,009	533,860	0.4%		
Intermediate Care	19,542	203,511	210,752	-3.4%		
MIU Attendances	9,612	107,167	94,036	14.0%		
Community Hospital Admissions	231	1,906	1,517	25.7%		
Community Hospital Occupied Bed Days (WK)	2,290	21,269	21,086	0.9%		
Community Hospital Occupied Bed Days (EK)	2,650	24,491				
Specialist and Elective Services	28,238	281,951	291,440	-3.3%		
Learning Disabilities - Face to Face	3,351	30,604	0	0.0%		
*Children's Universal Services	33,246	319,861				
Children's Specialist Services	17,291	137,529	141,248	-2.6%		
Dental Service - All currencies	14,175	114,613	135,650	-15.5%		
Health Trainers	148	2,288	2,504	-8.6%		
All Services and Currencies (Contracted)	**145,635**	**1,406,243**	**1,432,093**	**-1.8%**		

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

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

Adults: Long Term Conditions (LTC) contacts are 0.4% (2,149 contacts) below at M10. Intermediate Care and Rehab Services (ICT) are 3.5% below target (7,426 contacts) at M10 of 2017/18. Activity for the planned care services is 3.3% under target for the year (all currencies). Main variances are within Podiatry and Dental services. Dental activity is behind target YTD, mostly in East Kent (which has improved to green in recent months) and Kent OHP (the contract has now ended)

Children and Young People: It should be highlighted that the contract for Health Visiting does not have an activity target (hence the target and variance being greyed out). Health Visiting are measured against specific KPIs, although these still require a certain level of activity to ensure compliance with KPIs such as New Birth Visits, 1 year and 2 1/2 year development checks. Therefore is useful to see overall activity levels to highlight any major changes. Collectively the Childrens Specialist Clinical Services are 3% below target at M10, mostly attributed to West Kent Special Schools and ITAC in East Kent. Canterbury ITAC team have the largest variance due to staffing issues.

KCHFT Corporate Scorecard 2017/18

Strategic Goals

1. Prevent ill health

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
1.1	Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)	80.2%	97.0%	16.7%	100.0%	-3.0%	100.0%	N/A	-ve
1.2	Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)	100.3%	102.1%	1.8%	100.0%	2.1%	100.0%	N/A	-ve
1.3	Health Visiting - Increase the uptake of New Birth Visits by 14 days	85.8%	92.5%	6.7%	90.0%	2.5%	95.0%	N/A	-ve
1.4	Health Visiting - Increase the uptake of the 6-8 week assessment by 8 weeks	85.2%	90.8%	5.6%	85.0%	5.8%	90.0%	N/A	+ve
1.5	School Health - Reception Children Screened for Height and Weight*	93.9%	1.9%	-92.0%	90.0%	N/A	95.0%	N/A	-ve
1.6	School Health - Year 6 Children Screened for Height and Weight*	95.4%	94.8%	-0.6%	90.0%	4.8%	95.0%	N/A	+ve

2. Deliver high-quality care at home and in the community

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
2.2	Never Events: Number	1	0	-1	0	0	0	N/A	stat
2.3	Infection Control: C.Diff (Target <6 cases in year) (Target YTD)	7	4	-3	5	-1	5	N/A	-ve
2.8	Contractual Activity: YTD as % of YTD Target	97.4%	98.2%	0.8%	100.0%	-1.8%	100.0%	N/A	-ve
2.9	Trustwide Did Not Attend Rate: DNAs as a % of total activity.	3.2%	3.7%	0.5%	4.0%	-0.3%	3.0%	4.0%	+ve
2.10	LTC/ICT Response Times Met (%)	93.8%	96.5%	2.8%	95.0%	1.5%	98.0%	N/A	-ve
2.11	Rapid Response - Percentage of Consultations started within 2hrs of referral acceptance (Trustwide)	91.9%	94.1%	2.2%	95.0%	-0.9%	98.0%	N/A	+ve
2.12	Total Time in MIUs: Less than 4 hours	99.94%	99.88%	-0.1%	95.0%	4.9%	99.5%	99.5%	+ve
2.13	Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways	99.6%	97.9%	-1.7%	95.0%	2.9%	98.0%	96.8%	-ve
2.14	Allied Health Professionals Referral to Treatment Times (RTT)	92.8%	96.1%	3.3%	95.0%	1.1%	98.0%	97.6%	+ve
2.15	Access to GUM: within 48 hours (Monthly Target 100%)	100.0%	100.0%	0.0%	100.0%	0.0%	100.0%	N/A	stat
2.16	Length of Stay (Median Average)	21.6	20.2	-1.4	21.0	-0.8	21.0	25.6	+ve
2.17	End of Life Care: Percentage of patients dying in their preferred place.	86.3%	84.7%	-1.6%	95.0%	-10.3%	95.0%	83.2%	-ve
2.18	ADULTS - Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.	85.0%	97.1%	12.1%	80.0%	17.1%	90.0%	N/A	+ve
2.21	Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate	23.7%	19.3%	-4.4%	20.0%	-0.7%	30.0%	30.7%	-ve
2.23	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

3. Integrate Services

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
3.1	Delayed Transfers of Care as a % of Occupied Bed Days	12.1%	10.7%	-1.4%	9.5%	1.2%	3.5%	6.0%	+ve

4. Develop Sustainable Services

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
4.2	Bed Occupancy: OBDs as a % of available bed days	88.6%	90.8%	2.3%	87.0%	3.8%	91.7%	87.9%	+ve
4.3	Income & Expenditure - Surplus (%)	1.7%	1.6%	-0.1%	1.0%	0.6%	1.0%	1.0%	+ve

Be the Best Employer

KPI Ref	KPI Description	16/17	17/18	YoY Change	Target	RAG/ Variance	Aspiration	Bench Mark	Trend
5.1	Sickness Rate	4.30%	4.53%	0.23%	3.90%	0.63%	3.75%	4.30%	-ve
5.4	Mandatory Training: Combined Compliance Rate	94.7%	94.6%	-0.1%	85.0%	9.6%	92.5%	88.4%	+ve

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.8
Subject:	Monthly Quality Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary

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

- The 8 escalation beds continued to be open across east Kent community hospitals
- The fill rate for registered nurses is an overall 97% for days and 100% for nights. Five hospitals had fill rates below 95%
- There were no new pressure ulcers this month
- The have been 4 avoidable falls 2 of which caused serious harm
- There have been 3 infection outbreaks at community hospitals resulting in bed closure for periods of time
- Patient Experience continues to be strong at 97% with the Friends and Family test at 97%.

Proposals and /or Recommendations:

The Board is asked to note the report.

Relevant Legislation and Source Documents:

None

Has an Equality Analysis (EA) been completed?

No. High level position described and no decisions required.

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

Kent Community Health
NHS Foundation Trust

MONTHLY QUALITY REPORT

March 2018

1. Workforce Data and Quality Metrics

1.1 The shift fill rates for community hospital wards are set out below. The day fill rate for registered nurses (RN) in February was 97%, a slight decrease from 99% in January. The night shift fill rate for RN's increased slightly to 100%. The Chief Nurse will provide commentary on any areas less than 95%.

1.2 Escalation beds have been open in Deal (4), Faversham (2) and Whitstable and Tankerton (2) and registered nurse staffing has been increased to rotate to where the need is greatest to accommodate this, Health Care Assistants (HCA) have been increased on all 3 wards, and therefore have increased the fill rate in these areas.

1.3 Two hospitals had *day* shifts with an RN fill rate of below 95%, Edenbridge Hospital was 83.9%, QVMH had a fill rate of 92%.

1.4 Four hospitals had a *night* fill rate of below 95%, Deal 94.6, Whitstable & Tankerton 94.6, Hawkhurst 92.9 and Edenbridge 92.9. Where RN shifts were unable to be filled by bank or agency the wards increased the use of HCA staff to expand general capacity which has resulted in an overfill rate for HCAs. HCAs have also provided additional capacity as required to manage fluctuations in dependency.

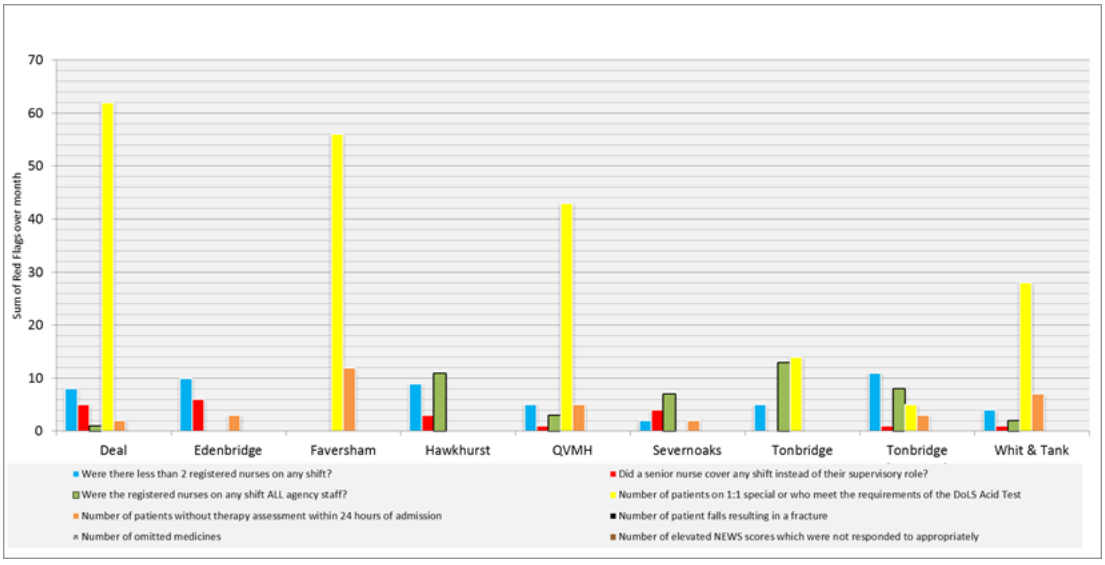
	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Faversham	111.6%	147.0%	130.4%	142.9%	840	937.5	1260	1852.5	616	803	616	880
Deal	95.5%	148.8%	94.6%	207.1%	840	802.5	1260	1875	616	583	616	1276
QVMH	92.0%	107.7%	101.8%	117.9%	840	772.5	1260	1357.5	616	627	616	726
Whit &Tank	99.1%	124.3%	94.6%	110.7%	840	832.5	1050	1305	616	583	616	682
Sevenoaks	97.3%	110.1%	96.4%	98.2%	840	817.5	1260	1387.5	616	594	616	605
Tonbridge - Goldsmid	99.1%	89.3%	96.4%	125.0%	840	832.5	1050	937.5	616	594	308	385
Tonbridge - Primrose (HCA% includes some RN activity)	N/A	106.0%	N/A	123.8%	0	0	1260	1335	0	0	924	1144
Hawkhurst	95.5%	106.5%	92.9%	100.0%	840	802.5	1260	1342.5	616	572	616	616
Edenbridge	83.9%	129.5%	92.9%	107.1%	840	705	840	1087.5	616	572	308	330
Total	**97%**	**119%**	**100%**	**127%**	**6720**	**6503**	**10500**	**12480**	**4928**	**4928**	**5236**	**6644**
	Over 90% Fill Rate			65% to 90% Fill rate				Less than 65%				

1.5 The fill rates for Westbrook and Westview KCC integrated units are set out below. The wards have reduced their beds to 15 at Westbrook, and 15 nursing and 10 social care at Westview. Data shows that Westview have high numbers of HCAs and this would be expected to provide care to the patients

in the social care beds. Staffing is reviewed daily and shortages are subject to the same escalation processes as other KCHFT wards.

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Westbrook	102.4%	98.9%	100.0%	100.0%	930	952.5	1395	1380	682	682	682	682
West View	98.2%	130.4%	103.6%	131.0%	840	825	1680	2190	616	638	924	1210

1.6 Below is a summary of data related to quality indicators taken from the Beautiful IT System. Faversham, Deal and Whitstable & Tankerton have required high numbers of additional staff to increase capacity on the ward. The operational manager has reported that there were a high number of patients with cognitive impairment on all east Kent sites during February. Data is now being collected regarding the number of inpatients with Dementia and this will be detailed in future reports.



There were 72 occasions when there was 1 RN on a shift because the shift could not be filled by substantive or temporary staff (76 last month), this is rarely a full shift as staff on the neighbouring shifts stay late/start early. This is consistent with last month and has been more of an issue over the winter months. Edenbridge, Deal, Hawkhurst and QVMH had the most 1 RN shifts. Tonbridge Primrose is not included in this table as it is staffed by Assistant Practitioners.

One RN shifts

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Deal	12	3	3	6	11
Edenbridge	6	11	24	24	22
Faversham	7	2	5	0	2
Hawkhurst	4	7	8	15	10
QVMH	15	8	6	11	10
Sevenoaks	3	5	9	7	7
Tonbridge (G)	3	11	13	13	4
Whit&Tank	3	2	3	0	6
KCHFT	**53**	**49**	**71**	**76**	**72**

1.7 **Incidents**

As part of quality triangulation incidents are monitored on shifts where 1 RN was recorded. The following chart shows that there were 24 incidents on these days. This is in line with January where 25 incidents on 1 RN shifts were recorded.

The severe harm at Westview in the chart below relates to a fall resulting in a fracture and this has been reported as an SI. The investigation to date suggests that this will be classified as avoidable because whilst a Falls Prevention Care Plan was in place there is no evidence that it was reviewed or followed. Further lessons will be identified as part of the root cause analysis process.

The moderate harm at QVMH related to a deteriorating patient who was transferred back to the acute hospital (this was managed appropriately by staff), and the moderate harm at Hawkhurst related to a fall which resulted in skin tears.

The low harm of abuse by staff at Deal related to an allegation of abuse by a patient following concern that mouth care for an end of life patient had caused a sore mouth.

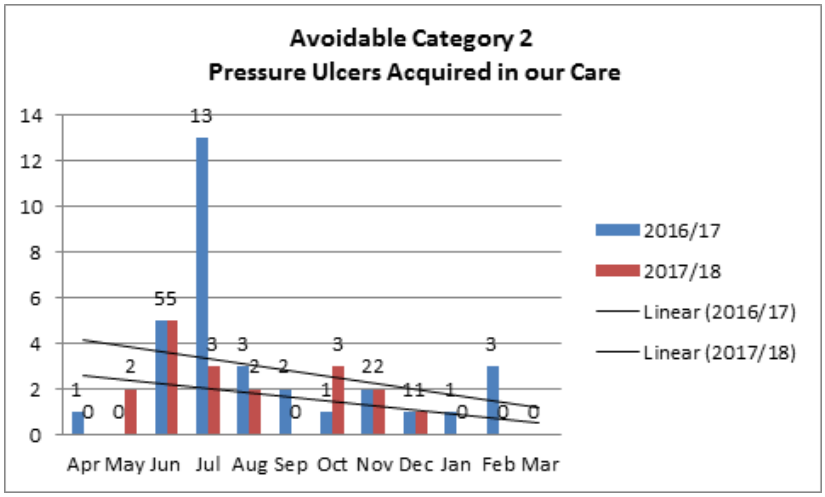
The no harm of exposure to a biological hazard at Tonbridge –Primrose related to a commode which was not cleaned thoroughly. All incidents are thoroughly investigated and learning is shared.

Hospital	Type of Incident	Impact on Patient
Westview	Fall with Fracture	Severe
QVMH	Transfer- deteriorating patient	Moderate
Hawkhurst	Fall	Moderate
Deal	Abuse of patient by staff	Low
Deal	Fall	Low
Deal	Pressure Ulcer – Transfer in	Low
Hawkhurst	Fall	Low
QVMH	Pressure Ulcer – Transfer in	Low
Faversham	Transfer	Low
Tonbridge-Goldsmidt	Transfer	Low
Tonbridge-Goldsmidt	Fall	Low
Westview	Pressure Ulcer– Transfer In	Low
Westview	Treatment/procedure	Low
Deal	Slip	None
Deal	Medication	None
Hawkhurst	Slip	None
Hawkhurst	Medication	None
QVMH	Treatment/procedure	None
QVMH	Transfer	None
QVMH	Diagnosis	None
Tonbridge - Primrose	Fall	None
Tonbridge - Primrose	Exposure to biological hazard	None
Westview	Transfer	None
Westview	Patient Information	None

1.8 **Pressure Ulcers**

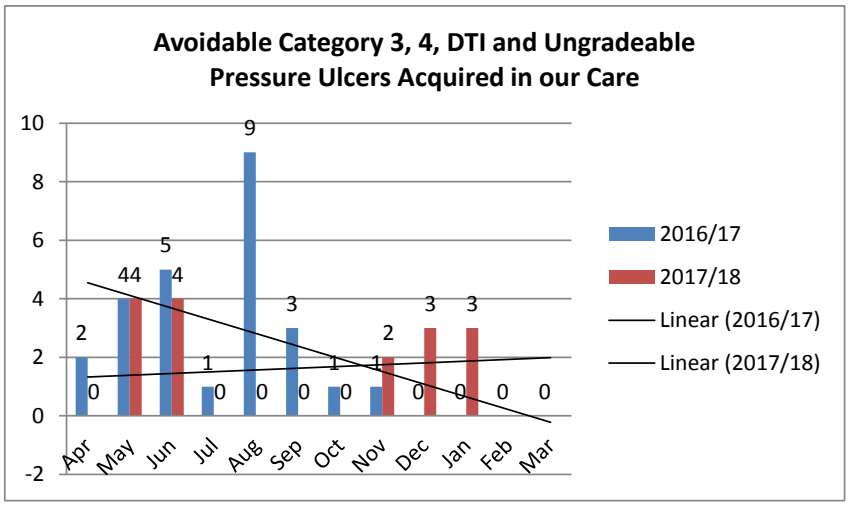
Category 2 Pressure Ulcers

There have been no category 2 pressure ulcers acquired in our care during February.



Category 3, 4 and ungradable pressure ulcers

There have been no category 3, 4, deep tissue injury and ungradable pressure ulcers acquired in our care during February.



1.9 **Falls**

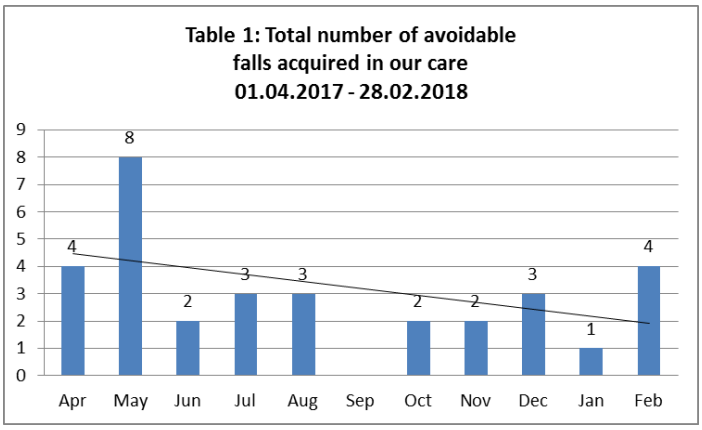
There were 47 falls reported across KCHFT (33 hospital and 14 community) in February, this is a reduction from 59 last month. There were 4 falls which were found to be avoidable, two at Westview which were declared as SIs, one at a patient's home and one at Westbrook. Causes of the avoidable falls include no evidence of the Falls Prevention Plan being reviewed or followed; attempting to weigh a patient with mobility problems, a call bell out of reach and hand rails in the up position.

The two falls related serious incidents at Westview were as a result of a head injury and the second as a result of a fractured neck of femur (the latter was referred to in 1.7 as there was 1 RN on the shift when this happened). These are currently under investigation and have initially been declared as avoidable while the investigations are completed.

The chart below shows the trend in falls since April 2017 and demonstrates that the total number of patient falls has been higher over the winter months and the number of moderate and severe harms is generally consistent.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual – Inpatient Falls	29	28	26	33	26	29	24	49	29	36	33	
Actual - Moderate and Severe Falls	0	1	1	0	1	0	0	1	1	1	2	

The trend in terms of avoidable falls is set out below and shows an increase for February; the ward matrons report this to be due to the increased number of frail patients over the winter period and the number of patients with cognitive impairment. Learning from the avoidable falls will be taken to the next Falls Prevention Improvement Group for discussion and action.



1.10 **Medication incidents**

A total of 18 avoidable medication incidents which were acquired in our care have been reported and investigated to date.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	39	60	67	42	43	45	69	47	55	48	18	
Near Miss	3	8	3	1	1	1	4	1	0	2	1	

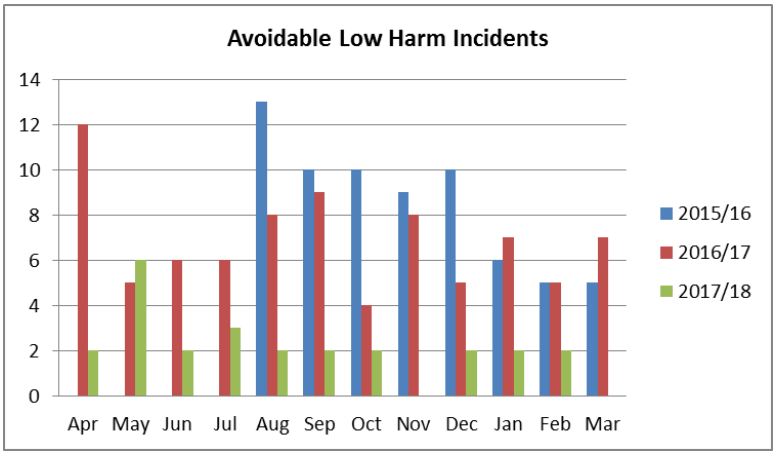
The highest reported category of avoidable incidents is omitted medication making up 39% of the total number logged since the last report. The second highest category is wrong quantity (29%) and the third highest category is wrong frequency (17%).

Of the 18 avoidable incidents that occurred during February 2018:

- 89% resulted in 'no harm' to the patient with the majority of these being omitted medication.
- 11% resulted in 'low harm', this equates to 2 incidents as follows
  1) Omitted insulin in community due to staffing pressures and miscommunication with patient

2) Patient thought to have been given 2 x 60mg dose of analgesia tablet instead of 2x 30mg as it was found that the blister pack has fewer tablets remaining than expected. Advice was sought from the pharmacy team and following assessment of the patient (there was no apparent impact) no further action was required.

There were no incidents that resulted in 'moderate harm', 'severe harm' or 'death' of a patient. Generally harms from medication are lower than in previous years as shown in the chart below.



1.11 Infection Prevention and Control

There have been 2 *Clostridium difficile* infections at Whitstable and Tankerton Hospital, the infection prevention and control team were informed on 6/3/18 that the ribotypes match. This is suggestive of cross infection, therefore the IPC team are supporting the ward staff and investigating further and a decision will be made about declaring this formally as an SI. The IPC team have requested further testing, which will prove whether or not this was an exact match of the infection, however it can take up to 10 weeks to obtain these results.

Outbreak season continues, with a further 3 outbreaks in February, 2 respiratory outbreaks (1 confirmed coronavirus at Whitstable & Tankerton, and one influenza A outbreak at Hawkhurst) and 2 patients and 2 staff with diarrhoea and vomiting at Deal hospital. All outbreaks were identified in a timely manner, and managed appropriately.

2. Patient Experience

2.1. Meridian Patient Experience survey results

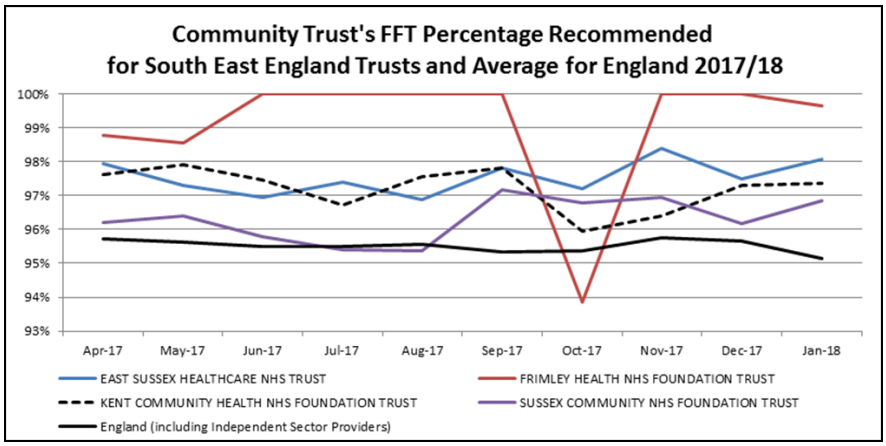
4,044 surveys were completed by KCHFT patients with a strong combined satisfaction score of 96.77% in February. This includes 1,169 short NHS FFT MIU surveys with a positive overall satisfaction score of 95.29%. Satisfaction levels remain consistently high.

Volumes

Aggregated monthly survey scores

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

The Trust has benchmarked FFT scores with other Community Trusts and the chart below demonstrates that KCHFT compares favourably in terms of the percent recommend score.



Positively KCHFT have a higher number of surveys than comparators.

Trust	Number of returns	Number eligible
EAST SUSSEX HEALTHCARE NHS TRUST	1,031	39,024
FRIMLEY HEALTH NHS FOUNDATION TRUST	281	421
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST	5,053	75,000
SUSSEX COMMUNITY NHS FOUNDATION TRUST	1,715	44,717

Future reports will contain more analysis of FFT data.

NHS Friends and Family Test (FFT) trust wide results for February demonstrate that only 0.67% of our patients chose not to recommend the service they received. There were 21 'extremely unlikely' responses in comparison to 12 in January. 8 of these were for Children & Young People's services, 5 of which are believed to have been answered incorrectly as the remainder of the survey feedback and comments were positive.

Survey Volumes have decreased in February. This is not in line with the usual trend seen over recent years. There was a shortfall of approximately 1,890 surveys completed in comparison to February 2017. It is likely that numbers of surveys completed towards the end of the month would have reduced as a result of the adverse weather conditions. The services detailed in the table experienced the biggest reductions.

Service	Feb-18	Feb-17	Total
MSK Physiotherapy	203	485	282
Dental Service	211	376	165
Lymphoedema Service	28	127	99
Minor Injury Units	1169	2018	849
Out Patient Departments	19	100	81

MIUs	Total Responses Feb 2018	Total Responses Feb 2017
Minor Injury Unit (Community Hospital at Deal)	141	249
Minor Injury Unit (Community Hospital in Edenbridge)	206	230
Minor Injury Unit (Community Hospital in Sevenoaks)	170	204
Minor Injury Unit (Gravesham Community Hospital)	5	142
Minor Injury Unit (Royal Victoria Hospital, Folkestone)	275	359
Minor Injury Unit (Sheppey)	214	372
Minor Injury Unit (Sittingbourne)	168	614
Summary	**1179**	**2170**

The largest drop in survey numbers has been for the Minor Injury Units with Gravesham returning only 5. The leads have been contacted to determine the cause for this and early feedback is that staff capacity to encourage and undertake surveys has been reduced.

2.2. Customer Care Team Enquiries

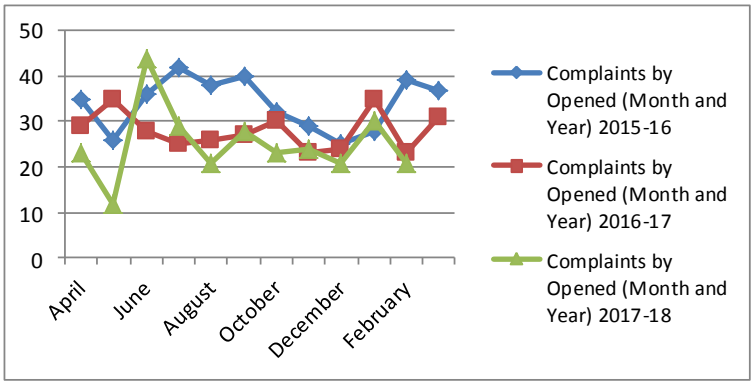
The Customer Care Team received a total of 579 enquiries in February, a reduction compared to 674 in January 2018.

Compliments

An increase in compliments was recorded by the PALS team in February; 191 compared with 165 in January.

2.3. Complaints

During February 2018, 3,564 people answered the survey question '*If you recently raised a concern or complaint directly with this service, do you feel it was responded to and* acted *upon?'* The Trust wide satisfaction score was 91.47%. There were 21 level 1 to 4 complaints and 7 concerns received in February, compared to 30 complaints and 12 concerns in January 2017 and 1 was a multi-agency complaint.



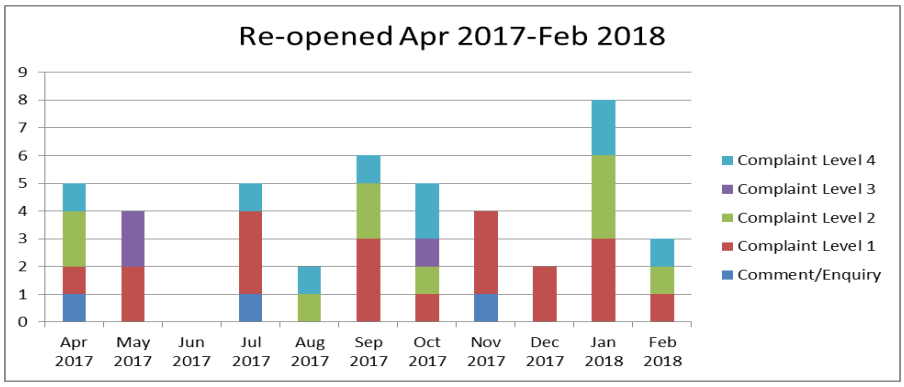
During February 2018, 21 complaints were closed in total. 16 of these were closed within the agreed timescales (77%) lower than 88% in December 2017 and 90 % in January 2018. The five cases were delayed due to scrutiny within the approval process, waiting for information from another trust and a delay in a service responding. There are currently no complaint cases with the Parliamentary and Health Service Ombudsman.

2.4. Themes and trends of closed complaints

The most complaints (4) were received for Community Hospital inpatient services, with 3 for West Kent. There were also 3 complaints for Community Paediatrics.

Re-opened comments and complaints from April 2017 to February 2018

The number of complaints reopened has decreased in February and this continues to be a focus for improvement.



2.5 Key Quality Improvements

- The Children's Specialist Community Nursing Service has made improvements to the service they provide following a complaint regarding poor communication. Assessment meetings are taking place within the school to discuss new children and also those young people moving from day schooling to a residential placement. The children's needs are discussed and a decision made about who is the most appropriate person to visit with the keyworker from the health team to undertake a full 24 hour assessment, to update the child's care plan and inform training. Some staff have undertaken training from a product representative. 3 nursing staff have undertaken the Crucial Conversations training course with 3 more booked to attend.

- A Patient Experience Team generic email address kentchft.patientexperience@nhs.net has been made available on the 'Have your say' feedback page on the KCHFT public website. This email offers patients another method of giving their feedback. Compliments and concerns are being received and the team is responding and sharing with the services involved.

- Senior representatives from the directorates who attend the KCHFT monthly Patient Experience Group now provide an update on quality improvements made by their services as a standard agenda item. This happened for the first time at the meeting on 19 February 2018 and was very well received by all attendees (which includes patient representatives and representatives from local voluntary organisations).

3. Patient Outcomes

3.1. Audit

Key Performance Indicators (KPIs)

The annual target is for 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year and is slightly below target this month.

Key Performance Indicators – Actions Stepped Target %	April >35	May >35	June >55	July >65	Aug. >75	Sept. >80	Oct. >80	Nov. >85	Dec. >85	Jan. >90	Feb. >90	Achieved
1. Due audit recommendations implemented - KPI 4.6 Target April >35%	43%	61%	51%	75%	78%	75%	78%	88%	81%	85%	84%	No
2. Actions overdue by more than 3 months -	3%	0%	6%	0%	5%	5%	8%	0%	2%	2%	3%	Yes

PI 36 Target <=10%												
3. Actions overdue by more than 6 months - PI 37 Target <=5%	3%	0%	0%	0%	0%	0%	0%	3%	2%	2%	1%	Yes

3.2 Clinical Audit Reporting

Dashboard and SBAR reporting was recently introduced for clinical audit. This relates to receiving the full report within a specified timeframe after receipt of dashboard reporting. This has been achieved this month.

Key Performance Indicators – Reporting Target 50% *	April	May	June	July	Aug.	Sept.	Oct	Nov.	Dec.	Jan.	Feb.	Achieved
Receipt of full report within specified timeframe following receipt of dashboard	25%	44%	47%	53%	50%	75%	77%	72%	68%	74%	74%	Yes

3.3 Research

KCHFT is set an annual target by the Kent Surrey and Sussex Clinical Research Network to deliver high quality national studies (known as portfolio studies) to local patients. This is a Key Performance Indicator for research and a Quality Objective for 2017/18 and it has been achieved.

Key Performance Indicators – Reporting Target 2017/18 = 200	Quarter 1	Quarter 2	Quarter 3	Quarter 4 (To Date)	Achieved
Recruitment to portfolio studies	179	236	282	303	Yes

3.4 National Institute for Clinical Excellence (NICE)

The process of how NICE standards are assessed and evaluated by the Trust is under review and will be included again in this report next month.

Ali Strowman
Chief Nurse
March 2018

Contributions from the Nursing and Quality and Audit and Performance teams

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.9
Subject:	Finance Report Month Eleven
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 2018.

The Trust achieved a surplus of £3,290k year-to-date (YTD) which was £565k better than plan. The Trust is forecasting to reach a surplus of £3,926k which is £900k ahead of plan.

Key Messages	
Surplus: The Trust achieved a surplus of £3,290k (1.6%) to the end of February. Cumulatively pay has underspent by £11,144k and non-pay and depreciation/interest have overspent by £1,384k and £2,316k respectively. Income has under-recovered by £6,879k.	●
Continuity of Services Risk Rating: EBITDA Margin achieved is 4.1%. The Trust scored 1 against the Use of Resources Rating, the best possible score.	●
CIP: £3,899k of savings has been achieved to February against a risk rated plan of £3,899k which is in-line with target. The full year savings target of £4,271k is forecast to be achieved in full.	●
Cash and Cash Equivalents: The cash and cash equivalents balance was £23,298k, equivalent to 40 days expenditure. The Trust recorded the following YTD public sector payment statistics 99% for volume and 98% for value.	●
Capital: Spend to February was £2,021k, representing 61% of the YTD plan.	●
Agency: Agency expenditure was below trajectory for February.	●

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 position described and no decisions required/no significant change. Papers have no impact on people with any of the nine protected characteristics*.
*** Protected characteristics:** Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.

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Kent Community Health
NHS Foundation Trust

FINANCE REPORT – FEBRUARY 2018 (MONTH 11 of 2017-18)

The Trust achieved a surplus of £3,290k year-to-date (YTD) which was £565k better than plan. The Trust is forecasting to achieve a surplus of £3.9 million, before any additional sustainability and transformation funding.

Dashboard

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	3,290	2,725	565
Year End Forecast £k	3,926	3,026	900

The Trust achieved a surplus of £3,290k to the end of February.

Pay has underspent by £11,144k and non-pay and depreciation/interest have overspent by £1,384k and £2,316k respectively.
Income has under-recovered by £6,879k.

The forecast is to deliver a surplus of £3,926k which is £900k ahead of the plan for the year.

Use of Resource Rating — Rag rating: Green

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

The Trust has scored the maximum '1' rating against the Use of Resource rating metrics for M11 2017-18.

CIP — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	3,899	3,899	0
Year End Forecast £k	4,271	4,271	0

The Trust achieved CIPs of £3,899k to the end of February against a plan of £3,899k, which is in line with the target.

100% of the total annual CIP target has been removed from budgets at month eleven.

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

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	23,298	22,265	1,033
Year End Forecast £k	23,733		

Cash and Cash Equivalents as at M11 close stands at £23,298k, equivalent to 40 days operating expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	2,021	3,304	1,283
Year End Forecast £k	3,733	4,179	446

Capital Expenditure year to date is £2,021k, representing 61% of the YTD plan. As at M11 the full year forecast has been reduced to £3.7m to reflect the confirmed delay of Estates Projects and the postponed procurement of IT Switches.

Agency Trajectories — Rag rating: Green

	M11			Year to Date		
	Actual £	Trajectory £	Variance £	Actual £	Trajectory £	Variance £
External Agency Expenditure (inc. Locums) £k	374	723	350	3,704	7,957	4,252
Locum Expenditure £k	66	106	40	723	1,169	446

External Agency Expenditure (Inc. Locums) was £374k against £723k trajectory in February. (YTD £3,704k against £7,957k trajectory).
Locum Expenditure in February was £66k against £106k trajectory. (YTD £723k against £1,169k trajectory).

1. Income and Expenditure Position

The position for February was £60k favourable compared to plan. The in-month performance comprised an underspend position on pay of £1,290k partly offset by overspends on non-pay and depreciation/interest of £508k and £35k respectively, and an under-recovery on income of £687k. 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	10,680	11,083	-403	-3.6%	117,598	120,846	-3,248	-2.7%
CCGs - Tariff	265	392	-126	-32.3%	3,127	4,272	-1,145	-26.8%
Charitable and Other Contributions to Expenditure	-29	6	-35	-627.8%	43	61	-18	-29.8%
Department of Health	0	0	0	0.0%	0	0	0	0.0%
Education, Training and Research	179	171	8	4.5%	1,932	1,882	50	2.7%
Foundation Trusts	273	285	-12	-4.1%	3,020	3,136	-116	-3.7%
Income Generation	47	13	33	254.2%	289	144	144	99.9%
Injury Cost Recovery	29	27	2	7.1%	377	293	84	28.6%
Local Authorities	3,775	4,021	-246	-6.1%	42,623	44,345	-1,722	-3.9%
NHS England	1,954	1,953	0	0.0%	20,128	21,487	-1,359	-6.3%
NHS Trusts	543	508	34	6.8%	5,264	5,592	-328	-5.9%
Non NHS: Other	154	99	54	54.8%	1,357	1,091	266	24.4%
Non-Patient Care Services to Other Bodies	71	63	8	12.4%	842	697	145	20.8%
Other Revenue	243	243	-1	-0.2%	2,897	2,465	432	17.5%
Private Patient Income	9	14	-5	-35.4%	84	149	-65	-43.6%
Sustainability and Transformation Fund	205	205	0	0.0%	1,554	1,554	0	0.0%
INCOME Total	**18,396**	**19,083**	**-687**	**-3.6%**	**201,136**	**208,015**	**-6,879**	**-3.3%**
Administration and Estates	2,513	2,739	226	8.3%	27,755	29,861	2,106	7.1%
Healthcare Assistants and other support staff	1,789	1,932	143	7.4%	19,633	20,473	840	4.1%
Managers and Senior Managers	807	876	69	7.9%	8,852	9,313	461	5.0%
Medical and Dental	779	822	44	5.3%	8,518	8,988	470	5.2%
Qualified Nursing, Midwifery and Health Visiting	4,199	4,734	535	11.3%	46,479	51,274	4,795	9.4%
Scientific, Therapeutic and Technical	2,428	2,674	246	9.2%	27,111	29,276	2,165	7.4%
Employee Benefits	3	65	62	100.0%	-132	626	758	100.0%
CIP Target Pay	0	22	22	100.0%	0	248	248	100.0%
CIP Achieved (next year) Pay	0	8	8	100.0%	0	43	43	100.0%
East Kent Savings	0	-57	-57	-100.0%	0	-644	-644	-100.0%
North Kent Savings	0	-8	-8	-100.0%	0	-98	-98	-100.0%
PAY Total	**12,518**	**13,809**	**1,290**	**9.3%**	**138,216**	**149,360**	**11,144**	**7.5%**
Audit fees	5	5	0	3.8%	53	55	2	3.8%
Clinical Negligence	41	41	0	0.1%	452	453	0	0.0%
Consultancy Services	54	57	4	6.7%	366	199	-167	-84.2%
Education and Training	57	67	10	14.5%	820	754	-66	-8.7%
Establishment	507	487	-20	-4.0%	6,910	7,607	697	9.2%
Hospitality	3	1	-2	-389.7%	21	6	-16	-269.1%
Impairments of Receivables	-11	0	11	0.0%	-103	0	103	0.0%
Insurance	2	1	-1	-104.1%	29	13	-16	-129.2%
Legal	62	26	-36	-141.0%	337	284	-53	-18.7%
Other Auditors Remuneration	0	0	0	0.0%	0	0	0	0.0%
Other Expenditure	9	10	1	8.6%	100	110	10	8.7%
Premises	1,936	1,360	-576	-42.4%	15,475	14,453	-1,022	-7.1%
Research and Development (excluding staff costs)	0	0	0	100.0%	0	5	5	100.0%
Services from CCGs	0	0	0	0.0%	0	0	0	0.0%
Services from Foundation Trusts	0	0	0	0.0%	0	0	0	0.0%
Services from Other NHS Trusts	159	42	-118	-284.0%	957	616	-341	-55.3%
Supplies and Services - Clinical	1,899	2,140	241	11.3%	23,591	23,233	-359	-1.5%
Supplies and Services - General	110	103	-7	-7.1%	988	1,135	147	12.9%
Transport	420	427	8	1.8%	4,743	4,684	-60	-1.3%
CIP Target Non Pay	0	-22	-22	-100.0%	0	-248	-248	-100.0%
NONPAY Total	**5,253**	**4,745**	**-508**	**-10.7%**	**54,741**	**53,357**	**-1,384**	**-2.6%**
EBITDA	625	529	96	18.1%	8,179	5,298	2,881	54.4%
EBITDA %	3.4%	2.8%	-0.6%		4.1%	2.5%	-41.9%	
DEPRECIATION/AMORTISATION	278	240	-38	-15.8%	4,942	2,639	-2,304	-87.3%
INTEREST PAYABLE	0	0	0	0.0%	0	0	0	0.0%
INTEREST RECEIVED	9	6	3	43.0%	54	66	-12	-18.8%
SURPLUS/(DEFICIT)	**355**	**295**	**60**	**20.5%**	**3,290**	**2,725**	**565**	**20.7%**
SURPLUS %	-1.9%	-1.5%	-0.4%		-1.6%	-1.3%	-0.3%	

Table 1.1: Trust Wide variance against budget in month

2. Risk Ratings

The Trust has scored a 1 against this rating.

3. Cost Improvement Programme

Year to date CIP target (£k)	Year to date CIP Achieved(£k)	Year to date variance – negative denotes an adverse variance (£K)	Full year CIP target (£k)	CIP Achieved (£k)	Full year CIP forecast (£k)	Full Year Total CIP	Full year variance (£k) – negative denotes an adverse variance
3,899	3,899	0	4,271	4,314	-43	4,271	0

Table 3.1: Cost Improvement Programme Performance

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

YTD achievement is in-line with plan as £3,899k has been removed from budgets at month eleven against a risk rated year to date plan of £3,899k. Of the total CIP removed from budgets for the year, all savings have been achieved recurrently.

The negative value in the forecast relates to the reinvestment of the overachievement against 2017-18 plans back into travel budgets.

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

4. Statement of Financial Position and Capital

	At 31 Mar 17 £000's	At 31 Jan 17 £000's	At 28 Feb 18 £000's	Variance Analysis Commentary
NON CURRENT ASSETS:				
Intangible assets	238	331	322	
Property, Plant & Equipment	16,717	13,983	13,786	
Other debtors	68	51	50	
TOTAL NON CURRENT ASSETS	**17,023**	**14,365**	**14,158**	
CURRENT ASSETS:				
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	13,715	12,978	14,451	**NHS & Non NHS - Invoiced Debtors (net of bad debt provision)**
NHS Accrued Debtors	2,026	4,476	4,123	The in-month increase is primarily due to the raising of an invoice to NHSE for
Other debtors	2,604	2,718	2,508	M1-7 17-18 high cost drugs (HIV) and the continual delayed payment of
Total Debtors	**18,345**	**20,172**	**21,082**	invoices with MTW.
Cash at bank in GBS accounts	2,118	22,019	23,235	
Other cash at bank and in hand	49	69	63	
Deposit with the National Loan Fund (Liquid Investment)	17,000	0	0	
Total Cash and Cash Equivalents	**19,166**	**22,088**	**23,298**	
TOTAL CURRENT ASSETS	**37,511**	**42,260**	**44,380**	
CREDITORS:				
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-5,322	-2,399	-1,753	
NHS - accrued creditors falling due within 1 year	-3,234	-2,705	-3,227	
Non NHS - accrued creditors falling due within 1 year	-8,283	-12,885	-14,876	**Non NHS - accrued creditors falling due within 1 year**
Other creditors	-6,993	-6,460	-6,206	The in-month increase is primarily as a result of a further one months accrual
Total amounts falling due within one year	**-23,832**	**-24,450**	**-26,061**	applied for o/s NHSPS charges.
NET CURRENT ASSETS	**13,679**	**17,810**	**18,319**	
TOTAL ASSETS LESS CURRENT LIABILITIES	**30,702**	**32,174**	**32,477**	
Total amounts falling due after more than one year	0	0	0	
PROVISION FOR LIABILITIES AND CHARGES	**-3,584**	**-2,121**	**-2,068**	
TOTAL ASSETS EMPLOYED	27,118	30,053	30,409	
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	-2,612	-2,612	-2,612	
Income and expenditure reserve	-23,740	-26,675	-27,031	
Revaluation Reserve	-766	-766	-766	
TOTAL TAXPAYERS EQUITY	- 27,118	- 30,053	- 30,409	

Table 4.1: Statement of Financial Position, February 2018

	Total Assets	Total Liabilities	Assets/ Liabilities
Feb-17	53,766	28,267	1.90
Mar-17	53,651	27,417	1.96
Apr-17	54,618	27,263	2.00
May-17	54,639	27,048	2.02
Jun-17	55,962	28,135	1.99
Jul-17	57,812	29,693	1.95
Aug-17	57,448	29,092	1.97
Sep-17	58,257	29,619	1.97
Oct-17	61,152	32,123	1.90
Nov-17	54,923	25,530	2.15
Dec-17	55,551	25,799	2.15
Jan-18	56,624	26,571	2.13
Feb-18	58,538	28,129	2.08

Table 4.2: Assets and Liabilities

5. Capital

The table below shows the Trust's total expenditure on capital projects for the year to date 2017-18 and reflects a £1.3m underspend in terms of the year to date plan. The year to date underspend is primarily due to the delayed commencement of projects across the programme. As at M11 the full year forecast has been reduced to £3.7m to reflect the

confirmed delay of Estates Projects and the postponed procurement of IT switches. These elements will now form part of the 18-19 Capital Plans.

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	980	1,066	86	1,134	1,326	192	YTD spend is primarily related to the works on the Orthotics Site, the completion of the Sevenoaks Wound Care Centre and works relating to service relocations at Gravesham CH (from Wrotham Rd/Rochester Rd). The forecast outturn has been reduced to reflect the delayed commencement in projects as advised by the Estates Capital Planning Manager. In turn the delayed projects will form an element of the 18-19 Capital plans.
Backlog Maintenance	299	440	141	447	698	251	YTD underspend is in the main due to the delayed commencement of projects. Actual expenditure YTD primarily relates to the Hawkhurst Flooring Project. The FOT includes works relating to LED Lighting upgrades, Fire compliance and installation of CCTV at Hawkhurst Hospital.
IT Rolling Replacement & Upgrades	616	1,381	765	1,756	1,663	-93	YTD underspend is as a result of the delayed commencement of projects and previously planned schemes now confirmed as no longer to proceed in 17-18. Actual expenditure YTD relates to Licensing Upgrade requirements, Hardware refresh and Switches. The FOT includes additional investment in IT Hardware and Servers to replace outdated equipment.
Dental SBU	4	242	238	177	242	65	YTD underspend is principally due to the delayed commencement of projects. Actual expenditure YTD in the main relates to the purchase of a mobile unit from Barts Health. The FOT includes the purchase of Dental X-ray and other equipment and works at Five Elms (London) which is expected to be completed by the end of March.
Other Minor Schemes	122	175	53	219	250	31	Actual expenditure YTD relates to an upgrade of the Trust's Qlikview reporting capabilities and costs relating to the new integrated Health Improvement System and Learning and Performance System. The FOT includes further set-up costs for the new Learning and Performance system and investment in medical equipment for Respiratory Services and Podiatry.
Total	**2,021**	**3,304**	**1,283**	**3,733**	**4,179**	**446**	

Table 5.1: Capital Expenditure February 2018

Gordon Flack
Director of Finance
12 March 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.10
Subject:	Revenue and Capital Budgets 2018/19
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 income and expenditure budgets and capital plan for 2018/19. The income and expenditure budgets show that the Trust is planning to make a surplus of £3,128k in 2018/19, supported by £2,474k of STF funding, and is planning to spend £3,485k of capital. The Trust Board is asked to approve these budgets.

Proposals and /or Recommendations

The Board is asked to approve the budgets.

Relevant Legislation and Source Documents

Monitor NHS Foundation Trusts Annual Reporting Manual
NHS Manual for Accounts 2017-18

Has an Equality Analysis (EA) been completed

No. High level position described. 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

2018-19 Budgets for Approval

1. Summary

This paper presents the Board with the 2018-19 budgets for approval. It describes the assumptions made in arriving at these budgets.

2. Introduction

The 2018-19 budget has been built up from the rollover 2017-18 budget, and using the following assumptions:

- The budget delivers a surplus of £3,128k, 1.4%, including £2,474k of STF funding (0.3% 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 2017 and has been implemented in calculating 2018/19 budgets.

Budgets are based on the month nine full year budget adding in any full year effects from 2017-18 (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 17/18 and 18/19

Table 3.1 shows the summary income and expenditure budgets for 17/18 and 18/19.

	Closing Budget 17/18	Start Budget 18/19
Income	-226,243	-223,455
Pay	161,987	161,282
Non Pay	58,423	55,931
EBITDA	2,807	3,114
Grand Total	**-3,026**	**-3,128**

Table 3.1: Summary Income and Expenditure Budgets

4. Income and Expenditure and WTE Budgets for 17/18 and 18/19 – By Directorate

Table 4.1 below shows the income and expenditure budgets by directorate for 17/18 and 18/19 noting some income is devolved to directorate level.

Directorate	Closing Budget 17/18	Start Budget 18/19
Operations	140,398	139,688
Childrens Specialist Services	22,259	22,062
Dental	12,377	10,801
East Kent	32,032	33,885
Health Improvement Teams	2,922	2,770
Operations Management	1,302	1,376
Public Health	31,277	30,800
Specialist & Elective Services	19,022	18,545
West Kent	19,207	19,450
Corporate Services	4,014	4,120
Nursing & Quality	3,521	3,453
Medical Director	2,040	2,161
IT	6,575	6,445
Estates	16,228	15,409
Finance Directorate	3,214	3,276
HR, OD & Communications	3,822	3,824
Depreciation	2,807	3,114
Reserves	2,815	3,270
Central Income	-188,458	-187,889
Grand Total	**-3,026**	**-3,128**

Table 4.1 Income and Expenditure Budgets by Directorate

Table 4.2 below shows the WTE budgets by directorate for 17/18 and 18/19.

Directorate	Closing Budget 17/18	Start Budget 18/19
Operations	3,683	3,672
Childrens Specialist Services	614	606
Dental	219	210
East Kent	904	899
Health Improvement Teams	100	98
Operations Management	14	14
Public Health	721	719
Specialist & Elective Services	541	546
West Kent	571	582
Corporate Services	53	53
Nursing & Quality	58	65
Medical Director	48	51
IT	132	130
Estates	215	219
Finance Directorate	95	93
HR, OD & Communications	117	121
Reserves	-54	-93
Central Income	0	0
Grand Total	**4,347**	**4,311**

Table 4.2 WTE Budgets by Directorate

The budgets for 18/19 include the following changes from the 17/18 budgets:

- The full year effect of developments and service changes commencing in 2017/18. These include the removal of non-recurrent set up costs funding for London Dental Services (£1,800k), removal of non-recurrent set up cost funding for Kent School Nursing Service (£588k), removal of non-recurrent funding for East Sussex School Nursing (£150k) and the removal of non-recurrent funding for the East Kent Discharge to Assess Service (£524k).
- Setting an income budget under Central Income for Medway Sexual Health high cost drugs now the contract value has been sent to NHSE for their agreement (£1,280k)
- Funding the increase in depreciation charges from Reserves (£307k) - the increase in depreciation costs result from the increased size of capital programme in 2016/17 and 2017/18 and the relatively high proportion of capital spent on IT which depreciates more quickly than other capital assets. The increase in depreciation would have been greater if the CIS asset had not been fully depreciated in 2017/18.
- Reducing North Kent and Medway Sexual Health budgets by the contracting changes (£226k)
- Transfer funding for Dementia Nurses from Specialist Elective Services to East and West Kent (£83k).

The following funding for new service developments has been included:

- East Kent Frailty (geriatrician) (£500k)
- Dental minor oral surgery tender (£142k part year)

- AAC Growth (£213k)
- East Sussex weight management (School Nursing) (£195k)
- Looked after children (£173k)
- MIU triage service (£302k of which £142k has been funded by Swale and Medway CCGs)
- Patient choice navigator (£30k)
- Removal 8 months of East Sussex Immunisations budgets (-£237k)
- Move income targets from Central Income to Kent Immunisations Service as this service moves to activity based payments (£1,097k)
- Cessation of North Kent MSK Service (£5k – income budgets have been reduced offset by reductions in pay and non-pay budgets)

The CIP target for 2018/19 is £4.1m - equivalent to 1.8% of the operating expenditure budgets.

Demographic funding of £1.6m is included reflecting the funding included within the 2 year heads of agreement signed off in December 2016. This is still subject to discussion with EK CCGs.

A pay award of 1% (£1.6m) has been added to the pay budget.

A tariff inflator of 0.1% has been added to CCG and NHS trust income as per the national guidance. NHSE dental income has been uplifted by 1.4% in line with historic uplifts and NHSE Specialised Services Income by 0.3% in line with agreed contracts. No uplift has been applied to the income from local authorities. Non NHS SLAs have been uplifted by 1.1%.

Table 4.3 below shows the budgets and budgeted WTEs for 2017/18 compared to 2018/19 together with an explanation for significant movements in the budgets between years:

	2017-18 BUDGET £'000	2017-18 BUDGET WTE	2018-19 BUDGET £'000	2018-19 BUDGET WTE	Variance Between Years	Explanation of Main Changes
CCGs - Non Tariff	131,311	0	131,035	0	-276	
CCGs - Tariff	4,663	0	3,594	0	-1,069	Removal of North Kent MSK (9 months, -£1,087k)
Charitable and Other Contributions to Expenditure	67	0	67	0	0	
Clinical Income - Local Authorities	0	0	0	0	0	
Education, Training and Research	2,053	0	2,135	0	81	
Foundation Trusts	3,422	0	3,409	0	-12	
Income Generation	158	0	150	0	-8	
Injury Cost Recovery	320	0	368	0	48	
Local Authorities	48,366	0	46,765	0	-1,600	£535k reduction in Health Improvement contracts, £494k reduction in School Nursing contract (removal of funding for set up costs), £275k removal of Swale Weight Management Service, £142k Medway Sexual Health contract reduction, £80k removal of Kent chlamydia service
NHS England	23,440	0	21,689	0	-1,751	£1.8 million London Dental non-recurrent set-up costs funding removed from 18/19
NHS Trusts	6,100	0	5,958	0	-143	
Non NHS: Other	1,190	0	1,552	0	362	
Non-Patient Care Services to Other Bodies	533	0	681	0	148	
Other Revenue	2,585	0	3,325	0	740	£419k migrant funding, £377k increase in STP recharges
Private Patient Income	276	0	254	0	-22	
Sustainability and Transformation Fund	1,759	0	2,474	0	715	
INCOME Total	**226,243**	**0**	**223,455**	**0**	**-2,788**	
Administration and Estates	32,457	1,282	32,184	1,256	-273	
Healthcare Assistants and other support staff	21,960	849	22,058	838	98	
Managers and Senior Managers	10,164	152	10,652	149	488	£273k STP posts, £128k incremental drift
Medical and Dental	9,802	94	9,804	91	2	
Qualified Nursing, Midwifery and Health Visiting	55,709	1,228	56,945	1,280	1,236	£785k service developments, £188k cost pressures funding
Scientific, Therapeutic and Technical	31,927	741	31,108	726	-818	-£651k NK MSK (9 months)
Employee Benefits	532	0	5	0	-527	Non-recurrent budget for School Nursing & Dental redundancies in 2017/18
CIP Target Pay	265	-6	-777	-15	-1,043	
CIP Achieved (next year) Pay	49	0	89	2	40	
East Kent Savings	-701	7	-688	-16	13	
North Kent Savings	-178	0	-99	0	79	
PAY Total	**161,987**	**4,347**	**161,282**	**4,311**	**-705**	
Audit fees	60	0	64	0	4	
Clinical Negligence	494	0	566	0	72	
Consultancy Services	142	0	93	0	-49	
Education and Training	883	0	808	0	-75	
Establishment	7,940	0	8,324	0	384	Increase in Reserves
Hospitality	6	0	6	0	-1	
Impairments of Receivables	0	0	0	0	0	
Insurance	14	0	20	0	6	
Legal	310	0	310	0	1	
Other Auditors Remuneration	0	0	0	0	0	
Other Expenditure	120	0	110	0	-10	
Premises	15,679	0	14,591	0	-1,087	-£375k London Dental as funding not agreed for 18/19 yet (in 17/18 funded from set up costs), -£420k NK MSK, -£281k CIP
Research and Development (excluding staff costs)	5	0	0	0	-5	
Services from CCGs	0	0	0	0	0	
Services from Foundation Trusts	0	0	0	0	0	
Services from Other NHS Trusts	668	0	704	0	36	
Supplies and Services - Clinical	25,266	0	24,869	0	-397	CIP schemes
Supplies and Services - General	2,054	0	1,202	0	-852	£816k London Dental set up cost budgets non-recurrent, removed in 18/19
Transport	5,111	0	5,597	0	486	£174k cost pressures, £101k service developments, balance moved from other codes to fund overspends
CIP Target Non Pay	-327	0	-1,222	0	-894	
Sexual Health Savings	0	0	-112	0	-112	Savings required by Medway Council
NONPAY Total	**58,423**	**0**	**55,931**	**0**	**-2,492**	
DEPRECIATION/AMORTISATION	2,879		3,186		307	
INTEREST RECEIVED	72		72		0	
BUDGET TOTAL	**-3,026**	**4,347**	**-3,128**	**4,311**	**-102**	
SURPLUS %	1.3%		1.4%			

Table 4.3 – Budgeted Income and Costs and Budgeted WTEs by Subjective Category for 2017/18 and 2018/19

5. Cost Pressures

£2.8m of cost pressures have been funded from non-pay inflation and demographic growth.

6. Contingency

£1.1m (0.5% of income) of reserves are being held in reserves as a contingency against unknown risks and pressures.

7. Capital Plan

Table 7.1 below shows the capital plan for 2018/19 which totals £3.485 million. The capital programme will be financed by £3.1m depreciation plus £0.4m generated from retained surpluses.

Capital Projects	2018-19 Capital Plan £000s
Estate Developments (incl. Backlog Maintenance and Energy Efficiency)	1,650
IT Rolling Replacement and Network/Server Upgrades (investment in Infrastructure)	1,255
IT Developments	157
Dental	173
Other Minor Schemes (incl. Specialist Medical Equipment)	250
Total Capital Plan 2018-19	**3,485**

Table 7.1 - Capital Plan for 2018/19

8. Cashflow

The Trust's cash position for 2018/19 is expected to be good, with a planned improvement in the overall cash balance from £21.8m in March 2018 to £24.8m in March 2019.This will be subject to change, as a result of any additional STF funding which the Trust may receive related to 2017/18.

STATEMENT OF CASH FLOWS	Plan 31/03/2019 Year Ending £000s
Cash flows from operating activities	
Operating surplus/(deficit)	**3,319**
Non-cash income and expense:	
Depreciation and amortisation	2,923
(Increase)/decrease in trade and other receivables	4,478
(Increase)/decrease in other current assets	0
(Increase)/decrease in other assets	0
(Increase)/decrease in inventories	0
Increase/(decrease) in trade and other payables	-1,557
Increase/(decrease) in other liabilities	-458
Increase/(decrease) in provisions	-1,932
Tax (paid) / received	0
Other movements in operating cash flows	0
Net cash generated from / (used in) operations	**6,773**
Cash flows from investing activities	
Interest received	72
Purchase of property, plant and equipment and investment property	-3,485
Proceeds from sales of property, plant and equipment and investment property	0
Net cash generated from/(used in) investing activities	**-3,413**
Cash flows from financing activities	
PDC dividend (paid)/refunded	-263
Cash flows from (used in) other financing activities	0
Net cash generated from/(used in) financing activities	**-263**
Increase/(decrease) in cash and cash equivalents	**3,097**
Cash and cash equivalents at start of period	**21,734**
Cash and cash equivalents at end of period	**24,831**

Table 8.1: Cashflow Statement for 2018/19

9. Working Capital

The Trust's planned monthly cash position reflects a cash level sufficient for liquidity purposes and indicates no requirement to enter negotiations for a committed Working Capital Facility or to request financial assistance from the Department of Health.

10. Recommendation

The Trust Board is recommended to approve these budgets.

Gordon Flack
Director of Finance
20th March 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	2.11
Subject:	Standing Financial Instructions
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary (including purpose and context)

Some minor changes have been made to the Standing Financial Instructions (SFIs)

- to recognise the Department of Health's expanded portfolio and now Department of Health and Social Care
- updated references for General Data Protection Regulations
- changes reflecting current practice i.e. Audit and Risk Committee approving debt write offs instead of the Board. (2.1.6)

There is work being done to revise the Scheme of Delegation to promote further devolution and this will be a further update that will come back to the Board mid-year once completed.

Proposals and /or Recommendations

To approve the Standing Financial Instructions.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. High level position described.

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Kent Community Health
NHS Foundation Trust

Standing Financial Instructions

1 Introduction

1.1 General

1.1.1 These SFIs are issued in accordance with the Code of Accountability, which requires the Trust to agree SFIs for the regulation of the conduct of its Directors and Officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders.

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with Laws and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation.

1.1.3 These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. For the avoidance of doubt, all financial procedures must be approved by the Director of Finance.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Standing Orders.

1.1.5 The failure to comply with SFIs and SOs may in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.1.6 Overriding SFIs – if for any reason these SFIs or the SOs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification by the Board. All Directors and Officers have a duty to disclose any non-compliance with these SFIs to the Chief Executive as soon as possible.

1.1.7 All figures detailed within these SFIs are to be deemed exclusive of VAT (except where VAT is not recoverable by the Trust).

1.2 Responsibilities and delegation

The Board of Directors

1.2.1 The Board exercises financial supervision and control by:

1.2.1.1 formulating the financial strategy;

1.2.1.2 requiring the submission and approval of Budgets within approved allocations/overall income;

1.2.1.3 defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

1.2.1.4 defining specific responsibilities placed on Directors and Officers as indicated in the Scheme of Delegation.

1.2.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation. All other powers have been delegated to such other committees as the Trust has established.

The Chief Executive and Director of Finance

1.2.3 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

1.2.4 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that the Trust's financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.2.5 It is a duty of the Chief Executive to ensure that Directors and Officers and all new appointees are notified of, and put in a position to understand, their responsibilities within these SFIs.

The Director of Finance

1.2.6 The Director of Finance is responsible for:

1.2.6.1 implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

1.2.6.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal

checks are prepared, documented and maintained to supplement these SFIs;

1.2.6.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time; and

1.2.6.4 without prejudice to any other functions of the Trust and its Officers, the duties of the Director of Finance include:

1.2.6.4.1 the provision of financial advice to Directors and Officers;

1.2.6.4.2 the design, implementation and supervision of systems of internal financial control; and

1.2.6.4.3 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.2.7 **Directors and Officers**

All Directors and Officers, severally and collectively, are responsible for:

1.2.7.1 the security of the property of the Trust;

1.2.7.2 avoiding loss;

1.2.7.3 exercising economy and efficiency in the use of resources;

1.2.7.4 conforming with the requirements of SOs, SFIs, financial procedures and the Scheme of Delegation.

1.2.8 For all Directors and Officers who carry out a financial function, the form in which financial records are kept and the manner in which Directors and Officers discharge their duties must be to the satisfaction of the Director of Finance.

Contractors and their employees

1.2.9 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income on behalf of the Trust shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

2 Audit

Audit and Risk Committee

2.1 In accordance with the SOs, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit and Risk Committee Handbook, which will provide an independent and objective view of internal control by:

2.1.1 overseeing internal and external audit services;

2.1.2 reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

2.1.3 review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives;

2.1.4 monitoring compliance with SOs and SFIs;

2.1.5 reviewing schedules of losses and compensations and making recommendations to the Board;

2.1.6 reviewing aged debtors/creditors balances and explanations/action plans and approval of any write offs;

2.1.7 reviewing the arrangements in place to support the Assurance Framework process prepared on behalf of the Board and advising the Board accordingly;

2.2 Where the Audit and Risk Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit and Risk Committee wishes to raise, the chairman of the Audit and Risk Committee should raise the matter with the Director of Finance in the first instance, followed by the Board. Exceptionally, the chairman of the Audit and Risk Committee may refer the matter directly to NHS Improvement.

2.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Audit and Risk Committee shall be involved in the selection process when/if an internal audit service provider is changed.

2.4 **Director of Finance**

The Director of Finance is responsible for:

2.4.1 ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function;

2.4.2 ensuring that the internal audit function is adequate and meets NHS mandatory audit standards;

2.4.3 deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; and

2.4.4 ensuring that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board of Directors. The report must cover:

2.4.4.1 a clear opinion on the effectiveness of internal control in accordance with current Assurance Framework guidance issued by NHS

Improvement including for example compliance with control criteria and standards;

2.4.4.2 major internal financial control weaknesses discovered;

2.4.4.3 progress on the implementation of internal audit recommendations;

2.4.4.4 progress against plan over the previous year;

2.4.4.5 strategic audit plan covering the coming 3 years; and

2.4.4.6 a detailed plan for the coming year.

2.5 The Director of Finance or designated auditors are entitled, without necessarily giving prior notice, to require and receive:

2.5.1 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

2.5.2 access at all reasonable times to any land, premises or Director or Officer;

2.5.3 the production of any cash, stores or other property of the Trust under a Director's and/or an Officer's control; and

2.5.4 explanations concerning any matter under investigation.

2.6 **Role of internal audit**

Internal audit will review, appraise and report upon:

2.6.1 the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

2.6.2 the adequacy and application of financial and other related management controls;

2.6.3 the suitability of financial and other related management data;

2.6.4 the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

2.6.4.1 fraud and other offences;

2.6.4.2 waste, extravagance, inefficient administration;

2.6.4.3 poor value for money or other causes.

2.6.5 Internal audit shall also independently verify the draft Statement of Internal Control for approval by the Board.

2.7 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the

exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.8 Internal auditors will normally attend Audit and Risk Committee meetings and the Head of Internal Audit has a right of access to the chair of the Audit and Risk Committee.

2.9 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit.

2.10 **External audit**

The external auditor is appointed by the Council of Governors and paid for by the Trust. The Audit and Risk Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the external auditor, then this should be raised with the external auditor.

Fraud and corruption

2.11 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with directions issued by the Secretary of State on fraud and corruption; and shall ensure compliance with the provisions of the Bribery Act 2010 (where relevant), with particular regard to the offence in Section 7 of that legislation.

2.12 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual, and associated guidance.

2.13 The LCFS shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud Service (CFS) and the Operational Fraud Team (OFT) in accordance with the NHS Counter Fraud and Corruption Manual.

2.14 The LCFS will provide a written report, at least annually, on counter fraud work within the Trust.

Security management

2.15 In line with his responsibilities, the Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State on NHS security management.

2.16 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State guidance on NHS security management.

2.17 The Trust shall nominate a Non-Executive Director to oversee the NHS security management service which will report to the Board.

2.18 The Chief Executive has overall responsibility for controlling and co-ordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

Finance, Business and Investment Committee (FBI)

2.19 The FBI committee has responsibility for the following ;

2.19.1 Scrutinise current financial performance and future financial plans (Annual Plan and Budget and Long Term Financial Model);

2.19.2 Monitor performance against Cost Improvement Plans;

2.19.3 Overseeing individual business cases and tenders approving within delegated limits and making recommendations to the Board outside of these limits.

2.19.4 Approve treasury management policy and scrutinise implementation.

3 Allocations, planning, budgets, budgetary control, and monitoring

Preparation and approval of plans and Budgets

3.1 The Chief Executive will compile and submit to the Board an annual operating plan which takes into account financial targets and forecast limits of available resources. The annual operating plan will contain:

3.1.1 a statement of the significant assumptions on which the plan is based; and

3.1.2 details of major changes in workload, delivery of services or resources required to achieve the plan.

3.2 Prior to the start of the financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit Budgets for approval by the Board of Directors. Such Budgets will:

3.2.1 be in accordance with the aims and objectives set out in the annual operating plan;

3.2.2 accord with workload and manpower plans;

3.2.3 be produced following discussion with appropriate Budget Holders;

3.2.4 be prepared within the limits of available funds; and

3.2.5 identify potential risks.

3.3 The Director of Finance shall monitor financial performance against Budget and forecast, periodically review them, and report to the Board.

3.4 All Budget Holders must provide information as required by the Director of Finance to enable Budgets to be compiled.

3.5 All Budget Holders will sign up to their allocated Budgets at the commencement of each financial year.

3.6 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to Budget Holders to help them manage successfully.

3.7 **Budgetary delegation**

3.7.1 The Chief Executive may delegate the management of a Budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

3.7.1.1 the amount of the Budget;

3.7.1.2 the purpose(s) of each Budget heading;

3.7.1.3 individual and group responsibilities;

3.7.1.4 authority to exercise virement;

3.7.1.5 achievement of planned levels of service; and

3.7.1.6 the provision of regular reports.

3.8 The Chief Executive and delegated Budget Holders must not exceed the budgetary total or virement limits set by the Board.

3.9 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.10 Non-recurring Budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

3.11 **Budgetary control and reporting**

The Director of Finance will devise and maintain systems of budgetary control. These will include:

3.11.1 monthly financial reports to the Board in a form approved by the Board containing:

3.11.1.1 income and expenditure to date showing trends and forecast year-end position;

3.11.1.2 movements in working capital;

3.11.1.3 movements in cash and capital;

3.11.1.4 capital project spend and projected outturn against plan;

3.11.1.5 explanations of any material variances from plan and changes in forecasts; and

3.11.1.6 details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

3.11.2 the issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible;

3.11.3 investigation and reporting of variances from financial, workload and manpower Budgets;

3.11.4 monitoring of management action to correct variances; and

3.11.5 arrangements for the authorisation of Budget transfers.

3.11.6 **Each Budget Holder is responsible for ensuring that**:

3.11.6.1 any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

3.11.6.2 the amount provided in the approved Budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

3.11.6.3 no permanent Officers are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment as approved by the Board of Directors.

3.11.7 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the annual operating plan and a balanced Budget.

3.12 **Capital expenditure**

The general rules applying to delegation and reporting shall also apply to capital expenditure.

3.13 **Monitoring returns**

The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the requisite monitoring organisation.

4 Annual accounts and reports

4.1 The Director of Finance, on behalf of the Trust, will:

4.1.1 prepare financial returns in accordance with the accounting policies and guidance given by NHS Improvement, the Trust's accounting policies, and generally accepted accounting practice;

4.1.2 prepare and submit annual financial reports to NHS Improvement in accordance with current guidelines;

4.1.3 submit financial returns to NHS Improvement for each financial year in accordance with the timetable prescribed by NHS Improvement.

4.2 The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the NHS Improvement's Manual for Accounts.

5 Bank and GBS accounts

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by NHS Improvement.

5.1.2 The Board shall approve the Trust's banking arrangements.

5.2 **Bank and GBS accounts**

The Director of Finance is responsible for:

5.2.1 bank accounts and GBS accounts;

5.2.2 establishing separate bank accounts for the Trust's non-exchequer funds;

5.2.3 ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

5.2.4 reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn; and

5.2.5 monitoring compliance with NHS Improvement's guidance on the level of cleared funds.

Banking procedures

5.3 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

5.3.1 the conditions under which each bank and GBS account is to be operated; and

5.3.2 those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.4 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

Tendering and review

5.5 The Director of Finance will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.6 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6 Income, fees and charges and security of cash, cheques and other negotiable instruments

Income systems

6.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.2 The Director of Finance is also responsible for the prompt banking of all monies received.

Fees and charges

6.3 The Trust shall follow the NHS 'Approved Costing Guidance' in setting prices for NHS service agreements.

6.4 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS Improvement or by Law. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the Department of Health and Social Care guidance "Commercial Sponsorship: Ethical Standards in the NHS" shall be followed.

6.5 All Officers must inform the Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

Debt recovery

6.6 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.7 Income not received should be dealt with in accordance with losses procedures set out in SFI 15 below.

6.8 Overpayments should be detected (or preferably prevented) and recovery initiated.

Security of cash, cheques and other negotiable instruments

6.9 The Director of Finance is responsible for:

6.9.1 approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

6.9.2 ordering and securely controlling any such stationery;

6.9.3 the provision of adequate facilities and systems for Officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

6.9.4 prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.10 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs. Any Officers or Directors found in breach of this provision may face disciplinary action and/or dismissal.

6.11 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.12 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7 Tendering and contracting procedure

7.1 Duty to comply with SOs and SFIs

The procedure for making all contracts by or on behalf of the Trust shall comply with the SOs and these SFIs (except where SO 3.13 is applied).

7.2 EU Directives governing public procurement

Directives by the Council of the European Union promulgated by the Department of Health prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in the SOs and these SFIs.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.gov.uk/guidance/eauctions.

7.4 Other Department of Health and Social Care guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care “Estatecode” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and with NHSI guidance..

Formal competitive tendering

7.5 **General applicability**

7.5.1 The Trust shall ensure that competitive tenders are invited for:

7.5.1.1 the supply of goods, materials and manufactured articles;

7.5.1.2 the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by NHS Improvement); and

7.5.1.3 the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.6 **Health care services**

Where the Trust elects to invite tenders for the supply of health care services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI 8 below.

Exceptions and instances where formal tendering need not be applied

7.7 Formal tendering procedures need not be applied where:

7.7.1 the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000;

7.7.2 where the supply is proposed under special arrangements negotiated by the Department of Health and Social Care and / or within NHS Supply Chain frameworks in which event the said special arrangements must be complied with;

7.7.3 regarding disposals as set out in SFI 7.24 below;

7.8 Formal tendering procedures may be waived in the following circumstances:

7.8.1 in very exceptional circumstances where the Chief Executive or as delegated the Finance Director decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

7.8.2 where the requirement is covered by an existing contract;

7.8.3 where national agreements are in place and have been approved by the Board;

7.8.4 where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

7.8.5 where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

7.8.6 where specialist expertise is required and is available from only one source;

7.8.7 when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

7.8.8 there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

7.8.9 for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Solicitors Regulation Authority for the conduct of their business (or by the Bar Council in relation to the obtaining of counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work; and

7.8.10 where allowed and provided for in the Capital Investment Manual.

7.9 The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

7.10 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit and Risk Committee.

7.11 **Fair and open procurement process**

Where the exceptions set out in SFIs 7.7 and 7.8 above apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than 2 firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.12 **List of approved firms**

The Trust shall ensure that the firms/individuals invited to tender are among those on approved lists. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive.

7.13 **Building and engineering construction works**

7.13.1.1 Invitations to tender shall be made only to firms included on the approved list compiled in accordance with SFI 7.12 above.

7.13.1.2 Firms included on the approved list shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with the law and for the avoidance of doubt this includes all relevant employment legislation and guidance and the Bribery Act 2010.

7.13.1.3 Firms included on the approved list shall conform at least with the requirements of the Health and Safety at Work Act 1974 (as amended) and any amending and/or other related Laws concerned with the health, safety and welfare of workers and other persons, and to any relevant British standard code of practice issued by the British Standard Institution. Firms must provide to the appropriate Officer a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.14 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in the SFIs for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.15 **Contracting/tendering procedure**

Invitation to tender

7.15.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

7.15.2 All invitations to tender shall state that no tender will be accepted unless:

7.15.2.1 submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or Nominated Officer has not expired;

7.15.2.2 that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

7.15.2.3 every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable, and shall include (where relevant) reference to the provisions of the Bribery Act 2010.

7.15.3 Every tender for building or engineering works (except for maintenance work, when Estatecode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is

primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

Receipt and safe custody of tenders

7.15.4 The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

7.15.5 The date and time of receipt of each tender shall be endorsed on the tender package.

Opening tenders and register of tenders

7.15.6 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by 2 Officers designated by the Chief Executive and, subject to SFI 7.15.10 below, not from the originating department.

7.15.7 A member of the Board will be required to be one of the two approved persons present for the opening of all formal tenders estimated above £50,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Scheme of Delegation.

7.15.8 The 'originating' department will be taken to mean the Trust department sponsoring or commissioning the tender.

7.15.9 The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Officer from the Finance Directorate from serving as one of the 2 Officers to open tenders.

7.15.10 All Executive Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

7.15.11 The Company Secretary will count as an Executive Director for the purposes of opening tenders.

7.15.12 Every tender received shall be marked with the date of opening and initialled by those present at the opening.

7.15.13 A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

7.15.13.1 the name of all firms individuals invited;

7.15.13.2 the names of firms individuals from which tenders have been received;

7.15.13.3 the date the tenders were opened;

7.15.13.4 the persons present at the opening;

7.15.13.5 the price shown on each tender;

7.15.13.6 a note where price alterations have been made on the tender.

7.15.14 Each entry to this register shall be signed by those present.

7.15.15 A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

7.15.16 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (see SFI 7.17).

7.16 **Admissibility**

7.16.1 If for any reason the designated Officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

7.16.2 Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.17 **Late tenders**

7.17.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his Nominated Officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

7.17.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his Nominated Officer or if the process of evaluation and adjudication has not started.

7.17.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents

shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his Nominated Officer.

7.18 **Acceptance of formal tenders**

7.18.1 Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

7.18.2 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

7.18.3 It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

7.18.3.1 experience and qualifications of team members;

7.18.3.2 understanding of client's needs;

7.18.3.3 feasibility and credibility of proposed approach;

7.18.3.4 ability to complete the project on time.

7.18.4 Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

7.18.5 No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Board and which is not in accordance with these SFIs except with the authorisation of the Chief Executive.

7.18.6 The use of these procedures must demonstrate that the award of the contract was:

7.18.6.1 not in excess of the going market rate / price current at the time the contract was awarded;

7.18.6.2 that best value for money was achieved.

7.18.7 All tenders should be treated as confidential and should be retained for inspection.

7.18.8 **Tender reports to the Board of Directors**

Reports to the Board will be made on an exceptional circumstance basis only.

7.19 **Quotations: competitive and non-competitive**

7.19.1 **General position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not £50,000.

7.19.2 **Competitive quotations**

7.19.2.1 Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

7.19.2.2 Quotations should be in writing unless the Chief Executive or his Nominated Officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

7.19.2.3 All quotations should be treated as confidential and should be retained for inspection.

7.19.2.4 The Chief Executive or his Nominated Officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.19.3 **Non-competitive quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

7.19.3.1 the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

7.19.3.2 the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

7.19.3.3 miscellaneous services, supplies and disposals;

7.19.3.4 where the goods or services are for building and engineering maintenance the responsible works Officer must certify that the first two conditions of this SFI (SFIs 7.19.3.1 and 7.19.3.2 above) apply.

7.19.4 **Instances where competitive quotation need not be obtained**

Competitive quotation need not be applied where:

17.19.4.1 the intended expenditure or income does not, or is not reasonably expected to exceed £10,000; or

17.19.4.2 the Assistant / Deputy Director has authorised, and recorded in an appropriate Trust record, the use of a single quote on the basis that the competitive quotation process would not be suitable or practical given the circumstances of the transaction.

7.19.5 **Quotations to be within financial limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Board and which is not in accordance with SFIs except with the authorisation of either the Chief Executive or Director of Finance.

7.19.6 **Authorisation of tenders and competitive quotations**

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following Officers to the value of the contract as follows:

7.19.6.1 **Designated Budget Holders** - up to £19,999;

7.19.6.2 **Assistant / Deputy Directors** - between £20,000 and £49,999;

7.19.6.3 **Directors** - between £50,000 and £99,999;

7.19.6.4 **Director of Finance** - between £100,000 and £499,999

7.19.6.5 **Chief Executive** - between £500,000 and £999,999;

7.19.6.6 **Finance, Business and Investment Committee** – between £1,000,000 and £2,999,999

7.19.6.7 **Board of Directors** - over £3,000,000.

These levels of authorisation may be varied or changed by the Board at its sole discretion and need to be read in conjunction with the Scheme of Delegation. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors, this shall be recorded in its minutes.

7.20 **Preferred procurement route**

7.20.1 The NHS Supply Chain is the preferred procurement route of all goods and services unless the Chief Executive or nominated Officers deem it inappropriate. The decision to use alternative sources must be documented.

7.20.2 If the Trust does not use the NHS Supply Chain the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

7.21 **Private finance for capital procurement**

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

7.21.1 the Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

7.21.2 where the sum exceeds delegated limits, a business case must be completed for approval.

7.21.3 the proposal must be specifically agreed by the Board.

The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.22 **Compliance requirements for all contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

7.22.1 the Trust's SOs and SFIs;

7.22.2 EU Directives and other statutory provisions;

7.22.3 any relevant Laws, directions or guidance issued by the Secretary of State;

7.22.4 such of the NHS Standard Contract Conditions as are applicable.

7.22.5 contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

7.22.6 where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

7.22.7 in all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an Officer who shall oversee and manage each contract on behalf of the Trust.

7.23 **Personnel and agency or temporary staff contracts**

The Chief Executive shall nominate Officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.24 **Health care services agreements**

7.24.1 Service level agreements with NHS providers for the supply of healthcare services are legal documents and are enforceable in law.

7.24.2 The Chief Executive shall nominate Officers to commission service agreements with providers of healthcare in line with a commissioning plan approved by the Board.

7.25 **Disposals**

Competitive tendering or quotation procedures shall not apply to the disposal of:

7.25.1 any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his Nominated Officer;

7.25.2 obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

7.25.3 items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

7.25.4 items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

7.25.5 land or buildings concerning which DHSC guidance has been issued but subject to compliance with such guidance.

7.26 **In-house services**

7.26.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.26.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

7.26.2.1 **specification group**, comprising the Chief Executive or nominated officer/s and specialist;

7.26.2.2 **in-house tender group**, comprising a nominee of the Chief Executive and technical support;

7.26.2.3 **evaluation team**, comprising normally a specialist Officer, a supplies Officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £1,000,000, approved by the Finance, Business and Investment Committee.

7.26.3 All groups should work independently of each other and individual Officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.26.4 The evaluation team shall make recommendations to the Board.

7.26.5 The Chief Executive shall nominate an Officer to oversee and manage the contract on behalf of the Trust.

7.27 **Applicability of SFIs on tendering and contracting to Funds Held on Trust**

These SFIs shall not only apply to expenditure from exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

8 NHS service agreements for provision of services

8.1 Service Contracts

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services.

8.1.2 In discharging this responsibility, the Chief Executive should take into account:

8.1.2.1 the standards of service quality expected;

8.1.2.2 the relevant national service framework (if any);

8.1.2.3 the provision of reliable information on cost and volume of services;

8.1.2.4 the NHS National Performance Assessment Framework; and

8.1.2.5 that contracts build where appropriate on existing joint investment plans (if any).

8.2 Reports to Board of Directors on Service Contracts

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the Service Contracts. This will include information on costing arrangements.

9 Terms of service, allowances and payment of directors and officers

9.1 Remuneration and terms of service

9.1.1 In accordance with the SOs the Board shall establish a Remuneration and Terms of Service Committee with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

9.1.2 The duties of the Remuneration and Terms of Service Committee will include, but not be limited to:

9.1.2.1 advising the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors and other senior Officers, on matters including:

9.1.2.1.1 all aspects of salary (including any performance-related elements/bonuses);

9.1.2.1.2 provisions for other benefits, including pensions and cars; and

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

9.1.2.2 making such recommendations to the Board on the remuneration and terms of service of Directors and senior Officers to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

9.1.2.3 monitoring and evaluating the performance of individual Executive Directors (and other senior Officers); and

9.1.2.4 advising on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

9.1.3 The Remuneration and Terms of Service Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of officer members. Minutes of the Board's meetings should record such decisions.

9.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those Officers not covered by the Remuneration and Terms of Service Committee.

9.1.5 The Trust will pay allowances to the Chairman and Non-Executive Directors in accordance with Council of Governors agreement.

9.2 **Funded establishment**

9.2.1 The manpower plans incorporated within the Trust's annual Budget will form the funded establishment.

9.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive.

9.3 **Staff appointments**

9.3.1 No Director or Officer may engage, re-engage, or re-grade Officers, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

9.3.1.1 authorised to do so by the Chief Executive; and

9.3.1.2 within the limit of their approved Budget and funded establishment.

9.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for Officers.

9.4 **Processing payroll**

9.4.1 **The Director of Finance is responsible for:**

9.4.1.1 specifying timetables for submission of properly authorised time records and other notifications;

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates; and

9.4.1.4 agreeing method of payment.

9.4.2 **The Director of Finance will issue instructions regarding:**

9.4.2.1 verification and documentation of data;

9.4.2.2 the timetable for receipt and preparation of payroll data and the payment of Officers and allowances;

9.4.2.3 maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

9.4.2.4 security and confidentiality of payroll information;

9.4.2.5 checks to be applied to completed payroll before and after payment;

9.4.2.6 authority to release payroll data under the provisions of the Data protection Act 1998 and subsequent General Data Protection Regulation;

9.4.2.7 methods of payment available to various categories of Officers;

9.4.2.8 procedures for payment by cheque, bank credit, or cash to Officers;

9.4.2.9 procedures for the recall of cheques and bank credits;

9.4.2.10 pay advances and their recovery;

9.4.2.11 maintenance of regular and independent reconciliation of pay control accounts;

9.4.2.12 separation of duties of preparing records and handling cash; and

9.4.2.13 a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

9.4.3 **Appropriately Nominated Officers have delegated responsibility for:**

9.4.3.1 submitting time records, and other notifications in accordance with agreed timetables;

9.4.3.2 completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

9.4.3.3 submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement. Where an Officer fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Director of Finance must be informed immediately.

9.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.5 Contracts of employment

The Board shall delegate responsibility to an Executive Director for:

9.5.1 ensuring that all Officers are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation; and

9.5.2 dealing with variations to, or termination of, contracts of employment.

10 Non-pay expenditure

10.1 Delegation of authority

10.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Officers with Budget responsibility.

10.1.2 The Chief Executive will set out:

10.1.2.1 the list of Officers, Directors, Nominated Officers and Deputy Directors who are authorised to place requisitions for the supply of goods and services; and

10.1.2.2 the maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, requisitioning, ordering, receipt and payment for goods and services

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance and/or the Chief Executive shall be consulted.

System of payment and payment verification

The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.3 **The Director of Finance will:**

10.3.1 advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the SOs and SFIs and/or Scheme of Delegation (as appropriate) and regularly reviewed;

10.3.2 prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

10.3.3 be responsible for the prompt payment of all properly authorised accounts and claims;

10.3.4 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

10.3.4.1 a list of Directors (including specimens of their signatures) authorised to certify invoices;

10.3.4.2 certification that:

10.3.4.2.1 goods have been duly received, examined and are in accordance with specification and the prices are correct;

10.3.4.2.2 work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

10.3.4.2.3 in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

10.3.4.2.4 where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

10.3.4.2.5 the account is arithmetically correct;

10.3.4.2.6 the account is in order for payment;

10.3.4.2.7 a timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

10.3.4.2.8 instructions to Officers regarding the handling and payment of accounts within the Finance Department; and

10.3.4.2.9 be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 10.5 below.

10.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

10.4.1 prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%);

10.4.2 the appropriate Officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

10.4.3 the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold); and

10.4.4 the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

10.5 **Purchase orders**

Purchase orders for goods and/or services must:

10.5.1 be consecutively numbered;

10.5.2 be in a form approved by the Director of Finance;

10.5.3 state the Trust's terms and conditions of trade; and

10.5.4 only be issued to, and used by, those duly authorised by the Chief Executive.

10.6 **Duties of Officers**

Officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

10.6.1 all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

10.6.2 contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

10.6.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care;

10.6.4 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or Officers, other than:

10.6.5 isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

10.6.5.1 conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with SO 6, the individual and collective offences in Sections 1,2 and 7 of the Bribery Act 2010; and the principles outlined in the national guidance contained in:

10.6.5.2 HSG 93(5) "Standards of Business Conduct for NHS Staff';

10.6.5.3 the Code of Conduct for NHS Managers 2002; and

10.6.5.4 the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry;

10.6.5.5 no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

10.6.5.6 all goods, services, or works are ordered on a purchase order except works and services executed in accordance with a contract and purchases from petty cash;

10.6.5.7 verbal orders must only be issued very exceptionally - by an Officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "confirmation order";

10.6.5.8 orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

10.6.5.9 goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

10.6.5.10 changes to the list of Officers authorised to certify invoices are notified to the Director of Finance;

10.6.5.11 purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

10.6.5.12 petty cash records are maintained in a form as determined by the Director of Finance.

10.6.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the SFIs 7.15.3. The technical audit of these contracts shall be the responsibility of the relevant Director.

11 External borrowing

11.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividend on, and repay public dividend capital and any proposed new borrowing, within the limits of the planned Finances and Use of Resources Metrics. The Director of Finance is also responsible for reporting periodically to the Board concerning the public dividend capital debt and all loans and overdrafts.

11.2 The Board will agree the list of Officers (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Director of Finance.

11.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

11.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cashflow position, represent good value for money and comply with the Treasury Management policy.

11.5 Any short-term borrowing must be with the authority of 2 Executive Directors, one of which must be the Chief Executive or the Director of Finance. The Board of Directors must be made aware of all short term borrowings at the next Board meeting.

11.6 All long-term borrowing must be approved by the Trust Board.

11.7 All borrowing must be in line with the conditions stipulated in the Treasury management policy as delegated by the Board to the Finance, Business and Investment committee.

12 Investments

12.1 Temporary cash surpluses must be held only in safe haven public or private sector investments as authorised by the Board.

12.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board as delegated to the Finance, Business and Investment Committee concerning the performance of investments held.

12.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

13 Capital investment, private financing, non-current asset registers and security of assets

13.1 Capital investment

The Chief Executive:

13.1.1 shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

13.1.2 is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

13.1.3 shall ensure that the capital investment is not undertaken without confirmation of the availability of resources to finance all revenue consequences, including capital charges.

13.2 For every capital expenditure proposal the Chief Executive shall ensure:

13.2.1 that a business case is produced setting out:

13.2.1.1 an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

13.2.1.2 the involvement of appropriate Trust personnel and external agencies; and

13.2.1.3 appropriate project management and control arrangements;

13.2.2 that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case.

13.2.3 that for capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of Estatecode.

13.3 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

13.4 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

13.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

13.6 The Chief Executive shall issue to the Officer responsible for any scheme:

13.6.1 specific authority to commit expenditure;

13.6.2 authority to proceed to tender;

13.6.3 approval to accept a successful tender.

13.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Estatecode guidance and the Trust's SOs.

13.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account any current delegated limits for capital schemes.

13.9 **Private finance**

The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its allocations, the following procedures shall apply:

13.9.1 the Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector;

13.9.2 where the sum involved exceeds delegated limits, the business case must be referred to NHS Improvement or in line with any current guidelines; and

13.9.3 the proposal must be specifically agreed by the Board of Directors.

13.10 **Asset registers**

13.10.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

13.10.2 The Trust shall maintain an asset register recording non-current assets.

13.10.3 Additions to the non-current asset register must be clearly identified to an appropriate Budget Holder and be validated by reference to:

13.10.3.1 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

13.10.3.2 stores, requisitions and wages records for own materials and labour including appropriate overheads; and

13.10.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

13.10.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

13.10.5 The Director of Finance shall approve procedures for reconciling balances on non-current assets accounts in ledgers against balances on non-current asset registers.

13.10.6 Where a full valuation of assets has not been undertaken, the value of each material asset shall be indexed to current values in accordance with the most up-to date BCIS Index (Building Cost Information Service of RICS). The BCIS Index fulfils the requirement of being current and is approved by the Royal Institution of Chartered Surveyors. Where the BCIS Index is not appropriate for a class of asset i.e. Land, an assessment of current valuation will be provided by an approved External Chartered Surveyor. Non-Property assets, those assets which have short useful lives or low values (or both) are not re-valued.

13.10.7 The value of each asset shall be depreciated using methods applicable to NHS Improvement's Manual for Accounts and relevant International Accounting Standards.

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13.11 **Security of assets**

13.11.1 The overall control of non-current assets is the responsibility of the Chief Executive.

13.11.2 Asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

13.11.2.1 recording managerial responsibility for each asset;

13.11.2.2 identification of additions and disposals;

13.11.2.3 identification of all repairs and maintenance expenses;

13.11.2.4 physical security of assets;

13.11.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;

13.11.2.6 identification and reporting of all costs associated with the retention of an asset; and

13.11.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

13.11.3 All discrepancies revealed by verification of physical assets to non-current asset register shall be notified to the Director of Finance.

13.11.4 Whilst each Director and Officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors and Officers to apply such appropriate routine security practices in relation to NHS and/or Trust property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

13.11.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Officers in accordance with the procedure for reporting losses.

13.11.6 Where practical, assets should be marked as Trust property.

14 Stores and receipt of goods

14.1 General position

Current accounting practice is not to account for Inventory. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

14.1.1 kept to a minimum;

14.1.2 subjected to proper control and recording; and

14.1.3 valued at the lower of cost and net realisable value.

Control of stores, stocktaking, condemnations and disposal

14.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical inventories shall be the responsibility of a designated Officer for pharmaceutical matters; and the control of any fuel oil and coal shall be the responsibility of a designated Officer for estates matters.

14.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated Officer. Wherever practicable, inventories should be marked as Trust property.

14.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

14.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

14.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

14.7 A designated Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 Goods supplied by NHS Supply Chain

For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the

store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15 Disposals and condemnations, losses and special payments

Disposals and condemnations

15.1 **Procedures**

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to Directors and Officers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or their authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

15.1.3.1 condemned or otherwise disposed of by an Officer authorised for that purpose by the Director of Finance;

15.1.3.2 recorded by the condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Director of Finance.

15.1.4 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

Losses and special payments

15.2 **Procedures**

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

15.2.2 Any Director or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an Officer charged with responsibility for responding to concerns involving loss. This Officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant LCFS and CFSMS regional team.

15.2.3 The Director of Finance must notify the NHS CFS and the external auditor of all frauds.

15.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

15.2.4.1 the Board of Directors; and

15.2.4.2 the external auditor.

15.2.5 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

15.2.6 For any loss, the Director of Finance should consider whether any insurance claim can be made.

15.2.7 The Director of Finance shall maintain a "Losses and Special Payments Register" in which write-off action is recorded.

15.2.8 No special payments shall be made without the prior approval of the Board. .

15.2.9 All losses and special payments must be reported to the Audit and Risk Committee at six monthly intervals unless a significant loss has been incurred.

16 Information technology

16.1 Responsibilities and duties of the Director of Finance (or nominated officer)

The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

16.1.1 devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data protection Act 1998 and subsequent General Data Protection Regulations;

16.1.2 ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

16.1.3 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

16.1.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

16.2 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.3 The Trust Secretary shall publish and maintain a "freedom of information (FOI) publication scheme", or adopt a model "Publication Scheme" approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

16.4 **Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application**

In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of NHS trusts in the region wish to sponsor jointly) all responsible Directors and Officers will send to the Director of Finance's Nominated Officer:

16.4.1 details of the outline design of the system; and

16.4.2 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.5 **Contracts for computer services with other health service bodies or outside agencies**

The Director of Finance shall ensure that contracts for computer services for financial applications with another health service body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes. Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.6 **Risk assessment**

The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

16.7 **Requirements for computer systems which have an impact on corporate financial systems**

Where computer systems have an impact on Trust financial systems the Director of Finance shall need to be satisfied that:

16.7.1 systems acquisition, development and maintenance are in line with Trust policies such as an information technology strategy;

16.7.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

16.7.3 Director of Finance staff have access to such data; and

16.7.4 such computer audit reviews as are considered necessary are being carried out.

17 Patients' property

17.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

17.2.1 notices and information booklets; (notices are subject to sensitivity guidance);

17.2.2 hospital admission documentation and property records; and

17.2.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the custody and security of a patient’s money.

17.4 Where Department of Health and Social Care instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

17.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

17.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18 Funds held on trust

18.1 Corporate trustee

18.1.1 SO 2.8.2 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 18.2 below, which defines the need for compliance with Charities Commission latest guidance and best practice.

18.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Director of Finance shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission and Secretary of State

18.2.1 The Trust's trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Scheme of Delegation makes clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Directors and Officers must take account of that guidance before taking action.

18.3 Applicability of SFIs to funds held on trust

18.3.1 In so far as it is possible to do so, most of the sections of these SFIs will apply to the management of funds held on trust.

18.3.2 The overriding principle is that the integrity of each trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

19 Acceptance of gifts by staff and link to standards of business

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health and Social Care circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of the SOs and SFIs.

20 Retention of records

20.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health and Social Care guidelines.

20.2 The records held in archives shall be capable of retrieval by authorised persons.

20.3 Records held in accordance with latest Department of Health and Social Care guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

21 Risk management and insurance

Programme of Risk Management

21.1 The Chief Executive shall ensure that the Trust has a programme of risk management which must be approved and monitored by the Board.

21.2 The programme of risk management shall include:

21.2.1 a process for identifying and quantifying risks and potential liabilities;

21.2.2 engendering among all levels of staff a positive attitude towards the control of risk;

21.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

21.2.4 contingency plans to offset the impact of adverse events;

21.2.5 audit arrangements including; internal audit, clinical audit, health and safety review;

21.2.6 a clear indication of which risks shall be insured; and

21.2.7 arrangements to review the risk management programme.

21.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement of Internal Control within the annual report and accounts as required by current NHS Improvement guidance.

21.4 **Insurance: risk pooling schemes administered by NHSLA**

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHSLA or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.5 **Insurance arrangements with commercial insurers**

The Trust, as a Foundation Trust, can enter into insurance arrangements, for areas not covered by the risk pooling schemes, with commercial insurers. The Board will approve commercial insurance arrangements.

21.6 **Arrangements to be followed by the Board in agreeing insurance cover**

21.6.1 Where the Board decides to use the risk pooling schemes administered by NHSLA the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

21.6.2 Where the Board decides not to use the risk pooling schemes administered by the NHSLA for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.6.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the "**Deductible**"). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the Deductible in each case.

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	3.1
Subject:	Charitable Funds Committee Minutes
Presenting Officer:	Richard Field, Deputy Chair of the Charitable Funds Committee

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

Report Summary (including purpose and context):
The paper presents the confirmed Minutes of the Charitable Funds Committee meeting of 25 October 2017.

Proposals and /or Recommendations:
The Board is asked receive the confirmed minutes.

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

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

Kent Community Health NHS Foundation Trust

CONFIRMED Minutes of the Charitable Funds Committee held on Wednesday 25 October 2017 in at Discovery Orthotics, 3 Hugin Lane, Discovery Park, Sandwich CT13 9FG

Present:	Richard Field, Non-Executive Director Carol Coleman, Public Governor, Dover and Deal Lesley Strong, Chief Operating Officer/ Deputy Chief Executive
In Attendance:	Gina Baines, Committee Secretary/Assistant Trust Secretary (note-taker) Jo Bing, Assistant Financial Accountant Victoria Cover, Head of Clinical Services, Mid Kent West Kent Locality Julia Rogers, Assistant Director of Communications and Marketing Neil Sherwood, Acting Deputy Convenor Staff Side Carl Williams, Head of Financial Accounting

025/17 Introduction by Chair

Richard Field welcomed everyone present to the meeting of the Charitable Funds Committee meeting.

026/17 Apologies for Absence

Apologies were received from Gordon Flack, Director of Finance, Jane Kendal, Community Services Director East Kent (Fund Manager); Claire Poole, Community Services Director Public Health/Deputy Chief Operating Officer, Jen Tippin (Chair) Non-Executive Director and Jo Treharne, Head of Marketing.

The meeting was quorate.

027/17 Declarations of Interest

There were no Declarations of Interest given apart from those formally noted on the record.

028/17 Minutes and Matters Arising from the Meeting of 26 April 2017

The minutes were **AGREED** by the Committee.

Matters Arising

The Matters Arising from the previous meeting were reviewed and updated as follows:

020/17 Terms of Reference Review – it was agreed that the information relating to the Trustee Act 2000 would be recirculated to the Committee.

020/17 Terms of Reference Review – The Committee agreed that the minutes should be presented in the Public Board Part One meeting going forward. Action open.

023/17 Any Other Business – Considerable work had been undertaken to refresh the Dementia Strategy. Action Closed.

All other open actions were closed.

The Matters Arising Table was **AGREED.**

029/17 Marketing the Charitable Funds Report

Julia Rogers presented the report to the Committee for assurance.

In response to a question from Richard Field as to whether the Finance Team could provide administrative support for the Pennies From Heaven scheme, Carl Williams indicated that there would be capacity. In response to a further question regarding whether the Trust could attract sponsorship to cover the set up costs of the scheme, it was agreed to ask Jo Treharne to investigate whether this could be obtained
Action – Julia Rogers

After further discussion, the Committee gave its support in principle for an opt-in scheme to proceed. It was suggested that the views of staff should be sought as well as a discussion with Staff Side, before a final proposal was presented to the Board.
Actions – Julia Rogers

It was agreed to ask Louise Norris, Director of Workforce, Organisational Development and Communications to present a paper regarding the scheme to the Staff Partnership Forum in November 2017.
Action – Julia Rogers

The Committee **NOTED** the Marketing the Charitable Funds Report.

030/17 Annual Marketing Plan (Including the Annual Marketing Objectives)

Julia Rogers presented the report to the Committee for assurance.

With regards to the charity objectives for 2017/18, it was proposed that a dedicated fundraiser be appointed. Carol Coleman questioned whether the appointment would make financial sense considering the limited target the fundraiser would be required to achieve. It was suggested that, as the target was achievable, it was not unrealistic that a greater amount would be

raised.

In response to a question from Richard Field regarding whether the post could be developed, Julia Rogers indicated that this was a possibility which would allow for the fundraiser's contractual arrangements to change.

With regards to the Forget Me Not campaign, Richard Field highlighted the tension between fund raising across the whole of the Trust and reassuring donors that their donation would be spent locally. Lesley Strong indicated that the community services needed a boost to the funds available to them rather than the community hospitals which already had access to restricted funds. Community hospitals also received funding from the League of Friends. However, it was agreed to ask Jo Treharne to liaise with Claire Poole regarding what items the community hospitals required to support the implementation of the Trust's Dementia Strategy.
Action – Julia Rogers

With regards to who should benefit from the Forget-Me-Not campaign, Jo Bing indicated that there were no specific funds available for children and young people. It was agreed that the objective relating to the appeal would be reviewed.
Action – Julia Rogers

To leverage the charitable funds to their maximum, it was suggested asking Jo Treharne to investigate match-funding with the community hospitals' Leagues of Friends and other charities.
Action – Julia Rogers

With regards to legacies, Jo Bing confirmed that none had been received this year. It was agreed to ask Jo Treharne to include in the next Community Health magazine a piece on leaving a legacy to the Trust's Charitable Funds.
Action – Julia Rogers

The Committee **NOTED** the Annual Marketing Plan (Including the Annual Marketing Objectives).

031/17 Fund Manager Presentation – Bow Road Charitable Fund

Victoria Cover presented the report to the Committee for assurance.

Although the priority was to spend the fund within the specified geographical area, Victoria Cover suggested that some might be used in other areas in Maidstone as the fund area was very small.

In response to a question from Lesley Strong regarding what view the Charities Commission would take on widening the geographical scope of spend of the fund, it was agreed to seek the commission's advice.
Action – Carl Williams

It was agreed that Victoria Cover would order the equipment for the Speech

and Language Service in the meantime.

In response to a question from Lesley Strong regarding what further items could be purchased if the scope of spend was widened, it was agreed that Victoria Cover would advise Carl Williams. A number of suggestions were made and it was agreed that she would discuss these with the new GP cluster leads in the area. She would also consider the purchase of a mobile unit.
Actions – Victoria Cover

The Committee **NOTED** the Fund Manager Presentation.

032/17 Draft Accounts

Carl Williams presented the report to the Committee for comment.

In response to a question from Victoria Cover regarding whether restricted funds had been used to support the Staff Awards in 2017, Jo Bing confirmed that any support had been from the general fund.

Carl Williams commented that there would be some further iteration of the accounts but any changes would be immaterial. The final accounts would be presented at the January 2018 Charitable Funds Committee meeting for approval.

The Committee **NOTED** the Draft Accounts.

Post-meeting note from Jo Bing

For clarification, the Staff Awards costs for June 2016 (2016/17 Accounts) were apportioned over restricted and unrestricted funds where appropriate and as agreed. The costs for June 2017/18 (2017/18 Accounts) were fully funded via the general fund. This has been accounted for as per discussions that took place and actions agreed.

033/17 Reserves Policy 2017/18

Carl Williams presented the policy to the Committee for approval.

There were no changes to the policy.

The Committee **APPROVED** the Reserves Policy 2017/18.

034/17 Forward Plan

Richard Field presented the report to the Committee for approval.

It was suggested that a new objective be proposed in the Marketing the Charitable Funds Report. This would be presented at the next meeting or earlier by virtual agreement if necessary.

The agenda items for the January 2018 Committee meeting were agreed.

The Forward Plan would be updated.
Action - Gina Baines

The Committee **APPROVED** the Forward Plan.

035/17 Any Other Business

The meeting ended at 1.30pm.

036/17 Date and time of next meeting

Thursday 25 January 2017 9am in The Council Chamber, Sevenoas Town Council Offices, Bradbourne Vale Road, Sevenoaks TN13 3QG

Kent Community Health NHS
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	3.2
Subject:	Quarterly Infection Prevention and Control Report.
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 (IPC) activity between 1 November 2017 and 28 February 2018.

- There were two *Clostridium difficile* infections reported in January and February. The first case was deemed unavoidable. The second case is still being investigated declared as a Serious Incident (SI).
- The Trust-wide Clostridium difficile reduction action plan has been completed, however, local actions continue for cleaning in 2 hospitals.
- There have been no MRSA bacteraemias attributed to KCHFT in this period, but one case in November was identified where KCHFT staff provided care.
- MRSA screening for patients in community hospitals has been 100% compliant throughout this reporting period, except December, where one patient screen was missed.
- KCHFT have continued with all gram negative bacteraemia surveillance in order to help focus both local and Kent-wide IPC programmes.
- The cleaning reports continue to fail to reach target in the wards in Faversham and Queen Victoria Memorial Hospital (QVMH) consistently however standards have been consistently improved in Sevenoaks. The new Head of Facilities continues to work with the teams in these areas.
- Trust compliance with hand hygiene training was reported as 88% and mandatory training 95% in January.
- The Trust has breached its annual target for CAUTI's by 4 cases, a reduction campaign has been launched locally. The Trust is on track to achieve the UTI reduction.
- The Trust Staff Flu Vaccination Campaign has concluded with 59% of staff receiving the vaccine. The highest percentage compliance yet.
- The Trust Occupational Health provider continues to evidence to the Infection prevention and control committee their compliance with guidelines on staff checks and vaccinations.

- The Assistant Director of IPC has undertaken an audit, alongside the Trust's Medical Devices Manager and Authorised Engineer for Decontamination at the central sterilisation services, and compliance was found.

- The Water Safety Committee continues to meet to highlight gaps in assurance and evidence risk reduction actions. Recently, it has been reviewing a number of incidents relating to water supply and contamination in a variety of settings; all of which are now resolved.

- The Antimicrobial Stewardship Committee continues to meet. Currently, focus remains upon collaborative working across Kent through clinical commissioning group (CCG) lead Antimicrobial Stewardship groups.

- The SEPSIS algorithms and prompt cards have been implemented and the ongoing education and training is currently being planned.

- Outbreaks - There have been 11 outbreaks in this timeframe, 6 respiratory / influenza outbreaks, 5 diarrhoea / norovirus outbreaks.

- The 2018 Infection Prevention and Control Declaration was presented at the Quality Committee meeting.

Proposals and /or Recommendations:
The Board to note the report for assurance.

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

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

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT

1. Introduction

The content of this report was presented and discussed at the Quality Committee on 20 March 2018.

2. Clostridium difficile

Target: The national objective has remained unchanged in 2017/18, therefore the Trust must be attributed no more than 5 cases of *Clostridium difficile* infections with no level 3 lapses in care.
There have been 2 Clostridium difficile infections reported on Friends ward at The Whitstable and Tankerton Hospital, one in January and one in February. A full Root Cause Analysis (RCA) of each case was undertaken, and a 'period of increased incidence' meeting held with Kent Community Health NHS Foundation Trust (KCHFT) staff and the clinical commissioning group (CCG) – prior to obtaining results of the ribotyping. At these meetings it was identified that in both cases the most likely cause of the infection was antimicrobials given for sepsis in the acute organisations.

The ribotypes were reported to match on 6 March, suggestive of cross infection. Further investigations (known as MLVA's) are currently occurring whilst awaiting the final definitive testing to identify if it is definitely cross infection (which can take a further 10 weeks). A Serious Incident (SI) has been declared.

Clostridium difficile cross infection – Trust Action plan.

Trust-wide, the Clostridium difficile action plan has been completed, with one outstanding area relating to cleaning performance on wards at Queen Victoria Memorial Hospital, Herne Bay (QVMH) and Faversham ,which have not consistently achieved the national cleaning standard target. The Head of Facilities continues to address some of the issues. However, recruitment and retention continue to be a problem.

3. MRSA

There was one MRSA bacteraemia case in November investigated where KCHFT staff provided care. The case was not attributed to KCHFT. In the investigation it was documented nursing care of the patient's wounds were excellent, and had healed chronic wounds well, but a system for checking results of wound swabs was required. This has now been addressed.

During this timeframe compliance with MRSA screening in both inpatient units and Podiatric surgery was 100% except in December, where an in-patient's screen was missed in Deal due to human error. Subsequent tests showed the patient to be MRSA negative, and the Infection Prevention and Control (IPC) Team have produced an aide memoir for staff, and undertaken further training in wards.

4. Gram negative bacteraemias

Between 1 October and 31 January were, 496 E-Coli bacteraemias in Kent, 51 of which had input from KCHFT staff, 51 pseudomonas bacteraemias, 11 of which had KCHFT input, and 119 Klebsiella bacteraemias, 16 of which had KCHFT input.
Over the course of the year so far, it appears in Kent there has been a very slight decrease in reported E-coli cases, no change in pseudomonas, and a slight increase in Klebsiella cases. However, it is notable that number of cases where KCHFT staff have provided care has decreased across all reports.

5. Cleaning

The IPC Team continues to work alongside the Facilities teams, as Heron Ward at QVMH, and Faversham continue to struggle to achieve consistent improvements. Training and support is ongoing. However recruitment and retention remains an issue and is being addressed by the Head of Service.

6. Training

The Learning and Development Department collect and collate all training figures on behalf of the IPC Team – target - 85% compliance for all infection control training.

Trust compliance with hand hygiene training was reported as 88%, and mandatory training 95% in January, and compliance amongst clinical staff was 86% for hand hygiene, and 93% for mandatory training. However, in east Kent operations, and the Learning Disabilities services, reported compliance has fallen below this, and heads of service have been contacted by the Assistant Direction of Infection Prevention and Control for actions to address this.

7.Urinary Tract Infections (UTI's) and Catheter Associated UTI's (CAUTI's)

The target for 2017/2018 is to reduce CAUTI's by 15% and UTI's by 10%, in hospitals – translating to no more than 102 UTI's and 12 CAUTI's. Currently the Trust is 4 cases over trajectory to achieve the CAUTI target. A full campaign has been launched, initially locally within KCHFT, then roll out to the wider Kent health and social care economy. The catheter passports have been revised and the initial focus is on removing unnecessary catheters using the pseudonym: HOUDINI' – make that catheter disappear.

An ongoing plan will further target prevention of urinary tract infection through hydration and hygiene, and this is launching with the national 'TARGET campaign' and the KCHFT summer Community Health magazine.

8. Flu campaign

The Trust Staff Flu vaccination campaign has concluded, with 59% of staff receiving the vaccine – the highest percentage compliance yet. A learning event was held by the 'flu team' at the near end of this season, and plans are already being commenced for next year flu season programme.

9. Decontamination

The Assistant Director of IPC has undertaken an audit, alongside the Trust's Medical Devices Manager and Authorised Engineer for Decontamination at the central sterilisation services, and compliance was found.

10. Water safety

The Water Safety Committee continues to meet to discuss the assurances required, revise polices and protocols and identify gaps and actions where necessary.

There has been one legionella incident, where a dental practice was found to have a positive legionella reading in some outlets. All IPC measures were implemented immediately, and an assessment of potential risk to patients deemed negligible. Negative results have since been received.

11. Antimicrobial Stewardship.

The Antimicrobial Stewardship Committee continues to meet, and implement actions from the Five Year plan. The group are already planning activity and awareness raising for the forthcoming months.

12. SEPSIS

The SEPSIS algorithms and prompt cards have been fully implemented, and planning is ongoing for continued awareness and education on this subject.

13. Outbreaks

There have been 11 outbreaks in this timeframe, 6 respiratory / influenza outbreaks, 5 diarrhoea / norovirus outbreaks. In the first 2 influenza outbreaks in the West hospitals, the outbreaks were not recognised in a timely manner. The teams believed that because the GPs had reviewed the patients and commenced them on antibiotics, that the cause of their symptoms would not be infectious. These two outbreaks highlight the importance of swift recognition, and implementation of effective infection control precautions to minimise spread, as in the other outbreaks, swift recognition allowed for effective cohorting, and prevention measures to reduce spread, and reduce bed closures.

14. INFECTION PREVENTION AND CONTROL DECLARATION 2018

The 2018 Infection Prevention and Control Declaration was presented at the Quality Committee.

Lisa White
Assistant Director of Infection Prevention and Control
20 March 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	3.3
Subject:	Quarterly Patient Experience Report
Presenting Officer:	Ali Strowman, Chief Nurse

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):

- The overall Kent Community Health NHS Foundation Trust (KCHFT) Patient Experience score for Quarter 3 is a strong 97% based on over 15,000 surveys
- The Friends and Family Test (FFT) Recommend Score is 98.1% and was at its highest point in December 2017
- There were 68 complaints in Quarter 3 compared to 79 in Quarter 2
- KCHFT continues to have a lower number of complaints than other community trusts.

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.

Ali Strowman, Chief Nurse	Tel: 01622 211900
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Kent Community Health NHS Foundation Trust

QUARTERLY PATIENT EXPERIENCE REPORT

1. Introduction

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

Kent Community Health NHS Foundation Trust is committed to improving patient experience. Our key values are to ensure good care that meets our organisational values: compassion, aspirational, responsive and excellence. This report details patient and service user feedback for Quarter 3, 1 October to 31 December 2017.

Data is taken from the Meridian surveys and is reported by team/locality. Complaints are recorded following the Trust's complaints process.

2. Patient Experience

Meridian data

The Trust's overall patient experience score for quarter 3 is 96.85% based on 15,070 completed surveys. There was a small decrease in survey returns compared with quarter 2 (15,435 surveys) where the satisfaction score was 96.86%.

Friends & Family Test

The Trust's NHS Friends and Family Test (FFT) score demonstrates an extremely positive recommend rate of 96.46% over the quarter, which is just under a 1% decrease compared with the last quarter (97.36%).

14,408 people answered the FFT question, with a minority of 94 patients being unlikely or extremely unlikely to recommend the service they used. The table below compares the first 3 quarters of 2017/18.

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q1 2017/18	97.66%	0.56%	16,824	13,887	2,544	193	46	49	105
Q2 2017/18	97.36%	0.68%	14,463	11,937	2144	178	41	57	106
Q3 2017/18	96.46%	0.65%	14408	11627	2271	280	43	51	136

FFT Recommend Score

The FFT Recommend Score was at its highest point in December this year.

The FFT score findings demonstrate high levels of satisfaction within the services. All surveys which receive an unlikely or extremely unlikely response to the FFT question are recorded are included in reporting and teams take action and make improvement in response to negative feedback, whenever possible.

Examples of negative feedback and actions taken in relation to the Friends and Family Test question

Service	Comments made by client/patient and action taken by service
Dental Service, Aylesham	Feedback was received from a parent who had arrived at the clinic for son's appointment only to find out that it had been cancelled and the letter sent by the service had not been received in time. **Action taken**: A new process has been implemented to try and minimise the risk of cancelling patient appointments within 48 to 72 hours who cannot be contacted by phone. Instead of letters being sent by clinics via the internal mail to Capital House for posting, copies will be sent by email for staff at Capital House to print and post. Urgent cancellation letters will be sent by 1st class post.
Podiatry Service, Folkestone	A patient was unhappy that after attending a Podiatry Group Nail Surgery Assessment there was no order in which patients were called in to be seen. **Action taken:** The feedback was discussed with the team leader of Folkestone clinic. In future the team will to print a list of attendees, documenting who has arrived and the order in which they arrived so patients can be seen accordingly.
Community Chronic Pain - Thanet	Patient did not receive an appointment reminder message as promised or even a letter and felt that that staff member was rude and judgemental on the phone. Patient advised that it is known that their medication gives them a bad memory and feels there is still no help. The patient also contacted the Customer Care Team identifying herself and raising the same issues. **Action taken:** The service made contact with the patient to discuss her concerns. The patient was given an apology and urgent medication issues dealt with. The member of staff involved in the telephone conversation was also spoken to by the Deputy Head of Service.

Competencies

Patient experience is measured across seven key areas and the overall scores are very positive. There were four services which have scores just below 90% as follows:

- Ashford; coordinated care (88%)
- Palliative Care, given necessary information (86%), involved in decision's or treatment (88%), listened to (88%)

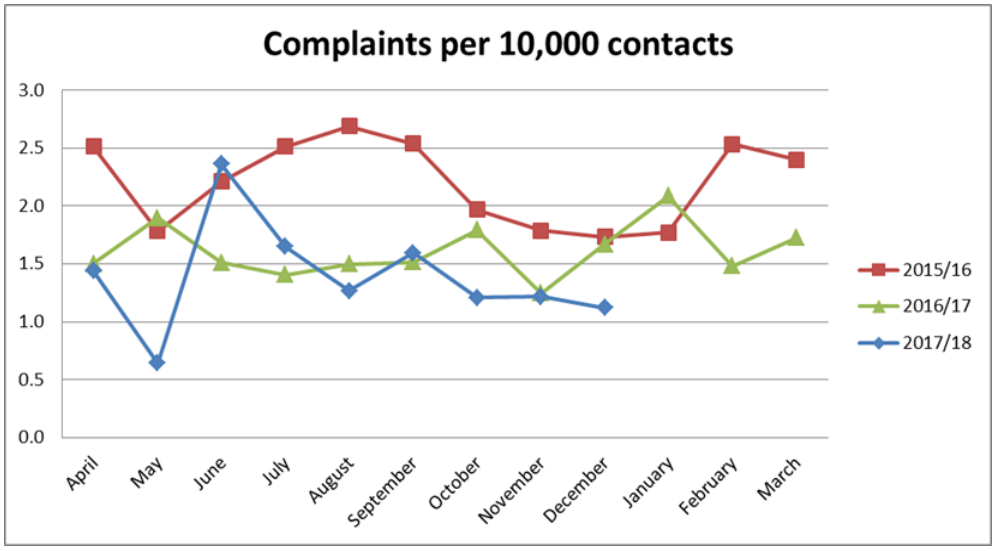
Locality	Returns	Communi-cation	Co-ordinated Care	Equality and Diversity	Given necessary info	Involved in decisions about care and treatment	Listened to and worries taken seriously	Staff Attitude
Trust Total	**8472**	**97.87%**	**94.00%**	**99.44%**	**97.80%**	**98.25%**	**99.16%**	**99.33%**

Palliative Care Surveys

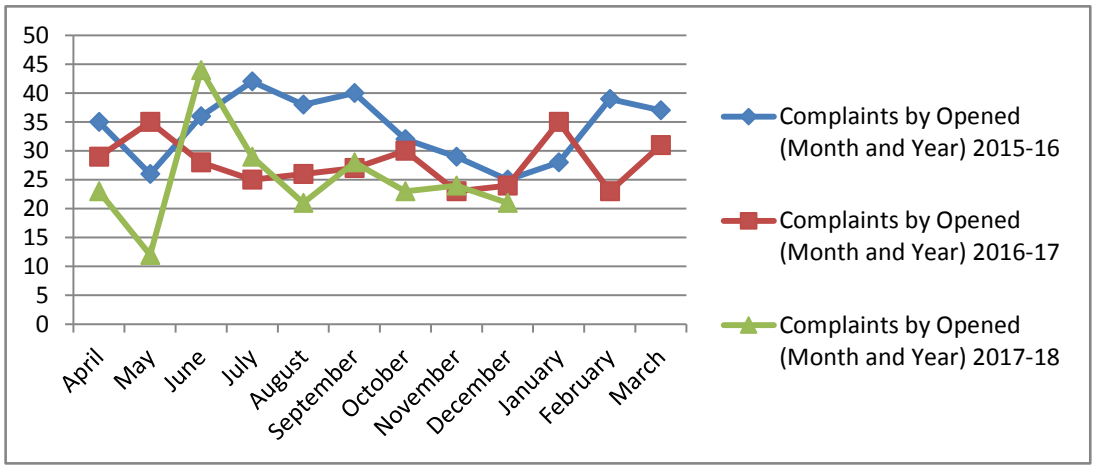
The Trust has a Quality Goal to increase survey returns from patients, families and their carers receiving palliative care. Q3 saw a return of 16 surveys which is an improvement on Q2 which returned 6. The results of these surveys will be reported to the End of Life Steering Group for discussion and to identify areas for improvement. The Patient Experience Team is actively working with Community Nurses to help them increase their feedback.

3. Complaints

During Quarter 3, 7,675 people answered the survey question ***'If you recently raised a concern or complaint directly with this service, do you feel it was responded to and* acted *upon?'*** The Trust wide satisfaction score was **93.52%.**
The graph below reflects the number of complaints per 10,000 contacts up to the end of December 2017. There have been 68 complaints in Q3 compared to 79 in Q2 this year. 226 complaints were received in the first 3 quarters of 2017 in comparison with 248 in 2016 showing a downward trajectory.



These results demonstrate that numbers year on year for Q3 have reduced slightly as there were 76 complaints in Q3 last year.



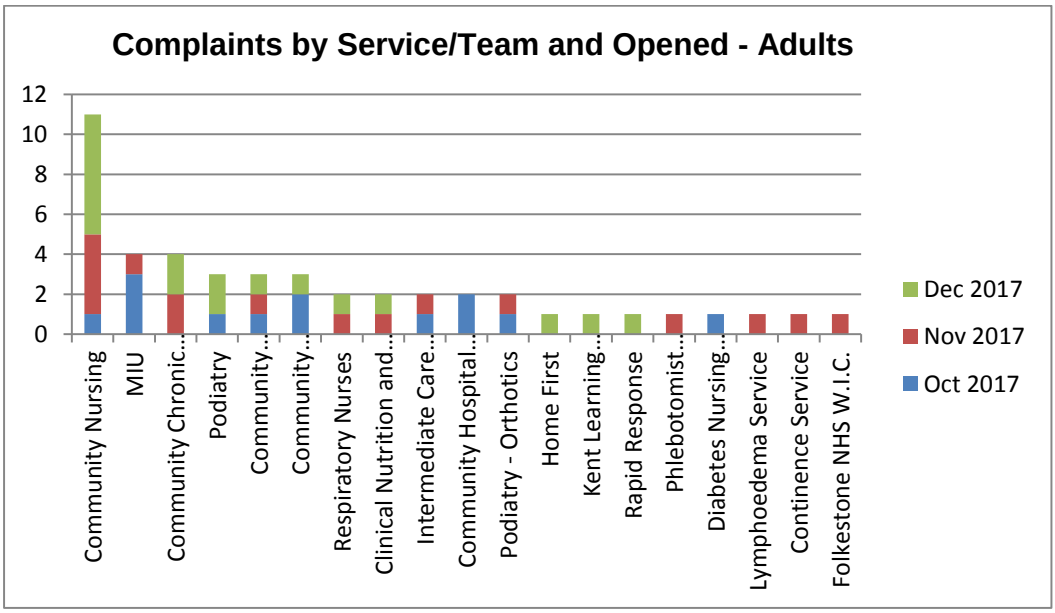
Benchmarking against other providers

KCHFT has benchmarked with other community trusts via the Benchmarking Network and have a favourably low number of complaints than others. This data reflects the information shared by Healthwatch who have confirmed that they receive very few negative comments about the Trust.

Complaints across services

The number of Q3 complaints by service is set out in the chart below. Community Nursing services continue to receive the highest number as would be expected as they have the highest number of patient contacts.

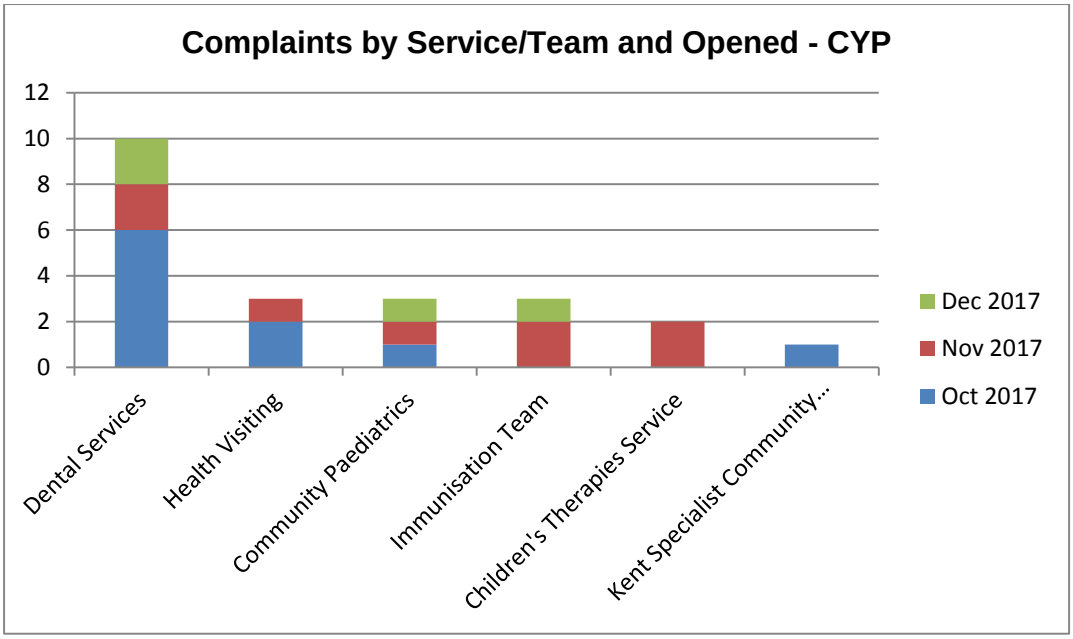
Complaints in Adults services



Complaints in CYP and Dental Services

The Dental Service has seen an increase of 50% in numbers of complaints received from Quarter 2 to Quarter 3. There has, however, been a reduction from 6 in October to 2 in November and a further 2 in December. The rise in complaints is mainly due to operating a newly commissioned service in London and patients have made complaints due to changes in access criteria. There are particular issues caused by the fact that patient transport is no longer being provided. The service is currently looking at re-introducing transport for patients following very strict criteria.

Health visiting has seen a reduction in the number of complaints since the last quarter from 6 in Quarter 2 to 3 in Quarter 3. There has also been a decrease in Kent Specialist Children's Community Nursing complaints from 3 in Quarter 2 to 1 in Quarter 3.



Themes and details

Please note that the descriptions of the complaints received are mainly as described in the complainants' words.

Clinical Treatment

During the quarter there were 16 complaints that fell into this category, a significant decrease from Q2 (28). There were 14 for adult services and 2 for children's services.
Examples:

- Lack of physiotherapy in care home in 2015 – no notes for when patient in care home, advised can provide information on other periods of care – no response from complainant.
- Unhappy that staff did not follow protocol after child's fall in school – fully investigated and ADHD appointment held.
- Patient given flu vaccine with no consent – currently being investigated as an SI
- Lack of podiatry diagnosis – patient has now been seen and accepted apology

Admissions, discharges and transfers

During the quarter there were 0 complaints in this category, there were 8 in the Quarter 3.

Access to treatment and medication

During the quarter there were 16 complaints that fell into this category which was the same for Quarter 2 (10 for adult services, 4 for children's services and 2 for Dental). Examples:

- Unhappy with delays in receiving insoles
- Unhappy that patient is not receiving continuing health care and believes it is the nurse's fault
- Unhappy that had not received portable suction machine
- Request for information on dietetic care provided at QEQM
- Patient given impression they were too old to get support from service

Values and behaviours

During Quarter 3 there were 12 complaints that fell into this category (10 in adult services and 2 in Dental); this is an increase on Quarter 2(9).
Examples:

- Unhappy with diabetic nurse's attitude and plan implemented – agreed to provide more support in future and apology made
- Felt that staff member did not listen and was dismissive – patient arrived at MIU near closing time – service rang to apologise.
- Unhappy about being sent a warning letter and attitude of reception staff
- Staff lost patient's dentures – service arranged for new dentures to be made and paid

Communication

During the quarter there were 14 complaints that fell into this category (10 in adult services, 4 in children's services). This is a decrease from 18 in Q2.
Examples:

- The lack of night cover on Rapid Response Team
- 2 x difficulty with contacting services
- Lack of communication about home visits, catheter care and warning letter
- Unhappy with comments seen on draft minutes of professionals' meeting
- Patient turned up for appointment and it had been cancelled

Ombudsman Cases

There are currently no complaint cases with the Ombudsman.

Complaints Responses

During Q3 the Trust responded to 84% of all complaints within the timescale initially agreed. 11 complaints did not meet the deadline, 6 were less than a week late, 2 less than 10 days late, 1 less than 20 days late and 2 over 20 days late. Reasons were delays in receiving the draft (5), delays in approval process (5) and 1 delay due to process unclear with other organisation compiling a joint response. Responses within agreed timescales will continued to be monitored. Improvements have been introduced which include a clear template detailing timescales to those involved in

the investigation and approval process and escalation to Line Manager's for delayed drafts from the Investigating Manager. Complaints are to be acknowledged within 3 workings days. In Q3 95.6% of complaints met this target. 3 out of 68 complaints were not acknowledged in the agreed time period. 2 due to lack of contact with service to advise whether this had been done/not done quickly enough and 1 query on service involved so delay in sending.

Complaints Process Feedback

In Quarter 3 there were 7 responses to the Trust's survey sent to complainants. This is a small decrease on the 8 surveys received in Q2. 4 complainants would have liked more contact with their complaints officer and 4 were not satisfied with the outcome of their complaint investigation as outlined in the response they received.

One complainant had given feedback that the summary of her complaint had never been shared with her for accuracy and therefore she wasn't completely aware of the points that the investigating service had been asked to look into. In future the complaints officers are to ask complainants if they wished to see a written summary of the information given verbally. The acknowledgement letter has been updated to include a question about the complainants preferred method of communication, a summary of the scope of the investigation, advice about being updated with timescales, direction to the Customer Care Policy and the opening hours of the Patient Experience office. Complainants will also be advised that they will be asked for feedback on the complaints process once the complaint is resolved.

The Complaints survey questions are under review and are being taken to the January meeting of the Patient Experience Group for feedback.

4. The Customer Care Team (PALS)

Key themes from PALS feedback:

- Improvements in the delivery of the Podiatry Service have resulted in fewer patients contacting the Customer Care Team due to being unable to get through to make an appointment. The survey question *'Were you happy with the way your appointment was arranged?'* has increased from 90.4% of respondents answering positively in November to 97.28% in December.

- Calls are being made to PALS from patients thinking they are contacting services direct. This is due to misleading information on service appointment letters. These templates have now been amended by the Communications Team to try and prevent future problems and numbers of calls have decreased.

5. Compliments

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

Directorate	Written Compliments	Verbal Compliments	Total
Adults	109	45	154
Adults – Health Improvement &	14	28	42

Self-Management			
Children and Young People	32	19	51
CYP- Dental	-	1	1
CYP – Sexual Health	-	35	35
Other Directorate	-	-	
TOTAL	**155**	**128**	**283**

Selection of compliments recorded by the PALS team

- Very reassuring to know this service is available. Gave a great deal of confidence that the required treatment both medically and personally is available and carried out with efficiency and understanding of how I felt at the time. The service & attention to detail I received today were 1st class. There was a very good balance between my medical needs and my emotional/personal needs (Heart Failure Nursing, Canterbury)
- Thank you for keeping me 'fit' and on the road to recover! You'll never know how your devotion and happy outlook benefits your patients and raises spirits when it's so easy to feel down and despondent as a long term patient. I'll miss you when I'm better!" (Adults LTS – Wound Medicine Centre QVMH).
- We were unaware of the existence of this marvellous place and the excellent service it provides. We are most grateful for the high standards of therapeutic and nursing care that my husband has experienced here. It has enabled him to walk with confidence again following his hip operation, while his other medical needs have received your attentive and careful nursing (ICT Westbrook)
- Came to you after having my left femur fixed following a fall at home. My confidence was rock bottom. The whole team helped me regain my health & confidence. They all treated me with respect and kindness but firmness. Two of the team went more than the extra mile and deserve gold stars (ICT Westbrook)
- Fantastic service, Non-judgmental staff, I am losing weight and I am very pleased with the results. I feel empowered and very motivated to lose more. I also recommended this service to my friends and family. (Health Improvement - Fresh Start)
- Thank you for wonderful treatment. Caring efficient good humoured team. All 1st class - excellent service - should be very proud (Podiatric Surgery – QVMH)

6. NHS Choices

There were **27** comments on NHS Choices during the quarter. A selection of these is listed below. Services have been alerted to negative comments and taking action as appropriate.

Service	Review	KCHFT response

Minor Injury Unit, QVMH, Herne Bay	Lovely staff in Urgent Care Centre I popped into the Queen Vic today following surgery to have my wounds checked and dressings changed. The staff were lovely, friendly, reassuring and professional. I just would like to say thank you and keep up the excellent work on the NHS.	Many thanks for your review about the care you received from the staff in Queen Victoria Memorial Hospital. We will pass on your kind comments and gratitude to the team there.
Podiatry Service, QVMH, Herne Bay	Unable to contact anyone I telephoned the central number to enquire about shoe insoles. The recorded announcement said 'do NOT leave more than one message'. That was a month ago and I have never received a reply from them.	We are very sorry that you have not received a call back from the Podiatry service re. shoe insoles. We would be grateful if you could try and contact them again. The details are as follows: Tel: 0300 123 6756 Monday to Friday, 8.30am to 4.30pm. Press 2 for clinics in Canterbury, Faversham, Herne Bay, Whitstable and Thanet Email: kcht.podiatrycc@nhs.net If you still have difficulty please don't hesitate to call the Customer Care Team with your contact details and they will forward these to the Podiatry Service on your behalf.
Minor Injury Unit, Sevenoaks Hospital	Treatment of foot injury I was seen in the Sevenoaks and MIU politely efficiently and with great care on visiting recently. I was seen an x-ray was taken and I was on my way home within 3/4 of an hour. Everyone was very caring and particularly (staff name). Many grateful thanks.	Many thanks for your review about your positive experience at Sevenoaks Minor Injuries Unit recently. It is good to know you were seen quickly and given all the care and treatment you needed for your foot injury by polite and efficient staff. We will pass on your kind comments to the team there.

7. Improvements/Innovations

Meridian Survey Questions

A project plan is being drawn up to update the current Meridian patient experience surveys. Core questions will be amended or added to align questions to the 5 key CQC domains and the Key Lines of Enquiry (KLOEs). This will create more measurable outcomes and richer data in line with the domains of safe, effective, caring, responsive and well led. The questions to be asked will be submitted to the Quality Committee and to the Patient Experience Group for comment and approval before being implemented.

Complaints Handling Training

The Patient Experience team has designed e-learning training for all staff that describes exactly what to do if approached by someone raising a concern and/or wishing to make a complaint. This training is now live on ATP and the results of the quiz at the end of the training are to be recorded by Learning & Development. Staff are expected to have undertaken this training before attending the half day face to face training designed for team leaders and managers.

Complaints Process/Handling

The team undertook a self-assessment exercise against the required standards for CQC. They identified gaps in assurance and areas for improvement and an improvement plan has been written with the following objectives:

- There is an active review of complaints, management and responses.
- People who use the services are involved in the review.
- It is easy for people to complain or raise a concern and they are treated compassionately when they do so. All staff know how to support people to raise a concern or make a complaint.
- Staff who are involved in handling complaints and working with complainants have the relevant training to enable them to investigate effectively.

The plan has contains SMART actions and will be measured and monitored through the monthly Patient Experience Team meetings and reported to the Senior Nursing & Quality Meeting.

8 Key Quality Improvements

Phlebotomy QVMH

The Phlebotomy service at QVMH is now ready to start receiving patient feedback. Their survey has been built; they have an iPad ready to be wall mounted; paper copies of the survey and 'How Did We Do Today?' cards to give to patients to direct them to the feedback page on the public website.

Community Nurses

A family member complained that the patient had not received a visit by the Dover/Deal Team following an urgent referral from the GP. The process was reviewed and as result all telephone referrals will now be processed by the Local Referral Unit and followed up with notes being added to CIS to avoid any miscommunications.

Podiatry

Improvements in the delivery of the Podiatry Service has resulted in less patients contacting the Customer Care Team due to being unable to get through to make an appointment. The survey question 'Were you happy with the way your appointment was arranged?' has increased from 90.4% of respondents answering positively in November to 97.28% in December. IT connectivity affects the entire QVMH site and the Podiatry team are now using MI-FI and dongles to improve access for patients. Tthis has had a considerable affect in relation to speed and call bookings.

9 Recommendations

The Board is asked to note the report.

Sue Mitchell
Head of Patient Experience and Complaints
January 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 March 2018
Agenda Item:	3.4
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 and effective approach to Risk Management across the organisation by embedding it into the Trust's processes and practices.

Changes to the document are as follows:

- Change from a Strategy to a Policy and Strategy
- Insertion of new risk management model
- Inclusion of new trust training on risk and incident management
- Updated definition of tolerated risk
- Update to governance group responsibilities
- Updated risk categories
- Update of related Policies/Procedures
- Updated monitoring of risk and incident compliance

Proposals and /or Recommendations

Following the full review of the Risk Management Strategy, it is proposed that the new Risk Management Strategy is noted.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed? Yes

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Kent Community Health
NHS Foundation Trust

Risk Management Policy and Strategy

Document Reference No.	CQS017
Status	Draft
Version Number	Version 3.7
Replacing/Superseded policy or documents	Risk Management Policy Version 3.7
Number of Pages	23
Target audience/applicable to	All staff
Author	Head of Risk
Acknowledgements	Assistant Director of Compliance, Corporate Services Director
Contact Point for Queries	Head of Risk
Date Ratified	
Date of Implementation/distribution	
Circulation	Policy dissemination / Flo
Review date	February 2020
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EXECUTIVE SUMMARY

This Policy and 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 policy and 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 policy and Strategy also sets out a longer term plan to further integrate risk management within the culture of the organisation. The policy and Strategy will be reviewed at least two yearly, and more frequently if required.

Governance Arrangements

Governance Group responsible for developing document	Corporate Assurance and Risk Management Group - CARM
Circulation group	FLO, Policy Distribution
Authorised/Ratified by Governance Group/Board Committee	Audit and Risk Committee
Authorised/Ratified On	
Review Date	February 2020
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
Managing Violence and Aggression Policy	HS018
Standard Infection Control Precautions Policy	IPC010
Education and Workforce Development Policy	HR016
Privacy and Dignity Policy	QC001
Accessible Information Policy	IML006
Learning from Experience Policy	IML005

Document Tracking Sheet

Version	Status	Date	Issued to/approved by	Comments / summary of changes
3.7	Draft	01/2018		Change from a Strategy to a Policy and Strategy Amendments including insertion of training, definition of tolerated risk, update to governance group responsibilities and risk categories.
3.6	Approved	25/02/2016	Board	Minor amendments to the strategy
3.5	Approved subject to amendment as noted in 3.5	15/02/2017	Audit and Risk Committee	Updated wording of strategic goals

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 policy and 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 policy and Strategy aims to do that and is therefore based on current best practice in the field of risk management.

1.8 Who this Policy and Strategy applies to

1.8.1 This policy and 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 policy and 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 Policy and 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 has identified four key areas:

(1) Building high performing local integrated teams, with GPs and based around groups of General Practices

(2) Dedicating time, resources, expertise and leadership to fully implement the 'Home First' service model across Kent.

(3) Ensuring that patients and clinicians have access to high quality specialist community services.

(4) Making a step change impact in prevention and health promotion in Kent.

1.9.3 This policy and 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 policy and 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 policy and 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 Policy and Strategy defines the Strategic Goals which guide decisions on the organisation's future and help to prioritise competing requirements. This policy and 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 Trusts 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 policy and 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 Policy and 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
- Learning From Experience 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 and Strategy 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 Operating Officer, 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 and managed effectively within their service.
- Reviewing all high and medium level risks regularly 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 and managed effectively 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.
- Where needed, meet with the risk team to review and update risks.
- Consulting the relevant subject matter expert when determining controls and producing an action plan to reduce the risk further.

- The management of all low and medium 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.
- Receive training to support the implementation of risk management

2.8 All employees

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

- Familiarise themselves with this policy and 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 Policy and Strategy

- Defines the organisation's overall risk appetite.
- Receives sufficient assurance that the Risk Management Policy and 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 Trust and for providing assurance to the Board that the model 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 Policy and 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 Patient Safety and Clinical Risk Group

The Patient Safety and Clinical Risk Group review all high rated clinical risks and there movement. Additionally the group identifies themes and trends throughout clinical services. Areas of concern are escalated to the Executive Team as appropriate.

2.16 Operational Directorates' Quality Groups

2.16.1 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 Trusts 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.

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 flo 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 flo 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 (or delegated responsible person) 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 through the bi monthly risk meetings with services/directorates.

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 and analysis. 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 flo 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 policy and Strategy is ensuring that all staff are aware of what this policy and 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 policy and Strategy, and all high graded risks are reviewed and updated as appropriate. Where the need is identified, additional training sessions are arranged.

5.4 Risk Management awareness training sessions are delivered by the Risk Management Team by contacting directly.

5.5 Online ‘How 2’ Training is available through flo.

6.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY AND STRATEGY

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 policy and 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 PSCRG Internal Audit	Six monthly Quarterly Monthly Annually
Manager's knowledge of this policy and Strategy 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 and Strategy.

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
PSCRG	Patient Safety and Clinical Risk 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:	29 March 2018
Agenda Item:	3.5
Subject:	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 2017 to March 2018.

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 2017 to March 2018.

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@nhs.net

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 2017 to March 2018.

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 2017 to March 2018 (inclusive).

Gina Baines
Assistant Trust Secretary
20 March 2018

Kent Community Health NHS Foundation Trust

The Register of the Kent Community Health NHS Trust Foundation Seal 2017/18

No	Date of Sealing	No of copies sealed	Description of Document	Parties	Relating to	Names of persons attesting sealing	How document disposed of
Lease	05.04.2017	1	ULPA Underlease	Community Health Partnerships Ltd Kent Community Health NHS Foundation Trust	Barking and Havering NHS Lift Part of South Hornchurch Health Centre, 106 South End Road Rainham RM13 7XJ	Paul Bentley, Chief Executive Louise Norris, Director of Workforce, Orgnanisational Development and Communications	Mr N Battrick Bevan Brittan Kings Orchard 1 Queen Street Bristol BS2 0HQ
Lease	06.04.2017	1	ULPA Underlease	Community Health Partnerships Ltd Kent Community Health NHS Foundation Trust	Redbridge and Waltham Forest NHS Lift Part of Hainault Health Centre, Manford Way Chigwell IG7 4DF	Lesley Strong, Deputy Chief Executive Louise Norris, Director of Workforce, Organisational Development and Communications	Mr N Battrick Bevan Brittan Kings Orchard 1 Queen Street Bristol BS2 0HQ
Lease	28.02.2018	1	Lease	Brisbane House Ltd and Kent Community Health NHS Foundation Trust	Part Third Floor Mill Lane Wing Mill Lane House Mill Lane Margate	Gordon Flack, Director of Finance	Fran Bassil, KCHFT Legal Services Department Trinity House 110 -120 Upper Pemberton Eureka Park Ashford Kent TN25 4AZ

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 29 March 2018
The Oak Room, Oakwood House, Maidstone Kent
ME16 8AE

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 25 January 2018	Chairman	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 25 January 2018	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 Patient Story	Chief Nurse	
2.2	To receive the Quality Committee Chair's Assurance Report • Annual Infection Prevention and Control Declaration	Chair of Quality Committee	

2.3	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee
2.4	To receive the Charitable Funds Committee Chair's Assurance Report	Deputy Chair of Charitable Funds Committee
2.5	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee
2.6	To receive the Workforce Report	Director of Workforce, Organisational Development and Communications
2.7	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive Chief Nurse
2.8	To receive the Monthly Quality Report	Chief Nurse
2.9	To receive the Finance Report Month Eleven	Director of Finance
2.10	To approve the 2018/19 Finance Plan • Final Revenue and Capital Budgets 2018/19 • Capital Plan 2018/19	Director of Finance
2.11	To approve the Standing Financial Instructions	Director of Finance
3.	**REPORTS TO THE BOARD**	
3.1	To receive the approved Minutes of the Charitable Funds Committee meeting of 25 October 2017	Deputy Chair of the Charitable Funds Committee
3.2	To receive the Quarterly Infection Prevention and Control Report	Chief Nurse
3.3	To receive the Quarterly Patient Experience Report	Chief Nurse

Kent Community Health NHS Foundation Trust

3.4	To receive the Risk Management Strategy	Corporate Services Director
3.5	To receive the Use Of The 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 24 May 2018
Tonbridge and Malling Council Offices, Gibson Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ